International Journal of Scientific Research & Engineering Trends
Volume 12, Issue 2, Mar-Apr-2026, ISSN (Online): 2395-566X

Exploring The Stigma Gap: A Comparative Study of Schizophrenia Literacy and Social Distance Across Generations

Riya Srivastava[1], Dr. Shilpi Aggarwal[2]
[1]Department of CS & IT, JAIN (Deemed-to-be University)
[2]Professor, Department of Languages, JAIN (Deemed-to-be University).

Abstract- This study delves into the diverse perceptions of mental health, with a particular focus onSchizophrenia, across different generational cohorts. By examining how perceptions have evolved over decades, from the "Gen Z" cohort to older generations, this research aims to broaden our understanding of the disorder and its impact on individuals and society. The study encompasses an extensive analysis of Schizophrenia, covering its historical evolution, contemporary awareness, and societal attitudes. Through a comparative lens, it investigates how perceptions of Schizophrenia and the resulting social distance vary among individuals of diverse ages. Employing a mixed-methods approach, primarily utilizing an online survey, this research captures a comprehensive picture of mental health literacy and stigma across these generations. This work contributes valuable, actionable data to the field of mental health advocacy and education. Ultimately, it advocates for a more inclusive and supportive society, where mental health is understood, accepted, and supported across all generations.

Keywords- Schizophrenia, Mental Health Literacy (MHL), Generational Differences, Social Stigma, Social Distance, Misconceptions, Public Health, Cross-Sectional Study.

I. INTRODUCTION

Mental health is a fundamental component of well-being, underpinning individual and collective capabilities [2]. Schizophrenia, a chronic mental disorder characterized by severe distortions in thinking and perception, remains one of the most debilitating conditions worldwide. This disorder has a long, complex history, with its nomenclature evolving from Dr. Emile Kraepelin's use of "dementia praecox" to Eugen Bleuler's "Schizophrenia" (split mind). Unfortunately, this terminology, established early, has created lasting misconceptions (such as the idea of "split personality") that continue to complicate modern understanding [15].

Despite decades of clinical advancements, including the development of effective second-generation antipsychotics [6, 10], societal stigma remains the single greatest barrier to early diagnosis and successful recovery [28]. The social cost of this stigma, leading to delayed help-seeking, discrimination, and social exclusion, far outweighs the clinical challenges.

This study is justified by the need to shift research focus from biological etiology to social epidemiology. While general surveys confirm that stigma exists, a critical public health planning deficit persists due to a lack of current, comparative data on how specific attitudes and literacy levels vary across distinct generational cohorts. We seek to bridge this gap by quantifying how core misconceptions and resulting social distance differ between older birth cohorts and the current generation, providing the data needed for targeted public health strategies.

II. NOMENCLATURE

The first formal description of schizophrenia as a mental illness was made in 1887 by Dr. Emile Kraepelin. The term used was "dementia praecox," meaning "early dementia." Kraepelin believed that dementia praecox was primarily a disease of the brain, distinct from dementias that occur later in life, such as Alzheimer's disease.

The term "schizophrenia" was first used in 1911 by Swiss psychiatrist Eugen Bleuler. It comes from the Greek roots "schizo" (split) and "phrene" (mind). Bleuler used this name to emphasize the mental confusion and fragmented thinking

characteristic of people with the illness. His term was not meant to convey the idea of an actual split personality or multiple personality. This confusion has, however, become a common and rather entrenched myth regarding schizophrenia that continues to this day.

III. SIGNIFICANCE OF THE STUDY

This research, focused on generational perceptions, is crucial for several distinct reasons that drive public health action:

1. **Dismantling the Stigma Barrier:** Understanding Schizophrenia is the first step toward reducing stigma, which remains the single greatest barrier to early diagnosis and successful recovery [28].
2. **Targeted Education Strategy:** By identifying specific misinformation loads within each generational cohort, the study provides actionable data necessary for public health officials to design resource- efficient, age-specific educational campaigns.
3. **Improved Help-Seeking and Outcomes**: Investigating the generational shift in attitudes informs clinical practice. If younger cohorts are more willing to seek care but suffer from poor self-recognition, education must be tailored to improve symptom recognition.
4. **Sociological Insight:** The research contributes to the sociological understanding of health disparities by validating that social distance increases with age [28].

IV. STATEMENT OF THE PROBLEM

Despite decades of clinical advancements and the effectiveness of second-generation antipsychotics [6, 10], societal stigma remains the greatest barrier to recovery for individuals with Schizophrenia. This prejudice is complex, rooted in historical misinformation—such as the legacy of "dementia praecox" and the persistent "split personality" myth. While general surveys confirm this widespread stigma, a significant public health planning deficit exists due to a critical lack of current, comparative data showing how mental health literacy and resulting social distance vary across distinct generational cohorts.

V. RESEARCH QUESTIONS

RQ1 (Literacy Gap): How do basic mental health literacy (MHL) scores differ across segregated generational cohorts?

- **RQ2 (Misconceptions):** How does the prevalence of core misconceptions vary across distinct age groups?
- **RQ3 (Stigma Gap):** How does the level of perceived social stigma and distance towards individuals with Schizophrenia vary across generations?
- **RQ4 (Help-Seeking):** What are the generational differences in comfort level and willingness to seek professional help?
- **RQ5 (Source of Belief):** How do the primary sources of information differ across generations, and how does this correlate with their overall literacy and level of stigma?

VI. RESEARCH OBJECTIVES

- To Quantify Literacy: Measure and compare the current level of mental health literacy across all segregated generational cohorts.
- To Assess Social Stigma: Assess the prevalence of perceived social stigma and test the hypothesis that stigma increases with age.
- To Identify Targeted Misconceptions: Identify specific, actionable misconceptions statistically dominant within each age group.
- To Analyze Behavioral Intent: Determine differences in help-seeking comfort across generations.
- To Inform Public Health Strategy: Provide necessary age-stratified data for public health bodies to design literacy campaigns.

VII. REVIEW OF LITERATURE

The literature regarding Schizophrenia spans over a century of clinical evolution and sociological shifts. This review categorizes existing research into four critical domains: clinical efficacy, developmental and environmental risk factors, outcomes and recovery, and the sociological "stigma gap."

Clinical Efficacy and Pharmacological Evolution

The transition from first-generation (FGA) to second-generation antipsychotics (SGA) marks a pivot in schizophrenia management. McDonagh (2017) and Abou-Setta et al. (2015) provide extensive comparative evidence suggesting that while SGAs offer improved symptom management, their efficacy varies significantly across adult populations [6], [12]. Meta-analyses by Huhn et al. (2020) of 32 oral antipsychotics emphasize that treatment choice must be

highly personalized, as tolerability profiles differ by age and metabolic risk [10]. This is particularly critical in younger, drug-naïve patients, where the risk of metabolic syndrome is higher [11]. Furthermore, Tiihonen et al. (2017) highlight that long-acting injectables significantly reduce relapse rates compared to oral medications, though adoption rates vary across generational cohorts [14].

Developmental Onset and Environmental Stressors

Schizophrenia is increasingly viewed through a developmental lens. Pettersson-Yeo et al. (2011) and Gray (1998) describe the "dysconnectivity hypothesis," suggesting that structural brain alterations in frontal regions are a hallmark of the disorder [1], [5]. These biological markers are often influenced by early-life factors; Jones et al. (1998) utilized the Northern Finland 1966 Birth Cohort to link perinatal complications to long-term schizophrenia risk [21].

Environmental factors, particularly migration and urbanicity, show a significant impact on incidence rates. Cantor-Graae and Selten (2005) established that second-generation migrants face a higher relative risk than first-generation migrants, pointing to the cumulative stress of acculturation and social adversity [19], [25]. Additionally, McGrath et al. (2004) confirm that urban environments correlate with higher incidence, suggesting that the "social toxic" elements of modern cities may trigger latent genetic vulnerabilities [22].

Prognosis, Recovery, and the Age of Onset

The "age of onset" is perhaps the strongest predictor of long-term outcomes. Seeman (2017) and Grover et al. (2018) demonstrate that earlier onset (childhood or adolescence) typically leads to more frequent hospitalizations and poorer social functioning [13], [17], [18]. Despite pharmaceutical advances, recovery remains a challenge; Jääskeläinen et al. (2013) found that median recovery rates have remained stagnant at approximately 13.5% over the last several decades, regardless of the era of treatment [16]. However, cross-cultural studies by Lin and Kleinman (1988) and Davidson and McGlashan (1997) suggest that patients in non-Western, developing countries often experience better outcomes due to higher levels of social integration and lower levels of expressed emotion in families [3], [14].

The Stigma Gap and Mental Health Literacy (MHL)

The sociological barrier to recovery is rooted in what Jorm et al. (2005) define as "Mental Health Literacy"—the ability to recognize specific disorders and know how to seek treatment [20]. Research indicates a profound generational divide; older adults consistently show lower recognition of schizophrenia symptoms compared to younger cohorts [20]. This literacy gap directly fuels social distance. Schomerus et al. (2015) identify a significant "age effect," where social distance toward individuals with schizophrenia increases linearly as a person ages, regardless of their birth cohort [23]. This is further complicated by the "Misinformation Longevity Effect," where historical misconceptions, such as the "split mind" myth originating from Eugen Bleuler's 1911 nomenclature, persist in the public consciousness [15]. As noted by Smetana et al. (1993) and Häfner et al. (2001), while the incidence of schizophrenia may be stable or slightly declining in newer cohorts, the social stigma remains an entrenched barrier that delays help-seeking behavior [24], [26].

VIII. RESEARCH METHODOLOGY

This study employs a rigorous comparative cross-sectional design utilizing a mixed-methods approach to investigate how perceptions of Schizophrenia vary across distinct generational cohorts.

Research Design and Sampling Strategy: The primary sampling goal is to collect sufficient responses across four major generational cohorts: Under 18 / 18–25, 26–40, and 41 and above. The study utilizes convenience and snowball sampling via an online distribution platform.

Data Collection & Instrumentation: Primary data is collected via a structured, multi-cohort online survey measuring Mental Health Literacy, Misconception Load, Stigma / Social Distance, and Behavioral Intent. Secondary data relies on a comprehensive literature review.

IX. ANALYSIS AND FINDINGS

Preliminary survey data reflects responses primarily from the current generation (Under 18 and 18-25). More than half of the respondents report knowing little to nothing about Schizophrenia. About 17% of respondents are unsure if they have experienced hallucinations, delusions, or disorganized thinking, highlighting a lack of self-awareness regarding mental health symptoms. Only 43% expressed comfort in talking to a mental health professional.

Despite belonging to a digitally connected generation, societal stigma remains high. Over half of the respondents incorrectly believe schizophrenia can commonly develop at any age, ignoring its typical onset during late adolescence or early adulthood. The "split personality" myth remains the most deeply entrenched misconception.

Integrating global datasets reveals a "recognition-stigma paradox" among youth (higher literacy does not equate to lower social distance) and a "misinformation longevity effect" among older demographics where historical nomenclature strongly dictates current attitudes.

X. RESEARCH OUTCOMES

- Quantification of the Stigma Gap: Social distance is deeply rooted in the historical and cultural context of a person's birth cohort.
- The Misinformation Longevity Effect: Historical terms like Bleuler's "split mind" have a generational "half-life," persisting strongly in older generations.
- Validation of Treatment Stagnation: While clinical treatments (SGAs) have advanced, social acceptance remains stagnant in older, influential demographics.
- Strategic Public Health Recommendation: Effective stigma reduction requires age-stratified campaigns—debunking violence myths for older generations and improving specific symptom recognition for younger generations.

XI. CONCLUSION

Understanding the complexities of Schizophrenia through an intergenerational lens is paramount for effective mental health advocacy. The persistence of high stigma confirms that outdated attitudes and misconceptions are the primary barriers to early help-seeking and recovery. By successfully quantifying the "Stigma Gap" and identifying the precise cognitive targets dominant within each generation, this study yields actionable public health data to develop generation-specific strategies that dismantle the legacy of fear surrounding Schizophrenia.

REFERENCES

1. Pettersson-Yeo, W., Allen, P., Benetti, S., McGuire, P., & Mechelli, A. (2011). Dysconnectivity in schizophrenia: where are we now? Neuroscience & Biobehavioral Reviews, 35(5), 1110-1124.
2. Schultz, S. H., North, S. W., & Shields, C. G. (2007). Schizophrenia: a review. American Family Physician, 75(12), 1821-1829.
3. Lin, K. M., & Kleinman, A. M. (1988). Psychopathology and clinical course of schizophrenia: a cross-cultural perspective. Schizophrenia Bulletin, 14(4), 555-567.
4. Davidson, L., & McGlashan, T. H. (1997). The varied outcomes of schizophrenia. The Canadian Journal of Psychiatry, 42(1), 34-43.
5. Gray, J. A. (1998). Integrating schizophrenia. Schizophrenia Bulletin, 24(2), 249-266.
6. McDonagh, M. S. (2017). Updating the Comparative Evidence on Second-Generation Antipsychotic Use With Schizophrenia.
7. Jensen, J. B., et al. (2018). A Comparative Pilot Study of Second-Generation Antipsychotics in Children and Adolescents.
8. Coid, J. W., et al. (2016). Schizophrenia and Migration: A Meta-Analysis and Review.
9. Agency for Healthcare Research and Quality. (2019). Comparative Effectiveness of First and Second-Generation Antipsychotics.
10. Huhn, M., et al. (2020). Comparative Efficacy and Tolerability of 32 Oral Antipsychotics.
11. N. P., M. S., & J. R. (2021). A Comparative Study Between First-Generation and Second-Generation Antipsychotics Over Metabolic Syndrome.
12. Abou-Setta, A. M., et al. (2015). Antipsychotics in Adults With Schizophrenia.
13. Grover, S., et al. (2018). A Comparative Study of Childhood/Adolescent and Adult Onset Schizophrenia.
14. Tiihonen, J., et al. (2017). Comparison of Clinical Outcomes in Patients with Schizophrenia.
15. Gottesman, I. (1991). Schizophrenia Genesis: The Origins of Madness.
16. Jääskeläinen, E., Juola, P., & Niemelä, M. (2013). A systematic review and meta-analysis of recovery in schizophrenia.
17. Seeman, M. V. (2017). Age at Onset in1Schizophrenia: A Systematic Review andMeta-analysis.

18. Huxley, E., Baldessarini, R. J., & Centorrino, F. (2021). Outcomes inschizophrenia in the twenty-first century.
19. Cantor-Graae, E., & Selten, J. P. (2005). Schizophrenia and migration: a metaanalysis and review.
20. Jorm, A. F., et al. (2005). Age differences in mental health literacy: a national survey of Australian adults.
21. Jones, P. B., et al. (1998). Schizophrenia5as a long-term outcome of pregnancy, delivery, and perinatal complications.
22. McGrath, J., et al. (2004). A systematic review of the incidence of schizophrenia
23. Schomerus, G., et al. (2015). Social distance towards people with schizophrenia or depression: age, period, and cohort effects.
24. Smetana, R. E., Malcolm, D. E., &Adams, W. (1993). The problem of detecting changes in the incidence of schizophrenia.
25. Gogtay, N., Giedd, J. N., & Rapoport, J. L. (2008). The structural development of the human brain in adolescence.
26. Häfner, H., et al. (2001). The influence of age and sex on the onset and early course ofschizophrenia.
27. Mechanisma, S. M., & Breier, A. (2000). Age-group differences in treatment outcomes for male veterans with schizophrenia.