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Mental illness and destigmatization: The case of Sidi Chami psychiatric hospital of Oran, Algeria

Sarra Samra Benharrats*, Oran University, Faculty of Medicine, J9PM+WXG, Es Senia, Algeria https://orcid.org/0000-0002-6144-5383

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Abstract

The definition of mental illness, the description of the experience of the subject affected by this disorder, and the decision of what is necessary for the experience of the carrier of this illness are always established by the "healthy" subject, who himself has certainly not experienced living mental illness. In this regard, it is rare and unlikely to refer to the person having this disorder, even if he is completely stabilized and in remission. The patient suffering from mental disorders defines and expresses his disease, and social sufferings secondary to his malaise, in several forms ranging from words to carrying his voice, to destigmatizing himself. In this article, a qualitative study, based on the interpretation of speech and the observation of behavior, we illustrate some cases of subjects with mental disorders followed up at the Sidi Chami Psychiatric Hospital of Oran in Algeria. These patients, as a result of their resilience, have been able to open a new path toward destigmatization.

Keywords: Destigmatization; Empowerment; Mental Disorders; Mental Health; Psychiatric Hospital.

* ADDRESS FOR CORRESPONDENCE: Sarra Samra Benharrats, Oran University, J9PM+WXG, Es Senia, Algeria.
E-mail address: s.s.benharrats@gmail.com

1. Introduction

The definition of mental illness, the description of the experience of the subject affected by this disorder, and the decision of what is necessary for the experience of the carrier of this illness are always established and dictated by the "healthy" subject, who himself does not certainly experience mental illness. The latter is therefore the result of "*the function of well-meaning elites, which consists in stigmatizing and punishing behavior of individuals that deviates from the dominant norm of society. The disease would be experienced as a reaction of withdrawal into oneself and disgust vis-à-vis the incomprehension of the entourage, in the broad sense*" (Dorvil, 1982).

Despite advances in care and destigmatization strategies undertaken by different societies, it is unfortunately rare and unlikely to refer to persons with mental disorders in the disease management process, even if they are fully stabilized and in complete remission. A way of destigmatization which is not only the work of the "non-sick", perceived as a neo-development, allows the subject to continue to exist despite the handicap and the suffering (Boris, 2001; Boris, 2005; Benharrats, 2020).

1.1. Purpose of study

This work aims to contribute to establishing a new non-medicalized and non-stigmatizing look toward mental health patients and bring a new form of listening to what is said and unsaid too by the carrier of mental illness who is still qualified as "crazy" nowadays.

2. Materials and Method

Through a qualitative study based on speech interpretation and behavior observation, we illustrate some cases of people with mental disorders followed at the Sidi Chami Psychiatric Hospital of Oran in Algeria who have chosen the path of resilience as the only way out for destigmatization, having "*the art of navigating between the torrents*" (Boris, 2001).

2.1. Definition of terms

SAP: Société Algérienne de Psychiatrie (Psychiatric Algerian Society).

APO: Association des Psychiatres d'Oranie (Oran Psychiatric Association).

SAEP: Société Algérienne d'Epidémiologie Psychiatrique (Epidemiological Psychiatric Algerian Society).

APAMM: Association des Parents et Amis des Malades Mentaux (Association of Parents and Friends of the Mentally Ill).

ASAOR: Association des Autistes d'Oran (Oran Autism Association).

AAT: Association Autisme Tlemcen (Tlemcen Autism Association).

3. Results

3.1. To be "mad "!

Mental illness is a disruption of an individual's biological, psychological, and social balance. It affects all the social, personal, and physical resources allowing the individual to realize his aspirations and satisfy his needs. It erases the individual's relationship with his society, hindering his socialization, social control power, and participation in social changes. On the sociological hand, mental illness is an outbreak of the space-time balance and the social space of the individual considered by society as a situation of almost permanent deviance. Indeed, even if it is a biopsychosocial imbalance that occurs in the biographical course of the individual, the return to balance is possible but not recognized.

The behavior and experience of the subject with mental disorders have always been labeled as dangerous and marginal (Benharrats, 2013; Benharrats, 2014; Sider, Kacha, Benradia, Roelandt, & Mouchenik, 2015). About the functionalism theory (Talcott, 1975), the disease, whether physical or

mental, is a deviance, prohibiting the patient from carrying out his daily tasks, while putting him in a position of "powerlessness" and passivity to accomplish and ensure his various roles in the society. This is the erasure of *Homo œconomicus*, about Talcott Parsons's action system theory. Homo œconomicus means an economic man in Latin, by imitation of the denominations used in paleoanthropology. It is a theoretical representation of human behavior, which is the basis of the neo-classical model in economics. In this sense man is rational, that is to say, he seeks to achieve objectives in the best possible way according to the constraints at his disposal (Dortier, 2013). Talcott (1975) was an American sociologist who developed a theory he calls systemic functionalism of action. This theory borrows elements from different authors and has made it possible to develop different more “operative” approach to socialization.

Stigma goes hand in hand with the exclusion of a slice of society considered deviant and opprobrium to social norms. It is a contented, conscious, and developed process by the elite of society. The subject affected by mental disorders is seen as deviant and considered passive and in a situation of consumption of care and of the decisions concerning him. This situation marginalizes this subject from society and dissociates him from his citizenship.

3.2. I am stigmatized by my caregiver!

“*Health promotion is the process of enabling people to increase control over and to improve their health. To reach a state of complete physical, mental, and social well-being, an individual or group must be able to identify and realize aspirations, satisfy needs, and change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector but goes beyond healthy lifestyles to well-being*” (WHO, 1986).

The vocation of psychiatric care is to help the carrier of mental disorder to integrate the society providing family, social, and professional stability. In this aim, several care programs have been proposed, such as cognitive remediation (Wykes & Gaag, 2001; Wykes & Reeder, 2005; Wykes, et al., 2007; Gerrard, Inglis, Morris & Austin, 2020) and psychosocial rehabilitation (Cnaan, Blankertz, Messinger, & Gardner, 1988; Brekke & Long, 2000; Lucca & Allen, 2001; Denis Leguay, 2008). These are care programs newly integrated into the care process and have proven certain effectiveness, with positive feedback on the population suffering from mental disorders considered to have serious cognitive repercussions, such as schizophrenia.

Earlier, in the 60s, some psychiatrists joined the antipsychiatric current (Laferrière, 1977; Nasrallah, 2011; Feys, 2017), believing that it was the only way to help this slice of society. They wanted to fight against the isolation and marginalization of patients to the point of extracting them from hospital structures, described as coercive and totalitarian (Goffman, 1961) which until now are considered as the place of care and "protection" of patients and society on a mutual basis.

The antipsychiatric current has made it possible to critically question classic psychiatric practices centered on the disease itself, by concealing the identity of the sick subject (Mervat, 1995; Marmion, 2012; Lawn et al., 2022). It has also made it possible to establish a form of social recognition for people with mental disorders and to show the importance of their social integration to benefit society from their citizenship (Roelandt, 2004; Dsouza, Saran & Krishnan, 2021).

The antipsychiatric current came to initiate the concept of mental health, a repository of health practices and political discourse at the international level (Roelandt, 2015). Gradually, the concept of mental health has become part of a current that focuses on the description of good functioning instead of the dysfunction of the individual’s psychic life. It has converted social and collective conflicts into individual or interrelational intrapsychic conflicts, to be treated in a personalized and individual way. We have gone

from the collective to the individual, compartmentalization of the individual in its pathological dimension, or its precursor dimension of mental illness by concealing the possibility of the link of society in the definition and the probable etiology of this type of disorder.

Mental health has contributed to the creation of new health "standards", by broadening the spectrum of people with mental disorders, where all complaints are signs of suffering and psychic distress to be taken care of (Jaiswal et al., 2020; Bonhoure et al., 2023). All these methods have unfortunately contributed to some degree to the creation of a new form of marginalization and stigmatization within societies.

In addition to the aforementioned methods, approved and adopted by the World Health Organization in mental health policy (WHO, 2019; WHO, 2022). The WHO has worked for the application of its triptych: Empowerment / Recovery / Citizenship (WHO, 2003; Roelandt, 2017; Eiroa-Orosa & Tormo-Clemente, 2021) to integrate the individual with mental disorders into society, "*Working with the environment to regain a place in the City*" according to the speech of Roelandt & Ghozi, (2015). Four principles emerge from this slogan (Koenig, Caria & Roelandt, 2017):

- "Being" a care partner for the patient, supporting him in his decisions concerning him in terms of care and management. This is the principle of empowerment (Roelandt, 2016).
- Promote the autoionization of users of mental health care, always based on the principle of empowerment: "nothing about us without us". To this end, the Algerian state has facilitated the creation of learned societies (SAP, APO, SAEP, etc.) and associations to help people with mental illnesses, for example, APAMM, ASAOR, and AAT.
- Prioritize the prevention of the disorder by emphasizing the presence of caregivers in the community. In Algeria, the Ministry of Health maintains the opening of job positions for psychiatric care specialists in the various regions of the country, insisting on their installation in isolated regions of the country, to ensure Proximity Care (APS, 2022).
- Develop mobile home care teams for the maintenance of remission and the prevention of probable relapse. In Algeria, this practice has been challenging to apply in psychiatric care, because of the nature of the disorders treated and to extract the patient from his home and away from hospital structures, to facilitate the verbalization of his disorder, and social integration.

To implement the above-mentioned principles, the type of doctor-patient relationship in psychiatric care has gradually evolved in a synchronic and diachronic way. It has gone from the character of the active doctor and passive patient, or so-called "paternalistic" relationship to the "participatory" relationship, which positions the patient in his status as an actor in the decision and in the care which implies collaboration and consent, for a reciprocal and responsible compromise between the two actors (See **Error! Reference source not found.**) (Benharrats, 2020).

Table 1

The type of doctor-patient relationship in psychiatric care

		Type of Patient-Doctor relationship in psychiatric care			
		Paternalistic	**Consensual**	**Cooperative**	**Participatory**
Care Actors	**Patient**	Passive	Request for help already convinced	A patient agreement (to be convinced)	Must change habits and lifestyle
	Doctor	Asset	Active with the help of the patient	The patient follows the doctor	Reciprocal and responsible compromise to be found

3.3. I am a care mediator!

Despite this neat and politicized language, partially applied in the care system in Algeria, the care structures in psychiatry paradoxically continue to convert into a family structure that protects and takes

care of the patients, removing them from any margin of autonomy and freedom. This produces a situation of totalitarian control daily: taking treatment, washing, food, bedtime, getting up, going out, permissions, visits, etc., will be calculated and planned inside and outside the institution, on an almost continuous basis (Benharrats, 2020).

> "*In this hospital, I am suffocating, I feel like I am in prison, everything is calculated, even if I don't want to sleep, I have to do it because otherwise I will be reported to the doctor for a sleep problem and then he will give more treatment. In the evening, you don't see the television, the light is turned off almost directly after dinner and taking the medicine, and if you want to stay awake, you risk being reported again for agitation or something else!*" says a patient hospitalized in the psychiatric hospital.

The subject with mental disorders deploys daily complex social practices, indicating the multiple circumventions of the medical order operated by "patient-actors": health mediators. These are inventive practices, based on social logic. Among those, sharing help, and care advice without introducing the caregiver into their care circuit, and this, implicitly, with the sole aim of getting closer to care and achieving "recovery". An organization of solidarity takes place between the patients who express themselves through the psychological or emotional support advocated about their sick neighbor, or direct him, as is the case of this patient towards another doctor who is more personable and considered to be more attentive to patients.

> "*I advised her to see another doctor, preferably a woman, because she was raped, and rape is best told to a doctor of the same sex […]. She took my advice, she's better now. Her first doctor didn't listen to her and only prescribed treatment, he didn't even offer her a person with whom she could chat and empty her heart and her sorrow* [she means a psychologist]*"*.

In addition, it has been noticed that some hospitalized patients opt resolutely for tactics of negotiations with the nursing staff. The objective is to be able to carry out certain tasks devolved in principle to service agents, such as: ensuring the role of messenger between services and hospital administration, feeding other patients, and making their beds. Also, report a symptom or behavior considered pathological of another patient to the caregivers, such as an attempt to run away, a refusal to eat, or even help the staff to contain agitation.

> "*In the evening [such patient] is insomniac, he disturbs the other patients… I saw [such patient] talking to himself… [such patient] plans to run away… [such patient] conceals his treatment ».* Says a hospital patient.

Another example of a care mediator is a former patient of the psychiatric hospital for whom the support took the form of pictorial works (See Figure 1). He wanted to convert the hospital structures in his way through his paintings which brought a little life, by a possibility of the change from the bland and lifeless walls to a form of source of cognitive jubilation. The author of these paintings said that the patients saw life and hope through his paintings, giving the patient the power to escape by piercing his psychic partitions. His works are invisible, free, and often little-recognized work. It is the art of making, and taking care of yourself, by having the will to transform your living space, represented by the hospital service, by making it more pleasant.

Figure 1

Patient pictorial works

Art therapy is a psychotherapy long adopted by psychiatric caregivers that uses artistic creations, a form of expression of creativity, verbalizing another type of language besides words. The paintings of this patient are an example of this art therapy, but not only because they reflect a state of personal development and mediation of pictorial art for care. The "beauty" of their art incorporates the postures of the "sick" who are not always what people think spontaneously and stereotypically, to label them "crazy".

We quote another form of creativity and resilience of a patient who chose to come out of the walls of stigmatization by joining a training course in ready-to-wear sewing that lasted three months (See **Error! Reference source not found.**). At the end of this training, the patient in question decided to enter the professional world to meet her personal and family needs. She fellow the program « Working First », without having the slightest information about this program and without the help or suggestion of another person, whether it is her family circle or her caregivers. The choice of this patient is an explicit desire for social integration and to get rid of the label of the disease. Her goal was to show her unrecognized normality and the possibility of getting out of it despite the vagaries of the disease, she said "I am like you".

Figure 2

Patient handmade dresses

We qualify the various examples cited above as practices for increasing capacities for action and empowerment strategies, closely linked to recovery. The subject with mental disorders is therefore in

power to develop autonomy, with a consideration of his future, and this, by participating in the decisions concerning him in terms of care.

4. Conclusion

The patient taught us through the various examples cited above that the normal and the pathological are not necessarily in radical opposition. They can intersect and intertwine to give a possible and peaceful form of life. It is not a medical diagnosis that determines whether a person can fulfill his social role, but his commitment, will, and empowerment to get by. Their creativity within hospital structures and also in society has exceeded the expectations of their caregivers to achieve recovery.

Beyond recovery, all examples cited in this article were able to de-stigmatize themselves and emerge from marginalization to ensure a place for their citizenship in society, maintaining their different forms of identity: an identity for themselves, a personal identity, and a social identity. This leads us to admit that It is not the doctor who overcomes the disease, but the patient. The patient heals himself by his strength, as it is by his strength that he walks, eats, thinks, breathes, and sleeps.

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