Pegem Journal of Education and Instruction, Vol. 16, No. 1, 2026 (pp. 1433-1444)

RESEARCH ARTICLE WWW.PEGEGOG.NET

"The Human Being" Diagnosed with Schizophrenia: A Lived Experience Between the Symptoms of the Disorder and Multidimensional Stigma- Diagnostic, Social, and Self-Stigma-

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Received : 08/01/2026 ; Accepted : 25/01/2026 Published : 25/01/2026

Abstract:

This article adopts a human-centered perspective to explore the lived experience of the human being diagnosed with schizophrenia, moving beyond purely clinical descriptions of the disorder. It argues that the individual's suffering is not limited to the core symptoms of schizophrenia but is deeply shaped by multidimensional stigma operating at diagnostic, social, and self levels. Diagnostic stigma emerges through reductionist psychiatric labeling that often overshadows the person's identity, while social stigma manifests in exclusion, stereotyping, and discrimination within family and community contexts. Over time, these external forms of stigma may be internalized, giving rise to self-stigma that undermines self-esteem, hope, and the capacity for recovery.

By integrating psychological, social, and phenomenological perspectives, the article highlights how stigma interacts dynamically with symptomatology, exacerbating distress and hindering therapeutic engagement and social integration. The paper emphasizes the ethical and clinical necessity of recognizing the human being behind the diagnosis and advocates for stigma-sensitive, person-centered approaches in mental health practice. Ultimately, the article positions recovery not merely as symptom reduction, but as the restoration of dignity, agency, and meaning in the life of the person diagnosed with schizophrenia.

Keywords: Human Being ; Schizophrenia; Lived Experience; Multidimensional Stigma; Diagnostic Stigma; Social Stigma; Self-Stigma.

Problematic:

Despite the extensive accumulation of clinical research on schizophrenia, dominant psychiatric and psychological approaches continue to focus primarily on the classification, regulation, and treatment of symptoms, often at the expense of understanding the human being behind the diagnosis and the richness of their lived experience. This prevailing biomedical orientation tends to reduce schizophrenia to a symptom-based pathological construct, thereby marginalizing the subjective, emotional, and social dimensions that constitute the core of the experience of being diagnosed with the disorder. Within this framework, suffering is not viewed as arising solely from clinical

symptomatology, but rather as the outcome of a complex interaction between the disorder itself and multidimensional stigma—diagnostic, social, and self-stigma.

Diagnostic stigma, grounded in the authority of medical labeling, may contribute to the fixation of a pathological identity that envelops the human being and limits recognition of their individuality and humanity. Social stigma, in turn, manifests through exclusion, stereotyping, and discrimination within familial and broader societal contexts, weakening opportunities for social participation and meaningful integration. Over time, sustained exposure to these external forms of stigma may be internalized, giving rise to self-stigma that reshapes self-perception and undermines self-esteem, hope, dignity, and a sense of agency.

Despite the profound impact of this interplay between symptoms and stigma, it remains insufficiently examined from a human-centered and phenomenological perspective that listens to the voice of the human being diagnosed with schizophrenia and places their lived experience at the heart of scientific understanding. Accordingly, the central problem of this research lies in examining how schizophrenia symptoms and multidimensional stigma interact to shape everyday life, identity construction, and possibilities for recovery and social integration, moving beyond a narrow logic of symptom reduction toward the restoration of meaning, dignity, and humanity.

Thus, the presentation proceeds by posing the following questions:

- **Is it the schizophrenia that is central, or the human being diagnosed with schizophrenia?**
- **Is it merely a clinical case, or a person living a genuine experience of suffering?**
- **Does the diagnosis of schizophrenia serve the purpose of supporting the human being, or is it merely a diagnostic label?**
- **Is the label "schizophrenic" essentially the same as "mad" or "insane," but expressed in scientific language?**
- **How does the human being diagnosed with schizophrenia become a victim of a social structure that endorses and sanctifies stigma?**
- **How do diagnostic and social stigma influence the course of the disorder and the trajectory of this person's life?**
- **How do diagnostic and social stigma evolve into exhausting self-stigma that can be destructive for this individual?**
- **Is there a solution or pathway to support this human being?**

1- Schizophrenia as a human suffering – The individual diagnosed with schizophrenia as a victim of the disorder:

1-1-Definition of Schizophrenia: Schizophrenia is defined as a severe mental disorder classified under psychotic disorders. It is a chronic psychotic disorder characterized by disturbances in thinking, perception, emotion, and behavior, including delusions, hallucinations, disorganized speech and behavior, and impaired social and occupational functioning, with symptoms persisting for at least six months (APA, 2022).

In complementary modern models, schizophrenia is described as a complex disorder resulting from the interaction of biological, psychological, and social factors, which collectively lead to disturbances in brain functions and in the individual's psychological and social adaptation **(Tandon, R., & al., 2009).**

Clinically, the diagnosis includes positive symptoms such as hallucinations, delusions, disorganized speech, and disorganized behavior, alongside negative symptoms such as social withdrawal, psychomotor slowing, loss of motivation, and emotional blunting.

1.2 Diagnosis of Schizophrenia according to DSM-5

Schizophrenia (F20.9) – Diagnostic Criteria:

A. Two (or more) of the following must be present for a significant portion of time during a one-month period (or less if successfully treated), and at least one must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., diminished emotional expression or avolition)

B. For a significant portion of time since the onset of the disorder, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or fail to reach the expected level in personal, academic, or occupational functioning if onset occurred in childhood or adolescence).

C. Continuous signs of the disorder persist for at least six months. This six-month period must include at least one month (or less if successfully treated) of active-phase symptoms meeting Criterion A and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the disorder may manifest only with negative symptoms or with two or more symptoms listed in Criterion A in attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with

psychotic features have been ruled out because:

1. No major depressive or bipolar episodes occurred concurrently with the active-phase symptoms; or
2. If mood episodes occurred during the active phase, they were present for a brief portion of the total duration of the active and residual phases.only

E. The disturbance is not attributable to the physiological effects of a substance (e.g., drug of abuse, medication) or another medical condition.

F. If there is a history of autism spectrum disorder or communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations are also present and other required symptoms of schizophrenia have been present for at least one month (or less if successfully treated).

Specifiers

- First episode, currently in acute episode: The first manifestations meet diagnostic criteria in terms of symptoms and duration.
- First episode, currently in partial remission: Partial remission is the period in which improvement is maintained, and diagnostic criteria are partially met.
- First episode, currently in full remission: Full remission is a period after the previous episode with no specific symptoms of the disorder present.
- Multiple episodes, currently in acute episode: Multiple episodes are defined after at least two episodes (i.e., after the first episode, a period of remission and one relapse).
- Multiple episodes, currently in partial remission
- Multiple episodes, currently in full remission
- Continuous: Diagnostic criteria symptoms are present throughout most of the course of the disorder, with periods of sub-threshold symptoms being very brief relative to the overall course.
- Unspecified

With catatonia: (See criteria for catatonia associated with another mental disorder)

Coding note: Use an additional code (F06.1) for catatonia associated with schizophrenia to indicate its presence.

Current Severity

Severity is rated quantitatively for core psychotic symptoms, including delusions, hallucinations, disorganized speech, abnormal motor behavior, and negative symptoms. Each symptom is

rated for current severity (most severe over the past seven days) on a five-point scale ranging from 0 (absent) to 4 (present and severe). (Refer to the clinician's assessment of psychotic symptom severity in the "Assessment Procedures" section.)

Note: Schizophrenia can be diagnosed without using this severity specifier. **(DSM-5-TR, 2022)**

Psychotic Symptoms: Fragmentation of the Self and the External World: Psychotic symptoms involve a fragmentation of the psychic structure and a disruption between the self and the external world, such that a person immersed in hallucinations and delusions loses the protective function of the self and the intermediary representational system that mediates their relationship with reality. The individual experiences a state of a "divided self," lacking a stable center, which makes it difficult to maintain a sense of psychological coherence.

For example, when a patient reports, "The voices speak to me, telling me I am worthless… and I feel the world around me has changed, and I am no longer part of it," this expression reflects an internal existential disconnection, not merely a behavioral symptom. This clinical dimension—the ongoing psychological suffering and the fear of losing control over one's subjective experience—renders the person with schizophrenia a primary victim of the disorder itself.

2. The Individual Diagnosed with Schizophrenia as a Victim of Diagnostic and Social Stigma

What is stigma?

Erving Goffman defines stigma as "an attribute that is deeply discrediting, reducing the individual from a whole and usual person to a tainted, discounted one, compelling the individual to hide or alter themselves" (Goffman, 1963). Stigma can take multiple forms: public stigma, self-stigma, and structural (institutional) stigma. According to the U.S. Centers for Disease Control and Prevention (CDC), stigma encompasses negative expectations, stereotypical beliefs, and discriminatory behaviors directed against individuals with mental disorders **(Corrigan, P., & al., 2016).**

2.1 Diagnostic Stigma

2.1.1 Diagnostic stigma in the form of the label "schizophrenic" – science-encased stigma: Diagnostic stigma is one of the most critical aspects in dealing with individuals with schizophrenia. Here, the medical diagnosis transforms from a mere identification of the disorder into a "new identity" that adheres to the individual, reshaping both their self-perception and the way others perceive them. Once a diagnosis of "schizophrenia" is applied, the person often carries this label as if it were a permanent title throughout life, regardless of symptom remission.

This classification can lead to self-stigma, whereby the individual internalizes society's negative view of people with schizophrenia, resulting in decreased self-esteem and diminished confidence in social integration or professional success **(Corrigan et al., 2016).**

Diagnostic stigma also serves as the gateway to social stigma, as family and community attitudes begin to shift toward the patient, who may be regarded as "dangerous" or "unstable," creating increasing isolation and hindering psychological and social rehabilitation (Link et al., 2017). Often, this stigma is more painful than the symptoms themselves because it reduces hope for recovery and weakens adherence to treatment.

Some researchers argue that psychiatric diagnoses should be applied with a cautious humanistic approach, viewing schizophrenia as a disorder with potential for positive development rather than a fixed identity that excludes the individual from themselves and society **(Pescosolido, 2013).**

2.1.2 Diagnostic stigma in the form of care practices:

2.1.2.1 Continuation of the confinement and isolation model:

Ossoukine Abdelhafid, in his article "Law and Mental Illness," notes that "the 1985 reform of the health law did not fundamentally change the old French law, which remained based on confinement. It relied on a medico-legal conception that continually viewed the

mentally ill as a source of danger" **(Abdelhafid Ossoukine, 2002).**

Sharifa Sider echoes this view, stating that organizing mental health care is essentially a form of imprisonment. The only concern of these institutions is to provide the minimum "security" care without genuine attention to prevention, ongoing treatment follow-up, rehabilitation, or the actual social reintegration of individuals diagnosed with schizophrenia.

In reality, despite efforts and the desire to move from psychiatry to mental health care, the confinement model remains the primary reference in Algeria. According to the World Health Organization, it perpetuates stigma, marginalization, and exclusion of individuals with mental disorders, severely hindering their social integration opportunities.

2.1.2.2 Continuation of the emergency treatment model:

Regarding rehabilitation, current structures that provide support and social reintegration for individuals with mental disorders often limit their role to simple follow-up and routine examinations. Outpatient clinics providing care for inpatients also largely operate under a model of emergency medical treatment, as noted by psychiatrist Mahmoud Boudaran: "The care of mentally ill patients in our country is limited to temporary medical-pharmacological treatment. Post-treatment support is practically nonexistent" **(Chérifa Sider et al., 2015).**

Indeed, the medical approach still dominates care for individuals with mental disorders in Algeria, focusing primarily on symptom alleviation rather than psychological rehabilitation, social reintegration, or inclusion in their natural environment.

2.2 Social Stigma

2.2.1 Manifestations of stigma in the life of people with schizophrenia, globally and locally:

Global research indicates that individuals with schizophrenia are subject to high levels of anticipated and perceived stigma. One study found that approximately 64.5% of people with schizophrenia experience anticipated or perceived stigma. Experienced stigma includes daily relational rejection, denial of employment opportunities, social isolation, and mistreatment within mental health systems.

For example, a World Health Organization report notes that more than two-thirds of individuals experiencing psychosis do not receive specialized care, with stigma and rights violations being key contributing factors. The long history of stigma against mental illness spans all societies, even in developed countries, where discrimination in employment, housing, and social integration remains common (Stigmatization as an environmental risk in schizophrenia: A review, 2010).

According to Norman Sartorius, stigma today clearly affects individuals with mental disorders, causing significant exclusion and discrimination in daily life and serving as a major barrier to social integration. Numerous studies conducted in 21 countries show consistent results: there is no society where people with mental disorders are treated equally to others.

The manifestations of mental illness stigma arise both from social representations of the disorder and from the realities of the institutional settings responsible for care (سريدي وبلعادي، 2022، ص ص253-264). Social representations provide insight into attitudes toward mental illness and explain how societies interact with and relate to the mentally ill. Jean-Yves Giordana identifies three core social representations underpinning stigma: violence and danger, nonconformity to social norms, and childlike behavior. These lead to three societal responses: fear generates social exclusion, presumed irresponsibility triggers authoritarian attitudes, and society justifies limiting rights and imposing barriers, depriving these individuals of social recognition and rights **(Giordana, 2010, p. 34).**

In Algeria, stigma and exclusion remain daily realities for patients. Data from the WHO-partnered SMPG survey at the Chéraga Psychiatric Hospital on a sample of 466 individuals confirm widespread marginalization, social exclusion, and professional discrimination against people with mental disorders. These outcomes are linked to negative social representations portraying patients as dangerous, violent, or incapable of recovery **(Chérifa Sider et al., 2015).**

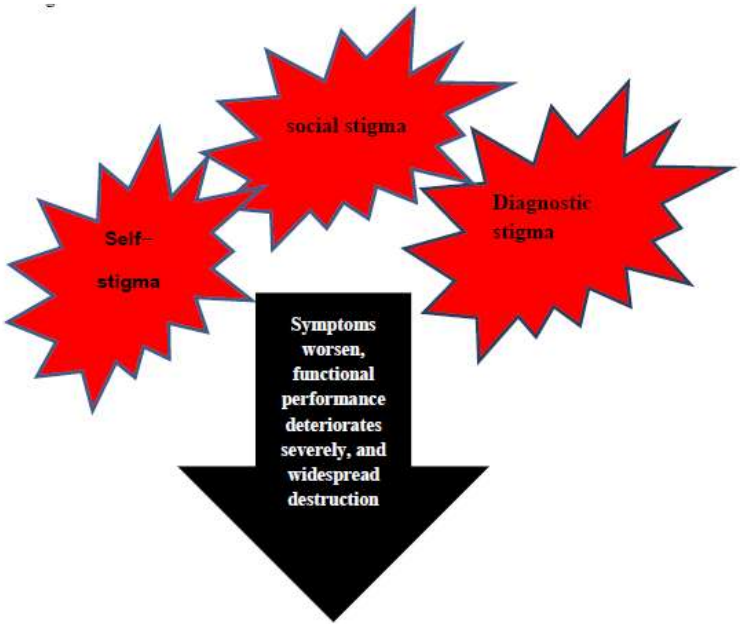
2.2.2 The relationship between diagnostic stigma, social stigma, self-stigma, and the course of the disorder:

Stigma is not merely a negative perception of a person with schizophrenia; it functions as a risk factor for the worsening of the disorder. For instance, feelings of shame or social withdrawal can lead to self-deterioration, treatment avoidance, and diminished motivation, which exacerbate negative symptoms and slow recovery.

Data indicate that internalized stigma is associated with worse clinical and functional outcomes in individuals with psychotic disorders.

At the Arab and local levels, although research is limited, societal realities confirm the presence of marginalizing attitudes that label individuals as “different” or “deviant,” intensifying alienation and reducing opportunities for dignified living and social integration.

-An illustration of the intervention process: from diagnostic stigma to social stigma to self-stigma to total destruction-



3-Towards a Humanistic Clinical–Social Perspective

3.1 Role of the Clinical Psychologist

In clinical practice, it has become widely accepted to understand schizophrenia not merely as a biological or purely psychological disorder, but within a biopsychosocial model that integrates biological, psychological, and social factors. This perspective enables a shift from "symptom treatment" to "rebuilding the self and the relationship with society."

From this vantage point, the human being diagnosed with schizophrenia is seen as suffering from a "symbolic wound" resulting from the rupture between self and world, and between self-knowledge and external stigma—not solely from the pathological symptoms themselves.

Within this framework, the clinical psychologist or therapist becomes more than a medical professional; they act as a symbolic mediator assisting the person with schizophrenia in meaning-making and in restoring the recognized self that has been harmed by the disorder and stigma. The therapist's commitment to a human-centered approach—acknowledging suffering and respecting the individual as an agentic self rather than a mere "case"—is a vital cornerstone of stigma-free clinical practice.

Here, the social dimension also plays a role: the therapist helps empower the patient to resist stigma, strengthen self-worth, and link therapeutic progress to opportunities for social and occupational integration **(The Stigma of Mental Illness in Numbers, 2021)**.

3.2 Towards an Anti-Stigma Clinic & Recovery-Oriented Approach

From an operational perspective, modern mental health approaches advocate the Recovery Model, which views the person not only as a patient to be treated but as a partner in the recovery process. They define their own

identity, set goals, and actively participate in treatment planning.

Moreover, building a treatment environment that respects the patient's culture, combats institutional stigma, and provides community awareness programs is central to restoring dignity to individuals with schizophrenia. For example, anti-stigma campaigns in several countries, such as the "Changing Minds" campaign in the UK, have helped raise awareness and reduce discrimination.

Integrating this clinical–social dimension opens a new space to overcome the double tragedy of schizophrenia: the suffering caused by the disorder itself on one hand, and societal stigma on the other **(Mental Health Stigma, 2025).**

Conclusion

Through this discussion, it is evident that the human being diagnosed with schizophrenia experiences two parallel paths of suffering:

1. The clinical disorder path—marked by symptoms, disconnection, and loss of meaning.
2. The stigma path—marked by the label "schizophrenic," social perceptions, marginalization, and deprivation of integration opportunities.

Thus, considering the individual as a double victim facilitates a deeper understanding of their suffering and highlights our human and scientific responsibility.

Recommendations:

1. **Train mental health professionals in cultural and social sensitivity, including understanding the dynamics of stigma and how to address it in clinical practice.**
2. **Launch community awareness campaigns to correct stereotypes about schizophrenia, reveal the dangers of stigma, and promote acceptance of these individuals as active citizens.**
3. **Develop psycho-social rehabilitation programs targeting the patient, family, and community, providing access to employment, housing, and social support, so that the individual is no longer a victim.**
4. **Shift clinical perspectives away from mere diagnostic labeling and symptom-focused treatment, which reduce the "human" to a "case." "He is a human being, not a case"—"He is a person, not a diagnosis".**
5. **Work on empowering the self, involving individuals in defining their goals and treatment, and enabling them to reclaim their intrinsic value.**
6. **Implement human-centered mental health policies that place respect for human rights and dignity at the core of intervention and treatment.**

Let us strive to re-humanize clinical psychology, reconsider individuals diagnosed with mental disorders as human beings, and reintegrate them into human life, rather than leaving them as victims suffering from both disorder and stigma.

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- والاجتماعية، المجلد 6، العدد 24، 2022 ص253-264.