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Original Research Article

Resilience in the Face of Mental Illness: Analysis of the Social Trajectories and Exclusion Mechanisms of Post-Psychiatric Patients in Bingerville

Ablakpa Jacob Agobe[1*], Adjoumani Kobenan[2]

[1]Senior Lecturer (CAMES) Doctoral School SCALL-ETAMP, Félix Houphouët-Boigny University, Department of Sociology
[2]Assistant Professor (CAMES) Félix Houphouët-Boigny University, Department of Sociology

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Abstract: This study examines the configurations of psychosocial resilience developed by former psychiatric patients in Bingerville, within a context marked by intense post-hospitalization stigma. Drawing on a qualitative methodology (including interviews, participant observation, and document analysis), it highlights how these individuals deploy relational and symbolic strategies to resist exclusion. The absence of integrated public policies underscores the pressing need for intersectoral mechanisms that promote their social recognition, autonomy, and effective reintegration into local communities.

Keywords: Resilience, Mental Illness, Social Trajectories, Mechanisms, Exclusion, Psychiatric Hospitalization.

INTRODUCTION

Mental health constitutes a paramount public health challenge in Africa, particularly in Côte d'Ivoire, where it remains profoundly stigmatised. Mental disorders are frequently intertwined with cultural and religious beliefs, thereby exacerbating the social marginalisation of affected individuals. The Bingerville Psychiatric Hospital, the country's principal specialised facility, admits patients from diverse backgrounds. Yet, beyond inpatient care, social reintegration represents a formidable challenge. Upon discharge, former patients often confront persistent stigma, sometimes fragile familial relationships, and a conspicuous absence of structured support mechanisms. Their post-hospital trajectories are characterised by social exclusion, economic precarity, and insufficient psychosocial assistance, although some succeed in deploying resilience strategies, often anchored in familial or personal support networks. This context reveals inherent tensions between individual resilience and systemic exclusion, familial support and rejection, the central yet transient role of institutions, and the patients' latent potential juxtaposed with social repudiation.

The analysis of these trajectories uncovers a central paradox: former psychiatric patients are simultaneously architects of their own resilience and victims of social and institutional frameworks that undermine their reintegration. Five principal tensions underpin this paradox: (i) individual adaptive efforts are confronted by structural social exclusion; (ii) the family can constitute both a vital source of support and a factor of exclusion; (iii) the hospital institution plays a crucial role during hospitalisation but leaves a post-therapeutic void; (iv) despite their inherent potential, patients are perceived as incapacitated, thereby curtailing their opportunities; (v) non-governmental organisations endeavour to fill these gaps, yet their resources remain limited.

These findings call for a structural transformation of public policies. The research question derived from this paradox may thus be formulated as follows: How do former psychiatric patients articulate their individual resilience strategies to counteract mechanisms of social exclusion, and to what extent are these coping practices modulated, supported, or undermined by prevailing structural, institutional, cultural, and socio-economic constraints within their environment?

This study is situated within the sociology of health, documenting the complex interplay between stigmatisation, mental illness, and resilience in an

***Corresponding Author:** Ablakpa Jacob Agobe
Senior Lecturer (CAMES) Doctoral School SCALL-ETAMP, Félix Houphouët-Boigny University, Department of Sociology

African context. Employing a triangulated methodology comprising interviews, participant observation, and documentary analysis it explores post-hospitalisation pathways. Resilience is conceptualised as a multidimensional process at the intersection of the personal, familial, and institutional spheres. By illuminating the disjunctions between individuals' capacities to act and systemic constraints, this research exposes shortcomings in follow-up care provision. It also enriches existing scholarship, such as Couture's work (2012, 2014, 2024) on the "search for balance" among individuals with multiple sclerosis, and Thibault's (2018) analyses of "work arcs" in illness trajectories. Furthermore, Ferrari *et al*., (2013) and Aubin & Dallaire (2008) underscore the critical importance of continuity of care to prevent life-course disruptions. Finally, this study amplifies patients' narratives, raises community awareness, and serves as a strategic resource for NGOs and policymakers. It advocates a reimagining of mental health policies in favour of sustainable inclusion that honours the dignity of former psychiatric patients.

1. Theoretical and Methodological Framework

This study is grounded in Erving Goffman's (1963) theory of social stigma to analyse the exclusion experienced by former psychiatric patients in Côte d'Ivoire, where mental illness is widely perceived as a stigma associated with danger or weakness, thereby engendering marginalisation and rejection. Such stigmatisation, compounded by cultural beliefs such as notions of curse propels patients to adopt adaptive strategies (including concealment and self-redefinition), which are mediated by personal, relational, and institutional resources. Complementarily, resilience theory elucidates the capacities of certain individuals to reconstruct their lives despite these impediments, notably through active social engagement. Nonetheless, these trajectories are impeded by enduring structural barriers. The interplay of these two theoretical frameworks enables a comprehensive understanding of the mechanisms of exclusion and the dynamics of resistance within the sociocultural context of Bingerville, whilst suggesting avenues for more inclusive interventions.

Methodologically, this research employs a qualitative approach founded on data triangulation to explore in depth the post-hospitalisation trajectories of former psychiatric patients at Bingerville. The study draws upon semi-structured interviews conducted with 20 patients discharged for at least six months, 10 family members, and 5 healthcare professionals (psychiatrists, nurses, social workers), with the aim of elucidating the dynamics of stigmatisation, barriers to reintegration, and resilience strategies. This was supplemented by documentary analysis of mental health policies and reports from the psychiatric hospital, allowing for the juxtaposition of personal narratives against the institutional framework. A purposive sampling strategy ensured diversity across profiles age, gender, socio-economic status, nature of family relationships, and professional roles. Data analysis was conducted using thematic and comparative methods, traversing individual, familial, and institutional levels, whilst identifying discrepancies between official provisions and lived realities. This integrated methodology thus facilitated a nuanced delineation of exclusionary processes and the resources mobilised for social reconstruction.

2. RESULTS

2.1. Stigmatisation and recomposition of identity: a socio-anthropology of social perceptions of mental illness among post-hospitalisation patients in Bingerville

In Bingerville, cultural and religious beliefs, combined with a lack of mental health education, fuel a persistent stigma that severely hinders the community reintegration of former psychiatric patients.

This Statement Illustrates:

"*I am a former psychiatric patient, aged 35, I was hospitalised for a psychotic disorder at the psychiatric hospital in Bingerville. After my release, I returned to live in my family neighbourhood. But my relationships with the people around me have changed completely. My neighbours whisper about my past, calling me 'crazy' or 'bewitched'. Comments like 'You have to be careful with him, he could become violent' spread, despite the fact that I have undergone treatment and am now stable. I used to attend meetings of our community association, but I'm no longer invited on the grounds that I might disrupt the discussions*".

This statement exemplifies, through the lens of social stigma and symbolic exclusion, the process of negative labelling endured by former psychiatric patients. Despite clinical stabilisation, the individual remains entrapped within a social stigma characterised by pejorative representations mental illness being equated with madness or witchcraft that activate mechanisms of interpersonal and communal discrimination. These pervasive judgments underpin manifest social exclusion by restricting access to collective participation and isolating the individual from the social fabric of their neighbourhood. This scenario epitomises the double burden borne by the mentally ill: confronted not only with their pathology but also subjected to social ostracism legitimised by collective beliefs and fears, following a logic of othering and social control.

A sociological analysis of testimonies from former psychiatric patients reveals an intricate entanglement of exclusionary mechanisms and symbolic domination. Drawing on Erving Goffman's (1963) theory of stigma, individuals are reduced to their psychiatric pasts, rendered socially disqualified figures. Norbert Elias (1987) demonstrates how these patients are perceived as threats to communal order, thus fuelling irrational exclusions. This marginalisation also manifests

economically and professionally, as Pierre Bourdieu (1986) elucidates through the erosion of social and economic capital, compounded by subtle yet efficacious symbolic violence. Michel Foucault (1975) further illuminates the effects of normative discourses on mental health, which indefinitely position individuals as "abnormal," even post-stabilisation.

These dynamics are further reinforced by local cultural beliefs, exemplified by the perception of mental illness as a curse necessitating spiritual purification. This interpretation, which resonates with Émile Durkheim's reflections on social deviance (1895), intensifies exclusion by attributing psychic suffering to supernatural transgressions rather than medical realities. In sum, these intertwined mechanisms—stigmatisation, social exclusion, economic devaluation, and normative power confine former patients within a marginalised status. To address this, inclusive policies, reintegration programmes, and social education on mental health are imperative to break the cycle of social disqualification and promote genuine reintegration.

2.2. Socio-Institutional Dynamics and Post-Hospitalisation Reintegration Trajectories of Psychiatric Patients in Bingerville: Between Stigmatisation, Resilience, and Identity Reconfiguration

The post-hospitalisation trajectories of psychiatric patients in Bingerville unfold within a complex dynamic where social stigmatisation, institutional shortcomings, and individual resources are intricately intertwined. Social stigmatisation operates as a process of symbolic and social relegation, establishing a negative mark that undermines the social recognition of individuals, thereby diminishing their prospects of gaining employment, engaging in community participation, and receiving effective familial support. This relegation is frequently accompanied by self-exclusion, a psychological and social consequence of communal rejection. Moreover, the inadequacy of institutional mechanisms for follow-up and reintegration exacerbates this marginalisation, revealing a structural failure in the comprehensive management of patients' return to social, economic, and familial life. Indeed, the absence of tailored programmes impedes the social stabilisation of patients, intensifying their socio-economic vulnerability.

Within this context, the family assumes an ambivalent role: it may serve as a crucial source of emotional and material support or, conversely, function as a vector for perpetuating cultural and social stigmas, thereby reinforcing marginalisation. Confronted with these conflicting social injunctions, patients develop strategies of resilience and adaptation, articulating a pursuit of autonomy and recognition within their environment. These mechanisms whether economic, social, or symbolic attest to individuals' capacities to negotiate and reinterpret their social positions despite prevailing constraints. Accordingly, the trajectories of former psychiatric patients can be read as processes of adjustment to conflicting social demands, reflecting tensions between institutional exclusion, collective stigmatisation, and individual resistance. This perspective underscores the necessity of a holistic sociological analysis that integrates cultural, institutional, and interactional dimensions to fully apprehend the challenges of post-hospital reintegration.

Verbal Material Produced by Social Actors:

"When I left the hospital, people in the neighbourhood no longer looked at me the same way. Even my former friends avoided me. It was as if I had caught a shameful disease. I had to learn to manage on my own. It was thanks to my sister that I managed to hold on. She found me a small job and always told me I was worth as much as anyone else."; "We often see people coming out of there [the psychiatric hospital], but there really isn't any follow-up. It's up to the family or neighbours to do what they can. The State provides nothing. Yet some want to get better they come to our meetings, they participate. But without help, it's very difficult."

This material highlights the tangible effects of the stigma associated with mental illness, which operates as a mechanism of symbolic disqualification, resulting in social distancing and a weakening of close ties. The absence of structured public post-hospital care systems transfers responsibility for support to the domestic and community spheres, making the management of vulnerability an informal matter. In this context, individuals mobilise relational and subjective resources, reflecting a dynamic of emancipation under normative pressure in an environment marked by inadequate institutional frameworks and low levels of social recognition.

2.3. Socio-Cognitive-Cultural Resilience and Adaptive Strategies in Response to the Stigmatisation of Post-Psychiatric Hospitalisation Patients in Bingerville

Resilience in the face of stigmatisation refers to the capacity of individuals who have experienced mental illness to confront social prejudice, preserve their dignity, and reconstruct their lives despite socially devaluing perceptions particularly salient within the cultural context of Bingerville. To achieve this, such patients mobilise individual adaptive strategies, including seeking support within benevolent groups, engaging in protective self-isolation, or undertaking processes of identity reconstruction, with the aim of overcoming social obstacles and facilitating community reintegration.

Discursive Material Collected:

"When I was discharged from the psychiatric hospital in Bingerville, I joined a Facebook group for cultural joking alliances, so I could talk with other members and feel useful among others."

This statement exemplifies a strategy of identity-based resilience through recourse to virtual

spaces as alternative relational microcosms, in which the individual endeavours to rebuild weakened social capital eroded by post-hospitalisation stigma. Engagement in a Facebook group dedicated to joking kinship alliances reflects a desire for renewed social inscription via shared cultural practices and playful symbolic interactions. These foster the reassertion of collective belonging and serve as compensatory mechanisms for exclusion experienced in physical social settings. This approach constitutes a tactical adaptation to marginalisation processes, wherein digital networks are mobilised to restore a sense of social function and perceived usefulness, transcending the negative identity assignments associated with mental illness.

The account reveals a strategy of social reintegration in which the individual articulates traditional cultural resources, such as joking kinship alliances, with relational digital spaces. This socio-technical hybridity enables an identity reconfiguration, a quest for recognition, and resilience in the face of stigmatisation, by symbolically reinvesting inclusive forms of interaction. The resilience of patients in Bingerville is largely contingent upon ambivalent familial and communal support, which may alternately offer emotional and material refuge, or reinforce stigma through rejection and shame particularly in view of local beliefs that associate mental illness with supernatural causes.

Corpus of Collected Statements:

"After my psychiatric hospitalisation in Bingerville, everyone in my family was happy. I now eat from the same bowl as my sisters. Our conversations are enjoyable I'd say even more interesting than before the illness. I have regained my self-confidence thanks to my family." ; *"Since I came back from the psychiatric hospital in Bingerville, I no longer receive phone calls from certain family members with whom I used to communicate very well. And when I try to call them, they engage in only brief conversation. It's frustrating. It can lead to suicide, because their reactions show that I no longer matter to them. But I stay strong. Only God knows that I am truly healed, and God's love is enough for me to live. I was born alone and one day I shall return alone to my Creator, God."*

These testimonies reveal the ambivalent dynamics of social reintegration following psychiatric hospitalisation, marked by a familial duality: on the one hand, warm inclusion where symbolic and material co-presence (shared meals, enriched verbal exchanges) fosters identity reconstruction and strengthens self-esteem, constituting a crucial source of emotional support; on the other hand, latent rejection characterised by diminished contact and truncated communication, which engenders potentially deleterious social disaffiliation, intensifying feelings of exclusion and devaluation. This duality illustrates the precariousness of social ties for individuals who are clinically recovered, yet remain vulnerable to the long-term effects of stigma, and who must therefore summon spiritual resilience as a final bulwark against isolation.

These accounts illustrate the familial duality between inclusion and rejection in the aftermath of psychiatric hospitalisation. The family may function as a vital sphere of support that enhances self-worth, or conversely as a site of exclusion and stigmatisation that exacerbates marginalisation. This ambivalence reflects the persistence of negative social norms surrounding mental illness, while individual resilience is sustained either by familial emotional support or by spiritual resources thereby underscoring the complexity of social reintegration trajectories within a specific cultural and socio-symbolic milieu.

3. DISCUSSION

In Bingerville, collective representations of mental illness are deeply rooted in cultural and religious belief systems, compounded by a lack of mental health awareness, thereby perpetuating a structural stigmatisation that impedes the social, economic, and familial reintegration of patients following psychiatric hospitalisation. These reintegration trajectories unfold within a context shaped by the complex interplay of social prejudice, institutional inadequacies, economic constraints, and community dynamics—together forming multidimensional obstacles which individuals must negotiate through adaptive resilience strategies aimed at reconstructing a devalued identity and social status.

In light of the findings previously presented, our analysis is framed around the discursive economy centred on: *"The Resilience of Post-Psychiatric Hospitalisation Patients in Bingerville in the Face of Stigmatisation Dynamics."*

Resilience to stigmatisation refers to the capacity of individuals who have been observed and treated for mental illness to confront social judgement, preserve their dignity, and reconstruct their trajectories within an environment that often perceives them as marginal or "inferior". In Bingerville, where cultural and social beliefs reinforce the deep stigmatisation of mental illness, the resilience of individuals who have undergone psychiatric hospitalisation depends upon their capacity to adapt, to overcome social barriers, and to restore their ties with the social and community environment.

This resilience involves the ability to navigate prejudice, to rebuild interpersonal relationships, and to re-establish one's place in a context often characterised by social hostility, exclusion, and mistrust, in which the stigma attached to mental illness may isolate the individual thus hindering prospects for social, professional, and familial reintegration, and creating additional impediments to personal wellbeing and fulfilment. This observation is consistent with the

conclusions drawn by Baronnet and Alberghini (2006), who emphasise that the visible presence of numerous homeless individuals suffering from psychological disorders in public spaces is a daily reminder of the delays in integrating housing considerations into the psychiatric care trajectories of those in precarious situations. Moreover, the inclusion of mental health disorders within "mainstream" social structures represents a further significant challenge. These disruptions extend beyond psychiatric care to encompass issues of accommodation and social support. Furthermore, certain individuals, perceived as undesirable by both institutions and society, face outright rejection and lack of assistance, leading to protracted states of acute distress and isolation, in the absence of adequate frameworks and sufficient resources to meet their specific needs and secure their inclusion within a social and institutional context appropriate to their condition.

4. CONCLUSION

The resilience of former psychiatric patients in Bingerville in the face of challenges related to mental illness unfolds within a multifactorial dynamic in which individual, social, and institutional determinants are intricately interwoven. This resilience is not confined to personal capacity to overcome adversity, but is also contingent upon the social structures and resources available that condition reintegration pathways. Indeed, these individuals confront not only internal obstacles linked to their experience of illness and hospitalisation, but also external barriers fuelled by stigmatising social norms and institutional shortcomings.

Improving their reintegration therefore necessitates a reassessment of support mechanisms, including the enhancement of post-hospital care and the establishment of personalised frameworks tailored to the specific needs of each individual, within a coherent intersectoral coordination (encompassing health, education, employment, and social services). Simultaneously, it is essential to foster heightened community awareness aimed at deconstructing stereotypes and culturally embedded beliefs that reinforce stigmatisationthrough participatory educational campaigns that actively involve the patients themselves. This approach valorises their lived experience and encourages collective engagement, thereby strengthening both their sense of belonging and the broader imperative of social responsibility.

Furthermore, the implementation of inclusive programmes combining psychological support, vocational training, and access to economic opportunities constitutes a crucial lever for sustainable reintegration. These initiatives must ensure personalised support that addresses the emotional and economic needs of patients, while promoting autonomy and social justice. Reintegration should not be limited to the mere alleviation of stigma, but must instead guarantee genuine equality of rights and opportunities, enabling these individuals to participate fully and without discrimination in social, economic, and political life.

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