



Discrimination and Social Exclusion of People Experiencing Mental Disorders in Burkina Faso: A Socio-anthropological Study

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Abstract

Stigma has been pointed out as a barrier to mental healthcare in sub-Saharan Africa. Among the manifestations of stigma, the use of physical restraints is condemned as a form of violation of basic human rights. Research on this phenomenon is limited in West Africa and more particularly in Burkina Faso. This study explores the phenomenon of stigma of individuals experiencing mental disorders in Bobo-Dioulasso (Burkina Faso). As part of 8 months of socio-anthropological fieldwork, we interviewed 94 informants (7 focus groups and 25 individual interviews) to document exclusionary practices, their perceptions, and justifications. Exclusionary practices can be divided in five subgroups: ignoring, physically and sexually abusing, abandoning, banning, and restraining. Some practices were linked to a lack of financial and material resources, while others were justified by an inferior moral status. We observed differences in the type of exclusion experienced between men and women. Restrictive, abusive, and exclusionary measures are common in Bobo-Dioulasso. These practices can either be understood as part of families' adaptative strategies when dealing with chronic conditions, as part of security measures in the case of patients with aggressive behaviors, or as part of punitive measures when transgressions are committed. We conclude the article by addressing the tensions between local and global meanings of stigma.

Keywords Global mental health · Stigma · Burkina Faso · Social representations

Introduction

Since the early 2000s, social inequalities in health have become a top priority for international health agencies. As a result, mental health has gradually emerged as a field to target to ensure greater health equity worldwide (Collins et al., 2013; Patel et al., 2008; Saraceno, 2020). The adoption of the Sustainable Development

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Goals, the Global Burden of Disease Survey, and the production of various guidelines by the World Health Organization have largely contributed to the recognition of the influence of social determinants on mental health outcomes. Likewise, the emergence of the Global Movement for Mental Health, and more recently the *Lancet* Commission on global mental health and sustainable development, have played a key role in addressing issues of access to psychiatric care in low- and middle-income countries, and in putting the rights of people with mental disorders on the map.

It is commonly claimed that 80% of people suffering from a mental disorder live in a low- or middle-income country, and only 10% receive care (Petersen et al., 2017). Economic and geographic barriers (associated with out-of-pocket expenses required for medical or psychosocial consultations, as well as to the limited number of mental health facilities) limit the ability to seek help in these contexts (Saraceno et al., 2007; Sarikhani et al., 2021). The issue of stigma is identified as an additional barrier limiting access to mental healthcare and explaining the low frequentation of mental health facilities when they are accessible (Hatzenbuehler et al., 2013; Link & Hatzenbuehler, 2016; Semrau et al., 2015; Yearwood & Hines-Martin, 2016).

Stigmatization of people experiencing mental disorders has significant repercussions on their living conditions (housing, employment, health status, social support, social participation) (Clement et al., 2015; Sharac et al., 2010). Aside from public stigma (stereotypes, attitudes, and discrimination) that people with mental disorders face, they also have to navigate structural barriers such as cultural norms, institutional policies, and underfunding of mental health resources (Corrigan et al., 2004; Voldby et al., 2022). It is not rare that people develop stigmatizing attitudes toward themselves, referred to as self-stigma, which is associated with lower self-esteem and lower rate of recovery (Corrigan & Watson, 2022; Evans-Lacko et al., 2012; Watson et al., 2007). It is well documented that both public stigma and self-stigma lead to underutilization of healthcare resources, and thus to a deterioration in symptomatology (Clement et al., 2015; Dubreucq et al., 2021). Although stigma is observed worldwide, it is a phenomenon deeply rooted in social and cultural norms, and therefore expresses itself differently from one context to another (Javed et al., 2021; Krendl & Pescosolido, 2020; Ojagbemi & Gureje, 2021; Yang et al., 2014). Most research addressing stigma around mental disorders has been conducted in Western countries, limiting the possibility of having a detailed understanding of its manifestations in other regions of the world (Heim et al., 2020; Mascayano et al., 2015; Semrau et al., 2015).

In several countries of sub-Saharan Africa, it has been reported in media publications as well as in humanitarian organizations' reports that people with mental disorders suffer poverty, social exclusion, and abuses (confinement, shackling, physical abuses). Concerned about the visibility of stigmatization and its consequences on individuals and communities, a growing number of studies have focused on it recently (Heim et al., 2020; Mehta et al., 2015; Thornicroft et al., 2016, 2022). The available scientific literature confirms that people with mental disorders in sub-Saharan Africa experience various forms of discrimination (Adewuya & Makanjuola, 2008; Crabb et al., 2012; Girma et al., 2022; Mfofo-M'Carthy & Sossou, 2017; Potts & Hendersen, 2021). For example, Dako-Gyeke and Asumang's study (2013) in Ghana highlights that people with a psychiatric diagnosis experience

discrimination in family settings, community interactions, and in the workplace. In their comparative study, Makanjuola et al. (2016) showed that people with severe mental disorders report high levels of internalized stigma in Ghana, Nigeria, and Kenya. This would be associated with the fact that in the sub-Saharan region, people with mental disorders are generally perceived as dangerous, harmful, immoral, and guilty (Audu et al., 2013; Barke et al., 2011; Gureje et al., 2005; Okpalauwaekwe et al., 2017).

To avoid being associated with these social representations, people experiencing mental disorders seem to hide their difficulties. For example, this was observed by Barke et al. (2011) in Ghana, who questioned individuals with a psychiatric diagnosis. They reported being considered less intelligent, less credible, and being discriminated against in employment since their hospitalization, which was why 70% of them now concealed their mental health challenges. A recent systematic review of the literature in sub-Saharan Africa revealed that self-stigma is frequent and elevated across settings, but that in some countries it was higher, which could be related to social representations and communities' attitudes (Alemu et al., 2023). Hiding psychological distress may not only be a strategy adopted by patients, but also by family members, as reported in Botswana (Gaolaolwe et al., 2023), Ethiopia (Shibre et al., 2001; Tekola et al., 2020), Ghana (Ofori-Atta et al., 2018; Quinn, 2007), and South Africa (Monnapula-Mazabane & Petersen, 2023; Nxumalo & Mchunu, 2017). Moreover, it seems that to avoid suffering stigma, relatives adopt physical restraint measures and turn to prayer camps where patients find themselves shackled (Asher et al., 2017; Ofori-Atta et al., 2018; Read et al., 2009).

In line with these observations, studies carried out in sub-Saharan Africa generally explain stigmatization by communities' low levels of mental health literacy (Benedicto et al., 2016; Chikomo, 2011; Ganasen et al., 2008; Hanlon et al., 2014; Kometsi et al., 2020; Reta et al., 2016; Salifu Yendork et al., 2016; Shah et al., 2017; Spittel et al., 2019). According to this literature, communities that are insufficiently informed about the etiology of mental disorders and their treatment tend to distance themselves from individuals with mental health challenges and adopt overtly discriminatory behaviors that fit their social representations. Like others, we have previously argued that these findings are reductive and fail to take sufficient account of the structural dimensions of stigma (legal frameworks, policies, media, healthcare organization, chronic poverty) contributing to the construction of widespread stereotypes and prejudices about psychiatric disorders (Atilola, 2015; Pigeon-Gagné et al., 2023; Read et al., 2009; Read, 2012; Read and Nyame, 2019, 2019). As pointed out by Thornicroft et al. (2022), recent studies increasingly tend to take a systemic view of the problem and propose educational, interpersonal, and structural solutions to tackle stigma.

In Burkina Faso, the phenomenon of stigma remains little studied. It is therefore difficult to assess the nature of the exclusion experienced by people with mental disorders and to have an insight on how communities perceive this exclusion. Previous research in the city of Ouahigouya has pointed out that community members tend to be intolerant toward people with mental disorders since they are perceived as responsible for their condition after engaging in occult and reprehensible practices (Gombri et al., 2016). In the city of Bobo-Dioulasso, we have previously identified

that people with mental disorders are socially represented as transgressive (Pigeon-Gagné et al., 2023) and dangerous (Pigeon-Gagné et al., submitted) and therefore stigmatized. Stigma has also been reported in rural areas, where people face exclusion within their own households (Kadio et al., 2014), fear of being marginalized (Pigeon-Gagné et al., 2022; Porfilio-Mathieu et al., 2022), and experience shame and guilt related to family honor and social cohesion (Nanama & Frongillo, 2012). Both in urban and rural settings, stigma is thus reported, but current research does not provide enough information regarding processes leading to social exclusion, nor the way communities perceive discriminatory practices. This limits the possibility of developing anti-stigma interventions adapted to the sociocultural context. The aim of the current study is to fill this gap and provide a qualitative insight on exclusion processes in the city of Bobo-Dioulasso.

Context

The choice of conducting this study in the city of Bobo-Dioulasso (second-largest city of Burkina Faso) was guided by the research team's preexisting collaborations with field partners that confirmed the salience of stigma and the relevance of a research on this topic. People with mental disorders are frequently found wandering around, begging for food in the streets of the city, and looking for shelter, sometimes totally naked.

In Bobo-Dioulasso, three types of care systems are available to people with mental disorders. First, the psychiatric facility is one of two hospital centers offering psychiatric care nationwide. The treatment team is made up of 12 professionals (psychiatrists, nurses, and a social worker) who offer pharmacological care (mainly antipsychotics) and support treatment adherence. Consultations cost 500–4500 CFA francs, and hospitalizations' daily charge is 2000–4000 CFA francs¹. To be hospitalized, it is required for a patient to be accompanied by a relative who ensures hygiene, basic care, and monitors medication intake. Because of the costs associated with treatment, as well as mistrust of the psychiatric institution, this care system is mainly used in case of emergencies (e.g., for psychotic episodes).

Second, traditional healers are widely recognized as indispensable practitioners in the treatment of mental disorders. In 2013, an accreditation system was set up by the Ministry of Health to facilitate collaboration between the public healthcare system and traditional practices. At the time of the fieldwork, more than 200 traditional healers were members of an association in Bobo-Dioulasso, but only 5 had received formal accreditation. Whether accredited or not, healers use a variety of treatments (herbalism, prayers, incantations, sacrificial rituals, etc.) mainly rooted in animist worldviews, but also in Muslim and Christian spiritualities. Very few of them offer treatments for mental disorders. These treatments are lengthy and expensive (some patients report having paid 100,000 CFA francs), a reason why patients tend to abandon them.

¹ In Burkina Faso, the average annual income is 940,000 CFA francs (<https://donnees.banquemondiale.org/pays/burkina-faso>).

Finally, until recently, there were no formal community mental health initiatives; support was thus provided by family members and close relatives. In 2014, a few months before we started conducting our study, the Saint-Camille association started offering shelter and pharmacological treatment to people shunned by their families for mental health reasons. The association aims at social reintegration through the acquisition of employment skills. At the time of the study, resources were not sufficient to support these reintegration activities for some 50 people found wandering the city or brought in by relatives were being sheltered.

Methods

This study is part of a socio-anthropological investigation (Olivier de Sardan, 2008) for which two periods of fieldwork took place (April–August 2015, January–May 2017). The main objective of the study was to document interpersonal and public components of stigma. Since it was the first study on the topic in Bobo-Dioulasso, we adopted an inductive and exploratory approach in which we were interested in exploring local conceptions of mental disorders.

Data Collection

The first period of fieldwork focused on exploring popular conceptions of mental disorders and patients' therapeutic itineraries through the various care systems. In the second period of fieldwork, we were interested in documenting discriminatory behaviors and social exclusion through the eyes of patients, families, and communities.

During these periods of fieldwork, observations were carried out in care settings to better understand the larger context of access to mental healthcare and to develop trust relationships with potential research participants. The principal investigator was integrated into the clinical activities of the psychiatric unit, where she daily attended consultations, clinical meetings, home visits, and other activities. Regular visits were made to the Saint-Camille association, where it was possible to interact with residents and caregivers. Sporadic observations were made of traditional therapists who had been introduced to the researcher by key informants. The researcher had no specific role nor tasks to perform other than taking notes. We also carried out observations in public places where it was possible to observe several discriminatory practices and to meet socially excluded individuals. On the basis of these observations, the research team developed semi-structured interview grids focusing on social representations of mental disorders, care systems' utilization, and exclusion.

To document the vast range of discriminatory practices and to better understand how these practices are perceived, endorsed, and justified, we conducted focus groups (FG) and individual interviews (II) with patients, family members, traditional healers, healthcare professionals, and community members. FG aim at

grasping information on larger social representations about social exclusion, and II were relevant to obtain clarifications.

Seven 2-h discussion groups were organized with various stakeholders ($n = 69$). Between 9 and 12 participants were present in each FG discussion. Four FG were conducted with community members ($n = 42$), two with patients ($n = 17$), and one mental health professionals ($n = 10$). Men and women were interviewed separately, in accordance with cultural customs. People in positions of authority were not admitted to facilitate participants' free expression. The FG were first announced by a key contact person (i.e., psychiatrist, association's coordinator, and active community members) a week prior to the event. Potential participants were then informed of the format and themes to be addressed. FG were conducted in Dioula² and animated by a key informant who had previous research experiences in the context and who had a deep understanding of social and cultural norms. The principal investigator was present and taking notes on non-verbal information, which were discussed afterward with the animator.

A total of 25 individual interviews (II) lasting 1 h and 30 min were conducted with four patients, two relatives, seven health professionals, three traditional healers, and nine key informants (merchants, artists, researchers, religious figures). Key informants were chosen for their tacit knowledge and ability to contextualize observations. All individual interviews were conducted in French, a language in which the participants felt comfortable expressing themselves. During interviews, people were asked about explanatory models of illness, discrimination, and perception of exclusion (Table 1).

Data Analysis

Once the interviews had been transcribed, several readings were made by the research team. Impressions of the co-researchers were noted and discussed. A thematic analysis (Paillé and Muchielli, 2021) was then carried out with the support of NVivo 11. All the material was coded inductively, then organized according to recurrence or salience of themes without any conceptual framework in mind. The focus groups served as a starting point for the analysis, since we wanted to better understand how exclusion was socially perceived, understood, and endorsed. Once the coding was completed, the individual interviews were added to the thematic analysis. Finally, observation notes were coded to add nuance to the participants' discourse and to include non-verbal components. This step-by-step process enabled us to identify recurring themes, as well as contradictions, oppositions, and gray areas. These drew particular attention from the team, as they indicated dimensions that could not be named explicitly either because they were unconscious or that it was not socially advisable to talk about openly. Because the aim of this study was to document the variety of discriminatory practices and their social representations, we selected recurring themes across the discourse of participants.

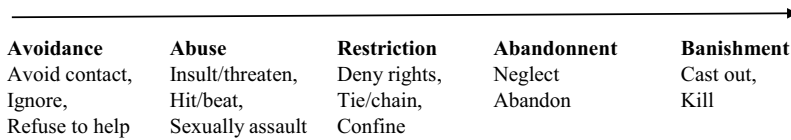
² The FG with healthcare professionals was conducted in French since it was the language used in everyday interactions.

Table 1 Sociodemographic characteristics of participants

Individual interviews	Focus group discussions
<i>Gender</i>	
Men: 20	Men: 40
Women: 5	Women: 29
<i>Age, years</i>	
Younger than 20: 2	Younger than 20: 4
20–30: 5	20–30: 12
30–40: 5	30–40: 21
40–50: 6	40–50: 16
50–60: 5	50–60: 9
60+: 2	60+: 7
<i>Ethnic group</i>	
Mossi: 14	Mossi: 22
Bobo: 5	Bisa: 9
Dagara: 3	Bobo: 7
Bisa: 2	Samo: 7
Peul: 1	Dioula: 6
	Gourounsi: 5
	Dagara: 4
	Peul: 3
	Other: 6
<i>Education</i>	
None: 3	None: 16
Primary: 7	Primary: 21
Secondary: 11	Secondary: 17
University: 6	University: 15
<i>Socioeconomic situation</i>	
No income: 3	No income: 12
Informal sector: 15	Informal sector: 41
Formal sector: 7	Formal sector: 16

Ethics

Ethical approval was obtained from *anonymous* and *anonymous*. Written consent was obtained from participants. The risks, benefits, and purpose of the project were explained to participants, who could refuse to join. People with mental health problems were visited several times beforehand. The researcher checked with relatives and caregivers to ensure that the person's psychological condition was stable and that they were fit to take part in an interview. During all stages of the research, we were sensitive to make sure that results would not make any prejudice either to individuals or to care systems. For this reason, we chose not to present vignettes or case studies to illustrate exclusion because that would not



Avoidance	Abuse	Restriction	Abandonment	Banishment
Avoid contact, Ignore, Refuse to help	Insult/threaten, Hit/beat, Sexually assault	Deny rights, Tie/chain, Confine	Neglect Abandon	Cast out, Kill

Figure 1 Exclusionary behaviors toward people with mental disorders

ensure anonymity. At the opposite, we chose to prioritize quotes from community members to avoid the risk of stigmatization.

Results

Participants in our interviews identified five common types of discriminatory behavior toward people with mental disorders (Figure 1). The forms of discrimination were grouped according to the underlying explanatory logic.

Avoidance

A variety of distancing behaviors such as avoiding or fleeing contact is common. According to our informants, people with mental disorders are harmful and aggressive, and that is why they must be discarded, chased away, or shunned to prevent insults or attacks. Mistrust leads informants to ignore people identified as having a mental disorder:

You're not nice to these people, because if you get used to them, they'll get used to you, and they'll kill you one day. You can't play with crazy people, you have to be very strict. If you give money to a madman³, the day that you don't have any, he'll demand it... he won't try to understand, he'll pretend to leave and he'll come with a stick to shoot you. That's why they say you can't go near abnormal people (Man, unemployed, FG).

Many participants desire to distance themselves from a relative with a mental disorder to avoid being treated differently by their neighbors. It is frequently reported that it is preferable to avoid sharing a meal with a person with a mental disorder to avoid being stigmatized:

The madman is often seen near where there is food. He's there, approaching to ask. We don't serve the madman with the customers' food, otherwise people won't come anymore. We put the food in a bag and tell him to go away. Recently, one came to my kiosk and asked for money and for food, so I said: "OK, stand over there and I'll send you some food". He wanted to come and sit at the table where people sit. I said: "No, you can't sit there, you'll chase

³ In Dioula, people used the term *fato* to designate a person with a mental disorder. The term used in French was *fou*.

away my customers! “If customers see this dirty man at the table where they sit, they won’t come anymore. Because no one wants to go near that madman, and no one wants to eat with him. Personally, I’ve never eaten with a madman, I wouldn’t want to eat with them because they are dirty, and they smell bad... how could I sit down and eat with them? People will say that you’re crazy too, that’s for sure. And people will even chase you away (Woman, merchant, FG).

Health workers and traditional therapists also observe that some healers refuse to offer traditional care for mental disorders for fear “that the illness will turn against them or their family.”

People with lived experience of mental disorders were commonly reporting being left out and avoided:

Since I was 15...I said I was shaking; I told the whole family that I didn’t feel well, they didn’t take it seriously, otherwise I wouldn’t be where I am today. But they didn’t take it seriously... from the age of 15 until I was 29. It’s only now that I’m in hospital that they know it’s serious. And today, because of my tremors and my mental illness, when people pass me on the road, they ignore me. They pretend I don’t exist. They don’t want anything to do with me. When I go out to sell (honey), people never come to buy with me, so I stay at home and spend the whole day here alone (Woman, patient, II).

Abuse

It is frequently reported that people with mental disorders are threatened by neighbors or strangers in the streets. These threats aim at keeping them away when they get close to a yard or a kiosk and can be made with weapons such as wooden sticks, rocks, knives, or machetes. According to participants, it is common practice for wandering patients to be beaten (by both children and adults), ranging from blows with no physical after-effects to blows causing accidental or intentional death. This practice is reported and observed as much by strangers and family members as by traditional healers. Participants stated that they considered it appropriate to hit a “sick person” to prevent disease’s transmission, to defend themselves against physical aggression, and to punish disruptive behaviors:

P1: If a madman hits you, you must hit him back.

P2: Very hard indeed!

P3: Here, we say that when a madman hits you, you must hit him, otherwise the madness will turn against you, you can become a madman yourself, it’s contagious. We say that if a madman hits you, if you don’t hit back, the madness will turn against you, that’s why people hit him. If he doesn’t hit you, there is no reason to hit him.

P4: Some people come and hit you for no reason when you’re sitting calmly. If you don’t hit him back, he’ll keep on going. That’s what we say. We have to make him stop, so we hit him.

P2: That's right! If you see a madman being beaten, he's beaten first. There was a young lunatic who wanted to catch women and abuse them. He went to find the rice seller and tried to abuse her, so we beat him up hard.

P5: When he becomes violent, it becomes a matter of life and death, you must defend yourself! (Community women, FG)

Psychiatric patients and people with lived experience also reported being victim of violence from their relatives:

Since I was wandering the streets and getting into mischief, he (my father) would tie me up. You see, I showed you the scars? That was with wires that he wrapped around my wrists, very tightly. It became a wound that took months to heal. It hurt a lot. Sometimes he used chains. My husband, sometimes he would heat water and throw it on my body and hit me. He'd even hit me with a hammer. When he was angry, he looked like a madman too, and he'd hit me hard with a stick. That was when I got into mischief, when I got naked, when I went into the neighbors' yards, when I screamed (Woman, patient, II).

People with mental disorders also experience forms of physical abuse in some traditional care settings. In these contexts, patients are sometimes beaten for healing purposes. According to certain beliefs, it is by beating a person that it is possible to chase away the djinn or evil spirits responsible for their illness and inhabiting their body.

Cases of sexual abuse have also been reported and observed. Two main cases stand out. Firstly, according to certain beliefs associated with witchcraft, having sexual intercourse with a "madwoman" would enable a man to become richer:

P1: There are men who assault crazy women on the street to get money... there's a conception... There are some who say that if you sleep with a crazy woman, you can get money, it can make you rich. It's often the marabouts who tell them to sleep with a crazy woman to get rich...

P2: The motivation is the quest for money, which leads to aggression. There's a crazy woman here nearby, and at night, you can see the vehicles coming, they park, and they come to attack her while nobody sees. It's rape! And the selection criterion is to be someone labeled mentally ill.

P3: There are also those who are pregnant and whose father is unknown, because the child is the fruit of rape. There's this idea that runs through the population, a mystical practice, that to make a fortune, the candidate for wealth must have sex with a schizophrenic. And so, as often happens, they get pregnant, and the social services get the child back. (Health professionals, FG)

Cases of sexual abuses are also reported in care settings, both in medical and in the traditional or religious structures. These cases of sexual assault are rarely discussed, as they are associated with shame for the patients and their families:

B. and then A. (hospitalized patients), they too have been mistreated, beaten, and raped, and that's why they're like this today... One is silent and strange

and the other talks too much. They were raped in the village at the healer's house. And A.'s problem is that it happened again here (in psychiatry) and she wants to report it, but her mother doesn't want her to speak out, saying it's a disgrace. She came here to be hospitalized for a month because she had a relapse of her madness. And then here, there's a doctor or a nurse who raped her. The man lured her into the shower over there and then abused her. She's told me this several times. The mother doesn't want her to talk anymore... (Woman, patient, II)

Restriction

Exclusionary behavior within households is also common. The "sicks" are considered as not having the same status as a "normal person." As such, it is not uncommon for them to be ignored, excluded from decision-making, or denied the same privileges as other family members. This manifests itself differently for men and women:

They don't let him speak when he wants to. They don't call him by his name, they call him "crazy." The family will say: "Don't take his words seriously, because he's worthless." We see this with a lot of families. Also, for former mental patients... when there's a problem to be solved, the family council sits down, and they don't count them. People hold the meeting without informing them, and in the meantime, they're left in their corner. They're not considered. They're often confined. He's the big brother, he's the one who should be considered, they should ask for his decision. But when because he's sick, he's not counted, he's left alone in a corner (Men, merchant, II).

P1: When women recover, they return to their household, but they can no longer cook, whereas a housewife's job is to cook...She's told not to leave the house, not to cook, so she no longer has a role in the household. She has to stay inside the house and do nothing.

P2: Not cooking also means not having sex with her husband...So, she loses all her rights and privileges. She's no longer considered a wife. She's there, in the family, as if she's integrated, but in reality, she's excluded because she has no rights.

P3: She's in the family because you can't kick her out...because marriage isn't between two people, it's between communities and families. You, as the husband, can't chase your wife away, so you keep her, but she can't go out and she can't do anything (Health professionals, FG).

Participants consider it useful to tie up patients with ropes or chains, or to lock them in a closed and locked room, to restrict their mobility. Several reasons are given for using restrictive measures: to avoid the family being perceived negatively by neighbors, to prevent the person from committing dishonorable actions (e.g., wandering naked in the streets), to punish aggressive, violent, or shameful behaviors, and to

avoid providing surveillance. According to the interviewees, the fact that patients do not have the same moral status justifies the use of restraint:

Madmen are people, but not in the same way as other people. Nobody wants to see them or sit with them. At home, they stay in the corner, we leave them there, we don't let them go anywhere else, nobody looks at them. We don't want them to visit us, so when they start coming home, we tell them to go away, we chase them away. The madman in the house, since he's dirty, he's in his corner... nobody comes to see him, we don't sweep up where he is, we prevent him from changing corner, we don't want him to go out, so we tie him up somewhere or lock him up so we don't have to worry about him anymore. You can even go so far as to tie him up in a hut, almost like a dog. That's what we do here (Man, merchant, FG).

Abandonment

The "chronically ill" are seen as burdens for their relatives and are therefore frequently neglected and sidelined. When the illness persists over time, families must bear the recurring costs of medication. In that context, some families stop providing medical follow-up and day-to-day care. The combination of the chronicity of the disorder, lack of financial resources and absence of care facilities is cited as the reason for the exclusion of people suffering from chronic disorders:

Treating a madman is difficult, it's too expensive. People can't treat them because the cost of medication is so high. The problem is poverty. People want to help him, but as they don't have the means. With time, they are forced to abandon him (Man, teacher, 45 years, FG).

The typical cases we receive here...Those who lack financial means are the most numerous. Those who come and...obviously...the family has financial difficulties. They're tired, because of relapses. They make efforts, but with the cost of medication, they can't take it anymore. So, they give up, and they let the patient wander around without taking care of him. And there's nothing more we can do for him (Man, social worker, II).

"Chronically ill" are perceived as more aggressive than those with temporary difficulties. This aggressiveness leads their family to neglect them more and more, until they find themselves wandering the streets. According to interviewees, this form of exclusion is justified, as it ensures that the household can get back to its normal equilibrium and functioning:

It's there, at the healer in the village, that we finish the healing when we're on the verge of giving up! Those who push their madness to the limit, those who keep coming back for treatment, those who are aggressive...Those are the ones we take to...there's a healer, he's well known, he treats the mad near Ouagadougou, all that is when the family isn't ready to let you go. Otherwise, you're quickly put aside, left on your own, and that's the end of it. People have a lot of children, usually 7 or 8. If there's one who's crazy, we try to do what we

can...But then we leave him, especially when he becomes aggressive, there are still 6 children to manage. We can't kill ourselves for that one. We don't have the means...One going crazy...it's like one dying out of 7 children, it's not too serious. You don't want to, but you don't kill yourself for that one (Woman, housekeeper, FG).

Wandering is therefore the result of abandonment by families, who are taking fewer and fewer measures to ensure the care of their relative. The participants said they could easily identify these individuals as they have been ill for a long time and often end up in the same places in the city. Although these people are tolerated, they do not receive aid and they are ignored and excluded.

People with lived experience of mental disorder and excluded from their families and, thus living in the community association, largely discussed this issue during focus groups:

Most of us here, we're people who need affection, love. But still, our families drop us off here, they say it's only for a while, but we never see them again. They disappear. We never get a visit (Woman, patient, II).

This one (pointing to another man), he wants to go home. Here, he says he feels stuck, he can't do his job so he wants to leave. But he's here because his family came to leave him, they don't want to look after him anymore. He's staying here, sitting around all day doing nothing, and it makes him sad (Man, patient, FG).

Banishment

Banishment refers both to expelling a person from a community and to murdering a person to make them disappear. Numerous cases are described of people who have committed reprehensible and socially intolerable acts:

There are those we banish. Those who have committed homicide, infanticide, incest, sleeping with his brother's wife, or even with his sister, something like that. These are the outcasts. There was a patient who killed her mother. We wanted to provide her treatment, but none of her family wanted to stay here with her. The day she left here, the family took her and dropped her off in the bush at 50 kilometers from the village and told her to never come back (Men, psychiatrist, II).

Other people are banished for having "sequestered morality" more generally (i.e., not having respected ancestral rules or having engaged in occult practices). The most frequently discussed examples are those of women who, following the death of a family member, are accused of having caused the death by witchcraft:

Then there are the so-called witches. They're expelled from the village or stoned to death in the community if they don't flee, even though they're mentally ill. They can't even talk to you. And there's a village of outcasts in the north, so if you're chased away from your family, you can go and live there.

And it's difficult for people from these villages to marry someone from another village. Most of the time, it's people who are accused of witchcraft who are mentally ill. If you're banished, you're out of society and you don't know what's going to happen to you, because you can't talk to your relatives (Man, pastor, II).

According to participants, banishment is justified and desirable, as it enabled to "keep out those who are not needed from society." It is a form of legitimate punishment, a way of "making the perpetrator of a transgression pay," even going as far as killing them to preserve customs. Several health professionals report accounts of people being hospitalized after committing a reprehensible act, and then being "exterminated" by their loved ones once out of the hospital. Unlike the other forms of exclusion for which we were able to gather patient testimonials, none of our participants admitted to having been banned. The examples cited were of family members or people known in the neighborhood.

Discussion

This study identified a variety of discriminatory practices toward people experiencing mental disorders in Bobo-Dioulasso where stigma was not researched before. Our findings suggest that some of these behaviors are integrated into daily lives and are normalized (e.g., ignoring, avoiding, hitting), while others appear less frequent, but charged with social and cultural significance (e.g., banishing, sexually assaulting). By adopting an inductive posture, our study enables us to identify the underlying justifications for the adoption of these practices. The results of this study are particularly informative in a context where stigma is a priority in global mental health and is considered one of the main determinants of mental health, even though this phenomenon remains poorly understood in Burkina Faso.

For several decades, it has been widely documented that people with lived experience of mental disorders are likely to experience discrimination in access to employment, safe housing, public services, and community inclusion (Javed et al., 2021; Krendl & Pescosolido, 2020). Our study is in line with this body of literature and shows that this problem is indeed present in West African urban environments. Our results suggest that restrictive measures (confinement, physical restraint) are frequent and that people with mental disorders are subjected to physical violence, whether by family members, caregivers, or strangers. We found that psychiatric patients, and women in particular, appear to be victims of sexual violence, whether during the care process, even when they still receive support from their families, or once they have been completely ostracized and homeless. A specific feature of our findings is that the phenomenon of stigmatization sometimes takes the form of banishment. This form of exclusion seems to be justified by a person's inferior moral status, which seems to particularly affect people in a state of significant psychic disorganization (Omigbodun et al., 2023), as well as women who are likely to be accused of witchcraft (Barbier, 2020).

In the context of our investigation, we have previously identified the importance of the notion of transgression in social representations of “madness” explaining why some people are more stigmatized than others (Pigeon-Gagné et al., 2023). We also identified that mental health services’ utilization is largely influenced by economic factors, and that, due to a lack of means, families adopt restrictive practices in the pursuit of care and assistance (Pigeon-Gagné et al., 2022). Finally, we observed the predominance of the stereotype of dangerousness, as well as reactions of fear and shame towards people identified as having a mental disorder, which can be explained by the widespread perception that these are permanent conditions (Pigeon-Gagné et al., submitted).

Taken as a whole, our previous results and the one discussed in this paper inform on underlying mechanisms of exclusion of people with mental disorders. Indeed, our investigations suggest that some people are explicitly excluded because they are perceived to be transgressive and/or aggressive, and they are thus perceived as a threat to physical security, to social cohesion and/or to cultural values. Other people seem, however, to be tacitly and progressively excluded because they represent a burden for their relatives since they are perceived to have a permanent and incurable condition. This observation leads us to propose three distinct but overarching mechanisms of exclusion based on the various form of discrimination observed in Bobo-Dioulasso.

First, exclusion seems to be justified in a punitive way when deviant behaviors are committed. It seems that the mere commission of transgressive acts represents a threat to social cohesion, generating a form of hatred and disgust among family and community members. Outspoken exclusionary behavior toward those deemed dishonorable is thus socially indicated. Banishment represents the most violent form of exclusion and seems to symbolize the ultimate form of punishment. Banishment seems not only to punish the perpetrator of the suspected transgressive acts, but also to provide a reminder of the moral imperatives ensuring proper social functioning and structuring relations between community members.

Secondly, some forms of exclusion appear to be adaptive for families who, without totally abandoning their relative with a condition deemed irreversible and incurable, come to put their energy back into their respective roles and tasks within the household for lack of alternatives. The energy deployed to protect the patient, previously the family’s priority, is reinvested in protecting the family unit, which finds itself financially constrained. The constraints experienced by family members seem to be directly associated with the inability to ensure both the care of their loved one and the family functioning. Despite a patient’s neglect and lack of consideration, some families still seem to take steps to avoid wandering, while others totally abandon them.

A third mechanism seems to come into play when a person is perceived as being aggressive or at risk of being so, notably due to the failure of care (inaccessible or ineffective treatments). The person associated with dangerousness seems to arouse reactions of distrust in those around them, as well as in community members who anticipate manifestations of aggression. Fear leads relatives to exert control, leading to confinement or seclusion, and to various forms of verbal and physical abuse.

These behaviors seem to ensure security: to prevent patients from being harmful to themselves or others, they are confined, locked away, and restricted in their mobility.

Our results are an addition to a sparse but growing body of information available in the region on the control, restraint, and abuse of people with mental health disorders in sub-Saharan Africa. Available studies illustrate that the main reason for using restraint is to ensure the protection and safety of patients who may be aggressive toward themselves and others, or who may become disoriented (Arias et al., 2016; Asher et al., 2017; Ofori-Atta et al., 2018; Read et al., 2009).

In the same vein as our results, these studies illustrate the influence of several factors involved in the choice of caregivers to use restrictive methods, including lack of access to other alternatives (Asher et al., 2017; Read et al., 2009). The use of restraint is, therefore, in this case, linked to a form of helplessness and the absence of community support resources. A few authors have previously raised a paradox in which families find themselves having to find a way to reconcile their moral obligation to care for their sick relative while meeting the imperatives of daily life, which is often impossible to reconcile (den Hertog & Gilmoor, 2017; Read & Nyame, 2019; Sibeko et al., 2016). It is also documented that the burden of care falls on the family, and particularly on women, who bear the moral obligation of care. This burden can eventually lead to a breakdown in family equilibrium resulting in the family's inability to provide for its basic needs (Asher et al., 2018; Gureje & Bamidele, 1999). Read et al. (2020) identified that people who are unable to contribute economically to the household are perceived as a burden conferring a lower social status. This is in line with a widespread representation that poor people who do not fulfill their socioeconomic duties are generally perceived as useless, justifying their social exclusion (Soors et al., 2013).

Available studies document that formal care settings use restrictive methods to limit patients' movements and displacements. This practice takes place to compensate for the lack of available human resources, as the volume of staff is not sufficient to ensure patient care (Alem, 2000; Arias et al., 2016; Ofori-Atta et al., 2018). Faced with a lack of means or with ineffective means, managing aggression represents a challenge for which contention then become attractive to caregivers (Nyame et al., 2021; Read, 2012). In psychiatry, the use of coercive measures is perceived as necessary as a last resort but is also used for punitive purposes. It has been documented that healthcare professionals then resort not only to chemical restraints and isolation, but also to the use of chains and sexual abuse to exert control over patients (Moro et al., 2022; Oyine-Aluh et al., 2022). Punitive logics seem to come into play when reprehensible or transgressive behaviors are identified, justifying abuse and brutal exclusion (Asher et al., 2017; Pigeon-Gagné et al., 2023; Read et al., 2009).

As previously theorized, the provision of mental healthcare responds to a dual mandate: that of offering treatment aimed at recovery, and that of controlling and sanctioning patients (Fanon, 1961; Foucault, 1972, 1975; Goffman, 1961; Rhenter, 2014). We note in the context of the city of Bobo-Dioulasso that the various care systems (informal, traditional, and psychiatric) take on this dual mandate at different points in the help-seeking process. Each system then becomes a space where acts of care and control overlap, making it difficult to distinguish exclusionary behavior from behavior aimed at security and inclusion.

Implications for Intervention and Research

The most common solution to tackle stigmatization is to set up information campaigns and awareness programs. However, little information is available about the effectiveness of these programs in generating long-term attitudinal changes, and that these changes in attitudes translate into behavioral changes (Corrigan & Fong, 2014; Corrigan & Penn, 2015; Rüscher et al., 2005; Schomerus et al., 2012; Wei et al., 2018). Moreover, it seems that improved literacy (focused on biomedical explanatory models of mental disorders) can, in some contexts, lead to a deterioration of preexisting stigmatizing attitudes and the reinforcement of negative stereotypes (Angermeyer & Dietrich, 2006; Angermeyer et al., 2015; Corrigan, 2018; Dietrich et al., 2004; Rüscher et al., 2010; Schomerus et al., 2014; Van Beveren et al., 2020; Wiesjahn et al., 2016).

It is particularly important to consider the potential iatrogenic effects of dominant anti-stigma approach when programs are designed and implemented in the Global South. Not only is the efficacy of such programs unproven (Heim et al., 2020), but these are contexts where macro-systemic factors are at play as well, such as the impact of (neo)colonialism reinforcing already strongly entrenched power dynamics and epistemic violence. In continuity with the work of several critical authors in global mental health, we consider that reducing the stigmatization to a lack of knowledge represents a form of medical imperialism presupposing that scientific data represent valid sources of “acultural” knowledge (Atilola, 2015; Bracken et al., 2016; Cooper, 2015; Kleinman, 2012; Ojagbemi & Gureje, 2021).

We find it particularly problematic that mental health literacy programs focus on the knowledge and practices of families and communities. Instead, our study reveals that the explanatory factors for exclusion are mainly related to the failure of care systems to provide effective and safe treatment. Rather than conceiving cultural beliefs as an expression of “ignorance,” we believe it is essential to recognize these worldviews as valid, since they refer to fundamental community and societal values. Rather, popular conceptions might be understood as a reflection of communities’ unique and distinct ways of representing their social reality and their relationship to illness. It is therefore possible to interpret them as reflecting the way in which mental health issues are experienced subjectively and socially on a day-to-day basis, where social factors (economic insecurity) and political factors (lack of structuring policies) are at play.

In this sense, our study suggests that exclusion take various forms. We believe it would be relevant to develop interventions that are consistent with the underlying explanatory factors that we identified. More specifically, it could be useful to support structures offering treatments in distinguishing between care and control practices, and to identify the motives leading them to resort to coercive practices. Since exclusionary behaviors often seem to be based on economic constraints and lack of safe and effective therapeutic means, it is essential that structural mechanisms be proposed to make healthcare services more accessible (Thornicroft et al., 2022). The current ineffectiveness of care structures underlies adaptive and punitive forms of exclusion, which could be reduced by a greater access to quality treatments, and which could in turn reduce negative stereotypes about mental health disorders.

In terms of research, since several discriminatory practices are rooted in a punitive logic, it would be advisable to conduct more research to better understand the codes, norms, and values involved. Our results suggest that women are particularly at risk of experiencing sexual violence, both in public places and in care settings. More research is needed to understand the mechanisms of gender-based exclusion to identify the needs for which interventions should be developed. Additionally, it would be informative to better understand patients' lived experience.

Limits

This study has certain limitations. Firstly, the length of the fieldwork (8 months) limits the possibility of observing all manifestations of stigma. Since stigma refers to hidden dynamics, it is highly likely that the researcher did not have access to certain practices that would have enabled us to deepen our understanding. Secondly, coming from a different cultural universe, the principal researcher was also limited in her ability to offer a culturally sensitive interpretation of certain traditional practices. In this context, participants were sometimes suspicious and reluctant to talk about some topics. Thirdly, the fact that individual interviews were conducted in French induce a sample bias, because it is possible that less educated people have other experiences and perceptions of social exclusion. Finally, to avoid confirmation bias, we chose to approach mental health issues very broadly. This way of conducting our inquiry, however, leads to general results that do not allow us to distinguish social exclusion according to the types of disorders people experience (e.g., mood disorders, anxiety, psychotic disorders, etc.).

Conclusions

This study highlights the existence of a variety of discriminatory practices against people experiencing mental disorders in Bobo-Dioulasso. By adopting a qualitative and socio-anthropological approach to the study of stigma, we were able to distinguish three mechanisms explaining social exclusion of people with mental disorders. We see these results as contributing to a growing body of literature that is an alternative to the mainstream view of stigma, which generally focuses on the literacy level of communities. Our findings are part of an ecosystemic perspective on global health, in which popular conceptions and representations are legitimized and linked to the structural dimensions at the root of the social exclusion of psychiatric patients.

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Declarations

Conflict of interest The authors have no competing interest to declare.

Ethical Approval This study was conducted in accordance with the Declaration of Helsinki. Prior to data collection, ethical approval was obtained by (*masked for review*) and by the Ministry of Health of Burkina Faso.

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