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Original Research Article

Mental Patient Labelling: An Analysis of the Patient's Recovery Confronted To Families' Anathematizing In the District Of Abidjan

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Abstract: The paper provides an analysis of some of the explanatory elements of stigmatization and the issues related to family therapy for the healing and social reintegration of the mentally ill. The study is based on a purely qualitative approach with appropriate investigative tools and analyses this social fact through the structural approach, which is a fundamental theoretical current of systemic analysis (Alpe et al. 2007). In this study, the structural approach allowed us to identify the cultural symbols and norms that codify and guide behaviours, the opinions of social actors to the mechanisms of care for the mentally ill**.**

Keywords: Mental illness, Stigmatization, Family therapy.

INTRODUCTION

Mental illness is associated with an increased incidence of mortality and morbidity (Chafetz et al., 2005) and a low quality of life (Dickerson et al. 2008; Sánchez-Araña Moreno et al. 2010 cited by Annick Simard, 2011). Standardized mortality rates for people with mental health disorders are four to six times higher than those of the general population (Politi & al. 2002; Meloni & al. 2006 cited in Annick Simard, 2011). More specifically, in people living with schizophrenia, up to 60% of excess mortality is attributed to preventable natural causes (Bradshaw et al. 2005; Compton & Newcomer 2007 cited by Annick Simard, idem). The presence of unhealthy lifestyles such as physical inactivity, poor nutrition, substance abuse and smoking are partly responsible for rising morbidity and mortality rates (Faulkner & Cohn 2006 cited by Annick Simard, 2011). Quality of life is an important element to consider in the treatment of psychiatric disorders as it influences treatment response, disease progression and mortality.

In this situation, while the management trajectories produced by the reorganization of care are not well known, a number of questions can be asked. The study of the trajectories or careers of mental patients is the subject of an important chapter in the sociology of health (François Sicot, 2006). For these authors, the notion of disease trajectory refers not only to morbid development "but also to the entire organization of work deployed to follow its course", which can lead to a significant change, "as well as to the impact that this work and its organization have on those who are involved". The term trajectory thus covers all the different aspects contained in the temporal phases of the disease, including the disease management work carried out by the various actors involved, medical and non-medical, and the interactions between each of them [...]. This concept, because it prevents the observer from being locked into the "only" perspective of professional medical actors, makes it possible to "see" another form of work performed by and around the patient and often obscured or even denied (Bungener, 1995, 103-104 quoted by François Sicot, idem). Culture has evolved, and so has medical science for the care of the mentally ill. We now know the etiology of mental illness and the different possible routes for the patient's recovery.

Today, mental illness is a real health problem and reveals a behavioural dimension that health sociology must address. To integrate this dimension into the resolution of health problems, there are criteria for defining mental pathology. The conceptions we make of it depend on the geographical environment, the mores of each culture or civilization at a given moment

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in its evolution. Indeed, the distinctive criteria of mental illness are based on the exteriority of the disease. It is therefore, through the cultural framework, that we can highlight what mental illness is. Thus, the cultural framework appears as a clinical framework. From these values and norms, patient care and the combination of collective medical practices result (Y. Léopold, 1991 cited by Agobe & al. 2016).

In Cote d'Ivoire, on the occasion of World Health Day, the director of the Bingerville Psychiatric Hospital, Kangoua Badi, indicated that schizophrenia (a brain disease that affects thinking, feelings and emotions), bipolar disorders (abnormal mood swings) and anxiety disorders (acute panic attacks or crises, phobias...) are the dominant pathologies. Two thirds of the patients treated are social cases, either because they come from the street or because they are abandoned by their families. We provide them with help and assistance in various forms (clothing, hygiene kits, medication, free consultations and hospitalization, occupational therapy, family tracing and social reintegration). The author also revealed that the hospital operates with 120 staff, including 6 psychiatric doctors, and carries out an average of 5000 consultations and 1000 hospitalizations per year. Indeed, when parents resign, staff are forced to play both the role of carer and parent of the sick, often even at the risk of their lives. It is not uncommon for staff to contribute to pay for laboratory tests or transport of the patient to return to the family (Kangoua Badi, 2016).

This observation leads to an analysis of the problem of the quality of public health care and services, which is based on the dimensions of health quality. Indeed, the sense of quality comes up against the perceptions and sensitivities of the different actors (Health Agents, COGES, Patients, community in general, administrators). These perceptions, to which particular attention must be paid, are commonly referred to as the elements or dimensions of quality. These elements constitute a theoretical framework for assessing the quality of public health care and services. Thus, these different dimensions can be translated into criteria for assessing the conformity of practices. Professional competence applies to the technical, interpersonal, and management skills of health workers, managers, and support staff. It includes the clinical approach, the knowledge "technical knowledge" and the know-how "technical gestures", (Ministry of Health and Public Hygiene, 2016).

Despite all this scientific knowledge, the evolution of society and changes in society. Families have not always accepted to reintegrate without prejudice and stigmatize their relatives who have suffered from mental illness. This study questions some of the explanatory elements of stigmatization and the issues related to family therapy for the healing and social reintegration of the mentally ill. Specifically, these are: i) Describe the etiology and typology of mental illness stigmatization among actors ii) Describe the impact of stigmatization on the healing and social reintegration of the mental patient; iii) Establish the link between family therapy and the healing of the mental patient.

Theoretical and Methodological Approach

The structural approach is a fundamental theoretical current of systemic analysis (Alpe et al. 2007). In this study, the structural approach allowed us to identify the rules and norms that codify and guide behaviours, the opinions of social actors and the mechanisms of care for the mentally ill. The methodological approach favoured an essentially qualitative approach. Indeed, seek to grasp the ideological productions that legitimize the stigmatization of patients by their entourage and the essence of family therapy for the reintegration of the mentally ill. Thus, data collection techniques include direct observation and semi-directive interviewing. This data collection phase took place from 12 November 2018 to 23 December 2018 inclusive. We interviewed 23 people, including 10 women and 7 men (relatives of the patients) and 6 people living in families who had previously reported mental illness. The data collected were subjected to a content analysis that made it possible to capture the ideological references that structure and legitimize the care of the mentally ill. Direct observation made it possible to examine, through our presence in families, all social activities and the symbolic dimension of caring for the mentally ill (Agobe & al.2016).

RESULTS

Etiology and Typology of Mental Illness Associated With Stigmatization among Actors

The stigmatization of the mentally ill by their entourage is not a "new" social fact. The perception of stigmatization is perceptible through the label of mental patient. The mental patient who has undergone psychiatric treatment or medical assistance and who is now declared healthy when he or she does not comply with all the norms of his or her environment, challenges and provokes in others an uneasiness and a tendency to label him or her, to apply a devaluing identity centred solely on the deviant action he or she has taken. This is what T.P. testifies in these terms: *"Mental illness is not like a skin disease in order to see the healing of the wound or the disappearance of lesions, always puts us in doubt. Even people who are supposed to be mentally normal very often show justifiable discontent. This is not the case for a mental patient who has recovered, if the results of the health specialists are any indication. For a loved one who has experienced a mental illness, there is always no fear that they will relapse and fall back into their state of illness. It is therefore in the family's interest to watch over their behaviour".* In this context, the phenomenon of deviance is an infringement of the norms generally accepted by the community as a

whole. Deviance does not consist in a purely individual phenomenon, i.e. an individual committing a specific act, but in the relationship between this act performed by an individual and the societal reaction, i.e. the reaction of the environment. All interactions including expectations and behaviours in relation to the roles normally assumed by the individual are replaced by a new network of interactions centred exclusively on his new role as a deviate. When this deviant role is marked by institutionalized behaviours, in this case, the family's perception of asylum in a psychiatric hospital. Once the family has already manifested itself in the face of a deviant act, it does not stop its effect. Then, all his socio-professional entourage and family, give him a uniform status in terms of stereotype of deviant and marginal, in these words, Y.F. *"During the illness, I was in an unconscious universe controlled by clinicians and my family. My status as a mental patient in the past has left me with enormous consequences. However, whether I give my position or vision during a discussion or activity that involves the responsibility of all family members, the eyes of others always leave me in doubt. However, psychiatric tests give me the status of a patient who has regained stability and recovery. I have also resumed my professional activities. But, I'm still coming in the old madman. This is a bit like the daily life of a person who is cured from a psychiatric hospital."* This traditional stereotypical image of the deviate becomes a new form of legitimization of the new status and social role of the admitted cured mental patient. This situation will inevitably produce feelings of exhaustion and deconstruct their family's social relationships with the patient, irreversibly marking the stigmatization. Stigma is therefore a social relationship that involves an individual and a set of elements that devalue their status. Indeed, the terms used by society in general (Former madman, madman heals etc.) to designate the mentally ill clearly show this stigmatization. In addition, religious beliefs are also a fundamental element of stigmatization. Because by their practices, religious beliefs influence laws and norms pre-determined by populations. These values were originally conceived as the people's compass. So any behaviour would be considered normal, the people who embody these social values.

Impact of Stigmatization on the Healing Trajectory and Social Reintegration Of The Mental Patient.

In a study on the trajectories of the mentally ill, Bungener attempted to overcome the diversity of trajectories and identifies lifestyles with the disease (imposed, separate, compensated, tamed) and types of disease management (parental, institutional, marital, reappropriated). Indeed, the author's study identifies sequences in these different forms of management, "the passage from one balance to others", trajectories seeming more frequent than others; thus from "the passage from parental management to institutional management following the break-up caused by the death of the parents or by the inability of the entourage to continue the work of previous support and management". The determining elements of these trajectories are the pathology, the age at which the original phase of the disease occurred, the family characteristics and the availability of action by those around them, the local supply of equipment and care. The first hospitalization is also a decisive moment, the effect of which will be reinforced by the following ones. Age no longer seems to be a fundamental factor at this particular point in disease trajectories, its major influence being upstream. These seem to be mainly determined by the duration of hospitalizations and in particular by the duration of this initial hospitalization (Bungener, 1995, 115).

The way mental illness is managed in a society is therefore determined by culture. The negative image that brings culture to mental illness is at the root of the stigma associated with mental illness. Rejected and marginalized by the community, patients have always suffered from the explanations used to explain their mental illness. There are two possible hypotheses about the presence of stigma in our societies: the first is related to cultural symbols, which are implied by the different forms of behaviours, actions and achievements that are positively assessed, or others (on the contrary) negatively. Since mental illness affects behaviours of all kinds (individuals) that are not "normal", this directly affects the negative perception of this abnormality (Bungener, idem). In response to this concern about stigmatization, G.M. explains*: "No one would want to see their loved one or parent in a state of depression or mental illness. The meaning of this sometimes divine disease; God's wrath could fall on someone who has committed acts that do not honour God. For example, taking the life of one's fellow human being, a practice prohibited in the Bible. If such a case were to occur, God or nature as the guardian angel of weak men would do justice to the person who committed his atrocities".* This statement by G.M. highlights Bungener's (1995) first hypothesis of stigmatization. Consequently, cultural symbols, which are implied by the different forms of behaviours, actions and achievements that are positively assessed, or others (on the contrary) negatively (idem).

Experience of Illness and Social Representations

Man is always looking for the causality of the evil from which he suffers. Knowledge of the etiology of the disease in some cases allows a more appropriate therapeutic approach, while uncertainty about the causes of a disease handicaps all therapies, even if this does not prevent the use of empirical techniques that sometimes prove to be effective. In this respect, the etiological aspect of mental illnesses should be shown according to the actors involved in the care of mental patients (Agobe & al. 2016).

Mental illness is a complex phenomenon with multiple perceptions. It has always been present in

collective representations described as personifications of an absence of reasons. Mental illness is an area where social representations are strong and diverse. The image of "madness" and its actors remain harmful. Psychic suffering leads to rejection, fear and exclusion. The fear of the mentally ill is thus embedded in cultures and traditions. As a response, TM, a parent of a mentally ill person said in these words: "The illness made my sister nervous. At home, we are all afraid to communicate with her. Since it acts brutally. As in this context, it would be appropriate to take into account the patient's behaviour and his interaction with his entourage before the disease in order to understand the origin of his current attitude. More specifically, it would be interesting to study the socio-cultural context in which the sick subject evolves in order to identify the situations at the origin of his illness (Agobe & al. idem). These different perceptions of mental illness, and especially the "mental illness label", guide and legitimize the interaction between families and the integration of people who have experienced mental illness in the past.

However, the representations remain quite complex to identify. While those who personally know a demented patient are most afraid of the disease, those who help a demented parent feel that ultimately the patients are happy. In fact, it is the caregivers who present themselves as victims. This is likely because these caregivers focus on caring for their demented parent at home in particular, as long as long-term care admission appears to be a major source of anxiety (Corner and Bond, 2004). The authors also advocate for a better understanding of the disease experience; "improving public understanding of the dementia experience can help to improve responses to dementia and their caregivers and, in turn, help to improve the quality of life of dementia patients and their caregivers".

DISCUSSION OF THE RESULTS

In short, the study relied mainly on the structural approach, which is a fundamental theoretical current of systemic analysis (Alpe etal., 2007), to account for the cultural symbols and perceptions that codify and structure families' behaviours with their sick or previously ill relatives. The study also highlighted the opinions of social actors on the mechanisms of care for the mentally ill. It is therefore understandable that the "mental patient label" refers to two hypotheses that seem to be in conflict: a cultural perception and a scientific perception. Cultural perception is perceived through the cultural symbols that give meaning to normal behaviours acceptable to society, but these cultural perceptions of mental illness highlight abnormal and therefore deviant behaviours that are unacceptable to society. In this respect, the study is similar to that of Bungener (1995). Indeed, the author presents culture as an important link in the way mental illness is managed in a society. The negative image that brings culture to mental illness is at the root of the stigma associated with mental illness and "patient labelling". Stigmatized by families, patients have always suffered from the perceptions that families have to explain their mental illness.

As a result, the scientific perception of mental illness is more integral to patients in society. The presence of stigma in families is related to cultural symbols, which are implied by different forms of behaviour, actions and achievements that are positively assessed, or others (on the contrary) negatively. Since mental illness affects behaviours of all kinds (individuals) that are not "normal", this directly affects the negative perception of this abnormality (Bungener, idem).

It appears that the perception of mental illness has structured the dependency relationships of families with their sick relatives in the past. This study result is consistent with the Agobe & al. study (2016). The author through his study has shown that the socio-cultural system in which the individual explains and interprets the etiology of mental illness.

Another series of studies involves patients and their families more closely. Following Beard's (2004) theory of contexts of consciousness from Glaser and Strauss (1965), Hutchinson (1997) collected various data (including autobiographical writings) on 14 probable cases from the experiences of recent Alzheimer's patients and their caregivers. The context of consciousness, according to Glaser and Strauss, is defined as the complex situation that places interacting social actors according to the degree of knowledge they have of a problem. This result of the authors' work easily confirms the result of this study. Indeed, the authors define four types of contexts of consciousness which are thus defined, from the "closed" to the "open" context. For example, the closed context is the one in which one of the interaction partners knows that the diagnosed memory loss means probable Alzheimer's disease (mental illness), and does not want to share the information with those involved. The author shows the heuristic utility of this theory, which allows us to think of the conditions of open contexts of consciousness, which other research has shown to weaken disagreements between patients and carers (Quayhagen, 1996). To explain the reintegration problems of the mentally ill, Sur (2006) through the socio-biographical approach showed the experience of self-awareness from fourteen (14) people diagnosed with dementia (MMSE: 20 or less), able to sustain 3 to 8 interviews over a minimum of six months. The results of the author's study show the importance of the self-reporting in maintaining the self. Self-preservation (always in the second sense of self of Sabat and Harré, 1992). Indeed, the author assumes the ability to narrate about oneself. "Despite memory problems, many participants appeared able to generate a life story and place their present

(illness) experience in the context of their past and in order to maintain a sense of self" (Sur, 2006). But also relationships with the family, with other residents, with the care team, appear important in maintaining the self, insofar as these different actors can develop opportunities for the patient or on the contrary block them: "those participants to whom it seemed that they had an undesirable role or who did not allow them to adopt the role they perceived as desirable suffered a weakening of their self" (p. 1728). These results highlight the significance of family therapy for the healing and reintegration of the patient. Based on the example of Alzheimer's disease developed by the authors, we retain the possible integration of people who have developed mental illnesses in the past.

CONCLUSION

This study is intended as a contribution to the sociology of chronic diseases. She analyzed some ideological productions of stigmatization and the issues related to family therapy for the healing and social reintegration of the mentally ill. Indeed, the study was based on a purely qualitative approach with appropriate investigative tools by analyzing this social fact through structuralist theory, which is a fundamental theoretical paradigm of systemic analysis (Alpe et al. 2007). From this structural study we were able to identify the cultural symbols and norms that codify and guide behaviours, the opinions of social actors to the mechanisms of care for the mentally ill and their difficult reintegration into the social sphere.

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