Stigma, Self-Stigma, and Psychosocial Disability in Colombia: A longitudinal review of public policy, Institutional Recognition, and Lived Experience through the Lens of Pre-Policy, Certification Process, and Post-Pandemic Perspectives

Lina Maria Gonzalez Ballesteros, Camila Andrea Castellanos Roncancio , Luis Eduardo Mojica Ospina, Jennifer Clavijo Marin, Isabela Jaramillo Osorio, Santiago Lopez Zuluaga

https://doi.org/10.1590/SciELOPreprints.13016

Submitted on: 2025-08-18
Posted on: 2025-08-22 (version 1)
(YYYY-MM-DD)

Stigma, Self-Stigma, and Psychosocial Disability in Colombia: A longitudinal review of public policy, Institutional Recognition, and Lived Experience through the Lens of Pre-Policy, Certification Process, and Post-Pandemic Perspectives.

Authors:
Lina María González-Ballesteros [1, 2, 3] Camila Andrea Castellanos [2, 3], Luis Eduardo Mojica Ospina[2, 3], Jennifer Clavijo-Marín [2, 3] Isabela Osorio Jaramillo[3], Santiago Lopez Zuluaga[3]

Affiliations:

[1] Departamento de Psiquiatría y Salud Mental, Facultad de Medicina, Pontifica Universidad Javeriana, Bogotá.
[2] Semillero de Promoción en Salud Mental y Resiliencia, Facultad de Medicina, Pontificia Universidad Javeriana, Bogotá.
[3] Fundación Saldarriaga Concha, Bogotá.

ORCID iDs
Lina María González Ballesteros: https://orcid.org/0000-0003-1557-1036
Camila Andrea Castellanos-Roncancio: https://orcid.org/0000-0002-9677-8559
Luis Eduardo Mojica Ospina: https://orcid.org/0000-0003-4003-2093
Jennifer Clavijo Marin: https://orcid.org/0000-0003-1264-3778
Isabela Osorio Jaramillo: https://orcid.org/0009-0003-8748-1520
Santiago Lopez Zuluaga: https://orcid.org/0000-0001-5417-0994

Emails
Lina María González Ballesteros: lgonzalez@saldarriagaconcha.org ; lgonzalezb@javeriana.edu.co
Camila Andrea Castellanos-Roncancio: ccastellanos@saldarriagaconcha.org
Luis Eduardo Mojica Ospina: lmojicao@saldarriagaconcha.org
Jennifer Clavijo Marin: jclavijor@saldarriagaconcha.org
Isabela Osorio Jaramillo: isabela.osorio@javeriana.edu.co
Santiago Lopez Zuluaga: slopez@saldarriagaconcha.org

Corresponding Author
Lina María González Ballesteros[1],[2]
Fundación Saldarriaga Concha. Bogotá, Colombia
Email: lgonzalezb@javeriana.edu.co

Abstract:

In Colombia, a country marked by armed conflict and deep social inequalities, stigma and perceptions of psychosocial disability critically influence access to rights and services. This qualitative study examines how these perceptions have evolved through a review of previous qualitative research. Organized around three key moments-the period prior to the implementation of the National Mental Health Policy, the disability certification process, and a recent participatory research initiative-the analysis identifies persistent tensions in institutional narratives and first-person accounts. The findings show a consistent gap between legal frameworks and lived experiences, particularly in indigenous and Afro-Colombian communities affected by violence. Although official policies promote inclusion and rehabilitation, they often fail to connect with local realities due to the persistence of stigma and discrimination, the effects of self-stigma on the subjective appropriation of rights, and the limited meaningful participation of persons with disabilities in key processes such as peacebuilding. Victims with disabilities face additional challenges that affect their mental health and restrict their social participation. While there have been institutional efforts to establish care pathways and guarantee rights, there remains limited understanding of how stigma and self-stigma have evolved - if at all - since the implementation of the National Mental Health Policy, as well as the impact of bureaucratic processes, such as certification, on subjective representations of disability. This analysis underscores the need for community strategies that consider cultural differences and confront structural and symbolic exclusion. The recent approval of the Mental Health Law 2025 represents a renewed opportunity to move forward, highlighting the importance of longitudinal and participatory monitoring to assess its impact on access, equity and social participation.

Key Words: Disability, stigma, self-stigma, internalized stigma, armed conflict

Introduction

According to the World Health Organization, approximately 1.3 billion people, or 16% of the world's population, live with significant disabilities, a figure that continues to rise due to the aging of the population and the increasing burden of non-communicable diseases. WHO defines the generic term “disability” as a broad concept encompassing all impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between a person (with a health condition) and his or her contextual (environmental and personal) factors. It therefore encompasses both physical and mental disabilities. People with disabilities face poorer health outcomes, largely due to systemic health inequities. These inequities stem from unfair and disproportionate conditions such as stigma, discrimination, poverty, social exclusion, and significant barriers within health care systems (WHO 2024).

Within contemporary theoretical frameworks, disability is understood as a dynamic and multidimensional phenomenon arising from the interaction between individual health conditions and environmental, social, economic, and political barriers (UN 2006; González-Ballesteros, 2024). This conception aligns with the biopsychosocial model, which is currently one of the most widely accepted approaches. As defined by the International Classification of Functioning, Disability and Health (ICF), disability encompasses impairments, activity limitations, and participation restrictions, reflecting the negative aspects of the interaction between an individual and contextual factors, including environmental and personal elements (WHO 2001). This integrated perspective advances a structural and systemic understanding of disability, emphasizing that the persistence of exclusionary barriers is a societal responsibility rather than an inherent attribute of individuals.

Over the past two decades, Colombia has advanced significant legal reforms to safeguard the rights of people with disabilities, drawing on constitutional mandates and enacting key legislation such as Law 1145 of 2007, which established the National Disability System, and Law 1618 of 2013, which promotes inclusive measures and reasonable accommodations (Departamento Administrativo Nacional de Estadística [DANE] 2023). These laws align with the UN Convention on the Rights of Persons with Disabilities by recognizing disability as the result of the interaction between individual impairments and various social, physical, and cultural barriers that limit full participation on equal terms.

Building on this framework, Colombia's National Mental Health Policy, adopted through Resolution 4886 of 2018, represents a pivotal moment (Ministerio de Salud y Protección Social, 2018). This policy provides a strategic framework for ensuring the full exercise of mental health as an integral component of the right to health, anchored in a primary health care approach.

It outlines several cross-cutting implementation axes, with Axis 4 being particularly relevant for psychosocial disability, focusing on comprehensive rehabilitation and social inclusion. This axis emphasizes coordinated, community-based, and multisectoral strategies aimed at restoring functional capacities—physical, psychological, educational, social, and occupational—among people with mental disorders or epilepsy. Its purpose is to ensure equal opportunities and active social integration through sustained collaboration among individuals, families, communities, and institutional services. Notably, it promotes psychosocial rehabilitation as a community-driven, rights-based process that addresses stigma, supports family caregivers, and strengthens social and institutional networks to improve access to education, employment, and cultural life. This policy axis not only highlights the importance of disability as a social issue but also reframes mental health interventions around inclusion, participation, and dignity (Ministerio de Salud y Protección Social 2018).

Nevertheless, the internal armed conflict has produced severe and enduring consequences for people with disabilities, generating complex structural and psychosocial barriers that hinder the realization of fundamental rights, including access to healthcare (Rodríguez Caicedo et al. 2023). The conflict has not only been a direct cause of disability but has also exacerbated pre-existing vulnerabilities within this population (Biel Portero and Bolaños Enríquez 2018). Despite the existence of protective legal frameworks, many people with disabilities lack the resources and institutional support required to effectively claim their rights (Biel Portero and Bolaños Enríquez, 2018). Psychosocial consequences have been especially acute for women, with Indigenous and Afro-Colombian women disproportionately affected. Paramilitary groups were frequently identified as key perpetrators of violence against these populations (Arnoso Martinez et al. 2017). Although there have been initiatives to promote the inclusion of people with disabilities in peacebuilding processes, their meaningful participation remains limited (Biel Portero and Bolaños Enríquez 2018) and victims with disabilities face multiple challenges, including stigma and discrimination, which affect their mental health and social participation (Campo-Arias and Herazo 2014). This context of armed conflict is particularly relevant as it has intensified the challenges faced by these communities, making the study of stigma in these populations even more critical.

According to Santos, Barros, and Santos (2016), stigma is understood as an undesirable difference—a pejorative attribute associated with intolerance—which, when linked to mental illness, generates fear of the unknown, social exclusion, and false beliefs stemming from a lack of knowledge and understanding of mental disorders. Thornicroft (2006) further explains that stigma is not only rooted in stereotypes arising from insufficient information, but also manifests in prejudice, discrimination, and the social withdrawal of those affected, ultimately reinforcing their marginalization. Stigma against individuals with psychosocial disabilities is conceptualized as a structural human rights violation, contributing to marginalization and rights infringements (Mahomed, 2016). It impedes access to healthcare, education, and employment, necessitating a multifaceted approach to address ignorance, prejudice, and discrimination (Mahomed, 2016; Mahomed and Stein, 2021). The de-prioritization of mental health in policy and resource allocation is itself a form of systemic stigma (Mahomed and Stein 2021).

Furthermore, the concept of self-stigma in mental health involves internalizing negative stereotypes, leading to reduced self-esteem, self-efficacy, and help-seeking behaviors (Corrigan et al. 2006; Mittal et al. 2012). It is conceptualized as a process of stereotype acceptance, internalization, and personal impact (Fernández et al. 2023). Interventions to reduce self-stigma primarily focus on altering stigmatizing beliefs or enhancing coping skills through improving self-esteem and empowerment (Mittal et al. 2012).

Despite institutional efforts to establish care pathways and guarantee rights, a critical gap persists between formal mechanisms and the subjective appropriation of these rights by individuals, shaped by the dynamics of self-stigma. While prior research has informed the development of public policies, there remains limited understanding of how stigma and self-stigma have evolved—if at all—since the implementation of Colombia’s National Mental Health Policy. Furthermore, there has been no systematic inquiry into how representations of psychosocial disability have changed from the perspective of those directly affected, or how such representations intersect with bureaucratic processes such as disability certification.

To address this critical gap and provide a nuanced longitudinal perspective, this article analyzes how perceptions of stigma and psychosocial disability in Colombia have transformed across three distinct temporal moments, considering the profound societal shifts, including the COVID-19 pandemic and the ongoing implementation of the National Mental Health Policy of 2018, as well as the new 2025 Mental Health Law. Specifically, this study aims to qualitatively evaluate the evolution of stigma associated with psychosocial disability in different populations by examining data from the period preceding the National Mental Health Policy (2018), the disability certification process (2024), and a recent participatory research initiative (2024 - 2025), identifying common elements and changes over time.

Methods

This study adopted a longitudinal qualitative integrative review design, a valuable approach for studying phenomena that change over time, particularly in health and social sciences (Nevedal, Ayalon, and Briller 2019) This design aimed at examining the evolving perceptions of stigma and psychosocial disability in Colombia over time. The analysis was based on secondary data and selected segments of previously published qualitative studies conducted under diverse methodological frameworks. These source studies included interviews, focus groups, and participatory research exercises, developed in the context of institutional initiatives, public policy implementation, and community-based mental health projects. This approach allows for a rich, nuanced understanding of lived experiences across different periods, aligning with the journal's focus on human-centered perspectives.

Regarding the methodological and data selection strategy, the study adopted a time frame between 2019 and 2024, in which three qualitative research studies previously developed by the team were intentionally selected for convenience and for their direct thematic relevance and availability: (1) a study of the relationship between stigma and psychosocial disability preceding the implementation of the National Mental Health Policy in 2018; (2) a study of the institutional and social representations surrounding the process of psychosocial disability certification in 2024; and (3) a participatory research initiative from 2024 until 2025 developed under the framework of Science, Technology, and Innovation projects. No inclusion or exclusion criteria were applied beyond their thematic and temporal relevance, as this approach allowed for a longitudinal and context-sensitive understanding of how psychosocial disability has been socially constructed and perceived throughout different historical moments in Colombia, allowing for the identification of changes and commonalities in perceptions of stigma throughout these different periods and in relation to the evolving political landscape and the impact of events such as the COVID-19 pandemic.

Data were analyzed using discourse analysis techniques, with particular attention to the meanings ascribed to disability, stigma, and institutional recognition processes. Special emphasis was placed on how social actors name, negotiate, or reject the category of psychosocial disability and the implications of these discursive practices for access to rights and institutional inclusion. This methodological approach enabled a critical reading of the symbolic and institutional barriers that contribute to self-stigma and hinder formal recognition as persons with disabilities. In doing so, the study offers a nuanced perspective on the limitations of current mental health and disability policies and the sociocultural conditions that shape lived experiences of psychosocial disability in Colombia.

Results

The findings are presented according to the three analytical phases that structure this study.

Each phase captures a different moment in the evolution of perceptions of stigma and psychosocial disability, highlighting key themes that emerged from the qualitative analysis. The results reflect both continuities and shifts in how these phenomena are constructed and experienced across time and institutional settings, offering a longitudinal perspective on how stigma is navigated and resisted within the Colombian context.

First phase: Relationship Between Stigma and Psychosocial Disability, Conceptual Contributions Derived from Social Intervention with Ethnic Approach

The research presented in the article "Relación entre estigma y discapacidad psicosocial: aportes conceptuales derivados de la intervención social con enfoque étnico" (González-Ballesteros, 2024) was published in 2024 and is based on a territorial intervention carried out with Indigenous and Afro-Colombian communities affected by the armed conflict in Colombia. The fieldwork was done in 2018, before the National Mental Health Policy was implemented. This initial study provides a crucial baseline to evaluate the state of stigma related to psychosocial disability before the public policy went into action and offers a pre-pandemic perspective on these communities' experiences.

In the aftermath of Colombia's armed conflict, peacebuilding efforts increasingly required a focus on ethnic and social diversity. One key area involves understanding the stigma experienced by individuals with psychosocial disabilities, particularly among Afro-Colombian and Indigenous populations. These communities often face structural violence that blocks their inclusion in society. This article offers insight into the conceptual relationship between stigma and psychosocial disability in those communities. The research, conducted by Fundación Saldarriaga Concha in alliance with the Ford Foundation, included communities such as the Emberá-Katío, Pastos, Wiwas, Wayús, and young members of the Obonuco cabildo.

The authors use ideas from Foucault and Symbolic Interactionism to understand how people's views and actions shape the experience of psychosocial disability. Then they use grounded theory to organize and analyze the qualitative data. Foucault's concept of biopower helps explain how society uses rules and norms to control people who are seen as "different," such as those with mental illness or trauma. Goffman's (1963) theory of stigma is used to show

how daily interactions and social judgments create exclusion and marginalization. Barnartt (2016) builds on Goffman by saying that disability is not something fixed, but something that can change depending on how people interact. This helps explain how stigma can be either absorbed or challenged. The authors also draw on Link and Phelan (2001, 2014), who describe different types of stigmas: structural (built into systems) , interrelational (between people) , and internalized (when people believe the stigma themselves). Although other studies (Cook et al. 2004; Campo-Arias and Herazo 2014; Cayuela Sánchez 2023) have looked at these topics, the authors point out that such knowledge has not yet been applied in many of the areas most impacted by violence.

Empirical Findings: Types of Stigma and Participant Narratives

The study draws on empirical material from a social intervention project working with Indigenous and Afro-Colombian communities. The findings reveal a high density and groundedness of stigma-related themes. Verbatim testimonies from participants were categorized under four dimensions: self-stigma, structural discrimination, interrelation, and positive resignification. The testimonies are presented below in English; however, it should be noted that they are translations from Spanish, the language in which the original statements were given.

a. Self-Stigma

Self-stigma was frequently expressed as internalized shame, fear of judgment, or rejection of one’s own emotional or mental state. This was one of the paper's main findings, as it was important both in density and connection. We will present a short selection of testimonies to illustrate the paper's key points. The first concept will be the internalization of societal beliefs about mental health illness.

> "The main difficulties are, first, self-recognition and self-acceptance. So, when someone has a type of condition that involves mental health, it’s very hard to see themselves as part of a group of people who have difficulties or who might have a disability. If you don’t recognize and accept yourself, that’s where the challenge begins, because it becomes much harder to tell others what’s going on and to allow yourself to receive help as well." (Focus group, Bogotá, 2019)

This testimony illustrates a key mechanism of self-stigma: the internalization of negative societal beliefs about mental illness, which hinders self-identification and acceptance. The reluctance to recognize oneself as having a psychosocial disability reflects how stigma can disrupt help-seeking behavior and reinforce isolation. This aligns with Link and Phelan's (2001) model, where self-stigma reduces agency and impedes access to support.

b. Structural Discrimination

Participants referenced discriminatory practices embedded in institutional systems, ranging from health services to documentation processes:

> “Government agencies and the health system as an institution represent the greatest form of stigma, and you can see it in the existing regulations—what you are entitled to and how. In mental health, there are restrictions on the number of hospitalizations and consultations. Some are explicitly stated in the rules, others are not, but they occur in practice, by delaying appointment availability or shortening consultation times. Even if it's not officially regulated, I think there's a consensus.” (In-depth interview, Bogotá, 2019)

This excerpt is a clear example of structural discrimination, where formal policies and informal practices within health institutions restrict access to care for individuals with psychosocial disabilities. The participant notes that the limitations on hospitalizations and consultations—whether explicitly codified or operationalized through bureaucratic delays—reflect institutionalized stigma. This aligns with Link and Phelan's (2014) notion of stigma power, where systemic barriers in health governance undermine equitable access and reinforce exclusion.

c. Interrelational stigma (and relationship with professionals)

Interrelational stigma manifests in everyday social interactions, where people with psychosocial disabilities often face rejection and misunderstanding. This type of stigma creates significant barriers to social participation and emotional well-being, as reflected in personal testimonies from affected individuals.

> "I try, I try to connect with society, but I feel rejection, uh… which only revictimizes me worse, you know? It's like it makes me want to stay locked up, not wanting to go out." (Focus Group, Bogotá)

This testimony reflects how social rejection by others leads to further isolation and revictimization, impacting the individual's willingness to engage socially.

One crucial limitation identified in the study is the strained and stigmatizing relationship between people with psychosocial disabilities and health professionals, which exacerbates barriers to effective care and social inclusion.

> "I go to the association meetings where nowadays psychiatrists help us. People share [when asked], how was your week? [They usually respond] No, I had a relapse, I'm feeling this craziness. The first question from the psychiatrist [who works outside the association] is, 'What pills are you taking?' [To which we now respond] No doctor, the question isn't what pills you're taking, ask: what caused the relapse?" (Interview, Bogotá)

This testimony reveals a stigmatizing clinical approach focused on medication rather than understanding the person's lived experience and triggers. It reflects a medicalized, depersonalized interaction that can alienate patients, hinder trust, and discourage open communication, ultimately affecting treatment outcomes and reinforcing stigma.

d. **Positive Resignification**

Despite all these limitations, people with psychosocial disabilities find ways to reinterpret their experiences and resist stigma positively. Through self-awareness, visibility, cultural connection, and the development of personal agency, they challenge negative labels and reclaim their identities. The following three testimonies illustrate how these processes unfold daily, offering insight into the power of resignification and resistance.

> "Mental health is still seen as a topic for crazy people. My dream was to one day have enough money to put up lots of signs that say, 'Yes, I'm schizophrenic, but I have kids, a wife, a family, I have sex, I love, I laugh—and yes: I'm bipolar.' That dream of

> using more active media… but no, it's still treated like a crazy topic." (In-depth interview, Bogotá)

This person reflects on how society continues to label mental illness as something shameful. Despite this, they strongly desire to challenge public stereotypes by highlighting their whole and everyday life. This imagined campaign represents a powerful moment of self-awareness and defiance against stigma. It shows that self-stigma can be resisted through affirming one's humanity and complexity, even when dominant narratives remain negative.

> "Support also came to our territory from other Indigenous communities, especially the Cofani brothers, who shared Yagé medicine with us… personally, I've considered it a great contribution." (Focus group, Pasto)

This testimony shows how socialization within an ethnic and cultural framework—specifically, through shared traditional healing practices—can help reframe the experience of psychosocial disability. Instead of internalizing stigma, the person views the intervention as healing and empowering. Here, culture and community act as protective factors, allowing for a more positive self-concept and a reduction of self-stigma.

> "The psychologist giving the workshop told the community, 'You're stupid, you're country folk, you don't know how to live in the city, you're here to take care of horses, donkeys, pigs, whatever.' One day I had to stop her and say, 'Are you a psychologist? Because you don't seem like one. You weren't put here to insult us, you were supposed to give a talk on coexistence." (Focus group, victims, Barranquilla)

This testimony highlights how individuals build agency in the face of direct verbal discrimination. Rather than accepting the insult, the participant defends their dignity and demands respect. This confrontation shows a break with self-stigma and signals the person's ability to resist imposed stereotypes. It also reflects how marginalization can lead to a stronger sense of rights and political awareness.

Second phase: **Barriers in the Disability Certification Process in Colombia**

The study “Impulso a la certificación de discapacidad en Colombia: La percepción de actores estratégicos” (Fundación Saldarriaga Concha, 2024) draws on data from a broader qualitative investigation into the disability certification process in Colombia, which involved semi-structured interviews with decision-makers, certifying health institutions, and professionals, as well as focus groups with persons with disabilities and leaders of social organizations. Participants were recruited through snowball sampling , and fieldwork was conducted across 16 departments and 18 municipalities, including remote and socioeconomically diverse regions. The fieldwork was done in 2023, after the National Mental Health Policy was implemented. This study therefore offers insights into the certification process during a post-pandemic period, highlighting the practical challenges encountered after the policy's adoption. Thematic analysis was guided by an iteratively developed codebook and organized through a category tree framework, allowing for the identification of patterns in perceptions, institutional practices, and barriers related to certification. Full methodological details are available in Fundación Saldarriaga Concha, 2024; where the verbatim interview transcripts in their original language, Spanish, can also be found.

At the beginning of the article, the authors point that an estimated 2.65 million individuals in Colombia—equivalent to 5.6% of the population aged five years and older—are living with a disability (DANE 2020; Fundación Saldarriaga Concha 2024), and the country’s current certification system formally recognizes seven categories of disability (Fundación Saldarriaga Concha 2024). Although Colombia has made significant normative progress, disability certification remains a major bottleneck for the effective implementation of rights and access to services. As of October 2023, only 283,623 individuals had been officially certified, representing less than 1% of the Colombian population (Fundación Saldarriaga Concha 2024), thus reflecting a critical gap between recognition and formal validation of disability status.

A key finding in this study was the limited awareness and understanding of the certification process among individuals with disabilities and their families, who often reported confusion about its purpose, benefits, and steps—largely due to technical complexity and poor dissemination of information. Institutional fragmentation also emerged as a major barrier; the involvement of multiple entities, including health providers and administrative bodies, led to inconsistent practices, unclear referral pathways, and delays:

> “One of the main barriers […] is the doctors. When a person goes to a medical appointment through their EPS, the diagnosis is not issued using the ICD-10 classification. As a result, the medical records sent to the local authorities lack the proper diagnostic coding. That becomes the first barrier […] the person must return to the EPS, schedule another appointment, and wait for the treating physician to provide the correct diagnosis” (TD9, Health Secretariat, Tolima; Fundación Saldarriaga Concha 2024).

In addition to these structural and institutional barriers, the study shed light on a less visible but equally significant challenge: the lack of self-recognition as a person with a disability. This is illustrated in the following quote:

> “Disability is socially understood as lacking capacity and, as a consequence, being excluded” (GF1, Ibagué; Fundación Saldarriaga Concha 2024).

Among the findings, both people with disabilities and community leaders interviewed in the study reported that not all individuals identify themselves as such.

While disability certification provides access to certain benefits, it also exposes individuals to persistent social barriers. For many adults with disabilities, receiving a formal diagnosis is a key step toward self-recognition, as it helps them understand the origins of their limitations and anticipate the challenges they may face in everyday life. This awareness often leads to a difficult but necessary process of accepting that disability entails an ongoing struggle—one that requires personal strategies for self-management and resilience. A child with a disability may initially become aware of their condition when they begin to perceive differences in how they function compared to others:

> “(...) they perceive that they do not do things in the same way as their classmates or playmates. This is followed by a process of denial and frustration as they experience exclusion and mockery in their environment. Once they accept their condition, they

> recognize themselves as such, embrace it, and may begin to seek help and accept support" (GF2, Mitú; Fundación Saldarriaga Concha 2024).

The study describes how the recognition of stigmatizing societal perceptions of disability adds an additional layer of difficulty for individuals (Fundación Saldarriaga Concha 2024, 2024). However, it also highlights that this awareness can become a catalyst for collective action, encouraging community-based advocacy and the pursuit of rights (Fundación Saldarriaga Concha,2024).

The family plays a dual role in the process of self-recognition (Fundación Saldarriaga Concha 2024). On one hand, it can act as a facilitator by encouraging the person with a disability to acknowledge their abilities and develop strategies to overcome barriers (Fundación Saldarriaga Concha 2024):

> "It is difficult at first, but there came a moment when I was able to overcome all those barriers—sadness, internal conflicts, and obstacles—and instead began to educate others and to accept my daughter as she is, to live in peace and harmony with her" (GF1, Armenia; Fundación Saldarriaga Concha 2024).

On the other hand, the study found that families may also hinder this process. In some cases, families deny the existence of the disability or its associated limitations, avoiding open conversations out of fear that acknowledging it might lead to greater stigma or social exclusion. This silence can delay self-recognition and reinforce social invisibility.

The community plays a crucial role in shaping self-recognition processes, as it serves as the primary space for interaction between individuals with disabilities and their families, and as the setting where access to rights and services should be realized. However, the study found that many individuals and families lack awareness of available programs, leading to uncertainty about the value of self-recognition and certification. As a result, some lose interest in obtaining or renewing the disability certificate. This issue is particularly pronounced among people with psychosocial disabilities, who often perceive greater risks in identifying as disabled due to the invisible nature of their condition. Social questioning of the legitimacy of their self-identification negatively affects their inclusion in work, social, and recreational spaces. These challenges may prompt individuals and families to forgo or even renounce the certification process. The study also highlighted an important cultural dimension: in some Indigenous communities, disability is understood collectively. If an individual's condition does not disrupt communal life, it is not considered a disability; but when it does, the community mobilizes to provide support, reflecting a relational and solidarity-based perspective (Fundación Saldarriaga Concha 2024).

Additional barriers included attitudinal challenges within institutions. Participants described stigmatizing and dismissive behavior from service providers, which eroded trust and discouraged engagement with the system. Geographic disparities were noted as well, with people in rural or remote areas facing limited access to evaluations and administrative procedures due to inadequate infrastructure and trained personnel.

> "Among the barriers we have identified is internet access. We are in a region where internet connectivity is very limited. We work with telemedicine, and sometimes we are connected to certain municipalities, but the internet does not support those telemedicine services. Another barrier is distance… the population to be certified lives in rural areas (...)" (PF7, nurse; Fundación Saldarriaga Concha 2024).

Lastly, the absence of a post-certification follow-up mechanism was highlighted; individuals who obtained the certificate often lacked support on how to use it to access services or claim rights, thereby limiting its effectiveness as a tool for inclusion (Fundación Saldarriaga Concha 2024).

Third phase: Stigma and Mental Health in Educational Settings

Beyond formal definitions, the third phase of this study, drawing on qualitative data from the "Conmigo, Contigo y Con Todo" (3C) participatory initiative (conducted between November and December 2023), reveals nuanced perceptions and lived experiences related to stigma in mental health within educational settings in Amazonas, Vaupés, and Boyacá. Although the term "stigma" was not always explicitly used by participants, their narratives frequently depicted its manifestations, particularly concerning emotional expression, help-seeking behaviors, and social judgment. This initiative, described in previous work (Fundación Saldarriaga Concha 2024), aims to strengthen resilience, compassion, and mental health literacy in these vulnerable contexts, addressing the widespread treatment gap in mental health in Colombia.

a. Perceptions and Experiences of Stigma among Students

Difficulty in Emotional Expression and Help-Seeking:

Many students expressed reluctance to discuss their problems or difficult emotions, often choosing to internalize them: "I prefer to stay quiet, just as I am" or "not talking much about what I feel".

Some resorted to self-isolation: "I prefer to maintain distance" or "I prefer to stay locked up, not wanting to go out".

A significant barrier to seeking help was the fear of parental or institutional repercussions: "the college, well, it's scary because they always have to visit the parents and all that... and then at home it's another thing, they scold you, they hit you, for why one is saying that. If it's at home, it has to stay at home, not go out in public".

Students acknowledged not having confidence to share problems even with family: "You mean, you don't even have the confidence to tell your mom, your dad? No".

Coping strategies often involved avoidance, such as "not thinking about it" or "distracting my mind with other things", rather than direct emotional processing.

Impact of Bullying and Discrimination:

Students reported direct experiences of bullying, including "bullying for the color of my skin" or being compared negatively: "My mom has compared me to other people. She tells me, 'you are useless,' 'you don't do that.' I see many children who are smarter than you. I see children who do things well and you can't". These experiences caused "a lot of pain" and affected their self-perception.

The lingering effect of stigma was evident even after direct bullying ceased: "the hardest thing for me was having to see my classmates almost every day, because I don't know, but from afar, even though they no longer bothered me, I felt that they still looked at me badly".

Manifestations of Internalized Stigma:

Students described the struggle with self-recognition and self-acceptance, particularly when dealing with mental health challenges: "The main difficulties are, first, self-recognition and self-acceptance. So, when someone has a type of condition that involves mental health, it's very hard to see themselves as part of a group of people who have difficulties or who might have a disability. If you don't recognize and accept yourself, that's where the challenge begins, because it becomes much harder to tell others what's going on and to allow yourself to receive help as well".

The internal conflict stemming from substance use was also evident: "My most difficult situation was when I first tried psychoactive substances, like marijuana... The problem was that my parents never knew... I just left it without my parents knowing that I was like that, I just distanced myself from those things, because I was already aware of what would happen if I consumed more".

b. Perceptions and Experiences of Stigma among Teachers

Recognition of Invisible Suffering and the Need for Support:

Teachers frequently observed profound emotional struggles in their students, noting that "the Tikuna culture is very quiet, young people observe a lot, but talk little, and one doesn't perceive what might be happening to them... the risk of suicide is very high". This highlights the silent burden some students carry due to potential stigma.

They expressed feelings of helplessness when faced with deep-seated issues like abuse or family conflict: "I had a child who... was sexually abused... that year was too hard. There were impressive cases".

Teachers recognized the systemic lack of mental health support for students: "I spoke with my principal, who was supposed to be a protector. I asked him that we urgently needed a psychologist in that class. We needed help because the children really had some voids".

Institutional and Systemic Barriers:

Teachers frequently reported a lack of formal training in emotional management or mental health interventions from their institutions: "No, in the institution we haven't had [training]". One teacher noted, "we have not received [training] within the process we carry as teachers. However, we are working on a public mental health policy, and that is part of it".

Critiques of governmental initiatives highlighted inefficiency and potential misuse of funds, leading to a lack of tangible results: "only came and... made some surveys, and that was it... and with that, they charged almost 700 million pesos, for something that did not... because they did not reach all corners". This further contributes to a sense of abandonment and perpetuates the problem.

The difficulty in finding appropriate professional help and establishing trust was also noted: "I was attending therapy with a psychologist from the EPS, but I couldn't connect with her. I went to about four sessions, but I didn't feel it helped me".

Teachers' Role in Counteracting Stigma:

Despite personal and systemic challenges, teachers actively engaged in fostering emotional well-being and challenging negative perceptions. They saw their role as going "beyond simply transmitting knowledge," also teaching "character" and values.

They actively sought to build student confidence: "I have managed to talk to them, to make them trust, to make them have that courage that 'I can do it'".

Many teachers found "great satisfaction" in helping students, emphasizing that active listening and empathetic dialogue could provide "a peace inside that 'yes, I could do it'". This commitment highlights their potential as key agents in mitigating the effects of stigma in their classrooms.

These findings from the third phase reveal that, while the direct term "stigma" might not be universally used, its underlying manifestations—fear of judgment, self-censorship, and inadequate institutional support for mental health—are deeply ingrained in the educational experiences of both students and teachers in these vulnerable communities. The "Conmigo, Contigo y Con Todo" program, as a school-based intervention, emerges as a valuable initiative that addresses these gaps by fostering emotional expression, resilience, and compassion, thereby contributing to the broader goal of destigmatizing mental health and promoting inclusive environments.

Discussion

The findings from this longitudinal qualitative review reveal profound tensions between the normative ambitions of Colombia’s disability policy and the lived experiences of people with psychosocial disabilities and their families. The findings of this longitudinal review reveals that stigma related to psychosocial disability in Colombia is not only persistent but also deeply rooted in structural, cultural, and institutional dynamics that predate—and have been exacerbated by—recent crises such as the armed conflict and the COVID-19 pandemic. While each of the three phases analyzed (2018, 2024, and 2023–2025) presented distinct features, common patterns emerged, particularly around the invisibility of psychosocial disability, the limitations of institutional responses, and the resilience and agency of affected individuals.

In alignment with global frameworks such as the WHO's biopsychosocial model (WHO, 2001; 2024) and the ICF, this study supports the view of disability as the result of systemic barriers rather than intrinsic deficits. Despite progressive legislation in Colombia (e.g., Law 1618 of 2013; Resolution 4886 of 2018), the evidence underscores a critical implementation gap, particularly regarding mental health services, disability certification, and community-based interventions. The low rate of disability certification—less than 1% of the population—exemplifies how bureaucratic processes may reinforce exclusion rather than facilitate rights-based access, echoing critiques about the disconnection between legal frameworks and lived experiences (Biel Portero & Bolaños Enríquez, 2018).

Stigma, both structural and internalized, emerged as a major barrier throughout all phases, consistent with prior conceptualizations of stigma as a form of symbolic violence and a human rights violation (Mahomed, 2016; Thornicroft, 2006). Importantly, this study contributes to the growing body of literature that calls for stigma to be understood not only as an individual or interpersonal phenomenon, but as a consequence of social inequities, systemic neglect, and institutional inertia—particularly in marginalized populations such as Indigenous and Afro-Colombian communities affected by violence and displacement.

The third phase, centered on the 3C educational intervention, highlights the potential of community-based, school-centered strategies to foster resilience and emotional well-being. By focusing on self-knowledge, emotional regulation, and compassion, the intervention aligns with international evidence supporting early-life self-compassion as a protective factor against internalized stigma and poor mental health outcomes (Papadimitriou & Karakasidou, 2024). These results also respond to calls for intersectoral approaches that include education systems as active agents in mental health promotion, especially where access to specialized services is limited (Corbière et al., 2012; Buertey et al., 2025).

Taken together, the study suggests that while institutional frameworks have evolved, they remain insufficient to address the lived complexity of psychosocial disability. Bridging the gap between formal policy and subjective experience requires sustained longitudinal monitoring, meaningful participation of affected populations, and the expansion of culturally grounded, community-based strategies that directly challenge stigma and promote rights-based inclusion.

These findings carry significant implications for theory, practice, and policy in public health education. Theoretically, the study underscores the importance of an "appropriation" lens to understand how psychosocial interventions are truly integrated by beneficiaries, especially in culturally diverse and vulnerable contexts. It highlights that resilience and compassion are not just traits to be measured, but dynamic capacities that are re-negotiated and enacted through lived experience. This aligns with ecological and cultural perspectives on resilience, which emphasize its dynamic and socially embedded nature (Bonanno 2004; Bertsia and Poulou 2023; Theron, 2016). Practically, the results emphasize the value of experiential and culturally adapted approaches, like those in the 3C model, that empower children and adolescents as active agents in their own well-being. The positive shifts in emotional regulation, self-knowledge, and prosocial behaviors suggest that such programs can equip young individuals with crucial life skills for navigating adversity. School-based interventions have shown promise in enhancing socioemotional skills and resilience in rural communities, effectively improving resilience, academic functioning, and emotional regulation (Rich et al., 2022; Westhues et al. 2009). These programs are particularly beneficial for students from economically marginalized communities, addressing barriers to mental health care access (Rich et al. 2022; Stavrou and Kourkoutas, 2017). For policy, these findings provide evidence supporting the continued investment in school-based mental health initiatives within national frameworks, such as Colombia's National Mental Health Policy (Ministerio de Salud y Protección Social, 2018). The observed appropriation of the model by children and adolescents advocates for integrated, long-term strategies that acknowledge local realities and foster community-led mental health promotion, rather than top-down content delivery. Meta-analyses have confirmed the overall efficacy of school-based interventions in promoting resilience (Cai et al., 2025).

Importantly, the findings show that psychosocial disability is often difficult to detect without appropriate conceptual frameworks that account for the interplay between psychological and social dimensions—especially in regions affected by displacement and systemic neglect. At the same time, the study illustrates that people with psychosocial disabilities are not merely passive victims but active agents capable of resisting stigma through social engagement and cultural meaning-making. Recognizing the intersections of race, disability, and victimhood emerges as essential for designing effective, inclusive interventions. To address entrenched discrimination and promote healing, the study calls for rights-based, community-centered approaches that affirm cultural resilience and challenge both institutional and internalized stigma.

Although the legal framework recognizes multiple disability categories and aims to guarantee rights, the extremely low number of certified individuals suggests that institutional mechanisms are failing to reach those most in need. The second study's insights into self-recognition processes illuminate how stigma, silence within families, lack of community support, and the invisibility of psychosocial disabilities collectively limit the policy's transformative potential. In particular, the gap between official discourse and first-person narratives underscores the importance of developing culturally sensitive, community-based mental health strategies that acknowledge not only structural barriers but also subjective and collective dimensions of disability. By contrasting regulatory frameworks with everyday experiences, this study contributes to a more nuanced understanding of stigma and psychosocial disability in Colombia.

The recent approval of Colombia's new Mental Health Law in 2025 marks a significant policy in the recognition of psychosocial disability and the right to inclusive mental health care. While the law reinforces key principles of equity and intersectoral coordination, its effective implementation remains to be seen. Future longitudinal research will be essential to monitor how this legal framework translates into concrete changes in stigma, access, and social participation for people with psychosocial disabilities.

Limitations

This study has some limitations inherent to its design and sources of information. First, as this is an integrative qualitative review based on secondary data from previous research, the findings depend on the theoretical frameworks, methodological approaches and specific contexts of each original study. This implies that certain local dynamics or cultural nuances may not have been captured in the same depth in all cases. Furthermore, although different historical moments were addressed and diverse populations were included, it was not possible to guarantee an exhaustive representation of all regions of the country or of all ethnic groups. Another relevant aspect is that much of the analysis relied on data collected before the full implementation of the Mental Health Law 2025, which limits the possibility of assessing its direct impact.

Acknowledgments

We extend our deepest gratitude to the Colombian Ministry of Science and Technology, the Saldarriaga Concha Foundation, the Pontificia Universidad Javeriana, and the Ford Foundation for their invaluable institutional support throughout these research initiatives. We are profoundly thankful to all individuals who participated in each study, including the dedicated researchers, facilitators, and field teams. Above all, our heartfelt appreciation goes to every person who generously shared their words, ideas, and deeply personal experiences and emotions, making this longitudinal exploration possible and enriching our understanding of stigma and psychosocial disability.

Funding

This Project is funded by the Ministry of Science, Technology and Innovation of Colombia (Minciencias), Call 919 for the financing of mission-oriented scientific ecosystems in partnership that strengthen national capacities for the care and management of mental health and social coexistence in Colombia. The Ministry of Science, Technology and Innovation of Colombia (Minciencias) had no role in the design of the study.

Declaration of interests

The authors declare no financial or commercial conflicts of interest. However, it should be noted that some of the authors were also involved in the design, implementation, or analysis of the three prior studies whose findings are revisited and further interpreted in this article. This continuity of authorship is disclosed in the interest of full transparency and academic integrity.

Disclosure of Generative AI Use

During the preparation of this manuscript, ChatGPT (OpenAI, GPT-4o, 2024) was used to assist with language editing and improving clarity. All content was reviewed and verified by the authors. The tool was not used for data analysis, interpretation, or generating original research content.

Authorship Contribution

LEM, JCM, IJS, and SLZ were responsible for drafting the manuscript. All authors (LEM, JCM, IJS, SLZ, LMGB, and CACR) were actively involved in the design, critical revision, and editing of the article. LMGB and CACR provided overall supervision during the planning, writing and review process. All authors reviewed the final version and approved its submission.

References:

Arnoso Martínez, Maitane, Manuel Cárdenas Castro, Carlos M. Beristain, and Carla Afonso. 2017. “Armed Conflict, Psychosocial Impact and Reparation in Colombia: Women’s Voice.” *Universitas Psychologica* 16 (3): 1–12. https://doi.org/10.11144/Javeriana.upsy16-3.acpi.

Barnartt, Sharon N. 2016. “How Erving Goffman Affected Perceptions of Disability within Sociology.” In *Sociology Looking at Disability: What Did We Know and When Did We Know It*, edited by Barbara M. Altman, 29–37. *Research in Social Science and Disability*, vol. 9. Bingley: Emerald Group Publishing Limited. https://doi.org/10.1108/S1479-354720160000009004.

Bertsia, Vasiliki, and Maria Poulou. 2023. “Resilience: Theoretical Framework and Implications for School.” *International Education Studies* 16 (2): 1–12. https://doi.org/10.5539/ies.v16n2p1

Biel Portero, Israel, and Tania G. Bolaños Enríquez. 2018. “Are Persons with Disabilities Included in the Colombian Peace Process?” *Disability & Society* 33(4): 638–643. https://doi.org/10.1080/09687599.2018.1423940.

Bonanno, George A. 2004. “Loss, Trauma, and Human Resilience: Have We Underestimated the Human Capacity to Thrive After Extremely Aversive Events?” *American Psychologist* 59 (1): 20–28. https://doi.org/10.1037/0003-066X.59.1.20.

Buertey, Abigail Ansere, Gideon L. Puplampu, Mary Ani-Amponsah, Mohammad Amin Ibrahim Jibril, and Alexander Attiogbe. 2025. “Lived Experiences of Ghanaian Community

Psychiatric Nurses' Resilience Strategies in Combating Stigma: An Interpretive Phenomenology." *BMC Nursing* 24. https://doi.org/10.1186/s12912-025-02818-2.

Cai, Chenyi, Zhengyang Mei, Zirui Wang, and Shi Luo. 2025. "School-Based Interventions for Resilience in Children and Adolescents: A Systematic Review and Meta-analysis of Randomized Controlled Trials." *Frontiers in Psychiatry* 16 (May): Article 1594658. https://doi.org/10.3389/fpsyt.2025.1594658.

Campo-Arias, Adalberto, Héctor C. Oviedo, and E. Herazo. 2014. "Stigma and Mental Health in Victims of Colombia's Internal Armed Conflict in Situation of Forced Displacement." *Revista Colombiana de Psiquiatría* 43 (4): 212–17. https://doi.org/10.1016/j.rcp.2014.09.004.

Cayuela Sánchez, Sergio. 2023. "Towards a Biopolitical Analysis of Physical Disability: A Methodological Proposal." *Encrucijadas: Revista Crítica de Ciencias Sociales* 22 (2): Article a2205. https://recyt.fecyt.es/index.php/encrucijadas/article/view/93953.

Cook, Joan M., David S. Riggs, Richard Thompson, James C. Coyne, and Jawad I. Sheikh. 2004. "Posttraumatic Stress Disorder and Current Relationship Functioning among World War II Ex-Prisoners of War." *Journal of Family Psychology* 18 (1): 36–45. https://doi.org/10.1037/0893-3200.18.1.36.

Corbière, Marc, Esther Samson, Patrizia Villotti, and Jean-François Pelletier. 2012. "Strategies to Fight Stigma toward People with Mental Disorders: Perspectives from Different Stakeholders." *The Scientific World Journal* 2012: Article ID 516358, 10 pages. https://doi.org/10.1100/2012/516358.

Corrigan, Patrick W., Amy C. Watson, and Leah Barr. 2006. "The Self-Stigma of Mental Illness: Implications for Self-Esteem and Self-Efficacy." *Journal of Social and Clinical Psychology* 25 (8): 875–84. https://doi.org/10.1521/jscp.2006.25.8.875

Departamento Administrativo Nacional de Estadística (DANE). 2023. El diamante del cuidado frente a la experiencia de la discapacidad en Colombia: una aproximación a los requerimientos diferenciales de las Personas con Discapacidad y de sus propios cuidadores en 2021. Nota Estadística No. 1 de 2023. Bogotá: DANE

Departamento Administrativo Nacional de Estadística (DANE). 2020. *Estado actual de la medición de la discapacidad en Colombia*. Gobierno de Colombia, 2020.

https://www.dane.gov.co/files/investigaciones/notas-estadisticas/abr_2022_nota_estadistica_Estado%20actual_de_la_medicion_de_discapacidad_en%20Colombia_presentacion.pdf.

Fernández, Dany, Pamela Grandón, Yaranay López‐Angulo, Alexis Vladimir‐Vielma, Wenceslao Peñate, and Gabriela Díaz‐Pérez. 2023. "Internalized Stigma and Self‐Stigma in People Diagnosed with a Mental Disorder. One Concept or Two? A Scoping Review." *International Journal of Social Psychiatry* 69 (8): 1869–81. https://doi.org/10.1177/00207640231196749.

Fundación Saldarriaga Concha. 2024. *Impulso a la certificación de discapacidad en Colombia: La percepción de actores estratégicos*. Bogotá, D.C.: Fundación Saldarriaga Concha.

Goffman, Erving. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Princeton, NJ: Prentice‐Hall. PDF edition accessed July 4, 2025. https://sociologiaycultura.wordpress.com/wp-content/uploads/2014/02/goffman-estigma.pdf

González Ballesteros, Lina María, Camila Andrea Castellanos Roncancio, and Jeimmi Paola Carvajal Guzmán. 2024. *Relationship Between Stigma and Psychosocial Disability: Conceptual Contributions Derived from Social Intervention with Ethnic Approach*. July 5. SSRN. https://ssrn.com/abstract=4998415.

González Ballesteros, Lina María, José M. Flores, Ana María Ortiz Hoyos, Amalia Londoño Tobón, Sascha Hein, Felipe Bolívar Rincón, Oscar Gómez, and Liliana Angélica Ponguta. 2021. "Evaluating the 3Cs Program for Caregivers of Young Children Affected by the Armed Conflict in Colombia." *Journal on Education in Emergencies* 7 (2): 212–52. https://doi.org/10.33682/14b2‐4nmm.

Link, Bruce G., and Jo C. Phelan. 2001. "Conceptualizing Stigma." *Annual Review of Sociology* 27 (1): 363–85. https://doi.org/10.1146/annurev.soc.27.1.363.

Link, Bruce G., and Jo C. Phelan. 2014. "Stigma Power." *Social Science & Medicine* 103: 24–32. https://doi.org/10.1016/j.socscimed.2013.07.035.

Mahomed, Faraaz. 2016. "Stigma on the Basis of Psychosocial Disability: A Structural Human Rights Violation." *South African Journal on Human Rights* 32 (3): 490–509. https://doi.org/10.1080/02587203.2016.1258199

Mahomed, Faraaz, and Michael Ashley Stein. 2021. "De-Stigmatising Psychosocial Disability in South Africa." *African Disability Rights Yearbook* 5 (2017): 64–83. https://doi.org/10.29053/2413-7138/2017/v5n1a4

Ministerio de Salud y Protección Social. 2018. *Resolución 4886 de 2018: Por la cual se adopta la Política Nacional de Salud Mental*. Bogotá: Ministerio de Salud y Protección Social. https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/resolucion-4886-de-2018.pdf

Ministerio de Salud y Protección Social. 2018. *Política Nacional de Salud Mental*. Bogotá: Ministerio de Salud y Protección Social. Accessed July 4, 2025. https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/politica-nacional-salud-mental.pdf.

Mittal, Dinesh, Greer Sullivan, Lakshminarayana Chekuri, Elise Allee, and Patrick W. Corrigan. 2012. "Empirical Studies of Self-Stigma Reduction Strategies: A Critical Review of the Literature." *Psychiatric Services* 63 (10): 974–81. https://doi.org/10.1176/appi.ps.201100459

Nevedal, Andrea L., Liat Ayalon, and Sherylyn H. Briller. 2019. "A Qualitative Evidence Synthesis Review of Longitudinal Qualitative Research in Gerontology." *The Gerontologist* 59(6): e791–e801. https://doi.org/10.1093/geront/gny134.

Papadimitriou, Anna, and Eirini Karakasidou. 2024. "Self-Compassionate Children, Resilient and Empathetic Adults." *Journal of Educational & Psychological Research* 6 (3): [pages if known]. https://doi.org/10.33140/jepr.06.03.02.

Rich, Brendan A., Nina S. Shiffrin, Christopher J. Senior, Melissa M. Zarger, et al. 2022. "Improved Resilience and Academics Following a School-Based Resilience Intervention: A Randomized Controlled Trial." *Evidence-Based Practice in Child and Adolescent Mental Health* 8 (?): 1–17. https://doi.org/10.1080/23794925.2022.2025630.

Rodríguez Caicedo, Nicolás, Sebastián León-Giraldo, Catalina González-Uribe, and Oscar Bernal. 2023. "Access to Health Services during the Colombian Armed Conflict: A Challenge for the Population with Disabilities in the Department of Meta." *BMC Health*

Services Research 23 (1): 628. https://doi.org/10.1186/s12913-023-09472-x.

Santos, Jussara C., Sônia Barros, and Irma M. M. Santos. 2016. "Stigma: The Perspective of Workers on Community Mental Health Services—Brazil." *Global Qualitative Nursing Research* 3:1–9. https://doi.org/10.1177/2333393616670442.

Stavrou, P.-D., and E. Kourkoutas. 2017. "School-Based Programs for Socio-Emotional Development of Children with or without Difficulties: Promoting Resilience." *American Journal of Educational Research* 5 (2): 131–37. https://doi.org/10.12691/education-5-2-4

Theron, Linda C. 2015. "Towards a Culturally and Contextually Sensitive Understanding of Resilience: Privileging the Voices of Black South African Young People." *Journal of Adolescent Research* 31 (6): 635–70. https://doi.org/10.1177/0743558415600072.

Thornicroft, Graham. 2006. *Shunned: Discrimination Against People with Mental Illness*. Oxford: Oxford University Press. ISBN 0198570988

Westhues, Anne, Alice Schmidt Hanbidge, Robert J. Gebotys, and Angela Hammond. 2009. "Comparing the Effectiveness of School-Based and Community-Based Delivery of an Emotional Regulation Skills Program for Children." *School Social Work Journal* 34: 74–95.

World Health Organization. 2025. "Disability." *Health Topics*. World Health Organization. Accessed July 3, 2025. https://www.who.int/health-topics/disability#tab=tab_1.

World Health Organization. 2001. *International Classification of Functioning, Disability and Health: ICF*. Revised edition. Geneva: World Health Organization. ISBN 9241545429 nla.gov.au+9apps.who.int+9

This preprint was submitted under the following conditions:

- The authors declare that they are aware that they are solely responsible for the content of the preprint and that the deposit in SciELO Preprints does not mean any commitment on the part of SciELO, except its preservation and dissemination.
- The authors declare that the necessary Terms of Free and Informed Consent of participants or patients in the research were obtained and are described in the manuscript, when applicable.
- The authors declare that the preparation of the manuscript followed the ethical norms of scientific communication.
- The authors declare that the data, applications, and other content underlying the manuscript are referenced.
- The deposited manuscript is in PDF format.
- The authors declare that the research that originated the manuscript followed good ethical practices and that the necessary approvals from research ethics committees, when applicable, are described in the manuscript.
- The authors declare that once a manuscript is posted on the SciELO Preprints server, it can only be taken down on request to the SciELO Preprints server Editorial Secretariat, who will post a retraction notice in its place.
- The authors agree that the approved manuscript will be made available under a Creative Commons CC-BY license.
- The submitting author declares that the contributions of all authors and conflict of interest statement are included explicitly and in specific sections of the manuscript.
- The authors declare that the manuscript was not deposited and/or previously made available on another preprint server or published by a journal.
- If the manuscript is being reviewed or being prepared for publishing but not yet published by a journal, the authors declare that they have received authorization from the journal to make this deposit.
- The submitting author declares that all authors of the manuscript agree with the submission to SciELO Preprints.