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Resisting epistemic violence in global mental health: Listening to local understandings of mental health and emotional distress among victims and ex-guerrilla members in Southern Colombia

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ABSTRACT

Background: While there is consensus that local knowledge is important to build better mental health responses, integration of this knowledge into mental health services remains a work in progress. In this paper, we explore local understandings of mental health, mental illness, well-being and emotional distress building dialogical spaces that enable community perspectives to inform academic knowledge and health systems.

Methods: We identified local understandings of mental health, emotional distress, and wellbeing among two conflict-affected communities in Southern Colombia, including victims of the conflict and FARC ex-combatants. We conducted focus groups in Florencia (n = 8) and La Montañita (n = 7) (N = 99). Data was analysed using thematic analysis.

Results: We found a lay theory of mind emphasising the mind-body-context relationship as central for health and wellbeing. Mental health and mental illness are explained through biomedical categories underpinned by social representations of 'madness' and the stigma associated with the conflict and using services in Colombia. Well-being and emotional distress are determined by relational, political and economic factors, and understood in relation to culture, sociability, religiosity, nature and physical health.

Discussion: Accounting for local knowledge allows working with community members to identify how their experiences, values, beliefs, and the context they live in can support or hinder their emotional wellbeing. Central to this effort is to open hegemonic biomedical models to transformational dialogues that integrate the perspective and needs of the communities we work with. Our study provides actionable insights relevant for community-based mental health and primary care services, as well as those services across sectors that can contribute to the mental health of this population.

1. Introduction

Conflict-affected populations face a high mental health burden of disease, with depression, post-traumatic stress disorder (PTSD), anxiety, and substance use highly prevalent and on the rise (Lim et al., 2022). Effective mental health interventions to address these conditions in context are urgently needed (Charlson et al., 2019; Tamayo-Agudelo and Bell, 2019). Yet, existing interventions have a narrow focus on trauma-related symptoms, rooted in a core assumption that the mental health burden in conflict-affected populations is primarily explained by

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war (El-Khodary and Samara, 2020). Research in these settings has long called for moving beyond linear causal understandings between war exposure and mental illness, with the daily stressors model highlighting the need to address a wider set of contextual determinants originating in the social, economic, and political factors leading to political unrest and violence (Miller and Rasmussen, 2014).

Marginalised populations living through chronic poverty and weak institutions are often those who are most exposed to the consequences of war (Burgess and Fonseca, 2020; Laplante, 2007; Martín Baró et al., 1990; Panter-Brick and Eggerman, 2012). Evidence from Colombia and other conflict-affected societies shows that scarcity of resources, multiple deprivations, and inequality prevent marginalised citizens from accessing basic services including educational, employment, general health, and mental health services (Asi et al., 2022; Cuartas-Ricaurte et al., 2019; Miller and Rasmussen, 2014; Prieto, 2012). Mental health stigma, low awareness of mental health disorders, and distrust in the scarce state-led services are compounding factors affecting mental health in these settings (González-Uribe et al., 2022; Seidi and Jaff, 2019). Furthermore, war also diminishes interpersonal trust, social capital and a cohesive social fabric, all elements contributing to mental health and wellbeing. How actors understand and live through emotional distress is expressed in ways that go far beyond individualised symptoms, to include how proximal and distal contexts of human development shape the life-course in different domains (demographic, economic, neighbourhood, environment, and socio-cultural) (Lund et al., 2018). All of these contextual factors are major determinants of mental health experiences and services.

Local mental health systems are continually challenged by how they understand and respond to local communities. Cultural barriers such as stigma towards the mentally ill and the dominance of the biomedical model are frequently linked to power differentials between users and providers as well as limited collaboration between different stakeholders (van der van der Ham et al., 2013; White et al., 2021; Bergmark et al., 2024). While there is consensus that local knowledge is vital to build better mental health responses (Kohrt et al., 2018; Testa, 1997) it is clear that integration of this knowledge into services remains a work in progress. Devaluation of community knowledge continues to be prevalent among academic researchers and practitioners alike (van der Ham et al., 2013; Testa, 1997). Therefore, substantive challenges remain on how to include community knowledge in the development of locally relevant interventions (Rathod et al., 2017) and primary care services (Kohrt et al., 2018).

In this paper we draw on socio-cultural perspectives in psychological science to study community understandings of mental health, mental illness, wellbeing, and emotional distress in two conflict-affected communities in Colombia. Local perspectives based on shared everyday knowledge are powerful because, as social representations, they shape reality (Moscovici, 2000) and have material consequences for institutions, services and communities themselves. They articulate structures of signification that mediate the relations between the everyday consensual domain of culture and the reified institutional domain of expert knowledge and the interpenetrations between these two universes (Jovchelovitch and Gervais, 1999; Morant, 2006; Priego--Hernández, 2017). These approaches add to existing research and concepts in global mental that emphasise the importance of recognising these processes for improving mental health care for all (Choudhry et al., 2016; Lewis-Fernández and Kirmayer, 2019; Mendenhall and Kim, 2019). Here, we present the perspectives of victims, host communities, and former guerrilla members and argue that building community-led mental health interventions that recognise these perspectives can alleviate much of the barriers that separate local people from services and strengthen the responsiveness and resilience of institutions of health care in conflict-affected settings and beyond.

1.1. Local knowledge and participation to inform mental health responses

Community epistemologies and lived experience are central in building effective solutions to connect institutions to users and create resilience in the delivery of health care (Almeida, 2020; Hawke's Bay Emergency Management Group, 2024). Local systems of knowledge matter in the design of health systems because they are expressive of the ways of thinking, behaviours, identity concerns, values and overall culture of a community of people (Jovchelovitch, 2019; Martín Baró et al., 1990; Moffatt, 1975). Further, active community participation in the governance, design and delivery of mental health interventions produces synergy and adaptation to local needs as well as quality and effectiveness in systems of care (Heap et al., 2022). Building mental health interventions that are accessible, supportive and safe requires understanding and taking into account local narratives of emotional distress, and how it can be alleviated in a specific context, including priorities, and needs in relation to mental health (Burgess and Fonseca, 2020).

Recognising the key contribution people on the ground can give is a first step towards strengthening the socio-cultural grounding of systems of care and addressing historical epistemic injustices (Bhakuni, 2023). The prioritisation of communities' own perspectives and goals is intrinsically linked to the recognition of local knowledge as valuable and not inferior to other forms of expertise (Abimbola, 2021). It recognises the legitimacy of the knowledge produced by ordinary people, and the potential of local epistemologies to add resilience and validity to interventions and health care delivery. The efficacy of this recognition can be found in cases such as the impact of participatory budgeting and the inclusion of users knowledge in Brazil (Emerich et al., 2014; Guareschi and Jovchelovitch, 2004), and the Sonagachi Project that reduced the vulnerability of sex workers to HIV in India by including users in the leadership of care delivery and in negotiating rights with powerful stakeholders (Campbell and Cornish, 2012).

Mental healthcare systems however struggle to hear and respond to marginalised populations (Burgess et al., 2022). Mental health professionals often fail to understand marginalised groups and tend to devalue their knowledge, which prevents institutional actors from integrating the culture and practices that pertain to these populations (Almeida, 2020) into services and, by the same token, undermines their own caring capabilities. This is compounded by many research practices that continue to rely on consultation and traditional qualitative strategies that "extract" data from communities (Burgess, 2023). Indeed, mainstream qualitative approaches have led many communities to resist the appropriation of their knowledge by external agents, which usually involves silence, fragmented information and an overall sense of mistrust towards outsiders who claim to be interested in their communities (Novellino, 2003).

Involving community members as key actors in the research process and the design of interventions requires commitment to transformative participation (Heap et al., 2022; Campbell and Jovchelovitch, 2000) and developing effective partnerships that move beyond data collection to create platforms for encountering and acknowledging different systems of knowledge (Aveling and Jovchelovitch, 2014). Nevertheless, local knowledge is, in some cases, still treated as "misconception" when it does not fit mainstream definitions of mental health (Giebel et al., 2023). How we avoid falling into these epistemic wrongs (Bhakuni, 2023) towards knowers is an evolving process that entails neither idealisation nor dismissal of local representations (Campbell and Jovchelovitch, 2000) but efforts towards communicative systems that are not afraid to engage local participation. This requires that academics move beyond a narrow focus on health-related indicators and outcomes (Anckermann et al., 2005).

In this paper, we seek to meet this challenge by mapping out and integrating the many sources of knowledge and expertise emerging from community settings about mental health, mental illness, wellbeing and emotional distress. Our approach is focused on coproduction (Burgess

et al., 2022) and a conscious effort to integrate local knowledge into an expanded definition of evidence that includes but goes beyond our own scientific knowledge base. This integration requires dialogical spaces and participatory research structures, in which different systems of knowledge and practice can meet, be recognised and jointly elaborated by research collaborators. We argue that this not only avoids epistemic harms, but also expands our own understandings of what constitutes mental health and mental illness and what works for whom and why in different contexts. Breakthrough outcomes will not be achieved without digging deeper on the universalistic assumptions that continue to misrecognise the expertise of local populations on their own predicament and commitment to co-learning across different domains of thinking and doing.

2. Materials and methods

2.1. The STARS- C project

The STARS-C project is a Participatory Action Research partnership that aims to design, implement and evaluate a participatory intervention to strengthen community mental health care systems in two communities in Caquetá, Colombia. Our central question is how to develop collaborative action between communities and mental health care institutions for promoting an improving mental health services (Burgess et al., 2022). The project evolved over three extended work packages that included diagnostic, implementation and evaluation phases. Here, we report results of the study focused on local understandings of mental health, mental illness, wellbeing and emotional distress obtained during the diagnostic phase. We work in partnership with two communities in the department of Caquetá located in the south of Colombia in rural and urban territories of intense contextual adversity, where healthcare services are hardly present.

2.2. Developing research as collaborative partnership

STARS-C is the result of an ongoing alliance between academics and community organisations in Caquetá that started long before the design and implementation of the project and has persisted ever since.The participatory component arose from a longstanding partnership with CORPOMANIGUA, a women-led NGO in Florencia, and the Centro Poblado Héctor Ramírez, a community of former guerrilla members in La Montañita. The partnership seeks to develop research projects that respond to communities' needs and involve community leaders as part of the team's decision-making process. Consolidating these partnerships has required joint critical reflection by academics and community members about their different roles, different systems of knowledge, and what each side can contribute and learn from the other (Reinoso-Chávez et al., 2023). As a result, we have incorporated a multi-layered participation process involving community leaders as co-investigators, selected community members as community researchers and created participatory methodologies that engage a wider pool of community members in the project. We are weary of extractivist approaches that usually contact communities when there is a grant opportunity or once it is obtained. Instead, our partnership aims to make explicit the different representational projects, systems of communication and different interactions that mark our similarities and differences, working through tensions and building a shared intentionality towards the aims and the goals of the project (Aveling and Jovchelovitch, 2014; Quintero et al., 2024). Regular dialogue meetings are a key methodological component in our projects: they give us the spaces where we can meet, get to know each other and learn how to work together. They are instances for discussing every aspect of the project and for decision-making.

2.3. Setting

2.3.1. Colombia: protracted conflict and mental health

Colombia has endured more than six decades of internal armed conflict affecting primarily rural and marginalised urban areas. The peace agreement in 2016 between the Colombian state and the Revolutionary Armed Forces of Colombia- People's Army (FARC-EP in Spanish), introduced new laws and policies aimed at overcoming the historical burden of conflict, in particular the scarcity of state institutions in those settings most affected by the conflict. The Territorially Focused Development Programme (PDET) is one such national policy that has prioritised 170 municipalities (urban and rural) with high levels of poverty, conflict-related violence, institutional fragility, and illegal economies (Marriner Castro and Menjura, 2021). These territories host different conflict-affected actors, including displaced populations, host communities and former guerrilla members reintegrating into society.

Populations in these conflict-affected territories report higher levels of anxiety, mood disorders and suicide (Tamayo-Agudelo and Bell, 2019), higher levels of stigma, and several layers of social vulnerability like material and immaterial loss, changes in lifestyle, and displacement (Campo-Arias et al., 2017). These challenges are accentuated by barriers to accessing mental health services. Only 57.4% of the rural population report accessing health services compared to the urban setting (66.5%); instead, the rural population relies primarily on treatments linked to ancestral medicine (Ministerio de Salud y Protección Social, 2015).

The Caquetá department, where this research takes place, is one of the most heavily affected by the armed conflict, with all major armed actors having operated in the area. A high number of people forced into internal displacement live in the area. As a result, it is the only department with all its municipalities recognised as PDET territories.

2.3.2. Study sites

Two communities in Caquetá comprise the study sites: an urban community in the periphery of Florencia, Caquetá's capital city, and a rural community in La Montañita, a municipality located 30 km from Florencia. Florencia is the most populated municipality in Caquetá with roughly 173,000 inhabitants. Most of the internally displaced individuals and ex-combatants arriving in the city settle in the town's peripheral areas, where 27% of the population faces unmet basic needs including overcrowding, lack of basic income and employment, and access to basic services (DANE, 2018). There are no official mental health national statistics at the municipality level, although results from the latest National Survey of Mental Health show that the prevalence of severe anxiety (8.2%) and severe depression (5,6%) in the region is slightly higher than their overall prevalence of severe anxiety (6.7%) and severe depression (4,2%) in the country for adults older than 18 years old (Ministerio de Salud y Protección Social, 2015). Florencia is home to the only public hospital in Caquetá with a mental health unit; the city also has semi-private mental health facilities.

La Montañita, the second setting of the study, is a municipality with dispersed population living in small villages. This area has been historically and heavily affected by the armed conflict (DANE, 2020), with 8756 officially registered victims of the conflict. 36.7% of the population in rural areas face unmet basic needs. Our project was conducted in the *Centro Poblado* Héctor Ramírez, a village designated as a Territorial Space for Training and Reincorporation (ETCR in Spanish), where former guerilla members and their families live as part of their reintegration to civil society. The village is home to almost 300 people, including 126 former combatants, 90 children, and their extended families.

2.4. Participants

Participants comprised residents in Florencia (n = 57) and La Montañita (n = 42). Of the 57 participants in Florencia, 46 were victims of the armed conflict (29 female and 17 male), while in la Montañita, there

21 were former FARC-EP members (12 female and 9 male). Demographics are shown in Table 1.

2.5. Procedure

The project was conducted in partnership with local grassroot organisations: in Florencia, with the Manigua Corporation, a well-established NGO with experience in the design and implementation of projects with marginalised communities and in La Montañita, with the community's local cooperative, the Multi-active Cooperative for Well-being and Peace of Caquetá (COOMBUVIPAC).

Each local organisation selected two individuals to act as community researchers and join the research team. This process involved an open call in combination with recommendations from the leaders of each local organisation. A team comprising academics and community leaders constituted a panel to select applicants. Criteria included: time availability, basic skills for community work (experience managing groups, interpersonal skills, interest in mental health) and recognition at the community level, which was considered central to increase trust in the project, and facilitate recruitment and community participation throughout. Community researchers (KP, MFS) were trained by members of the research team on ethics and research implementation. Community researchers recruited participants using different strategies: 1) printed and online flyers; 2) snow-ball sampling; and 3) WhatsApp groups. Participants were grouped based on age and gender. Informed consent was obtained from all participants and parents in the case of adolescents. Underaged participants provided informed assent. Table 2 presents an overview of the focus groups conducted per site.

Focus groups were conducted in Spanish, by community researchers between October 2021 and April 2022 at communal spaces in each site. Focus groups were chosen because of their usefulness to elicit shared understandings of concepts and issues and observe social interactions as meanings evolve and are negotiated in real-time dialogue (Markova et al., 2007). Considering these topics might be sensitive and difficult to discuss, we divided the groups by gender and age, creating safe spaces where women, men and youth could share their worldviews in a group with similar characteristics. Focus groups lasted 2 h on average and were audio-recorded. The research protocol was approved by the Ethics Committees at University College London, UK and University of Los Andes, Colombia. Appendix 1 presents the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

2.6. Instruments

Focus Group Topic Guide.

Table 1
Participants' demographics.

Site Distribution		
	Florencia	**La Montañita**
	(N = 57)	**(N = 42)**
Age	**N**	**N**
16–24	21	13
25–34	3	9
35–44	6	7
45–59	14	13
60 or more	13	0
Gender		
Female	29	28
Male	28	14
Relation with conflict		
Victim	46	0
Former guerrilla member	0	21
Non-conflict related	11	21

Table 2
Data collection: Focus groups per site.

Participants	Number of focus groups per site	
	Florencia (8)	La Montañita (7)
Adult Women	3	3
Young Women	2	–
Adult Men	2	2
Young Men	1	–
Youth mixed-gender[a]	–	2

[a] We conducted mixed-gender focus groups following participants preferences in La Montañita.

The topic guide was organised to elicit local understandings of mental health, wellbeing and emotional distress drawing on participatory learning activities (Burgess and Fonseca, 2020). Section one asked participants to write a definition or draw an image of what that meant to them. The prompt was: *"When you hear [mental health, emotional distress or wellbeing], what comes to your mind?"*. Each response was recorded by the participant on a flash card and then discussed as a group. The second section was organised around two open questions about mental health and mental health services: *"What is the word that is used to describe someone whose emotional distress is so bad, that they are ill, and need treatment? Is this the same word used by health services?* Across the topic guide, "emotional distress" was used instead of specific disease categories to avoid imposing biomedical terminology in contexts where mental health and stigma may be high, or services are hard to reach (Burgess and Fonseca, 2020).

2.7. Data analysis

Thematic analysis was used, allowing for themes to be generated inductively and deductively (Braun and Clarke, 2006). The full corpus was transcribed verbatim and anonymised using participant and group numbers. Transcriptions were uploaded to NVivo 14. The analysis was guided by the question: *What are the local understandings of mental health, wellbeing and emotional distress?* and conducted collectively by the research team (eight researchers), who were either native or fluent Spanish speakers.

The analysis initiated by developing and annotating memos for each group discussion (gender and age) per site. Codes were created after repeated readings of the data, memos and annotations and organised in broad categories of mental health, wellbeing and emotional distress. This coding framework was deployed by eight coders working in pairs to reach consensus. The codebook was discussed, adjusted and refined through multiple iterations based on the coding and reviewed by the field coordinator who was familiar with local language and expressions. Community researchers contributed to the ecological validation process led by MCD, LF and SJ (Montero, 2006) by further refining some of the sub-themes and providing further adjustment to the created general themes. These iterations added contextual validation for the coding frame and were included in its final version.

2.8. Positionality

This paper incorporates the different voices and knowledges involved in the design and implementation of the STARS-C project. We are a group of female academics and community researchers who have contributed in different ways to the development of the project from the beginning. As Latin American and Caribbean descent researchers [MCD, LF, MGG, NC, NV, MC, RB, SJ], we hold both etic and emic perspectives on the field of study, share a common interest in sociocultural and community psychology and its links to mental health. Our long-term engagement with communities in Colombia has enabled trusting relationships and a collaborative approach to research. As community researchers [KP, MFS], we live in the territories studied and participated

in the project as "gatekeepers". We are deeply involved in supporting and leading social efforts in the community and have been key actors in the discussions regarding the design and implementation of the research.

Community researchers contributed in-depth knowledge and lived experience of local culture and the context of participants' responses and actions throughout the project. Academic researchers contributed theoretical and methodological knowledge and engaged in dialogue with community researchers to further refine the analysis.

3. Results

Across both sites we found a complex knowledge system integrating concepts into a comprehensive framework that describes and explains mental health and mental illness, wellbeing and emotional distress, what they are, and why they occur. This lay theory unfolds over three levels of lived experience: the individual or mental level, the interpersonal or relational level and the social or contextual level. There are differences between mental health and well-being, with the former being a remote, often unknown biomedical concept and the latter a notion much closer to everyday life. When present, mental health and mental illness are understood in relation to each other and frequently explained through biomedical categories, which hold a clear resonance with disease and are underpinned by social representations of 'madness', the persona of the mad (*el loco*) and the stigma that is associated with the armed conflict and using mental health services in Colombia. Wellbeing and emotional distress are closer to lived experience, frequently used and conceived in relation to the everyday as a holistic notion, frequently used and related to culture, sociability, religiosity, nature and physical health, and determined by relational and structural factors. A lay theory of mind in context that emphasises the power of mind and the mind-body-context relationship as central for health and wellbeing is at work cementing these understandings. Table 3 presents an overview of the findings in terms of these overall thematic structure.

3.1. Mental health and mental illness: definitions and determinants

Many participants referred to not knowing what mental health is and how to describe it. This reflects differences between the everyday understanding of mental health and mental illness and wellbeing and emotional distress that we discuss in more detail below. Several participants defined mental health based on negative descriptions of what it means to lack mental health. They defined the absence of mental health as being depressed, feeling low (*decaído*), or blue. When someone is *decaído*, they lack the willingness to get up and work or go about their day. Mental illness is expressed through emotions and thinking, involving a racing mind, letting one's problems take over, and lacking the ability to think straight, "feeling like your head is in a knot" (*tener la cabeza enredada*) (Young woman, Florencia).

Participants define mental health in terms of capacities, feelings and motivations, as a state of mind in which the individual feels well physically and mentally. As a state of mind, it means having 'mental capacity', a mind capable of learning, thinking, and solving problems. As an emotional state, it is defined by feelings of alignment and balance, with the metaphor 'peace of mind' being recurrent. As a motivational state, it is defined as grit to persevere (*echar pa'lante*) in the face of life challenges. Participants describe an intrinsic connection between mind and body and the interdependence between mental and physical health.

> *If I'm feeling well, my mind is well, my body is well, and I can do everything* (Adult Woman, La Montañita).

Contextual and relational determinants occupy centre stage in explaining what causes mental illness and prevents mental health. Importantly, these explanations do not refer to individual characteristics or individual-level phenomena that would lead to mental ill health. Economic instability was described at length as a source of mental ill health. Lack of money to pay for housing and food, unmet basic needs, unemployment and a general lack of opportunities are described as major in putting people at risk of mental illness. This is linked to food insecurity and bad eating habits provoked by poverty. The outcome is constant stress, which can lead to substance abuse, feeling burdened and overwhelmed by responsibilities, and ultimately generating mental illness. Lost and broken relationships and the grief that accompanies these experiences are expressive of the importance given to the relational dimension in the making or breaking of mental health. A cycle of mutual constitution from the individual, to the inter-relational to the social and back to the individual is integral to the reasoning of local communities in defining and explaining what causes mental health and

Table 3
Themes and sub-themes.

Themes	Sub-themes				
	Definitions (lived experience, diagnosis and prevention)		Determinants (power of context)	Cultural Knowledge	
Mental Health and Mental Illness	Capacities Feelings Motivations Emotional expression Quality of relationships	Balanced/Aligned Peace of mind Incoherent mind Memory difficulties Feeling unwell Depression (*decaimiento*)	Burdens of precarity and responsibility (women) Economic instability Unmet needs Grief Stress	Making Sense of Madness: 'El loco' (the mad as a character) Stigma (conflict-related) Stigma (treatment related)	Lay Theory of Mind and Context The Power of Mind Physical illness because of mental burdens Mind-body relationship Mind-context relationship
Well-being (*bien-estar emocional*)	Health as precondition for wellbeing Tranquillity (peace of mind) Emotional intelligence Emotional expression	Leisure activities Balance of life domains Connection to nature Wellbeing of the community Reparation of injustice Religiosity	Relational: Being with family Sociability (*convivencia*) Affection and solidarity Safe spaces in the community Structural: Meeting basic needs Opportunities: employment, education, access to health system		
Emotional Distress (*mal-estar emocional*)	Health problems Stress Low energy (*decaimiento*) Anger Being crazy Low self-esteem Emotional repression	Negative thoughts Feelings of overwhelm Collective-structural overwhelm	Economic problems Uprootedness and displacement Lack of state institutions (health care, basic services) Work related tension Conflict-related tensions (victims-former guerrilla members) Conflictive and violent interactions		

mental illness.

3.2. Wellbeing and emotional distress: definitions and determinants

Understandings of emotional wellbeing and emotional distress were situated in terms of the interaction between internal and external states, where cognitive, emotional, affective, and behavioural aspects were linked to the relational, societal, and structural spheres. These included meaningful relationships and influences from collective and social factors.

Emotional wellbeing stands apart from notions of mental health and mental illness in that it is a state understood through everyday categories and common-sense wisdom, typical of consensual universes of everyday life. Enjoyment, tranquility and peace of mind can be achieved through the protective factors of religiosity, community, leisure and connection to nature. A life lived well (*buen vivir*) with family, in safe spaces where conviviality, affection and solidarity are found is as constitutive of wellbeing as are structural determinants, such as meeting basic needs and full life opportunities (employment, education and access to services). In both sites, wellbeing is linked to a fulfilling social life and in La Montañita this is explicitly articulated through the concept of *buen vivir,* (Good Living) which has an emphasis on having a harmonious relation with nature and the community. In contrast, emotional distress entailed negative feelings resulting from multiple relational and structural factors. It was associated with mood swings, negative thoughts, low self-esteem, and feeling overwhelmed by one's emotions and/or by challenging situations in life. Participants saw the connection between experiencing emotional distress and mental illness, stating that emotional distress can be a preamble of more serious condition, and some people may feel like they have become 'crazy'. If not managed, emotional distress can escalate to an 'emotional breakdown' leading to depression or suicide.

Participants emphasized that what determines wellbeing and emotional distress are relational, societal, and political factors. Peaceful and friendly conviviality and sociability with people in the community and family are relevant to wellbeing (*es bienestar*); conflictive or violent interactions were described as a source of emotional distress (*malestar emocional)*. Participants described others in their community as 'quick to react', and hence interactions with neighbours or community leaders may turn conflictive or violent quickly.

> *Emotional distress, well … sometimes someone can be talking about something and then suddenly another person says something that annoys them, and then the other person bursts [revienta], so much that he/she gets a headache and then they end up in a fight* (Adult man, La Montañita).

Social and political determinants of emotional wellbeing and distress were understood differently across sites. Among the community of former guerrilla members in La Montañita, which is a cohesive community held together by a shared sense of collective identity and a political project, wellbeing and emotional distress were understood through their ontological understanding of the collective sphere. For them, wellbeing is a virtuous cycle of reciprocal development between the individual and the collective, where the economic and social wellbeing of the community and a healthy individual mutually constitute each other. Collective wellbeing is understood as a community project, where everyone ought to work together to achieve it.

> *[…] At the social level as well. If you are looking at people who are sick, and they are your friend, or from your collective, then you feel distressed and think "why is that person like that? I need to help them", so it causes distress* (Adult man, La Montañita).

In both sites participants understood emotional distress through societal causes related to poverty, economic instability and lack of access to basic services, including health services. Lack and poor quality of healthcare services are important daily stressors; participants explained how facing long trips to be able to access the nearest healthcare centre adds to the burden of being ill or having a family member with a health condition. In the urban site, participants' concerns centred on the poor quality of services: *"Emotional distress is when I'm sick and they [health centre] don't care for me and ignore me" (Adult woman, Florencia)*.

Lack of money and economic stability means people experience food insecurity, homelessness and unemployment, being unable to feed their family:

> *Well I have emotional distress when I have strong emotions about something that happens, for example, if someone has a serious illness, or someone dies, or if we have a difficult economic situation that can't be solved, that is an emotional affliction because you don't have the money to solve your problems, to manage the illness, or even to buy food* (Adult Woman, Florencia)

> *So there is no water sometimes, and when there is no electricity there is no internet, and people in Bogota don't understand that, so when we finally have electricity back we have tons of things to do and catch up with, and that is very stressful* (Adult woman, La Montañita)

An important political determinant is linked to the Colombian conflict and the peace process. Both victims and former combatants across the two communities see state neglect as a major source of distress. Unfulfilled policies co-exist with the hardships linked to displacement, rebuilding one's life in a new community and the tensions between conflict-affected actors:

> "*I don't know how us, the people who were displaced and victims of violence … and then these bastards (ex-combatants) and they knew there was going to be money, so they took their part and then back to the jungle again, so who took the money from the victims?"* (Adult Women, Florencia)

> *In the political realm … if there is bad political leadership, well that leads to distress, because the people that we voted for, they are not showing progress, and then we feel emotional distress* (Adult man, La Montañita).

3.3. Cultural knowledge: making sense of madness and lay theory of mind

Across sites we found a tension within cultural knowledge, between a shared representation of 'madness' as stigma and a holistic and situated lay theory of mind. The concepts investigated were linked to the idea of madness and the double stigma that derives from using services and presenting oneself in need of mental treatment and at the same time with the wisdom of good living and the many know-hows and cultural traditions that link a balanced mind to peace, tranquility and a healthy community, where social and economic needs are met.

Participants used multiple stigmatic labels commonly given to people behaving differently: loony, crazy, and local expressions such as *se le corrió la teja, se le corrió el champú*, which are impossible to translate but refer to something being off in the head. These labels were used to refer to people who think incoherently, talk to themselves out loud, are disoriented, see or hear things that are not there, live in alternate realities, and may become violent. "*Crazy people are adrift and may lose the motivation to thrive in life" (Adult Women, Florencia)*. Youth and women used clinical terms to refer to madness through words such as depression, stress, being bipolar, or experiencing hallucinations. Men in both communities described madness using the metaphor of '*el loco del barrio*', or 'the neighbourhood crazy man': a character who lives on the streets, talks to himself, and roams around a small geographical area. The crazy man is often (although not always) violent, and people ought to be careful not to bother him. This person is lonely and often ends up in this situation due to contextual factors:

> There are many ways in which a person can become crazy. I know the case of a young man; everyone calls him the loony [el loco], but he used to be normal. He had a wife, and when she left him, he went all

crazy. So he didn't eat, didn't sleep, and he passed out everywhere, and when his family picked him up [from living in the streets], it was too late. They didn't have the [economic] resources to help him. He lost all his senses, he went all crazy (Adult man, La Montañita).

In both communities, the stigma around mental ill health persists and is compounded by the negative encounters people face when accessing services. In Florencia, discussions revolved around debating whether only crazy people seek professional help, with a consensus centred on the notion that people in receipt of mental health services "are all crazy" (Adult woman, Florencia). Women expressed a general mistrust of mental health services, resulting from negative experiences accessing services and interactions with mental health professionals. These collective perceptions and experiences create symbolic barriers to accessing services, deterring people from seeking help for themselves and their family members. For male former combatants in La Montanita, the emphasis was on the stigmatizing and intersectional exclusionary practices they faced as former armed actors. Their stigmatised identity gets amplified when madness gets used as a term to limit their power or denigrate them. They described how they felt that both host community members and institutional actors often think of them as 'crazy' either because of their decision to join the armed fight or as a result of the potential mental health consequences left by the war.

Once we arrived, they [state institutions] thought we were crazy and that we all need to go to the psychiatrist […] and we participated in several workshops and they all asked us about trauma and then we told them to stop, we had to explain that what we thought was not harmful, otherwise they would have sent all of us to the psychiatrist" (Adult man, La Montañita).

These stigmatizing understandings and experiences co-exist with a cultural knowledge that recognises the power of mind and the profound connection it holds with the body and the context. Because body and mind are connected, physical health was identified as a precondition for emotional wellbeing and emotional distress as having the power to trigger health issues such as headaches or gastrointestinal symptoms: *'if one part is not well then the other can't be well' (Luis, Adult man, La Montañita)*. Participants also emphasise the contextual component of emotional wellbeing and distress, linking both to meaningful relationships in the proximal context and fairness, equality and citizenship in the distal context:

"We are all part of a community, there are no fights and people are not rude, we are very close to each other and share a lot of things, that is why our children can be outside and play in the park without being hurt by anyone, and all of that is wellbeing for us, because I trust my community, because I have my children, my family and I feel safe, right? So that is wellbeing for me" (Adult Woman, La Montañita)

So the other day she [a friend] had an argument with her neighbour and she was so angry she was starting to get sick because of that. I told her that fighting with your neighbours can do that to you, and then we went and talked to her to make her feel better (Adult woman, Florencia).

Overall, this lay theory of mind establishes a strong pathway to understand mental health and wellbeing as well as mental illness and emotional distress. It connects the individual to their circumstances and overwhelmingly recognises the power of context in shaping individual lives.

4. Discussion

In this study, we sought to identify local understandings of mental health and mental illness, emotional well-being and emotional distress among victims, host communities, and former guerrilla members in two conflict-affected communities in southern Colombia. Our overall results reveal a complex system of lay knowledge that describes and explains mental health and mental illness through a sophisticated understanding of the multiple levels of phenomena involved in these concepts. Central to these understandings are the distinct but overlapping conceptions of wellbeing and mental health, emotional distress and mental illness, which co-exist and correspond to different domains and systems of knowledge. Fig. 1 shows how this network of concepts is linked to structural and relational social determinants that in turn can inform the development of languages and practices that are able to accommodate the different needs and levels of attention required by this local knowledge. Recognising and engaging these understandings should be a critical foundation for the improvement of mental health systems and intervention development. These local epistemologies are not external to institutions of care but part of the discursive and behavioural patterns that structure how access to, and engagement with, these institutions take place.

In line with previous work (van der Ham et al., 2013; Kohrt and Mendenhall, 2015) we find that local understandings of mental health provide actionable insights for mental health systems to improve mental health and mental ill health in conflict-affected communities, while informing about some of the barriers keeping community members from seeking mental health services. A key set of findings relates to the prominence of social, economic, and political determinants of emotional distress, mental ill health and wellbeing, a finding largely aligned with previous work on the social determinants of mental health (Lund et al., 2011). In stark contrast with Western conceptions of mental disorders as a disease of the brain (Martin, 2010; Rose, 2007), emotional distress and mental disorders were understood as complex psychosocial processes, shaped by relational, social-economic, and political determinants related to inequality, poverty, lack of access to services, grief, loss, the experience of violence, and distrust in the state (Hall et al., 2019; Lin and Ma, 2023; Ventevogel et al., 2013) Alternatively, and in line with research that demonstrates cultural values as one of the key bedrocks of resilience in conflict-affected settings (Panter-Brick and Eggerman, 2012), mental health and wellbeing are deeply connected to good living, including positive family relationships, balanced relations to others, nature and body, and achievement of personal, social and cultural goals.

Clearly, the complex social and moral struggles that shape the experience of mental distress described in this research require actions beyond the health sector (Wahlebeck and McDaid, 2012). However, mental health services rarely conduct screenings or activate referrals to services that can help to manage the multiple and inter-related social determinants of mental health (Aguilar-Latorre et al., 2023). As a result, the underlying distal determinants of mental health and mental distress often remain unaddressed placing the burden at the community and individual levels. Local services operating in conflict and post-conflict settings could contribute to mental health by developing inter-sectoral initiatives and programmes that work to improve access to education, security, employment, and social protection services. A growing body of evidence from LMICs suggests that such actions can have a positive impact on mental health at the population level (Prencipe et al., 2021; Wahlbeck and McDaid, 2012; Zimmerman et al., 2021). This however involves political will and institutional integration, which are frequently lacking in LMIC and not always adjusted to the more granular responses required in territories such as the ones studied here.

Our findings suggest that the concepts of mental health and wellbeing, and emotional distress and mental illness are shaped by a different combination of social determinants and warrant different levels of intervention and care. Wellbeing and emotional distress pertain to everyday consensual universes and are determined by relational and structural determinants. Here, the relational determinants that both make and break good living are central, and correspond to culturally valued drivers of being well, such as conviviality, sociability, religiosity, family and community cohesion. Emotional distress and mental illness are both determined by structural determinants such as poverty, unemployment, lack of services, and State neglect. In our setting, the armed conflict contributed significantly to emotional distress, but its effect was linked to the role of the state in failing to provide services to

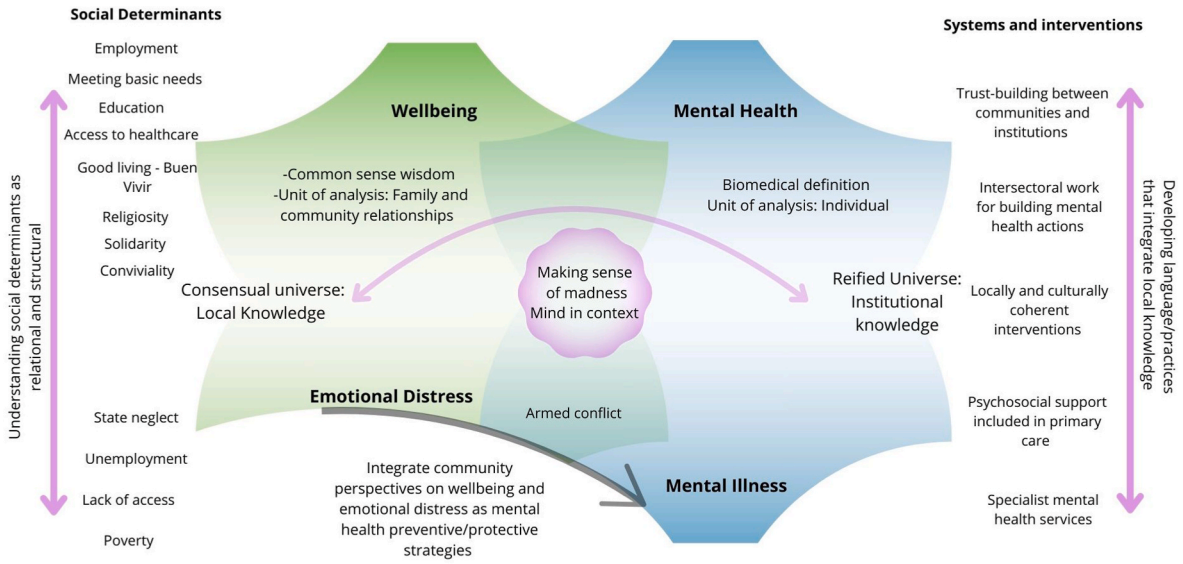

Fig. 1. A community-informed model of mental health, social determinants and interventions.

conflict-affected actors alongside the other structural social determinants identified. When left unattended, emotional distress can progress to mental illness, a common-sense insight that is coherent with the model of social determinants of mental health (Patel et al., 2018). Crucially, the community-informed model of mental health identified here suggests that interventions should be tailored and informed by ethnographic context (Kaiser et al., 2015) so to address the socially distressing experiences (Mendenhall and Kim, 2019) that go beyond psychological and individual interventions (Kaiser et al., 2015).

The body-mind-context connection underpinning the local understandings of mental health and wellbeing described in this research provides relevant information for local-level mental health interventions and primary care services seeking to be responsive to cultural and contextual characteristics. In line with previous studies in the global south (Keys et al., 2012; Kohrt and Hruschka, 2010; Wahid et al., 2022), community members see the mind and the body as intertwined entities, where malfunctions in the body can create or aggravate emotional distress, and a mind in distress can trigger physical symptoms in the body. The dismissal of the body-mind connection prevalent across different cultures in the global south (Lin and Ma, 2023) comprises a lost opportunity to develop mental health services attuned to local wisdom. Understanding the connection between body and mind can help health practitioners explore if the symptoms presented by patients can be linked to underlying emotional distress (Kohrt and Hruschka, 2010). Efforts to integrate mental health services into primary care and community-based mental health could build upon and capitalize on the non-binary view of mind and body to develop services with a holistic view of mental health, which resonates more effectively with the communities they seek to support (Davidsen et al., 2016). To do this, services need to develop languages and practices that integrate local knowledge, alongside new forms of communication between local institutions and community actors so that specific responses can be tailored to address experiences of emotional distress that can prevent mental illness. Further, local knowledge integration should not be limited to the health sector, but to the wider array of services discussed in the paragraphs above.

Our study shows the importance of sociocultural perspectives to understanding mental health and how biomedical knowledge is anchored into common sense knowledge. Contrary to other global south settings (Kohrt and Hrushka, 2010), our results corroborate Mendenhall and Kim (2019) in identifying the co-existence of biomedical terms to describe "madness" with local terminology and culturally-driven assessments, such as madness as loneliness and being socially ostracised. For former guerrilla members, the representation of madness is linked to stigmatised identities. By drawing from both systems of knowledge, participants make sense of themselves and the institutions that provide mental health services, which has a direct impact for service-seeking behaviour. For example, former combatants experience a stigmatised view of their group as 'crazy' for having joined the war and expressed distrust towards the services provided by the state. Further, conflict-affected actors described that policies often fail to meet their needs or are simply not adequately implemented. This stigma comprises an additional barrier of access to mental health services and corroborates previous research that has documented healthcare access barriers for this group (Reynolds et al., 2021). In the case of mental health care more specifically, local services targeting ex-combatants could develop plans to prevent and manage this barrier.

These findings show that shifting care models towards community-based approaches is not merely about relocating services. Instead, it is about crafting services that resonate with and embrace the community's perspectives and insights on mental health, and interventions that can contribute to trust-building among societal actors, services, and the State. Contextualisation and adaptation to local realities are major challenges yet demonstrated pathways for achieving inclusion and improvement in mental care (Heim et al., 2020; Heim and Kohrt, 2019; Sangraula et al., 2021). The costs of decontextualised interventions are both economic and psychosocial; purely technocratic interventions relying on a narrow/universalistic conception of evidence remain cold to what is real, relevant and effective for communities and are ultimately costly for states. In territories marked by protracted conflict, creating spaces for dialogue between conflict-affected actors and state institutions can offer effective responses to community needs, while providing spaces for mutual collaboration, recognition and trust-building, aspects that can also contribute towards societal reconciliation (Arias López and Valencia Pérez, 2022). Integrating mental health and psychosocial support as part of peacebuilding efforts has demonstrated positive effects on mental health outcomes, as well as enhanced trust, social support and solidarity, among other reconciliation-related factors (Simpson et al., 2023). Trust and cooperation among conflict-affected actors are key factors that support reconciliation efforts and have a direct effect on mental health (Mukashema and Mullet, 2013).

Our research partnership sought active engagement with community members, community organisations and community researchers to investigate and systematise local knowledge on mental health. This approach creates long-term collaboration between different actors and

stakeholders and improved capabilities for all involved. Importantly, it can contribute to shift current paradigms from monological medicalised approaches that position mental health and mental illness as opposite ends of a single continuum towards one of epistemic repair, where dialogue and recognition of local knowledge and expertise is central (Bhakuni, 2023; Rose, 2007). A dialogue between academics and communities about mental health knowledge needs to be joined by institutions to produce responses to community's needs and priorities.

4.1. Limitations

Our research took place in communities where mental health is difficult to discuss openly. Discussions with male participants were particularly difficult as they struggled to open up about their views and experiences of mental health and mental ill health. Working alongside community researchers helped us to address this challenge, through the effective creation of safe spaces (Burgess and Mathias, 2017) to discuss sensitive topics. A strength of the strategy was the closeness of community researchers' to the participants in the study; by means of their belonging to the same community there was understanding of local idioms of distress, cultural attunement, and trust (Kaiser et al., 2015). Former guerrilla members, who carry the stigma of their participation in the armed conflict and distrust external actors to talk about their mental health struggles, were able to discuss these sensible topics.

A limitation of our design was that we worked with very specific populations, which limits the generalizability of our findings and recommendations. However, this same limitation becomes a strength in the sense that it provides an account of voices that have been less often heard in the production of knowledge about mental health and emotional distress. Further studies need to explore the local understandings of wellbeing and mental health of actors in urban areas and in communities with different degrees of community leadership.

5. Conclusion

Despite a long-standing consensus on the importance of local knowledge in health care delivery, not enough is known about local understandings of mental health and mental illness in conflict-affected communities, and institutions struggle to address and communicate with local needs. Our research underscores the significance of understanding and recognising localized interpretations of mental health, a necessary foundation for developing stronger mental health systems that are attuned to the contextual and cultural factors affecting mental health. In this sense, our study provides actionable insights that should be relevant for community-based mental health and primary care services, as well as those services across sectors that can contribute to the mental health of this population.

Host communities, victims, and former combatants, or so called 'target populations' of mental health and post-accord policies, are rarely asked about their perspectives on these topics. The community-informed model of mental health we reported here shows a rich lay theory of mental health that includes a complex understanding of the individual, relational, socio-economic, and political levels influencing mental health and wellbeing among conflict-affected populations. Accounting for this local knowledge does not imply idealizing it (Campbell and Jovchelovitch, 2000; Guareschi and Jovchelovitch, 2004), but instead building conditions for working effectively with community members, by understanding how their experiences, values, beliefs, and the context in which they live support or hinder their emotional wellbeing. Central to this effort is to open hegemonic biomedical models to transformational dialogues that understand, recognise and integrate the perspectives, histories and needs of the communities we work with (Moffatt, 1975; Rose, 2007). Overcoming epistemic injustice begins by moving beyond the inconsequential 'listening to communities' towards a deeper and practical recognition of their regimes of expertise that pushes forward an expanded conceptualisation of evidence and our own ability to transform academic knowledge.

CRediT authorship contribution statement

María Cecilia Dedios Sanguineti: Writing – review & editing, Writing – original draft, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Laura Fonseca:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Rochelle A. Burgess:** Writing – review & editing, Methodology, Funding acquisition, Conceptualization. **Natalia Concha:** Writing – review & editing, Formal analysis, Data curation. **Mónica González:** Writing – review & editing, Project administration, Investigation, Formal analysis, Data curation. **Norha Vera San Juan:** Writing – review & editing, Funding acquisition, Formal analysis. **Mónica Carreño:** Investigation, Formal analysis. **Kely Johana Palacio:** Validation, Investigation, Formal analysis. **María Fernanda Sotto:** Validation, Investigation, Formal analysis. **Sandra Jovchelovitch:** Writing – review & editing, Writing – original draft, Supervision, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

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Appendix A. Supplementary data

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