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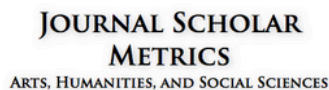
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The Impact of Stigmatizing Experiences and Self-Stigma on Mental Health and Suicidal Behavior: Results from the Community of Portuguese Language Countries

Mariana Coelho, Henrique Pereira

Universidade da Beira Interior, Portugal

ABSTRACT

Stigma is an attribute that discredits an individual from society, diminishing the person. People who have self-stigma endorse negative stereotypes about themselves, which leads to negative reactions and feelings of shame. Self-stigma affects overall health, particularly mental health, and quality of life, and can lead to suicidal behavior and poor self-esteem and self-efficacy. It has also been found to be a major barrier when it comes to seeking help from mental health professionals. This study aims (1) to assess stigmatizing experiences, self-stigma, mental health, and suicidal behavior, comparing differences between countries of residence; (2) to explore the associations between self-stigma, stigmatizing experiences, mental health variables, and suicidal behavior; and (3) to determine the predictive effect of self-stigma, number of stigmatizing experiences, and sociodemographic variables on mental health and suicidal behavior. Measurement instruments included a Sociodemographic Questionnaire, the Portuguese version of the Brief Symptom Inventory-18, the Suicidal Behaviours Questionnaire-Revised (SBQ-R), and the Paradox of Self-Stigma scale (PaSS-24). The results showed participants with higher levels of self-stigma and stigmatizing experiences presented significantly higher mental health issues and suicidal behavior. Correlational analyses showed significant correlations among mental health and suicidal variables and self-stigma variables. Regression analyses showed that sociodemographic variables, number of stigmatizing experiences, and self-stigma explained 25.3% of the variability in mental health issues while sociodemographic variables, number of stigmatizing experiences, and self-stigma explained 13.5% of the variability in suicidal behavior. This study was an important contribution to the knowledge regarding the relationship between stigma and mental health. *Key words:* stigmatizing experiences; self-stigma; mental health; suicidal behavior.

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Novelty and Significance

What is already known about the topic?

- Stigma aggravates psychological symptoms, which can cause a negative correlation with medication adherence and treatment seeking.
- Stigma is a risk factor for suicide and impedes efforts that may prevent suicide as people may feel ashamed to ask for help.

What this paper adds?

- Higher levels of number of stigmatizing experiences and self-stigma were predictors of poorer mental health and higher levels of suicidal behavior.
- Information about the effect of stigmatizing experiences in the Community of Portuguese Language Countries and the differences between countries.

Stigma is as an attribute that discredits an individual from society, diminishing the person (Goffman, 1963), and is associated with a process of denigrating someone based on usually negative perceived differences (Holder, Peterson, Stephens, & Crandall, 2019). Stigma and prejudice share many characteristics, including exposure to negative attitudes, experiences of discrimination or unfair treatment, and violence perpetrated against people in disadvantaged social groups (Stuber, Meyer, & Link, 2008). Phelan,

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Link, and Dovidio (2008) concluded that the social processes of stigma and prejudice are very similar and it is instead the historical factors that underlie why societies stigmatize or are prejudicial that vary. Therefore, the differences between stigma and prejudice have more to do with the subjects of interest than conceptual differences. For example, research on stigma traditionally focuses people with rarer conditions, such as physical illness (HIV/AIDS; disabilities), mental illness, or personal characteristics (short statures, weight) (Stuber *et alia*, 2008), while research on prejudice give more attention to aspects like age, gender, race, and class divisions (Stuber *et alia*, 2008).

There are several types of stigma, including social stigma, an extreme disapproval of a person or group in social characteristics; professional stigma, in which health care professionals reinforce stigmatization of their patients/clients; sexual stigma, in which society maligns, discredits and portrays sexual minorities as invalid in comparison to heterosexuals; public stigma, which involves stigmatizing attitudes of the general population towards a particular social group; internalized stigma, which is when people believe that negative stereotypes apply to themselves; perceived stigma, which is the expected negative reaction of the public by individuals in response to something about themselves; and self-stigma, which implies that the negative reactions or stereotypes are internalized (Holder *et alia*, 2019; Feldhaus *et alia*, 2018; Moses, 2010; Quinn & Earnshaw, 2013; Dreier *et alia*, 2019; Goepfert, Heydendorff, Dreßing, & Bailer, 2019; Conner *et alia*, 2010; Herek, Chopp, & Strohl, 2007). More specifically, people who present self-stigma tend to endorse negative stereotypes about themselves, which may lead to negative reactions and feelings of shame (Corrigan & Rao, 2012). Self-stigma is often associated with perceived stigma and affects overall health, particularly mental health, and quality of life, and can lead to poorer self-esteem and self-efficacy. It also has been found to be a major barrier in seeking help from mental health professionals (Holder *et alia*, 2019; Corrigan & Rao, 2012; Cheng, Wang, McDermott, Kridel, & Rislin, 2018).

Many studies have addressed the effects of self-stigma on people with mental illness. Research has found that people with mental illness who experience self-stigma are less likely to adhere to medication (Feldhaus *et alia*, 2018) and that they perceive stigma coming from their families, peers and school staff, claiming they are treated differently and that others have low expectations when it comes to them (Moses, 2010). Other studies have addressed how self-stigma affects treatment-seeking in people with mental illness, finding that those with more experiences of stigma and self-stigma seek less help from mental health professionals (Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014; Conner *et alia*, 2010; Cheng *et alia*, 2018). That being said, the empirical research evidence demonstrates an inconsistent relationship between stigma and mental health (Mak, Poon, Pun, & Cheung, 2007). Nevertheless, several studies demonstrate that weight stigma is highly associated with adverse mental health outcomes like depression, anxiety, psychological distress, eating disorders, poor quality of life, and low self-esteem (Emmer, Bosnjak, & Mata, 2020). Racial stigma related to racial discrimination also has been found to have an impact on mental health, as higher levels of racial discrimination lead to emotional regulation difficulties, anxiety, and depression (English, Rendina, & Parsons, 2018). Additionally, minority stress theory suggests that sexual minorities experience psychological stress related to their stigmatized social status, which leads to a higher prevalence of mental health problems (Meyer, 1995).

The relation between stigma and self-stigma and mental illness is reciprocal, which means that although stigma can have effects on mental health, people who already have

mental illness are also more likely to suffer from stigma and self-stigma. Research has found that the public attitudes toward people with mental illness have become more and more stigmatizing (Rüsch, Angermeyer, & Corrigan, 2005). For example, research conducted by Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999), concluded that public perceptions about people with mental illness had become more stigmatizing, specially regarding violence and dangerousness, concluding that people were more afraid of the mentally ill. These conceptions and stigmatizing attitudes towards people with mental illness contribute to lower rates of employment and income, depriving from affiliation with a group of people, socialization, better health care and an overall quality of life (Corrigan & Watson, 2002)

According to the World Health Organization (WHO, 2021), 703,000 people die by suicide every year, making suicide one of the leading causes of death worldwide. The psychological distress caused by stigmatizing experiences can be such a burden that they can result in extreme consequences (Carpiniello & Pinna, 2017). Furthermore, stigma itself can be seen as a risk factor for suicide, especially self-stigma, whose consequences (shame, hopelessness, social isolation, and low self-esteem) are also risk factors for suicide (Carpiniello & Pinna, 2017; Oexle *et alia*, 2017). Stigma also impedes efforts that may prevent suicide as people may feel ashamed to ask for help and inhibits help and treatment seeking behaviors (Reynders *et alia*, 2014).

Few studies have assessed the impact of stigmatizing experiences and self-stigma on the mental health and suicidal behavior, and literature is especially limited in the *Community of Portuguese Language Countries* (CPLC). The CPLC has a population of nearly 250 million and occupies an area of about 10.7 million square kilometres across four continents. Most of these countries are rich in cultural diversity and at the same time have a human development index below the global average. Although the CPLC share the influence of the Portuguese culture, their socioeconomic development patterns that differ, which may also influence the occurrence of stigmatizing experiences.

The majority of the studies conducted about self-stigma and stigmatizing experiences in Portugal, Brazil, and *African Countries with Portuguese as an Official Language* (PALOP; which includes Angola, Mozambique, Cape Verde, Guinea-Bissau, São Tomé and Príncipe, Macau, and Timor-Leste) are focused on mental health stigma and HIV/AIDS-related stigma (Holzemer & Uys, 2004; Abadía-Barrero & Castro, 2006; Monteiro, Villela, & Knauth, 2012; Andrade & Iriart, 2015; Mukolo, Torres, Bechtel, Sidat, & Vergara, 2013; Zhang *et alia*, 2019; Vedana, Silva, Miasso, Zanetti & Borges, 2017; Vázquez *et alia*, 2011; Oliveira *et alia*, 2020). Therefore, this study aims to address the lack of studies of the impact of stigmatizing experiences and self-stigma in the normative populations in these countries, and its objectives are (1) to assess stigmatizing experiences, self-stigma, mental health, and suicidal behavior, comparing differences between countries of residence; (2) to explore the associations between self-stigma, stigmatizing experiences, mental health variables, and suicidal behavior; and (3) to determine the predictive effect of self-stigma, number of stigmatizing experiences, and sociodemographic variables on mental health and suicidal behavior.

METHOD

Participants

The sample was collected online using an electronic survey. The inclusion criteria included being 18 years or older, speak Portuguese and live in the Community

of Portuguese Language Countries. The study sample consisted of 1006 participants, including 424 men, 576 women, and 6 people of another gender (42.1%, 57.3%, and 0.6% respectively), between the ages of 18 and 80 years old ($M= 41.76$; $SD= 14.19$). The sociodemographic characteristics are showed in Table 1.

Table 1. Sociodemographic characteristics.

		<i>n</i>	%
Gender	Male	424	42.1
	Female	576	57.3
	Other	6	.6
Country of residence	Portugal	296	29.4
	Brasil	409	40.7
	PALOP	301	29.9
Sexual orientation	Heterosexual	880	87.5
	Bisexual	66	6.5
	Gay/Lesbian	60	6.0
Ethnicity/race	White/European	502	49.9
	Black/African	253	25.1
	Mixed-race	241	24.9
Professional status	Employed	608	60.4
	Unemployed	47	4.7
	Student	143	14.2
	Student-worker	82	8.1
	Self-employed	65	6.4
	Retired	52	5.2
Educational attainment	Medical leave	3	.3
	Volunteer	6	.6
	Up to twelve years of education	100	9.9
	Bachelor's degree	249	24.7
	Master's degree	339	33.7
Socioeconomic status	Doctorate/Ph.D	318	31.6
	Very low	35	3.5
	Low	109	10.8
	Middle	584	58.0
Marital status	High	22	22.5
	Very high	51	5.1
	Single	221	21.9
Marital status	Dating	169	16.8
	Same-sex marriage	14	1.4
	Different-sex marriage	372	37.0
	Same-sex de facto union	12	1.2
	Different-sex de facto union different sex	134	13.3
	Divorced/separated to same-sex person	11	1.1
	Divorced/separated to different-sex person	60	5.9
	Widower of different-sex person	13	1.3

Instruments

Sociodemographic Questionnaire. Participants were asked about their country of residence, nationality, age, sexual orientation, ethnic group, profession, socioeconomic status, educational level, and marital status.

Brief Symptom Inventory-18 (BSI-18; Derogatis, 1993). BSI-18 was used to measure the participants psychosymptomatology over the previous week using three subscales that examine somatization, depression, and anxiety. These scales were evaluated by eighteen Likert-type response items ranging from 0 (nothing) to 4 (extremely). The somatization subscale assesses the distress associated with manifestations of automatically regulated systems (i.e., gastrointestinal and cardiovascular systems). The depression subscale focuses on the core symptoms of depressive disorders, such as dysphoric mood states, anhedonia, hopelessness, and suicidal ideation. Finally, the anxiety subscale captures symptoms indicative of panic states, which includes nervousness, tension, motor agitation, and apprehension (Derogatis, 1993; Nazaré, Pereira, & Canavarro 2017). The BSI-18 has a Cronbach's alpha of .865, indicating good internal consistency.

Suicidal Behaviors Questionnaire-Revised (SBQ-R, Portuguese version, Campos & Holden, 2019). Portuguese version of the SBQ-R was used to evaluate the frequency

and severity of participants' past and present suicidal behavior. The questionnaire is composed of four items that report lifetime suicidal thoughts (SBQ1), lifetime suicide attempts (SBQ2), suicidal thoughts in the last year (SBQ3), and suicide attempts in the last year (SBQ4) (Linehan, 1981; Campos & Holden, 2019). A fifth item (SBQ5) was added to assess the probability of committing suicide in the future.

Paradox of Self-Stigma (PaSS-24; Golay, Moga, Devas, Staecheli, Poisat, Israël, Suter, Silva, Morandi, Ferrari, Favrod, & Bonsack, 2021). This scale was used to evaluate the participant's self-stigma. The scale contains twenty-four items and three subscores (stereotype endorsement, non-disclosure, and righteous anger). These items were evaluated Likert-type response items ranging from totally 0 (disagree) to 5 (totally agree). The overall self-stigma scale possessed a Cronbach's alpha of .93, indicating excellent internal consistency.

Procedure

A link to the study website was disseminated through social media and mailing lists from May 2021 to October 2021 using a convenience sample method. This website was specifically created for the purposes of this study, and participants were invited to voluntarily partake in the study through a message containing a link to the website. This project was approved by the ethics commission of University of Beira Interior (Portugal), respecting all the ethical principles of anonymity, confidentiality, beneficence, and respect for physical and psychological integrity. IP addresses were kept confidential and anonymous, and the database was encrypted to guarantee anonymity of the data.

Data Analysis

Descriptive statistics were performed to describe the sample (mean, standard deviation, frequencies, and percentages). A one-way ANOVA was conducted to evaluate differences between comparison groups (countries of residence). To assess the association between age, overall psychological symptoms, probability of future suicide, self-stigma and number of stigmatizing experiences, a Pearson correlation coefficient was conducted. Finally, hierarchical linear regression analysis were conducted to examine the effects of independent variables (Includes age, country of residence, gender, sexual orientation, ethnicity, religion, number of stigmatizing experiences, stereotype endorsement stigma, righteous anger stigma and nondisclosure stigma) on the dependent variables (mental health and suicidal behavior).

RESULTS

As shown in Table 2, over half of the sample (53.7%) reported having had stigmatizing experiences. Of those who reported stigmatizing experiences, 15.9% had such experiences due to their skin color, 10.7% due to cultural or ethnic origin, 13.5% due to gender identity, 9.5% due to sexual orientation, 17.6% due to physical attributes, 8.3% due to age, 15.4% due to weight, 1.5% due to physical illness, 3.3% due to mental illness, 1.3% due to physical disabilities, 9.5% due to poverty, and 8.1% due to place of residence.

As showed in Table 3, the results showed statistically significant differences between countries ($p < .05$) for somatization ($t_{(2)}=4.543$, $p < .001$); depression ($t_{(2)}=9.714$, $p < .001$); anxiety ($t_{(2)}=17.668$, $p < .001$); overall psychological symptoms ($t_{(2)}=11.101$; $p < .001$), lifetime suicidal thoughts ($t_{(2)}=11.441$, $p < .001$); suicidal thoughts in the last year ($t_{(2)}=7.112$, $p < .001$); probability of future suicide ($t_{(2)}=5.525$, $p=.004$), righteous anger stigma ($t_{(2)}=9.680$, $p < .001$), nondisclosure stigma ($t_{(2)}=3.619$, $p=.027$); and total stigma ($t_{(2)}=3.203$, $p=.041$). Brazilian participants reported higher scores on all psychological symptoms, although the sample exhibits normative psychological

Table 2. Stigmatizing experiences

		<i>n</i>	%
Stigmatizing experiences	Yes	540	53.7
	No	466	46.3
	Skin colour	160	15.9
	Cultural or ethnic origin	108	10.7
	Gender identity	136	13.5
	Sexual orientation	96	9.5
Type of stigmatizing experience (only applies for those who mentioned having had stigmatizing experiences n=540)	Physical attributes	177	17.6
	Age	84	8.3
	Weight	155	15.4
	Physical illness	15	1.5
	Mental illness	33	3.3
	Physical disabilities	13	1.3
	Socioeconomic status (poverty)	96	9.5
	Place of residence	81	8.1
	Other	25	2.5

Table 3. Mental health, suicidal behavior, and self-stigma results by country of residence.

Mental health, suicidal behavior, self-stigma	Country of residence	<i>M(SD)</i>	<i>T</i> (df)	<i>p</i>
Somatization symptoms	Portugal	.51(.55)	4.543 (2)	.011*
	Brazil	.64(.69)		
	PALOP	.52(.57)		
Depression symptoms	Portugal	.84(.75)	9.716 (2)	.000**
	Brazil	1.03(.82)		
	PALOP	.79(.73)		
Anxiety symptoms	Portugal	.92(.70)	17.688 (2)	.000**
	Brazil	1.12(.86)		
	PALOP	.77(.69)		
Overall psychological symptoms	Portugal	.76(.59)	11.101 (2)	.000**
	Brazil	.93(.71)		
	PALOP	.71(.63)		
Lifetime suicidal thoughts	Portugal	1.48(.60)	11.441 (2)	.000**
	Brazil	1.56(.66)		
	PALOP	1.33(.55)		
Lifetime suicide attempts	Portugal	1.17(.58)	.451 (2)	.637
	Brazil	1.19(.62)		
	PALOP	1.16(.55)		
Suicidal thoughts in the last year	Portugal	1.32(.86)	7.112 (2)	.001**
	Brazil	1.43(.92)		
	PALOP	1.19(.63)		
Suicide attempts in the last year	Portugal	1.06(.38)	1.913 (2)	.148
	Brazil	1.03(.23)		
	PALOP	1.08(.42)		
Probability of future suicide	Portugal	1.44(.97)	5.525 (2)	.004*
	Brazil	1.38(.98)		
	PALOP	1.2(.71)		
Stereotype endorsement stigma	Portugal	1.56(.69)	.856 (2)	.425
	Brazil	1.54(.66)		
	PALOP	1.6(.69)		
Righteous anger stigma	Portugal	2.18(1.07)	9.680 (2)	.000**
	Brazil	2.91(1.19)		
	PALOP	2.47(1.11)		
Nondisclosure stigma	Portugal	2.18(1.07)	3.619 (2)	.027*
	Brazil	2.28(1.08)		
	PALOP	2.03(1.01)		
Total self-stigma	Portugal	2.15(.85)	3.203 (2)	.041*
	Brazil	2.22(.8)		
	PALOP	2.05(.82)		

Notes: * = $p < .05$; ** = $p < .001$.

symptoms (Nazaré *et alia*, 2017), suicidal thoughts and attempts, and overall stigma. On the other hand, PALOP participants reported less psychological symptoms, self-stigma, and suicidal thoughts and attempts. Finally, Portuguese participants had higher scores for probability of future suicide.

A correlation matrix was created to assess the levels of association among age, overall psychological symptoms, probability of future suicide, total self-stigma, and number of stigmatizing experiences. As displayed in Table 4, a significant negative correlation was found between overall psychological symptoms and age ($r = -.238$; $p < .001$). Additionally, significant positive correlations were found between overall psychological symptoms and total self-stigma ($r = .417$; $p < .001$), number of stigmatizing experiences ($r = .255$; $p < .001$) and probability of future suicide ($r = .357$; $p < .001$). Significant positive correlations were also found between probability of future suicide and total self-stigma ($r = .252$; $p < .001$) and number of stigmatizing experiences ($r = .191$; $p < .001$). Finally, a significant negative correlation was found between total self-stigma and age ($r = -.259$; $p < .001$) and a significant positive correlation was found between total self-stigma and number of stigmatizing experiences ($r = .396$; $p < .001$).

Table 4. Correlation values among variables.

	1	2	3	4
2	-.238**	--		
3	-.073*	.357**	--	
4	-.259**	.417**	.252**	--
5	-.225**	.255**	.191**	.396**

Notes: 1= Age; 2= Overall psychological symptoms; 3= Probability of ever committing suicide; 4= Total self-stigma; 5= Number of stigmatizing experiences; *= $p < .05$; **= $p < .001$.

A hierarchical regression model was performed to determine the predictive effect of sociodemographic variables, number of stigmatizing experiences, and self-stigma on mental health, through the overall psychological symptoms. As shown in Table 5, the first model included sociodemographic variables and explained 8.6% of the total explained variance of mental health, the second model included sociodemographic variables and number of stigmatizing experiences and explained 11.7 % of the explained variance, and the third model included sociodemographic variables, number of stigmatizing experiences and self-stigma variables and explained 25.3% of the explained variance.

Table 5. Mental health linear regression models.

	Model I*			Model II**			Model III**		
	B	SE B	β	B	SE B	β	B	SE B	β
Age	-.011	.002	-.220	-.009	.002	-.189	-.006	.002	-.123
Country of residence	.018	.040	.020	.001	.040	.002	.011	.037	.012
Gender	.192	.053	.146	.161	.052	.122	.198	.049	.150
Sexual orientation	.111	.046	.096	.036	.048	.031	.002	.045	.002
Ethnicity	-.029	.033	-.037	-.057	.033	-.071	-.067	.030	-.084
Religion	-.082	.056	-.058	-.108	.056	-.076	-.079	.051	-.055
Number of stigmatizing experiences				.084	.018	.196	.061	.018	.142
Stereotype endorsement stigma							.233	.044	.221
Righteous anger stigma							-.025	.025	-.045
Nondisclosure stigma							.153	.030	.239
R ²	.086			.117			.253		
F for change in R ²	10.23			12.33			22.04		

Notes: * = Includes age, country of residence, gender, sexual orientation, ethnicity and religion; ** = Includes age, country of residence, gender, sexual orientation, ethnicity, religion and number of stigmatizing experiences; *** = Includes age, country of residence, gender, sexual orientation, ethnicity, religion, number of stigmatizing experiences, stereotype endorsement stigma, righteous anger stigma and nondisclosure stigma.

Finally, as showed in Table 6, another hierarchical regression model was performed to determine the predictive effect of sociodemographic variables, number of stigmatizing

Table 6. Suicidal behavior linear regression models.

	Model I*			Model II**			Model III**		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Age	-.004	.003	-.052	-.002	.003	-.033	.000	.003	.007
Country of residence	-.047	.061	-.035	-.062	.061	-.047	-.068	.059	-.050
Gender	.073	.080	.038	.044	.080	.023	.100	.078	.052
Sexual orientation	.299	.069	.175	.230	.073	.135	.223	.071	.131
Ethnicity	-.012	.050	-.010	-.038	.050	-.033	-.043	.048	-.037
Religion	.138	.085	.066	.115	.085	-.055	.143	.082	.068
Number of stigmatizing experiences				.077	.027	.123	.081	.028	.128
Stereotype endorsement stigma							.391	.070	.250
Righteous anger stigma							-.071	.040	-.085
Nondisclosure stigma							.061	.048	.065
<i>R</i> ²	.052			.064			.135		
<i>F</i> for change in <i>R</i> ²	5.88			6.28			10.04		

Notes: * = Includes age, country of residence, gender, sexual orientation, ethnicity, and religion; ** = Includes age, country of residence, gender, sexual orientation, ethnicity, religion and number of stigmatizing experiences; *** = Includes age, country of residence, gender, sexual orientation, ethnicity, religion, number of stigmatizing experiences, stereotype endorsement stigma, righteous anger stigma and nondisclosure stigma.

experiences, and self-stigma on suicidal behavior, measured by the probability of future suicide. The first model included sociodemographic variables and explained 5.2% of the total explained variance in suicidal behavior, the second model included sociodemographic variables and number of stigmatizing experiences and explained 6.4 % of the variance in suicidal behavior, and the third model included sociodemographic variables, number of stigmatizing experiences, and self-stigma variables and explained 13.5% of the variance in suicidal behavior.

DISCUSSION

The main purpose of this study was to investigate the impact of stigmatizing experiences and self-stigma on mental health and suicidal behavior of people living in the CPLC. The study findings demonstrate that, although mental health levels are what would be expected for a non-clinical normative sample, both mental health and suicidal behaviors are impacted by number of stigmatizing experiences and self-stigma, as participants with higher levels of stigmatizing experiences and self-stigma also have higher levels of psychological symptoms and suicidal behaviors.

Statistically significant differences in mental health and suicidal behaviors were also found between countries of residence. Brazilian participants showed higher scores in psychological symptoms, suicidal behavior, self-stigma, and number of stigmatizing experiences. This is consistent with existing research, as according to WHO (2017), Brazil has the highest prevalence of anxiety disorders (9.3%) and the fourth higher prevalence depressive disorders (5.8%) globally. This may be explained by the fact that Brazil has high levels of poverty and social inequality, and contextual factors like poverty, low socioeconomic status and deprivation are related to higher mental health disorders (Ribeiro *et alia*, 2017; Silva & Santana, 2012). This is because factors such as risk of violence, health problems, and feelings of insecurity and hopelessness cause under-resourced communities to be more vulnerable to mental disorders (Silva & Santana, 2012). Poverty and deprivation, which contribute to increased stress and less access to health care, and are also prevalent in inequal societies, like Brazil (Ribeiro *et alia*, 2017).

Brazilian participants also shower higher levels of suicidal behavior. This is also consistent with previous findings, as WHO (2021) reported that Brazil is one of the top 10 countries globally with the highest prevalence of suicide in 2019. Additionally, mental disorders like depression are a risk factor for suicide and, as mentioned earlier,

Brazil has higher rates of anxiety and depression, which may contribute to the results of our study (Botega, 2014). Furthermore, Brazil has high levels of poverty and low income, which are also associated with suicide (Kim, Kim, Choi, Lee, & Park, 2016).

Results showed that PALOP participants, on the other hand, had lower levels of psychological symptoms, suicidal behavior, experiences of stigma, and self-stigma. Although the socioeconomic environment in African countries, which is more disadvantaged compared to Western standards, does not favor mental health, cultural traditions, belief systems, community support, a notion of shared responsibility, and religion are converted into a source of social support. This social support in turn, has positive repercussions on the mental health of these communities, decreasing psychological symptoms and suicidal behavior (Young African Leaders Initiative, 2014).

The results also demonstrated that age is negatively related to stigmatizing experiences, self-stigma, and psychological symptoms. This may be explained by the fact that older adults frequently report elevated levels of well-being despite losses in many domains and have a higher ability to regulate their emotions by optimizing and selecting particular emotional regulation processes in comparison to younger adults (Urry & Gross, 2010).

People who had experienced stigmatizing experiences and self-stigma also had higher levels of psychological symptoms. This is important as stigma can discourage stigmatized individuals from seeking the professional help that they may need (Clement *et alia*, 2015). Furthermore, people who are experiencing psychological problems and would benefit from professional care may choose not to seek help to avoid the label of mental illness and the stigma experiences that it can cause, thus further aggravating their mental health (Corrigan, 2004). People who have suffered stigmatizing experiences also tend to have low self-esteem and self-efficacy, which leads to a poorer quality of life and reduced well-being, which may contribute to poorer mental health and decreased efforts to seek professional help (Sickel, Seacat, & Nabors, 2014). Mental health stigma can be linked to lack of education, fear, or religious beliefs. Therefore, health literacy is essential in mitigating stigma and its effects in stigmatized individuals, in which the role of mental health professionals and educational professional is essential, as people are less likely to direct stigmatizing comments towards others when they are better-informed about mental illness, physical illness, and physical attributes (Amuyunzu-Nyamongo, 2013; Corrigan, 2004).

The results showed that self-stigma and stigmatizing experiences are positively associated with suicide, more particularly with the probability of future suicide. Individuals with suicidal ideation are sometimes understood as weak or selfish, making them more prone to stigma and, consequently, to attempting suicide (Rogers *et alia*, 2018). The consequences of self-stigma, such as shame, hopelessness, social isolation, and low self-esteem are risk factors for suicide and the social disconnection related to these consequences can aggravate suicide ideation (Carpiniello & Pinna, 2017; Oexle *et alia*, 2017; Rogers, Schneider, Gai, Gorday, & Joiner, 2018). Furthermore, self-stigma represents a major barrier to mental health care and professional help-seeking and has also been showed to impede efforts that prevent suicide. Therefore, by addressing stigma in our communities, we will be able to save lives by preventing suicides (Downs & Eisenberg, 2011; Reynders *et alia*, 2014).

This study is not without limitations. First of all, this study used a convenience sample, and the participants are highly differentiated as the majority of the participants have a university degree. Also, because internet access was necessary to complete

the online survey, many individuals, particularly in PALOP, may not have been able to participate. These factors make the results unrepresentative and ungeneralizable. Secondly, there are few studies about stigma in the African countries, making it difficult to compare results. Future studies should include more sociodemographic variation in samples, making a particular effort to include those who are socially disadvantaged. Additionally, future studies should aim to be more comprehensive and include other research methodologies, such as longitudinal studies and qualitative studies, to offer deeper insight into the relationship of variables in the study.

This study was an important contribution to the knowledge regarding the relationship between stigma and mental health. There is a large gap in literature related to the effects of stigma on the mental health, especially in the normative population so this study is important as it helps to fill that gap. Those who reported having had more stigmatizing experiences showed more psychological symptoms and, consequently, higher suicidal behavior. Stigmatizing experiences affect the well-being of individuals and have an impact on overall quality of life, highlighting the need to take measures to reduce the impact of stigma and the need to create political, social, educational and health policies and strategies. These policies should aim to prevent stigma and promote mental health and well-being through literacy programs, as people are less likely to direct stigmatizing comments towards others when they are better-informed about mental illness. Health care professionals and educational professionals should be made aware of the results of this study as to allow them to function as agents of social change who are involved in the reducing and/or eliminating stigma thus contributing to improving the quality-of-life people, thereby improving mental health and reducing suicidal behavior.

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