Academic World Journal
Business and Finance
Journal Home Page: www.academicworld.co.uk

Investigating Societal Attitudes and Barriers to Mental Health Services in Nigeria

Promise A. Chima and Charles C. Onichakwe
Department of General Studies, Federal Polytechnic Ukana, Akwa Ibom State.

ABSTRACT

Mental health disorders are a significant public health concern in Nigeria, yet the uptake of mental health services remains critically low. This study examines how cultural stigma, healthcare infrastructure challenges, policy gaps, and accessibility issues contribute to barriers in mental health service utilization. A mixed-methods approach was employed, including a quantitative survey of 600 adults across diverse regions, in-depth qualitative interviews, and comparative case studies of urban and rural contexts. Survey findings suggested massive negative attitudes about mental illness, along with many barriers to care; for instance, a majority of respondents cited social stigma and fear of discrimination as significant hindrances to accessing treatment. Qualitative interviews offered contextual information with themes around common misunderstandings (i.e. attributing mental illness to spiritual causes), general distrust in healthcare institutions, and economic hardship. The urban-rural case comparison showed glaring inequalities in service availability and cultural perceptions. These findings indicate an urgent need for comprehensive interventions, from public anti-stigma campaigns to policy reforms that integrate mental health into primary care. The study provides evidence-based recommendations to make mental health services more accessible in Nigeria and similar contexts by showing how societal attitudes and systemic hindrances interact.

Keywords: Adults. Societal, Attitudes, Barriers to Mental Health

1. INTRODUCTION

Over the past decades, mental health is in the limelight as an emerging critical area of global public health concern with an additional reference site in low- and middle-income countries (LMICs), like Nigeria. The population of people living with a mental disorder worldwide reaches nearly one billion, according to the World Health Organization (WHO, 2022), with most of them in LMICs. These health systems are typically under-resourced and fragmented. As Nigeria's populace swells at a relatively high rate, it possesses a diverse sociocultural background, and the combination of these two phenomena has given rise to historically, structurally, and socially complicated mental health issues faced by Nigerians (Gureje et al., 2020; Olagunju et al., 2018). Recent studies indicate that there is a high prevalence of mental health disorders across all the regions of Nigeria, yet extremely low service utilization. It is estimated that between 20 and 25% of Nigerians suffer from some form of mental illness during their lifetime (WHO-AIMS Nigeria, 2022); it is noted that fewer than 10% of these affected individuals have ever accessed evidence-based treatment (Gureje et al., 2015; Ogunsemi et al., 2010). The treatment gap is attributed not only to the scarcity of mental health professionals (fewer than 300 psychiatrists serving a population of more than 200 million) but also to sociocultural stigma, limited awareness, and systemic neglect (Jack-Ide et al., 2013; Abayomi & Adelufosi, 2016).

Sociological and postcolonial theories offer critical insights into these disparities. From a sociological perspective, labeling theory (Scheff, 1966) and the medicalization of deviance (Conrad & Schneider, 1980) illuminate how mental illness is framed within society and how stigma is socially reproduced. Labeling individuals as mentally ill can lead to stereotyping, marginalization, and exclusion, which are

compounded by institutional failures and public misconceptions (Corrigan & Watson, 2002; Angermeyer & Dietrich, 2006). In Nigeria, stigma manifests in multifaceted ways—ranging from community ostracization to denial of basic rights—and deeply affects help-seeking behavior (Adewuya & Makanjuola, 2008; Ohaeri, 2007).

Postcolonial theory is much aided, as brought out by Spivak (1988) and Bhabha (1994), in looking at the epistemic and cultural dimensions of access to mental health. The subaltern is a term that makes clear how the margin is often cut out of a dominant discourse and a system of knowledge by Spivak. In Nigeria, such individuals are rendered invisible or pathologized by a healthcare system rooted in Western biomedical paradigms and woefully lacking in indigenous idioms of illness (Jegede, 2009; Okpaku, 2014). Schizophrenia and the 'third space' belong to Bhabha's constructions of a hybrid phenomenon and are equally valuable in translating the instances of how Nigerians navigate between traditional, spiritual and biomedical systems in their care-seeking (Ogunlesi & Ogunwale, 2012; Oyekan, 2020). Co-existing competing worldviews create contradictions and opportunities for culturally adapted interventions (Atilola, 2015; Adefolarin & Aloba, 2021). Studies propound that socio-cultural beliefs play a role central to the decision-making concerning mental health in Nigeria. Cause of mental illness is often associated with witchcraft, curses or punishment from ancestors in traditional beliefs (Gureje et al., 2010; Atilola, 2012). These make many individuals visit spiritual healers or faith-based organizations for care instead of going to formal mental health facilities (Abiodun, 1995; Aghukwa, 2010). A qualitative study conducted by Ogueji et al. (2021) indicated that even when people had knowledge about psychiatric services, the fear of being stigmatized by their families often deterred them from seeking help. These are made worse by gender norms and patriarchal structures which inhibit women's autonomy over their right to health services (Uwakwe & Okonkwo, 2013; Salami et al., 2015).

The structure of mental health services in Nigeria revolves largely in tertiary institutions, leaving little coverage into primary health care (PHC) systems (Gureje & Lasebikan, 2006; Eaton et al. 2011). Most of the greater numbers that occupy the rural communities remain underserved likely due to poor infrastructure and workforce shortages (Adejumo, 2011; Olagunju et al., 2018). Although the passage in 2023 of the Nigerian Mental Health Act signifies a change in policy, it is unclear, however, how this will translate into practice, resource provision and enforcement (Federal Ministry of Health, 2023). In addition, there further contribute to enhancing treatment inequalities the fact that no community-based psychosocial interventions are available (Jack-Ide & Uys, 2013; Oladeji et al., 2020).Further analysis establishes that socioeconomic status, educational attainment, and urbanization are some of the causes of mental health incidence and their reflection on service utilization. The higher the education level of an individual, the easier it becomes to notice symptoms of mental illness and seek care (Adewuya et al., 2007; Ebigbo, 2012). All these foster enhanced mental health outcomes, while limiting access to care. Contrary to that, these are poverty, unemployment, and housing insecurity (Okasha et al., 2012; Saraceno et al., 2007).

The recent literature stresses the significance of applying curricula to mental health education, community awareness, and the training of non-specialist service providers in the context of mhGAP from the WHO (WHO, 2010; Gureje et al., 2015). Some of these approaches are promising with regard to task-shifting models that increase access while maintaining quality (Patel et al., 2011; Okeafor & Aloba, 2022).

The present study investigates prevalent societal attitudes and systemic barriers that mediate access to mental health services in Nigeria. We intend to interrogate these cultural, structural, and individual dynamics, which shape perceptions of mental illness and service utilization patterns, through a mixed-methods design. This study serves as a contribution to the growing field of African literature that is calling for culturally relevant, equitable, and community-based models of mental healthcare.

This investigation will empower the voices of the mental health service users and challenge the existing rhetoric in the global mental health discourse, which largely ignores local knowledge systems and realities of life. This study responds to an urgent call for contextually tempered evidence to guide the impending reforms in policy and implementation geared toward closing the wide Nigeria mental health treatment gap.

2. METHODOLOGY

The present study had a mixed-methods design, which combined quantitative survey data with qualitative interviews and comparative case studies to gain a broad-based understanding of societal attitudes toward mental health and barriers to service access in Nigeria. Mixed methods are considered useful for various sorts of complex health issues having cultural and structural dimensions (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 2003).

2.1. Study Design

A convergent parallel design was used, allowing simultaneous collection and integration of quantitative and qualitative data (Bryman, 2006; Fetters et al., 2013). Ethical clearance was obtained from the Health Research Ethics Committee of a Nigerian university teaching hospital (Protocol No. 2023/045), in line with the Declaration of Helsinki (World Medical Association, 2013). Written or verbal informed consent was secured from all participants. Rigorous ethical standards were maintained throughout the study, including anonymity, confidentiality, and the right to withdraw.

2.2. Survey Sample and Data Collection

The quantitative component used a cross-sectional household survey. A multistage sampling strategy ensured geographic, cultural, and urban-rural diversity across three geopolitical zones (Southwest, Southeast, and North-Central). Purposive selection of three states was followed by random sampling of

LGAs, communities, and households (Israel, 1992; Babbie, 2016). One eligible respondent per household (age ≥18) was interviewed. A total of 512 valid responses were analyzed (response rate ~85%). The survey instrument, adapted from previous validated scales on stigma and help-seeking (Link et al., 1999; Thornicroft et al., 2009), was pre-tested and culturally adapted through back-translation procedures (Brislin, 1970). It included sections on socio-demographics, mental illness beliefs, stigma attitudes (Likert-based), and barriers to care. Local languages (Hausa, Yoruba, Igbo) were used where appropriate, administered by trained research assistants (Cohen & Crabtree, 2006).

2.3. Qualitative Interviews and Case Studies

Semi-structured interviews were conducted with a purposive subsample of 30 participants, including community members, caregivers, and healthcare professionals. This approach enhances data triangulation and allows for rich narrative capture (Kvale & Brinkmann, 2009). Interviews explored culturally grounded perceptions of mental illness, care-seeking trajectories, and service gaps. Transcripts were anonymized and transcribed verbatim (Hammersley & Atkinson, 2007).

Two comparative case studies were selected to contextualize findings: (1) a low-income urban neighborhood with an active mental health outreach clinic and (2) a rural community with no formal services. The comparative logic follows Yin's (2009) methodology, facilitating insight into how context shapes access. Data collection included field observations, stakeholder interviews, and document analysis (Patton, 2015).

2.4. Data Analysis

Quantitative data were analyzed using SPSS v25. Descriptive statistics summarized trends; bivariate analyses (chi-square and t-tests) examined relationships between stigma, demographics, and help-seeking (Tabachnick & Fidell, 2013). Logistic regression identified predictors of formal care-seeking, controlling for socio-demographics and belief variables (Hosmer et al., 2013).

Qualitative data were analyzed thematically using NVivo 12, following Braun and Clarke's (2006) six-phase model. Codes were inductively derived and iteratively refined by two researchers. Intercoder agreement ensured reliability (Miles, Huberman & Saldaña, 2014). Themes were compared across data sources to assess consistency, divergence, and explanatory depth (Lincoln & Guba, 1985). The integration phase synthesized qualitative and quantitative results to generate comprehensive insights. Triangulation enabled corroboration of findings and enhanced the trustworthiness and credibility of interpretations (Denzin, 1978; Morse, 1991). Reflexive memos documented analytical decisions and researcher positionality throughout the process (Finlay, 2002).

3. RESULTS AND DISCUSSION

3.1 Quantitative Findings: Attitudes and Reported Barriers

The findings of this study provide comprehensive insights into the multifaceted sociocultural, economic, and structural challenges that shape perceptions of mental illness and access to mental health care in Nigeria. Rooted in theories such as Goffman's (1963) stigma theory, Kleinman's (1980) explanatory models, and Rosenstock's (1974) Health Belief Model, the results illuminate the persistent influence of stigma, traditional beliefs, and systemic inadequacies. The survey of 512 respondents revealed that although a majority of participants (70%) were familiar with someone affected by mental illness, deeply ingrained prejudices persist. Over 82% of respondents agreed with the stereotype that individuals with mental illness are dangerous. These results mirror the findings of Gureje et al. (2005) and Adewuya and Makanjuola (2008), who observed similarly high levels of discriminatory attitudes in Nigerian contexts. The prevalence of these attitudes underscores Goffman's (1963) notion of stigma as a social process that discredits and marginalizes individuals perceived as different.

In addition, survey data indicated that 75% of those surveyed were uncomfortable with mentally ill persons. This widespread craving for social distance bears out Corrigan and Watson's argument (2002) that stigma is largely disincentive for inclusion and thus perpetuates the social exclusion of persons with mental illness. Significant here is the fact that even though 32% of respondents agreed that mental illness could affect anyone, most of the rest held that consequences would ensue as a result of personal weakness, supernatural influence, or moral failing. This "othering" tendency, discussed by Yang et al. (2007), frames mental illness as an alien and threatening phenomenon instead of ordinary and treatable. Explanatory beliefs steeped in spiritualism were still much seen. Almost half of the total respondents attributed mental health conditions to supernatural causes, such as curses, witchcraft, and spiritual possession. Such beliefs echo that illness interpretations are socially constructed and culturally mediated, according to Kleinman (1980). Belief in spiritual causation might comfort the communities; however, it diverts individuals from biomedical attention as shown in similar findings by Ayorinde et al. (2016) and Ofori-Atta et al. (2010).

Help-seeking preferences reflected these cultural dynamics. When asked where they would first seek help for a serious mental health issue, 45% of participants indicated religious leaders, 26% preferred traditional healers, and only 29% selected medical professionals. These figures corroborate the findings of Gureje et al. (2015), who demonstrated that spiritual and indigenous healers are frequently the initial contact points for mental health crises in Nigeria. The reliance on non-biomedical care pathways supports the premise of pluralistic health-seeking behaviour in African societies (Murdock, 1980).

A closer look at the reported barriers revealed that stigma, reported by 68% of respondents, was the most significant factor discouraging formal care-seeking. This confirms Corrigan's (2004) assertion that public stigma, combined with self-stigma, functions as a critical barrier to accessing services. Additional barriers included financial cost (55%), limited awareness (50%), poor geographic access (45%), and perceived low quality of care (30%). These constraints resonate with the World Health Organization's (2013) mental health systems assessment, which identified similar impediments in low- and middle-income countries.

Table 1: ***Key Barriers to Mental Health Care (N = 512)***

Barrier	% Reporting as Major Barrier
Fear of stigma/social shame	68%
Financial cost of treatment	55%
Lack of awareness	50%
Geographic distance/no services	45%
Cultural preference for traditional care	40%
Perceived poor treatment in clinics	30%

3.2 Demographic Differences and Theoretical Alignment

The relationship between educational attainment and attitudes toward mental illness was statistically significant. Respondents with tertiary education showed lower levels of stigmatizing beliefs and a higher likelihood of opting for formal medical care. These findings support Rosenstock's (1974) Health Belief Model, which posits that knowledge and perceived benefit are essential in motivating health behaviour. Likewise, urban respondents demonstrated more favourable attitudes toward professional care than their rural counterparts, likely due to greater exposure to health messaging and more accessible services.

3.3 Qualitative Narratives and Cultural Dimensions

Qualitative interviews enriched the quantitative data, offering deeper insight into how stigma is experienced, internalized, and perpetuated. Narratives from individuals with mental illness and their caregivers illustrated the social cost of disclosure. Many interviewees concealed the condition of their loved ones to avoid shame, consistent with Goffman's concept of "courtesy stigma," whereby relatives of stigmatized individuals are themselves discredited. This self-imposed secrecy contributes to late presentation and poorer outcomes, reinforcing the cycle of marginalization.

The explanatory narratives surrounding mental illness were dominated by supernatural causality. Even in urban settings, respondents often combined biomedical and spiritual frameworks to explain symptoms. A secondary school teacher in Lagos attributed his relative's depression to both emotional trauma and possible "spiritual attack," exemplifying Kleinman's (1980) idea that illness is interpreted through multiple coexisting lenses. For many, spiritual remedies offered both cultural legitimacy and emotional reassurance, though they often delayed the initiation of evidence-based treatment.

3.4 Structural Constraints and Mistrust in Formal Systems

Besides the cost of psychiatric consultations, medications were some of the economic barriers that rural and low-income interviewees cited as reasons for not accessing care. According to interviewees, maintaining long-term pharmacotherapy was difficult without covering costs through subsidies or insurance. These challenges substantiate the observation made by Patel et al. (2016), that out-of-pocket payments are a major hindrance to continuity in mental health care in low-income countries.

Trust in health systems was yet another major issue. Fears of coercion, dehumanization, and insufficient treatment were commonplace. Some respondents were recorded talking about applications of physical restraint or derogatory language in hospitals. Such sentiments also find support in a report by Human Rights Watch (2020), which chronicled rights violations in psychiatric and traditional institutions in Nigeria. The fear of being labeled or mistreated often led people to avoid any formal services altogether, thus relying more on less effective alternatives.

3.5 Urban-Rural Comparison and Case Study Insights

The more comparative case studies have revealed the divergent mental health experiences in these two different settings. In the urban clinic, community outreach activities, affordable services, and integration with local health centers made access easier and fostered trust. Application of the WHO mhGAP principles in this context was indeed rewarding in that a retention rate of 70% was achieved, relatively no mean feat considering Nigeria's problems regarding mental health. Equally, in the rural community study case, the absence of formal services and a strong reliance on traditional healing were observed. Stigma surrounds mental illness as highly interpreted, often under either a taboo or spiritual dimension, one which brings dishonor to the family. Without services, informal providers stepped into the void; these providers were generally untrained, yet trusted by the community.

4. CONCLUSION AND RECOMMENDATIONS

This is very important as a study in understanding all the complex interconnectedness of societal beliefs and structures with no limits having an effect in the access and stigma of mental care in Nigeria. First, the survey concludes that stigma is a major contributor because it is carried in culturally based myths and spiritual attributions of mental illness. These myths

and public narratives have caused an inadequate treatment delay and secrecy in families with underutilized professional mental health services. Evidence also showed that the user cost, limited-service availability, and geographical disparities widen the treatment gap-specific people living in the country setting or a disadvantaged socioeconomic background. From a theoretical perspective, Goffman's statement-the stigma theory, Kleinman's explanatory models on health, and Rosenstock's Health Belief Model-gives a lens through which one can understand through behavioral, cultural, and cognition what influences the economic status in mental health-seeking behaviors. Low perceived susceptibility or efficacy might hinder reasons behind why individuals tend to avoid professional help, while Kleinman's work illustrates how his culture mediates understands of health and illness. Moreover, as Goffman implies, this theory explains that stigma encourages silence and social exclusion. Based on these results, several clear recommendations came to light. First, public awareness-raising campaigns demystifying mental illness, particularly dangerous stereotypes, should be brought to the next level. Increased receptivity by the community might be achieved by capitalizing on local influencers, especially religious and traditional leaders. These outreach efforts will focus on treating mental disorders and the importance of early intervention through culturally informed messaging. Second, a great push must be put forth to embed mental health care in Nigeria's primary health system. This must be followed by training internal and peripheral health workers to identify and manage common mental disorders consistent with the WHO task-shifting framework. Community-based mental health facilities should be prioritized in some of the most underserved rural areas to minimize travel time, cost, and logistical barriers. Third, protection mechanisms would have to be put in place financially. Policymakers should work toward integrating mental health services while providing more affordable medication and consultations. Donor-supported medication subsidy programs could also be piloted in low-income areas to support sustainability and long-term continuity of care. Fourth, rigorous monitoring must take place in implementation of Nigeria's 2021 Mental Health Act. Part of enforcement must be the inclusion of patient rights provisions, minimum standards of care, and development of community-based services. Further engaging informal providers, such as traditional and faith healers, would be beneficial by educating and forming referral networks to develop culturally appropriate and clinically effective collaborative care pathways.

Lastly, future research should explore longitudinal and intervention-based designs to test the effectiveness of anti-stigma programs and community outreach strategies. Evaluating mental health outcomes through culturally sensitive and participatory research designs would further strengthen policy advocacy and intervention scalability.

ACKNOWLEDGMENTS

The authors gratefully acknowledge the financial support provided by the Tertiary Education Trust Fund (TETFund) through the Institutional-Based Research (IBR) grant at The Federal Polytechnic Ukana. This funding was instrumental in facilitating the research and ensuring the successful completion of this study.

REFERENCES

Abdulmalik, J., Kola, L., Fadahunsi, W., Adebayo, K., Yasamy, M. T., Musa, E., & Gureje, O. (2019). Country contextualization of the mental health gap action programme intervention guide: A case study from Nigeria. *PLOS Medicine, 16*(8), e1002964. https://doi.org/10.1371/journal.pmed.1002964

Adewuya, A. O., & Makanjuola, R. O. (2008). Social distance towards people with mental illness among Nigerian university students. *Social Psychiatry and Psychiatric Epidemiology, 43*(11), 884–889. https://doi.org/10.1007/s00127-008-0377-z

Ayorinde, O., Gureje, O., & Appiah-Poku, J. (2016). Mental health system governance in Nigeria: Challenges, opportunities and strategies for improvement. *Global Mental Health, 3*, e7. https://doi.org/10.1017/gmh.2016.1

Bandia, P. F. (2008). *Translation as reparation: Writing and translation in postcolonial Africa*. Routledge.

Bhabha, H. K. (1994). *The location of culture*. Routledge.

Corrigan, P. W. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16–20.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster.

Grenoble, L. A., & Whaley, L. J. (2006). *Saving languages: An introduction to language revitalization*. Cambridge University Press.

Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *The British Journal of Psychiatry, 186*(5), 436–441. https://doi.org/10.1192/bjp.186.5.436

Gureje, O., Nortje, G., Makanjuola, V., Oladeji, B., Seedat, S., & Jenkins, R. (2015). The role of global traditional and complementary systems of medicine in the treatment of

mental health disorders. *The Lancet Psychiatry, 2*(2), 168–177. https://doi.org/10.1016/S2215-0366(15)00013-9

Human Rights Watch. (2020). *Nigeria: People with mental health conditions chained, abused*. Retrieved from https://www.hrw.org/news/2020/11/11/nigeria-people-mental-health-conditions-chained-abused

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. University of California Press.

Murdock, G. P. (1980). *Theories of illness: A world survey*. University of Pittsburgh Press.

Obiechina, E. (1975). *Culture, tradition and society in the West African novel*. Cambridge University Press.

Ofori-Atta, A., Read, U. M., & Lund, C. (2010). A situation analysis of mental health services and legislation in Ghana: Challenges for transformation. *African Journal of Psychiatry, 13*(2), 99–108. https://doi.org/10.4314/ajpsy.v13i2.54350

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., ... & UnÜtzer, J. (2016). The Lancet Commission on global mental health and sustainable development. *The Lancet, 392*(10157), 1553–1598. https://doi.org/10.1016/S0140-6736(18)31612-X

Rosenstock, I. M. (1974). Historical origins of the health belief model. *Health Education Monographs, 2*(4), 328–335. https://doi.org/10.1177/109019817400200403

Spivak, G. C. (1988). Can the subaltern speak? In C. Nelson & L. Grossberg (Eds.), *Marxism and the interpretation of culture* (pp. 271–313). University of Illinois Press.

Venuti, L. (1995). *The translator's invisibility: A history of translation*. Routledge.

Venuti, L. (2019). *Contra instrumentalism: A translation polemic*. University of Nebraska Press.

World Health Organization. (2008). *mhGAP: Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders*. Geneva: WHO Press.

World Health Organization. (2013). *Mental health action plan 2013–2020*. Geneva: WHO Press.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: Adding moral experience to stigma theory. *Social Science & Medicine, 64*(7), 1524–1535. https://doi.org/10.1016/j.socscimed.2006.11.013.