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A qualitative insight on stereotypes and prejudices toward mental disorders in Burkina Faso: the interaction of shame and fear as underlying influences of stigma

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Abstract

Background: Worldwide, stigma is recognized as a barrier limiting access to psychiatric care. The scope of stigma varies across cultural contexts and contributes to the social inequalities in health observed in many low- and middle-income countries.

Aim and methods: In this paper, we explore the way mental disorders are stigmatized in Bobo-Dioulasso (Burkina Faso). We conducted seven focus groups and 25 individual interviews with patients, family members, caregivers, and key informants. Interviews focused on stereotypes and attitudes toward individuals identified with mental disorders.

Results: A set of stereotypes is socially conveyed about people with mental disorders. The perceptions that these individuals are fragile, useless, dangerous, marginal, and adopt strange behaviors are common. These stereotypes could be related to emotional reactions, such as sadness, compassion, indifference, fear, disgust, and shame, that justify, in some cases, discrimination and unequal treatment.

Discussion: This study suggests that affective reactions are crucial to understanding stigma in Burkina Faso. The notion of shame seems to be rooted in a set of cultural norms and values, and fear seems to be related to structural stigma. Our results offer some insights for future anti-stigma programs in a context where resources are limited and where cultural characteristics must be considered.

Introduction

According to the latest epidemiological data, more than one billion people worldwide suffer from a mental health disorder, and approximately one in four people are personally affected at some point in their lives (WHO, 2016; Rehm & Shield, 2019). The morbidity of these disorders has been steadily increasing over the past 30 years, largely due to social inequalities and lifestyle changes brought about by urbanization (Ahmed & Hossain, 2018; WHO, 2017).

In addition to coping with their symptoms, many individuals living with mental health disorders must deal with the issue of stigma. People with severe and persistent mental disorders are particularly affected by this issue (Amsalem *et al*., 2021; Angermeyer & Dietrich, 2006). Although the so-called common disorders (anxious and depressive disorders) are less stigmatized, these conditions are still the target of significant stigma; this is particularly true when it comes to chronic difficulties (Alonso *et al*., 2008). Stigma has important consequences on quality of life, self-esteem, and symptomatology, as well as on employability and social inclusion (Valery & Prouteau, 2020; Sharac *et al.*, 2010). Stigma is also considered a social determinant of health limiting help-seeking and may, therefore, be associated with a deterioration of the person's physical and mental health (Clement *et al.*, 2015; Henderson, Evans-Lacko, & Thornicroft, 2013).

Stigma has been documented globally but shows significant variations across regions of the world (Javed *et al*., 2021; Krendl & Pescosolido, 2020). People with severe mental health disorders are more stigmatized in low- and middle-income countries than in high-income countries (Alonso *et al.*, 2008; Seeman *et al*., 2016). In these countries, it is estimated that between 76% and 99% of people with a severe mental health disorder do not consult available resources and that one of the important factors negatively influencing help-seeking is social stigma (Kenejad *et al.*, 2018). Little is known about the specific mechanisms explaining this phenomenon in resource-limited settings, as almost all research is conducted in Western countries (Clement *et al.*, 2015; Heim *et al.*, 2020). Existing cross-cultural studies highlighted that stigma is more prevalent in certain communities and that it manifests itself differently depending on socio-cultural contexts (Krendl & Pescosolido, 2020; Yang *et al.*, 2014). More specifically, it seems that the expression of stigma is shaped by social codes and cultural norms.

In sub-Saharan Africa, the issue of stigma has been highlighted by humanitarian organizations. Poor living conditions, social exclusion, and abuse of people with mental disorders have been identified as key priorities for the *Movement for Global Mental Health* (Kleinman, 2009; Semrau *et al.*, 2015). Although this phenomenon is very visible, very little research has been conducted in that regard. Existing studies identify the salience of stigmatizing attitudes in the general population, among health professionals, and among family members (Benedicto *et al.*, 2016; Hanlon *et al.*, 2014; Koschorke *et al.*, 2021; Reta *et al*., 2016; Salifu Yendork *et al.*, 2016; Shah *et al.*, 2017). Since most are descriptive and quantitative, these studies do not identify the dynamics underlying the phenomenon in these contexts.

Over the past few decades, social psychology literature has suggested that the study of stigma benefits from exploring the cognitive and affective components underlying observable discriminatory behaviors (Corrigan, 2004, 2018; *Fox et al.*, 2018; Link & Phelan, 1999; Major & O'Brien, 2005; Thornicroft *et al.*, 2007). In other words, discrimination experienced by people with mental disorders cannot be understood without lifting the veil on the stereotypes and prejudices from which it takes root. This literature also identifies a structural dimension to the phenomenon, referring to the influence of institutions and social structures contributing to the propagation of stigmatizing messages (Corrigan *et al*., 2004; Hatzenbuehler, 2016).

While research clearly identifies that addressing stigma requires looking at all cognitive, affective, and structural dimensions, most anti-stigma programs in Sub-Saharan Africa are based on the premise that discrimination and abuse of people with mental disorders are due to a lack of mental health literacy (Ganasen *et al.*, 2008; Naslund & Deng, 2021; Heim *et al.*, 2020). In Burkina Faso, where this research takes place, no study has previously been carried out on the issue of stigma, thus limiting the possibility of developing adapted interventions. It is in this context, where very little information is available, that our study was conducted. It aims at identifying stereotypes and attitudes associated with mental health disorders in Burkina Faso. The underlying objective is to guide the development of culturally adapted anti-stigma programs.

Context

Burkina Faso is a country in West Africa with a population of 20 million people from about 60 ethnic groups. According to the latest estimates, only 28.7% of the population is urban, mainly living in the cities of Ouagadougou and Bobo-Dioulasso. The proportion of the population living below the poverty line is 40.1%, ranking the country among the most vulnerable in the world. Facing many socioeconomic and public health challenges, very little attention is paid to mental health in Burkina Faso. The lack of political commitment to mental health is mainly reflected in 1) the absence of a national budget for mental health, 2) the insufficient number of health structures and mental healthcare professionals, and 3) the absence of a legal framework protecting the rights of people with mental disorders. In urban areas, such as the city of Bobo-Dioulasso, these people often find themselves wandering. They have little access to mental health care, especially since this is associated with an out-of-pocket payment that they often cannot afford.

Methods

This study is part of a socio-anthropological research documenting the full range of components of social stigma. To do so, an ethnographic field investigation was conducted between the months of April and August 2015 and January and May 2017. As part of this investigation, the principal researcher engaged in participatory and non-participatory observations in different care settings in the city of Bobo-Dioulasso (psychiatric services, traditional healing systems, charitable associations) which allowed for the development of interview grids addressing the use of mental health care, social representations of mental disorders, as well as the stigmatized facets of these disorders (stereotypes, attitudes). The results presented in this article focus only on the latter. The interview grids were developed by the principal researcher and validated by the co-researchers and the field collaborators. They were then pre-tested with a relative of a co-researcher, which led to modifications in the way we asked the questions to be congruent with local expressions.

In this research, an emic and inductive posture was adopted to unveil popular conceptions of mental health (Pigeon-Gagné et al., 2023) rather than using biomedical entities from Western psychiatry, which is why the term "mental disorder" was used rather than a more specific terminology. The objective was to provide a space for participants to identify the components of stigmatization. A total of 7 focus groups (FG) and 25 individual interviews (II) were conducted (Table 1).

Table 1. Sociodemographic characteristics of participants

		Individual Interviews	Focus Group Discussions
Gender			
	Men	20	40
	Women	5	29
Age			
	20 -	2	4
	20 – 30	5	12
	30 - 40	5	21
	40 - 50	6	16
	50 - 60	5	9
	60+	2	7
Ethnic group			

Mossi	14	22
Bisa	2	9
Bobo	5	7
Samo	0	7
Dioula	0	6
Gourounsi	0	5
Dagara	3	4
Peul	1	3
Other	0	6
Education		
Primary	7	21
Secondary	11	17
University	6	15
None	3	16
Socioeconomic situation		
Informal sector	15	41
Formal sector	7	16
No income	3	12

In the first fieldwork, 15 individual interviews were conducted with patients of the psychiatric service (n=4), relatives of patients (n=2), caregivers (n=4) and key informants (n=5). These interviews were conducted by the principal investigator in locations chosen by the participants, but where their words could remain confidential. The participants were people with whom the researcher had developed a trust relationship through her regular presence in the care settings. In addition, 7 focus groups were held with community members (n=4), patients (n=2) and caregivers (n=1). The groups were formed so that men and women were met separately, people in authority were not included, and they were held in the language of the majority (Dioula or French).

In these interviews, participants were asked open-ended questions about stereotypes related to mental health difficulties and endorsed attitudes. The questions asked in this regard were, "What comes to mind when you think of a person with a mental disorder?", "What characterizes these people?" "How do you feel when you meet them?", "How should they be treated?". The discussion was fueled by follow-up questions. In a second phase, participants were asked more specifically about specific stigmatizing attitudes: "Would you be willing to eat/befriend/marry a person with a mental disorder?". They were also invited to discuss concrete examples and personal experiences.

After being transcribed, the data was subjected to thematic analysis (Paillé & Muchielli, 2016). Several readings took place as a phase of immersion with the data allowing certain observations, impressions, feelings, and questioning to emerge. This was then discussed among co-researchers, which led to the identification of the main themes. The data was then reviewed by the principal investigator and a research assistant to code the excerpts inductively using NVivo software. Once the coding was done from the material obtained in the focus groups, the individual interviews were analyzed: the codes were integrated with the previous ones. This step-by-step process allowed for the identification of recurrences and salient discursive elements. Once the thematic groupings had been constructed, the material was analyzed deductively with a descriptive posture to identify the affective components of the stigma.

A second fieldwork took place in 2017, when 10 interviews were conducted with caregivers (6) and key informants (4) to further our understanding of stigma dynamics. Participants were identified based on their experiences and knowledge of exclusion dynamics. The interviews conducted were then informal but were guided by the researcher's preliminary understanding. These interviews allowed us to refine our understanding of certain themes. The data was then transcribed and subjected to the same analytical process, leading to a thematic reorganization.

Ethical approval was obtained from the ethics committee of the Université du Québec à Montréal and from the Ministry of Health of Burkina Faso.

Results

In the interviews, participants provided a wide range of emotional responses that they spontaneously associated with stereotypes of mental disorders (Table 2). Six different emotional responses were reported: sadness, indifference, disgust, fear, aggressiveness, and shame.

Table 2. Participants' attitudes toward people identified as having a mental health disorder

Affective reactions	**Stereotypes**
Sadness	Fragile people Vulnerable people Victims of certain situations
Indifference	Useless people Disturbing people Nuisance
Disgust	Marginal behaviors (dirtiness)
Fear	Aggressive behaviors Permanent condition Contagious condition Psychiatric consultation Psychiatric label
Aggressiveness	People who are responsible for their condition
Shame	Marginal behaviors (nudity) Aggressive behaviors

*Reactions in bold are those reported by all respondents.

Sadness

For most respondents, the first response given when asked to talk about how they felt about individuals with a mental disorder was sorrow: "it hurts", "it's a great pain", "our hearts are breaking", "we feel sorry" and "it makes us tired". Participants explained that they felt sorrow and pity when they observed the daily living conditions of people with mental illness and when they realized their distress. Many people expressed helplessness when faced with the wandering patients, not knowing how to help them, and thinking of their family’s suffering:

> *I: When meet a person with a mental disorder on the street, what comes to mind? What do you think about?*
> *M1: It makes you tired, it makes you sad. You would like to treat him, but you can't. He eats unhealthy things, it hurts because you can't do anything for him...*
> *M2: Crazy people are pitiful. When I see them, it makes me tired, it makes me sad because I think of their parents. We have children like them, that's why it hurts. If God makes it like that, it hurts us. So, you ask, "God! You have to save him, you have to help him, and you have to spare me from this too." That's what we ask when we see them.*
> *M3: Your heart breaks because childbirth is difficult, you think of his mother.*
> (FG with community members, men)

Participants explained that the sadness they felt was directly related to their perception of the person's degree of responsibility. They felt sorrow especially towards women who were ill, because they were victims of difficult situations or exclusion. Participants also reported examples of young men who were very studious or had a prosperous business and had been the object of jealousy and became ill because of an act of witchcraft for which they were not responsible:

> *I: Whose fault, is it?*
> *W1: The witchcraft (tears in the eyes). They have done nothing, but we envy him and we spoil him... we put a spell on him out of jealousy (trembling voice)*
> *W2: It was a man who put the spell on him, God doesn't give diseases to people. If you see that someone is sick, it's our fault. If you see that a person is doing fine, tomorrow someone puts a spell on him. Bad people make him crazy and then it's over. They don't have anyone's help...*
> *W3: There are also some people that we see with notebooks in the street. You'll find out that he was a very bright student that someone put a spell to spoil his studies. And so, he only sees his papers, but he can't do anything with them. It hurts us, it gives pain.*
> (FG with community members, women)

Indifference

Participants also expressed a form of indifference, especially when people wander around the city. These individuals were generally perceived as being a nuisance since they were not engaging in income-generating activities nor in household chores. They were therefore seen as a burden to families, but also as potentially a burden to the neighborhood and the community at large. Participants said things like "when you see them, you just go on your way", "when you're a crazy person, no one cares about you", "it's as if you were dead", "we don't need them", "they're a burden for all of us". Health professionals frequently referred to this phenomenon of indifference that they observed and that they associated to a form of disempowerment:

> *M1: There is a total indifference towards them. There is a generalized lack of responsibility. People have so many problems, if the patient is not aggressive, as long as he or she does not disturb their traffic or their peace of mind at home, they don't care. Because they say to themselves: "We don't know him, it's not our problem". They don't try to understand. They don't care...*
> *M2: A lot of these patients, when they go to a place where there's food, they stay there. You see him one morning he's sitting outside your door. You don't know where he's from, you don't know his village, you don't know his family... you can't just chase him away. But there is indifference towards him. Only what you have to do is maybe to keep him away from your door, that's all. And that's common, very common.*
> (FG, mental health professionals, men)

Disgust

Wandering people, described as people who engage in marginal, disturbing, and even immoral behaviors, evoked disgust. When talking about poor personal hygiene and nudity, several expressions of disgust were explicitly put forward. In addition to the unhygienic and bodily state, participants also named that their disgust stemmed from the fact that these individuals were "not of the same nature". They were sometimes considered as a dog or as a thing:

> *The excluded ones in general are the crazy ones. The madman walks around naked... he is dirty. A madman is like a dog... His saliva is contaminated, he is dirty, he smells bad, he is disgusting. He is not like us! That's why we leave him in his corner.*
> (II, man, merchant, 27 years)

Distrust and fear

The most common reactions were distrust, suspicion, and fear. These reactions referred both to a mistrust induced by the patients and by the psychiatric institution.

The aggressive and violent nature of people with mental disorders was the most frequently cited reason for suspicion and fear. According to respondents, the mentally ill are threatening because they can hit, kick, punch, assault, abuse, and insult for no apparent reason. The impossibility of foreseeing and predicting moments of aggressiveness and danger justified the participants' distrust. This precaution allowed them to avoid being the victim of an attack or an aggression; a concern that was discussed more by the women than by the men, the latter being afraid of being attacked without being able to defend themselves. Since most respondents considered these disorders to be permanent and incurable, mistrust had to be maintained even for people who had not had symptoms for several years:

> *A cured madman does remain mad. We'll say a former madman. He remains somewhere a madman; we are suspicious of him forever. I would not like to sleep with him, I would not sleep in peace. I tell myself that at any moment it can come back and then, he is capable of anything, so there is always this suspicion. I don't want to be unaware of a man or a woman like that who has had moments when he was attacking, trying to kill people and he was arrested. Even if he is cured, for us he is more dangerous than an HIV-positive person. Oh yes! Because the seropositive, by touching him there is nothing, by sleeping with him by getting up in the morning there is nothing. But with a madman or someone who tends to become mad, it is unpredictable. You don't know what he can do at any moment. You can't prevent it, he can't prevent it, nobody can prevent it. And so you have to be careful no matter what.* (FG with community members, housewife, 37 years)

Since some participants felt that people with mental health problems could be contagious, they mentioned that they were afraid to encounter them. In this regard, health professionals explain that certain widely held traditional beliefs contribute to mistrust of people with mental disorders:

> *P1: People think that these people are inhabited by spirits. If you are not careful, these same spirits can fall on you or come into you.*
> *P2: But there is also the fact that the patient is aggressive. In his crisis, he bites, he hits. If you get a blow from the patient, if he bites you or spits on you, you also become mentally ill. That's why people are suspicious of them.*

> *P3: People believe that some mental illnesses can be transmitted like malaria. Some people come here and say, "The patient bit me, I'm going to go crazy! These are traditional concepts. It's not easy to get them out of their heads...*
> (FG with mental health professionals, men)

Participants also said they were very suspicious of the psychiatric ward that they considered to be a place where patients came out looking strange. They also identified certain physical stigmas that were easily recognizable and disabling for people receiving this treatment:

> *In the psychiatric hospital, they have sedatives to weaken the madness. The day they are going to inject him, you will see his saliva will flow, it flows like a two-month-old baby. He's walking down the street, right away you know he's crazy... The person is weird, he walks like a truck. It's like a living dead person! It's the effect of the injection that weakens him, that makes him weird. And we distrust him, he even scares us.*
> (II, man, merchant, 27 years)

They stressed the need to be suspicious of anyone going there, regardless of whether the person was engaging in disruptive behavior. Participants also emphasized the need to be wary of health care staff working in psychiatry because they were seen as strange, out of the ordinary and different. Some participants explicitly stated that they considered the caregivers in this facility “being crazy themselves”, which is why they did not trust them. This was also reported by health care workers who said that they were distrusted by those around them:

> *We, as caregivers in psychiatry, are indexed and pointed at. People say, " Anyone who cares for a crazy person is a crazy person," so as soon as we behave in a way that is a little strange to them, they say, "That's it, because he's in psychiatry, he's a crazy person". Even when they don't see any signs of different behavior, when you have your normal character, your normal character becomes abnormal for them.*
> (II, mental health professional, man, 45 years)

Another characteristic associated with psychiatric care was the label that came with medical consultation, a label that people would seek to avoid or would hide. They emphasized the importance of the neighborhood not knowing if a person was attending this place; the mere mention of the names of mental illnesses made people afraid:

> *My niece had a difficult event in her life, her husband betrayed her... it shocked her, she could not eat, sleep, she did not do anything anymore. That's when she went to psychiatry and the doctors there helped her a lot, they gave her products and everything. Then they told her that it was depression that she had. As time went on, she got better. In the meantime, her girlfriend was telling anyone, «My girlfriend is crazy! When she heard this, she asked her friend, "Are you saying that about me? You know it's not madness; it's depression. And you know why I had this depression.’’ She said: "Depression*

> *is in French, for us in Africa, depression is madness". For her friend, as here we don't say depression, for her the diagnosis is madness, and here in Africa, the madman is the most dangerous of all! Once we say that you have a depression, people are afraid of you and will not want to approach you anymore.*
> (II, man, photograph, 51 years)

Aggressiveness

In contrast to the sadness felt towards some, others were more likely to provoke aggressive reactions since they were considered to be responsible for their condition. People we met mentioned that they felt like punching them when they thought that a person had used psychoactive substances or had committed reprehensible acts. The people considered responsible for their condition were men, in almost all the cases since drug use was associated with a male practice:

> *M1: The crazy people we see, a lot of them are drug addicts. They're on drugs and they're mostly boys. And that makes you want to beat them up...*
> *M2: That's true, those who have taken drugs, when you see them, you want to hit them! When I see them, I recognize them.... Those people, I just have to go on my way, I don't want to do anything for them. They just had to stay on the right path, that's all.*
> (FG with community members, men)

Shame

Participants identified disruptive behaviors and easily visible features of mental illness (wandering, nudity, dirtiness, and aggressivity) as shameful. Shame was reported by all but was particularly discussed by people who were caregivers themselves or by people who had been in close contact with a patient in the past. Participants recalled shameful situations that they said they could not talk about to those around them. It was difficult to get them to address these reactions compared to other spontaneously reported reactions (e.g., fear). Two shameful behaviors were reported by family members: aggression and nudity:

> *B: When her illness starts, everybody can tell because she comes out of our yard, she talks, she goes on the road, she goes into every yard she knows. She doesn't walk past the door without going into the yard and she'll do all kinds of things in people's houses. It makes us feel ashamed, that's why I don't let her out.*
> *D: She goes to people's houses, she spoils things, she breaks everything, she yells, she runs around the neighborhood, it makes me feel ashamed...*
> *B: When she is sick like that, her children are ashamed, because she insults everyone. Everything we can't think of, she insults us like that. It makes us feel ashamed...*
> (II, daughter and brother of a psychiatric patient, 17 and 42 years)
>
> *I have a friend who has a little sister like that, she must be 27-28 years old. The parents don't let her go out, when she goes out, they quickly pick her up and bring her home. Since she doesn't know*

> *anything about what she does. It is shameful for the family. If you say to her: "Take off your clothes, I want to see", she will do it and say: "Here are my breasts". You say, "Touch your breasts," she will do it. She says: "touch again? " If you say yes, she will do it, she doesn't know what she is doing… what a shame.* (II, research assistant, woman. 36 years)

Discussion

In this qualitative study, we interviewed 94 people in Bobo-Dioulasso where stigma had not been researched before. Our study aimed to provide a portrait of the attitudes endorsed towards people with mental disorders in a context where psychiatric patients are socially excluded. We met with patients, family members, friends, neighbors, community members, health professionals, and traditional healers to better understand the affective responses justifying discriminatory behaviors. In this exploratory study, we were able to identify a variety of affective reactions, but two (fear and shame) were reported by all participants. These reactions were associated with stereotypes related to: 1) specific behaviors (aggressivity, nudity, dirtiness), 2) perceived intrinsic characteristics (disturbing, useless, harmful), 3) perceived characteristics of mental disorders (permanent, transmissible), and 4) the psychiatric institution.

Our results are consistent with scientific literature in social psychology. Previous empirical studies reveal that the most widely held stereotype is that of dangerousness (Angermeyer & Matschinger, 2005; Corrigan *et al.*, 2005a; Mestdagh & Hansen, 2014; Seeman *et al.*, 2016). Participants in these studies report that people with mental health disorders are dangerous, unpredictable, and potentially violent individuals. In our study, as in previous ones in Sub-Saharan Africa, these stereotypes were associated with distrust and fear (Adewuya & Makanjuola, 2005, 2008; Gureje *et al.*, 2006; Okpalauwaekwe *et al.*, 2017). Research findings unequivocally identify fear as the most frequently reported emotion justifying social distance (Corrigan 2005, 2018; Lien & Kao, 2019; Link & Phelan, 1999; Major & O'Brien, 2005; Stuart *et al.*, 2012).

Beyond these similarities with the scientific literature, some of the attitudes documented in our study deserve further reflection and interpretation, as they seem to reveal specific aspects of stigma in Bobo-Dioulasso. Indeed, it seems that in addition to the perception of dangerousness, the dynamics of stigmatization are strongly based on 1) shame, which is linked to specific symptoms, and 2) mistrust, which is associated with social representations of psychiatry.

Shame seems to be an important reaction to consider to better understand the nature of the stigma in the West African urban context. In our study, we note that shame is unanimously reported by participants and is linked to a desire by relatives to hide their loved one who adopts disturbing and marginal behaviors. Research in Western contexts generally addresses shame as a consequence of internalization of social stigma by people with mental health difficulties (Buchman-Wildbaum *et al.*, 2020; Williamson *et al.*, 2020), rather than as a vector leading to their stigmatization. Aside from a few studies that have outlined the effects of vicarious stigma on family members and shame experienced by significant others (Corrigan & Miller, 2004; Larson & Corrigan, 2008; Moses, 2014; Reupert & Maybery, 2015; Sheehan *et al.*, 2017), this dimension of social stigma remains under-researched limiting the possibility of relying on this literature to interpret our findings. Moreover, this may reflect a fundamental difference in the expression of stigma in Western societies in comparison to its expression in other societies.

In our study, the direct entourage that constitutes the informal care system seems to carry a form of shame and dishonor related to the moral status of the person they care for. The shame experienced by relatives refers to the concept of courtesy stigma (Goffman, 1963). This concept describes the phenomenon of the propagation of the stigma that individuals carry to their proximal social networks, which in turn carry it. The influence of courtesy stigma has been documented in Asian cultures where shame acts as a structuring element of social organizations and where communities associate psychological distress with moral weakness (Abdullah & Brown, 2011; Burnard *et al.*, 2006; Chong *et al.* 2007; Krendl & Pescosolido, 2020; Kleinman 1977; Lam *et al.* 2010; Lauber & Rössler 2007; Yang *et al.* 2014; Zhang *et al.* 2020). These studies suggest that to avoid experiencing shame or humiliation, families may delay help-seeking to formal systems as much as possible. It also appears that once begun, this help-seeking process may be hidden or stopped prematurely by family members to avoid being stigmatized by their community.

Few studies in the sub-Saharan region on courtesy stigma could be identified (Dako-Gyeke & Asumang, 2013; Girma *et al.*, 2014; Shibre *et al.,* 2001; Quinn, 2007). Although courtesy stigma is not well documented in traditional African contexts, it appears that this phenomenon is exacerbated in these societies (where families act as the basic social unit and where interactions with extended community members represent a pillar in social organization) compared to Western societies in which individuals act as the basic unit to social functioning. As previously discussed, in Bobo-Dioulasso, it appears that the endorsement of stigmatizing attitudes is intimately linked to the notion of transgression and the perception of the degree of responsibility of individuals (Pigeon-Gagné et al., 2023). In this context, it is possible to believe that it is shameful for family members to be associated with reprehensible and socially sanctioned actions. It would be to avoid being the target of marginalization and exclusion within their community that family members would hide their transgressive behaviors (Quinn, 2007). Shame may also fulfill a protective function for people experiencing mental disorders. Their relatives may tend to hide them from social interactions to protect them from the social consequences that may result from the adoption of transgressive behaviors (Read *et al.*, 2009).

Although this study does not specifically address the structural components of stigma, they have emerged through the analysis process. Since the literature makes it clear that affective reactions and stigmatizing attitudes are highly shaped by social structures, it is essential to focus on these structural dimensions. The insidious effects of media treatment as well as the way rights are (or are not) protected by legal markers, and the way institutional policies promote (or limit) access to services have been documented in Western contexts (Corrigan *et al*., 2005a, 2015b; Hatzenbuehler, 2016; Van Beveren *et al.*, 2020). According to this literature, social structures highly contribute to perpetuating unfavorable power dynamics and reinforcing stigmatization. More specifically, the way in which the psychiatric institution contributes to the phenomenon of stigma has been documented with respect to the influence of diagnoses on help-seeking. It is known that individuals avoid seeking professional help despite the perceived accessibility and effectiveness to avoid being labeled (Clement *et al.*, 2015; Corrigan, 2004; Corrigan *et al.*, 2014; Fox *et al.*, 2018; Henderson *et al.*, 2013; Mestdagh & Hansen, 2014; Schnyder *et al*., 2017).

In our study, we observed that the psychiatric institution conveys a structural stigma that goes far beyond the negative influence of diagnoses on help-seeking. It seems that the institution itself carries a stigma and, therefore, generates reactions of distrust and fear in the community. A few studies in sub-Saharan Africa have identified the extent of authoritarian and punitive attitudes toward psychiatric patients in different urban or semi-urban settings (Adewuya & Makanjuola, 2005; Egbe *et al.*, 2014; Kapungwe *et al.,* 2010; Nortje & Seedat, 2013; Ssebunnya *et al*., 2009). These studies, however, do not provide insight into the constituent elements of this phenomenon, which appear to be particularly pronounced in the sub-Saharan region.

To understand the stigmatizing nature of psychiatry in the specific context of the city of Bobo-Dioulasso, it seems particularly important to highlight some factors. First, psychiatry was introduced in Burkina Faso at the end of the colonial period. It is, therefore, a practice instituted by the French colonial power and responding to the logic of Western medicine; a medicine that was foreign to the cultural worldviews at the time. The lack of familiarity and the lack of understanding of the communities concerning the underlying logic of healing can, in part, explain reticence and mistrust. Secondly, our results illustrate that psychiatric professionals are also perceived negatively. The lack of legitimacy of these caregivers cannot be understood without considering the current conditions of psychiatric practice in Burkina Faso. Government funding is limited, health structures are poorly maintained, there are not enough professionals to meet the population’s needs, and the ruptures in the supply of essential medicines remain recurrent problems. The poor quality of care provided (low efficiency of first-generation antipsychotics, stigmatizing side effects of available medication), explained by these structural problems, necessarily contributes to the negative social representations conveyed about the psychiatric institution, but also about the people who experience mental health challenges (Asher *et al.*, 2018; Nyame *et al.*, 2021; Read, 2012). Finally, since it is not located in the same location as the other medical specialties, psychiatry is dissociated from the hospital center which is recognized as a place of care by the population. This contributes to the lack of interaction between health professionals and seems to feed the stereotypes that are held about psychiatric care.

Implications for Intervention and Research

Most anti-stigma programs in Sub-Saharan Africa focus on sharing scientifically validated information with populations to improve their knowledge of psychiatric diagnoses and factors associated with the onset of these disorders (Mascayano et al., 2015; Lauber and Sartorius, 2007). However, scientific literature demonstrates that to understand the dynamics of stigma, it is essential to consider the affective reactions at play in the development of interventions rather than relying solely on the provision of information. Literacy-based programs tend to improve knowledge about mental disorders, which rarely translate into behavior changes and reduction of discrimination (Evans-Lacko *et al.*, 2014; Sampogna *et al.*, 2017; Thornicroft *et al.*, 2016). To be effective, anti-stigma interventions must address literacy concerns as well as legislative issues, the health system’s capacity, and barriers to access care (Javed et al., 2021).

This study provides an opportunity to critically reflect on anti-stigma program development in West Africa. Our results suggest that the affective reactions reported have little to do with a lack of mental health knowledge. On the contrary, we found that affective reactions (shame and fear) appear to explain the adoption of exclusionary behaviors, rather than a lack of knowledge. The affective reactions are, in some cases, related to cultural values (e.g., the importance of transgression in social organization), but seem to be mostly associated with structural factors (e.g., underfunding in mental health). It is, therefore, essential that these components be taken into consideration in developing programs aimed at reducing stigma. In this sense, it is unlikely that a program aimed at increasing mental health literacy will have any effect on the cultural and structural factors that our results reveal. Furthermore, in this study, we found that the first reaction reported by many people is sadness and compassion, which could be used as a lever for intervention in a stigma reduction program.

To develop contextually appropriate interventions, further research is needed to 1) deepen the understanding of the mechanisms underlying shame, 2) explore the meaning of specific cultural codes and values at stake, and 3) develop an understanding of the differential influence of gender on the way people with mental disorders are perceived and treated. It would also be highly relevant to develop a quantitative study with a broader spectrum of participants to document the extent of stereotyping and affective reactions that we have identified in the general population.

In this context, we see the role of community psychologists (especially research teams from outside the contexts under study) restating the importance of a systemic, nuanced and critical analysis of stigma and social exclusion. Both stigma research and anti-stigma program development in sub-Saharan Africa seem to be largely guided by evidence-based approaches and diagnostic categories derived from Western psychiatry. This has important repercussions not only on the provision of services, but also on the symbolic and epistemic realms, which can cause great harm to communities especially when colonial dynamics are at play. We therefore call on our community psychology colleagues to join the critical voices of the Global Mental Health Movement, and to promote intervention approaches that are culturally sensitive, socially grounded and, above all, adopted in collaboration with a diversity of stakeholders, not just researchers and health professionals, but also traditional healers, community gate keepers, and people with lived-experienced.

Limitations

This study has some limitations. It is an exploratory study in which a limited number of people were interviewed. The results of our study cannot be generalized but should rather be read as an initial understanding of the problem of stigmatization as it unfolds in Bobo-Dioulasso. The findings are closely linked to the context in which the study was carried out, more specifically to the relationship between the research team and the field. In this sense, it is possible that divergent points of view may be documented in the future. These results reveal the subjective views and perspectives of the people encountered at a particular time and should be read and interpreted as such. As the principal researcher herself does not speak Dioula, it is possible that some nuances were lost in the translation process and thus escaped the analytical process.

Conclusion

In Bobo-Dioulasso, as in other West African settings, mental disorders are stigmatized. In our study, we note that the main affective reactions underlying stigma are fear and shame, which may be associated with cultural codes, but also with structural issues. Further research is needed to better understand the dynamics of exclusion and the components of stigmatization. This research would lay the groundwork for the development of culturally sensitive anti-stigma programs.

References

Abdullah, T., et Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical psychology review*, *31*(6), 934-948.

Adewuya, A. O., et Makanjuola, R. O. (2005). Social distance towards people with mental illness amongst Nigerian university students. *Social psychiatry and psychiatric epidemiology*, *40*(11), 865-868.

Adewuya, A. O., et Makanjuola, R. O. (2008). Social distance towards people with mental illness in southwestern Nigeria. *Australian and New Zealand journal of psychiatry*, *42*(5), 389-395.

Ahmed, S. M., et Hossain, M. D. (2018). Social determinants in low-income countries. Dans Bhugra, D., Bhui, K., Wong, S. Y. S., et Gilman, S. E. (dir.), *Oxford textbook of public mental health* (pp. 177-180). Oxford University Press.

Alonso, J., Buron, A., Bruffaerts, R., He, Y., Posada-Villa, J., Lepine, J. P., ... & World Mental Health Consortium. (2008). Association of perceived stigma and mood and anxiety disorders: results from the World Mental Health Surveys. *Acta Psychiatrica Scandinavica*, *118*(4), 305-314.

Amsalem, D., Yang, L. H., Jankowski, S., Lieff, S. A., Markowitz, J. C., & Dixon, L. B. (2021). Reducing stigma toward individuals with schizophrenia using a brief video: a randomized controlled trial of young adults. *Schizophrenia bulletin*, *47*(1), 7-14.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163-179.

Angermeyer, M. C., et Matschinger, H. (2005). The stigma of mental illness in Germany: a trend analysis. *International journal of social psychiatry*, *51*(3), 276-284.

Asher, L., Fekadu, A., & Hanlon, C. (2018). Global mental health and schizophrenia. *Current opinion in psychiatry*, *31*(3), 193-199.

Benedicto, M., Mndeme, E., Mwakagile, D., et Mwansisya, T. (2016). Community knowledge, attitudes and perception towards mental illness in Dodoma Municipality, Tanzania. *ARC Journal of public health community medicine*, *1*(3), 10-8. http://dx.doi.org/10.20431/2456-0596.0103002

Buchman-Wildbaum, T., Váradi, E., Schmelowszky, Á., Griffiths, M. D., Demetrovics, Z., & Urbán, R. (2020). The paradoxical role of insight in mental illness: The experience of stigma and shame in schizophrenia, mood disorders, and anxiety disorders. *Archives of Psychiatric Nursing*, *34*(6), 449-457.

Burnard, P., Naiyapatana, W., et Lloyd, G. (2006). Views of mental illness and mental health care in Thailand: a report of an ethnographic study. *Journal of psychiatric and mental health nursing*, *13*(6), 742-749

Chong, S. A., Verma, S., Vaingankar, J. A., Chan, Y. H., Wong, L. Y., et Heng, B. H. (2007). Perception of the public towards the mentally ill in developed Asian country. *Social psychiatry and psychiatric epidemiology*, *42*(9), 734-739.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., ... & Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine*, *45*(1), 11-27.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American psychologist*, *59*(7), 614.

Corrigan, P. W. (2018). *The stigma effect: Unintended consequences of mental health campaigns*. Columbia University Press.

Corrigan, P. W., Markowitz, F. E., et Watson, A. C. (2004a). Structural levels of mental illness stigma and discrimination. *Schizophrenia bulletin*, *30*(3), 481-491.

Corrigan, P. W., Druss, B. G., et Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological science in the public interest*, *15*(2), 37-70.

Corrigan, P. W., & Miller, F. E. (2004). Shame, blame, and contamination: A review of the impact of mental illness stigma on family members. *Journal of Mental Health*, *13*(6), 537-548.

Corrigan, P. W., Watson, A. C., Heyrman, M. L., Warpinski, A., Gracia, G., Slopen, N., & Hall, L. L. (2005a). Structural stigma in state legislation. *Psychiatric Services*, *56*(5), 557-563.

Corrigan, P. W., Watson, A. C., Gracia, G., Slopen, N., Rasinski, K., & Hall, L. L. (2005b). Newspaper stories as measures of structural stigma. *Psychiatric services*, *56*(5), 551-556.

Dako-Gyeke, M., et Asumang, E. S. (2013). Stigmatization and discrimination experiences of persons with mental illness: Insights from a qualitative study in Southern Ghana. *Social work & society*, *11*(1).

Egbe, C. O., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G., et Petersen, I. (2014). Psychiatric stigma and discrimination in South Africa: perspectives from key stakeholders. *BMC psychiatry*, *14*(1), 191.

Evans-Lacko, S., Corker, E., Williams, P., Henderson, C., & Thornicroft, G. (2014). Effect of the Time to Change anti-stigma campaign on trends in mental-illness-related public stigma among the English population in 2003–13: an analysis of survey data. *The Lancet Psychiatry*, *1*(2), 121-128.

Fox, A. B., Earnshaw, V. A., Taverna, E. C., et Vogt, D. (2018). Conceptualizing and measuring mental illness stigma: The mental illness stigma framework and critical review of measures. *Stigma and health*, *3*(4), 348.

Ganasen, K. A., Parker, S., Hugo, C. J., Stein, D. J., Emsley, R. A., & Seedat, S. (2008). Mental health literacy: focus on developing countries. *African Journal of Psychiatry*, *11*(1), 23-28.

Girma, E., Möller-Leimkühler, A. M., Müller, N., Dehning, S., Froeschl, G., & Tesfaye, M. (2014). Public stigma against family members of people with mental illness: findings from the Gilgel Gibe Field Research Center (GGFRC), Southwest Ethiopia. *BMC international health and human rights*, *14*(1), 2.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster.

Gureje, O., et Lasebikan, V. O. (2006). Use of mental health services in a developing country. *Social psychiatry and psychiatric epidemiology*, *41*(1), 44-49.

Hanlon, C., Luitel, N. P., Kathree, T., Murhar, V., Shrivasta, S., Medhin, G., ... et Jordans, M. (2014). Challenges and opportunities for implementing integrated mental health care: a district level situation analysis from five low-and middle-income countries. *PloS one*, *9*(2).

Hatzenbuehler, M. L. (2016). Structural stigma: Research evidence and implications for psychological science. *American psychologist*, *71*(8), 742.

Heim, E., Kohrt, B. A., Koschorke, M., Milenova, M., & Thornicroft, G. (2020). Reducing mental health-related stigma in primary health care settings in low- and middle-income countries: a systematic review. *Epidemiology and psychiatric sciences*, *29*, e3.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American journal of public health*, *103*(5), 777-780.

Javed, A., Lee, C., Zakaria, H., Buenaventura, R. D., Cetkovich-Bakmas, M., Duailibi, K., ... & Azeem, M. W. (2021). Reducing the stigma of mental health disorders with a focus on low-and middle-income countries. *Asian journal of psychiatry*, *58*, 102601.

Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R., ... et Flisher, A. J. (2010). Mental illness-stigma and discrimination in Zambia. *African journal of psychiatry*, *13*(3).

Keynejad, R. C., Dua, T., Barbui, C., & Thornicroft, G. (2018). WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide: a systematic review of evidence from low and middle-income countries. *BMJ Ment Health*, *21*(1), 30-34.

Kleinman, A. (1977). Depression, somatization and the “new cross-cultural psychiatry”. *Social science & medicine (1967)*, *11*(1), 3-9.

Kleinman, A. (2009). Global mental health: a failure of humanity. *The lancet*, *374*(9690), 603-604.

Koschorke, M., Oexle, N., Ouali, U., Cherian, A. V., Deepika, V., Mendon, G. B., ... & Kohrt, B. A. (2021). Perspectives of healthcare providers, service users, and family members about mental illness stigma in primary care settings: A multi-site qualitative study of seven countries in Africa, Asia, and Europe. *PloS one*, *16*(10), e0258729.

Krendl, A. C., & Pescosolido, B. A. (2020). Countries and cultural differences in the stigma of mental illness: the east–west divide. *Journal of Cross-Cultural Psychology*, *51*(2), 149-167.

Lam, C. S., Tsang, H. W., Corrigan, P. W., Lee, Y. T., Angell, B., Shi, K., ... et Larson, J. E. (2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of rehabilitation*, *76*(1), 35.

Larson, J. E., et Corrigan, P. (2008). The stigma of families with mental illness. *Academic psychiatry, 32*(2), 87-91.

Lauber, C., et Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International review of psychiatry*, *19*(2), 157-178.

Lauber, C., & Sartorius, N. (2007). At issue: Anti-stigma-endeavours. *International Review of Psychiatry*, *19*(2), 103-106.

Lien, Y. J., et Kao, Y. C. (2019). Public beliefs and attitudes toward schizophrenia and depression in Taiwan: A nationwide survey. *Psychiatry research*, *273*, 435-442.

Link, B. G., et Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of sociology*, 363-385.

Major, B., et O'brien, L. T. (2005). The social psychology of stigma. *Annual review of psychology*, *56*, 393-421.

Mascayano, F., Armijo, J. E., & Yang, L. H. (2015). Addressing stigma relating to mental illness in low-and middle-income countries. *Frontiers in psychiatry*, *6*, 38.

Mestdagh, A., et Hansen, B. (2014). Stigma in patients with schizophrenia receiving community mental health care: a review of qualitative studies. *Social psychiatry and psychiatric epidemiology*, *49*(1), 79-87.

Moses, T. (2014). Stigma and family. Dans P. W. Corrigan (dir.), The stigma of disease and disability: Understanding causes and overcoming injustices (pp. 247–268). American Psychological Association.

Naslund, J. A., & Deng, D. (2021). Addressing mental health stigma in low-income and middle-income countries: a new frontier for digital mental health. *Ethics, Medicine and Public Health*, *19*, 100719.

Nortje, G., et Seedat, S. (2013). Recruiting medical students into psychiatry in lower income countries. *International review of psychiatry*, *25*(4), 385-398.

Nyame, S., Adiibokah, E., Mohammed, Y., Doku, V. C., Othieno, C., Harris, B., ... & Appiah-Poku, J. (2021). Perceptions of

Ghanaian traditional health practitioners, primary health care workers, service users and caregivers regarding collaboration for mental health care. *BMC Health Services Research*, *21*(1), 1-9.

Okpalauwaekwe, U., Mela, M., et Oji, C. (2017). Knowledge of and attitude to mental illnesses in Nigeria: a scoping review. *Integrative journal of global health*, *1*(5), 1-14.

Paillé, P., et Mucchielli, A. (2016). *L'analyse qualitative en sciences humaines et sociales* (4e édition). Armand Colin.

Pigeon-Gagné, É., Hassan, G., Yaogo, M., Saïas, T., & Ouedraogo, D. (2023). La maladie mentale et la folie: représentations sociales des troubles de santé mentale à Bobo-Dioulasso (Burkina Faso). *Sciences sociales et santé*, *41*(1), 41-64.

Quinn, N. (2007). Beliefs and community responses to mental illness in Ghana: the experiences of family carers. *International journal of social psychiatry*, *53*(2), 175-188.

Read, U. M., Adiibokah, E., & Nyame, S. (2009). Local suffering and the global discourse of mental health and human rights: An ethnographic study of responses to mental illness in rural Ghana. *Globalization and Health*, *5*(1), 1-16.

Read, U. (2012). "I want the one that will heal me completely so it won't come back again": the limits of antipsychotic medication in rural Ghana. *Transcultural psychiatry*, *49*(3-4), 438-460.

Rehm, J., et Shield, K. D. (2019). Global burden of disease and the impact of mental and addictive disorders. *Current psychiatry reports*, *21*(2), 10.

Reta, Y., Tesfaye, M., Girma, E., Dehning, S., et Adorjan, K. (2016). Public stigma against people with mental illness in Jimma Town, Southwest Ethiopia. *PloS one*, *11*(11).

Reupert, A., Cuff, R., et Maybery, D. (2015). Helping children understand their parent's mental illness. Dans Reupert, A., Maybery, D., Nicholson, J., Göpfert, M., et Seeman, M. (dir.), *Parental psychiatric disorder: Distressed parents and their families* (pp. 201-209). Cambridge University Press

Salifu Yendork, J., Kpobi, L., et Sarfo, E. A. (2016). "It's only 'madness' that I know": analysis of how mental illness is conceptualised by congregants of selected Charismatic churches in Ghana. *Mental health, religion & culture*, *19*(9), 984-999.

Schnyder, N., Panczak, R., Groth, N., et Schultze-Lutter, F. (2017). Association between mental health-related stigma and active help-seeking: systematic review and meta-analysis. *The British journal of psychiatry*, *210*(4), 261-268.

Seeman, N., Tang, S., Brown, A. D., & Ing, A. (2016). World survey of mental illness stigma. *Journal of affective disorders*, *190*, 115-121.

Semrau, M., Evans-Lacko, S., Koschorke, M., Ashenafi, L., & Thornicroft, G. (2015). Stigma and discrimination related to mental illness in low-and middle-income countries. *Epidemiology and psychiatric sciences*, *24*(5), 382-394.

Shah, A., Wheeler, L., Sessions, K., Kuule, Y., Agaba, E., et Merry, S. P. (2017). Community perceptions of mental illness in rural Uganda: An analysis of existing challenges facing the Bwindi Mental Health Programme. *African journal of primary health care & family medicine*, *9*(1), 1-9.

Sampogna, G., Bakolis, I., Evans-Lacko, S., Robinson, E., Thornicroft, G., & Henderson, C. (2017). The impact of social marketing campaigns on reducing mental health stigma: Results from the 2009–2014 Time to Change programme. *European Psychiatry*, *40*, 116-122.

Sharac, J., Mccrone, P., Clement, S., & Thornicroft, G. (2010). The economic impact of mental health stigma and discrimination: a systematic review. *Epidemiology and Psychiatric Sciences*, *19*(3), 223-232.

Sheehan, L., Nieweglowski, K., et Corrigan, P. W. (2017). Structures and types of stigma. Dans Gaebel, W., Rössler, W., et Sartorius, N. (dir.), *The Stigma of Mental Illness-End of the Story?* (pp. 43-66). Springer.

Shibre, T., Negash, A., Kullgren, G., Kebede, D., Alem, A., Fekadu, A., ... et Jacobsson, L. (2001). Perception of stigma among family members of individuals with schizophrenia and major affective disorders in rural Ethiopia. *Social psychiatry and psychiatric epidemiology*, *36*(6), 299-303.Ssebunnya et al., 2009

Stuart, H., Arboleda-Flórez, J., et Sartorius, N. (2012). *Paradigms lost: Fighting stigma and the lessons learned*. Oxford University Press.

Thornicroft, G., Rose, D., Kassam, A., et Sartorius, N. (2007). Stigma: ignorance, prejudice or discrimination?. *The British journal of psychiatry*, *190*(3), 192-193.

Thornicroft, G., Mehta, N., Clement, S., Evans-Lacko, S., Doherty, M., Rose, D., ... & Henderson, C. (2016). Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet*, *387*(10023), 1123-1132.

Valery, K. M., & Prouteau, A. (2020). Schizophrenia stigma in mental health professionals and associated factors: A systematic review. *Psychiatry research*, *290*, 113068.

Van Beveren, L., Rutten, K., Hensing, G., Spyridoula, N., Schønning, V., Axelsson, M., ... & Vandamme, J. (2020). A critical perspective on mental health news in six European countries: How are “mental health/illness” and “mental health literacy” rhetorically constructed?. *Qualitative Health Research*, *30*(9), 1362-1378.

Williamson, T. J., Ostroff, J. S., Haque, N., Martin, C. M., Hamann, H. A., Banerjee, S. C., & Shen, M. J. (2020). Dispositional shame and guilt as predictors of depressive symptoms and anxiety among adults with lung cancer: The mediational role of internalized stigma. *Stigma and health*, *5*(4), 425.

World health organization (2016). *World health statistics*. http://www.who.int/gho/publications/world_health_statistics/FR_WHS2016_Full.pdf

World health organization (2017). *Depression and other common mental disorders: global health estimates*. https://apps.who.int/iris/bitstream/handle/10665/ 254610/WHO-MSD-MER-2017.2-eng.pdf

Yang, L. H., Thornicroft, G., Alvarado, R., Vega, E., & Link, B. G. (2014). Recent advances in cross-cultural measurement in psychiatric epidemiology: utilizing 'what matters most'to identify culture-specific aspects of stigma. *International Journal of Epidemiology*, *43*(2), 494-510.

Yang, L. H., Purdie-Vaughns, V., Kotabe, H., Link, B. G., Saw, A., Wong, G., et Phelan, J. C. (2014). Culture, threat, and mental illness stigma: identifying culture-specific threat among Chinese-American groups. *Social science & medicine*, *88*, 56-67.

Zhang, Z., Sun, K., Jatchavala, C., Koh, J., Chia, Y., Bose, J., ... et Wang, J. (2020). Overview of Stigma against Psychiatric Illnesses and Advancements of Anti-Stigma Activities in Six Asian Societies. *International journal of environmental research and public health*, *17*(1), 280.