Psychology, Society & Education (2025) 17(2), 76-85

Psychology, Society & Education

www.uco.es/ucopress/ojs/index.php/psye

Mental health stigma in adolescents: a scoping review

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Keywords

Prejudice
Mental health
Students
Construct
Literature review

Abstract

Introduction. Mental health disorders are increasingly common in adolescence, and peer stigma represents a significant barrier. Defining this construct is essential for its evaluation, prevention, and intervention. The aim of this study was to conceptualize mental disorder stigma in adolescents. Method. A scoping review was conducted in the Web of Science, Scopus, Eric, PubMed, and PsycInfo databases (2011-2021), using descriptors in both English and Spanish. A total of 11,144 articles were retrieved; 51 were selected after screening, and six additional articles were included through other methods. Results. Social stigma in adolescents is described as negative beliefs that may lead to rejection and discriminatory behavior. Different types were identified (public stigma, self-stigma, structural stigma, and associative stigma). Stigma is considered a multidimensional construct (cognitive, emotional, and behavioral dimensions) and is influenced by variables such as sex, nationality, educational level, age, socioeconomic status, personal experience, mental health literacy, and help-seeking behavior. Discussion. Most studies are grounded in the theoretical contributions of Goffman and Corrigan. Recent literature highlights the urgent need to develop effective, sustainable, and culturally adapted prevention programs. The lack of consensus on conceptual and methodological frameworks hinders comparison across studies, reinforcing the importance of valid instruments tailored to adolescents. Identifying factors that influence stigma is essential to guide more inclusive educational interventions.

Estigma del trastorno mental en adolescentes: una revisión sistemática exploratoria

Palabras clave

Prejuicio
Salud mental
Estudiantes
Constructo
Revisión bibliográfica

Resumen

Introducción. Los trastornos mentales son cada vez más frecuentes en la adolescencia, y el estigma entre iguales representa un obstáculo relevante. Definir este constructo es esencial para evaluarlo, prevenirlo e intervenir. El objetivo del estudio fue delimitar el concepto de estigma del trastorno mental en adolescentes. Metodología. Se realizó una revisión sistemática exploratoria en las bases Web of Science, Scopus, Eric, PubMed y PsycInfo (2011-2021), empleando descriptores en inglés y español. Se recuperaron 11,144 artículos, de los cuales se seleccionaron 51 tras el cribado; otros seis fueron añadidos por métodos adicionales. Resultados. El estigma social en adolescentes se describe como creencias negativas que pueden generar rechazo y discriminación. Se identifican distintos tipos (público, autoestigma, estructural y por asociación) y se considera un constructo multidimensional (dimensiones cognitivas, emocionales y conductuales), influido por factores como sexo, nacionalidad, nivel educativo, edad, estatus socioeconómico, experiencia personal, alfabetización en salud mental y búsqueda de ayuda. Discusión. La mayoría de los estudios se basan en las contribuciones de Goffman y Corrigan. La literatura reciente subraya la necesidad de diseñar programas preventivos eficaces, sostenibles y culturalmente adaptados. La ausencia de consenso conceptual y metodológico dificulta la comparación de resultados, lo que pone de relieve la importancia de instrumentos válidos para adolescentes. Identificar los factores que influyen en el estigma es clave para desarrollar intervenciones educativas más inclusivas.

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Cite this article as: Elizalde-Resano, C., Ochoa-Linacero, B., & Reparaz, C. (2025). Mental health stigma in adolescents: a scoping review. *Psychology, Society & Education, 17*(2), 76-85. https://doi.org/10.21071/psye.v17i2.17748

Received: 6 January 2025. *First review*: 25 March 2025. *Accepted:* 26 May 2025.

ISSN 1989-709X

Over the past few years, particularly within the context of the COVID-19 pandemic, there has been a 47% increase in the prevalence of mental disorders among minors. Even before the pandemic, a progressive increase in mental health disorders among minors –particularly adolescents– was already evident, with a 10% rise in children and a 20% rise in adolescents, according to data from Spanish pediatric and psychiatric associations (Grupo de trabajo multidisciplinar, 2022). These organizations have highlighted that diagnoses of anxiety, depression, attention deficit hyperactivity disorder (ADHD), and other disorders quadrupled between 2019 and 2022.

This increase is particularly concerning given that adolescence is a critical period for the onset of mental disorders. Several studies (Casañas & Lalucat, 2018; Costello et al., 2011; Powers & Casey, 2015) emphasize that 50% of adult mental disorders begin between the ages of 12 and 18. Furthermore, the Mental Health Commission of Canada reports that 70% of individuals with mental illnesses develop symptoms before turning 18 (Pinto-Foltz et al., 2010). These findings underscore adolescence as a critical stage for mental health prevention and awareness. One of the main challenges associated with the rise in these cases is the stigma directed toward individuals experiencing mental health problems.

Adolescents tend to have lower levels of knowledge and less developed attitudes regarding mental illness, which may contribute to the emergence of misconceptions and stigmatizing attitudes when compared to the adult population. Therefore, adequate interventions could effectively reduce associated stigma (Corrigan et al., 2005; Mansfield et al., 2019). During adolescence, interpersonal relationships play a key role, and the perception of mental health issues within peer groups can pose a threat to affected individuals (Corrigan & Shapiro, 2010; Heary et al., 2017; Lau et al., 2016). Moreover, various studies demonstrate a negative correlation between stigma and help-seeking behaviors among young people with mental health disorders, as well as with their peers' ability to provide support (Clement et al., 2015; Pinto-Foltz et al., 2010; Yap et al., 2011). In this context, adolescents are an ideal group for implementing interventions aimed at reducing stigma. Research suggests that focusing on this generation offers a unique opportunity since young people tend to be more open, trusting, and willing to engage in discussions about their mental health and promote social change compared to previous generations (Pescosolido, 2016).

The educational environment is an ideal setting to address the stigma of mental disorders among adolescents, as it represents a space for development, learning, and socialization. Secondary education is a transformative stage where students shape their identities. Consequently, transmitting values, fostering social relationships with peers, and managing frustrations are critical factors (Ma et al., 2023; Rüsch et al., 2023; Unitat per a la integració de persones amb discapacitat & Asociación por la salud integral del enfermo mental, 2012). Additionally, schoolyards often become settings where young people with mental health problems experience exclusion, facing loss of friendships, teasing, and rejection (Chen & Li, 2000). Peer acceptance is crucial for maintaining good mental health and can foster recovery (O'Driscoll et al., 2015).

However, school-based interventions aimed at reducing the stigma of mental illness among adolescents often lack uniformity, making it difficult to compare programs (DeLuca, 2020). Similarly, the evaluation of the effectiveness of these interventions and the instruments used to measure stigma often lack methodological consistency. Additionally, many of these programs and instruments are not based on theories of adolescent development, as they adapt material originally designed for adults (Elizalde-Resano et al., 2023; Pinto-Foltz et al., 2010).

The present study

In this context, it is necessary to clarify and systematize the concept of stigma in relation to mental disorders during adolescence, given its relevance in educational settings and its impact on help-seeking behavior and social integration. Therefore, the aim of this study is to conduct a scoping review to define the construct of mental disorder stigma in adolescents by identifying its definitions, types, dimensions, and associated variables. To address this aim, the following research questions are proposed: 1) What is the definition of mental disorder stigma?; 2) What types of stigma can be identified?; 3) Is stigma a unidimensional or multidimensional construct? If multidimensional, what are its dimensions?; and 4) What variables have been associated with mental disorder stigma in adolescents?

Method

Literature search strategies

A scoping review is a method used to determine the current state of knowledge in a specific field. It is characterized by being a broad review that analyzes and synthesizes academic literature on a particular topic. This type of review is often conducted as a precursor to a systematic review, providing a more comprehensive perspective on a subject (Munn et al., 2018). In the present study, the review will be conducted in accordance with the PRISMA-ScR guidelines to ensure the quality and transparency of the study selection and analysis process (Tricco et al., 2018). Following this guideline, no formal assessment of the methodological quality of the studies was conducted. Unlike systematic reviews, which aim to evaluate the validity of the available evidence, scoping reviews seek to map the existing literature and describe the current state of knowledge on a given topic. Nevertheless, attention was paid to the diversity of methodological approaches among the included studies and to the potential influence of bias in the interpretation of the results.

The literature search was conducted across the following health and education databases: Scopus, PubMed, Web of Science, ERIC, and PsycINFO. Google Scholar was also consulted as a complementary source to identify key conceptual articles on stigma. Manual selection was performed for five works considered relevant for the theoretical foundation and definition of the construct, even if they did not meet all inclu-

Table 1

Search of information sources

Language	Spanish and English	
Time period	The last 10 years	
Information sources	Scopus, Pubmed, Web of Science, Eric and PsycINFO	
Terms	Individual	Stigma, self-stigma, discrimination, prejudice, attitude, perception, "social stigma" mental illness, mental disorder adolescent, teenagers, young, youth
	Combined	(stigma OR "self-stigma" OR discrimination OR prejudice OR attitude OR perception OR "social stigma") AND ("mental illness" OR "mental disorder") AND (adolescent OR teenagers OR young OR youth)

sion criteria, such as the publication date, since they were original and foundational studies in the field (Corrigan & Watson, 2002; Corrigan et al., 2003; Goffman, 2006; Link & Phelan, 2001; Muñoz et al., 2009). The results were exported to Mendeley, where duplicates were removed.

The following combined terms were used in the search: (stigma OR "self-stigma" OR discrimination OR prejudice OR attitude OR perception OR "social stigma") AND ("mental illness" OR "mental disorder") AND (adolescent OR teenagers OR young OR youth).

Inclusion and exclusion criteria

Specific eligibility criteria were established for this review to ensure the relevance and quality of the selected studies. These criteria are detailed below.

Studies were selected based on the following inclusion criteria: publications from the last 10 years; original research articles addressing the topic of mental disorder stigma in adolescence; studies on awareness and sensitization programs related to adolescent mental health, including their evaluations; language: articles published in English or Spanish only; studies that analyze components of stigma, its types, and related variables.

The exclusion criteria were as follows: studies with samples composed exclusively of children or adults, systematic reviews or meta-analyses, duplicates found across databases, articles not published in English or Spanish.

Selection process

As previously mentioned, a search was conducted in five databases, initially in March 2022 and later updated in June 2024. Once the records were retrieved from each database, they were exported to Mendeley software (Version 1.19.4, Elsevier). Duplicate entries were removed using the software. Subsequently, a peer review of titles and abstracts was carried out by two reviewers (CE and RG). For this purpose, two separate folders containing the same articles were created, one for each reviewer. Each reviewer independently included or excluded documents according to the established criteria. During this process, disagreements arose in approximately 15% of the articles, mainly due to differences in the interpretation of the inclusion criteria, such as the age range of the study population or the methodological rigor of the studies. These disagreements were discussed among the reviewers and, in cases where consensus was not initially reached, additional researchers (BO and CR) were consulted. They reviewed the studies in question and resolved the discrepancies through consensus. Ultimately, the full content of the 51 studies that met all the established criteria was analyzed.

Results

A total of 11,144 citations were identified from various electronic databases (Figure 1). After removing duplicates using Mendeley, 8,109 unique records remained. Based on titles, the lead author (CE) excluded 6,774 records, and the second reviewer (RG) excluded 7,562. During the abstract screening, the lead author excluded 1,129 publications, while the second reviewer excluded 323. This resulted in 206 full-text articles retained by the lead author and 224 by the second reviewer. Discrepancies were resolved through consensus with the other two authors (BO and CR), ultimately yielding 215 full-text articles for review.

After an exhaustive analysis, only 51 publications were deemed suitable for inclusion in this study. In addition, six additional citations from gray literature were included, such as scientific articles and documents from relevant mental health organizations, provided they met methodological rigor criteria and were available in the databases consulted or on official websites. The selection of these documents was based on their relevance to the study topic and their high frequency of citation. In total, this review includes 57 articles.

Based on these results, we will address the research questions posed in the article, following the previously established order.

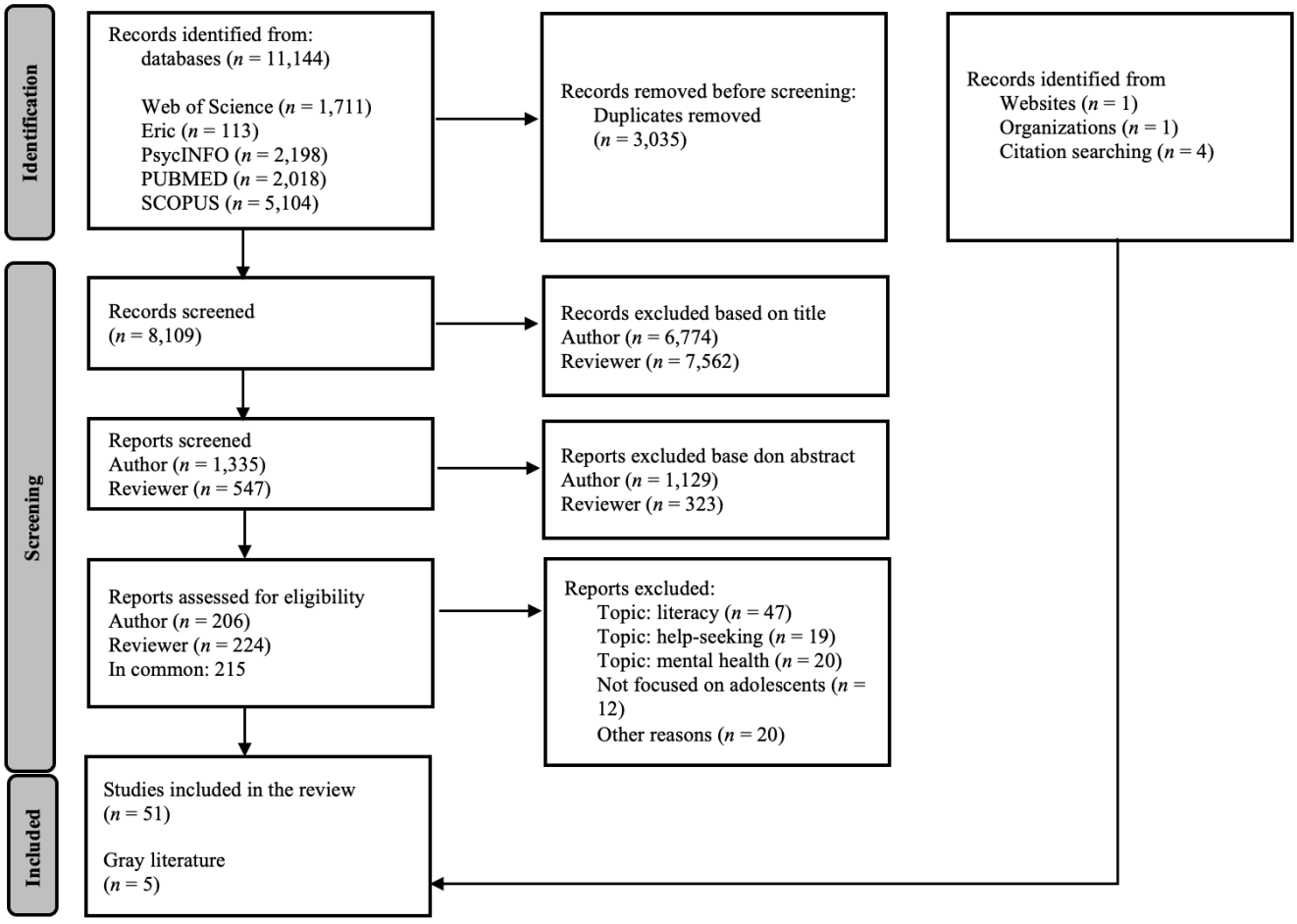
1. What is the definition of mental health stigma?

Appendix A includes the studies that refer to the definition of stigma, along with a brief mention of the term. These consist of 12 studies retrieved from the databases used in the systematic review and three gray literature articles containing key contributions from the original authors.

From the analysis of these sources, several insights regarding the definition of stigma can be drawn. During the Middle

Figure 1

Flowchart: Article Selection Process



Ages, the term "stigma" referred to defamation and public accusations of criminal behavior, often involving the physical branding of individuals with hot iron for recognition (Muñoz et al., 2009). Over time, the term has evolved significantly.

The concept of stigma has been explored by various disciplines, including sociology and social psychology. In sociology, Erving Goffman and Bruce Link are notable contributors. Goffman, regarded as a pioneer in stigma research, defined stigma as a deeply discrediting attribute that transforms an individual from being whole to being tarnished, thereby constructing a spoiled identity (Goffman, 2006). Link and Phelan (2001) complemented this definition with labeling theory, which occurs when individuals are categorized to establish a division between "us" and "them." This process results in loss of status, exclusion, and discrimination. These authors use the term "label" instead of "mark" or "attribute".

From the perspective of social psychology, Patrick Corrigan contributed significantly by defining stigma as a process comprising four sociocognitive elements: cues, stereotypes, prejudice, and discrimination. Cues are symptoms identifying individuals with mental disorders. Stereotypes reflect common beliefs, such as perceiving individuals with mental illness as incompetent, weak, or dangerous. These stereotypes may lead to prejudice, which are opinions grounded in stereotypes. As a result, discrimination arises, manifested as social exclusion (Corrigan, 2004; Corrigan & Bink, 2016; Stachelski et al., 2015).

Stigma is a universal phenomenon (Rodriguez-Meirinhos & Antolin-Suarez, 2020) or a social process (Chen et al., 2017) characterized by unfavorable labeling (Goffman, 2006; Link & Phelan, 2001; Škodová & Polčová, 2020; White et al., 2020) or by attributing an undesirable mark (Aguilar, 2021; Goffman, 2006; Pescosolido & Martin, 2015; Sakellari et al., 2016). It encompasses negative attitudes, feelings, beliefs, and behaviors toward individuals with mental illness (Del Casale et al., 2013; Ochoa et al., 2016; Oduguwa et al., 2017), resulting in discrimination, rejection, exclusion, loss of status (Chen et al., 2014; Link & Phelan, 2001; Rodriguez-Meirinhos & Antolin-Suarez, 2020), separation (Link & Phelan, 2001), blame (Chen et al., 2017), unfavorable social judgments (Škodová & Polčová, 2020), health inequalities (Sapiro, 2019), and barriers to accessing treatment or seeking help (DeLuca et al., 2020; Fung et al., 2016).

Overall, researchers agree that stigma is defined as a set of negative beliefs that incite fear, rejection, discrimination, and social exclusion toward individuals with mental illnesses.

2. What are the types of mental health stigma?

Appendix B presents the studies related to the different types of stigma. It includes six studies retrieved from the databases used in the systematic review and one gray literature article that provides relevant contributions from the original authors.

Researchers investigating stigma often refer to similar types, although terminology and classification methods vary. Below are the primary types identified in the literature:

Public stigma: also referred to as social stigma (Rodriguez-Meirinhos & Antolin-Suarez, 2020), it defines how members of a given society perceive and act toward individuals with mental disorders (Corrigan & Watson, 2002). Public stigma involves the interplay of stereotypes, prejudice, and discrimination (Dey et al., 2020). Subtypes of public stigma:1) Personal stigma: refers to individual attitudes toward people with mental disorders (Dey et al., 2020; McKeague et al., 2015); 2) Perceived stigma: refers to the perception of what others think and feel about a mental health condition (Calear et al., 2017); 3) Interpersonal stigma: refers to the interaction and experiences between a person and the stigmatized individual (Wright et al., 2011).

Self-stigma or internalized stigma: this occurs when individuals apply socially negative attributions related to their mental disorder to themselves (Bosco et al., 2019).

Structural stigma: refers to institutional policies, whether from private organizations or governments, that restrict opportunities for individuals with mental illnesses (Wright et al., 2011). This includes discrimination in laws, policies, and cultural and organizational practices, such as employment and training.

Stigma by association: affects people connected to a stigmatized individual, such as friends or family members, who experience secondary stigma, known as courtesy stigma or associative stigma. When this secondary stigma is internalized, it is referred to as affiliate stigma (Telesia et al., 2020).

There is no universal consensus on the naming or classification of stigma types. However, public stigma and self-stigma are the most recognized, though some authors include structural stigma and secondary forms such as personal, perceived, interpersonal, or associative stigma.

3. Is mental health stigma unidimensional or multidimensional? If multidimensional, what are its dimensions?

An analysis of the data presented in the 13 articles included in Appendix C reveals a consistent agreement among all authors in emphasizing that stigma is a multidimensional construct. The general dimensions of stigma are clearly defined and have been widely studied. The literature identifies three primary components:

Cognitive dimension: refers to general beliefs (stereotypes) about mental disorders, labeling, and lack of knowledge (Ahmad et al., 2020; Anis et al., 2020). It includes misconceptions (Akinbode & Tolulope, 2017), such as perceiving individuals with mental disorders as dangerous or responsible for their condition (Corrigan et al., 2003; Mannarini et al., 2023).

Emotional or affective dimension: relates to opinions (prejudices) about general stereotypes (Chen et al., 2018; O'Driscoll et al., 2015). It includes personal attitudes (Anis et al., 2020), feelings (Heary et al., 2017), and negative emotions (Pescosolido & Martin, 2015). Prejudices internalize negative stereotypes and are often associated with fear, pity, and anger (Corrigan et al., 2003).

Behavioral dimension: encompasses discrimination against individuals with mental disorders resulting from stereotypes and prejudices. It manifests in forms such as separation (Akyurek et al., 2019), loss of status (Akyurek et al., 2019), social distancing (Pescosolido & Martin, 2015), avoidance, segregation, or rejection of help (Corrigan et al., 2003).

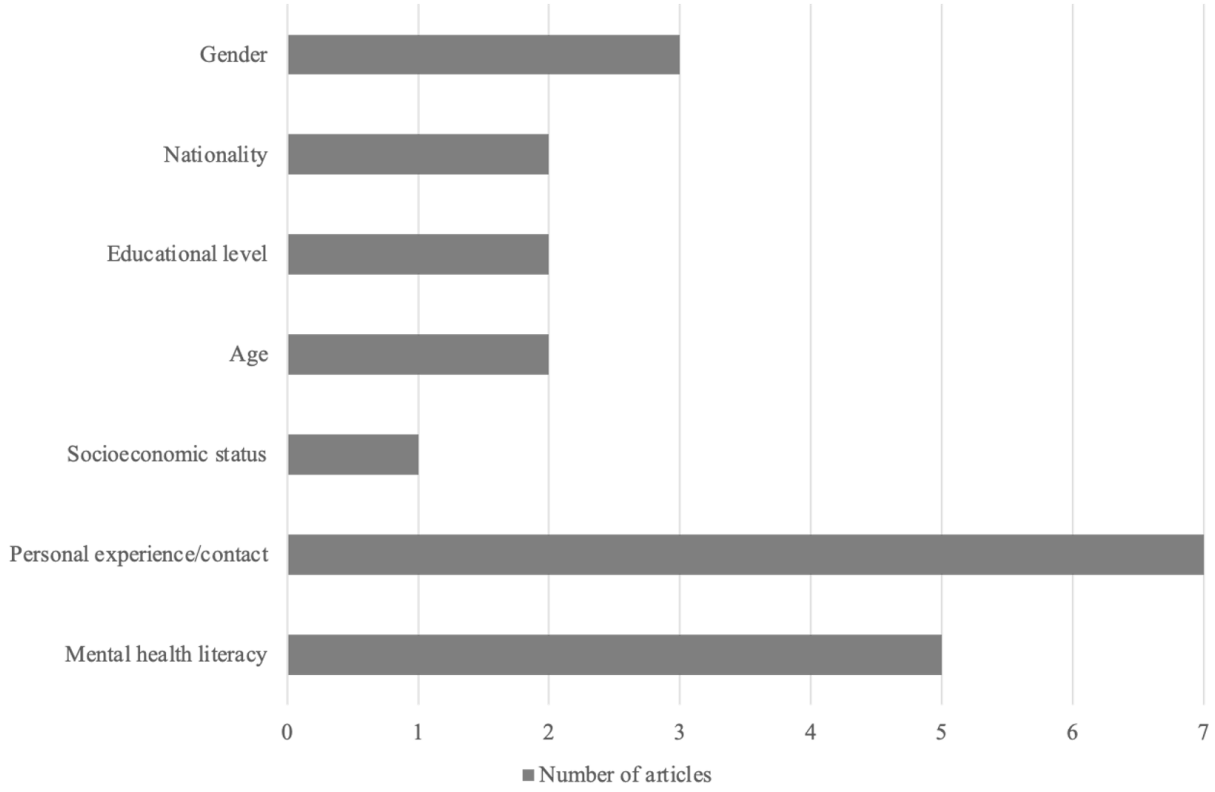
Structural dimension: less studied, this dimension pertains to policies, norms, and organizational practices that restrict rights and opportunities within public or private institutions (Sarfika et al., 2021).

4. Can other variables related to mental health stigma be identified?

A total of 22 articles included in Appendix D examined variables associated with stigma toward mental disorders in adolescents. The following section presents the main findings related to each of these variables. The most prominent was (see Table 2): 1) Gender: being female is associated with lower stigma levels among adolescents (Lynch, 2021; Martinez et al., 2020). Girls tend to exhibit greater empathy and more open attitudes toward individuals with mental disorders compared to boys; 2) Nationality or culture: cultural differences influence stigma perception. Nationality is significantly linked to levels of stigmatization, reflecting variations in cultural norms and beliefs about mental health (Martinez et al., 2016); 3) Educational level: higher educational levels are associated with less stigmatizing attitudes (Kumar et al., 2020; Martinez et al., 2016). This could be attributed to better access to information that demystifies mental illnesses; 4) Age: older adolescents tend to exhibit less stigma (Kumar et al., 2020; Martinez et al., 2016), likely due to greater maturity and exposure to experiences and knowledge related to mental health; 5) Socioeconomic status: individuals from lower socioeconomic backgrounds are more likely to exhibit higher levels of stigmatization toward mental disorders (Ibrahim et al., 2019), possibly due to reduced exposure to information and resources on mental health; 6) Personal experience (familiarity or contact): adolescents with direct contact with individuals with mental disorders tend to have fewer stigmatizing attitudes (Yamaguchi et al., 2014). Educational interventions based on contact utilize personal stories to foster positive attitudes toward recovery (Chen et al., 2017). This indicates that stigma is highest at the extremes: both when individuals have no relationship with someone experiencing a mental disorder (low familiarity) and when they have a very close relationship, such as with a direct family member or close friend (high familiarity). Conversely, when the relationship is moderate, such as with acquaintances or colleagues, stigma tends to decrease. This pattern can be

Figure 2

Number of articles addressing each variable associated with stigma toward mental disorders in adolescents



explained by the fact that at low levels of familiarity, stigma may be influenced by a lack of knowledge or preconceptions; at moderate levels, contact promotes greater understanding and acceptance; whereas in very close relationships, emotional challenges or perceived personal impact may lead to an increase in stigma; 7) Mental health literacy: school-based educational programs significantly reduce stigma by increasing knowledge about mental illnesses, treatments, and available resources (Austin & Schwartz, 2019; Sakellari et al., 2016). Informed students better interpret symptoms, avoiding erroneous attributions. For example, without knowledge about ADHD, a peer's behavior might be attributed to poor parenting (Clarke, 2021); and 8) Help-seeking behavior or lack of engagement with treatment: stigma can inhibit adolescents from seeking professional help and engaging with treatment due to fear of rejection and discrimination (Chen et al., 2014; Corrigan, 2004; Corrigan & Watson, 2002; Dardas et al., 2018; De la Higuera et al., 2020; Mulfinger et al., 2019; Vaquero et al., 2014). Positive attitudes toward help-seeking are linked to higher levels of mental health literacy (Al Omari et al., 2022).

Discussion

The alarming increase in mental disorders among adolescents, affecting one in eight students (Barican et al., 2022), raises the hypothesis of a parallel rise in social stigma, underscoring the importance of understanding this construct to develop effective and sustainable anti-stigma programs. This phenomenon has been exacerbated by the impact of the COVID-19 pandemic on adolescent mental health.

The recent surge in research reflects the topic's relevance to adolescent mental health. Prominent authors like Goffman and Corrigan define stigma as negative beliefs and attitudes that foster fear, rejection, and exclusion toward individuals with mental disorders. Therefore, it is essential to implement systematic interventions in educational settings that enable the identification, assessment, and understanding of the magnitude and direction of these negative beliefs and attitudes toward mental disorders. Such knowledge is crucial for designing effective educational strategies that are responsive to students' actual needs and sustainable over time.

While there is no consensus on stigma classification, the most frequent types are public stigma, related to social attitudes, and self-stigma, involving the internalization of negative beliefs. Given the focus on prevention and intervention in educational contexts, the present study concentrates on public stigma as a key construct to be addressed. According to Corrigan et al. (2003), stigma comprises three core dimensions: the cognitive dimension, which refers to societal beliefs or stereotypes about mental disorders, such as perceptions of dangerousness or blame; the emotional dimension, which involves prejudices based on emotions such as fear, pity, or anger; and the behavioral dimension, associated with discriminatory practices that lead to exclusion, avoidance, and rejection of

help. Depending on the specific context and a thorough needs assessment, interventions can be strategically directed toward modifying knowledge, managing emotional responses, or changing behaviors.

Moreover, sociodemographic and educational variables such as gender, nationality, educational level, age, socioeconomic status, familiarity with mental illness, mental health literacy, and help-seeking attitudes significantly influence levels of stigmatization. Considering these variables allows for the development of differentiated intervention groups, enabling tailored approaches that respond to the specific characteristics and needs of each group. Although the concept of stigma varies, making cross-study comparisons challenging, its investigation remains essential. Interventions must address the three dimensions of stigma and focus on aspects such as mental health literacy, familiarity with mental disorders, and the promotion of help-seeking behaviors. To achieve this, it is essential to develop accurate assessment instruments tailored to the adolescent population, considering all relevant variables that may influence levels of stigma. These variables play a decisive role in designing interventions, as they directly influence stigma levels within this demographic. Addressing them comprehensively is essential for implementing effective programs that promote both understanding and acceptance of mental disorders.

This review faces different difficulties, including methodological diversity, unclear definitions, and a lack of terminological consensus, complicating construct clarification. However, it provides a useful framework to guide future research and practice. Standardized definitions and evaluations of stigma are necessary for precise comparisons between studies. Additionally, identifying stigma's three dimensions offers a solid foundation for developing specific measurement tools. Practically, the results directly inform the design of interventions targeting adolescents, emphasizing strategic areas such as mental health literacy and familiarity. This innovative approach offers a roadmap for reducing stigma, fostering positive changes in perceptions and treatment of adolescents with mental disorders. In the school setting, these practical implications can be translated into concrete proposals such as the inclusion of mental health content in the curriculum, specific teacher training on stigma and psychosocial diversity, and the creation of safe spaces where students can express their experiences without fear of judgment or rejection. Additionally, implementing mental health literacy programs that incorporate first-person narratives, participatory activities, and audiovisual materials can be effective in reducing stereotypes and fostering empathy. These initiatives should be designed based on prior needs assessments and adapted to the sociocultural characteristics of each educational context.

Limitations

This scoping review has several limitations that should be acknowledged. First, although a systematic search strategy was employed across multiple databases, it is possible that some relevant studies were not identified, particularly those published in languages other than English or Spanish, or those appearing in non-indexed sources. Second, the methodological heterogeneity among the included studies –regarding research designs, measurement tools, and study populations– limits the comparability of results and precludes a quantitative synthesis. Third, in line with the nature of scoping reviews, no critical appraisal of the methodological quality of the included studies was conducted. This lack of quality assessment may affect the strength and reliability of some of the conclusions drawn.

Conclusions

In conclusion, this review provides a conceptual and practical framework for understanding the complexity of stigma toward mental disorders in adolescents and guides the development of contextualized and sustainable interventions. Addressing stigma in schools not only contributes to improving students' mental health, but also promotes a more inclusive, critical, and socially engaged educational culture. Future studies should focus on validating specific assessment instruments and evaluating longitudinal interventions that can measure real changes in students' attitudes, emotions, and behaviors.

Author contributions

Conceptualization: C.E.R., B.O.L., C.R.A.
Data curation: C.E.R.
Research: C.E.R.
Methodology: C.E.R., B.O.L., C.R.A.
Project administration: C.E.R., B.O.L., C.R.A.
Visualization: C.E.R.
Writing – Original draft: C.E.R.
Writing – Review & editing: C.E.R., B.O.L., C.R.A.

Funding

This work was funded by "Asociación de Amigos" of the University of Navarra (ADA).

Acknowledgments

The authors wish to express their gratitude to the Financial Aid Program of the Friends of the University of Navarra. Additionally, we extend our thanks to the University of Navarra for the support provided during this study.

Declaration of interests

The authors declare that there is no conflict of interest.

Data availability statement

Data sharing not applicable –no new data generated, or the articles describes entirely theoretical research.

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