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Dehumanization of psychiatric patients: Experimental and clinical implications in severe alcohol-use disorders

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HIGHLIGHTS

- Dehumanization is a frequent but underexplored process in psychiatry.
- Available data on this topic are reviewed, focusing on alcohol-related disorders.
- A research agenda is proposed to improve dehumanization's understanding.
- Critical experimental and clinical perspectives are identified.

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ABSTRACT

Dehumanization, defined as the denial of one's membership to humanity, is a process repeatedly reported in extreme contexts (e.g., genocides) but also in everyday life interactions. Some antecedents of dehumanizing experiences (e.g., social exclusion, negative stereotypes) have been reported among patients presenting psychiatric disorders, but dehumanization's experience remains completely unexplored in addictive disorders. We propose a theoretical model and research agenda to overcome this limitation and to improve our understanding of dehumanization's experience in psychiatry, with a special focus on alcohol-related disorders. We also propose much-needed clinical avenues to reduce dehumanization in clinical contexts, centrally by (1) improving dehumanization awareness among medical workers; (2) reducing the need for healthcare workers to use dehumanization to alleviate professional exhaustion; and (3) optimizing medical training to increase empathy toward patients. Finally, some additional improvements are proposed to promote patient's choices, comfort, dignity, and ultimately humanity in hospitals.

1. Introduction

1.1. Theoretical framework of dehumanization

Dehumanization, globally defined as the denial of one's membership to humanity, places the dehumanized person out of moral considerations (Opotow, 1990). It has initially been explored in extreme contexts, particularly as a crucial process underlying genocides and war crimes (Kelman, 1973). However, it is also evidenced in more subtle forms and in a large range of everyday life activities [e.g., sports, education (Haslam, 2006; Trifiletti, Di Bernardo, Falvo, & Capozza, 2014)], and is thus now considered a pervasive phenomenon (Leyens et al., 2001; Leyens, Demoulin, Vaes, Gaunt, & Paladino, 2007).

Haslam (2006) proposed a dual model of dehumanization that includes two distinct forms, namely animalistic and mechanistic dehumanization. Animalistic dehumanization emerges when a person is assimilated to animals and is perceived as lacking uniquely human characteristics (i.e. as being coarse, amoral, irrational, lacking culture, and childish). Mechanistic dehumanization appears when a person is seen as presenting reduced human nature characteristics (i.e. as being inert, cold, rigid, passive, fungible, and superficial). The lack of human nature characteristics assimilates the person to an automaton, a tool or

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an object (Haslam, 2006). This model has received large empirical support in various populations, cultures and contexts (Bain, Park, Kwok, & Haslam, 2009; Haslam, 2006; Haslam & Stratemeyer, 2016; Kteily, Hodson, & Bruneau, 2016; Loughnan, Haslam, Sutton, & Spencer, 2014; Park & Park, 2015). Neuroimaging explorations have also reinforced it, particularly by revealing distinct brain networks related to animalistic and mechanistic dehumanizations (Jack, Dawson, & Norr, 2013). This model is also closely related to well-established theories, such as the Stereotype Content Model, categorizing persons or groups along two axes: competence and warmth (Gervais, Bernard, Klein, & Allen, 2013; Li, Leidner, & Castano, 2014). For instance, past research has evidenced that persons perceived as both incompetent and cold are frequently dehumanized (Harris & Fiske, 2006). As a whole, the concept of dehumanization has gained a key conceptual and empirical position in social psychology during the last decades.

1.2. Dehumanization in medicine and the present research agenda

While mostly explored in intergroup relations, dehumanization has recently been investigated in medicine. In a seminal paper Haque and Waytz (2012), pointed out six inherent features of medical settings constituting potential dehumanization sources. The first three characteristics are categorized as nonfunctional for patients' care. Among these, *deindividuating practices*, which are common in clinical settings (e.g., through the use of uniforms for both patients and medical staff), reduce one's personal responsibility toward patients, as well as the time invested by doctors in patients' problem assessment (Haque & Waytz, 2012). Second, *impaired patient agency*, i.e. denying any active role for the patient in treatment, contributes to patient's dehumanizing experience, as the reduced perception of agency is an established criterion of mechanistic dehumanization. Finally, d*issimilarity,* i.e. the perceived differences in health and status between patients and medical staff (Haque & Waytz, 2012), contributes to patients' dehumanization as significant differences in appearance can generate dehumanization (Harris & Fiske, 2006).

Aside from these nonfunctional aspects of medical settings, some other dehumanizing dimensions are assumed to be more functional, as they partly contribute to efficient patient care. *Mechanization*, i.e. the treatment of people as mechanical systems made up of interacting parts, is considered as a prevalent and necessary feature in modern medicine, facilitating diagnosis and treatment (Haque & Waytz, 2012; Haslam & Loughnan, 2014). Similarly, e*mpathy reduction* and *moral disengagement,* which are both deemed somewhat necessary for limiting medical staff's discomfort at inflicting hurtful treatments to patients, might also increase patients' dehumanization. Indeed, making a decision that provokes pain to someone (e.g., choosing a painful but effective treatment) facilitates the emergence of dehumanization feelings toward this person (Lammers & Stapel, 2010).

These six features clearly illustrate how dehumanization might be pervasive in medicine. Despite its endemic presence, however, this phenomenon has received little attention in psychiatry, and even less so in addictive disorders research. Moreover, dehumanization is often explored from the author's[1] perspective (Bastian & Crimston, 2014), thus neglecting victims' *experience* of dehumanization (i.e. the genuine perception of being dehumanized by others).

In response to these shortcomings, we propose a research agenda focusing on dehumanization's experience by the victim. Such agenda offers crucial new perspectives in psychiatry in general, and more specifically in addictive disorders. We will first present a theoretical review of dehumanization research in psychiatry. Then, we will underline the limits currently hampering the development of an empirical exploration of dehumanization's experience in addictive disorders, before proposing a series of research lines aimed at better understanding the processes underlying dehumanization's experience among patients with addictive disorder. Finally, clinical programs to reduce this dehumanization's experience and its deleterious consequences will be explored. As patients with severe alcohol-use disorders are among the most rejected and stigmatized psychiatric populations (Schomerus et al., 2011), we argue that they are likely to endure intense dehumanization's experiences. As such, they will be considered as a representative example throughout the paper.

2. Dehumanization in psychiatry and severe alcohol-use disorders

2.1. Author's perspective

Social stigma toward patients with psychiatric disorders is largely present in our society (Angermeyer, Holzinger, Carta, & Schomerus, 2011; Angermeyer, Matschinger, Carta, & Schomerus, 2014; Schomerus et al., 2011): individuals presenting psychiatric disorders are perceived as aggressive and dangerous, leading most people to avoid interacting with them (Pescosolido et al., 2010). The presence of dehumanization in psychiatry has been reported in several descriptive papers (Brody, 1995; Swahnberg, Zbikowski, & Wijma, 2010; Szasz, 1991). Moreover, some recent empirical investigations have shown that dehumanization is the default response of lay people when judging patients with mental illness, which are considered as threatening (Martinez, Piff, Mendoza-Denton, & Hinshaw, 2011). Importantly, healthcare workers also present reduced humanity attribution towards patients (Trifiletti et al., 2014; Vaes & Muratore, 2013). This dehumanization is considered as a protective coping strategy for the psychiatric staff, as patients' dehumanization is related to decreased emotional involvement and reduced burnout risk (Vaes & Muratore, 2013). The use of dehumanization as a coping strategy to protect oneself against the emotional exhaustion and stress brought by everyday professional contact with patients presenting psychiatric disorders illustrates how dehumanization can be functional. Nevertheless, even if dehumanization presents some functional aspects for mental health workers, its potentially deleterious consequences (e.g., negative emotions, reduced self-esteem, relapse) for patients warrant our attention (Haque & Waytz, 2012).

2.2. Patients with severe alcohol-use disorders' perspective

Amongst populations with psychiatric disorders, patients with severe alcohol-use disorders are the most rejected and stigmatized (Schomerus, Corrigan, et al., 2011). They are perceived as more dangerous and unpredictable than patients suffering from depression or schizophrenia, leading to an increased desire for social distance from them (Schomerus, Lucht, et al., 2011). As it promotes dehumanizing effects (Bastian & Haslam, 2010), such social rejection is likely to lead to dehumanization's experience. As a matter of fact, patients with severe alcohol-use disorders have an increased sensibility to social rejection (Maurage et al., 2012), a well-known antecedent of dehumanization (Bastian & Haslam, 2010). Moreover, loneliness and social stigma, which are conceptually close to social rejection and dehumanization, have both been linked to poor prognosis in patients with severe alcohol-use disorders (Åkerlind & Hörnquist, 1992; Schomerus, Corrigan, et al., 2011). One may reasonably assume that a socially rejected person might develop loneliness feelings and that a stigmatized person is likely to feel dehumanized (as there is a strong tendency to dehumanize stigmatized populations (Cameron, Harris, & Payne, 2015; Harris & Fiske, 2006)). Even though it seems likely that all patients with psychiatric disorders could be victims of dehumanization, we argue that patients with severe alcohol-use disorders are particularly confronted with dehumanization feelings because they are particularly victims of,

[1] The term « perpetrator » is commonly used in the literature to characterize the author of dehumanizing behaviors. However, this term has a strong negative connotation. Considering that dehumanization attitudes are often involuntary in medical contexts, the term “author” has been used throughout the present paper, as it is less judgmental and guilt-inducing.

and sensitive to, social rejection (Maurage et al., 2012). Indeed, this addictive population is perceived as less mentally ill than people suffering from substance-unrelated mental disorders and, accordingly, as more personally responsible for the disease (Schomerus, Lucht, et al., 2011). As a consequence, they are more likely to be targeted by structural discrimination, and they elicit more negative emotions among both lay people and health professionnals (Schomerus, Lucht, et al., 2011). In view of the currently limited experimentally-based knowledge available regarding dehumanization processes in medicine (Haque & Waytz, 2012; Szasz, 1991), further exploring dehumanizing experiences in psychiatry and severe alcohol-use disorders would provide a better understanding of this phenomenon among victims, which might lead to major fundamental and clinical implications.

2.3. Currents limits in dehumanization research

The causes and consequences underlying the dehumanizing behaviors produced by authors (e.g., general population, nursing staff) are quite established (Bastian & Crimston, 2014). These behaviors can be blatant (e.g., mocking the naked legs of an old patient wearing hospital gown) or more subtle (e.g., doing the bare minimum work required toward a patient; neglecting patient's requests; ignoring a patient as much as possible). However, the processes related to the victim's experience of dehumanization (i.e. psychiatric patient's feelings and experience) are nearly totally unknown. Recent studies have started to investigate victims' dehumanization's experience in social psychology by exploring its causal factors [e.g., showing that previous maltreatment experiences foster dehumanization feelings (Bastian & Haslam, 2011)] and consequences [e.g., dehumanization victims present self-blame, guilt, shame or even cognitive deconstruction (Bastian & Haslam, 2011)]. Beyond these very preliminary results, a lot remains to be done to specify the necessary conditions for generating dehumanization's experiences and to understand their consequences for the victim. More importantly, no study has explored dehumanization's experiences of patients with psychiatric disorders, despite their potential importance for their wellbeing and treatment.

3. Research perspectives

In view of the complete lack of dehumanization's experience studies in populations with psychiatric disorders, particularly among persons presenting severe alcohol-use disorders, we will propose some avenues for an effective, experimentally valid and clinically grounded exploration of this phenomenon in psychiatry. This might lead to effective clinical programs countering this phenomenon and thus improving patients' quality of life and prognosis. Therefore, we will propose research perspectives divided into two axes. The first focuses on experimental perspectives aiming at the understanding of the phenomenon of dehumanization. The second focuses on clinical perspectives aiming at reducing dehumanization.

3.1. Axis 1. Experimental perspectives: improving the understanding of dehumanization's experience of patients with severe alcohol-use disorders

Due to the very limited experimental data currently available, dehumanization's experience in psychiatry and in patients with severe alcohol-related disorders is still poorly conceptualized. A first critical way to increase our understanding of this phenomenon would be to identify its causes and consequences, as well as the factors protecting patients from dehumanization's experience. We thus propose a theoretical model (summarized in Fig. 1), presenting the possible antecedents (green part of the Figure), moderators (blue part) and consequences (yellow part) of the dehumanization's experience that have to be analyzed to offer a complete understanding of the phenomenon.

3.1.1. Dehumanizing antecedents and fundamental needs

Different categories of antecedents should be experimentally investigated, particularly factors related to:

(1) *Social life and relations*, known to constitute crucial determinants of dehumanization's experience (Bastian & Crimston, 2014). We argue that variables such as loneliness, stigmatization, and rejection faced by patients with addictive disorders could be important predictors of dehumanization. Indeed, the emotional distance that predominates in clinical settings, as well as the social distance that most healthcare actors take from patients with severe alcohol-use disorders, provide the necessary conditions for the emergence of dehumanization (Schomerus, Lucht, et al., 2011; Väyrynen & Laari-Salmela, 2018).

(2) *Physical environment*, which could affect patients' dehumanizing experience. There is extensive evidence that hospitals' physical environment can widely influence patients wellbeing and needs. Numerous factors (e.g., presence of nature scenery, limited noise or sunlight exposure) have clinical consequences on patients' stress, sleep quality, pain, medical complications or recovery (Ulrich, 1984; Ulrich et al., 1991; Ulrich et al., 2008). In addition, we propose that some characteristics of psychiatric hospitals' architecture and clinical units (e.g., small room size, noise, dirtiness, lack of intimate space) can threaten patients' dignity and favor dehumanization's experience. For example, it may be assumed that standardized and shared rooms undermine patients' individuality and implicitly promote the idea that patients are fungible, which is an important criterion of mechanistic dehumanization (Haslam, 2006). Moreover, being locked for weeks in a closed center implicitly suggests that patients must be controlled as caged animals, which also conveys a dehumanizing message, as the lack of self-restraint is a known criterion of animalistic dehumanization (Haslam, 2006). The idea that some physical environments may generate dehumanization feelings has already been suggested in the literature (Liebling, 2011), specifically regarding mental health facilities (Bil, 2016). The simple fact that mental health facilities are usually less agreeable or comfortable than other types of housings further illustrates society's perception of people with mental illness, suggesting that they deserve or require less comfort than other human beings.

(3) *Contextual factors*, as the level of empowerment and control granted to patients on their treatment, also constitute potential predictors of dehumanization. The importance of patients' empowerment in medicine is largely known, as well as the relation between its antagonist (i.e. powerlessness) and dehumanization (Gwinn, Judd, & Park, 2013; Lammers & Stapel, 2010; Yang, Jin, He, Fan, & Zhu, 2015). Empowering patients with psychiatric disorders, by increasing their perceived control over their treatment, might reduce this powerlessness feeling and increase patients' agency and maturity [i.e. two characteristics involved in humanity attribution (Haslam, 2006)].

Furthermore, we suggest that these three categories of factors lead to dehumanization's experience because they can threaten patients' fundamental needs. Fundamental needs (e.g., need for belonging, self-esteem, control, or meaning) are the needs that are shared by all human beings and have important negative consequences when thwarted (Baumeister & Leary, 1995; Leary, Kelly, Cottrell, & Schreindorfer, 2013). We argue that dehumanization experience is one of the important consequences of unsatisfied fundamental needs. Factors related to social life can mostly thwart the need for belonging, while factors related to the environment and contextual factors (e.g., being in a locked environment or having a restricted phone use) can thwart the need for control. Other needs might also be threatened by the three categories of factors (e.g., self-esteem is negatively influenced by social rejection or by standing in a powerless position), leading the victims to

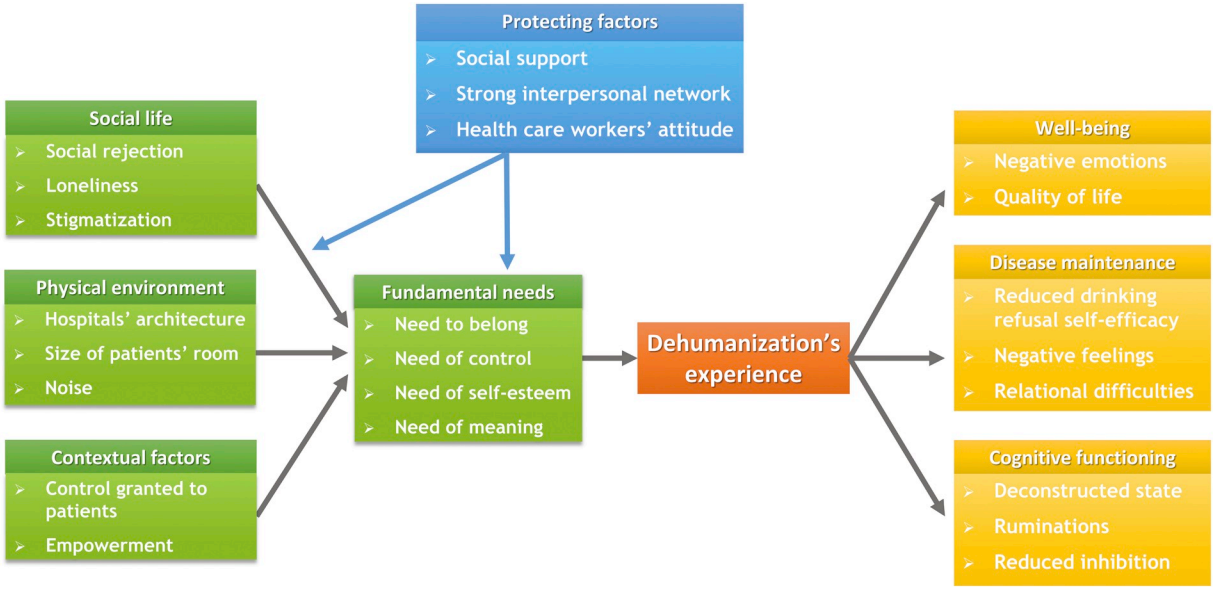

Fig. 1. Proposed theoretical model of dehumanization's experience in severe alcohol-use disorders, encompassing the antecedents (in green), protecting factors (in blue) and consequences (in yellow) of dehumanization's experience. (For interpretation of the references to colour in this figure legend, the reader is referred to the web version of this article.)

experience dehumanization. In view of their importance for satisfactory personal and interpersonal life, the nonfulfillment of these fundamental needs may thus constitute a key determinant of patients' dehumanizing experience. Furthermore, patients suffering from addictive disorders are, by definition, in a situation characterized by a lack of control over their substance use. As the need for control is one of the fundamental needs leading to the most deleterious consequences when denied (Baumeister & Leary, 1995; Leary et al., 2013), this nonfulfillment in addictive disorders might be strongly involved in dehumanization's experience.

3.1.2. Dehumanization consequences

While the consequences of dehumanization have not yet been empirically examined in psychiatry, it can be hypothesized that experiencing dehumanization can strongly reduce patients' well-being and quality of life (Saatcioglu, Yapici, & Cakmak, 2008). Indeed, these outcomes are related to the quality of social interactions (Foster, Powell, Marshall, & Peters, 1999) and dehumanization's experience is anchored in negative social interactions. Dehumanization's experience can also elicit negative emotions (Bastian & Haslam, 2011), known to favor increased alcohol consumption among patients with severe alcohol-use disorders (Cooper, Frone, Russell, & Mudar, 1995). Dehumanization's experience could thus also affect disease maintenance and relapse through the generation of negative emotions and relational difficulties (Cooper et al., 1995; Zywiak et al., 2006), initiating a vicious circle where increased alcohol consumption could be used as a coping strategy to face dehumanizing experience's negative consequences. Victims' cognitive functioning is also affected by dehumanization's experience as it can initiate a state of cognitive deconstruction, characterized by reduced affective expression, altered time perception and lethargy (Twenge, Catanese, & Baumeister, 2003; Zhang, Chan, Xia, Tian, & Zhu, 2017). The full extent of dehumanization's effect on cognitive functioning is currently unknown, and the impact of dehumanizing experiences on other cognitive factors involved in the maintenance of alcohol-use disorders [e.g., ruminations, impulsivity, motivation to interact with others (Åkerlind & Hörnquist, 1992; Brion et al., 2018; Grynberg et al., 2016; Quaglino, De Wever, & Maurage, 2015)] has still to be evaluated. Past research has shown that dehumanizing experience has specific effects on attitudes and behaviors, distinct from those related to the mere perception of being disliked [i.e. prejudice or meta-prejudice (Kteily et al., 2016; Kteily & Bruneau, 2017)].

3.1.3. Protecting factors against dehumanization

Variables potentially protecting patients against the aversive effects of dehumanization's experience should also be investigated. Centrally, the presence of social support might be of critical importance. Indeed, a strong interpersonal network and benevolent attitudes from relatives, friends, and practitioners could help to lower the consequences of dehumanizing experiences, as they satisfy patients' need to belong (Baumeister & Leary, 1995). As dehumanization is mainly an interpersonal phenomenon (Bastian et al., 2013), its reduction through rehumanization should also be deeply anchored in social relations. Accordingly, we suggest that the social inclusion induced by social support might have a humanizing and counterbalancing effect, which would finally buffer the negative effects related to experienced dehumanization (Bastian & Haslam, 2010). The proposition that social support can reduce dehumanization's feelings has already been experimentally tested (Caesens, Stinglhamber, Demoulin, & De Wilde, 2017). It is also known that social support has positive effects on drinking outcomes and wellbeing among patients with addictive disorders (Beattie & Longabaugh, 1997). In the same vein, just as maltreatments can provoke dehumanization's experience, we argue that healthcare workers' benevolent attitudes toward patients could constitute a protecting factor and have a humanizing effect on patients' experience.

3.1.4. Temporal dimension of dehumanization

Finally, a crucial aspect of dehumanization's experience, that has up to now been completely neglected, is its temporality, namely its evolution and variation across time and contexts. Investigating dehumanization's temporality could notably quantify the persistence of dehumanization feelings after a dehumanizing experience, or the ideal timing to promote protective factors reducing this experience. The impact of dehumanization repetition should also be clarified, as chronicity is a crucial factor to determine the consequences of negative events (e.g., the difference between acute and chronic stress). While up to now focused on unique dehumanizing events, studies should urgently examine the differences between sporadic and repeated dehumanization's experiences. It may be expected that dehumanization in psychiatry is particularly deleterious for patients because of its chronicity.

Beyond varying across time, dehumanization might also vary across populations with psychiatric disorders, which present different social exclusion levels and are differently stigmatized by lay people (Schomerus, Lucht, et al., 2011). Taking into account that extremely stigmatized groups are dehumanized, it could be expected that patients with severe alcohol-use disorders and other populations with addictive disorders are markedly dehumanized just as they are markedly stigmatized (Harris & Fiske, 2006; Room, 2005; Schomerus, Lucht, et al., 2011). Future research should investigate how dehumanization's experience can be modulated by patients' disease characteristics (e.g., mental versus physical disease, internal versus external/visible disease) and reveal the characteristics defining the extensive dehumanization faced by patients with severe alcohol-use disorders.

3.2. Axis 2. Clinical perspective: reducing dehumanization in psychiatry

3.2.1. Author's level: reducing dehumanization by the medical staff

In view of the deleterious consequences of dehumanization's experiences for patients, it seems important to develop countermeasures to be implemented in clinical practice. As suggested above, dehumanization is used by healthcare workers to reduce the emotional cost of working with suffering individuals (Cameron et al., 2015), and therefore burnout risk (Trifiletti et al., 2014). Healthcare workers report specific stigmatizing attitudes toward patients with substance-use disorders and the perception that healthcare delivery is impeded by their lack of motivation (Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013; Rao et al., 2009). The emotional cost of helping them might thus be perceived as particularly high. Implementing alternative methods to lower the emotional burden of clinical practitioners (e.g., social support, close supervision, mindfulness, stress management intervention) might reduce their use of dehumanization as a coping mechanism. Multiple interventions have shown encouraging results in reducing stress, burnout, and anxiety among healthcare workers (Ruotsalainen, Serra, Marine, & Verbeek, 2008). Moreover, organizational support should be reinforced as it reduces employees' own dehumanization feelings, as well as emotional exhaustion, psychosomatic strains, and job insatisfaction (Caesens et al., 2017). Additionally, prior research in the organizational domain showed that the way employees feel treated by their organization influences how they subsequently treat people they are in contact with in the workplace (e.g., customers, subordinates) (Masterson, 2001). Accordingly, reducing healthcare workers' dehumanization's feelings through valorizing organizational practices and policies might reduce the dehumanizing treatment they may perpetrate toward patients through a “trickle-down effect”.

Moreover, as dehumanization is most often involuntary and unconscious (Haslam & Loughnan, 2014), practitioners' awareness about this phenomenon should be increased. Empathy could also be targeted, as higher empathy is related to reduced self-other dissimilarity, which might in turn lower dehumanization (Martinez, 2014). Practitioners' empathy towards patients should thus be promoted during medical training, particularly because current training surprisingly reduces empathy and favors dehumanizing behaviors (Haque & Waytz, 2012). In the same vein, biology-based explanations of mental disorders (focusing on biological, genetic and neurological causes) have gained in popularity, notably following the emergence of neurosciences (Deacon, 2013). Unfortunately, this conception is related with reduced empathy toward patients (Lebowitz & Ahn, 2014), as well as with more dehumanizing perceptions and more favorable attitudes towards constraint-based therapeutic methods (Pavon & Vaes, 2017). Emphasizing empathy and consideration for patients' feelings during medical training could thus reduce patients' dehumanization (Haque & Waytz, 2012).

In addition, an efficient way to reduce dehumanization is to increase intergroup contacts (Greenaway, Quinn, & Louis, 2011; Haslam & Loughnan, 2014), as these contacts are associated with the emergence of a common identity and a reduction of intergroup boundaries (Capozza, Trifiletti, Vezzali, & Favara, 2013). Moreover, these changes are linked to higher levels of empathy and lower levels of anxiety (Capozza, Trifiletti, et al., 2013), which could both hold potential positive effects on dehumanization. Developing interactions between patients presenting psychiatric disorders and the general population might thus reduce the global dehumanization trend among lay people, and the same proposal applies for contacts between patients and healthcare professionals (Capozza, Falvo, Favara, & Trifiletti, 2013). While it has been suggested that mentally imagined contact might be sufficient to reduce dehumanization (Vezzali, Capozza, Stathi, & Giovannini, 2012), the richness of contacts should be promoted, as contacts' quality is more important than quantity to reduce intergroup prejudice (Keith, Bennetto, & Rogge, 2015). Quality of contacts can be improved by ensuring that the contact is voluntary, pleasant, cooperative and that both parties are on equal status (Islam & Hewstone, 1993). Finally, some promising avenues to foster humanization in medicine have been proposed by Haque and Waytz (2012), and could be implemented in psychiatry and addictive disorders. By example, they proposed that individuation should be promoted by making both patients and healthcare workers more identifiable (e.g., by adding personalized details on patients and workers' uniforms). Additionally, patients should be treated as active partners in clinical decision-making, to improve their empowerment and agency, which can reduce dissimilarity and balance the power dynamic (Haque & Waytz, 2012; Lammers & Stapel, 2010), ultimately lowering dehumanization.

3.2.2. Victim's level: reducing dehumanization's experiences in patients

In addition to the above proposals to reduce dehumanizing behaviors from lay people and healthcare workers, complementary interventions could more directly lower dehumanization's experience in populations presenting psychiatric disorders. A first lever would be to remodel psychiatric hospitals' environment to differentiate them from locked and impersonal structures. Consequently, patients should have an increased intimacy (reinforcing their perception of being treated as human beings rather than as caged and immature animals), be less watched or monitored (to satisfy their need of control) and have more possibilities to personalize their living space (to reduce the perception that they are fungible). Interestingly, outreaching and deinstitutionalization (where patients live in normal or adapted homes with the help of mental health services) could be a way to favor psychiatric patients' re-humanization. This method has shown a reduction in stigma, as well as a transition from avoidance and fear to compassion and kindness toward patients (Hickling, Robertson-Hickling, & Paisley, 2011). Deinstitutionalization is notably supported by United Nations' Special Rapporteur on the Rights of Persons with Disabilities based on the Convention on the Rights of Persons with Disabilities [i.e. *“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” (United Nations, 2007)*] and has been described as having extraordinary benefits for most patients (United Nations (UN) General Assembly, 2007; Eisenberg & Guttmacher, 2010), despite contradictory results (Torrey, 2010). Of course, the benefits and costs of this method for populations with addictive disorders should be thoroughly investigated to ensure that the potentially humanizing benefits (e.g., improved control or agency) are not counterbalanced by an increased confrontation with risky contexts favoring drug consumption.

Improving the hospital's context proposed to patients may also decrease dehumanization's experience during the detoxification process. Ensuring that patients are well informed regarding their treatment and have an influence on this treatment could contribute to control and agency, and thus re-humanize them (Yang et al., 2015). When possible, healthcare workers should be encouraged to consider patients as equals during social interactions, as having a perceived lower social status can provoke dehumanization's experience (Gwinn et al., 2013) while having equal status contributes to the quality of contacts (Islam & Hewstone, 1993). Moreover, punitive behaviors (e.g., confiscating

phones or forbidding a patient from going out) should be avoided as they correspond to known forms of dehumanization [i.e. treating the person as a child or devaluating his/her social identity by symbolically placing him/her under other individuals (Bastian & Haslam, 2011; Haslam, 2006)]. Many common but dehumanizing practices should also be reconsidered: dressing patients in the same outfits, forcing them to share a standardized room with strangers, or favoring physical promiscuity are all common practices in hospitals, which have economic and practical roots but might strongly favor the emergence of dehumanization feelings. Indeed, these practices increase dehumanization factors such as deindividuation, patients' fungibility and dissimilarity between medical staff and patients (Haque & Waytz, 2012; Haslam, 2006). It should be noted that these practices are also shared with prisons, which are known to constitute dehumanizing environments undermining prisoners' dignity and well-being (Liebling, 2011). Hospitals should thus urgently thrive to modify such standards in order to improve patients' choices, comfort, dignity, and ultimately, humanity.

Finally, another re-humanization perspective has been recently initiated by a study showing that participants perpetrating immoral behaviors, which drives self-dehumanizing feelings, later express an increased propensity to behave pro-socially (Bastian & Crimston, 2014). This suggests that participants behave pro-socially to regain their lost humanity (Bastian & Crimston, 2014). Providing patients with severe alcohol-use disorders the opportunity to behave pro-socially (e.g., by volunteering their time to a charity) might be an interesting way to re-humanize them. In addition to the direct benefits of the pro-social behavior, they might also regain agency, interpersonal warmth, and moral sensibility in their own eyes as well as in others' eyes. Moreover, activities such as volunteering can also satisfy fundamental needs such as the need to belong [as it can create social relations and provide a way to gain recognition (Fisher & Ackerman, 1998)] and the need of meaning [as volunteering activities typically provide life meaning (Bradley, 2000)]. Such activity might thus be promoted to improve public perception of patients with severe alcohol-use disorders and to reduce the stigma they suffer from, which is, an important step toward rehabilitation (Sartorius, 1995).

4. Implications and conclusion

The study of dehumanization from both the victim's and the author's point of view in psychiatry and severe alcohol-use disorders, which has been initiated in the present paper, has promising perspectives at both theoretical and clinical levels. At the theoretical level, it will offer a better understanding of the dehumanization phenomenon and provide experimental avenues to test how patients' treatment and well-being can be improved. At the clinical level, a first positive consequence of the deepened exploration of dehumanization processes would be to offer precise information to healthcare workers and hospitals, in order to underline the presence of dehumanization and its consequences for patients. In a second step, direct actions should be taken to reduce or prevent the identified causes of dehumanization, and thus its observed consequences. Multiple actions to reduce dehumanization toward patients have been proposed here, which could be directly implemented in clinical practice, for example reducing the emotional strain on healthcare workers by implementing stress management interventions, improving their empathy, promoting norms towards patients in hospitals, and creating high-quality contacts with patients. These actions should be implemented with care because dehumanization also plays a protective role for healthcare workers (Haque & Waytz, 2012; Trifiletti et al., 2014). Additionally, solutions to reduce patients' dehumanizing experiences have been proposed, such as improving patients' physical comfort, empowerment, fundamental needs' satisfaction, and dignity through practical changes. Furthermore, volunteering for charities, deinstitutionalization and increased individuation also constitute promising directions to protect patients against dehumanization or to re-humanize them. The research perspective presented here could thus constitute a first step towards a deeper fundamental understanding and an increased consideration of dehumanization's experience from the patient's point of view in psychiatry, initiating new research avenues as well as effective clinical changes.

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Contributors

All authors developed the study concept and contributed to the study. Sullivan Fontesse drafted the paper under the supervision of Pierre Maurage, Stéphanie Demoulin and Florence Stinglhamber. All authors approved the final version of the paper.

Conflicts of interest

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