Wiley
Mental Illness
Volume 2025, Article ID 5522798, 16 pages
https://doi.org/10.1155/mij/5522798

Research Article

Adapting to Stigma, Resilience and Systemic Barriers: Lived Experiences of Adolescents and Young Adults With Mental Illness

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Received 15 January 2025; Revised 6 June 2025; Accepted 19 June 2025

Academic Editor: Domenico De Berardis

Background: Mental illness amongst adolescents and young adults is a significant public health concern globally, particularly in low- and middle-income countries like Nigeria, where mental health infrastructure is limited. Young Nigerians face pervasive stigma, inadequate mental health literacy and limited access to care, often influenced by spiritual and sociocultural factors. This study explores the lived experiences of adolescents and young adults with mental illness, focusing on how they navigate stigma, emotional distress and systemic barriers whilst leveraging coping mechanisms.
Methods: Using an Interpretative Phenomenological Appraoch (IPA) approach, this longitudinal qualitative study examined the experiences of 16 participants aged 15–35 years diagnosed with mental illness. Participants were purposively sampled from a psychiatric hospital in southeastern Nigeria. Data were collected through semistructured, in-depth interviews over 9 months. Thematic analysis was employed to identify patterns and interpret the dynamic interplay between societal stigma, individual coping strategies and systemic challenges.
Results: Five key themes emerged: (1) perceptions of mental illness as abnormality and shame; (2) emotional and social struggles, including loneliness, strained family relationships and fear of the future; (3) coping mechanisms such as reliance on family, spirituality and professional care; (4) stigma and discrimination, highlighting both internalised stigma and advocacy efforts; and (5) barriers to care, including accessibility issues and the need for youth-specific services. Participants reported evolving perceptions and coping strategies over time, facilitated by therapy, social support and community awareness initiatives.
Conclusions: This study emphasises the complex interplay between stigma, resilience and systemic barriers in the mental health journeys of young Nigerians. Findings highlight the need for culturally sensitive interventions, family-focused psychoeducation, youth-specific services and community-integrated approaches to reduce stigma and enhance care. These insights provide actionable recommendations for improving mental health systems in resource-limited settings.

Keywords: adolescents; coping mechanisms; interpretative phenomenological analysis; lived experiences; mental illness; Nigeria; resilience; stigma; systemic barriers; young adults

1. Background

Mental illness amongst adolescents and young people is a growing global concern, particularly in low- and middle-income countries (LMICs) such as Nigeria, where mental health care infrastructure remains underdeveloped [1, 2]. Adolescents and young people in Nigeria represent a significant portion of the population, yet their mental health needs are often neglected due to pervasive stigma, inadequate mental health literacy and limited access to care [3, 4]. Despite increasing recognition of the global burden of mental illness, little is known about how young Nigerians navigate these challenges, leaving a critical gap in understanding their lived experiences.

Globally, mental health challenges are amongst the leading causes of disability amongst adolescents and young adults, with anxiety, depression and psychotic disorders being particularly prevalent [5, 6]. However, the situation is compounded in Nigeria by sociocultural factors such as entrenched stigma, which frames mental illness as a moral failing, spiritual affliction or personal weakness [7, 8]. This stigma not only exacerbates emotional distress but also discourages individuals and families from seeking care. Similarly, stigma is associated with chronic health conditions such as HIV; here, it can intensify emotional distress and serve as a significant barrier to accessing support, highlighting the universal and compounding impact of stigma on well-being [7]. The influence of stigma on young people's mental health perceptions and coping mechanisms remains underexplored, particularly in contexts where cultural norms heavily influence behaviour and attitudes [9].

Studies in LMICs have highlighted that adolescents with mental illness often experience intersecting vulnerabilities, including discrimination in educational settings, strained family relationships and diminished social opportunities [6, 10]. These vulnerabilities are amplified in Nigeria, where young people face additional barriers such as poverty, unemployment and weak policy frameworks supporting mental health [1, 2]. Whilst international studies emphasise the role of resilience in overcoming adversity, there is limited research investigating how Nigerian adolescents navigate systemic and social barriers to maintain their mental well-being [4, 8].

Coping mechanisms amongst adolescents with mental illness vary widely and are influenced by individual, familial and societal factors. For example, some studies suggest that young people adopt strategies such as social withdrawal, substance use or avoidance to cope with stigma and emotional distress [3, 9]. Conversely, others find that religion, peer support and access to culturally relevant therapeutic interventions can act as protective factors [4, 7]. Segovia (31) similarly identifies the importance of social support and spirituality as protective factors in mitigating the emotional toll of stigma, suggesting parallels across diverse health contexts. However, most research focuses on adult populations, overlooking the unique developmental, emotional and cognitive needs of adolescents and young people. There is a paucity of evidence on the role of social support systems and mental health services in fostering resilience amongst this demographic in Nigeria.

Existing literature also points to significant gaps in the systemic response to adolescent mental health needs in Nigeria. Mental health services are disproportionately located in urban centres, leaving rural and underserved communities with few or no options for care [2, 8]. Moreover, the integration of mental health services into primary care, a recommendation by the World Health Organisation, has seen limited implementation in Nigeria [5, 9]. As a result, young people face structural barriers that prevent them from accessing timely and effective care.

Whilst previous studies have highlighted the prevalence of stigma, barriers to care and the role of resilience in managing mental illness, there is a lack of in-depth research examining how adolescents and young people perceive their conditions and navigate these challenges. By exploring the lived experiences of young Nigerians with mental illness, this study is aimed at filling these gaps, offering insights into their emotional and social realities and informing strategies to improve mental health care and support systems in similar contexts. To the best of our knowledge, this is the first interpretive phenomenological study to explore the lived experiences of adolescents and young people with mental illness in Nigeria, focusing specifically on their perceptions, emotional and social challenges and coping mechanisms.

2. Research Aim

This study is aimed at exploring how adolescents and young people conceptualise their condition; navigating the interplay of stigma, emotional distress and social exclusion; and leveraging culturally relevant coping mechanisms. To achieve this aim, the study will address the following objectives:

1. Examine how adolescents and young people perceive their mental health conditions and the stigma associated with them.
2. Explore the emotional and social factors influencing their experiences.
3. Explore the coping strategies they adopt to navigate these challenges.
4. Provide recommendations for improving mental health care and social support systems for adolescents and young people in Nigeria.

3. Material and Methods

3.1. Study Design. This study adopted an interpretative phenomenological approach (IPA) design to explore and interpret the lived experiences of adolescents and young people with mental illness. IPA is rooted in phenomenology, hermeneutics and idiography, focusing on understanding how individuals make sense of their experiences within their unique contexts [11]. The design is particularly suitable for exploring underresearched phenomena, such as the emotional and social challenges faced by young Nigerians with mental illness, and it enables the researcher to delve deeply into participants' subjective interpretations [12].

IPA emphasises a double hermeneutic process, where participants make sense of their lived experiences, and the researcher interprets these understandings within broader sociocultural and theoretical frameworks [13]. This approach is well-suited for the current study, as it allows for the examination of individual experiences whilst also recognising the influence of societal and cultural contexts, such as the pervasive stigma surrounding mental illness in this context [14, 15].

The study design integrates qualitative, inductive methods to provide a rich, holistic understanding of the participants' lived realities. By focusing on adolescents and young people, this design acknowledges the developmental and social complexities of this group, aiming to generate actionable insights that could inform culturally sensitive mental health interventions. The interpretive nature of IPA ensures that the research goes beyond descriptive accounts, capturing the deeper meanings and implications of participants' experiences [15]. This design lays the groundwork for subsequent sections on data collection and analysis, where the methodological rigour and ethical considerations that underpin this study are elaborated.

Whilst standardised scales for measuring stigma, such as those validated in recent literature [16], offer valuable quantitative insights, this study intentionally adopted a purely qualitative design grounded in IPA. The primary aim was to capture the nuanced, subjective meanings that adolescents and young adults ascribe to their lived experiences of stigma. Given the limited research on this demographic within the Nigerian context, a detailed idiographic approach was prioritised to explore stigma not only as a quantifiable phenomenon but also as an evolving and deeply contextualised experience. Nonetheless, future studies could benefit from combining IPA with validated stigma scales to enable a mixed methods approach, offering both depth and generalisability.

3.2. Study Setting and Participants. The study was conducted at a large regional psychiatric hospital located in southeastern Nigeria. This facility serves as a primary mental health care provider for a population of over 20 million people, making it an appropriate site for exploring the lived experiences of young people with mental illness. The hospital's role as a central hub for psychiatric care in the region ensured access to a diverse pool of participants receiving treatment for a range of mental health conditions.

Participants were recruited using purposive sampling, a strategy aimed at including individuals who had directly experienced the phenomenon under investigation and could provide rich, detailed accounts of their experiences [17]. Recruitment was facilitated through collaboration with medical officers and prominent nurses who acted as gatekeepers. These gatekeepers identified eligible participants, distributed invitation letters and participant information sheets and maintained communication between the researcher and participants. This approach effectively addressed challenges related to accessibility, rapport-building and ensuring participants' suitability for the study [18].

A total of 16 participants were recruited, comprising 10 males and 6 females to ensure data saturation and the richness of data required for robust qualitative analysis. As outlined in Table 1, participants were aged 15 to 35 years, representing a broad range of psychiatric diagnoses, including schizophrenia, bipolar disorder, major depressive disorder, generalised anxiety disorder and posttraumatic stress disorder. This diversity allowed the study to explore variations in stigma, emotional impact and coping mechanisms across diagnostic categories, consistent with the interpretive phenomenological approach that prioritises individual lived experience over categorical generalisation [11, 12]. Inclusion criteria required participants to have a clinical diagnosis of a mental illness, to be actively receiving treatment either as inpatients or outpatients at the psychiatric hospital and to have sufficient insight into their condition to provide informed consent and engage meaningfully in the interview process. Proficiency in English, the dominant language in Nigeria, was another requirement to facilitate effective communication during interviews.

3.3. Data Collection. Data collection spanned a period of 9 months, from 2019 to 2022, and involved multiple rounds of semistructured, in-depth interviews with each participant. This extended timeframe was necessary for capturing the evolving nature of participants' experiences and ensuring emotional readiness to participate [11]. Each participant was interviewed two to three times, with sessions typically spaced approximately 3 to 4 months apart depending on the individual's treatment schedule and psychological stability. This longitudinal design reflects the interpretive phenomenological commitment to idiographic depth and temporal understanding [12].

Semistructured interviews allowed for flexibility in exploring participants' lived realities whilst maintaining alignment with core research objectives. The interview guide (see Table 2) included open-ended, exploratory questions designed to elicit rich personal narratives. These questions were revisited in subsequent interviews to explore changes in perceptions, coping mechanisms and engagement with care over time, thus allowing for both consistency and depth of insight across the study duration [13].

The interviews were conducted by the lead author, a trained qualitative researcher with expertise in mental health and phenomenological methods. This ensured consistency in data collection and strengthened rapport with participants, a key element in IPA [14, 15]. Interviews were conducted in private rooms within the psychiatric hospital to safeguard confidentiality and participant comfort. Each session lasted between 60 and 120 min and was audio-recorded with participants' informed consent. Adolescents aged 15–17 years participated with both assent and guardian consent, though guardians were not present during interviews in order to preserve the autonomy and privacy of the adolescent participants. Gatekeepers, including medical officers and nurses, supported recruitment and ensured clinical appropriateness and emotional readiness for participation [18]. The 9-month duration also allowed for flexibility in scheduling interviews to accommodate participants' treatment schedules and hospital-related activities. Throughout the study, emotional distress was occasionally encountered. In such cases, participants were offered breaks, rescheduling or termination of the interview. These procedures reflected the ethical imperative to uphold participant well-being in sensitive research involving mental illness [19, 20].

3.4. Ethical Considerations. This study adhered to the established ethical principles to safeguard participants' rights, autonomy and well-being. Ethical approval was obtained from the Research Ethics Committee of the psychiatric hospital in southeastern Nigeria (approval number: FNHE/HTR/REA/Vol 11/283), in compliance with the Declaration of Helsinki [19] and guidelines for research involving vulnerable populations [20]. A clinical trial number was not required, as this study is not a clinical trial. All participants received detailed information about the study's purpose, procedures, potential risks and benefits. Adolescents aged 15–17 years provided assent alongside parental or guardian consent, whilst participants aged 18–35 years provided informed consent independently. Participants were explicitly informed of their right to

TABLE 1: Participants' demographic information.

Participant ID	Sex	Age (years)	Duration of diagnosis	Primary diagnosis
P1	Female	28	4 years	Major depressive disorder
P2	Female	26	4 years	Schizophrenia
P3	Male	23	8 months	Bipolar disorder
P4	Male	16	2 years	Conduct disorder
P5	Male	15	8 months	Psychosis NOS
P6	Female	22	5 years	Major depressive disorder
P7	Male	17	18 months	PTSD
P8	Male	21	8 months	Schizoaffective disorder
P9	Male	27	13 months	Bipolar disorder
P10	Male	28	3 years	Schizophrenia
P11	Male	30	1 year	Major depressive disorder
P12	Male	27	3 months	Generalised anxiety disorder
P13	Male	26	4 years	Psychosis NOS
P14	Male	23	2 years	PTSD
P15	Female	29	4 years	Bipolar disorder
P16	Female	28	5 years	Schizophrenia

Note: Diagnoses were reported based on participants' medical records or self-report during the interview.
Abbreviation: NOS, not otherwise specified.

TABLE 2: Interview guide.

Primary question	Prompts
Can you describe your understanding of your mental health condition?	○ What do you think caused your condition? ○ Has your understanding of your condition changed over time? ○ How has your condition affected your daily life? ○ How do you feel others perceive your condition now, compared to earlier?
What are some challenges you face as a result of your mental health condition?	○ How has your condition affected your relationships with family and friends? ○ What difficulties have you encountered in accessing mental health care? ○ How have these challenges changed since you began receiving treatment? ○ How do you deal with feelings of stigma or discrimination now, compared to before?
What strategies do you use to cope with your mental health challenges?	○ Do you rely on family, friends, or professionals for support? ○ Have your coping strategies changed over time? ○ Are there particular activities or routines that help you manage your condition? ○ How effective do you think these coping strategies are currently?
What suggestions do you have for improving mental health care for young people?	○ What kind of support do you think would make the most difference for someone in your position? ○ What services or people have helped you most? ○ Are there changes you would recommend based on your own journey?

withdraw at any time without repercussions, ensuring voluntary participation and autonomy [17].

Confidentiality and anonymity were maintained by replacing participants' names with unique IDs in all records and publications. Audio recordings and transcripts were securely stored on password-protected devices, and hard copies of consent forms were kept in a locked cabinet. Identifying information was removed from all transcripts to further protect participants' identities [18]. To ensure psychological safety, interviews were conducted in private, quiet spaces within the psychiatric hospital. Participants could pause or terminate the interview if they felt distressed. Gatekeepers, including medical officers and nurses, were available to provide immediate support if necessary. Referrals to mental health services were arranged for participants requiring additional assistance [19]. The research team adhered to all ethical principles for working with a vulnerable population, including avoiding judgement, respecting privacy and being prepared to stop interviews if participants became distressed [21].

Cultural sensitivity was prioritised by using culturally appropriate language and conducting interviews in English, Nigeria's dominant language. The researcher's familiarity with the cultural context fostered trust and openness, ensuring participants felt comfortable sharing their experiences [17]. All data were securely stored, with digital files protected by passwords and physical documents kept in locked storage. Data will be retained for the duration specified by institutional guidelines before being securely destroyed. Findings will be reported transparently, ensuring participants' voices are authentically represented whilst maintaining confidentiality. These measures underscore the study's commitment to ethical integrity and participant welfare. The research team also maintained a reflexive approach throughout the study, recognising the potential for internalised stigma to influence data collection and interpretation. Regular self-reflection and peer discussions were used to identify and minimise personal biases, ensuring that participants' experiences were represented accurately and respectfully.

3.5. Data Analysis. The data analysis followed the interpretative IPA framework, which is suited for exploring the lived experiences of individuals and the meaning they ascribe to these experiences [13]. The process involved multiple stages of detailed and iterative analysis to ensure a robust understanding of the participants' narratives whilst maintaining their contextual integrity.

Step 1: *Data familiarisation*: The first stage of analysis involved repeated listening to the audio recordings and reading the transcripts to ensure immersion in the data. This process allowed the researchers to gain an in-depth understanding of the participants' stories and identify preliminary patterns and insights. Field notes taken during the interviews were also reviewed to enrich the contextual understanding of the narratives [13].

Step 2: *Initial coding*: An inductive approach was used for the initial coding process. Each transcript was carefully analysed, and segments of text that conveyed significant meaning or captured participants' unique perspectives were highlighted. Codes were assigned to these segments based on their content, such as 'feeling different' or 'fear of rejection'. This stage ensured that the analysis was rooted in participants' voices rather than predefined categories [12].

Step 3: *Developing themes*: The initial codes were then grouped into broader themes that reflected shared experiences across participants whilst preserving individual nuances. For example, codes such as 'avoiding public spaces' and 'feeling judged' were grouped under the theme 'shame and embarrassment'. Themes were iteratively refined to ensure they accurately captured the essence of the participants' lived experiences [12, 13].

Step 4: *Interpretative analysis*: Following the development of themes, an interpretative layer of analysis was applied. This stage involved examining the interplay between the participants' narratives, their sociocultural context and the study's longitudinal design. The researchers explored how participants' experiences evolved over time, focusing on the dynamic relationships between societal stigma, coping mechanisms and access to care [15].

Step 5: *Validation and reflexivity*: To enhance the credibility of the findings, the themes and subthemes were reviewed and validated by the research team. Regular discussions were held to challenge interpretations and ensure they were grounded in the data. Additionally, reflexive journals were maintained by the lead researcher to document personal biases and ensure they did not unduly influence the analysis [22].

Step 6: *Synthesis and presentation*: The final stage involved synthesising the themes and subthemes into a coherent narrative. The findings were structured to highlight the complexity of the participants' experiences, supported by illustrative quotes and contextual insights. The presentation was designed to balance descriptive and interpretative elements, aligning with the principles of IPA [13, 15].

3.6. Rigour and Reflexivity. To ensure the rigour and trustworthiness of the study, several strategies were employed, aligning with established qualitative research standards [23, 24]. Credibility was enhanced through prolonged engagement with participants and their narratives. The longitudinal design of the study allowed for a comprehensive understanding of participants' lived experiences, capturing the evolution of their perspectives over time [13]. Reflexive journaling by the lead researcher supported this process, providing a space to record methodological decisions and reflect on how personal experiences and assumptions could shape the research [22]. Given the sensitive nature of mental illness and the risk of internalised stigma influencing the study, reflexivity was an integral part of the research process. Before interviews and data analysis, both researchers engaged in structured self-reflection to identify and critically examine any preconceptions about mental illness. This involved documenting beliefs, emotional reactions and assumptions, with regular reviews throughout the study period. These reflections were discussed openly between the researchers to minimise bias and to ensure that participants' voices remained central to the analysis. Reflexivity was therefore not a one-time exercise but a continuous practice that enhanced the dependability and integrity of the findings.

Dependability was ensured by maintaining a detailed audit trail, documenting each stage of the research process, including recruitment, data collection and analysis [25]. Reflexive journaling by the lead researcher supported dependability by recording methodological decisions and the rationale behind them. This process enabled the research team to reflect on their positionality and potential biases throughout the study [22].

Transferability was supported by providing rich, detailed descriptions of the participants' contexts, including their sociocultural and health care environments. This approach allows readers to assess the applicability of the findings to similar populations or settings [26]. Verbatim quotes from participants were included to enhance the contextual richness of the findings, enabling a deeper understanding of their lived experiences [13].

Confirmability was achieved through triangulation of data sources and perspectives, including interviews, field notes and contextual observations, to corroborate the findings [27]. Regular peer debriefing sessions amongst the research team facilitated critical discussions, challenging assumptions and interpretations to ensure that the findings were firmly grounded in the data [25].

The study prioritised authenticity by faithfully presenting participants' voices and ensuring that their lived experiences were accurately represented [24]. The iterative process of analysis allowed for nuanced interpretations that captured both shared and unique experiences amongst participants, aligning with the principles of IPA [13].

4. Results

This section presents the key themes that emerged from the analysis of interviews conducted during this longitudinal study. The findings are structured around five interconnected themes: perceptions of mental illness, emotional and social struggles, coping mechanisms, stigma and discrimination and barriers and suggestions for improved care. Each theme delves into specific dimensions of participants' lived experiences, capturing the complexity of their journeys over the study period. These themes are summarised in Table 3, which provides an overview of subthemes and illustrative codes, ensuring clarity and depth in the analysis.

4.1. Perceptions of Mental Illness. This theme captures how participants made sense of their mental health conditions over time, reflecting a complex journey shaped by social narratives, personal reflections and therapeutic experiences. Participants' accounts illustrate a movement from internalised stigma and fear towards greater self-awareness and, in some cases, acceptance.

4.1.1. Mental Illness as an Abnormality. Many participants initially described their diagnosis in terms that echoed cultural misconceptions and deeply entrenched stigma. They often felt something fundamental was wrong with them, an abnormality of the mind that set them apart from others.

> *I feel like my brain is not normal. It's like something is broken inside me, and I can't fix it no matter how hard I try (P3, male, 23 years, schizoaffective disorder, first interview).*

Community beliefs around mental illness often compounded these feelings. The notion of mental illness as a spiritual punishment or family curse emerged frequently, suggesting that stigma was rooted not only in lack of knowledge but also in cultural and religious narratives.

> *People say it's a curse or a punishment for something you or your family did. Hearing that over and over makes you believe it (P5, male, 15 years, schizophrenia, first interview).*

> *People in my community say someone cursed me or did something spiritual to me. Sometimes, I wonder if that's true because nothing else makes sense (P5, male, 15 years, schizophrenia, second interview).*

Despite these early beliefs, some participants began to challenge these views after engaging with mental health services. For a few, medical explanations gradually replaced supernatural ones, opening space for acceptance and self-compassion.

> *I used to think it was my fault or something supernatural, but the doctors explained it's just like any other sickness (P2, female, 26 years, bipolar affective disorder, second interview).*

4.1.2. Shame and Embarrassment. Living with a mental illness carried an emotional toll, often marked by profound shame. This shame stemmed not only from the diagnosis but also from how participants were perceived or feared being perceived by others. Their accounts frequently described avoiding social settings and hiding their conditions from others.

> *The way people look at me when I walk on the street makes me want to hide. It's like they're saying I'm different, and not in a good way (P12, male, 27 years, generalised anxiety disorder, first interview).*

For several participants, side effects of psychiatric medications were particularly distressing. They were not only physically uncomfortable but also socially embarrassing, drawing unwanted attention and ridicule.

> *Sometimes, my medication makes me so sleepy that I've fallen asleep in public places…people laugh at me and ask what's wrong. It's so humiliating (P9, male, 27 years, schizophrenia, second interview).*

Some chose to avoid treatment altogether to protect themselves from further embarrassment, even when they recognised that doing so could harm their recovery. These experiences underscore how shame was not simply internal but reinforced by public reactions and cultural expectations.

4.1.3. The Journey to Acceptance. Whilst stigma and shame dominated early narratives, several participants also described moments of transformation. For some, acceptance came gradually, facilitated by therapeutic relationships, support systems or a deeper understanding of their condition.

> *At first, I hated myself for being like this. But over time, I realised it's not my fault. It's just something I have to learn to live with (P6, female, 22 years, bipolar affective disorder, second interview).*

This acceptance was not without struggle. The journey was rarely linear. Participants often wavered between progress and relapse and between confidence and doubt, as they learned to live with their condition.

TABLE 3: Themes, subthemes, and illustrative quotes.

Themes	Subthemes	Codes with examples
Perceptions of mental illness	Mental illness as an abnormality	"I feel like my brain is not normal…people in my village think it's a curse or punishment"
	Shame and embarrassment	"The way people look at me makes me want to hide… sometimes my medication makes me fall asleep in public…it's humiliating"
	The journey to acceptance	"At first I blamed myself, but therapy helped me see it's an illness like any other…there are days I feel okay, and some days I still struggle"
Emotional and social struggles	Loneliness and isolation	"It's like I live in a different world…my friends stopped calling after a while"
	Strained family relationships	"They think I'm just being lazy…when my mum cries, I feel like it's all my fault"
	Fear of the future	"Will I ever be able to finish school?...I used to think I'd never work again, but now I'm trying part time jobs"
Coping mechanisms	Support from family and friends	"My sister checks in every day…it keeps me going…I have one friend who just gets it, and that means everything"
	Religion and spirituality	"I pray for strength every morning…it keeps me hopeful…church helps me feel like I belong"
	Use of professional support	"The medication helps me stay balanced…my therapist makes me feel like I'm in control again"
Stigma and discrimination	Community perceptions	"People still call me mad for going to hospital…some attitudes have changed since health workers came"
	Internalised stigma	"Sometimes I believe maybe I am broken…I try to remind myself it's just like diabetes or asthma"
	Advocacy and resistance	"I speak up in church so people understand better…I tell people it's not a curse…it's just an illness"
Barriers and suggestions for improved care	Accessibility issues	"Transport is too expensive to go regularly…the community nurse visiting made it a lot easier"
	Community awareness campaigns	"Now some people ask questions instead of judging… education programmes in villages really help"
	Youth-specific services	"The youth group sessions made me feel safe…we need more spaces for young people to talk without feeling judged"

> *There are days I feel okay with myself, but other times, I still feel like I'm broken. It takes work to keep going (P3, male, 23 years, schizoaffective disorder, second interview).*

Such reflections demonstrate how time, education and empathetic care enabled some young people to redefine their mental illness not as a life sentence, but as a part of who they were, deserving of understanding rather than judgement.

4.2. Emotional and Social Struggles

4.2.1. Loneliness and Isolation. Many participants described a profound sense of isolation that permeated their daily lives. This loneliness was not just about being physically alone; it reflected an emotional disconnection from friends, family and broader society. The stigma attached to mental illness in their communities intensified this experience, making it difficult for participants to maintain social bonds or feel truly understood.

> *It's like I live in a different world from everyone else. No one wants to be close to someone like me (P15, female, 29 years, bipolar disorder, Interview 1).*

For younger participants, particularly adolescents, this disconnection was compounded by disrupted peer relationships and school attendance. The sense of being forgotten or left behind by peers emerged repeatedly.

> *At first, my friends would call to check on me, but after some time, they stopped. It felt like they moved on without me (P4, male, 16 years, generalised anxiety disorder, Interview 1).*

Hospitalisation or periods of relapse often led to further withdrawal and reinforced feelings of exclusion. Some participants reported a slow rebuilding of their social connections during recovery, made possible by therapy or group support initiatives.

> *After I started therapy, I felt more confident to reach out to my friends again, and some of them were willing to reconnect (P15, female, 29 years, bipolar disorder, Interview 3).*

This shift towards re-engagement underscores the need for community and therapeutic efforts to prioritise social reintegration as a key component of mental health recovery.

4.2.2. Strained Family Relationships. The family environment often mirrored the confusion and stigma surrounding mental illness in wider society. Participants spoke of being misunderstood, judged or seen as burdens by their families. Misinterpretations of symptoms as laziness or defiance were common, especially at earlier stages of diagnosis.

> *My family thinks I'm just being difficult or lazy. They don't understand that I can't control this (P7, male, 17 years, depression, Interview 1).*

This emotional strain worked both ways. Whilst families struggled to cope with their loved one's condition, participants themselves internalised guilt and hesitated to express their needs. In particular, watching their parents or siblings suffer emotionally often silenced them.

> *When my mom cries about my condition, I feel like it's all my fault. It makes me not want to talk to her about how I feel (P2, female, 26 years, bipolar affective disorder, Interview 2).*

Despite these difficulties, some relationships improved over time, especially when families participated in psychoeducation sessions or attended clinic visits. These changes, however, were not uniform and depended on the availability of supportive interventions.

4.2.3. Fear of the Future. A consistent thread running through the participants' narratives was anxiety about the future. This fear extended across domains education, employment, relationships and social acceptance. Many felt their dreams had become distant or even unattainable due to the unpredictability of their mental health.

> *Sometimes, I wonder if I'll ever finish school or get a job. It's like my dreams are slipping away (P1, female, 28 years, major depressive disorder, Interview 1).*

These fears were amplified by societal barriers. Participants believed that even with treatment, societal prejudice would prevent them from fully participating in public life. Yet some began to challenge this narrative over time by focusing on incremental goals and regaining confidence through therapeutic or occupational support.

> *I used to think I'd never work again, but now I'm starting with part-time jobs to see how it goes (P8, male, 21 years, major depressive disorder, Interview 3).*

The evolution in these stories suggests that hope and planning for the future can be restored with sustained care, but such progress remains vulnerable to external stigma and structural inequality

4.3. Coping Mechanisms

4.3.1. Support From Family and Friends. Social support from family and close friends emerged as a key protective factor, although its availability and consistency varied significantly. Some participants described initially strained relationships with family members, which improved over time with education and experience.

> *At first, my mum thought I was just being lazy, but after attending a session with my doctor, she started to understand more. Now she helps me a lot (P2, female, 26 years, bipolar disorder, second interview).*

Others noted the presence of a single trusted friend or sibling who remained a consistent source of support and understanding:

> *I have one friend who never makes me feel different. She's the only one I can talk to about everything (P14, male, 23 years, major depressive disorder, first interview).*

As the study progressed, participants who experienced ongoing support from loved ones reported improved emotional stability and a stronger sense of belonging. For those lacking support, feelings of isolation often persisted, underscoring the unevenness in social resources across contexts.

4.3.2. Religion and Spirituality. Faith and spirituality were central coping mechanisms for many participants, offering a sense of hope and continuity during episodes of distress. Religious belief often shaped how participants interpreted their illness and recovery process.

> *Every morning, I pray for strength. It's the only thing that gives me hope when things get hard (P5, male, 15 years, schizophrenia, first interview).*
>
> *I used to think God was angry with me, but now I believe He's giving me strength to overcome this (P10, male, 28 years, bipolar disorder, third interview).*

Several participants reported finding solace and acceptance in faith communities, where church gatherings and spiritual leaders offered moral and emotional support, particularly in the absence of formal mental health care. Others acknowledged a shift in their religious interpretations over time, reframing their illness from a divine punishment to a spiritual challenge.

4.3.3. Use of Professional Support. Accessing professional mental health services was viewed by participants as essential, yet experiences varied depending on resource availability and the quality of interaction with care providers. Most participants recognised the benefits of therapy and medication in stabilising their symptoms.

> *The medication has really helped me. It's not perfect, but it makes things easier to manage (P2, female, 26 years, bipolar disorder, third interview).*

Positive therapeutic relationships often provided participants with a space for reflection and guidance, improving their self-management and confidence.

> *The therapist helps me understand myself better. When I talk, I feel lighter (P6, female, 22 years, bipolar disorder, second interview).*

However, some participants encountered gaps in care, including infrequent appointments and long wait times. Despite these challenges, those who maintained regular contact with mental health professionals reported feeling more hopeful and in control of their conditions. Their narratives underscored the vital need for consistent, youth-friendly and affordable mental health services.

4.4. Stigma and Discrimination

4.4.1. Community Perceptions. Stigma in the community remained one of the most deeply felt challenges for participants, shaping not just how they saw themselves, but whether they felt safe enough to seek or continue treatment. Many described their communities as intolerant or misinformed, where mental illness was viewed as madness or a curse. These perceptions fuelled silence and shame, particularly in the early stages of their mental health journey.

> *In my village, if you go to a psychiatric hospital, people will say you're mad forever. That's why so many people hide their problems (P13, male, 26, schizophrenia, Interview 1).*

The consequences of this community judgement were not just emotional but practical. Several participants delayed or avoided care entirely out of fear of being labelled. Yet, over time, some participants began to notice subtle shifts in these attitudes, especially where outreach programmes or mental health awareness campaigns had taken place.

> *Before, people in my area used to cross the street when they saw me. But now, after the health workers came and spoke at the market square, a few neighbours actually greet me (P16, female, 28, depression with anxiety, Interview 2).*

This evolving dynamic illustrates how social attitudes are not fixed and can be influenced through deliberate education and visibility.

4.4.2. Internalised Stigma. The stigma from others did not just stop at the community gate; it seeped inward. Many participants internalised the shame and stereotypes they encountered, often blaming themselves or seeing their condition as a personal weakness. These internal narratives, though silent, were powerful in shaping how they approached recovery, relationships and even their self-worth.

> *Sometimes, I think maybe they're right maybe I am weak or broken. It's hard to fight those thoughts, even when I'm feeling better (P11, male, 30, PTSD, Interview 1).*

For some, the early stages of treatment did little to shake these feelings. Yet, as therapy and support progressed, a few began challenging this self-stigma. Exposure to new ways of thinking, especially through professional care, allowed participants to reframe their mental illness as a health issue rather than a moral failing.

> *I used to feel so ashamed, like I was dirty or cursed. But my therapist explained that it's just like having diabetes or asthma. That's helped me speak kinder to myself (P3, male, 23, schizoaffective disorder, Interview 2).*

Even so, the journey was rarely straightforward. Participants described oscillating between moments of self-compassion and relapse into shame, reinforcing the need for ongoing psychological support.

4.4.3. Advocacy and Resistance. Despite their own struggles, a number of participants found strength in speaking up, not only for themselves but also for others facing similar challenges. This advocacy was often born out of frustration and the desire to break cycles of ignorance and fear. Some began sharing their experiences in public forums, churches or informal conversations as a way to humanise mental illness.

> *At church, I spoke during a youth fellowship meeting. I told them I had bipolar, and that I still pray, still laugh, still live. Afterwards, two people came to thank me…they didn't know mental illness could look like me (P10, male, 28, bipolar affective disorder, Interview 2).*

These acts of resistance were not always met with acceptance, and some faced ridicule or dismissal. Still, many persisted, finding a sense of empowerment in reclaiming their narratives.

> *I started talking to my neighbours about what I've been through. Not all of them listened, but one woman said she now takes her daughter to the clinic. That felt good (P16, female, 28, depression with anxiety, Interview 3).*

For these participants, advocacy became more than just education—it was a way to heal, to challenge stigma and to build a more inclusive sense of self.

4.5. Barriers and Suggestions for Improved Care

4.5.1. Accessibility Issues. Access to mental health care was a recurring challenge across participants' narratives. Financial hardship, distance from the hospital and inconsistent availability of services left many feeling stuck and unsupported. For several participants, simply reaching the hospital was an ordeal that sometimes delayed their care for weeks or months.

> *Transport to the hospital is expensive, and sometimes I don't have the money to go. It makes everything harder (P9, male, 27, schizophrenia, Interview 1).*

This struggle was especially burdensome for those living in rural or semirural areas, where public transport was limited or nonexistent. The result was missed appointments, interrupted medication and heightened anxiety about relapse. Some participants resorted to irregular, self-managed routines due to the high cost and logistical strain of accessing consistent care.

> *Even after years of trying to get help, the hospital is still far. I have to wait until someone in my family can give me money or a lift (P14, male, 23, major depressive disorder, Interview 2).*

Yet there were signs of incremental progress. In a few locations, community outreach efforts had begun, offering mobile clinics or mental health check-ins closer to home. For some, this made a tangible difference.

> *Recently, a community nurse started coming to my area, and that has made things a bit easier. At least now I can talk to someone when I need to (P8, male, 21, major depressive disorder, Interview 3).*

These examples highlight how structural improvements however small can have meaningful impacts on continuity of care.

4.5.2. Community Awareness Campaigns. Participants consistently expressed that one of the most important ways to improve mental health care was to educate the public. For many, the burden of stigma was heavier than the illness itself, and they believed awareness campaigns could reshape perceptions and encourage earlier help-seeking.

> *If people understood mental illness better, maybe they would stop judging and start helping. Awareness is so important (P4, male, 16, generalised anxiety disorder, Interview 2).*

Encouragingly, several participants shared examples of how outreach programmes had helped shift community attitudes. Health worker visits, school talks and church discussions were all mentioned as strategies that slowly chipped away at long held taboos.

> *At first, people in my village used to call anyone who went to the psychiatric hospital 'mad', but now they are starting to see it differently after the health workers talked to them (P16, female, 28, depression with anxiety, Interview 2).*

In some cases, participants themselves contributed to these shifts by sharing their own experiences publicly. Doing so not only helped others but gave them a renewed sense of purpose.

> *I started talking openly about my illness at church meetings. I think people are listening now, and they ask questions instead of judging… (P10, male, 28, bipolar affective disorder, Interview 3).*

These moments reveal the transformative power of visibility and lived experience in fostering more compassionate communities.

4.5.3. Youth-Specific Services. A clear need emerged for mental health services designed specifically with young people in mind. Participants frequently said that existing programmes were either too generic, too formal or failed to address their age-specific concerns around school, identity and social connection.

> *We need places where young people can talk without feeling judged. A support group would make a big difference (P3, male, 23, schizoaffective disorder, Interview 1).*

The few who had experienced youth-focused services, whether through peer-led groups or targeted therapy sessions, described them as a lifeline. These services offered a rare space where participants felt understood, heard and supported without condescension.

> *I joined a programme where other young people like me talked about their experiences. It made me feel less alone and more hopeful (P6, female, 22, bipolar affective disorder, Interview 2).*

Participants also highlighted the importance of making these services consistent, inclusive and safe somewhere they could return to without fear of judgement or abandonment.

They wanted more than just clinical care; they wanted community, belonging and opportunity.

5. Discussion

The findings from this study provide a nuanced understanding of the lived experiences of adolescents and young adults with mental illness, highlighting the interplay between societal context, personal struggles and systemic barriers. Capturing participants' narratives across different stages of recovery and including their mental health diagnoses enables this study to offer a diagnosis sensitive, time-aware perspective on how young people make sense of mental illness in a stigmatising environment. Participants' perceptions of their mental illness were deeply influenced by societal and cultural narratives, often framing mental health conditions as abnormalities or spiritual punishments. This aligns with studies showing that in LMICs, traditional beliefs about mental illness frequently attribute conditions to supernatural forces or moral failings, perpetuating stigma and exclusion [1, 28]. Such narratives reinforce internalised stigma, contributing to feelings of shame, isolation and helplessness, which were evident in participants' accounts. However, the longitudinal nature of this research reveals an evolution in perceptions, with exposure to medical explanations and health care interventions challenging some of these misconceptions. This time-sensitive shift in understanding, particularly amongst participants with conditions such as schizophrenia and bipolar disorder, demonstrates how therapeutic encounters can reframe stigma as treatable illness. This contributes to the literature by illustrating the potential of longitudinal designs to capture dynamic changes in stigma and understanding over time, a gap in cross-sectional studies [29, 30].

Shame and embarrassment emerged as significant barriers to seeking and maintaining mental health care. Participants avoided public spaces and social interactions to escape judgement, whilst visible side effects of treatment, such as drowsiness or involuntary movements, exacerbated their discomfort; the current study's use of repeated interviews across different phases revealed how self-acceptance was not a linear process but evolved through episodic gains and losses. These findings resonate with research highlighting the role of public stigma in discouraging treatment adherence and participation [30, 31]. Notably, the persistence of these experiences over time, as revealed by the longitudinal approach, underscores the enduring nature of stigma and the need for integrated stigma-reduction interventions. This study contributes by demonstrating how stigma intersects with treatment-related factors, adding depth to existing frameworks on barriers to care.

Despite these challenges, some participants described their journey towards self-acceptance as a transformative process. Therapy, self-reflection and supportive relationships facilitated this change, highlighting the importance of psychosocial interventions in fostering recovery [32, 33]. Whilst previous research has underscored the role of therapeutic alliances in promoting self-acceptance, this study's longitudinal findings reveal the nonlinear nature of this process, marked by setbacks and progress over time. By capturing this complexity, the study contributes to a deeper understanding of the pathways to resilience and self-compassion amongst individuals with mental illness.

Emotional and social struggles were deeply intertwined with participants' mental health trajectories. Loneliness and isolation were particularly profound for adolescents, whose disrupted social connections exacerbated feelings of abandonment. These findings align with previous research highlighting the isolating effects of mental illness on young people [34]. However, the longitudinal design of this study reveals how social reintegration is possible through sustained therapy and access to support networks. The recovery of social confidence was notably evident amongst participants whose narratives spanned multiple timepoints, allowing for a richer appreciation of how therapeutic interventions, family reconciliation and peer support influenced re-engagement over time. This contrasts with cross-sectional studies that often fail to capture the gradual rebuilding of relationships, contributing novel insights into the dynamic interplay between mental health and social reintegration [35].

Family relationships played a dual role in participants' experiences, acting as both sources of support and strain. Participants who felt misunderstood or burdensome described strained family dynamics, consistent with research noting the emotional toll of caregiving for mental health conditions [36]. Conversely, family members who provided empathetic and practical support significantly improved participants' well-being, reinforcing the importance of family psychoeducation programmes to enhance understanding and reduce conflict [37]. This study builds on existing literature by highlighting how family dynamics evolve over time, influenced by external interventions and individual recovery trajectories. The study further contributes by showing how shifts in family dynamics were observed in participants with conditions such as bipolar disorder and PTSD across second and third interviews, reflecting the impact of clinical engagement on household perceptions.

Participants expressed significant anxiety about their futures, with fears about completing education, finding employment and forming relationships. These concerns were compounded by societal stigma and systemic barriers, aligning with research on the structural challenges faced by individuals with mental illness [38]. However, those who accessed consistent therapy or supportive networks were able to reframe these fears into smaller, more achievable goals, a process less frequently documented in existing studies. Notably, younger participants with generalised anxiety disorder and depression demonstrated increased future orientation in later interviews, highlighting the role of youth-specific interventions in building hope. This study highlights the importance of vocational training, educational support and policies aimed at reducing discrimination, contributing actionable insights to address structural barriers.

Coping mechanisms varied, with participants highlighting the critical role of family and friends in providing emotional resilience. Supportive relationships were crucial in mitigating the impacts of stigma, consistent with previous studies emphasising the importance of social support in fostering recovery [32]. Religion and spirituality also emerged as significant coping mechanisms, offering emotional strength and a sense of purpose. These findings resonate with research identifying spirituality as a protective factor in mental health. The evolving nature of spiritual coping where participants moved from viewing illness as punishment to interpreting it as a personal challenge was particularly pronounced amongst those with bipolar and depressive disorders, indicating a shift in meaning making over time. This study adds to the literature by illustrating how spirituality evolves over time and interacts with cultural and individual contexts to provide a framework for resilience.

Access to professional care was described as essential for participants' coping, with positive health care experiences enhancing stability and self-management. However, significant gaps in service delivery, including inconsistent follow-up and financial constraints, were persistent barriers. These findings mirror existing research emphasising disparities in mental health service access in LMICs [28, 29]. What distinguishes this study is its detailed tracking of these barriers across different timepoints and diagnoses, highlighting how challenges such as medication availability or transportation remain unchanged for some, whilst others experience improvement through community nurse outreach. This study's contribution lies in its detailed exploration of how these barriers evolve and interact with participants' lived experiences, offering a nuanced understanding of the systemic challenges in mental health care.

Stigma and discrimination were pervasive, shaping participants' interactions with communities and influencing their willingness to seek help. Community attitudes, often rooted in misconceptions, discouraged help-seeking behaviour, consistent with previous findings [31]. However, the longitudinal design revealed gradual shifts in attitudes in communities exposed to mental health awareness campaigns, underscoring the potential of sustained public education to reduce stigma. The change was especially evident amongst participants who themselves became advocates by their third interview, suggesting a link between personal empowerment and community level change. This finding contributes to the literature by demonstrating the effectiveness of targeted advocacy efforts in transforming societal perceptions over time. Some participants resisted stigma by advocating for greater understanding within their communities, using their experiences to challenge misconceptions. This advocacy emerged not spontaneously but as a cumulative outcome of therapy, family support and increased mental health literacy, particularly amongst participants with PTSD and depression. These efforts were empowering and contributed to changing community attitudes, aligning with research on the transformative potential of lived experience [30, 31]. This was especially true for adolescents with anxiety and mood disorders, who described peer-led spaces as safer and more engaging than general adult programmes. This study highlights the importance of supporting such advocacy efforts through training and platforms, amplifying their impact and fostering systemic change.

Barriers to care were a recurring theme, particularly for those in rural areas or with limited financial resources. Participants emphasised the need for youth-specific mental health services tailored to their unique needs. Group therapy and peer-led programmes emerged as particularly effective, echoing findings on the importance of youth-focused interventions [35]. This study contributes by highlighting the role of longitudinal approaches in capturing the sustained benefits of such programmes and the critical need for their integration into existing health systems.

Whilst the use of IPA provided rich, in-depth insights into the subjective experiences of stigma amongst young people, the absence of standardised quantitative measures represents a methodological consideration. Incorporating validated stigma scales, such as the Stigma and Self-Stigma Scales [16], could offer complementary data, allowing for broader comparison and quantification of stigma experiences. Future research could build on this study by adopting a mixed methods approach, integrating phenomenological inquiry with standardised instruments to enrich understanding and enhance the generalisability of findings.

5.1. Strengths and Limitations.

This study's longitudinal design was a key strength, enabling the exploration of how participants' experiences and perceptions of mental illness evolved over time. Unlike cross-sectional studies, this approach provided insights into the dynamic interplay between societal stigma, personal coping mechanisms and systemic barriers [29, 30]. Conducted in a resource-limited setting in southeastern Nigeria, the research addressed a significant gap in understanding mental health challenges in LMICs [1]. Its culturally relevant findings offer practical implications for tailored interventions in similar contexts.

The use of in-depth interviews and a phenomenological framework captured participants' lived experiences authentically, with verbatim quotes enhancing the richness and credibility of the data. The holistic exploration of societal, familial, emotional and systemic dimensions of mental illness added depth, providing a comprehensive understanding of the challenges faced by adolescents and young adults. Additionally, the study shed light on participants' advocacy efforts, contributing unique perspectives on stigma resistance and community education [31].

One limitation of the study is the absence of standardised quantitative measures of stigma, such as those developed in recent literature [16]. Whilst the IPA approach provided rich, in-depth insights into the subjective experiences of stigma, the use of a validated scale could have allowed for a more structured assessment and potential comparison across participants. Integrating standardised measures in future studies may enhance the generalisability of findings and provide complementary data alongside qualitative narratives. This would support a more comprehensive understanding of the complexity of stigma amongst adolescents and young adults with mental illness.

Despite its strengths, the study's small, purposively sampled group limits the generalisability of findings to broader populations. Conducting the research in a single psychiatric facility also restricted its transferability to other regions or health care settings. Furthermore, self-reported data, whilst valuable for capturing subjective experiences, may be influenced by recall or social desirability biases, potentially affecting the reliability of some findings.

The underrepresentation of younger adolescents was another limitation, as their unique developmental and social challenges were not fully explored. Whilst the 9-month data collection period provided longitudinal insights, a longer follow-up could have revealed more nuanced shifts in participants' experiences and societal attitudes. Ethical constraints, such as ensuring anonymity and safeguarding participants' well-being, also restricted the use of observational methods, which could have enriched contextual understanding [37–42].

Whilst diagnostic information was included to provide context to participants' experiences, caution must be exercised in interpreting these labels. Diagnoses were based on participants' self-report or hospital records and may not reflect full psychiatric assessment histories. Furthermore, ethical considerations required avoiding overly detailed psychiatric profiling to preserve participants' dignity and privacy, particularly given the vulnerability of the population. Whilst reflexive practices were employed to minimise researcher bias, including regular self-reflection and peer debriefing to address internalised stigma, it is acknowledged that complete elimination of researcher subjectivity is not possible in qualitative research. This limitation is inherent to interpretative methodologies and underscores the importance of transparency and critical reflexivity throughout the research process.

5.2. Implications for Practice. The study findings call for targeted interventions that address the dynamic interplay between societal context, individual struggles and systemic barriers. Mental health practitioners should prioritise community-integrated approaches that simultaneously reduce stigma and promote awareness of mental health conditions. For example, culturally tailored psychoeducation programmes could be delivered through faith-based organisations, schools and community health centres to challenge misconceptions and encourage help-seeking behaviours. These efforts must also extend to reducing the visible stigma associated with medication side effects, which discourage treatment adherence.

Given the critical role of family dynamics in shaping participants' experiences, family-focused interventions should be embedded in mental health care. Structured psychoeducation workshops that involve families can improve their understanding of mental illness and equip them with strategies to provide effective support whilst reducing the burden of caregiving. Such programmes should also address emotional responses like frustration and guilt to foster healthier family relationships and long-term recovery. To meet the unique needs of adolescents and young adults, mental health services must develop age-appropriate, youth-focused programmes. Safe spaces for peer-led discussions, youth group therapies and mentorship initiatives could help reduce the isolation and stigma experienced by this demographic. Importantly, these services should also address their fears about the future by integrating vocational training, educational support and career counselling into therapeutic frameworks.

The study also underscores the urgency of addressing barriers to accessibility. Expanding decentralised mental health services, including mobile outreach clinics and community health workers trained in basic mental health care, can significantly improve service delivery in underserved areas. Furthermore, collaboration with policymakers is essential to allocate funding for subsidised mental health care, ensuring affordability for low-income populations.

5.3. Implications for Research. Future research should build on the longitudinal design of this study to further explore the evolving interplay between societal stigma, personal coping mechanisms and systemic interventions. Expanding this approach to include multiple sites and cultural contexts would provide comparative insights and deepen understanding of how regional and cultural differences shape mental health experiences.

Research should also prioritise the development and evaluation of multilevel interventions that address stigma at the individual, family and community levels. Mixed methods studies could assess the impact of community awareness campaigns, family psychoeducation and youth-specific programmes on treatment adherence and social reintegration over time. Additionally, integrating validated stigma scales into future studies could facilitate the quantification of stigma levels and allow for comparisons across demographic groups, enhancing the robustness of findings alongside qualitative insight.

A deeper focus on the role of advocacy is warranted, particularly in understanding how individuals with lived experience can influence community attitudes and systemic change. Research could explore how training and empowering these individuals enhance their effectiveness as agents of stigma reduction and policy advocacy. Additionally, longitudinal studies that track the outcomes of advocacy efforts could provide valuable insights into their sustainability and broader societal impact.

Finally, there is a need for research into structural barriers to mental health care, particularly in resource-limited settings. Studies could examine the feasibility and scalability of decentralised models of care, as well as the impact of subsidised mental health services on access and outcomes. This would inform policies aimed at reducing inequities in mental health service delivery, especially for marginalised and underserved populations.

6. Conclusion

This study provides critical insights into the lived experiences of adolescents and young adults with mental illness in a resource-limited setting, highlighting the complex interplay between societal stigma, individual struggles and systemic barriers. The findings highlight the pervasive influence of cultural beliefs and societal misconceptions in shaping perceptions of mental illness, contributing to internalised stigma, social isolation and barriers to care. However, the longitudinal design of the study revealed the potential for change, as some participants redefined their understanding of mental illness and navigated pathways towards self-acceptance, resilience and advocacy.

The study emphasises the importance of addressing stigma at multiple levels, integrating culturally sensitive psychoeducation, family-focused interventions and community-based awareness campaigns. Strengthening youth-specific mental health services and improving accessibility through decentralised and community-integrated care models are critical steps towards reducing disparities in mental health care. Additionally, empowering individuals with lived experience to serve as advocates can foster societal change and promote inclusive mental health systems.

From a research perspective, this study contributes to the growing body of evidence on the dynamic and evolving nature of mental health experiences, particularly in LMICs. Future studies should build on this work by expanding longitudinal designs across diverse contexts, exploring the effectiveness of multilevel interventions and addressing structural barriers to care. By recognising and responding to the multidimensional challenges faced by young people with mental illness, mental health systems can foster recovery, resilience and dignity. The findings of this study provide a foundation for actionable strategies that bridge the gaps in understanding, support and service delivery, paving the way for a more inclusive and equitable approach to mental health care.

Nomenclature

IPA	interpretative phenomenological analysis
LMICs	low- and middle-income countries
NMC	Nigerian mental health care
REC	Research Ethics Committee
WHO	World Health Organisation

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

Ethics Statement

Ethical approval for this study was granted by the Research Ethics Committee of the psychiatric hospital (ethics approval number: FNHE/HTR/REA/Vol 11/283). Written informed consent was obtained from all participants, with additional assent and guardian consent for participants aged 15–17 years. Participants were informed about the purpose of the study, their right to withdraw at any time and the intended publication of results.

Consent

Written informed consent was obtained from all participants for the publication of anonymised data.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

A.N. conceptualised the study and led the design, data collection, analysis and manuscript drafting. A.N. conducted the interviews, developed the coding framework and interpreted the findings in alignment with the study's objectives. A.N. also took the lead in revising the manuscript to incorporate reviewers' comments and ensuring the alignment of the study with the journal's guidelines. J.O. contributed to the study's conceptualisation, provided critical input in refining the methodological framework and supported the thematic analysis process. J.O. reviewed and provided feedback on the manuscript drafts, ensuring the interpretation of findings reflected the broader implications for mental health research and practice. J.O. facilitated access to participants and oversaw the ethical compliance of the study. Both authors read and approved the final manuscript and agree to be accountable for all aspects of the work, ensuring accuracy and integrity.

Funding

No funding was received for this manuscript.

Acknowledgments

We thank all the participants for sharing their experiences and the staff of the psychiatric hospital for their support during this study. We also appreciate the contributions of colleagues who provided feedback on this work.

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