

Silenced Voices and Hidden Barriers: An Adolescent-Centric Analysis of Socio-Cultural Stigma, Familial Restrictions, and Structural Access Challenges in Mental Health Utilization

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ABSTRACT

Background: Adolescent mental health service utilization remains critically low in sub-Saharan Africa, particularly within primary healthcare settings, despite substantial unmet need. In Rivers State, Nigeria, significant levels of depression and psychological distress among adolescents persist alongside minimal engagement with formal mental health services at the primary care level.

Objective: To examine adolescents' perceptions of individual and socio-cultural barriers, including stigma, shame, fear of judgment, family restrictions, lack of autonomy, and religious and cultural beliefs, and access- and service-related barriers, including distance, cost, facility timing, confidentiality and privacy to the utilization of mental health services in selected primary healthcare facilities in Obio-Akpor LGA, Rivers State.

Methods: An exploratory qualitative cross-sectional design was adopted. Data were collected through in-depth interviews with 24 adolescents aged 13–19 years across eight purposively selected Model Primary Health Centres in Obio-Akpor LGA. Participants were recruited using purposive sampling to ensure diversity across age, sex, schooling status, and living arrangement. Interviews were audio-recorded, transcribed verbatim, and analysed using Braun and Clarke's six-step thematic analysis framework.

Results: Four major thematic barriers emerged. Predisposing barriers included stigma, shame, fear of judgment, masculine gender norms, family restrictions, limited autonomy, and religious interpretations of mental distress as spiritual problems requiring prayer rather than clinical care. Enabling barriers encompassed confidentiality concerns, poor facility privacy, financial dependence on caregivers, and inconvenient clinic timing for students. Need-related barriers reflected poor mental health literacy and the normalization of emotional distress as ordinary adolescent experience.

Conclusions: Adolescent mental health service underutilization in Obio-Akpor LGA is shaped by multidimensional personal, relational, and perceptual factors. Shame and confidentiality concerns emerged as particularly powerful barriers. Multidomain strategies addressing stigma, mental health literacy, and youth-friendly service delivery are essential to improve adolescent engagement with primary mental health care.

Key words: Adolescents, mental health, service utilization, barriers, stigma, primary healthcare, Nigeria

Word count: 248

INTRODUCTION

Adolescent mental health has emerged as a critical global public health priority, given that approximately 50% of mental health disorders manifest by age 14, with profound implications for educational attainment, interpersonal relationships, productivity, and long-term wellbeing if left untreated (UNICEF, 2021; WHO, 2022). Globally, an estimated 13-15% of adolescents aged 10-19 years experience a diagnosable mental health condition, with depression, anxiety, and behavioural disorders among the leading contributors to years lived with

disability in this age group (WHO, 2022; UNICEF, 2021). Despite this substantial burden, systematic reviews indicate that 75-90% of adolescents with mental health needs do not access formal mental health services, with treatment gaps particularly pronounced in low- and middle-income countries (LMICs) (Wahdi et al., 2025; Hill et al., 2025).

In sub-Saharan Africa, the adolescent mental health burden is substantial yet service utilization remains markedly low. A systematic review involving over 97,000 adolescents reported high prevalence estimates of emotional and behavioural difficulties, with depression affecting 10-20% and anxiety disorders affecting 12-18% of adolescents across the region (Jörns-Presentati et al., 2021; Jakobsson et al., 2024). However, utilization of mental health services remains limited, with less than 20% of adolescents seeking formal care despite experiencing significant psychological distress (Saade et al., 2023; Mubeen et al., 2024). Persistent barriers including stigma, low mental health literacy, fear of confidentiality breaches, cultural beliefs, cost, and limited adolescent-friendly services at primary health care (PHC) level continue to impede access (Wahdi et al., 2025).

Nigeria reflects these regional patterns with concerning statistics. As of 2021, Nigeria had only approximately 250 practicing psychiatrists for a population exceeding 200 million people one of the lowest psychiatrist-to-population ratios globally (Fadele et al., 2024). Mental health spending remains below 1% of the total health budget, with fewer than 40% of African countries having dedicated mental health budgets (Hart & Norris, 2025). Studies among Nigerian adolescents report low rates of professional help-seeking, with only 13.6% preferring mental health professionals compared to 64.9% preferring informal sources like parents or guardians (Osebhahiemen & Imarenezor, 2025). Furthermore, only 36.3% of adolescents correctly identified depression, while 22.8% identified anxiety, indicating critical gaps in mental health literacy (Osebhahiemen & Imarenezor, 2025).

Within Rivers State, emerging evidence indicates a significant adolescent mental health burden. Studies among in-school adolescents report notable prevalence of depressive symptoms, anxiety, and suicidal ideation, suggesting considerable unmet mental health needs (Alinnor & Okeafor, 2023; Onyechi & Adeniji, 2025). Additional studies among youth populations in Rivers State reveal high levels of psychological distress and low formal help-seeking behaviour, with many adolescents preferring informal coping mechanisms (Onwurah et al., 2024; Osaro et al., 2025). In Obio-Akpor LGA specifically, research has demonstrated gaps in mental health literacy and persistent stigma toward mental illness, both known predictors of reduced service utilization (Olowe et al., 2025). Substance use among junior secondary school students in Obio-Akpor LGA shows a lifetime prevalence of 9.4%, suggesting early exposure to behavioural and mental health vulnerabilities (Azi & Maduka, 2021).

Understanding these barriers requires theoretical grounding. This study adopts the Andersen Behavioral Model of Health Services Use (Andersen, 1968; revised 1995), which theorizes health service utilization through three categories of determinants: (1) predisposing factors (beliefs, attitudes, stigma, cultural norms); (2) enabling factors (resources, accessibility, confidentiality, provider attitudes); and (3) perceived need factors (subjective assessment of health status and necessity of seeking care). This framework accommodates both demand-side and supply-side determinants while providing coherent structure for analyzing perceived barriers within PHC settings. Complementary frameworks including the Health Belief Model (HBM) and Socio-Ecological Model (SEM) further illuminate cognitive determinants and multi-layered contextual influences on adolescent help-seeking behaviour.

Despite policy efforts emphasizing mental health integration into PHC, evidence consistently shows adolescent utilization remains low, particularly in LMIC settings (WHO, 2022; UNICEF, 2021). The gap is not solely due to service absence but is strongly influenced by stigma, fear of confidentiality breaches, negative provider expectations, poor mental health literacy, gender norms, and reliance on informal support systems (Wahdi et al., 2025; Mubeen et al., 2024). In Nigeria, young people report reluctance to seek professional help despite experiencing psychological distress (Kukoyi et al., 2022), and health system analyses highlight weak PHC integration and limited adolescent-responsive engagement (Fadele et al., 2024). However, few studies have qualitatively explored how adolescents within specific local government areas perceive PHC-based mental health services, particularly in Rivers State. Without understanding these perceptions, policy efforts to strengthen PHC mental health integration may not translate into improved service uptake. There is a clear gap in context-

specific qualitative evidence examining perceived barriers influencing adolescents' utilization of mental health services within selected PHC facilities in Obio-Akpor LGA. Addressing this gap is essential to inform targeted, adolescent-responsive interventions that move beyond structural integration toward meaningful service engagement.

METHODOLOGY

Research Design

This study adopted an exploratory qualitative design, specifically tailored to investigate the perceived barriers to the utilization of mental health services among adolescents in selected primary healthcare (PHC) facilities in Obio-Akpor Local Government Area (LGA), Rivers State. An exploratory design was deemed most appropriate as the research objective necessitated a deep, nuanced understanding of complex, context-specific phenomena rather than statistical generalization. Perceived barriers to mental health service utilization are multifaceted, involving intricate interactions between individual beliefs, socio-cultural norms, and structural constraints. A qualitative approach allows the researcher to uncover the range and nature of these barriers as experienced and articulated directly by adolescents, without imposing predetermined categories or hypotheses. This design facilitates the exploration of "why" and "how" adolescents navigate or avoid mental health care, providing rich descriptive data essential for theory building and intervention planning.

Population of the Study

The study was conducted in Obio-Akpor LGA, a rapidly urbanizing area within the Port Harcourt metropolis covering approximately 260 square kilometers. With a population of 464,789, the LGA comprises 21 PHC centers distributed across 17 electoral wards, of which 16 are validated as functional under the National Primary Health Care Development Agency (NPHCDA) criteria. The target population for this study consisted exclusively of adolescents aged 13–19 years who had accessed or attempted to access services at the selected PHC facilities within Obio-Akpor. This specific demographic was chosen because they represent the primary end-users of mental health services and possess firsthand insights into the individual, socio-cultural, and access-related barriers influencing their help-seeking behaviors. Recruiting adolescents directly from PHC settings ensured that the data reflected actual service utilization experiences rather than hypothetical perceptions.

Inclusion and Exclusion Criteria

Adolescents were included in the study if they were between the ages of 13 and 19 years, had visited or attempted to visit the selected PHC facilities for any health reason, and were willing to provide informed assent (with parental consent for minors). Conversely, adolescents experiencing severe emotional distress or an acute mental health crisis at the time of recruitment were excluded to prevent potential psychological harm during the interview process. Additionally, those unwilling to participate voluntarily or unable to communicate effectively in English or Pidgin English were excluded.

Sample Size Determination

In qualitative research, sample size is not determined by statistical power calculations but by the principle of data saturation. Data saturation is defined as the point at which additional data collection yields no new themes, categories, or conceptual insights relevant to the study objectives. Based on this principle and considering the heterogeneity of the adolescent population, the study targeted a sample of 24 adolescents. This number was calculated to allow for approximately three in-depth interviews per selected facility across eight facilities, ensuring sufficient variation in age, gender, schooling status, and living arrangements to capture diverse perspectives while maintaining analytic depth.

Sampling Techniques and Bias Mitigation

The study employed a multi-stage purposive sampling technique to ensure the selection of information-rich cases relevant to the research questions. Bias was addressed through stratification and deliberate selection to maximize contextual diversity.

Stage 1: Stratification by Wards. Obio-Akpor LGA was divided into its 17 political wards to serve as strata. This ensured geographical representation across the LGA. Stage 2: Facility Selection. From the 16 functional PHCs, eight facilities were purposively selected, representing approximately 50% of the wards. The selection criteria prioritized facilities located in diverse socio-economic settings (urban, peri-urban, and semi-rural) to capture variations in community norms and service organization. Stage 3: Participant Selection. Within each selected facility, adolescents were purposively recruited based on the inclusion criteria. The researcher worked with facility staff to identify eligible adolescents who had recently visited the center, ensuring they had direct experience with the PHC environment.

Bias was mitigated by avoiding convenience sampling of only the most vocal or cooperative adolescents. Instead, the researcher actively sought participants with varying backgrounds, including school dropouts, working adolescents, and those from different family structures, to prevent the overrepresentation of a single demographic subgroup.

Instrument and Data Collection

Data collection utilized semi-structured In-Depth Interview (IDI) guides specifically designed for adolescents. The instrument was developed based on the Andersen Behavioral Model of Health Services Use, focusing on predisposing (stigma, beliefs), enabling (access, cost, confidentiality), and need-related factors. The guide contained open-ended questions exploring adolescents' understanding of mental health, experiences with stigma, family restrictions, fears of judgment, and logistical challenges such as facility timing and privacy.

Data collection was conducted face-to-face in private, confidential spaces within the PHC facilities or at mutually agreed locations to ensure comfort. Before each interview, informed consent (and parental consent for minors) was obtained. Interviews were conducted in English or Pidgin English, depending on the participant's preference, and lasted approximately 25 to 30 minutes. All interviews were audio-recorded with permission and transcribed verbatim. Participants were assured of anonymity and the right to withdraw at any time without consequence.

Method of Data Analysis

The collected data were analyzed using thematic content analysis following Braun and Clarke's (2022) six-step framework.

Familiarization: Transcripts were read repeatedly to immerse the researcher in the data.

Initial Coding: Meaningful segments were coded using a hybrid approach: inductive coding allowed themes to emerge from the data, while deductive coding aligned with the study's theoretical framework (Andersen Model).

Categorization: Codes were grouped into broader categories reflecting recurring ideas about barriers.

Theme Development: Categories were refined into major themes and sub-themes representing key barriers to service utilization.

Reviewing Themes: Themes were checked against the original dataset to ensure accuracy and coherence.

Interpretation: Final themes were interpreted in relation to the study objectives and existing literature to provide a comprehensive explanation of adolescent perspectives. Dependability was ensured through an audit trail documenting all methodological decisions, while confirmability was maintained by grounding findings in direct participant quotations rather than researcher bias.

Ethical Considerations

Ethical approval was obtained from the Rivers State Health Research Ethics Committee (RSHREC) Approval No. RSHMB/RSHREC/2026/032), and administrative permission was secured from the Rivers State Primary Health Care Management Board. The study adhered to strict ethical principles:

Informed Consent: Written consent was obtained from all participants aged 18–19, while parental/guardian

consent and adolescent assent were secured for those under 18.

Confidentiality and Anonymity: All personal identifiers were removed from transcripts. Participants were assigned unique codes, and audio files were stored on password-protected devices accessible only to the research team.

Psychological Safety: Given the sensitive nature of mental health, interviews were conducted in private settings. Participants exhibiting signs of distress were offered a pause or termination of the interview, with referrals to available counseling services if necessary.

Voluntary Participation: Participants were explicitly informed that participation was voluntary and that they could decline to answer any question or withdraw from the study at any time without penalty.

RESULTS

Demographic Context: How Socio-Economic Status and Living Arrangements Shape Autonomy

The study involved 24 adolescent participants aged 13–19 years, with the majority between 16–17 years. Most participants were female (58.3%) and currently in school (79.2%), while a smaller proportion had dropped out due to pregnancy or financial constraints. Living arrangements varied, including residence with both parents, single parents, extended family members, or, in the case of teenage mothers, with a partner's family. These socio-demographic differences shaped how adolescents experienced and navigated barriers to mental health service utilization across facilities. For instance, younger participants and those under strict supervision emphasized dependence and restricted autonomy: "I'm fourteen... I can't just decide on my own to come here" (Adolescent 01, MPHC Ozuoba), while those living with guardians reported mobility limitations: "My aunty doesn't allow me to go anywhere... even if I want to go, I can't" (Adolescent 02, MPHC Rumueme). Similarly, adolescents in financially dependent or unstable living conditions described constrained decision-making: "I depend on my boyfriend's family for everything... that's not easy" (Adolescent 03, MPHC Rumuolumeni). These characteristics provide the contextual foundation within which both socio-cultural and service-related barriers operate.

Predisposing Barriers: Stigma, Shame, and Fear of Judgment

FINDINGS

Revealed that stigma, shame, and fear of judgment were central barriers preventing adolescents from seeking mental health services. Participants consistently described emotional distress as something to be concealed due to anticipated negative labeling and social consequences. One adolescent emphasized the internal struggle associated with disclosure: "It's about whether I have the confidence to sit in front of someone and talk about my feelings... that's not easy" (Adolescent 01, MPHC Rumueme). Among male participants, peer norms reinforced emotional suppression: "If you tell your guy... they'll say you're soft" (Adolescent 01, MPHC Rumuepirikom). Female participants, particularly teenage mothers, expressed stigma linked to social judgment and perceived failure: "I feel ashamed... people already look at me somehow" (Adolescent 03, MPHC Rumuolumeni). These accounts demonstrate that stigma operates both internally and socially, shaping adolescents' perceptions of acceptability and discouraging help-seeking behavior.

Predisposing Barriers: Familial Authority, Autonomy Constraints, and Cultural Beliefs

Further analysis showed that family influence, lack of autonomy, and religious/cultural beliefs significantly constrained service utilization. Adolescents highlighted the requirement for parental permission as a critical barrier, particularly when they were unwilling or unable to disclose their emotional challenges:

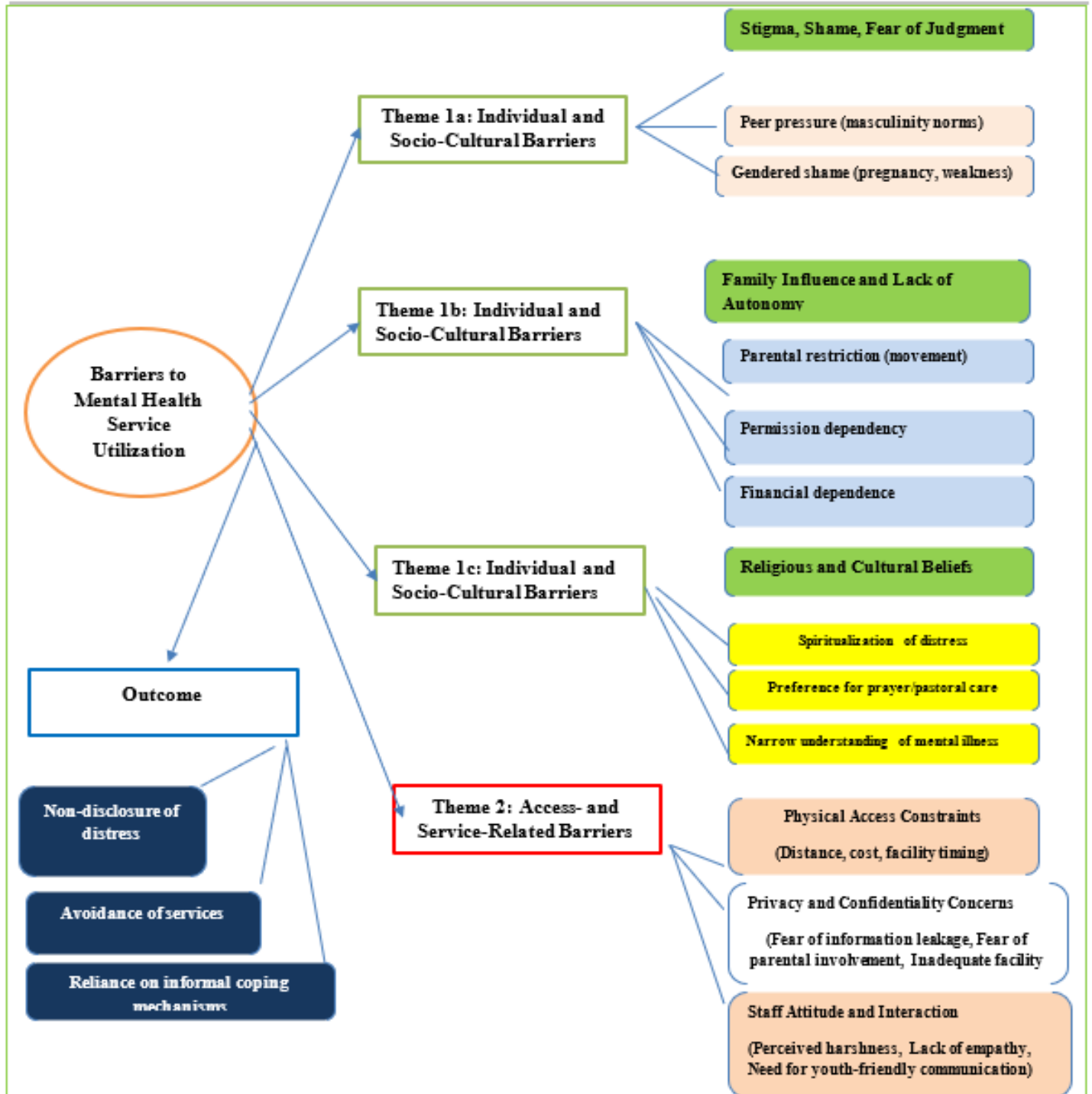
"You have to tell the adult before you can talk to the professional... that's the part that stops you" (Adolescent 02, MPHC Rumuepirikom).

In addition, families often redirected adolescents toward spiritual coping mechanisms rather than formal care:

“My parents would tell me to go to church... not the facility” (Adolescent 01, MPHRC Rumuodomaya).

Community Reinforcement of Norms: This was reinforced by broader community beliefs that normalized emotional distress unless it was severe: “People say you should pray and be strong... unless the person is seriously disturbed” (Adolescent 01, MPHRC Rumuolumeni). Together, these findings indicate that adolescents’ help-seeking decisions are embedded within family authority structures and culturally defined interpretations of mental health.

Figure 1 Thematic Analysis Tree: Adolescents’ Barriers to Mental Health Service Utilization



Enabling Barriers: Confidentiality Concerns, Staff Attitudes, and Structural Constraints Findings indicated that access- and service-related barriers—particularly confidentiality, staff attitude, and structural constraints—further limited utilization even when adolescents reached health facilities. While distance, cost, and timing posed challenges for some participants, relational barriers were more consistently emphasized. Concerns about

confidentiality were especially prominent, with adolescents fearing exposure of sensitive information: “She trusted that it would stay there... but it didn’t... so I told myself never” (Adolescent 01, MPHC Rumuigbo). Similarly, fear of parental involvement discouraged disclosure:

“I’m scared they would call my parents... I’d rather keep it to myself” (Adolescent 01, MPHC Rumuepirikom). Staff attitude also influenced engagement, as negative interactions reduced willingness to seek help: “Some health workers are very aggressive... they don’t listen” (Adolescent 03, MPHC Rumuigbo). Conversely, adolescents emphasized the importance of supportive interactions: “If they are calm and ready to listen... then I can open up” (Male Adolescent, 19, MPHC Rumueme). These findings highlight that beyond physical access, the perceived safety and quality of the healthcare environment are decisive factors in adolescents’ utilization of mental health services.

DISCUSSION

This study elucidates the multifaceted barriers hindering adolescent mental health service utilization in Obio-Akpor LGA, revealing a complex interplay of individual, socio-cultural, and structural factors. The findings confirm that the decision to seek care is rarely a singular event but a negotiated process heavily influenced by fear, autonomy, and environmental trust. The study identifies stigma, shame, and fear of judgment as primary deterrents, aligning with global and regional literature. Adolescents in this study feared being labeled “mad” or weak, a finding consistent with Radez et al. (2021) and Fadele et al. (2024), who note that perceived social stigma is a universal barrier in low-resource settings. Notably, this stigma manifested distinctly along gender lines; male adolescents suppressed distress to adhere to masculine norms of emotional stoicism, corroborating Agbaje et al. (2024) regarding the impact of toxic masculinity on help-seeking. Furthermore, the study highlights the critical role of family gatekeeping. The requirement for parental permission effectively strips adolescents of autonomy, a dynamic supported by Mubeen et al. (2024). This is particularly acute for teenage mothers, whose dependency on partners’ families creates a dual burden of stigma and resource control.

Religious and cultural interpretations of mental distress further complicate the landscape. The prevalent belief that emotional suffering is a spiritual trial requiring prayer rather than clinical intervention mirrors findings by Bamgbose and Pedersen (2023) and Edosomwan (2025). This “spiritual substitution” delays clinical presentation until crises occur. Additionally, the community normalization of mild-to-moderate distress as a “normal part of life” raises the threshold for recognizing the need for care, a phenomenon also observed in broader Nigerian contexts (Fadele et al., 2024). Furthermore, even when adolescents overcome socio-cultural hurdles, structural and service-related barriers persist. Confidentiality emerged as the most potent service-related barrier. The fear of information leakage, often fueled by witnessed breaches, creates a profound distrust in the healthcare system. This aligns with Lawrence et al. (2025), who emphasize that privacy is a prerequisite for adolescent engagement. Practical barriers such as distance, cost, and inconvenient clinic hours further restrict access, echoing Kukoyi et al. (2022) and Saade et al. (2023).

Crucially, the physical environment of Primary Health Care (PHC) facilities was found to be alienating. Open waiting areas, crowded spaces, and an adult-centric atmosphere made adolescents feel exposed and judged, supporting WHO (2022) recommendations for adolescent-friendly environments. Finally, staff attitudes proved decisive; dismissive or hurried interactions at the point of contact were sufficient to deter future help-seeking, a finding consistent with Roach et al. (2025). These results suggest that the “quality” of the encounter is as critical as the “availability” of the service.

Theory-Based Interventions Grounded in the Andersen Behavioral Model of Health Services Use

These findings suggest that interventions must target all three determinant categories: predisposing, enabling, and need factors. First, addressing predisposing factors requires community-wide stigma reduction campaigns that reframe mental health as a medical, not spiritual, issue. Programs should specifically target gender norms to encourage emotional expression among boys and engage religious leaders to promote collaborative care models rather than exclusive spiritual intervention. Second, modifying enabling factors necessitates structural reforms within PHCs. This includes establishing strict confidentiality protocols, creating dedicated youth-friendly zones

with private consultation rooms, and adjusting clinic hours to accommodate school schedules. Financial barriers can be mitigated through subsidized transport or fee waivers for adolescents. Third, enhancing need factors involves improving mental health literacy to help adolescents recognize symptoms and understand the necessity of professional care.

Furthermore, the model underscores the need for provider training. Since staff attitudes act as a critical enabling factor, continuous professional development focusing on youth-sensitive communication and empathy is essential to rebuild trust. By simultaneously addressing these domains, policymakers can shift the equilibrium from avoidance to engagement.

CONCLUSION

In conclusion, the underutilization of mental health services among adolescents in Obio-Akpor is not merely a result of service scarcity but a consequence of deep-seated socio-cultural beliefs and structural inadequacies. Effective intervention requires a holistic approach that dismantles stigma, empowers adolescent autonomy, and transforms PHC facilities into safe, confidential, and welcoming spaces. Future research should explore longitudinal outcomes of such targeted, theory-driven interventions.

Authors' Declaration

We, the undersigned authors, hereby declare the following:

Ethical Approval: This study was conducted in strict accordance with the ethical standards of the River State Health Research Ethics Committee (RSHREC) and the principles outlined in the Declaration of Helsinki. Formal ethical approval was granted by the Rivers State Primary Healthcare Management Board prior to the commencement of data collection. Written informed consent was obtained from all adult participants (aged 18–19), and written informed consent along with assent was secured from all participants under the age of 18, obtained from their legal guardians or parents.

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Data Availability: The datasets generated and/or analyzed during the current study are not publicly available due to privacy and ethical restrictions regarding participant confidentiality but are available from the corresponding author upon reasonable request.

Plagiarism Statement: This manuscript has been screened for plagiarism and contains no plagiarized material. All sources utilized in the preparation of this work have been appropriately cited and acknowledged.

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