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Lived Experiences and Challenges of Psychiatric Outpatients in Sokoto State, Nigeria

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Abstract
This study investigated the lived experiences and treatment challenges of psychiatric outpatients at the Federal Neuro-Psychiatric Hospital, Kware, and Usmanu Danfodiyo University Teaching Hospital Sokoto State, Nigeria, using a mixed-methods approach. Anchored in Social Constructionist Theory, the research explores how mental illness and its treatment are shaped by socio-cultural narratives, institutional practices, and interpersonal interactions. Quantitative data from 820 outpatients revealed that while over 70% reported treatment improvements, 58% experienced rights violations, including lack of privacy, poor communication, and limited autonomy in care. Stigma-related impacts included employment denial (10.49%), marriage obstacles (63.54%), and business restrictions (28.05%). Social reactions varied—45.98% reported kindness, 5.61% faced rudeness, and 21.71% noted authoritative behavior. Complementary qualitative interviews with 36 participants, including patients, caregivers, healthcare providers, and traditional healers, uncovered the continued role of spiritual beliefs and cultural interpretations in treatment pathways. Traditional healers often serve as first-line providers, offering culturally resonant, though sometimes coercive, interventions. The findings highlight the urgency of developing community-informed, rights-based mental health services that respect patient agency, improve institutional communication, and ethically integrate traditional care practices. The study advocates for reforms that align with both global standards and local realities.

Keywords: Mental illness related stigma, lived experiences of psychiatric patients, Rights-based mental health services

Introduction

Mental illness is a global issue, but its manifestation varies across societies due to cultural beliefs, social norms, and healthcare access. In Nigeria, around 60 million people suffer from conditions like depression, anxiety, and substance abuse (Erubami *et al*., 2023; Fadele *et al*., 2024). Despite the high prevalence, mental healthcare infrastructure is underdeveloped, with significant gaps in services, with widespread societal stigma further hindering treatment (Wada *et al.*, 2021; Ahad *et al.*, 2023). The lived experiences of those with mental illness go beyond clinical symptoms, but are shaped by social and cultural factors that affect their recovery and reintegration (Levy-Fenner et al., 2022; Almu & Amzat, 2024; Jundeekrayom *et al*., 2025). Many face stigmas rooted in misconceptions, such as attributing mental illness to supernatural causes or moral failings, leading to isolation and emotional distress (Esan *et al*., 2019; Jidong *et al.*, 2021). This is especially true in Sokoto State, where psychiatric patients encounter societal challenges that complicate their healing.

Understanding these lived experiences is key to addressing the complex issues faced by individuals with mental illness, particularly in regions with limited mental health resources (Samra, 2025). Cultural beliefs often result in patients seeking spiritual healing rather than professional care, as traditional healers are commonly the first contact for many (Ahmed et al., 2023; Berhe et al., 2024). Moreover, the inadequate mental healthcare system, combined with stigma, severely limits access to quality treatment, especially in rural areas like Sokoto (Wada *et al*., 2021; Abdulmalik *et al*., 2019). Incorporating the experiences of those affected by mental illness into research and policymaking can improve treatment outcomes and reduce stigma (Vojtila *et al*., 2021). More research is needed to explore these experiences in regions like Sokoto, where cultural beliefs and stigma pose unique challenges. Understanding these narratives is crucial for developing culturally sensitive mental health policies that address both clinical and social dimensions of mental illness (Gopalkrishnan, 2018; Ahmad *et al.*, 2023).

This study investigates the lived experiences and societal challenges of psychiatric outpatients in Sokoto State, Nigeria. Specifically, it examines the social, economic, and treatment-related effects of mental illness on identity and recovery. It explores the role of support systems, such as family and community, and examines how stigma, discrimination, and social beliefs influence experiences. It also seeks to understand how traditional and modern treatments affect reintegration and well-being.

Theoretical Framework

The Social Constructionist Theory, articulated by scholars such as Peter Berger and Thomas Luckmann, serves as framework for explaining the lived experiences of individuals with mental illness. This theory underscores the significant impact of societal perceptions and treatment environments on these experiences. A major strength of the Social Constructionist Theory lies in its

exploration of the dynamic relationship between cultural and social contexts and individual experiences, revealing how societal attitudes shape the journey of mental health (Berger & Luckmann, 1966). For instance, the theory elucidates the dual character of society, where stigma surrounding mental illness often arises from societal biases that do not accurately represent an individual's condition, ultimately leading to social exclusion and challenges in reintegration (Link & Phelan, 2006).

Despite its strengths, the Social Constructionist Theory has limitations, particularly regarding its tendency to prioritize social factors over biological or psychological aspects of mental illness. This focus may result in a reductionist perspective that neglects the intricate nature of mental health conditions. Furthermore, while the theory recognizes the constitutive role of language and acknowledging that language can either perpetuate stereotypes or challenge them (Volkow *et al*., 2021; Doll *et al*., 2022), which it may not fully encompass the subtleties of individual experiences outside societal discourse.

The principles of this theory are especially relevant in understanding the multiplicity of meanings associated with mental illness across different cultural contexts. In certain cultures, mental illness may be interpreted as a personal failure rather than a legitimate health concern, thereby influencing the support available to affected individuals (Amzat & Razum, 2014). Moreover, the societal context significantly impacts the resources and support accessible to individuals with mental illness; communities characterized by strong stigma often create barriers to acceptance and recovery (Hu *et al*., 2022).

By applying the Social Constructionist Theory to research on the lived experiences of individuals with mental illness, we can better grasp how cultural and societal factors shape these experiences (Booysen *et al*., 2021; Kuek *et al*., 2024). The theory highlights the necessity of addressing societal attitudes and cultural perceptions, which profoundly influence individuals' interactions with healthcare systems and their overall well-being. It advocates for culturally sensitive mental health care approaches that acknowledge social stigma and foster acceptance, thereby improving the effectiveness of treatment and support.

Therefore, the Social Constructionist Theory offers significant insights into the interplay of cultural and societal factors in shaping perceptions and treatment of mental illness. Its relevance to understanding the lived experiences of individuals emphasizes the importance of addressing social constructs surrounding mental health, ultimately contributing to the development of a more inclusive and supportive environment for recovery.

Methods

This study utilizes a mixed-methods design that combines quantitative and qualitative approaches, allowing for a comprehensive understanding of the complexities involved in delivering mental health care within psychiatric settings. Data were collected from two major health institutions Federal Neuro-Psychiatric Hospital Kware and Usmanu Danfodiyo University Teaching

Hospital Sokoto), which play critical roles in regional mental health care provision.

The study population consisted 820 outpatients for quantitative part. From qualitative part, there are six (6) healthcare providers, including doctors, nurses, and other clinical staff; six (6) traditional healers; as well as a purposively selected sample of twelve (12) stable outpatient service users who were clinically assessed as having the capacity to provide informed consent and could reflect on their long-term care experiences; and twelve (12) outpatient relatives who escorted them to the facility and had the capacity to provide information about their patients. Both categories were selected to contribute valuable insights that could enhance mental health care delivery and support. However, it is acknowledged that the perspective of significant others of patients on admission was not included, representing a limitation that future research should address to capture the full pattern of care.

Systematic sampling was used in selecting of quantitative respondents using the exit interview format while purposive sampling was employed to select individuals from both groups for qualitative participants likely to provide rich, relevant data related to the research objectives. Data collection involved semi-structured questionnaires for quantitative insights from providers, facilitating the analysis of systemic challenges, as well as key informant interviews (with healthcare providers) and in-depth interviews (with stable service users and their relatives) to gather qualitative data that explored these participants' distinct experiences and perspectives.

The quantitative data were analyzed using SPSS, while qualitative data were subjected to thematic analysis, allowing for the identification of underlying patterns and challenges (Castleberry & Nolen, 2018; Kiger & Varpio, 2020). Ethical considerations were paramount, with approvals secured from relevant institutional review boards and the State Ministry of Health. Participant confidentiality was maintained through data anonymity, and informed consent was obtained prior to data collection. Challenges such as logistical constraints and variations in provider availability were effectively managed through flexible scheduling and ongoing communication with hospital administration.

Results

This section examines the lived experience of people living with mental illness. The section was designed with two tables: Table 1 (mental illness: effects on opportunities, treatment, and social interaction) and table 2 (mental illness: identity impact and support systems), respectively, for the quantitative data. Additionally, the qualitative data was presented in thematic form. The quantitative data collected underscores the significant barriers faced by individuals with mental illness, revealing pervasive social and systemic challenges. Notably, 10.49% of participants reported being denied employment, 63.54% encountered obstacles in marriage opportunities, and

28.05% experienced restrictions in business activities due to their mental health status. A minority (6.78%) reported no restrictions, but the majority.

Table 1: Mental Illness: Effects on Opportunities, Treatment, and Social Interaction

Experiences and Challenges	Response	Frequency	Percentage
Kind of opportunities denied due to mental illness **multiple options applied** (each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option)	Employment	86	10.49%
	Marriage	521	63.54%
	Business activities	230	28.05%
	Leadership Position	60	7.32%
	Continue study	207	25.24%
	Involvement in decision making	132	16.10%
	None of the above	32	3.90%
	Others (Pls specify)……	1	0.12%
Nature of approach	Very rude	46	5.61%
	Authoritative	178	21.71%
	Very soft and lightly	377	45.98%
	Sometimes rude sometimes soft	216	26.34%
	Others (Pls specify)	3	0.37%
	Total	820	100%
Pattern of respect given to people affected with mentally illness	No respect at all	208	25.37%
	Deceitful respect	423	51.59%
	Very good respect	85	10.37%
	Good respect	104	12.68%
	Total	820	100%
Extent of movement restrictions	Tight restriction	87	10.61%
	Light restriction	276	33.66%
	No restriction	457	55.73%
	Total	820	100%
Types of abuses experienced from the community when mentally ill **multiple options applied** (each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option)	Stoning	24	2.93%
	Beaten	43	5.24%
	Chaining	338	41.22%
	Verbal abuses	201	24.51%
	None of the above	261	31.83%
	Others (Pls, specify)	2	0.24%
Places called with derogatory names, like "mad man," when mentally sick **multiple options applied** (each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option)	At Home	81	9.88%
	At Community	610	74.39%
	At Hospital	52	6.34%
	None of the above	145	17.80%
	Others (Pls specify)	1	0.12
Places where valuable items get seized due to mentally illness **multiple options applied** (each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option)	At family level	311	37.93%
	At Community level	381	46.46%
	At Hospital	79	9.63%
	None of the above	199	24.27%
	Others (Pls specify)	2	0.24%

faced some form of discrimination or limitation, highlighting widespread social exclusion.

Social Attitudes and Discrimination

Attitudes toward individuals with mental illness varied significantly. While 45.98% reported being treated kindly, 5.61% faced outright rudeness, and 21.71% experienced authoritative behavior. Reports of compromised dignity were common, with 25.37% indicating they received no respect, while 51.59% experienced deceitful respect (see Table 1). These indicated the need to address societal stigma at multiple levels. The inconsistency in treatment—from kindness to outright disrespect—indicates that awareness campaigns alone may not be sufficient. Broader cultural shifts are required, suggesting that community-based interventions should focus not only on promoting kindness but also on addressing underlying power dynamics and prejudices that lead to authoritative or degrading behavior.

As one participant, whose statement reflected what several others observed, noted

> We have tried traditional methods, religious methods... including smoke inhalation... My son is unable to remove his hand because of the heat, not realizing that the fire is affecting him... (*IDI with female patient's relative*)

Healthcare providers also expressed concerns about traditional methods:

> These methods are generally ineffective and sometimes abusive, involving physical restraint and beatings… (*KII with Male healthcare provider*)

These highlight the tension between cultural practices and modern healthcare. Traditional methods are not only ineffective, as noted by healthcare providers but also potentially abusive. This tension necessitates a culturally sensitive approach to mental healthcare that acknowledges traditional beliefs while promoting safer, evidence-based treatments. Efforts to collaborate with traditional healers and educate communities about the dangers of certain practices are vital to improving patient outcomes.

Basic Needs and Living Conditions

Meeting the basic needs of individuals with mental illness is essential for their recovery, including adequate nutrition, personal hygiene, and safe accommodation. Participants reflected on the challenges they faced:

> He used to get all these, but now the food is not adequate like before… (*IDI with female patient's relative*)

> I need nutritious food and proper hygiene. I share a small room with family members... (*IDI with female patient*)

These challenges point to the importance of addressing not only the mental health needs of patients but also their basic living conditions. Adequate food, hygiene, and housing are essential for overall well-being and recovery. This suggests that mental health interventions in Sokoto should include components that ensure patients' access to essential resources, either through social support systems or policy interventions targeting poverty alleviation and housing support.

Social Support and Understanding

Social inclusion and understanding are crucial for the well-being of individuals with mental illness. Participants emphasized the importance of reducing stigma and providing emotional support:

> They require food, access to healthcare services, and understanding. Stigmatizing them worsens the situation... (*IDI with male patient's relative*)

This highlights the vital role of social inclusion and understanding in the recovery of individuals with mental illness, emphasizing the need for access to food, healthcare, emotional support, and a stigma-free environment. Stigmatization worsens their isolation and health, making community support crucial. This aligns with broader mental health advocacy, which promotes reducing stigma and fostering empathy to improve patients' quality of life, recovery, and societal reintegration. Public health interventions should address both the material and emotional needs of psychiatric patients to ensure holistic care.

Movement Restrictions

Most relatives affirmed that movement restrictions are often imposed to ensure safety. The statement shows how movement restrictions are used by caregivers as a protective measure to ensure the safety of individuals with mental illness, reflecting the challenges of balancing freedom and oversight in their care. Movement restrictions have profound implications beyond safety, creating a ripple effect across an individual's life. They enforce social isolation and strain family dynamics, while also creating economic barriers to employment and education that foster financial dependence. Furthermore, these restrictions reinforce stigma by marking the individual as dangerous and cause psychological harm through a loss of autonomy, ultimately sacrificing personhood and dignity for the sake of safety.

Perceptions of Traditional Healing

The perception of traditional healing practices revealed mixed outcomes. Many testimonies ultimately led to the realization that traditional methods were ineffective in the long term, prompting a shift to medical treatment:

> Yes, we initially used traditional medicine, and it sometimes seemed effective. However, it would relapse later on. Eventually, we decided to seek medical help at the hospital. (*IDI with male patient's relative*)

This illustrates a significant shift in health-seeking behavior and highlights a critical limitation of traditional medicine. Although the relative acknowledges its occasional effectiveness, they note that it provided only temporary relief, ultimately failing to deliver a sustainable cure and resulting in relapse. The recurrence of the illness prompted the family to seek hospital treatment, which they perceived as a more reliable and long-term solution. This transition was not a dismissal of traditional practices, but rather a pragmatic adaptation based on outcomes, a common pattern in which biomedical care is sought as a final option when other treatments prove insufficient. Traditional healers acknowledged their methods are often the first line of treatment but emphasized the variability in outcomes:

> Some individuals and families immediately recognize the spiritual nature of the problem and seek our assistance... If we confirm spiritual involvement, we proceed with our methods; if not, we advise them to seek help from hospitals. (*KII with male traditional healer*)

Healers recognized their limitations:

> We initially believed it was jinn possession, so we took her to a *Mallam* who performed *Rukya*. After several attempts, he advised us to seek hospital treatment. (*IDI with Female Patient*).

The analysis shows that traditional healers while often the first point of contact for mental illness treatment, recognize the variability in outcomes and their limitations, sometimes advising patients to seek medical care when spiritual causes are ruled out or traditional methods prove ineffective.

Transition to Medical Treatment

Several testimonies reflected a pattern where traditional methods provided initial relief but failed to sustain improvement:

> To be frank with you, we relied on traditional medicine in the early stages. They would prescribe drugs for various conditions. However, as things worsened, I was admitted. It was there that my problem was diagnosed as drug abuse… (*IDI with male patient*)

The limitations of traditional approaches became clear, as one patient noted:

> These techniques were attempted several times, but no progress was recorded. He was then taken to the hospital, where they said if he didn't stop taking drugs, his brain would be affected. (*IDI with male patient's relative*)

Meaning that while traditional methods offered initial relief, their inability to provide lasting improvement became evident, especially when underlying issues like drug abuse were diagnosed. This highlights the limitations of traditional approaches and the need for medical intervention for more accurate diagnoses and effective long-term treatment.

Mixed Outcomes and Delayed Care

Healthcare providers observed that cultural beliefs and desperation often lead patients to seek traditional and religious methods first, sometimes delaying proper medical treatment:

> Nearly all patients try various medications before seeking hospital treatment... These methods, including traditional and Islamic medicines, are often ineffective. (*KII with male HCP*)

> Seeing the positive outcomes of hospitalization motivates families to bring their loved ones for treatment. (*KII with male HCP*)

Despite these challenges, providers noted an increasing trend in awareness and access to medical care over time. Individuals with mental illness face numerous barriers, including social exclusion, discrimination, and inadequate access to basic needs and healthcare. The transition from traditional methods to medical treatment highlights the need for effective interventions that integrate both approaches, emphasizing the importance of timely medical care and improved awareness of mental health issues within the community.

The analysis reveals that cultural beliefs and desperation often lead patients to initially rely on traditional or religious methods, delaying necessary medical treatment. Healthcare providers note these methods are frequently ineffective, though increasing awareness of positive medical outcomes is gradually encouraging families to seek hospital care earlier. This highlights the need for integrated interventions that combine traditional and medical approaches while promoting timely access to healthcare and raising mental health awareness in the community.

Table 2: Mental Illness: Identity Impact and Support Systems

Impact and Support	Response	Frequency	Percentage
Places were identity get tampered due to mental illness **multiple options applied** **(**each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option**)**	At family level At community level At Hospital At Working place At Religious place Others (Pls, specify)	129 591 59 29 23 1	15.73% 72.07% 7.20% 3.54% 2.80% 0.12%
Forms of family support benefited when **mentally** sick **multiple options applied** **(**each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option**)**	Food assistance Medical assistance Financial assistance Material assistance Others (Pls, specify) None of the above	677 690 289 84 4 42	82.56% 84.15% 35.24% 10.24% 0.49% 5.12%
Level of involvement in domestic activities by the family after recovering from mental illness	High Middle Low Total	72 240 508 820	8.78% 29.27% 61.95% 100%
Level of involvement in social activities by community after mental illness recovery	High Middle Low Total	43 218 559 820	5.24% 26.59% 68.17% 100%
Level of involvement in health condition decisions by healthcare providers after recovering from mental illness	High Middle Low Total	135 574 111 820	16.46% 70.00% 13.54% 100%
Source of social support **multiple options applied** **(**each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option**)**	Family Friends Neighbors Coworkers Organizations Self-sponsored Others (Pls specify)	751 105 165 34 25 15 3	91.59% 12.80% 20.12% 4.15% 3.05% 1.83% 0.37%
Shouldering the economic burden of mental sickness **multiple options applied** **(**each response indicates the frequency of selection out of the 820 total respondents who chose that option, as indicated in the first option**)**	Family members Neighbors/Community members Co-workers Religious body NGO Government agencies Self-sponsored Others (Pls, specify)	704 153 30 92 30 9 21 2	85.85% 18.66% 3.66% 11.22% 3.66% 1.10% 2.56% 0.24%

Impact of Mental Illness on Identity and Community

Table 2 illustrates that 72.07% of individuals feel their identities are most affected at the community level, while 7.20% report significant impacts in hospitals. This highlights a substantial community influence on individual identity. The importance of family support is evident, with 84.15% receiving medical assistance and 82.56% benefiting from food assistance, reflecting a heavy reliance on familial aid. Post-recovery, 61.95% reported low family involvement in domestic activities, and 68.17% experienced limited community engagement, indicating ongoing reintegration challenges. The data reveals that while mental illness significantly affects identity within the community (72.07%), there remains a heavy reliance on family for medical

(84.15%) and food (82.56%) support, yet post-recovery reintegration is hindered by low family involvement in domestic activities (61.95%) and limited community engagement (68.17%), underscoring ongoing societal challenges for individuals recovering from mental illness.

Economic Exploitation and Dispossession

Qualitative data reveals that individuals with mental illness often face economic exploitation. One patient recounted.

> My money was taken, and I faced theft. People stole my property when I was sleeping in the hospital. (*IDI with Male Patient*)

This indicates that the patient experienced financial loss and theft of his personal belongings while he was hospitalized, indicating vulnerability and exploitation during his time in the hospital; this emphasizes the vulnerability of individuals during hospitalization, where their rights are overlooked. Furthermore, cognitive impairments lead to deceit in financial transactions, as noted by a relative:

> Due to his tendency to forget things, he faced challenges in business dealings. (*IDI with Male Patient Relative*)

This statement indicates that the patient's forgetfulness created difficulties in managing business transactions, likely leading to misunderstandings, errors, or missed opportunities, which negatively impacted his ability to conduct business effectively.

Safety Measures vs. Abuse

In various settings, safety measures can lead to abusive behavior. A traditional healer stated:

> Physical punishments and severe restrictions are often justified for safety. (*KII with Traditional Healer*)

> While hospitals may confiscate personal items for safety, they strive to maintain dignity as noted. Patients are treated with respect and dignity (*KII with Healthcare Providers*).

Safety measures can sometimes result in abusive behavior, as evidenced by traditional healers justifying physical punishments and severe restrictions in the name of safety. In contrast, hospitals prioritize safety through measures like confiscating personal items but emphasize treating patients with respect and dignity, highlighting differing approaches to patient care and protection across traditional and modern settings.

Supportive vs. Stigmatizing Environments

Support varies greatly, with some families providing essential support. However, stigma persists. This shows a stark contrast in family and community responses to mental illness. Some families provide essential support and respect, as seen in the case of the female patient, demonstrating positive familial involvement. However, stigma remains prevalent, as indicated by the male patient's relative, who reports negative comments from neighbors, highlighting persistent social stigma and its impact on mental illness experiences. This underscores the variability of support systems and the enduring societal challenges of mental health stigma. This dichotomy reveals the complexity of community interactions, where empathy coexists with misunderstanding.

The findings obtained from this study aligned with Social Constructionist Theory (SCT), demonstrating that mental illness is socially constructed through cultural beliefs and societal norms. The substantial social exclusion faced. Such as denial of employment and marriage opportunities, illustrates how mental illness is viewed as a disqualifying factor in social roles. Moreover, the varying degrees of respect in treatment reflect the multiplicity of meanings attributed to mental illness in different contexts.

This is indicating that appearance can mitigate stigma. The prevalence of derogatory terms further emphasizes how societal attitudes shape interactions, reinforcing barriers to recovery. This study illustrates the multifaceted challenges faced by individuals with mental illness and the critical role of familial and social support. The findings highlighted the need for comprehensive interventions addressing medical treatment, social stigma, economic support, family education, and community integration to foster supportive environments for individuals with mental health challenges. By reshaping societal perceptions, we can promote inclusivity and enhance recovery outcomes.

In line with the above, the study tested a null hypothesis which stated that there is no significant relationship between the perception of mental illness condition (curable, non-curable, mixed feelings) and the nature of community interaction with patients when mentally sick.

The hypothesis aims to determine if different perceptions influence community interactions, ranging from supportive to negative. Given that both variables are categorical (perceptions of illness and types of community interactions) the chi-square test of independence is the most appropriate method. This test assesses the association between categorical variables by comparing observed and expected frequencies, making it ideal for this analysis as it does not require assumptions about linear relationships or interval-level data.

Table 3: Cross Tabulation for Perception of Mental Illness Condition and the Nature of Community Interaction

Community Interaction	**Curable**	**Non-curable**	**Mixed feelings**	**Total**
Relate with sympathy and good approach	213	153	110	476
Relate with bad approach and abuses	96	64	62	222
Blaming the family for the sickness	22	21	20	63
Mixed approach (Good and Bad)	22	20	15	57
Others	1	1	0	2
Total	354	259	207	820
α=0.05 df: 8	Calculated Values: 5.82		Critical Value: 15.51	

The analysis for hypothesis shows that the chi-square value (5.82) is significantly lower than the critical value (15.51), leading us to fail to reject the null hypothesis. This indicates no significant relationship between the perception of mental illness (curable, non-curable, mixed feelings) and the nature of community interaction with patients. The type of interaction—whether sympathetic, abusive, or mixed, does not significantly depend on how the illness is perceived. This result suggests that community interactions with mentally ill patients are consistent, regardless of their views on the illness's curability. It highlights those other factors, such as cultural norms, stigma, or personal beliefs, may be more influential in shaping community engagement.

Discussion of the Findings

The findings from this study illuminate the multifaceted barriers faced by individuals with mental illness in Sokoto State, Nigeria, revealing significant social and systemic challenges. A notable 10.49% of participants reported being denied employment, 63.54% encountered obstacles in marriage opportunities, and 28.05% experienced restrictions in business activities due to their mental health status. These statistics underscore the pervasive stigma surrounding mental illness, affecting individuals' self-perception and societal integration. Social attitudes towards these individuals present a dichotomy; while 45.98% reported kindness, 5.61% experienced outright rudeness, with 21.71% noting authoritative behavior. This aligns with existing literature highlighting the negative impact of societal stigma (Jidong *et al*., 2021; Alemu *et al*., 2023; Gyamfi *et al*., 2025) and suggests that systemic discrimination remains a significant barrier despite some positive interactions.

Participants' narratives about traditional healing practices reveal a complex link between cultural beliefs and treatment outcomes. While some initially found comfort in traditional methods, many later transitioned to medical treatment, highlighting the need for better access to healthcare (Amzat &

Razum, 2018; Almu & Amzat, 2024). Basic needs like nutrition, hygiene, and safe housing are crucial for recovery, emphasizing the role of social support, consistent with prior findings on family and community involvement (Wada *et al*., 2021). This study also shows how stigma, socio-economic barriers, and cultural views of mental illness are interconnected, offering a more nuanced perspective on traditional healing's role in mental health care.

The findings resonate strongly with Social Constructionist Theory (SCT), which posits that societal perceptions and cultural beliefs significantly shape individual experiences of mental illness (Berger & Luckmann, 1966; Bwanika *et al*., 2022; Asiimwe *et al*., 2023). Barriers such as employment denial, social discrimination, and inadequate healthcare access illustrate how mental illness is constructed as a disqualifying factor within societal roles. Furthermore, the respect and dignity received by individuals appear contingent on their social context and personal circumstances, supporting SCT's assertion that societal attitudes can create divergent realities for those with mental illness. Participants' experiences of mixed treatment—ranging from kindness to disrespect—underscore the multiplicity of meanings attributed to mental illness, as illustrated by one participant's observation that respect could be influenced by visible attributes, highlighting the contextual nature of stigma.

Overall, this study sheds light on the complex landscape of mental illness in Sokoto State, emphasizing the urgent need for comprehensive interventions that address medical treatment while also working to reduce stigma and enhance community support systems. Integrating traditional and modern approaches to mental health care is crucial for fostering understanding and inclusivity within the community. By reshaping societal perceptions through culturally sensitive practices, it is possible to create a more supportive environment for individuals with mental health challenges, ultimately improving their recovery outcomes.

Conclusion

This study highlights the urgent need for systemic change in the perception and treatment of mental illness in Sokoto State, Nigeria. Pervasive stigma and social discrimination hinder recovery and societal integration. The interplay between cultural beliefs, socio-economic status, and healthcare access calls for a multifaceted approach. Addressing these barriers and creating a supportive environment can significantly improve the well-being and reintegration of individuals with mental health challenges.

Recommendations

1. **Launch Awareness Campaigns**: Awareness campaigns should be spearheaded by government agencies, non-governmental organizations (NGOs), and mental health advocacy groups throughout Sokoto State. Utilizing social media platforms, local radio stations, and community gatherings, these campaigns aim to educate the public about mental illness, its effects, and the importance of compassion. By addressing the pervasive

stigma associated with mental health, these initiatives will help foster a more inclusive environment, particularly in urban centers and rural communities, where misinformation often prevails.

2. **Implement Training Programs for Healthcare Providers**: Healthcare authorities, in collaboration with training institutions, should implement specialized training programs focused on mental health care. These programs must emphasize cultural sensitivity, effective communication, and the integration of traditional healing practices with modern medical approaches. This training will enhance the quality of care provided to individuals with mental illness, ensuring that healthcare providers are equipped to address their unique needs effectively. Training should take place in hospitals, clinics, and training centers across Sokoto State to reach a broad spectrum of healthcare professionals.
3. **Establish Support Groups**: Local governments, NGOs, and community leaders should take the initiative to establish support groups for individuals with mental illness and their families. These groups would provide resources and training on coping mechanisms and available treatments, aiming to create a supportive network that facilitates recovery and reduces feelings of isolation. Support groups can be set up in community centers, schools, and religious institutions, making them easily accessible to those in need.
4. **Advocate for Policy Reform**: Advocacy efforts should be directed toward government policymakers and stakeholders to push for reforms that protect individuals with mental illness from discrimination in employment and ensure equal access to healthcare services. This advocacy is crucial to eliminate systemic barriers that hinder individuals from achieving their full potential. Engaging with legislative bodies and government offices in Sokoto State will help create a more equitable environment for those affected by mental health issues.
5. **Facilitate Dialogue Between Practitioners**: Facilitate dialogue between mental health professionals and traditional healers to create a collaborative treatment framework that respects cultural beliefs and offers evidence-based care. Workshops, conferences, and local health facilities can promote these discussions, enhancing treatment options and fostering mutual respect between modern and traditional practices.

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