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Replacing fear with familiarity: Schizophrenia, stigma, and the shared work of recovery

Amelia Sim[1] *MRCPsych*, Si Min Joanna Tan[2] *MPhil (Anthropology)*, Christopher Yi Wen Chan[3] *MMed (Psychiatry)*

World Mental Health Day, observed annually on 10 October, is an opportunity to reflect on how far Singapore has come in improving public understanding of mental illness. Public recognition of common mental illnesses in Singapore increased substantially between surveys conducted in 2014–2015 and 2022–2024, from 43.7% to 59.3%, respectively.[1] Schizophrenia, however, has not shared in this progress. In this issue of the *Annals*, Cao et al. report findings from 2 nationwide cross-sectional surveys conducted from March 2014 to April 2015 and from September 2022 to February 2024. Correct recognition of schizophrenia increased from 11.5% to 15.1%, but this difference was not statistically significant, before or after adjusting for sample differences.[2] Although fewer respondents in the later survey believed that schizophrenia reflected personal weakness rather than illness, perceptions of dangerousness and the desire for social distance remained unchanged after adjustment. This contrasts with the pooled trend from the same survey, in which Subramaniam et al. found small but statistically significant declines in perceived dangerousness and social distance across all disorders studied, although social distance remained substantial.[3] Stigma towards mental illness in general may be easing, but not measurably for schizophrenia.

The study deserves credit for addressing an important gap in the Asian literature, particularly in the Singapore context. Its strengths include the use of a nationally representative sample, oversampling of minority ethnic groups, and the use of consistent survey instruments across both study periods. However, the 2 cohorts differed substantially in educational attainment: the proportion of university graduates increased from 29% to 47%, while the proportion with 6 years of schooling or less declined from 15% to 4%. Although survey weights were post-stratified for age and ethnicity, they did not account for education, meaning that part of this shift likely reflects sampling differences rather than true population change. Regression adjustment and inverse probability weighting can mitigate, but not eliminate, confounding of this magnitude. If anything, a more highly educated sample would have been expected to demonstrate better recognition of schizophrenia, making the absence of improvement all the more striking. The study may also have been underpowered to detect a modest real improvement.

Recognition required respondents to identify the vignette as schizophrenia or psychosis. Those who instead described its defining features—such as hallucinations or delusions—were not credited, even though they had arguably recognised the core clinical syndrome. Inter-rater reliability for coding these open-ended responses was also not reported. Perhaps the most informative finding is under-emphasised. In the later survey, fewer respondents described the vignette as a vague emotional problem, while more identified it as another form of mental illness. This suggests that public understanding may have progressed from failing to recognise mental illness altogether to recognising psychiatric illness without yet distinguishing psychosis from other disorders. In addition, the personal stigma items were adapted from a depression stigma scale, and the factor structure adopted from an Australian study was applied without validation in the Singapore context.

The authors' explanations for ethnic differences also invoke religious and cultural beliefs that were not measured. Cao et al. do not report response rates, and a companion analysis of the same survey programme reported that these fell from 71% to 62%, with some residents declining because the survey concerned mental health, raising the possibility of selection bias.[1,3] Handling of missing data was not described, and the vignette was built on the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition criteria that predates current classification. Finally, the sample was limited to adults aged 65 years and below, excluding older Singaporeans in whom stigma may be the highest—an important gap in a rapidly ageing society.

Despite these limitations, the study is a stark reminder that public understanding of schizophrenia has barely

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[1] Department of Psychosis, Institute of Mental Health, Singapore
[2] School of Anthropology and Museum Ethnography, University of Oxford, UK
[3] Psychiatric Care Clinic, Gleneagles Medical Centre, Singapore
Correspondence: Dr Amelia Sim, Department of Psychosis, Institute of Mental Health, 10 Buangkok View, Buangkok Green Medical Park, Singapore 539747. Email: peiling.amelia.sim@nhghealth.com.sg.
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advanced. It suggests that the relationship between knowledge and stigma is more complex than is often assumed. Recognising schizophrenia did not translate into less fear or greater social acceptance, implying that knowledge and prejudice may coexist. In Cao et al.'s data, correctly recognising schizophrenia was not associated with lower perceptions of dangerousness or less desire for social distance, only the belief that the illness reflects personal weakness was linked to poorer recognition.[2]

A more nuanced picture emerges from how respondents described the vignette. In the later survey, more respondents identified it as some form of mental disorder and fewer dismissed it as a vague emotional problem. This suggests that the public may now be better at sensing that there is a psychiatric illness, yet still struggles to specifically identify psychosis. Schizophrenia presents in complex ways that can be difficult to understand. Its negative symptoms, such as withdrawal and loss of motivation, are easily mistaken for laziness or stress. Naming the illness, however, does not by itself dispel fear. Where familiarity is absent, stereotypes readily fill the gap, and popular media often reinforce the image of the violent, unpredictable patient. Such portrayals are known to perpetuate stigma.[4] In 2025, a psychiatrist writing in *The Straits Times* warned that a Singapore television series risked reinforcing precisely this stereotype by portraying its villain as having schizophrenia.[5] Singapore is more educated and more digitally connected than ever, and awareness campaigns now reach millions through social media. Yet societal progress does not seem to have translated into better understanding one of the most stigmatised conditions. Online platforms appear to reward the sensational over the ordinary story of recovery, and broad well-being campaigns rarely mention psychosis. Moreover, digital channels are less likely to reach older and less digitally literate residents. More information has not meant less fear. Stigma, like schizophrenia itself, is socially patterned. The illness is shaped by social determinants, including childhood adversity, poverty, migration, and isolation. Those living with it often experience downward drift in employment and housing.[6] Anti-stigma work that ignores these conditions addresses attitudes while leaving intact the circumstances that sustain them.

Peer contact and support remain among the most promising approaches to reducing stigma, and the findings from Cao et al. are consistent with this view. In the later survey, respondents with a family member or close friend with similar experiences were more likely to recognise schizophrenia and expressed less desire for social distance.[2] Because these data are cross-sectional, the direction of this association is uncertain. People with less stigmatising views may also be more likely to form or disclose such relationships. A meta-analysis found that face-to-face contact outperformed education among adults, but education was more effective among adolescents, a point that is relevant to school-based programmes.[7] How such contact is organised and facilitated is equally important. A common pitfall is tokenism, in which a person with lived experience is invited to share a testimony within a campaign designed without them. This may achieve little and can feel extractive. Genuine co-creation involves peers in every step of the design, delivery, and evaluation of programmes, and ensures that peers are appropriately recognised and fairly remunerated. As the Lancet Commission on ending stigma and discrimination in mental health argues, co-created messages are more credible, culturally grounded, and ultimately more likely to change attitudes.[4]

Examples in Singapore already exist, including co-created interactive theatre and schizophrenia workshops supported by the Community Health Assessment Team (CHAT). Those of us who work alongside people living with schizophrenia see time and again that personal stories change minds in ways that clinical explanations alone cannot. Lived experience should not simply be showcased in campaigns—it should help shape them. People with lived experience deserve not only a voice, but also a seat at the table.

Public narratives that dwell on risk also obscure the hope that modern treatment can offer. An early evaluation of Singapore's Early Psychosis Intervention Programme (EPIP) published in 2005 found that the median duration of untreated psychosis fell from 12 months to 4 months after the programme was established.[8] In a Swedish nationwide cohort of nearly 30,000 patients, clozapine and long-acting injectable antipsychotics were associated with the lowest risk of rehospitalisation.[9] More recently, in a 5-week placebo-controlled trial conducted in the US, xanomeline–trospium became the first antipsychotic in decades to demonstrate efficacy without directly blocking dopamine receptors.[10] It is not yet registered for use in Singapore, and longer-term and Asian data are awaited. These advances reinforce an important point—schizophrenia is a treatable condition, and many people achieve meaningful recovery. Stating this plainly is itself an act of anti-stigma.

Yet recovery is not only a clinical or individual achievement, it is also a social one. Singapore's cultural traditions offer potential resources, rather than evidence, for this work. Confucian ideals of *ren* (humaneness and mutual obligation), Malay *gotong-royong* (mutual cooperation), and Indian *seva* (selfless service) each frame care for those who are ill as a shared responsibility. Their shadow is that concern for family face and fear of family stigma can drive concealment and delayed

help-seeking.[11] As Tan et al. writes, stigma towards a diagnosis of psychiatric illness is intertwined with a predominantly Chinese cultural concept of "face", which constitutes one's social identity and standing. A loss of face experienced by someone who receives a psychiatric diagnosis can thus extend beyond the individual and be associated with a perceived moral defect on the part of the sufferer's family.[12] The question, then, is not only whether a person with schizophrenia is ready to rejoin society, but also whether society is ready to receive them.

Several priorities follow. Future surveys should include adults over 65 years, weight samples for educational attainment, report effect sizes, and further validate psychosis-specific stigma measures. Public education should be schizophrenia-specific, address both negative and positive symptoms, and reach older and lower-income residents through non-digital channels. Campaigns should be co-created with people with lived experience, and anti-stigma initiatives should be evaluated not only by their reach, but also by their measurable impact on knowledge, attitudes, behaviour, and help-seeking.

Cao et al. have shown that the gains made in general mental health awareness have not yet extended to schizophrenia. Closing this gap will require replacing fear with familiarity and stigma with understanding. It will also require recognising that recovery is not the responsibility of the individual alone, but a shared commitment of the person, the family, and the community.

Keywords: *mental health literacy, mental illness, schizophrenia, Singapore, vignette approach*

Ethics statement

Not applicable, as no study participants were recruited.

Declaration

The authors declare that they have no affiliations or financial involvement with any commercial organisation with a direct financial interest in the subject or materials discussed in the manuscript. AS is employed by the Institute of Mental Health, whose Research Division conducted the Mind Matters surveys reported by Cao et al. and in references 1 and 3. AS was not involved in the design, conduct, or analysis of the surveys. AS heads EPIP, which is discussed in this editorial. CHAT sits within the wider department in which AS works, but AS has no direct role in running it.

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