University of Salford
MANCHESTER

EXPLORATION OF THE LIVED EXPERIENCE OF YOUNG ADULTS DIAGNOSED WITH A MENTAL ILLNESS AND BEING TREATED AT A NIGERIAN PSYCHIATRIC HOSPITAL, REGARDING THEIR MENTAL HEALTH PROBLEMS.

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PhD THESIS NOVEMBER 2019

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THESIS
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Dedication

With gratitude I dedicate this thesis to God almighty who granted me the privilege and grace to start and accomplish this journey. I also dedicate it to my lovely daughter Akuchinyere Aileen Aaron whom I left in Nigeria for this study when she was barely six months old and to my two sons who were born during the period of this study and to my family. I am forever grateful for their patience, love and unwavering support.

Acknowledgements

There are several people I need to acknowledge and appreciate immensely for their unwavering supports throughout this intense four-year period of this study. Firstly, my special thanks go to the almighty God whose infinite mercies and grace kept me strong and resilient throughout this journey. Even when the turbulent became extremely and humanly unbearable His words and love comforted me. I would also like to specially thank the young adults in Federal Neuro-Psychiatric Hospital Enugu Nigeria, who participated in this study. They bestowed their confidence in me by sharing their difficult and emotional experience. And I am confident that I have presented their experiences very confidentially and at the same time giving voices to them in the society. This work would be incomplete if I fail to acknowledge and thank my indefatigable supervisors; Professor Susan McAndrew and Dr Eunice Ayodeji who provided me with all the supports and guidance and made me believe that I could successfully complete this study. I would also like to acknowledge and appreciate my family and friends who supported me in various ways to ensure that record success in this study. Their prayers and good wishes for me were faithfully granted by God. To my sponsors (TETFund/Ebonyi State University) who granted me a study leave, provided all the funds needed and believed that I can successfully undergo this study.

List of common Abbreviations

APA	American Psychiatric Association
CAMIMH	Canadian Alliance on Mental Illness and Mental Health
CBHSQ	Centre for Behavioural Health Statistics and Quality
DALY	Disability Adjusted Life Years
DOH	Department of Health
DSM	Diagnostic and Statistical Manual
FMoH	Federal Ministry of Health
GDP	Gross Domestic Product
GP	General Practitioner
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IFRCRCS	International Federation of Red Cross and Red Crescent Societies
MHLAP	Mental Health Leadership and Advocacy Programme
NNMHPAP	Nigeria National Mental Health Policy and Action Plan
NNYP	Nigerian National Youth Policy
NBS	National Bureau of Statistics
PHC	Primary Health Care
SSCSAST	Standing Senate Committee on Social Affairs, Science and Technology
UN	United Nations
WHO	World Health Organisation
WHO-AIMS	World Health Organization – Assessment Instrument mental Health System
WHO-MHAP	World Health Organisation – Mental Health Action Plan
WMHS	World Mental Health Survey

Declaration

I, Aaron Beryl Nwedu declare that every portion of the research work referred to in this thesis is my own original work and has not been submitted to any other university or organisation. To my best of knowledge, every other resource used to support this research work has been duly acknowledged by a way of citation within the text and included in the reference list.

ABSTRACT

Background: Globally mental illness is recognised as a public health issue with over 450 million people affected. Of that number 21% are young adults, with the majority living in low and middle-income countries such as Nigeria. In western society the service user movement has been active in developing policies and guidelines governing mental health care delivery, recognising the centrality of a person's expertise in his/her own life trajectory. However, little research has been carried out into young adults' lived experiences of their mental illness and wellbeing in Africa, and no such studies have been carried out in Nigeria.

Aim: This study aimed to explore Nigerian young adults' lived experience of their mental health problems and to ascertain how this affects their mental wellbeing.

Design: A phenomenological approach was used for this study. A convenient purposive sample of 16 young adults with a diagnosed mental illness was selected from a Nigerian neuro-psychiatric hospital. Semi-structured interviews were used to collect data and thematic analysis was undertaken.

Findings: Five major themes emerged from this study. These include: being mentally ill; violence and vulnerability; hopelessness; fear of the unknown; and spirituality, religion and faith.

Conclusion: The young adults emphasised that treating them in their own homes, having knowledge of their problems, being loved and accepted by the society, and being supported in returning to their careers would enhance their mental wellbeing and prevent subsequent crisis. Spirituality and religious faith provided hope and emotional support, and this needs to be incorporated into everyday practice if their mental health needs are to be holistically addressed. Future research needs to identify the willingness of health professionals and religious leaders to work together for the wellbeing of young adults with mental illness

Chapter 1 Introduction

1.1 Statement of the Problem

This study focuses on exploring the lived experience of young adults who are diagnosed with mental illness. According to Wakefield (2013), mental illness is a phrase mostly used by people to refer to mental disorders, mental conditions, or mental health problems when trying to endorse a biological model of why people have emotional distress. According to Szasz (2003), the actual behavioural syndromes in the Diagnostic and Statistic Manual (DSM) are disorders and not illnesses as there are no physical markers for them. In light of the above, mental illness, mental health problems, mental disorders, and mental health conditons are used interchangeably in this study. Moreover, most authors acknowledged in this study used those terms interchangeably.

Mental health problems are considered a major global public health issue (Prince *et al.*, 2007; Jacob, 2012; Whiteford *et al.*, 2013), with over 450 million people affected (World Health organisation, (WHO, 2011). Globally it is estimated that 300 million people are living with major depression, 90 million with substance abuse and 60 million having a diagnosis of schizophrenia. The majority of these individuals are living in low and middle-income countries where many non-biological factors that contribute to mental illness are evident.

The WHO (2013); Petrie *et al*. (2008) recognises the significant role of mental wellbeing as part of health per se, defining health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. Considering the above definition, WHO (2003) suggest that a definition of mental health should go beyond simply the absence or presence of diagnosable mental disorders, to consider the subjective wellbeing, perceived self-efficacy, competence, financial and physical autonomy, intergenerational dependence and recognition of the ability to realise one’s intellectual and emotional potentials. In light of the above definition mental health should not simply be considered as the absence of disorder, but rather a state of wellbeing in which an individual realises his or her own potential, can cope with the normal stresses of life, work productively and fruitfully, and is able to contribute to his or her society (WHO, 2003). This definition is particularly pertinent to young adults who are perhaps at the point of transitioning from dependent to independent life, and who are faced with the problems of mental ill-health. Globally over twenty percent of young adults have been reported to be experiencing some form of mental illness with the majority living in low and middle-income countries (Fisher *et al.*, 2011).

Mental illness can have profound impact on a person's quality of life (United Nations, 2014). Such consequences could be worst for young people considering the complexity of the processes they undergo during their transition to adulthood, and the nature of life demands within that phase, especially those in low and middle-income countries. For instance, mental illness remains the leading cause of adjustment problems in young adults and contributes largely to disability and lost productivity across the life course (Bradshaw *et al.*, 2010; Gore *et al.*, 2011). Other negative impacts of mental illness on young adults include; decreased quality of life, educational difficulties, poverty, inability to successfully form supportive and healthy relationships and lack of ability to manage conflict within those relationships (Kessler *et al.*, 2005; Bradshaw *et al.*, 2010).

While mental illness can have devastating and long-lasting effects on a person's life, in low and middle-income countries these are usually neglected as a public health issue due to a historical focus on communicable and other diseases that are presumed to be life-threatening, for example HIV/AIDS, tuberculosis, and malaria (Legido-Quigley *et al.*, 2013; Maartens, Celum and Lewin, 2014). The narrative is different in developed countries where some significant reforms in the mental health care system have taken place in the recent times (Power, 2010). Part of those reforms is the emergence of service user movement whose interest was to achieve holistic care by changing treatment philosophies and models of care. The service user movement in part is a response to the perceived inadequacies of the medical model that dominated mental health care delivery. The traditional interpretations of mental illness were challenged as service users' voices were brought to the fore in those countries (Power, 2010). The service user movement is now evident in the western world with their lived experience firmly embedded and driving official policies and guidelines governing mental health care delivery and recognising expertise by experience as a good resource (Attree *et al.*, 2011). However, the voices of young adults experiencing mental illness in low and middle-income countries have not been accorded the same opportunity despite acknowledgement of the majority of those experiencing mental illness being located in such countries. In the light of this, exploring the lived experience of young adults who are living with mental illness could generate a wealth of knowledge that would help service providers and practitioners provide individualised and more holistic care for those experiencing mental health problems. While some studies have tried to explore young adults' lived experiences of mental illness in western countries, only a few studies have been carried out in Africa and there has been none undertaken in Nigeria. Therefore, owing to the importance of this topic, this study will start to address this gap in mental health literature, and the findings will add important knowledge to the currently small existing body of knowledge in Nigeria which aims to improve the care of young adults diagnosed with mental illness.

1.2 Mental Well Being

To date, discussions around mental health appear to be associated with the elimination of mental illness with little or no attention to mental wellbeing. However, the WHO's (1948) definition of health acknowledged that *"health is not merely the absence of disease or infirmity, but a state of complete physical, mental and social wellbeing."* At a simplistic level this definition suggests that a balance has to be maintained between the physical, mental and social aspects of an individual for health to be achieved. Likewise, the WHO's (2004) definition of mental health acknowledged the centrality of wellbeing in a person's life; defining mental health as a state of wellbeing in which an individual realizes his or her abilities, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his or her community. In both definitions, the concept of wellbeing appears to be central to achieving health. A critical analysis of the definition of mental health suggests that mental wellbeing is interchangeable with mental health, as both terms emphasise a state of well-being and this being more than a simple absence of infirmity. However, achieving mental health and mental wellbeing is something that requires consideration of a person's life holistically, noting relevant factors that could negatively compromise it. According to the Department of Health (2011), mental wellbeing is having a positive state of mind and body, feeling safe, and able to cope, with a sense of connection with people, communities and the wider environment. Mental wellbeing may not indicate an absence of mental illness, as it is possible for mental wellbeing to be present in those who are diagnosed with mental illness (Cooke *et al.,* 2011).

In trying to ascertain factors inherent in mental welling Oguz *et al.* (2013) suggested wellbeing varies according to age, gender, and ethnicity. Moreover, a number of models have been developed to explain wellbeing; for example, Riff's Psychological Wellbeing Model (Ryff, 1989). Riyff's model of psychological wellbeing determines six factors which contribute to an individual's psychological well-being, contentment and happiness. His model of wellbeing suggests that psychological wellbeing consists of positive relationships with others, personal mastery, autonomy, a feeling of purpose and meaning in life and personal growth and development. He further suggested that psychological wellbeing is attained by achieving a balance of both challenging and rewarding life events (Ryff, 1989). While Ryff's original model contributed to addressing the neglected aspects of positive functioning, a more recent revision of the model suggests mental wellbeing could be subjective and may depend on a variety of factors (Ryff, 2014; Paul, 2017). Mental wellbeing is essential to every individual (Department of Health, 2011) and could mean different thing for different people, hence there is not a universally accepted definition of mental wellbeing (Oguz *et al*., 2013). What constitutes mental wellbeing may differ from individual to individual; hence, achieving mental wellbeing requires looking beyond the obvious, for example diagnosis and/or medication, to applying a holistic approach.

1.3 **Nigeria and Mental Health**

Nigeria is a country with an approximate area of 924,000 square kilometres and a population of about 180 million (Horton, 2007), accounting for approximately one sixth of the population of Africa. Of the 180 million people, about 42% live in the cities (Oyedeji *et al*., 2004).

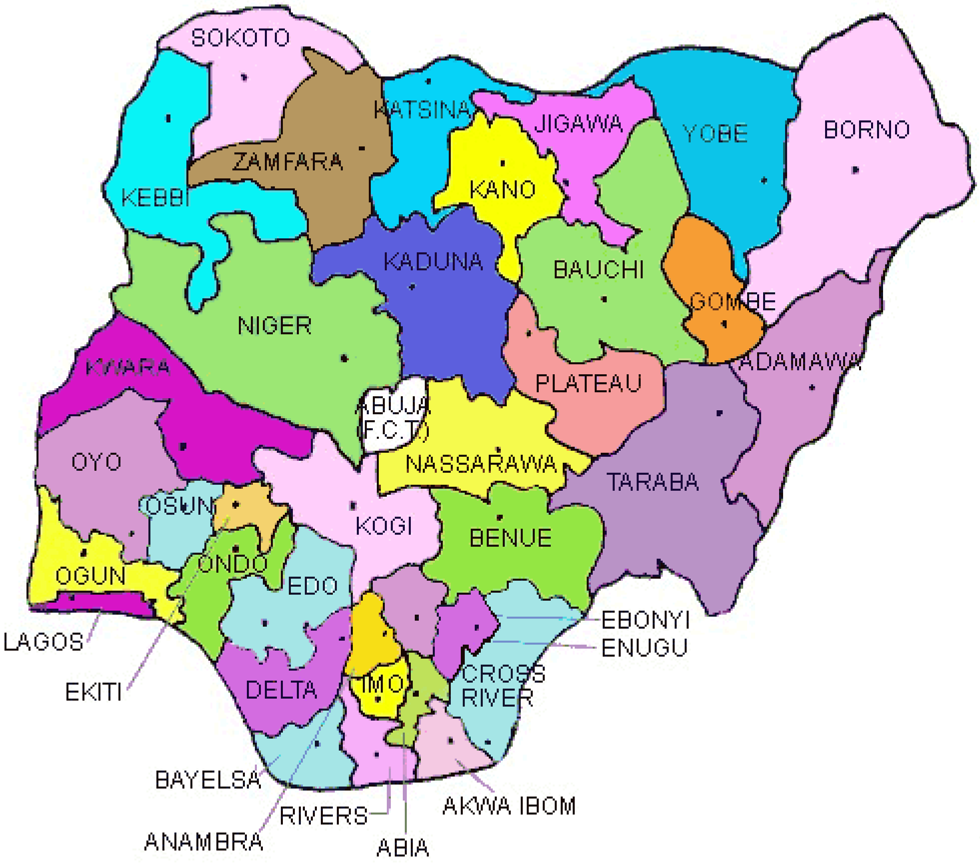

Figure 1.1 Map of Nigeria

The country has a diverse ethnic mix with over 200 spoken languages, of which three (Igbo, Hausa and Yoruba) are used by approximately 80% of the population. However, the official language of the government and educational instruction is English. Religious practices have a major role in Nigerian culture, influencing people’s attitudes and perceptions towards mental illness. Two main religions dominate; Christianity in the southern part of the country and Islam in the north. However, a large proportion of the population still embrace traditional religions exclusively or interwoven with either Christianity or Islam. Regardless of religious practices all influence the way most Nigerians perceive or view mental illness (Kabir *et al.*, 2004).

Although Nigeria is known as the most populated and richest country in Africa (WHO, 2005), it is still regarded as one of the low-income countries based on World Bank 2004 criteria. Crude oil, natural gas and agriculture remain the major source of income. The percentage of health budget to GDP is 3.3%. The per capita total expenditure on health is US $31, of which US$7 represented government expenditure (World Health Organization, 2004).

1.3.1 Nigerian Beliefs about Mental Health Problems

Historically there are varied explanations and interpretations regarding the nature, cause, symptoms and interventions for mental illness (Ahmed, Sun & Nazar, 2015). Mental health is said to be a socially constructed and defined concept, implying that every society, cultural or ethnic group and professional body have different ways of conceptualising its nature and causes, deciding what is mentally healthy or unhealthy and determining what interventions are the most appropriate (WHO, 2010).

In Africa, mental illness is always conceived to be a forbidden subject by most individuals because of the associated stigma, with many people shying away from any discussion relating to it (Amuyunzu-Nyamongo, 2015). For example, in a Ugandan study, many respondents expressed mental illnesses, such as depression, as being culturally forbidden (Ehiemua, 2014). Similarly, in Nigeria, mental illness is perceived as a curse or manifestation of evil spirits, with many people feeling uncomfortable in discussing the topic openly, especially if a family member is affected (Bakare, 2014). This is due to negative misconceptions, and people responding with fear, avoidance and anger to those observed to be mentally ill. Further, many Nigerians view mental illness as being underpinned by supernatural dimensions (Gureje *et al.*, 2005; Ojua & Omono, 2012). Supernatural beings, God, gods, evil spirits, witches, and their activities, are considered to be one of the major sources of mental illness, as well as part of the cultural asset which is often mobilised to treat mental illness (Oluwole, 1995).

Like other African countries, Nigerians attribute mental illness to an ancestral curse, charms, evil spell or possession or punishment, meted on the individual by the punitive gods (Garske & Stewart, 1999). Stigma attached to mental illness is the result of lack of education, fear, religious reasoning and general bias (Arboleda-Florez, 2002). However, a recent study (Ukpong & Abasiubong, 2017) revealed that beliefs about mental illness being associated with a supernatural cause are not only common among the uneducated, but also among educated people. This suggests cultural influence regarding mental illness is entrenched and exists irrespective of educational background. Beliefs about mental illness are usually based on the prevailing local belief system (Kabir *et al.*, 2004), with attached social stigma in Nigeria, and Africa at large, causing it to be a hidden topic equating to a silent epidemic. As a result of such attitudes, families now conceal mental illness among their members to avoid being discriminated against and ostracised by society.

1.3.2 Prevalence of Mental illness in Nigeria

In Nigeria, epidemiological psychiatric studies are scarce. Most of the studies measuring prevalence of mental disorders have been conducted in different regions using specific population samples (Afollayan *et al.,* 2015; Amoran *et al.*, 2005; Gureje *et al.*, 2006; Lasebikan *et al.,* 2012). Lasebikan *et al.* (2012), investigating the overall prevalence rates of mental disorders in Nigeria, found over 45.8% of the population had experienced some form of mental disorder, with somatoform disorder having a prevalence rate of 57.5%. Young age, gender and being single were reported as contributing factors. A retrospective study undertaken by Afollayan *et al*. (2015) revealed a high prevalence rate of schizophrenia (56.7%) among 4,494 patients admitted or in receipt of care between 2005 and 2009. Finally, a study carried out by Amoran *et al.* (2005), investigating the prevalence rates of mental illness in Oyo State, Nigeria, found prevalence rates of 21.9% among 1,105 respondents. Their study further revealed that 28.4% of the disorders occurred in rural areas and approximately 18.4% occurred in urban areas (Amoran *et al.,* 2005). This indicates a need to take mental health services to the rural areas, in addition to those provided within the cities.

1.3.3 Nigeria Mental Health Care System

The mental health system of Nigeria is a subsystem of the general health care system. The way in which services are organised, delivered and financed is significantly influenced by the way in which the country’s overall health system is organised (Olson, 2006;Jack-Ide & Uys 2013).

For instance, mental health has no clearly defined budgetary allocation in the national health budget of the country even though estimates indicate that approximately 3% of the annual health budget goes to institutional based services provided through twelve major psychiatric hospitals in the country (Gureje *et al.*, 2015). However, those who seek help through these hospitals are always made to pay for treatment and care out of their own pockets since the National Health Insurance Scheme (NHIS) coverage is limited only to federal government employees and large corporations.

Mental health services are mainly provided by government through dedicated psychiatric hospitals, psychiatric units and clinics (Mental Health Leadership and Advocacy Programme (MHLAP), 2012). Most of mental health services are provided by the twelve regional psychiatric centres and departments in the country, with the ratio of psychiatric beds being about 4 to 100,000 population (WHO, 2006). The private health care sector offers a very limited role in the provision of mental health services, however, most people with mental health problems turn to spiritual or traditional healers for help. Families who find their relatives' mental health issues too difficult or expensive to deal with at home simply pass the responsibilities to the prisons, creating a class of persons known as 'civil lunatics' (Westbrook, 2011). Instead of receiving treatment at a hospital or mental health institution, 'civil lunatics' are jailed in asylums within prisons where they obtain little or no treatment (Westbrook, 2011).

1.3.4 Human Resources in the Mental Care System of Nigeria

Human resources are the most important asset of mental health services (Che *et al.*, 2016; WHO, 2005). Such services heavily depend on the work force, competency, and motivation of its personnel to promote mental health, prevent mental illness and offer appropriate care to those in their care. Most mental health services in the developed world spend the largest portion of their annual recurrent budget on the training of personnel (WHO, 2005), resulting in having knowledgeable, skilled experts in the field. In Africa, there is still inequality and gaps in mental health care systems, with mobilization and development of manpower and resources being neglected (Dussault & Franceschini, 2006).

In Nigeria, the mental health care system is one of the least funded in Africa (Adebowale *et al.*, 2014). Psychiatric personnel are a scarce resource in the Nigerian mental health care system. There are only 130 psychiatrists covering a population of over 180 million Nigerians, with over 20 million Nigerians estimated to be living with a mental disorder (WHO, 2004; Gureje & Lasebikan, 2006; Adebowale *et al.*, 2014). The above suggests a ratio of 1:1milion.

One psychiatrist to one million people, while the ratio for nurses is 4: 100,000 population, and psychologists and social workers 0.2: 100,000 population.

1.3.4.1 The Relevance of this Study Regarding Mental Health Care in Nigeria

As stated above, Nigeria is the largest African country with a population of 180 million people, comprising of many ethnic groups with multiple languages, cultural and religious practices, influencing the way people perceive and make sense of mental health issues. Being a Nigerian citizen, who was born and bred in Nigeria, I have been exposed to a number of critical issues surrounding mental health and illness and how the latter affects Nigerian people. Also, having trained and practiced as a qualified nurse in Nigerian hospitals has further exposed me to mental health problems and the treatment and care the people of Nigeria receive. These experiences and more prompted me to explore how people with mental illness interpret and make sense of their mental health problems and to contribute information targeted at improving mental health care services in Nigeria. Hence, this research is geared towards contributing to the already existing, but limited body of knowledge regarding the mental health care system of Nigeria to help improve mental health services for the general Nigerian population.

1.3.4.2 Mental Health Policies and Mental Health Practices in Nigeria

Mental health policy is a framework by which a government highlights its plans towards tackling mental health problems within that country. In Nigeria, despite mental health problems being a constant challenge to the public health agenda, commensurate policies have not been established to help tackle its menace. To date the Nigerian government is yet to develop and adopt any plans that would mitigate mental health problems, despite the steady increase in the number of mentally ill people roaming the streets of Nigeria (MHLAP, 2012). In 2003, a draft mental health bill was presented to the National Assembly. The bill aimed to protect the rights of those with mental health challenges, ensure equal access to treatment and care, discourage stigma and discrimination, and establish a standard for psychiatric practice in Nigeria (Federal Ministry of Health (FMoH), 2015). Also, the bill made provisions for access to mental health care and services, voluntary and involuntary treatment, accreditation of professionals and facilities, law enforcement and other judicial issues pertinent to people with mental illness, mechanisms to oversee involuntary admission and mechanism to implement the provision of mental health legislation (FMoH, 2015).

However, the bill was not followed up or taken seriously until 2009 when it was eventually withdrawn (Jack-Ide, Uys & Middleton, 2013). Prior to the 2003 proposed bill, a Nigerian National Mental Health Policy and Action Plan (NNMHPAP) was formulated by the Nigeria Federal Ministry of Health (NFMoH) with the aim of integrating mental health care into primary health services (NFMOH, 1991). By propagating this policy, mental health became the ninth component of the country's primary health care (PHC) services, which was geared towards promoting, protecting, preventing, restoring and rehabilitating mental health. The motivation for this initiative was to ensure a socially and economic productive and fulfilling life for every individual living with mental illness (Adebowale *et al.*, 2014). While primary health care has seen increasing levels of specialisations from the primary to tertiary levels of care, despite the inception of the 1991 policy, mental health services have been systematically excluded from Nigeria's primary health facilities (Gureje, 2003; WHO-AIMS, 2006), with no trained psychiatric health professionals being assigned to community sites. The implication for failing to establish and implement robust mental health policies is that treatments for mental health problems are now being sought from traditional and religious healers by many Nigerians, thereby encouraging a double standard in Nigerian mental health practices (Lasebikan *et al.*, 2012; Nonye & Oseloka, 2017).

Generally, mental healthcare practices have been broadly categorised into modern (conventional, orthodox, western or allopathic) and traditional (indigenous, complimentary, alternative or integrative) groups (Adeosun *et al.*, 2013). Traditional medicine is described by WHO as the sum of all knowledge and practices, whether explicable or not, used in diagnosing, preventing and eliminating physical, mental or societal imbalances (WHO, 2003). Treatment of mental illness in Nigeria was predominantly through traditional healing (Oyewunmi *et al.*, 2015), until the wake of colonisation by the British government, when western (orthodox) methods of treatment were adopted as the mainstream approach for addressing mental illness (FMoH, 2005). However, despite the introduction and adoption of orthodox methods of treatment within the Nigerian mental health care system, failure by the government to reinforce it through robust mental health policies has created room for dual (orthodox and non-orthodox) and, in some instances substandard, mental health practices in Nigeria (Omogbadegun & Adegboyega, 2013). However, the Nigerian government has been anti-traditional and religious medicine practices in the country by refusing to fund them, patronage from the people remains widespread. Traditional healing has continued to thrive not only in the rural areas where over 70% of the population reside, but also in urban areas where people have greater access to orthodox medical facilities (Adefolaju, 2014).

Several studies undertaken in Nigeria (Aniebue & Ekwueme, 2009; Aghukwa, 2012; Adeosun *et al.*, 2013; Oyewunmi *et al.*, 2015) have uncovered a wide patronage of non-orthodox medicine. Lasebikan *et al*. (2012) reported that over 78.9% of the patients attending clinic in the western part of Nigeria confirmed that they have sought mental health treatment from traditional and religious healers first, before presenting at a hospital for orthodox treatment. Moreover, over 40% of patients attending clinic in the Northern part of Nigeria (Abdulmalik & Sale, 2013), 69% of patients in Lagos State Psychiatric Clinic (Adeosun *et al.*, 2013), and over 48% of patients in the South-South region of Nigeria (Jack-Ide *et al.,* 2013) all reported having sought traditional care services before approaching orthodox services. Lasebikan *et al.* (2012) and Adeosun *et al.* (2013) further revealed that most of the mentally ill people who attend psychiatric hospitals have also been found to be combining both orthodox and non-orthodox treatment at the same time, a situation that may complicate the recovery process. This is a serious concern for mental health care providers in Nigeria. For example, Adeosun *et al.* (2013) found people who patronise traditional and religious healers often have to visit six care providers before coming to the hospitals to seek professional help. This process exacerbates the delay in seeking professional help and when they do, they remain reluctant to adhere to their formal prescribed treatments (Ikwuka *et al.*, 2016). Considering this, many scholars (Gureje & Lasebikan, 2006; Horton, 2007; Saraceno *et al.*, 2007; Gureje *et al.*, 2015) suggest an official integration of both orthodox and non-orthodox medicine to help close the existing gaps in mental health practices in Nigeria. These authors argue that since the majority of people who experience mental illness patronize traditional and religious healers, either alone or in combination, any programme that will bridge the gap between the mental health needs of the Nigerian people and services must take account of the role played by traditional and religious healing. Uwakwe and Otakpor (2014) argues that while this might appear a good idea, a collaboration of orthodox and non-orthodox practices is a complex issue. Patel (2011) believes that mutual suspicion between the two sectors as the greatest obstacle to a positive collaboration. Patel further states that the major barrier in any such collaboration includes the fact that there is a great diversity of traditional healers and moreover, there is no agreement on what constitutes evidence to guide policy and practice when the epistemologies of traditional practice differ so much from that of orthodox practices (Patel, 2011).

Various explanations have been given as to the reason why traditional healing has thrived for so long, despite the acceptance of western medicine with regard to psychiatry by the health authority of the Federal Republic of Nigeria. Adefolaju (2014) believes traditional medicine had survived years of strong opposition and maintained a high level of patronage from society because it was developed in response to the dictates of their environment. Consequently, it is affordable, accessible and considered efficacious by the people. Others (Ayonrinde *et al.*, 2004) explain that the supernatural perspective of mental illness makes it more likely for treatment to be sought from religious and traditional healers who reiterate such underlying causes. Another school of thought (Gureje *et al.*, 2015) takes a more pragmatic view, indicating poor government policies on mental health, lack of trained professionals, inadequate treatment facilities and the high cost of services perpetuate double standards within the Nigerian mental health care system.

Regardless of the explanations given concerning the high level of patronage towards traditional healing, it is important to acknowledge Nigeria, as a country, continues to have a dual system of mental health care delivery which include; the officially recognised orthodox system and traditional system. Traditional medicine has suffered condemnation from the Nigerian government and westernised professionals have contributed to its relegation in favour of western medicine. This is a consequence of non-orthodox medicine being labelled as fetish, primitive, non-modern and non-rational (Ikwuka *et al.*, 2016). However, although the Nigerian government provides quantifiable formal mental health services that provide treatment and care to Nigerian communities, cultural beliefs regarding traditional and religious healers cannot be ignored.

1.3.4.3 Young Adults

Young adult is a term often used to describe the stage in which a person is considered to be mature and can independently start to take roles and responsibilities commensurate with their actions (Kunnuji, 2014). The United Nations (UN) define youth for the purpose of statistics as those between the ages of 15 to 24 years (United Nations, 2008), however, they acknowledge that this definition is without prejudice to other definitions by Member States. The UN also define adolescent as those between the ages of 10 to 19 years, leading to some confusion, with them referring to both groups as young people (UN, 2008). This implies that there is a class of adolescents that falls within the category of young adults and this could be referred to as late adolescence. Furthermore, the International Federation of Red Cross and Red Crescent Societies (IFRCRCS, 2011) defined “youth” and “young people” to cover persons in the age range of 5 to 30 years, however, IFRCRCS was made more explicit by categorizing each group according to their age brackets. For instance, they described children as those between 5 – 11 years, adolescents are those between 12 to 17 years and young adults are those between 18 to 30 years (IFRCRCS, 2011).

In Nigeria youths are defined as any individual between the age of 18 and 35 years (Nigerian National Youth Policy (NNYP), 2009). Although in Nigeria the official age at which a person becomes an adult and is responsible for their actions is 18 years (National Bureau of Statistics, NBS 2011) the reality is that, it is difficult to find an 18-year-old person in Nigeria who is financially independent and can comfortably raise a family independently. At age 30, most Nigerian youths are just finishing their tertiary education to start seeking employment, and at 35, some are still unmarried because of lack of financial resources. This is contrary to their counterparts in western countries, where it is commonplace for youths aged 18 or 23 to have a very clear sense of purpose and direction (National Bureau of Statistics, 2011). Focusing on young adults was considered important for this study because of the psychological, emotional and economical challenges which Nigerian young adults encounter while assuming an adult's roles, not least that of economic hardship and its implications on mental wellbeing.

1.3.4.4 Young Adults and Mental Health Problems

Having grown up and spent most of my life in Nigeria, coupled with my years of experience as a qualified nurse who has worked in a psychiatric hospital, I observed with dismay the number of young adults who were living with a mental health disorder. Nigeria being African most populated country has over 67 million young adults (Dowdy *et al.*, 2013). However, the official statistics for young adults living with mental illness is hard to establish, but reports suggest over 29% of the young adult population are living with a mental disorder, but unfortunately less than 10% of them access mental health care from specialist services (Abdulmalik & Sale, 2013; Adebowale *et al.*, 2014). An earlier study reported prevalence estimates for Nigerian youth with mental illness accounting for approximately 13% of the country's burden of diseases (WHO, 2006), this figure may have increased by now. Whilst there are mixed opinions regarding the actual age of onset of mental illness (CBHSQ Centre for Behavioural Health Statistic and Quality, 2011), in western society half of all mental health problems are said to be established by the age of 14 years, rising to 75% by the age of 24, indicating that problems increase with age (MHT Mental Health Taskforce, 2016). This is also reflected in the study of Merikangas *et al.* (2010) in which there was almost a twofold increase in mental disorders from the 13 to 14-year-old age group to the 17 to 18-year-old age group. Also, when comparing the rate of mental disorder among young adults aged 26 or older it is more than two times higher than it is for younger aged adults (CBHSQ, Centre for Behavioural Health Statistic & Quality, 2013).

Transition to young adult has been described as a critical period for young people (McGrandles & McMahon, 2012). This assertion is premised on the fact that during the transitioning stage, young adults are expected to be physically, psychologically, financially, and socially competent in order to face the responsibilities of adulthood (Xie *et al.*, 2014). Undergoing this transitional stage whilst experiencing mental illness could be very challenging and may hinder their preparedness to undertake adult roles and responsibilities compare to their peers who are mentally healthy (Davis, 2003). Studies have also shown up to 30% of disability-adjusted life years (DALY) among young adults up to the age of 30, have been attributed to mental health problems (Lopez, 2006; Kieling *et al*., 2011). Apart from the untold burden mental illness brings to any country, the young adult's development, quality of life, role functions and ability to fully participate in their communities are often compromised (Fisher & Cabral de Mello, 2011). Furthermore, a prolonged transition to adulthood due to mental illness may further increase the demands on relatives to continue to care for the young adult, even though they have attained the age of being independent (Lindgren, & Derberg, 2016).

Despite the negative impact mental illness can have on young adults, their families and society at large, commensurate attention has not been paid to their mental health and wellbeing (Bradshaw *et al.*, 2010). For example, the mental health system in Nigeria has previously been described as being inept in meeting or addressing the needs of young adults with mental health problems (Issa *et al.*, 2008). Nigeria is a typical example of low-income countries, with mental health services being poorly structured and funded; making it difficult to be accessed by those who really need such services (Abdulmalik & Sale, 2013). Nigeria's mental health care system has, for a long time, been based on narrow biological and/or medical ideation, with very little attention being given to other factors that could influence the wellbeing of those living with mental illness. Exploring the lived experience of young adults who are at a stage in life when they will be expected to take on full adult roles and responsibilities, but are struggling with mental illness, could generate a wealth of knowledge that would help service providers and practitioners in Nigeria deliver more holistic care.

While many studies have tried to explore this phenomenon in developed countries (Prins *et al.*, 2008; McCann & Lubman, 2012; Simmons *et al.*, 2014; Montague *et al.*, 2015), little research has been carried out in Africa, and no such studies have been carried out in Nigeria. In Nigeria there remains a lack of research on how the experience of mental illness affects young Nigerian adults' mental wellbeing and future life. In western society the service user movement has recognised the centrality of a person's expertise in his/her own life trajectory (Warne & McAndrew, 2007; Norman, & Ryrie, 2013; Simmons *et al.*, 2014). Accepting such expertise regarding their mental health is particularly important as this can often determine the kind of help seeking behaviours he/she pursues and subsequently inform how services are best delivered (Simmons *et al.*, 2014). In the light of the above evidence, this study aimed to explore Nigerian young adults' lived experience of their mental health problems and to ascertain what factors they feel might influence their mental wellbeing and the implications of such for future service delivery.

1.3.4.5 Stigma and Mental illness

Mental health problems have constantly been shown to be one of the major contributors to the global disease burden (Ross & Goldner, 2009), and its impacts on co-morbidity, disability and mortality are often experienced at regional, national and international levels (SSCSAST, Standing Senate Committee on Social Affairs, Science and Technology, 2006; CAMIMH, Canadian Alliance on Mental Illness and Mental Health, 2007; Lauber & Sartorius, 2007). Although, the prevalence of mental illness is high (WHO, 2004), efforts to ameliorate the situation are often sabotaged by the low level of treatment seeking behaviours often exhibited by the affected groups (CAMIMH 2007; Lauber & Sartorius, 2007).

A global statistic suggests that over 70% of people diagnosed with mental illness do not seek nor receive treatment from health care professionals (Thornicroft *et al.,* 2007). One of the major reasons identified for the low level of treatment seeking behaviour is stigmatization (Fung *et al.*, 2007; Henderson *et al.*, 2013). Stigma is described as a devaluing attribute that marks person(s) as stained, calls their identity into question and allows them to be devalued, compromised and regarded to be less of a human being (Abdullah & Brown, 2011). People with mental illness often have to battle with dual challenges (Rüsch *et al.*, 2005; Rüsch *et al.*, 2011; Corrigan *et al.*, 2016). Amidst the numerous devastating symptoms of mental illness which interfere with their normal daily lives, a mentally ill individual also often experiences the stigma born out of societal misconceptions about mental illness (Overton & Medina, 2008). The negative and false assumptions associated with mental health problems could be as harmful as the illness itself. Those who experience mental illness are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of the society (Benbow, 2009). The consequences of such attitudes towards those who experience mental illness may be a significant reduction or limit opportunities that should be available for them throughout their lives. There is also a general view that stigmatization benefits from multi-cultural and religious practices (Nieuwsma *et al.*, 2011), implying stigmatization is limited to or more prevalent in non-western countries where multiple cultures and religions are being practiced (Mark *et al.,* 2007; Ross & Goldner, 2009). Abdullah and Brown (2011) recently uncovered a wide range of cultural beliefs in a review of ethno-cultural beliefs and stigma in mental illness; while (Nieuwsma *et al.*, 2011) asserted that cultural and religious teachings often influence people's beliefs about the etiological origin and nature of mental illness and helps to determine or shape people's attitudes towards the mentally ill. For instance, in western countries, there is a high acceptance of scientific explanation indicting biological and genetic factors as the causes of mental illness (Pescosolido *et al.*, 2008). This speculation aligns with the findings of a recent study by WonPat-Borja *et al.* (2012) involving Chinese Americans and European Americans. Genetic attribution of mental illness reduced the unwillingness to marry and reproduce among the Chinese Americans but increased the unwillingness to marry and reproduce among the European Americans. Rüsch, Angermeyer and Corrigan (2005) earlier argued that as far as mental illness is concerned, stigma seems to be widely endorsed and supported by the public, including those living in western countries irrespective of the inconsistent reasons for stigmatization across global communities. More studies also revealed that majority of citizens in the United States and many European countries have stigmatising attitudes about mental illness (Corrigan & Watson, 2002; Rüsch, Angermeyer & Corrigan, 2005; Bresnahan *et al.*, 2008; Mascayano *et al.*, 2016).

A recent national poll in America (Barry *et al.*, 2013) revealed a high level of stigmatization with 47% of the population believing that people with serious mental illness are by far more dangerous than the general population, 67% of the respondents were unwilling to have a person with a serious mental illness as a neighbour and 71% were unwilling to have a person with a serious mental illness working closely with them on a job. This counters the views that stigmatizing attitudes are limited to those countries with multiple cultural and religious practices (Mark *et al.,* 2007; Ross & Goldner, 2009). Nevertheless, a World Mental Health Survey (WMHS) involving 16 countries from America, Europe, Middle East, Africa, Asia and South Pacific, showed that cultural and religious practices have a significant role on stigmatization in mental illness (Alonso *et al.,* 2008). The survey showed that 22.1% of the participants from developing countries and 11.7% of participants from developed countries experienced stigmatization due to their mental illness. Moreover, a study carried out in England and Scotland demonstrated a drop in stigmatization rates being attributed to the ongoing anti-stigma campaign "time to change" (Mehta *et al.*, 2009).

In Nigeria, the burden of mental health problems is always being compounded by stigma and discrimination, which in turn compromises the provision and utilization of mental health services (Ssebunnya *et al.,* 2009). Nigeria being a country with multi-cultural and religious groups, hold diverse views about the origin and nature of mental illness (Adewuya & Makanjuoal, 2008). Some of the origins of mental illness includes; it being the result of one's sins or evil deeds, drug misuse, charm, punishment from God, traumatic event, and/or stress, with little belief on biological and genetic causation. The subject of mental illness is always culturally avoided in Nigeria, with many people feeling uncomfortable in discussing the topic openly, especially if a family member is affected (Bakare, 2014). The affected individuals often feel ashamed of themselves and find it difficult to freely relate with people in their society, due to misconceptions, and people responding with fear, avoidance and anger to those observed to be mentally ill. The stigma, myths and superstitious beliefs surrounding mental illness helps in encouraging the discrimination and human rights violations often experienced by those with mental illness in Nigeria (Adewuya & Makanjuoal, 2008). In addition, the laws, cultural practices and social norms in Nigeria gives extensive powers to guardians or families of individuals with mental illness to decide where they should live, their movements, personal and financial affairs and their commitment to mental care services (Ude, 2016).

Regardless of the reason(s) for stigmatization in Nigeria, studies from Nigeria show stigmatization against mental illness is high (Kabir *et al.*, 2004; Gureje *et al.*, 2005; Barke, Nyarko & Klecha, 2011). In the study of Barke *et al.* (2011), it was highlighted that patients extensively experienced stigmatization with most of them feeling devalued, discriminated, and socially deprived. A high level of social distance was also revealed among the general Nigerian population and among a population of Nigerian University students (Adewuya & Makanjuoal, 2008).

While making sense of prejudice, stereotypes and discrimination experienced by people who live with mental illness, researchers have distinguished public stigma from self-stigma (Corrigan *et al*., 2016). Public stigma represents is the prejudice and discrimination directed at a group by the general population of which that group belongs (Corrigan & Bink, 2015). Self-stigma occurs when the stigmatized group holds and internalize the negative attitudes held against or about them by the general population (Corrigan *et al.*, 2006). Those stigmatized often experience numerous negative consequences as a result of the internalization. The more the mentally ill persons feel stigmatized, the lower their self-esteem, the lower their social adjustment and the lower their quality of life (Link *et al.*, 2001; Perlick *et al.*, 2001; Graf *et al.*, 2004). The adverse effects of stigma in mental illness on the family relationship, employment discrimination and general social rejection have been studied (Corrigan *et al.*, 2001; Stuart, 2006). Moreover, stigma influences access to care because the individuals with mental illness feel reluctant to seek help from professionals because they are afraid of being sighted by peers (Rüsch *et al.,* 2005; Schomerus, Matschinger & Angermeyer, 2009).

In summary, negative and stigmatizing attitudes towards mentally ill people have direct negative consequences on prevention, treatment, rehabilitation and quality of life of those affected (Barke *et al.,* 2011). Two Nigerian studies (Jack-ide *et al.,* 2013 & Ikwuka *et al*., 2016), revealed that stigma prevented people who have mental health problems from seeking help from professionals.

1.3.4.6 Service Users/Survivor Movement

In western countries the active involvement of service users in shaping and influencing services has been part of health policy for over 3 decades (Lewis, 2014). In the UK for instance, this has been incorporated into health policy (Lewis, 2014). The service user movement has continued to gather momentum, grown in strength and remains central to the field of psychiatry (Millar *et al.,* 2016). The mental health service users' movement is believed to have its origin in the 1990s, a period which witnessed unusual interest in, and collective action to secure equality and protect their human rights (Lakeman *et al*., 2007).

The mental health service user movement is believed to have drawn much of its strength from the anti-psychiatry movement (Szasz, 2007), whose campaign opposed the medicalisation of problems of living (Lakeman *et al*., 2007). While other social groups could have triggered the emergence of service users/survivor's movements, it is important to note that central to this particular movement was a high level of human rights abuses and injustices experienced by those labelled mentally ill (Cohen, 1998). The mental health service user movement was able to articulate a number of challenges regarding the abuse of human rights and injustice, including; physical restraints, stigmatisation, discrimination, poor treatment methods, substandard hospital environments and poor food (Lakeman *et al.,* 2007). While patients from other medical specialties have successfully campaigned for more patient centred care and mutual support (Baggott *et al.,* 2006), mental health service user groups sought a complete change in the way services were organised and delivered, a change in their living conditions and the way in which mental illness is understood and treated (Mansbridge, 2001).

The service user movement was geared towards giving voice to the voiceless mental health service users (Lakeman *et al*., 2007), acknowledging their first-hand experience of illness and the services they receive. Getting service users actively involved in their care would give them the opportunity to say what they want and how they should be treated, hopefully leading to improved policy and practice (DoH, 2009; Lewis, 2009 Lewis, 2009). This has eventually led to service users being acknowledged as ‘experts -by –experience’ with a privileged understanding of their mental health problems, what they want for their wellbeing and how current service provision is or is not meeting their needs (Department of Health, 2011). This implies that the service user voice is not only important for their own interest, but also for the interest of those who may experience similar problems in the future and those providing care. The involvement of service users in mental health policy, planning, legislation, provision of service, and onward evaluation is also enshrined in the WHO Mental Health Action Plan (WHO-MHAP) (WHO, 2012).

However, despite the wide acknowledgement of the importance of service user expertise, little or no effort has been made towards involving service users in strengthening mental health service in low- and middle-income countries (Semrau *et al.*, 2016). For instance, in Nigeria, Nwaopara and Daniel (2016) identified lack of mental health service user involvement in the Nigerian mental health care system and linked it to an unsatisfactory service. In conclusion Nwaopara and Daniel (2016) called for studies to be more service user oriented in order to promote a sense of involvement and belonging. In addition, acknowledging service users’ first-hand experience of being diagnosed with mental illness and engaging in the care services will generate a wealth of knowledge that will help mental health professionals in Nigeria further improve services and ultimately the wellbeing of its population.

1.4 **Psychiatric Models**

There are many models of mental illness such as Harry Stack Sullivan’s development model (Regan, 1990), Maslow’s/Roger’s humanistic model (Maslow & Rogers, 1979), life course model approaches and more, however, for the purpose of this thesis I have presented below a brief overview of four of the more popular ones that often feature in mental health literature namely; the medical model, anti-psychiatry, sociological and psychological models.

1.4.1 A Medical Model of Mental Illness

The medical model of psychiatry is described as a scientific procedure involving observation, description and differentiation which has moved from the task of recognising and treating symptoms to identifying disease aetiologies (Shah & Mountain, 2007). The uncertainties surrounding the medical model has led to it being described as an old-style, unfashionable, and often criticised way of interpreting mental illness (Shah & Mountain, 2007). It has been noted that a level of confusion exists regarding what constitutes the medical model, however, several interpretations have been given. While some perceive the model as a scientific process that produces new information about mental illness (Eisenberg, 1986), others suggest it as a cold, reductionist science that is determined to reduce every emotional behaviour to a biological origin (Bracken & Thomas, 2001). The fundamental belief of advocates of the medical model is that those disorders that people refer to as mental problems such as schizophrenia, depression, bipolar disorder and others are not mental problems per se, but they are diseases of the brain which can only be studied through scientific means (Deacon, 2013). This view has been influential in the field of psychiatry to the extent that other important aspects of peoples' lives are often omitted or ignored (Nesse & Stein, 2012). The influence of the medical model was evident in a WHO report (2007) which reiterates mental illnesses having a physical origin in the brain.

Although, in the western world, it is generally accepted that mental disorders involve a disruption in one or more areas of human functioning such as thoughts, emotions, and behaviours, explanations for mental illness are still being debated (Pilgrim & Rogers, 2005; Harper & Cetin, 2008) There are contrasting notions between, and to some extent within the various disciplines concerned with the field of mental health, about the aetiologies and management of mental illness (Szasz, 2003; Frances, 2009; Insel, 2009; Whitaker, 2010). However, the current language and practice of mental health appears to be resting exclusively on the medical model which only involves the observation of human emotions and behaviours, the identification of pathological symptoms, the diagnosis of illness and the prescription of an appropriate treatment (Szasz, 2011). In the opinion of Bracken and Thomas (2001), the medical model of psychiatry only operates on assumption, given that mental health diagnosis is all about accurate naming of an objective disease process as enlisted in Diagnostic and Statistical Manual published by American Psychiatric Association. Current recognised mental illnesses are those contained in the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association, 2013) and International Classification of Disease (WHO, 2005), guidebooks that inform professionals about what and what not to be diagnosed as mental illnesses. Both are commonly used in western society promoting medical concepts and terminology and outlining categorical disorders that can be diagnosed by set lists of criteria. However, these are always subject to change over time, allowing the authors of such to remove and add categories of illness periodically (WHO, 2005). This reflects the assumption that mental illness is a construction which are not static, but can be altered over time (Szasz, 2003). Regardless of the assertions underpinning the medical model, one thing remains certain, the presence of mental illness cannot be scientifically tested or measured in laboratories like other physical ailments such as infections, heart diseases, and fractured bones (Szasz, 2015).

In contemporary psychiatric practice, a diagnosis of mental illness is still a subjective assessment based on professional opinion (Tew, 2005). This has led to psychiatrists having varied perceptions about diagnosis, prognosis, aetiology, and treatment of mental illness when compared with other branches of medicine (Colombo *et al.*, 2003).

While sociologists have been particularly critical of the medical model (Batrusaityte, 2003; Walker, 2006), the most robust criticisms have come from psychiatrists themselves. Prominent among the critics from the profession of psychiatry who strongly challenged the assertions of the medical model includes Thomas Szasz, Laing and David Cooper (Roberts & Itten, 2006). They were labelled as being ‘anti-psychiatry’ because they rejected the biological explanation of mental illness and their critiques publicly threatened the credibility of the medical profession.

1.4.2 Anti-psychiatry

While many professionals and social groups still accept psychiatry as having validity and legitimacy, others consider it to be pseudoscientific and an unsupportive form of medicalising or pathologizing common feelings and behaviours (Szasz, 2003; Wakefield, 2013). Thomas Szasz, a trained psychiatrist, was one of the most prolific critics of the medicalisation of mental illness, thereby tagging psychiatry as a pseudoscience (Szasz, 2003). In one of his influential books titled ‘The Myth of Mental Illness’ (Szasz, 1960) he argued that mental illness is a metaphor for human problems in living, and mental illnesses are not real unlike other physical ailments that have a pathology. By this statement, he did not mean that such problems do not exist (Roberts, 2007), rather such things referred to as mental illnesses did not meet the characteristics of disease or illness as to be called such. Szasz described mental illness as the struggle to confront and tackle life’s problems, and by classifying such issues as a disease or illness could result in hiding the very real problems people face in their daily lives (Robert, 2007; Szasz, 2007). For some, Szasz’s work holds contemporary relevance, because it has provided mental health professionals the opportunity to understand mental health problems in the context of an individual’s life (Robert, 2007).

The social uses, functions and consequences of a medical model of psychiatry is further criticised on the ground that it is an ideology which defends covert social control in some societies (Leifer, 1982). Establishing that person/s who complain of or exhibit certain forms of undesirable thoughts, mood or behaviour are mentally ill, will not only render them vulnerable to being managed by the mental health system, but also will exposes them to stigmatisation, deprivation of freedom and coerced treatment (Wakefield, 2013). Forceful confinement and the medicating of an individual could be judged as a means of social restriction and infringement of human rights. Although Szasz contends the medical model of psychiatry, he maintained that he is not anti-psychiatry, but rather he is anti-coercive psychiatry practice (Szasz, 2007). He was a known opponent of civil commitment and involuntary psychiatric treatment but believed in and practiced psychotherapy and psychiatry between consenting adults. He maintained that if mental illnesses are truly medical illnesses as claimed, then treatment following the ethical injunction of western medicine and resting on the premise that every adult patient has the freedom to seek, accept or reject medical diagnosis and treatments, should be available (Szasz, 2003). In contrast, psychiatric practice is based on the premise that a mentally ill person may constitute danger to self and/or to others and as such psychiatrists have the moral and professional right to enforce involuntary treatments which contravenes western medical ethics (Szasz, 2003).

Szasz insists that the physical illnesses have causes that can only be prevented or cured by dealing directly with the causes. Conversely, those said to have mental illness that cannot be accounted for by any biological factors may have reasons for their problems which may be understood but cannot be treated or cured with medications or other medical procedures (Szasz 2007). The internal critics of the medical model of psychiatry are of the opinion that people with such emotional and psychological problems may benefit more from those who respect them, listen and understand their predicament from their own perspectives rather than treating them based on the clusters of signs and symptoms as evident in the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association, 2013). It is believed that the subjective experience of an individual may help care providers to gather a wealth of knowledge that may reflect non-pathological factors which will in turn determine the kind of treatment that will benefit the person most (Lauber and Sartorius, 2007).

1.4.3 Sociological Model of Mental Illness

The applicability of the medical model to mental illness has also been questioned by sociologists over the years, the meaning of the term remaining a contentious issue (Murali, 2004; Albrecht, 2012). The medical model has been accused of being myopic in its attempts to explain the aetiology and treatments of mental illness (Batrusaityte, 2003), this is because it focuses on biological factors, thereby omitting interpersonal and social factors, particularly those based upon social variations, conflicts, and power differentials (Deacon, 2013; Geller, 2011; Read & Harré, 2001).

Although medical science has over the years tried to lay claims that mental illnesses are purely biological and pathological disease of the brain (Cockerham & William 2011), sociologists view mental illness and its consequences as the product of multiple factors, including environmental and social factors (Scheff, 1984; Branaman, 2006; Peng, 2009; Thoits, 2012). This reinforces the notion of understanding health as being more than the absence of disease and acknowledges the fact that being healthy is a dependant of several factors including a healthy environment and stable mind (Bhattacahrjee *et al.*, 2011), with wellness comprising of; emotional stability, clear thinking, the ability to love, create, embrace change, exercise and perceiving and experiencing a continuing sense of spirituality (Swarbrick, 2006). Hence wellness is said to be multidimensional (Hettler, 1976). Sociologists strongly believe that the causes and treatments of mental problems cannot be fully discussed without exploring other possible associated social factors such as social relationships (Turner & Brown, 2010). For example, research has revealed that married people are less vulnerable to distress than those not married (Ames, 2000; Mirowsky & Ross, 2003). Also, the mental health of people with regular contacts with family, friends, and neighbours, involvement with voluntary organisations, and participation in religious communities appears to be more protected (Lin, Ye and Ensel, 1999; Thoits & Hewitt, 2001). With regard to young people, poor mental health has been strongly predicted among those who experienced breakups in a romantic relationship (Stoyanov *et al.*, 2016).

Research on social determinants of mental illness focused on a variety of demographic variables, such as race/ethnicity, socioeconomic status, age, marital status, and gender (Murali, 2004; Mossakowski, 2009). Two important social theories arising from the existent research are social causation and social selection/drift theories (Dohrenwend *et al.*, 1992), both of which attempt to better explain mental illnesses. In social causation theory Dohrenwend *et al.* (1992) suggest that the adverse social and economic effects of poverty such as financial problem, experience of violence, income insecurity, food insecurity, lack of education, and scarce resources to protect an individual in the moments of adverse life events intensify risk for mental problems.

Muntaner *et al.* (2004); Nielsen *et al.* (2004) also explained that people of lower social class are usually at higher risk of encountering negative factors such as adversity and stress which make them more vulnerable to mental illnesses. The socioeconomic factor was found to be consistently associated with raised odds of poor health outcomes, especially when in receipt of income support (Grundy & Sloggett, 2003). Although a causal link between mental illness and socioeconomic factor is strongly stipulated, the mechanism is not completely clear (Warren, 2009). However, the idea could be attributed to the fact that people of lower socioeconomic status often experience an untold economic hardship that barely allows them to afford the basic needs of life such as a healthy diet, good home, good education, access to health facilities and/or a good social life (Kaplan *et al.*, 2001; Thomas *et al.,* 2007). On the other hand, social selection/drift theory opposes social causation theory, suggesting that it is the mental illness that causes individuals to shift in social class and not the opposite (Dohrenwend *et al.,* 1992). This was premised on the ground that individuals experiencing mental illness drift into poverty due to disability, reduced economic productivity, loses through health expenditure, increased stigma brought about by their mental illness (Elstad, 2001; Chandola *et al.*, 2003). For example, in a longitudinal study carried out in Hagerstown, Maryland (Warren, 2009) concluded that the relationship between socioeconomic status and chronic illness has a strong tendency of causing chronically ill individuals to drift downward in their socioeconomic statuses. In a more recent study, Chandola *et al.* (2003) found significant effects of mental health on changes in socioeconomic status among men and women.

However, although some researches have been directed towards assessing which of the two theories explains the relationship better, a critical analysis of the two acknowledges that both social causation and social selection/drift theories may have merit and have illuminated the impact of social inequality on people’s mental health (Mulatu & Schooler, 2002).

Two other important sociological theories about mental illness are the sick role (Faris and Parsons, 1953) and labelling theory (Scheff, 1974). Both the sick role and labelling theories accept that mental illness is attributed to people by society and/or professionals. Sociologists believe sickness is seen as a form of deviant behaviour (Cockerham, 2016). The sick or illness role and labelling theory both suggest mental illness is often depicted as a social deviant role which differentiates those who experience mental illness from other members of the society (Smith & Smith, 2006). Both Parsons and Scheff maintain a similar idea, that those defined as mentally ill take and internalize an altered interpretation of their real selves and their behaviours, as part of a re-socialization process into a deviant status according to their illness.

Although Parson is regarded as the first person to conceptualise illness as deviance, his focus was on how the various components of society function so as to keep the whole system in equilibrium (Conrad & Barker, 2010). His concern was specifically related to the social control of deviant behaviour, arguing that the sick role is usually achieved through primary socialization processes. Faris and Parsons (1953) further suggested people could voluntarily decide to be sick, adopting the sick role in order to be excused from their social responsibilities. However, because of the high expectation placed on professionals, and in order to protect their professional credibility, the psychiatrist may feel forced to classify people presenting to services into a unitary group and create an opportunity to treat them in order to satisfy societal expectations (Jutel, 2010; Mik-Meyer & Obling, 2012). Similarly, because of the benefits attached to being sick, and in order to be seen as legitimate patients, an individual may adopt a sick role by engendering the symptoms of sickness which are then labelled.

Scheff (1974) went further in explicating Parson's theory through labelling theory. Labelling theory holds that deviance is not inherent to an act, but is imbedded in symbolic interactionism (Stryker, 1980). Hence, in terms of symbolic interactionism the meanings of social objects (persons and actions) are socially constructed, and responses in social interactions are always based on assigned meanings that are drawn from a shared cultural knowledge and the internalised attitudes of the generalised others (Markowitz, 2011). Within labelling theory, the primary concern is with how self-identity and behaviour of individuals may be determined or influenced by the terms used to describe or categorise them (Scheff, 1984). Scheff argues that it is merely deviance from the societal norms that results in people accepting and believing they are experiencing mental illness.

Different societies have what they regard as social norms upon which people's behaviours and actions are judged. If a person's behaviour does not coincide with the societal norms, the person will be labelled as a deviant. Scheff (1984) argued that the concept of mental illness is a cultural way of explaining behaviour that is not easily understood within the cultural framework of a society, suggesting such behaviours that violate the societal norms may constitute residual forms of deviance which the psychiatrist diagnoses as mental illness. However, as different people react differently to various situations, the behaviours may not be enough to prove that the person is mentally ill (Mirowsky & Ross, 2003).

Labelling people with mental illness is problematic as it is often associated with an array of negative stereotypical behaviours such as dangerousness, incompetence, and weakness, all of which are widely stigmatised by the public (Phelan, 2005). Hence, the moment people are labelled, certain expectations are placed on them, with individuals internalising the label of mental illness and its associated stigma. Labelling an individual could reinforce his/her deviant role in the community, legitimizes his isolation from the rest of the population and further contribute to the stripping of the person’s self-respect, civil rights and personal independence (Livingston & Boyd, 2010).

The sociological theories discussed here demonstrate the malleable boundaries of mental illness and how randomly labels are assigned to people. The flexible nature of sociological theories has challenged the medical model for its rigidity. From a sociological perspective, mental illness cannot be separated from the socioeconomic and cultural factors evident within a given society (Muntaner *et al.*, 2004). This contrasts with medical model of psychiatry which maintains that mental illnesses are biological and pathological (Clarke, 2007).

1.4.4 Psychological Model of Mental Health and Mental Health Problems

Psychodynamic theory was considered as one of the dominant school of thoughts in psychiatry and much of clinical psychology during the first part of twentieth century, with regard to conceptions about how psychotherapy should be conducted (Gabbard, 2000). Freud (1989) who is credited with formulating psychodynamic theory and psychoanalysis, convincingly suggested that the unconscious mind is divided into different parts which include the irrational and impulsive Id (a representation of primitive animal desires), the judgemental super ego (a representation of the internalised rules and norms of society) and the rational ego (which serves as an attempt to bridge the id and the super ego) (Sandler *et al.*, 2003). Freud (1989) believed that human behaviours is the product of unconscious forces that operate within an individual’s mind. He is also of the opinion that early childhood experiences can have a profound impact on the person’s behaviour during adolescence and adulthood. Every stage of a child’s development starting from birth is believed to be directly related to specific needs and demands, each need is based on a particular body part and all rooted in a sexual base (McLeod, 2008). Freud referred to these as psychosexual stages of development. The conflicts that occur at various psychosexual stages of development usually impact a person’s ability to operate normally as an adult (Bartol, 2002). The conscious and unconscious parts of the mind are believed to come into conflict with one another, leading to repression, a state where one is unaware of having certain troubling motives, wishes or desires yet they influence the person’s thinking and behaviours negatively (Bateman & Holmes, 1995).

In general, psychodynamic theory demonstrates how human psychological processes can lead to mental disorders in adult life. Freud used his theories along with other existing theories to explain mental illness, arguing that deviant behaviours that are regarded as mental disorders are actually the residual effects of difficulties or needs an individual could not resolve during the developmental stages (McLeod, 2008). To overcome repression and maintain good mental health, one must successfully resolve early developmental conflict such as gaining trust, affection, successful interpersonal relationships and mastering body functions (Bem & Jong, 2017). However, Freud’s theories have been criticised for their lack of empirical evidence and an overemphasis on the sex drive (Englander, 2007). Nevertheless, it is important to note that Freud’s theories of development opened the way for other psychologists to further develop theories on how child development and childhood experiences can influence the mental health of adults.

Behavioural theories however challenged psychodynamic theories by proposing that all human behaviours are learned through interaction with the social environment (Englander, 2007). The theorist argued that behaviour is not inborn, rather individuals learn to think and behave as a result of their day to day experiences (Bandura, 1977). The behaviourists maintain that these experiences can be reinforced by observing friends or family being rewarded for their behaviours or by witnessing the glorification of certain behaviours in the media.

Much like Freud, Erikson believes personality develops in phases (Cherry, 2010). In contrast to Freud’s psychosexual stages, Erikson concept explains the impact of social experiences across the lifespan. He developed eight stages of human development and within each stage, he specified the inclusion of an emotional crisis in development which is conceptualised in various expressions and which the individuals must encounter and resolve successfully to proceed with development (Sokol, 2009). It is important to acknowledge that Erikson used the term crisis in a developmental sense to mean a turning point, and not a threat of disaster, these being important times of heightened vulnerability and increased potential (Erikson, 1968). His theory tries to address both personality stability and change. He believed that personality is stable to some extent, because childhood experiences is known to have some influence on people as adults (Lerner, 2009). Yet personality also changes and develops over the life span as individuals confront different and new problems in life. Erikson acknowledged that each psychosocial stage of development includes both successful and unsuccessful consequence. For example; trust versus mistrust, initiative versus guilt, intimacy versus isolation (Erikson, 1968). Successes in the earlier stages serve as determinants for success in the later stages. Failure to successfully resolve conflict in the earlier stages is considered a risk factor for failure in the later developmental stages (Marcia, 1993).

Erikson also emphasised the importance of socio-cultural factors in the determination of one’s personality (Hoare, 2002), believing a person cannot be understood outside his or her social context. This idea concurs with the sociological perspectives about mental health (Batrusaityte, 2003). Although Erikson mentioned several psychosocial stages of development, he particularly emphasised the importance of identity formation, commonly associated with the adolescent stage of development. He considered the age of adolescent to be from 12 through to 18 years. However, Arnett (2000) has since postulated a period of development referred to as ‘emerging adulthood’ which includes the ages 18 through to 25 years. Erikson believed adolescence to be a transitional stage, with identity formation being an essential element of emerging adulthood, as it refers to a sense of who an individual is as a person and as a contributor to society (McAdams *et al*., 2006). Marcia (1993) argued that identity formation is a crucial aspect in the development of one’s personality and Hoare (2002) asserts that identity provides a deep sense of ideological commitment and encourages an individual to recognise his or her place in the world.

It is important to note that not every person successfully resolves these developmental stages (Sokol, 2009). According to Bosma *et al*. (1994), role confusion can lead individuals to some very difficult human experiences. It can cause the person to seriously begin to question the characteristics of their personality, their view of self, and perceived view by others. Kroger (2004) suggests that due to changing physical, cognitive, and social factors, almost all adolescents are prone to experiencing role confusion, however most actively resolve these issues, but for those who are not able to they may find their mental health compromised.

In summary, mental illness affects many people globally. Young adults represent a large percent of the affected persons with majority of them living in middle and low-income countries such as Nigeria where many superstitious beliefs about mental illness and its treatments abound. The existent literature suggests that mental illness is the result of the interplay of several factors; including biological, psychological and sociological factors, with mental wellness being dependent on the same factors. Hence, psychological and sociological factors should be given further attention, particularly with regard to the different roles they can play in the manifestation of mental disorders; causes, symptoms and treatments. In terms of its treatment, there is an overreliance on medical model without commensurate attention on other factors. The various theories explored above have thrown light on the possible causes of mental illness and how best to deal with such problems. However, the best possible way of uncovering such factors is by exploring the patient’s subjective experience and perceptions about his or her problems. Hence, the aim of this present study.

1.5 Aim of the Study

The aim of this study was to explore Nigerian young adults' lived experience of their mental health problems and to ascertain how this affects their mental wellbeing.

1.5.1 Research Question

As phenomenology considers experiences from the point of view of the person who has lived experience of the phenomenon under investigation it is the choice of approach for this research (Byrne, 2001). The aim of phenomenology is not to find an answer to a question, but to raise understanding and thereby modify human behaviour (Van Manen, 1999). Phenomenology is a qualitative strategy, often associated with an interpretive descriptive approach facilitating the acquisition of in-depth data that is reliant on experience and enabling those who have experienced the phenomenon having a voice (Thorne, 2008). In light of this there are no research questions as such, but an overall aim for the study as per **(1.4)** above.

1.5.2 Study Objectives

The specific objectives of this study were to:

- Explore young adults' lived experience of their mental health problems.
- Understand how young adults' lived experience of their mental health problems affects their mental wellbeing.
- Extrapolate what the enablers would be for promoting their mental wellbeing and preventing mental ill health.
- Consider the above in terms of improving mental health care in Nigeria.
- Contribute original knowledge to the small body of knowledge regarding mental health in Africa.

Chapter 2 Literature Review

2.1 Introduction

The overall aim of this study was to explore the lived experiences of young adults who are diagnosed with mental illness and are being treated in a Nigerian psychiatric hospital. In this chapter, literature related to the present study is presented. The purpose of undertaking this literature review is to provide an overview of previous related studies in order to identify existent gaps regarding the topic area, thus ensuring this doctoral study is able to make a unique contribution to field. A traditional literature review is an essential and foundational aspect of a research process as it provides a framework, focus and/or context for the new study (Baker, 2016). It focuses on a broad overview of the literature, being mindful of the strengths and weaknesses of studies, but it is also significant to ensuring the existent knowledge base is expanded (Wallace & Wray, 2011). Hence, its primary purpose is usually to provide the reader with a comprehensive, critical and objective analysis of current knowledge available on a given topic, identifying gaps or inconsistencies and highlighting the need for new research (Cronin *et al.*, 2014).

In this study, a traditional literature review was considered important as it provided a constructive and critical account of the available published studies on the topic area, highlighting gaps in knowledge as well as the evidence currently available. However, since studies that focused on lived experiences of young adults with mental illness seemed to be scarce, a decision was taken to broaden the initial literature search on this topic. This review considered studies that have explored young adults lived experiences and perceptions of their mental illness. This decision was taken because these were considered most appropriate for the topic being studied. The decision to include studies that explored perceptions of young adults living with mental illness was predicated on the premise that such perceptions could be coming from their lived experiences. However, the literature search was focused on identifying studies which explored and presented the voice of those who had personally experienced mental illness.

2.2 Search Strategy

The search strategy is an important component of a literature review. Carnwell and Daly (2001) suggest that a good literature review contains a clear search and selection strategy. A traditional literature review has been criticised for its lack of transparency in the search strategy (Wallace & Wray, 2011). Nevertheless, in this study, to ensure relevant studies were accessed, a systematic approach to searching was employed. The University of Salford Solar library system together with other various electronic databases, such as PsycINFO, PsycEXTRA, PsycARTICLES, PsycBITE, PsychiatryOnline, PubMed, Medline, BioMed, British Nursing Index, and Cinahl were used to look for relevant papers. These databases contain professional and academic literature which cover a wide range of professional disciplines including psychiatry, psychology, nursing, social sciences, sociology, complementary therapy, occupational therapy, social sciences and social work. Nevertheless, each of these databases has its unique focus and style, requiring individual consideration when undertaking a review of the literature. While other databases are also very useful sources of information on psychiatry, PsycINFO is considered a prime source devoted to peer reviewed literature in mental health and psychology (McDonald *et al*., 1999). It provides access to psychiatric references selected from international materials from over 2,500 journals since 1806 to the present. A simple combing through PsycINFO using the term ‘mental’ proved an effective way of knowing what studies exist in this database on lived experience of mental health problems. This term ‘mental’ yielded over 8,700 hits and 935 out of these articles were published from July 9th 2004 to April 24th 2015. In order to ensure all available literature was recovered, different key words were either used independently or combined to search for literature in the various databases. These include mental illness, mental health problems, young adults, perceptions, service user’s experience, consumers’ experience, lived experience of mental illness, see table 2-2 below for details. In addition to identifying various words and phrases, an inclusion/exclusion strategy was also identified.

Table 2.1 Shows the key words used and additional search words and subject headings

Key words used	Additional search words/subject headings
Mental health problems	Young adults
Mental illness	Perceptions
Mental illness	Lived experience
Management of mental illness	Service users' views
Living with mental illness	Service users' movement
Life history	Quality of life
Well being	Enhancing factors
Life course	Illness impacts
Being diagnosed	Stigma
Being mentally ill	Subjective meaning
Being in treatment	Consumers' experience
Enduring illness	Patients' story
Mental illness in early life	Young adults' perspectives
Recovery	Hindering factors

The keywords and subject heading as mentioned in table 2.1 are two commonly used search methods that effectively identify any existing literature on a particular topic area (Ferris, 2018). These two methods among other options are usually offered to researchers by any database, index or online library catalogue (Ferris, 2018). Although both searching methods have been acknowledged for their important advantages, knowing how to apply them and how they differ from each other is key to retrieving better and more accurate results (Jeffrey, 2007). In this study, using keywords to search databases yielded too many and some irrelevant items. This is because keyword search is believed to be broad in nature (Ferris, 2018). However, when subject headings were used, it reduced the amount of garbage and irrelevant results earlier retrieved through keywords search leading to the identification of those specific studies that best relate to this topic area. This affirms the assertion of (Ferris, 2018) who asserted that subject search is more specific than keyword search as it further redirects the search engines to the specific papers that directly address the topic area.

2.2.1 Inclusion Criteria

The studies to be retrieved were assessed to ensure they meet the inclusion criteria for this review which included: (1) studies from July 9th 2004 to April 24th 2015, using 2004 as a starting point was to enable me to find the most up to date research papers, and this period being enough to allow reliable conclusion to be drawn. (2) Papers that offered service user views of mental illness. (3) Papers that explored young adults' subjective experience of mental illness. (4) Studies published in the English language. (5) All research-based papers and studies that included young adults with mental illness – although the current study focused on young adults between the ages of 18 and 30 years, but because of the scarcity of literature that included such age range, this literature review included any study that considered young people from age 15 to 35.

2.2.2 Exclusion Criteria

The following were the exclusion criteria: (1). Studies conducted before 2000. (2) Studies that did not focus on service users' perceptions. (3) Studies that did not explore young adults' subjective experience of mental illness. (4) Studies that were not published in the English Language. (5) Papers that were not research based

The initial scoping search after the key words were used provided 7,738 hits. Abstract screening resulted in the identification of 316 potentially relevant articles. Subsequently, reading and further screening of abstracts online and applying the above inclusion and exclusion criteria, most of the papers were again removed on the ground that those studies were not conducted in English, did not focus on exploring lived experience of young adults with mental illness, or studies were conducted before year 2000. Papers were also removed because they were aimed at exploring perceptions of causes and treatments of mental illness, and/or used participants who were not diagnosed with mental illness, leaving only 21 articles as possibly being relevant. In the opinion of Reid *et al.* (2005), lived experience describes a personal knowledge about the world garnered through direct or first-hand involvement. On the other hand, perception is a representation constructed by people about an event they were not directly involved (Brewer, 2011). However, the limited literature on young adults' lived experiences of mental illness necessitated the inclusion of studies that focused on the subjective perceptions of young adults with mental illness. Although such studies were tagged an exploration of perceptions of people with mental illness however, the researcher argues that such could be a language issue as the participants could have responded from their experiences and not a mere perception. Finally, the retrieved articles were further scrutinized to ensure that they satisfied the inclusion criteria as identified above, leading to the removal of further five articles on the ground that such articles were duplicated. Sixteen articles were finally deemed relevant for the review with regard to the phenomena under investigation.

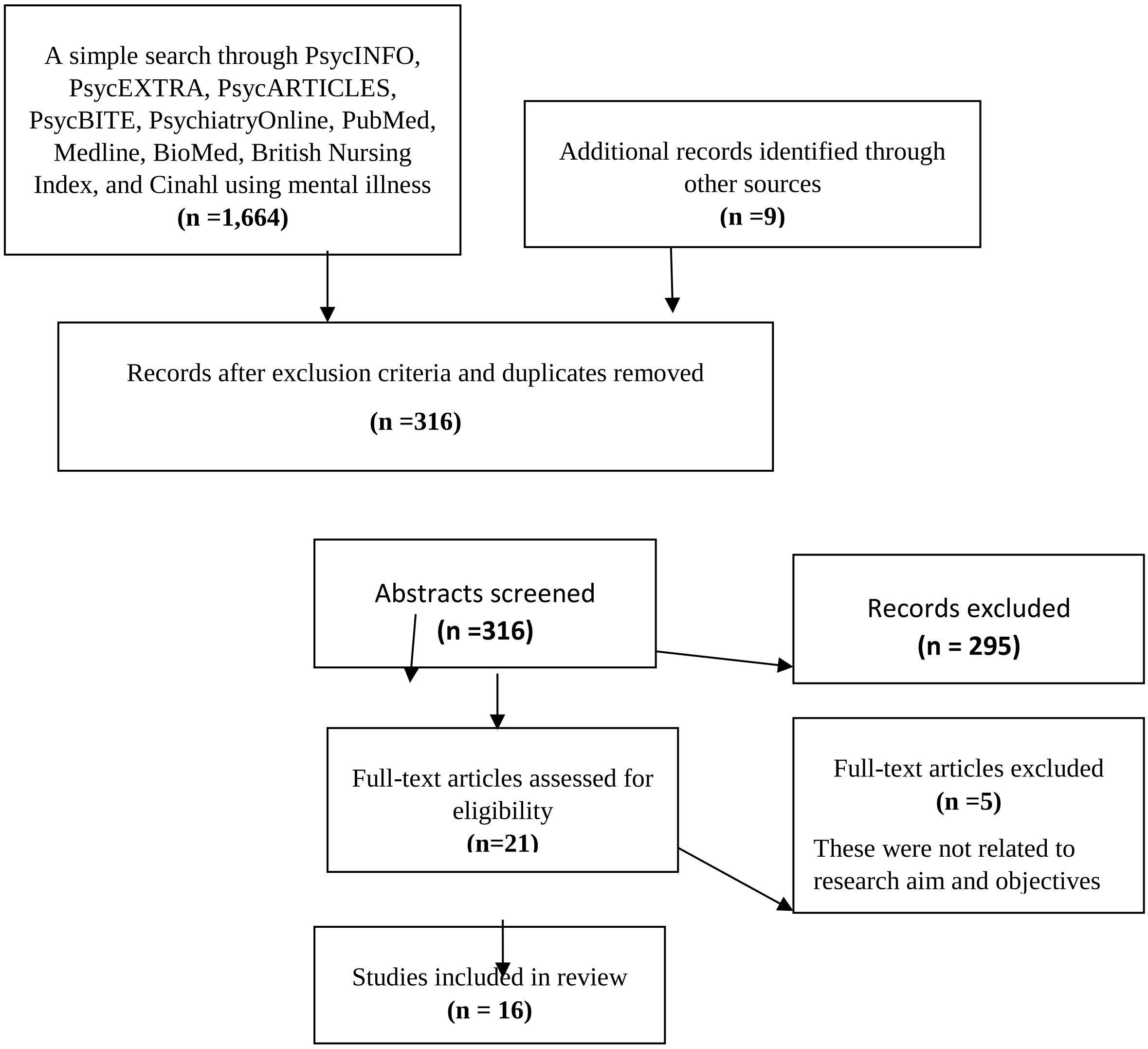

Figure 2.1 Prisma diagram for literature search.

2.3 Critical Appraisal of literature on Lived Experiences of Young Adults with Mental Illness

Due to a plethora of medical literature being published every year, readers find it almost impossible to read all the articles (Umesh *et al.,* 2016). Apart from the difficulties of reading all the literature, many of the sources are believed to be subject to various forms of bias (Brealey, 2001). In order to avoid such bias in this literature review, a critical appraisal was employed to ensure the careful selection of relevant studies. All literature reviews should include an evaluation or appraisal of the research evidence (Evans *et al*., 2011). The purpose for such appraisal is usually to assess the methodological quality of a study and to ascertain the extent to which it has addressed the possibility of bias in its design, conduct and analysis (Young & Solomon, 2009).

In this study, a critical appraisal tool developed by the Joanna Briggs Institute (JBI) was used to scrutinize all papers selected for inclusion in this literature review (Lockwood *et al*., 2015). The JBI critical appraisal tool has ten questions in its checklist. These questions include; is there congruity between the stated philosophical perspective and the research methodology; is there congruity between the research methodology and the research questions or objectives; is there congruity between the research methodology and the methods used to collect data; is there congruity between the research methodology and the representation and analysis of data; is there congruity between the research methodology and the interpretation of results; is there a statement locating the researcher culturally or theoretically; is the influence of the researcher on the research, and vice-versa addressed; are participants, and their voices, adequately represented; is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body; do the conclusions drawn in the research report flow from the analysis or interpretation of the data? The answers to the above questions informed the researcher’s decision to include the 16 studies that are presented in this literature review.

2.4 The Reviewed Studies

The 16 papers that were found relevant as they specifically focused on exploring the lived experience of mental illness and its treatments included the following: three quantitative papers; Andersson *et al.* (2013); Day *et al*. (2011); Gómez-de-Regil (2014). The remaining 13 articles (McCann & Clark, 2004; Biddle *et al.*, 200s6; Woodgate, 2006; Kuwabara *et al.*, 2007; Mayers *et al.*, 2010; Elliott *et al.,* 2012; Naeem *et al.,* 2012; McCann & Lubman, 2012;

McCann *et al*., 2012; Watsford, Rickwood & Vanags, 2013; Güner, 2014; Hailemariam, 2015; Murphy *et al*., 2015) all used qualitative research.

Location of the reviewed Studies

Table 2.2 below shows where the studies were carried out

Western Papers	African Papers	Other Papers
UK Biddle *et al*. (2006) Day *et al.* (2011) AUSTRALIA McCann & Clark (2004) Watsford *et al*. (2013) McCann & Lu bman, (2012) McCann *et al*. (2012) USA Kuwabara *et al.* (2007) Elliot *et al*. (2011) CANADA Woodgate (2006) Murphy *et al.* (2015)	SOUTH AFRICA Anderson *et al*. (2013) Meyers *et al.* (2010) ETHIOPIA Hailemariam (2015)	MEXICO Gomez-de-Regil (2014) TURKEY Guner (2014) PARKSTAN Naeem *et al.* (2012)

As presented in the table above, ten studies are from the western countries, three papers were from Africa of which none was undertaken in Nigeria and three papers are from Middle Eastern and Asian countries. See appendix I for the summary of the 16 articles. The findings and themes emerging from the literature review are presented under two separate sections; Non-African studies and African studies.

2.5 Quality of the Reviewed Studies

From the summaries of the retrieved studies (appendix 1), the quality of these studies is challenged in different ways identifying a need for further studies to be conducted in this topic area. For instance, in terms of age range some studies (Elliot *et al*., 2011; Guner, 2014) were not clear of the age range of participants as they simply stated 18 years and above. Hence these two studies cannot be said to have explored young adults lived experience of mental illness.

Likewise, the studies of Anderson *et al.* (2013); Mayer *et al.* (2010); Hailemariam (2015); Gomez-de-Regil (2014); and Naeem *et al.* (2012), recruited participants whose ages ranged from 18 – 40years, 25 – 60years, 15 – 65years, 16 – 45years, and 16 – 45years respectively. Based on this age range, these studies cannot be justified as exploring the lived experience of young adults with mental illness.

Apart from the limitation associated with age range other issues arose when appraising the studies. For example, while attempting to study the lived experiences people diagnosed with mental illness, Anderson *et al.* (2013) and Gomez-de-Regil (2014) used quantitative methodology thus limiting participants' in expressing their feelings about the phenomena. In the study undertaken by Hailemariam (2015) participants were not all diagnosed with mental illness, hence, an outcome of this study cannot be regarded as a true experience of living with mental illness. While the above studies have included participants whose age range are likely to be considered above that of young adults, other studies (Murphy *et al.,* 2015; Biddle *et al.*, 2006; Watsford *et al.,* 2013; Day *et al.*, 2011; McCann & Lubman, 2012; McCann *et al.*, 2012) have included participants whose age range fall below what could be considered as young adults. Moreover, apart from the study by McCann *et al.* (2012) the aim of which was designed to explore lived experiences of mental illness, other studies (Biddle *et al.,* 2006; Day *et al.,* 2011; Watsford *et al*., 2013; Hailemariam, 2015) had a narrower focus exploring the experience of using services including; service satisfaction, perceptions and expectations.

Only two studies (Kuwabara *et al*., 2007; McCann & Clark, 2004) used what could be considered a normal age range for young adults and were designed to specifically explore the lived experience of young adults living with mental illness. In terms of methodology and sample size, apart from Anderson *et al.* (2013) and Gomez-de-Regil (2014), others used methodologies suited to achieving the aims of the studies and justified sample sizes for their studies. The major limitation of the reviewed studies lies with the age range of participants. In light of this and the number of papers reporting the experience of living with mental illness a decision had to be regarding the inclusion of these papers. Given the dearth of available literature with regard to young adults I decided to include the 16 papers but would advise the reader to note that the papers presented below are not necessarily obtained from young adults.

2.6 Emerging Themes from the Studies from Non-African Countries

I organised the findings from studies undertaken in countries other than Africa into the following themes; **Theme 1** Perceived causes of mental illness, including; spirituality, social taboo, biological factors, psychological factors, and painful life experiences. **Theme 2,** Attempting to explain mental illness and its impact including; mental illness as a catastrophic experience, illness as a mediator of social relationships, mental illness as a complex illness, mental illness as a mystery and embarrassment. **Theme 3**, Uncertainties and Hopelessness, encompassing; mental illness as a lost life, living in the shadow of fear, stigmatisation, being identified as a mentally ill person, relationship difficulties, and loss of dignity. **Theme 4,** Influencing factors to promote mental wellbeing, involving; social support, being valued and having a sense of belonging, communication, clinicians being approachable and adopting a broad-based approach to care.

2.7 **The Emerging Themes from the Studies from the African Countries**

Reviewing studies from non-western countries also yielded some important themes which included; **Theme 1,** Perceived causes of mental illness, encompassing social stress, intimate relationship problems, parenting, finance, work, extended family, military combat, charm, poverty, evil spirits, genetics, and environmental factors. **Theme 2**, Treatment preference, including; religious healing, traditional healing and psychosocial therapy. **Theme 3,** Influencing factors, taking account of social support. **Theme 4**, Factors that hinder wellbeing, involving; inadequate communication, methods of containment, use of sedation and involuntary/forceful treatment. **Theme 5**, Violation of human rights, encompassing loss of dignity and stigmatization.

The themes identified above are discussed under two separate sections (2.3.2 and 2.3.7). All findings from studies conducted in both Western and 'Other' countries are discussed under the heading of non-African studies, while all findings from African countries are discussed under the heading of African studies. Section 2.3.8 entitled 'treatment of mental illness' is a combination of findings from African and non-African studies.

2.7.1 Discussion of the Findings from the Studies from Non-African Countries

2.7.1.1 Perceived Causes of Mental Illness

Evidence emerging from the existing literature regarding participants' lived experiences of their mental illness indicate that as individuals they conceptualise mental illness differently (Elliott *et al*., 2011; McCann *et al.*, 2012; Naeem *et al.*, 2012; Gomez-de-Regil, 2014; Guner, 2014). While some participants demonstrated a level of insight regarding the cause of their mental health problems (Elliott *et al*., 2011; Naeem *et al*., 2012; Gomez-de-Regil, 2014), others found it difficult to think of anything that could be responsible for their mental illness (McCann *et al.*, 2012; Guner, 2014). In Australia McCann *et al.* (2012) conducted a study exploring the lived experiences of 26 young adults (16 - 25) diagnosed with depression, their findings revealing how some of the participants struggled to make sense of their problems. Implicit in this study was the young adults' inability to discuss what they perceived as the cause of their illness, but readily acknowledged their mental illness was real. Knowing that something was wrong with them, but not being able to come up with any explanation for it caused them further confusion (McCann *et al.*, 2012).

In attempting to make their confusion understandable they resorted to questioning themselves about their existence, believing that their particular condition was different from other individuals in their peer group. However, within their experiences was their ability to realise that their circumstances were unique to each person, with some of them believing the severity, duration and after effects of their mental illness were mild, whereas for others they were considered severe and unmanageable (McCann *et al.*, 2012). Regardless of the above findings, the researchers were not explicit about the basis of young adults' inabilities to understand their illness, leaving the reader questioning whether participants had a knowledge deficit of mental illness per se, or if the complex nature of the illness and/or its symptomatology made it difficult for them to clearly identify a cause. Symptoms of mental illness and its complex impact can be overwhelming (MacDonald *et al.*, 2005), and this might have been the case for those participating in McCann *et al.*'s (2012) study.

In a similar study, Guner (2014) focused on understanding the illness perceptions of nine Turkish research participants (18 years and above) who were diagnosed with schizophrenia. Guner (2014) demonstrated similar findings to those of McCann *et al*. (2012) in that the participants struggled to make sense of their illness in terms of causation and its impact on their lives. Guner (2014) reported mixed responses from the participants, but the uniqueness of their subjective experiences accounted for this. According to Guner (2014), some participants found it difficult to comprehend what was happening to them and could not link their illness to a cause and consequently, recovery did not seem achievable for them. Although, Guner (2014) did not explain how participants' inabilities to comprehend their situations diminished their hopes for recovery, McCann *et al*. (2012) earlier reported that young adults' inability to understand their conditions hindered their abilities to work out things or find a way forward. Moreover, the impact of illness has been reported to influence the way in which a person interprets their illness (Choudhry *et al.*, 2016). This concurs with the finding of McCann *et al.* (2012) who associated young adults' inability to conceive recovery as an achievable task due to the long-standing effects of the illness on their lives. This could be the case with the participants in Guner's (2014) study, in which the long-standing impact of their schizophrenia was asserted as being indescribable. While Guner's (2014) findings showed some similarities with those of McCann *et al.* (2012), there was also some discrepancy. In Guner's (2014) study some participants attributed the cause of their mental illness as being; stressful life experiences; loneliness, poor family relationships, academic failures, being too intelligent, economic hardship, excessive studying during childhood, not placing importance on one's social life, obsessing about certain things, personality traits (introversion), depressive and oppressive settings, working in difficult jobs, being subjected to ill-treatment, the loss of loved ones, punishment from God, and/or evil spirits. Other participants believed their illness was caused by; genetics, chemical imbalance, or a blow on the head leading to seizure (Guner, 2014). However, some of their ideas regarding the causes of their illness may have been influenced by the interplay of cultural, religious, economic, social and age-related factors. Their failure to achieve certain targets, meet personal needs, and being maltreated constituted stress for those participating in Guner's (2014) study. Inherent in their experiences and perceptions of their illness was uncertainty about their recovery. Recovery did not seem achievable to them because they could not understand the origin of their illness, hence it was difficult for also predict its prognosis.

In contrast to the above studies, Elliott *et al.* (2011); Naeem *et al*. (2012); and Gomez-de-Regil (2014) presented results that were more explicit in terms of participants having strong views about how their mental illnesses is linked to certain factors. In a study carried out in the US, Elliott *et al.* (2011) investigated the subjective accounts of the causes of mental illness from the perspectives of 50 participants, who were 18 years and older. Findings suggest that participants demonstrated a reasonable knowledge of mental illness, with 43 out of the 50 inpatients who participated believing they have mental illness which is an indication that they have insight. According to Elliott *et al*. (2011), 42 participants attributed their mental illness to painful life experiences believing that their childhood trauma, adulthood stressors, and loss of loved ones were responsible for their mental illness irrespective of diagnosis. The most mentioned childhood trauma includes neglect, and sexual abuse, followed by physical and verbal abuse. However, Elliott and colleagues were not clear regarding the nature of childhood trauma or adulthood stressors, hence leaving the reader to speculate regarding the kind and degree of trauma and stressors that resulted in their mental illness. Life experiences were believed by the participants to be outside of their control but related to their condition. Approximately half of the participants attributed their mental illness to biological factors, perceiving these as internal and outside their control. Those who cited biological factors specifically attributed it to genetic predisposition, physiological conditions and chemical imbalance. Elliott *et al*. (2011) showed that only 11 (26%) of participants perceived their own shortcomings or mistakes that were within their control as being responsible for their mental illness. Those who did identified such issues cited; inability to deal with problems, drug abuse, stopping their psychotropic medicines, and a belief that their personality is prone to mental illness, as possible causes for their illness (Elliott *et al.* 2011). Prominent in this study is the casual attribution of mental illness to life experiences. The unrestricted age range used in this study could account for this, as such an open-ended age range may have encouraged recruitment of higher number of older adults who have had a long life which may have involved bad experiences. Therefore, the study conclusion may not apply to the current study which is focusing strictly on young adults. Nevertheless, the large number of participants used in this study was appropriate for the explorative study. Similar to Elliott *et al.*'s (2011) findings are those of Naeem *et al.* (2012 and Gomez-de-Regil, (2014). In a study carried out in Pakistan eliciting nine participants' views of their depression, Naeem *et al.* (2012) reported that participants showed little or no understanding of the cause of their illness and did not know what the recovery process involved. Medicine was perceived as the only treatment for mental illness however, it was perceived as unhelpful. Participants attributed the causes of their mental illness as being; trauma, tension, too much thinking, worries, problems at work and home, stressful life events, and genetic factors. These are in keeping with Elliott *et al.'s* (2011) findings in which stressful life events or negative life experiences was most frequently identified as the cause of their mental illness. The participants' conceptualisation of mental illness appeared to be in keeping with psychosocial model of mental illness as it was only one person who cited biological factors.

Inconsistently, in Naeem *et al*.'s (2012) study the participants' views about causes and treatment of mental illness is confusing. While their views about the cause of mental illness appear to align with a psychosocial model, believing medicine to be the only treatment does not justify their understanding. However, given that participants were drawn from an outpatient department of a teaching hospital, it could be suggested that the participants may believe medicine is the only available treatment. Implicit in that, is the participants' report that 'medicine is unhelpful' (Naeem *et al.,* 2012, p.1088). In Mexico, Gomez-de-Regil *et al*. (2014) presented similar findings to those of Elliott *et al.* (2011) and Naeem *et al*. (2012) in that stressful life events were the most frequently identified factor causing mental illness, with biological factors coming second. The 62 participants aged 16 – 45 years all attributed their mental illness to the following, stressful life events, but less than half of the participants mentioned biological factors, followed by personality factor, family, societal, esoteric and environmental factors (Gomez-de-Regil *et al*., 2012). Also, not placing importance on one's social life, being obsessive about certain things, depression and depressive settings, working in difficult jobs, being subjected to ill treatment, and the loss of loved ones were all stressful events participants identified (Gomez-de-Regil *et al*., 2014).

In general, stressful life events, social and genetic factors appear to be the most frequently cited factors by participants as causes of their mental ill health across all the studies (Elliot *et al*., 2011; Naeem *et al.*, 2012; Gomez-de-Regil, 2014; Guner 2014). Uncontrollable life experiences including stressful events and ongoing problems that occurred throughout their life course were mostly attributed as the cause of mental illness. In terms of one's own mistakes or shortcomings, the participants in the above studies showed reluctance in attributing the illness to their own mistakes or shortcomings. Instead, they preferred to attribute it to external factors in order to preserve their self-esteem. This is understandable as it is in keeping with attribution theory which opined that people always try to externalize responsibility for negative occurrences involving themselves in order to protect their self-esteem (Moskowitz, 2005).

Regardless of the similarities in the findings of Elliot *et al*. (2011); Gomez-de-Regil (2014); Naeem *et al*. (2012), some discrepancies still exist. In Elliott *et al.*'s (2011) and Gomez-de-Regil's (2014) studies, life experiences were further divided into; childhood psychological trauma (neglect, sexual abuse); family (broken home, lack of parental love, parent attitude being hostile-rejecting, father too severe, overprotective mother, parental expectations too high), personal/personality (failure in life, avoidance of everyday life problems, did not deal with problems, personality prone to mental illness, lack of willpower, too bright or too intelligent, too ambitious, drug/alcohol abuse, came off psychotropic medicines) and stressful life events in adulthood (constant strain in school/job, failure in life and loss due to death, neglect and sexual abuse).

Notwithstanding the similarities that exist between the findings of Elliott *et al*. (2011) and Gomez-de-Regil (2014), variation still exists in their studies. In addition to the findings reported above, Gomez-de-Regil *et al.*'s (2014) study added that some participants attributed their own mental illness to mysterious things, with some saying mental illness is the result of possession by evil spirits, lack of vitamins, punishment by God, unfavourable horoscope, radiation and environmental factors. This is difficult as these things are likely to be influenced by a lot of factors including cultural beliefs and social environment. This could also be accounted for by the sample population used by Gomez-de-Regil *et al.* (2014). The inclusion of participants who have been exposed to both formal and informal information about mental illness but were not in receipt of mental health care at the time of the study could have influenced the findings. This inconsistency in the recruitment of participants raises questions regarding participants providing data based on mere perceptions and not experiences of living with mental illness. Moreover, the age ranges used in the studies; 18 years and older (Elliott *et al*. 2011) and 16 to 45 years (Gomez-de-Regil *et al.,* 2014) also raises the question as to whether or not these voices represent the true voice of young adults.

Also common in the studies of Elliott *et al.* (2011); McCann *et al.* (2012) and Guner (2014) is the participants' beliefs that their personalities are prone to mental illness. Having this belief was reported to have had some negative implications on the way in which they perceived their illness. One of the implications was that they perceived themselves as being abnormal and tried to separate themselves from those they had judged to be normal. Withdrawing from families and friends might encourage isolation and loneliness. In McCann *et al.*'s (2012) study, young adults who withdrew from friends in a bid to conceal their mental illness and retain their dignity got more depressed and expressed suicide ideation. What these studies did not appear to explore was if the way in which these young adults attributed their mental illness affected their help seeking behaviours. However, these studies (Elliott *et al*., 2011; McCann *et al.,* 2012; Naeem *et al.,* 2012; & Guner, 2014) did acknowledge that some participants expressed uncertainty about their recovery and feared having treatments that might be irrelevant. Additionally, hiding from friends and others to avoid being identified as a mentally ill person also indicates that they may feel shame in presenting themselves to professionals for treatment (McCann *et al.*, 2012).

Among the factors that were perceived by participants as being responsible for their illness, genetic factor appears to be thought of as secondary factors (Elliott *et al.,* 2011). In the study undertaken by Elliott *et al*. (2011), and despite it being conducted in a place where the medical model dominates, biological factor was not mentioned first as one of the causes of mental illness but the second perceived causes of mental illness. This finding is consistent with other studies presented in this review (McCann *et al.*, 2012; Naeem *et al.*, 2012; Gomez-de-Regil *et al*., 2014; & Guner, 2014) where biological factors were not mentioned as being the major factor responsible for their mental illness.

While three studies (Elliott *et al.,* 2011; Naeem *et al.,* 2012; Gomez-de-Regil *et al.,* 2014) seemed to have focused their research more on participants' perceptions of causes of their mental illness, others (McCann & Clark, 2004; Woodgate, 2006; Kuwabara *et al*., 2007;

McCann *et al.,* 2012; Guner, 2014; Murphy e*t al.,* 2015) reported findings which are more central to the focus of this review: the lived experience of young adults with mental illness. These findings included; Mental illness is a mystery, a complicated illness, a lost life, and a dynamic journey (Guner, 2014); living in the shadow of fear, containing the shadow of fear, keeping oneself alive, maintaining a sense of belonging in the world, feeling valued as a human being (Woodgate, 2006); mental illness as a catastrophic experience, mental illness being a mediator of social relations, medication side effects as burdensome (McCann & Clark, 2004); struggling to make sense of their situation, spiralling down, withdrawing, contemplating self-harm or suicide (McCann *et al.,* 2012); identification as an individual with depression, healthcare experiences related to diagnosis and treatment, relationships and social support, role transitions from adolescence into adulthood and general functioning (Kuwabara *et al.,* 2007); ambivalence, desires for alternative, gaps in support (Murphy *et al.,* 2015).

2.7.2 Attempting to Explain Mental Illness Based on its Impacts

Also emerging from the studies were the attempts made by the individual participant to understand and communicate the impacts of their mental illness (McCann & Clark, 2004; McCann *et al.,* 2012; Guner, 2014). The meanings participants attributed to their mental illness which were framed in different words and phrases are believed to be reflecting the impacts their illness has had on their lives. In the study of McCann *et al.* (2012), some participants were found struggling to make sense of their mental illness due to the severe impacts the illness had on several aspects of their lives. However, participants in Guner's (2014) were able to use different words and phrases to make sense of their mental illness with some of them describing it as *'a complicated illness', 'a mystery'* and *'an indescribable pain'* (Guner, 2014, p,408). Struggling to make sense of mental illness (McCann *et al*., 2012) and conceptualisation of mental illness as a mystery (Guner, 2014) are both interesting finding in the two studies which did not only indicate knowledge deficit regarding mental illness and its recovery process but also its unexplainable effects. This might be suggesting that improving people understanding of their mental illness and its treatment is a crucial aspect of intervention. Regardless of that, Guner (2014) was able to establish from some of his participants a strong sense of the reality of their mental illness because of the devastating impacts the illness had on many aspects of their lives (Guner, 2014).

More also referring to their illness as indescribable only epitomised the overwhelming nature of their illness, such that some participants preferred not to speak about it, believing their words would not be enough to explain their experiences to anyone who has not had the same experience (Guner, 2014). Apart from believing that the experience is too difficult to explain, they also felt that nobody would understand them, including doctors and their families (Guner, 2014). While the focus of Guner’s (2014) study was to explore the subjective experience of individuals regarding their mental illness, this appears to have been hindered by some of the participants being unable to articulate it. Hence, the findings may not be comprehensive.

However, Guner’s (2014) study unveiled many important issues as experienced by participants which were in keeping with the findings of McCann and Clark (2004). McCann and Clark (2004) explored the lived experiences of 9 young adults living with schizophrenia. Their findings showed that young adults conceptualised their experiences of mental illness as a catastrophic experience (McCann & Clark, 2004). The choices of these phrases were predicated on the shattering experiences of living with mental illness. Summarising their experience of living with mental illness as a *“catastrophic experience*, (McCann & Clark, 2004, p. 787) and a *‘complicated experience’* and *‘a lost life”* (Guner, 2014, p. 408) reflects the negative impacts the illness had on both sets of participants. Furthermore, impacts of mental illness were also felt in the aspect of their social life. The young adults spoke of how their mental illness had impacted their social life and relationships with some referring to it as *an embarrassing situation* (McCann & Clark, 2004). Evidence from the studies (McCann & Clark, 2004; Kuwabara *et al*., 2007; Day *et al.,* 2011; McCann *et al.,* 2012; Guner, 2014; Murphy *et al.,* 2015) suggest the participants felt the way they experienced their mental illness truncated their social life and relationships. The effect of mental illness on relationships was reported as a serious concern leading McCann and Clark (2004, p.787) to describe it as a ‘*mediator of social lives and relationships*. However, the findings presented in the above studies suggest there are several aspects to this process. Firstly, according to McCann *et al.* (2012), participants affirmed that their illness affected their social lives and relationships because it caused them to withdraw from families and friends. Fear of being identified as a mentally ill person and consequently losing respect and being devalued prompted their withdrawal from friends to conceal their illness and preserve their friendships. Secondly, there was always a deep sense of shame and embarrassment each time they realise they might have said or done some irrational things when they were sick. This is a difficult aspect of the experience as such feeling will continue to affect their social lives even when they have totally recovered from the illness. Such actions were seen to have affected their social lives and relationships (McCann *et al.,* 2012). This was reiterated in the study by Kuwabara *et al*. (2007), who reported that young adults did not experience smooth and steady relationships because of their mental illness.

Although all the young adults acknowledged the importance of social support for their recovery, the belief that nobody understands their experience of mental illness prompted them to withdraw from families and friends (Kuwabara *et al*., 2007). Hence, accessing support was an issue of concern for them because they did not make themselves available to be helped. The findings from McCann and Clark's (2004) study aligns with those of Kuwabara *et al.* (2007) and McCann *et al.* (2012), in that mental illness caused a disruption in the social life and relationships of participants. McCann and Clark's (2004) study found that young adults explained their experience of mental illness as having a paradoxical effect on their relationships. This implied that young adults experienced unsteady relationships because of their mental illness which sometimes prompted support from families and friends and at other times destroyed their relationships with them (McCann & Clark, 2004). The researchers did not offer further explanation as to the reasons or events that prompted support from people or that damaged their relationships with people. Other studies (Day *et al.,* 2011; Guner 2014; Murphy *et al.,* 2014) all reported participants' social lives and relationships were affected by their mental illness. However, some studies (Day *et al.,* 2011; McCann *et al.*, 2012; Kuwabara *et al.,* 2014) appeared to have attributed all the negative impacts experienced by participants to mental illness only, without paying attention to other impacts, for example side effects of medication, or other traumatic experiences.

In some of the studies reviewed the impacts with regard to the role of mental illness and side effects of antipsychotic and antidepressant medications was considered. McCann and Clark (2004); Murphy *et al.* (2015) and Guner (2014) all discussed this phenomenon as experienced by young adults, bringing both the roles of symptoms of mental illness and side effects of medications to the fore, but their studies had some shortcomings. Murphy *et al.*'s (2015) study focused on understanding the lived experiences of young adults who were prescribed antipsychotics. Their methodology (interpretative phenomenology) and sample size (18 young adults) were suitable for their research topic, and the age range (aged 16 to 25) of the participants was well defined, however, the participants comprised of young adults who were not in current receipt of treatments. Participants had their last prescriptions within the last two years, leaving the reader to question whether the participants' responses were actually what they experienced during their illness and when taking medication. Similarly, Guner (2014) was determined to explore the lived experience and perceptions of people with schizophrenia, but the age range utilised, 27 to 54 years, was far beyond what could be considered as young adults. Hence, the findings of this study may not reflect the true experience of young adults with mental illness. Moreover, just as it was noted in Murphy *et al.*'s (2015) study, participants in Guner's (2014) study were recruited from an association for those diagnosed with schizophrenia in a community in Turkey. It is not clear whether participants were in receipt of treatment, as two of the participants were already noted to have never had hospitalization for their schizophrenia. Hence, their responses may not reflect the experience of young adults with mental illness. In the study undertaken by McCann & Clerk (2004) although their aim was to explore the lived experiences of young people with schizophrenia, it was not clear to the reader whether the participants were in receipt of treatment for their problems.

2.7.3 Uncertainties

For individuals living with mental illness, their situation was surrounded by several uncertainties (McCann & Clark, 2004; Guner, 2014) predisposed them to fear and hopelessness. Living in the shadow of fear was a strong phrase some participants used to express the impact of mental illness on their lives (Woodgate, 2006). Fear has been noted as having a negative impact on the mental wellbeing of an individual (Bünnings, Kleibrink & Weßling, 2017). In a Canadian study Woodgate (2006), explored the lived experiences of 14 young people (aged 14 – 18 years) to understand what it is like to be a young person living with depression. Living in the shadow of fear emerged as the essence of the young peoples' experience of mental illness. Implicit within the concept of fear was the young adults' excessive fear of a return of the bad feelings related to depression, fear of not getting help, not surviving the bad feelings and fear of having to do all the hard work again in overcoming the bad feelings.

According to Woodgate (2006, p. 263), depressed young people faced problems of; *"containing the shadow of fear, keeping the self-alive, maintaining a sense of belonging in the world and feeling valued as a human being."* Maintaining a sense of belonging and feeling valued as a human being are findings in keeping with Kuwabara *et al.* (2007) and McCann *et al.* (2012) whose studies also reported that participants feared being exposed, identified as people with mental illness and subsequently stigmatised. Exposing their illness or being identified as people with mental illness posed a threat to their relationships, personal identities and being valued within the society. Although, the participants in Woodgate's (2006) study showed resilience in their efforts to contain their fears, they were also overwhelmed with guilt and self-blame when setbacks with their depression occurred. The fear of the effects of depression might have on their future lives (Woodgate, 2006) is similar to the findings of Guner's (2014, p. 408) study in which people diagnosed with schizophrenia perceived their lives as *'lost life'* and *'hopeless'* and there being no cure, concluding there is no future for them. The participants involved in this study talked of how they used adverse effects of their illness on their lives to judge their futures, hence describing their lives as *'a lost life'* (Guner, 2014, p. 408.). This could have had severe implication on them as conceiving mental illness as ‘a lost life’ might indicate the participants have lost hope in themselves. Yet hopelessness is a recognised predictor of suicide in people with mental illness (David Klonsky *et al.*, 2012). As evidenced in the study of McCann *et al.* (2012), most of the participants who contemplated suicide at some point during their illness did so because they felt their quality of life has been deeply affected by their mental illness and they were uncertain where such situation was leading them. As important as the concept of hopelessness in mental illness because of its role in suicide (Klonsky *et al*., 2012), it appears that (McCann & Clark, 2004) did not give detailed account of how hopelessness was developed among young adults with mental illness who participated in the study. Stating that uncertainties caused hopelessness appears to be ambiguous.

2.7.4 Factors Influencing Mental Wellbeing

While Woodgate (2006); Kuwabara *et al.* (2007); McCann *et al.* (2011); and Guner (2014) investigated patients’ lived experience of different mental illnesses, with participants in each study expressing fear of the unknown about their condition. However, participants in the studies undertaken by Woodgate (2006), Kuwabara *et al.* (2007), Guner (2014) and Murphy *et al.* (2015) further reported a perceived lack of support from friends, family, financial/social security issues, fear of being deprived of certain rights, being judged by healthcare professionals and others, as major factors hindering their recovery. Feeling neglected, being judged, stigmatised or not given proper attention by healthcare professionals have been reported in other studies in the wider literature (Bennett, Coggan & Adams, 2003; Wisdom & Green, 2004; Draucker, 2005). The latter might be a contributory factor for not using mental health services, and in turn this may hinder recovery. Woodgate (2006) was explicit in his findings and did not make any assumptions which reflected the hermeneutic phenomenology he conducted. However, while the sample size (14 young people) in Woodgate’s (2006) study would be considered good enough for a qualitative study, all were females, hence there may be a gender bias within the findings. However, regardless of the weaknesses and shortcomings noted in most of the studies, they have provided an insight on young adults’’ lived experience of mental illnesses. Nevertheless, the studies included in this review so far are studies from Western, Middle Eastern, and Asian countries, with a number of factors influencing the way young adults experienced their mental illness, but these experiences may differ in those living in low and middle-income countries, such as those on the African continent.

2.7.5 African Studies

African studies regarding young adults’ lived experiences and perceptions of their mental health problems are scarce. While only three studies (Meyers *et al.*, 2010; Anderson *et al.*, 2013; Hailemariam, 2015) that have attempted to study African young adults' perceptions of their mental illness, none of them seemed to have specifically explored the lived experiences of young adults with mental illness. Meyers *et al*. (2010) and Anderson *et al.* (2013) designed their studies to focus on patients' experiences and perceptions of their treatment. Nevertheless, both studies (Meyers *et al.,* 2010; Anderson *et al.,* 2013) have been included in this review and are discussed below.

Hailemariam (2015) conducted a study in Ethiopia, exploring 25 participants' perceptions of mental illness and their treatment. Although Hailemariam's (2015) study included participants who were diagnosed with mental illness, the overall aim focused on exploring their perceived causes and treatment of their mental illness. Arguably, the participants might have given their responses based on their lived experiences of mental illness, whereas the researcher could have based his findings on their perceptions of mental illness per se. Regardless of that, results showed that participants attributed their mental illness to various causal factors. More than 84% (21) participants attributed mental illness to supernatural agents such as; curse from God, social taboo, spell from the evil spirits, using malicious powers gained from the devil to inflict on others, working in the mid-night. Just over half, 14 participants, also believed environmental factors, social stressors, traumatic events, over thinking daily life experiences, poor social relationships, poverty and failure to achieve life goals were the causes of their mental illness. Regarding biomedical factors, only 6 participants attributed their illness to genetic factors (Hailemariam, 2015).

Hailemriam's (2015) findings reiterate those of (Nsereko *et al.*, 2011) in Uganda, whereby most participants cited supernatural agents as the cause of their mental illness and showed a strong preference for spiritual and herbal or traditional medicine. All participants in Hailemriam's (2015) study attended Holy Water Sprinkling Site for Healing, indicating their level of beliefs in spiritual healing. However, and contrary to the assertion of Nsereko *et al.* (2011), Hailemriam (2015) had some findings which suggested participants' perceptions of their illness may not be a determining factor for the kind of treatments they will seek. Study participants who cited psychosocial factors as reasons for their mental illness agreed to seek professional help, but only as a second option. More than 46% of participants still believed religious practices and the removal of environmental stressors would promote their mental wellbeing. Good family support and relationships, and financial support were also thought to enhance wellbeing. Significant also in the study of Hailemriam (2015) is that regardless of the fact that few of the study participants attributed their illness to genetic factors, they still believed that modern medicine could not help them. This finding is consistent with Naeem et al. (2012) whose study also established that some participants did not find their medications helpful despite their perceptions about the causes of mental illness and their belief that they could get better by taking their medicines. This could be accounted for by a number of factors including; culture, belief system, social environment, and non-adherence to medications due to its perceived inefficiency or unwanted side-effects.

Although Hailemariam (2015) showed cultural and religious factors have influenced perceptions of illness and treatment, his findings in terms of the factors that promote wellbeing are similar to Western studies (Elliott *et al.*, 2011; Guner, 2014; Woodgate, 2006) irrespective of the differences in culture, environment, level of knowledge of mental illness and educational background. While Hailemariam (2015) specifically aimed at understanding the perceptions of people with mental illness regarding its cause and how it influences their help seeking behaviours, it restricted participants from discussing their overall experiences of living with mental illness. Also, although Hailemariam (2015) collected data from those with various illnesses who were at Holy Water Sprinkling site which is a prayer camp, it was not clear if participants were receiving care from a psychiatric hospital either as an inpatient or outpatient at the time when the study was conducted. Those who have mental illness and are being treated in a psychiatric hospital may have a different experience and perception of their mental illness from those who are not in receipt of psychiatric treatment from professionals. It was not clear whether the participants in his study spoke about their personal experiences of being mentally ill or their perceptions of mental illness which may have been influenced by religious and cultural beliefs, even though they were being treated for mental illness at the time of the study. Moreover, the study used a wide age range (16 to 45) and it is possible that generational influences may have impacted on the data. However, apart from the above weaknesses, the study involved a good sample size (28 participants) which seemed reasonable enough to come to a logical conclusion in a qualitative study. Nevertheless, Hailemariam (2015) recommends that further study be conducted on perceptions of those experiencing mental illness to better understand its manifestations and how it affects their overall wellbeing.

2.7.6 Treatment of Mental Illness

While the significance of identifying factors that hinder the success of treatment from a service users' perspective is generally recognized, few studies are available, and the majority of these studies are from western countries (Day *et al.*, 2011; Biddle *et al.*, 2006; Naeem *et al.*, 2012; Watsford *et al.*, 2013; McCann & Lubman, 2012; Mayer *et al.*, 2010). Biddle *et al.* (2006) used semi-structured interviews to explore young adults' perceptions of GPs as a source of help for mental distress in the UK. In total, 23 participants aged 16 to 24 years, comprising males and females participated. Findings showed 12 (four males and eight females) had consulted GPs about mental illness on at least one occasion and six were consulting at the time of interview. Many had withdrawn from psychiatric treatment and some chose not to consult with their GP for a subsequent episode.

According to Biddle *et al.* (2006), most consultations occurred after a considerable delay and were prompted by a crisis, such as a suicide attempt, and instigated by friends or family. Only three participants consulted promptly and freely, while 11 never consulted at all. In what could be described as lack of knowledge, Biddle *et al.* (2006) reported that more than 17 participants believed GPs are not an appropriate source of help for their mental illness. This was associated with the belief that GPs deal exclusively with physical illness, lacked training in mental health, cannot provide talking therapy and could only prescribe unwanted medicines and thereafter refer them to a more appropriate source of help. Those whose pathway to the GPs had been good did not share such perceptions but valued the use of medication to control symptoms. While the researchers clearly reported their findings some of the participants had never consulted any professional for treatment of mental illness, and therefore may not be a true representation of the voice of young adults receiving treatment.

An Australian study by Watsford *et al.* (2013), involving 20 young adults (12 – 24yrs), explored their expectations of a youth mental health care service. Findings showed participants were unsure of what to expect from attending a mental health service, with regard to their role as a client, who they would see, and what that person would be like or arrangements for their meeting. This may indicate a lack of knowledge about treatment, what it would entail and what they, as a client, may be expected to do in the treatment sessions. Such unknowns are likely to cause anxiety, which could deter young adults from seeking professional help. In Naeem *et al.'s* (2012) study, carried out in Pakistan, nine participants aged 18 and above, were asked about treatment of depressive illness. Seven participants believed that medicine is the only cure for their problems and had no knowledge of the role of psychologists or psychotherapists. Their preference for medicine was attributed to the fact that those interviewed had already had contact with psychiatrists for treatments. Thus, they may have had different views from their counterparts who had not sought help outside of the GP. Although the findings of both Biddle *et al.* (2006) and Naeem *et al.* (20l12) reflect participants' preference for drug treatment, their findings also demonstrate a lack of knowledge of the importance of combining both drug therapy and psychotherapies in the treatment of mental illness (Biddle *et al.*, 2006).

Guner (2014), Mayers *et al.* (2010), Day *et al.* (2011) and Andersson *et al.* (2013) all reported people diagnosed with schizophrenia expressed dissatisfaction with the treatment they received. Dissatisfaction with treatment was associated with different factors including; lack of communication and poor relationships with care providers, family and friends (Guner, 2014; Day *et al.*, 2011; Mayers *et al.*, 2010), and seclusion, restriction and lack of privacy (Mayers *et al.*, 2010; Day *et al.*, 2011). According to Mayers *et al.* (2010), participants experienced abuse in their treatment and felt there was a need to humanize their experiences during episodes of acute illness. Care providers not maintaining adequate communication with patients during acute episodes of illness was seen as an infringement on their human rights, as it made them feel excluded from their treatment plans. Likewise, methods of containment including seclusion, restriction and sedation were interpreted by participants as punitive and not therapeutic. This made the participants feel more distressed (Mayers *et al.*, 2010). Participants expected treatment measures to include; prevention of human rights abuses, improvement of communication between service providers and service users, minimization of isolation and promotion of attitudinal changes which reflects respect for patients' dignity.

A study carried out in Australia by McCann and Lubman, (2012) examined how satisfied individuals with depression were with the quality of care they received. Results showed that all 26 participants expressed satisfaction with their treatment, and this was associated with clinicians being youth friendly. Youth friendliness was equated with clinicians being approachable, respectful, supportive, understanding and non-judgmental. Also, the combination of psychosocial therapies and antidepressant medications, as adopted by the clinicians, was received favourably by youths. These were found to facilitate recovery and in turn enhanced satisfaction with GPs. and participants expressed their willingness to continue to seek professional help (McCann & Lubman, 2012).

Although, the findings of McCann and Lubman (2012) are in contrast to the findings of Mayers *et al*. (2010), this could be accounted for by factors related to geographical location, sample population and methodology. For instance, Mayers *et al.*'s. (2010) study was conducted in South Africa. Moreover, the age range (25 – 60yrs) of their participants was too wide and far beyond the acceptable age range for young adults. Also, apart from the 8-focus groups, the study also utilized a questionnaire to collect data from 43 participants which is not suitable for exploring experiences. This may have restricted the information participants were able to give. McCann and Lubman (2012) used a specified age range (16 – 25yrs) for young adults and their methodology applicable for the research topic. However, this study was conducted in a western country and a repeat of the study in a non-western country might yield a different result.

Nevertheless, in South Africa, findings similar to that of McCann and Lubman (2012) were reported by Anderson *et al*. (2013), investigating help seeking behaviour, barriers to care and experiences of care among people with depression. In a group of 307 who were considered to be depressed people, aged 18 – 40 years, showed that over 126 individuals (41%) reported they had sought help from professionals for their problems. Approximately, 80-90% said they were very satisfied with the services they received. The perceived satisfaction was associated with; support the care givers provided by answering their questions about medicines, giving them information about their illness, discussing their treatments and onward referrals. Consequently, the proportion of people that were not satisfied ranged between 10 and 19%. Those dissatisfied were mostly those who believed care providers had a cold approach, judgemental attitudes towards their illness and appearance, not adequately supportive, prolonged waiting time, refusal to listen to them, forcing their own views on them and lack of empathy. Over 40 (13%) of participants had visited traditional healers for their emotional problems and 81% felt satisfied with this service. The perceived satisfaction with traditional healing could possibly be due to the negative experiences with professional care. Also, as identified in Hailemariam's (2015) study, the findings of Anderson *et al*. (2013) may not be a true representation of the lived experience of people with mental illness, as their study involved both participants who have and those who have never accessed help for their problems. Moreover, whereas Anderson *et al.* (2013) shares similar findings with McCann & Lubman (2012), the former's methodological approach was not suitable for the topic, hence, their findings may not be accurate. Similar to the study of Mayers *et al*. (2010), Anderson *et al.* (2013) undertook a quantitative study using questionnaires to collect data which is not appropriate for studying lived experiences, as questionnaires do not give opportunity for participants to freely express their experiences.

In the available literature originating from Africa, there is an absence of a purely young adult perspective, as none of the reviewed African studies used an appropriate age range for young adults or involved a sample population who had all experienced the phenomenon of living with mental illness. Therefore, using an appropriate age range for young adults and a population sample drawn from those who are, of have experienced living with a mental illness and are in receipt of professional treatment could yield different results.

Meanwhile, in Nigeria, a critical search through data bases showed no study has explored the lived experiences of young adults with mental illness. Hence, the present study seeks to explore this area and start to address the current knowledge gap identified within this literature review. Understanding patients' lived experiences of their mental illness and factors influencing their wellbeing, especially in a country with multi-cultural and religious practices, could generate a wealth of unique knowledge that would help to improve care and ultimately improve young adults' mental wellbeing.

2.7.7 Summary

Evidence from the reviewed literature identifies there is a gap in knowledge of young adults' lived experiences of mental illness in Africa, and more precisely in Nigeria. While there are a number of studies exploring people's lived experience of mental illness, studies specifically exploring the lived experience of young adults living with mental illness remain scarce. Of the few studies found approximately 62.5 % (10) are from the western countries, 18.75% (3) from the Middle East/Asian countries, with the remaining 18.75% (3) being from African countries, but surprisingly, none of the studies is from Nigeria.

As demonstrated by the 16 studies reviewed above, people experience and perceive their mental illness differently. How participants experienced the impact of their mental illnesses informed the way they conceptualized it, with some describing mental illness as a *'complicated issue'*, others said it is a *'lost life',* while others said they lived in the *'shadow of fear'*. Also, the way people make sense of their mental illness seems to be influenced by their cultural beliefs and level of enlightenment which in turn could influence their help-seeking behaviour. While all the studies share similar views about the impact of mental illness on people's lives, the studies still revealed differences in terms of causal attribution and treatment preferences. Studies from western and non- western countries acknowledged biological factors, however evidence did not show it as being considered the leading cause of mental illness. Participants in all studies, irrespective of country, identified stressful life experiences, and social and psychological factors as the major causes of their mental illness. Stigmatisation, communication problems, abuse, loss of dignity, are some of the factors identified by the participants as affecting their mental wellbeing. Good communication, being listened to, positive relationships with clinicians and others, a good support system and less stressful jobs were recognised as enhancers of recovery and mental wellbeing.

Most of the research from non-western countries, and particularly the African studies, found mental illness was also attributed to evil spirits in addition to social and psychological factors and stress. But despite the variation in their beliefs about the causes of mental illness, both western and non-western countries demonstrated a lack of knowledge about mental illness, but in different ways. While the western studies showed that participants did not believe GPs can help them to manage their mental health problems, the non-western studies showed that some participants preferred traditional and religious healings. This may have been influenced by some factors including lack of enlightenment with regard to mental illness and its treatments and also cultural beliefs.

The various meanings participants gave to their experiences of mental illness and their divergent views of what they think is affecting or enhancing their wellbeing in the studies reviewed provides evidence through giving voice to young adults who have experienced mental illness that has the potential to lead to better mental health care. The service user movement has over the years strived to give voice to those in receipt of mental health services. Through giving voice to young adults, in terms of involvement in their own care plans, professional education, service design and health research, their recovery from mental illness and overall mental wellbeing can be enhanced. If young adults' experiences of mental illness can vary as has been noted in this review, it implies that help and support should be individually structured to meet their emotional needs.

While these studies have made good attempts to explore the lived experiences of young adults with mental illness, evidences from those studies are suggesting there is a gap in the existing knowledge. A number of shortcomings were noted in the studies attempting to explore and/or examine young adults' lived experience of mental illness. While most of the studies intended to study lived experience of mental illness, they recruited participants from communities who had no clear history of mental illness and people who were not in receipt of and have never been treated for mental illness. Additionally, the majority of the studies had varying age ranges for young adults with one study including participants who were 60 years of age and another with no upper age limit. Methodologically some of the studies utilized quantitative methods to study lived experience; a method not appropriate for the topic of interest and thus compromising the aims of the studies. A different result could be yielded if this phenomenon is explored by utilizing an appropriate methodology, an acceptable age range for young adults and young adults who are diagnosed with mental illness and are still in treatment. And above all, a study of this kind has not been carried out in Nigeria. Hence, this study aimed to explore the lived experiences of young adults diagnosed with mental illness and being treated in a psychiatric hospital in Nigeria. This doctoral thesis provides the body of knowledge in relation to the lived experience of young adults living with mental illness and the treatment they are receiving in a Nigerian psychiatric hospital which when applied will improve the care and wellbeing of this group of people.

In order to understand the lived experiences of young adults with mental illness, I have used the articles reviewed as a starting point to understand and inform my own research. There are limited studies on the lived experience of young adults who are using mental health services in Africa and there is none in Nigeria, yet specific studies are significant in the development of mental health services that would be sensitive to the unique needs of young adults living with mental illness. In aiming to address this gap this research is therefore based on the subjective experience of young adults living with mental illness and the treatments they are receiving in a Nigerian psychiatric Hospital.

Chapter 3 Research Methodology

3.1 Introduction

This chapter explains the research methodology that was used in this study, outlining details of the steps undertaken within this process. A methodology chapter should give a detailed description of the procedures followed to achieve the study purpose. In this study, the Onion Model (Saunders *et al*., 2009) was used. The Onion Model contains many layers; the first layer being regarded as fundamental with its focus on the principal philosophy for undertaking the study. The next layer involves consideration of the research being deductive, abductive or inductive. This directs the researcher's choice of appropriate methodological approach; quantitative, qualitative or mixed methods. The next layer prompts the researcher to consider suitable methods to be used for data collection and data analysis, and to think about these in terms of the final layer, the time horizon and appropriate techniques. (See figure 3.1)

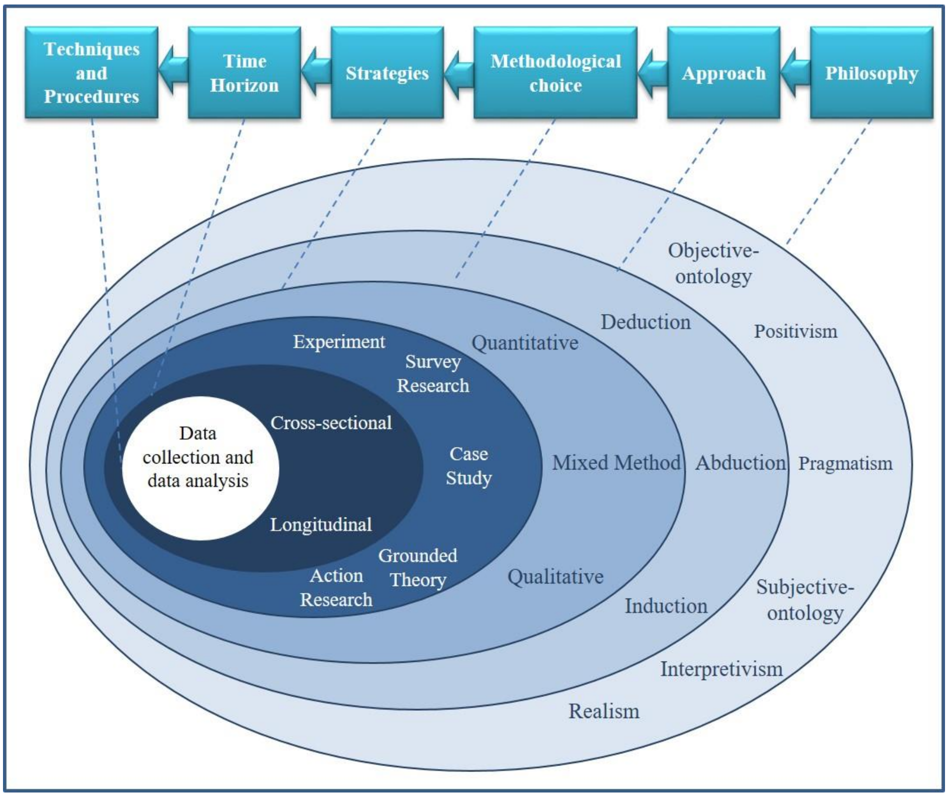

Figure 3.1 The Research Onion Model. (Saunders, Lewis & Thornhill, 2009)

3.1.1 Research Philosophy

A research philosophy describes a set of theories relating to the nature of the reality being studied (Bryman, 2012). Saunders *et al*. (2008) suggest a research philosophy focuses on the development of *"knowledge and the nature of the knowledge"*, while (Flick, 2015) believes it is the assumption created by a research philosophy that provides justification for the research design. There are different philosophical approaches, and each could be applied according to the research goals and on the best way of achieving those goals (Saunders *et al*. 2009; Tobergte and Curtis, 2013). Within the philosophical underpinnings of a research approach are its ontological and epistemological premises. The former ontological premise is mainly concerned with objectivism and subjectivism reality; while epistemology relates to knowledge and includes pragmatism, realism, interpretivism and positivism. In addition to the above, axiology is another branch of research philosophy that directs the researchers' judgements about value within the research. In other word, axiology is specifically engaged in the assessment of the role of researchers' own value on every stage of the research process.

To help define research philosophy, three major questions can be raised; (i) what is the nature of reality? (ii) What is the relationship between the researcher (the knower), and the researched (the known)? and (iii) how can we know it? (Pickard, 2018, p.6.). Being able to articulate the research philosophy is important as it will help to design a successful and coherent study; choose an effective and appropriate design that is most related to the purpose of the study; and enhances the researchers' ability in engaging in the research process (Easterby-Smith *et al.*, 2014). In conclusion, research philosophy is based on ontology, epistemology and axiology in order to determine the research designs. The subsequent sections will outline brief and concise descriptions of ontology, epistemology and axiology used as the premise for this study.

3.1.2 Ontology

Ontology is the study of 'being' (Levers, 2013, p.2), sometimes referred to as the 'nature of reality' (Saunders *et al.*, 2009; Bryman, 2012; Pickard, 2018). Two main ontological positions can form the research process; objectivism and subjectivism (Monette *et al.*, 2005; Saunders *et al.,* 2012). Different authors might describe these two positions as empiricism and interpretivism, but the underlying concepts are the same (Bryman, 2012).

3.1.2.1 Objectivism

Objectivism maintains the view that reality exists independently of the thing being investigated (Bryman, 2012). Social entities exist in a reality external to, and independent of social actors. This ontological stance is practically related to positivism – an epistemological philosophical branch which argues that truth and reality are free and independent of the researcher. For a positivist, knowledge is factual and trustworthy if it is gained through observation and measurement (Collins, 2010). Saunders *et al.* (2012) therefore opined that objectivism is suitable for use with positivism to explain and test theories. In the light of the above, Bryman and Bell (2015) further stated that objectivism is an ontological position which believed that social phenomena and their meanings have an existence that is independent of any social actors.

3.1.2.2 Subjectivism

Conversely, subjectivism is of the belief that reality is fixed in a subjective experience (Denzin & Lincoln, 2006), in other words, subjectivism suggests that the inherent meaning of a phenomena is socially constructed (A-stlund *et al.*, 2011). Subjectivism is about the interactions between the researched, phenomena and process in order to understand the situation; the influence of the phenomena and the reasons for such influence will inform the nature of reality (Saunders *et al.*, 2012). Subjectivism is often accompanied by interpretivism and those adopting a position of subjectivism acknowledge there are multiple realities regarding a specific phenomenon and these come with multiple interpretations of experience (Levers, 2013).

In the light of the above, within this study I adopted the ontological position of subjectivism. The focus for my study was to explore the lived experiences of young adults living with mental illness. From my own experiences within nursing, and in particular mental health nursing, and from the evidence I found when undertaking my literature review, I believe that people experience their situations differently and these will be temporally situated within a given context.

Before making a final decision based on my ontological position, I also needed to consider the epistemology that would underpin the research designs for this study.

3.1.3 Epistemology

Epistemology is the study of knowledge, a way of understanding and explaining how we know what we know (Crotty, 1998). Epistemological inquiry takes into consideration the relationship between the knower and the knowledge by asking question such as; "how do I know the world?" (Denzin & Lincoln, 2005, P.183). As a branch of philosophy, epistemology deals with the source of knowledge. More specifically it is concerned with possibilities, nature, sources and limitations of knowledge (Pandey, 2016; Saunders *et al.*, 2008). There are three major types of epistemology; positivism, interpretivism, and pragmatism (Saunders *et al.*, 2012). Positivism and interpretivism contend over the fundamentals of truth.

3.1.3.1 Positivism

Positivism is conceptualised as having an objectivist epistemology and critical realist ontology (Denzin & Lincoln, 2005). Hence, positivist is of the opinion that there is only single truth or reality. Positivism requires rigor, precision, logical reasoning and attention to empirical evidence, but unlike positivism, this is not confined to what can be physically observed (Crossan, 2003).

3.1.3.2 Interpretivism

The interpretivist paradigm is conceptualised as having a relativist ontology with a subjectivist epistemology and is aligned with postmodern thought. Hence, interpretivist is of the opinion that there are multiple realities in every knowledge (Saunders *et al.*, 2012). Interpretivist research is guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied (Denzin & Lincoln, 2005, p.22). The interpretive paradigm believes knowledge is relative to particular circumstances; historical, temporal, cultural, subjective, and it exists through different representations of reality (Benoliel, 1996). The interpretive paradigm focuses mainly on recognizing and narrating the meaning of human experiences and actions, and is concerned with social science and the knowledge generated by the participants (Fossey *et al.*, 2002; Pickard, 2018).

3.1.3.3 Pragmatism

This is conceptualised as having aspects of both the positivist and interpretivist paradigms. In pragmatism, meaning is created through an interaction of the interpreter and the interpreted (Crotty, 1998). The interpreter though not entirely objective, is separate from the phenomenon to be observed and the meaning making interaction is strongly influenced by the phenomenon and society (Levers, 2013). It is not simply the researcher's interpretation, rather the phenomenon affects the interpretation with equal force. How the interpreter make sense of and understands the thing to be interpreted cannot be approached as a blank state with the goal of observing something in its true form (Levers, 2013). Rather, the interpreter's observations are shaped by phenomena and societal influences and the interpreter is aware that his interpretations are influenced and does not claim to be discovering truth. The researcher recognises that the findings are a construct produced by the interaction between the interpreter and the interpreted as situated in society.

Interpretivism was the preferred epistemology for this study as it lends itself well to studies that aim to explore the lived experience of people. It can also be used effectively with subjectivism (Saunders *et al*., 2012) which was my preferred ontological position chosen for this study. Interpretivism is an approach emphasising how people make sense of their lived experiences and the meaning they attach to them (Elster, 2015). It also acknowledges people's knowledge of reality is socially constructed by human actors, thus rejecting natural science

(Elisaeson, 2002). Moreover, interpretivism is deeply rooted in the philosophical practices of phenomenology which specialises in exploring the lived experience of people (Chowdhury, 2014). These epistemological and ontological positions informed the researcher's decision to employ phenomenology in this study considering the nature of the topic and objectives of the research.

3.2 **Research Method**

There are three main paradigms of research; qualitative, quantitative and mixed methods (Creswell, 2009). Each method is employed for a particular study according to the nature of the phenomenon being investigated (Saunders *et al.,* 2012).

3.2.1 Quantitative Method

Quantitative approaches are a method of research investigating the connections between research variables (Saunders *et al*., 2012). Its procedure is based on measuring numerical data, using statistical techniques for data analysis and maintains an objective stance. More also, one of the goals in conducting quantitative study is to determine the relationship between variables within a population. Positivism and deductive theories are well applied in quantitative method (Pickard, 2013).

3.2.2 Qualitative Method

Qualitative research is a method used to investigate people's behaviour, attitudes and experiences. It employs data gathering techniques such as observation, interviews, pictures and focus groups (Denzin & Lincoln, 2011). Generally, the qualitative paradigm is regarded as a naturalistic, interpretive approach, which is concerned with exploration of phenomena from the interior (Flick, 2015), using the perspectives and accounts of the research participants as a starting point. To do this, qualitative method uses the conceptual frameworks that are tied to it. Interpretivism and an inductive approach are characteristic features of qualitative research which makes it appropriate for a study that seeks to explore the subjective meaning of events (Saunders *et al.,* 2012).

3.2.3 Mixed Methods

This is the combination of both quantitative and qualitative methods being used for a study. To use mixed methods in a research study implies that the research is using more than one data collection technique (Creswell & Clark, 2011). It is assumed that the essence of combining the paradigms for a particular study is to get a deeper understanding of the phenomenon being investigated (Cresswell & Plano Clark, 2010).

Nevertheless, mixed method was not considered necessary for this study as the researcher was wanting to explore young adults' experience of having a mental illness, rather than measure its impact on different aspects of their lives. Philosophically, the ontological and epistemological stance of quantitative methods does not support interpretation of people's subjective lived experience (Crossan, 2003) as it includes the use of deduction which involves testing hypothesis and theories (Namey *et al.*, 2008).

Moreover, one of the reasons that necessitate the application of a mixed methods study is when neither quantitative nor qualitative methods are considered sufficient enough to understanding in detail the trends of a phenomenon (Creswell & Clark, 2009). However, in this study a qualitative approach as a single method was considered sufficient enough to explore the phenomenon under investigation. Creswell and Creswell (2017) identifies a qualitative approach as *"a method of inquiry which offers the researcher a means for exploring and understanding the meanings individuals or groups attach to a social or human problem."* Hence, the aim of qualitative research is to explore factors surrounding a central phenomenon and present varied meanings or perspectives held by participants (Reiners, 2012).

The most fundamental notion underlying qualitative research is that reality is socially constructed on an individual basis and is therefore is multifaceted (Wills, 2007). Qualitative research is usually driven by a desire to gain insight into people's perspectives, views, experiences, and meanings, and to prioritize them when reporting the research (Braun and Clarke, 2013). Midgley (2004) highlighted the usefulness of qualitative methods in elucidating the meanings people use to make sense of their experiences, predicated on data that relates to language, interactions and observations. A qualitative approach elicits "thick" data, through a process whereby there is a steady interaction between discussion and understanding, as well as an acknowledgement of the presence of values and ethical issues (Maxwell, 2013). However, within a qualitative approach there are several types of methods for researchers to choose from (Green, 2013). For example, qualitative approaches that are often used in nursing include; narrative, grounded theory, ethnography, phenomenology and case study. While each of these qualitative approaches has relevance, their application is dependent on what the study seeks to achieve and the scope of the study. For instance, narrative methods focus on weaving together a sequence of life histories or stories to examine how each individual makes sense of events in his/her life (Squire *et al.*, 2008).

Moreover, the current study is not seeking to harness individual stories of those young adults who have experienced mental health problems. Ethnography is committed to understanding the culture of the target population through the researcher becoming embedded in that culture (Reeves, Kuper & Hodges, 2008). This was not possible or required for this study as I was wanting to explore the young adults' experience of living with a mental illness from their own perspectives. Therefore, ethnography was not considered appropriate for this study. Grounded theory is another popular qualitative approach, particularly when the intent is to develop theory or provide an explanation behind events (Birks & Mills, 2015). However, it was considered inappropriate for this study as I was not aiming to generate theory, but to instead initiate a database of young Nigerian adults in personal experiences of living with mental illness. Narrative, ethnography and grounded theory were all considered inappropriate for the current study, due to their idiosyncrasies in what they seek to achieve and how they would go about this. Phenomenology, another relevant and popular qualitative approach, specifically seeking to explore the lived experience of people and with the aim of understanding the meaning and essence of such experience was deemed the most suitable for achieving the aim of this study (Lopez & Willis, 2004).

3.3 **Research Design**

As this study aimed to explore young adults' lived experience of their mental health problems and what factors might promote their mental wellbeing, a phenomenological design was considered to be suitable for this study. Phenomenological study is underpinned by the idea that the reality of any situation can only be described by those who experience it (Ingleton & Seymour, 2014). The aim of phenomenological research is to illuminate the specific; to identify phenomena through how they are perceived by individuals in a given situation (Chan *et al.,* 2013). Phenomenological research allows for an in-depth exploration of peoples' views and experiences through interviews (Barbour, 2008), giving participants the opportunity to share their subjective experiences and perceptions regarding a phenomenon (Creswell, 2007).

Phenomenological research supports the re-examination of neglected experiences/perceptions and through examining the characteristics of the experience allows people to identify its essence (Balls, 2009). Thus, developing a theory or model is not the goal of phenomenological research, but to describe the subjective views or experience of a person in relation to what is being studied is core to its underlying philosophy (Kafle, 2013). Although phenomenology is not devoid of weaknesses (Chan *et al.,* 2013), its methods of data collection gives it many advantages over other research methods, particularly with regard to this study. The data in this type of study is most commonly collected through interviews with the relevant people who have had, or may be having, the experience related to the focus of the study (Freeman, 2011).

The characteristic flexibility of this method will give the participants the freedom to discuss their perceptions according to their subjective experiences. Balls (2009, p 30.), suggests that findings from phenomenological research are useful in *"improving patients' health problems and wellbeing, nursing education and nursing practice."* He further stated that surgical phenomenological research in nursing provides *"a comprehensive yet straightforward introduction to research, enabling nurse researchers to use the method systematically and rigorously"* (p. 30).

While a phenomenological approach may be appropriate for exploring lived experience and perceptions, there are many different schools of thoughts about the phenomenological approach (Chan *et al.,* 2013). Embere (1997) identified five phenomenological approaches which include; transcendental constitutive (descriptive) phenomenology, naturalistic constitutive phenomenology, hermeneutic (interpretive) phenomenology, existential phenomenology, and realistic phenomenology. The two major approaches that guide most qualitative studies are transcendental (descriptive) and hermeneutic (interpretive) phenomenology (King, 2007). However, the argument between transcendental and hermeneutic phenomenological schools of thoughts has remained unresolved. Transcendental phenomenology was championed by Edmund Husserl, regarded as the father of phenomenology (McConnell-Henry *et al.,* 2009). It emphasises '*bracketing' or 'phenomenological reduction'* meaning laying aside researcher's assumptions, regarding the question/s to be answered. The aim of transcendental phenomenology is to generate data that will be devoid of researcher's bias, leaving data close to the original exposition in its rawness and complexity (Giorgi, 2011). Some authors (Churchill, 2003; Garza, 2007; Dahlberg, Dahlberg & Nyström, 2008), argue that such data only results in the description of participants' lived experiences rather than explaining or interpreting the meanings of such experiences. This idea was founded on Martin Heidegger's notion of hermeneutic phenomenology, who challenged Husserl's school of thought, by suggesting it is impossible to disregard researchers' pre-knowledge of the phenomenon under investigation (Mulhall, 2014). Heidegger further suggested that a researcher is as much part of the study as their participants, and their penchant to interpret data will be based on their previous knowledge (Finlay, 2009). Heidegger's premise suggests phenomenology is more than descriptive research, as it requires interpretation of that data on the part of the researcher. For Heidegger, there was no discernible difference between epistemology and ontology, suggesting 'knowing', albeit knowledge or on one's own intuition (values and beliefs) is realised from interpretation and understanding of the phenomenon being studied.

While the debates concerning transcendental and hermeneutic schools of thoughts are yet to be resolved, within this study I have adopted hermeneutic phenomenology as proposed by Heidegger, as it aims to explore the lived experiences of young adults regarding their mental illness and their mental wellbeing. By using hermeneutic phenomenology, I intend to stay close to Heidegger's philosophy of recognising my own influence on the research data and how this will lead to my interpretation of that data, rather than simply describing the data. Furthermore, since the essence of all research is to produce new knowledge, employing a hermeneutic approach in this study will enable me as the researcher to enter the world of the participants and interpret the meaning they assign to their experiences. This process will give voice to the participants and generate invaluable new knowledge.

3.3.1 Participants and study setting

The Federal Neuro-Psychiatric Hospital, Enugu, Nigeria, which is one of the major psychiatric hospitals in Nigeria, was selected for recruiting participants for this study. The Federal Neuro-Psychiatric Hospital is the only major psychiatric hospital located in South-East of Nigeria, with a population of over 20 million people. Choosing this facility for this study was a decision informed by two major reasons. Firstly, I was born and bred in South-Eastern Nigeria, hence I understand their cultural heritage better than those from other parts of the country. Secondly, I have had clinical experience in the same hospital whilst I was an undergraduate student. My clinical experience and observations during that time compelled me to select this hospital as a setting for my study.

After ethical approval for this study was granted by the Research Ethical Panel at the University of Salford (see appendix iii) and through the ethics committee of the selected hospital in Nigeria (see appendix iv), potential participants were approached through letters of invitation (appendix v) and this was followed up with a participant information sheet (appendix vi) giving more details of the study. For this study a purposive sampling technique was used, permitting the researcher to intentionally select participants who have experienced the phenomenon under investigation (Parahoo, 2014). I intended to recruit approximately 10-15 young adults, but actually recruited 16 participants (ten males and six females). Criteria for participation included; (i) participants must be within the age range of young adults (ii) participants must have been diagnosed with a mental illness (iii) participants must be receiving treatment, either as an inpatient or out-patient, for their mental illness at the identified hospital (iv) participants must have insight into their problems in order to be able to give informed consent and engage in an interview process and (v) participants must be able to communicate using English language (this is the dominant language spoken in Nigeria).

In addition to the inclusion criteria I collaborated with the responsible medical officers and prominent nurses who served as gatekeepers in the process of participant recruitment. This was important as it helped me, as researcher, to overcome the challenges related to accessing potential participants and maintaining contact with them throughout the interviews (Patternson *et al.*, 2010). The gatekeepers who were already familiar with the patients served as a bridge linking both the researcher and participants. Through the gatekeepers the researcher distributed invitation letters and participant information sheets and was able to establish a rapport with potential participants. Also, considering the nature of the target group, using gatekeepers ensured that those who wished to participate were deemed fit to do so. Prior to being interviewed participant were asked to sign a consent form (appendix vii).

3.3.2 Method of Data Collection

Semi-structured interviews were employed as the method of data collection with those who volunteered to participate in the study. The flexible nature of interviews allows both the interviewer and interviewee the freedom to respond and explore whatever issues they find relevant to the study (Brown & Lloyd, 2001). Each interview lasted for approximately one hour and took place in a suitable location at the hospital. With the participant's permission the interview was audio-recorded, and following each interview the researcher, in keeping with a phenomenological approach, made notes pertaining to non-verbal aspects of the interview. As the researcher I tried to keep time and do my best to make the interviewee comfortable during the interview process. More especially, participants were able to stop and/ or end the interview at any time without giving a reason. If the interviewee was distressed by reiterating their experiences, I ensured appropriate support was available immediately following the interview. A short time was allocated at the end of the interview for debriefing, this was not recorded, and it did not form any part of the research data. This gave me chance to check with the participant how they were feeling at the end of the interview and what, if any, further support they might need. I followed this by offering the participant advice about what support was available to them in the longer term.

3.3.3 Ethical Consideration and Research Governance

As this study involved human beings, before the commencement of this study, the full required ethical approval was sought and obtained from the School of Health and Society's Post Graduate Research Ethics Panel, University of Salford (appendix ii), which was also the sponsor of this study, and the second ethical approval was obtained from The Research Governance and Ethics Committee of the Federal Neuro-Psychiatric Hospital Nigeria (appendix iii) where the participants were recruited. Prior to data collection, the researcher issued invitation letters to young adults receiving treatment from the facility. For those who showed an interest this was followed by giving them a participants' information sheet detailing what the research was all about, what to expect and what not to expect. The questions raised by participants after they have studied the information provided regarding the study were carefully answered by the researcher. Participants who volunteered to take part in the study and met the inclusion criteria where asked to sign a consent form prior to data being collected. Copies of these documents were stored in keeping with the data management policies as determined by the Research Ethics Panel on behalf of the University of Salford.

As part of qualitative studies, conducting in-depth interviews with a vulnerable group is an area of concern because of the emotional issues that may arise before, during or after data collection. In preparedness for such unpredictable circumstances, I ensured that psychological support services were available throughout the period of the interviews. Also, the nature of the participants' illness and their sensitivity to health needs demanded careful thought and planning, and to achieve this my professionalism as a nurse was utilised. (Clarke, 2006) suggests researchers should act professionally and with some level of empathy during distressing moments while conducting studies. This involves not being judgemental, avoiding unnecessary probing and also offering to stop the interview if the interviewee becomes distressed and/or emotionally unstable. My experience as a nurse who has previously worked with people with mental health problems and from different age brackets, I was aware of the need on my part to demonstrate respect to each participant and not to ask questions that could be construed as an invasion of privacy. In addition, the lone worker policy training I attended at the university prepared me for working on my own during the data collection, and thus prompted me to ensure a member of the hospital staff knew where the interview was taking place, who I was with and an approximate time it would last.

Also, as part of adhering to ethical principles, special attention was given to audio voice recording equipment and the transcription process. At the point of recruitment, participants were asked if their interviews could be audio recorded and the reason for requesting this was clearly explained to allay any fears they may have had. This was reiterated again at the start of the interview. To ensure confidentiality was maintained throughout the research process, I tried to avoid using participants' real names during interview and if they did appear on a transcript they were replaced with pseudonyms. This made it impossible for external persons to identify who had participated and/or which transcript belonged to which participant. Electronic copies of the anonymised transcripts were securely stored on a password protected computer only accessible to myself and my supervisors. Hard copies of the transcripts, used in the process of analysis, had all identifying information removed and the voice recorder containing the audio voices of the participants were securely locked in a drawer in my office. Dissemination of outcome of research is also another area of ethical consideration. In respect of this, I explained to the participants that the outcome of this study will be published in my PhD thesis, in academic journals and presented at seminars and conferences to help health professionals improve on their knowledge and skills and in turn improve the patients' care. However, I also reassured them that none of their identities would be revealed in any of the publications or presentations.

3.3.4 Reflexivity

The growing acknowledgement of the importance of qualitative research has attracted an increased demand to employ strategies, criteria and tools that will help to promote the rigour and quality of research findings (Zitomer & Goodwin, 2014). Quality in nursing research is important for the promotion of evidence-based practice that will in turn enhance the overall quality of patience care services (Bishop & Holmes, 2013; Bover, 2013). Reflexivity is acknowledged as one of the most reliable and valuable means to achieve quality results in qualitative research (Freysteinson *et al.*, 2013; Houghton *et al.*, 2013). Reflexivity describes the continuous process of self-reflection in which researchers continue to reflect on their values, actions, feelings, preconceptions and those of the participants which can interfere with the interpretation of responses (Anderson, 2008; Parahoo, 2014; Murphy *et al.*, 2015). While reflexivity can be a good strategy to maintaining transparency in qualitative studies, it is not without limitations.

Reflexivity as a concept is still being debated as there is no a consensus yet regarding its meaning and how and when it can be employed as a strategy for rigour in qualitative studies (Darawsheh & Stanley, 2014). Mauthner and Doucet (2003) warned that the information reported in a reflection may not be a genuine experience and there is no tool for measuring the originality of researchers' reflection. However, Jootun *et al.* (2009) asserted that the benefits of reflexivity in a qualitative study outweigh its limitations. Personally, reflecting on the process of your research implies the researcher will pay close attention to his involvement to ensure that his or her values and personal views do not influence the outcome of the research (Jootun *et al.*, 2009). It requires the researcher to enter the process with the right instrument and to ignore whatever pre-conceived ideas or views he has about the topic. This in turn adds credibility to the research.

The importance of reflexivity in qualitative research cannot be over emphasised. Studies in qualitative research (Smith & Smith, 2006; McCabe & Holmes, 2009; Lambert *et al.,* 2010) have continued to acknowledge the relevance of reflexivity. Finlay (2006) asserted that reflexivity in research improves transparency in the researchers' subjective involvement, both in conducting research and in data analysis. It helps to keep the subjective roles of the researcher in check during the research process by exposing it to scrutiny and thereby undermining the authoritative and dominant influence of the researcher (Ritchie *et al.,* 2013). However, throughout my research journey, a reflexive diary was kept. I carefully documented my experiences before and after the participants' interviews. In keeping with qualitative research in nursing (Anderson, 2008; Houghton *et al.*, 2013; Houghes, 2014; Parahoo, 2014), this reflexive experience offered me an opportunity to evaluate my influence on the data, as well as keeping an account of participants' non-verbal communication and other relevant events that happened during the interviews. In this study, reflexive notes were kept which also helped to keep a check on my own influence so as to avoid interfering with the data (Jootun, McGhee & Marland, 2009). From this point on my reflections can be seen in the reflexive boxes throughout the thesis.

Reflexivity on recruitment of participants

Prior to the recruitment and interviewing of the research participant, I had a disturbing thought about how to gain access to the targeted group. Knowing that I was going to deal with a vulnerable group i.e. people with mental health problems, I was faced with the challenge of how to approach and convince them to voluntarily participate in the research. Secondly, I was also faced with the fear of how and what will I do if any of the vulnerable persons eventually turned violent or experienced crisis during the interview. Problems with recruitment of research participants can interfere or disrupt the researcher's schedule for a research project (Patel et al. 2003). However, understanding the barriers to recruitment in a research project is a key to identifying the facilitators (Bucci et al. 2015). I entered the targeted group through gatekeepers (the units' managers) who served as facilitators in recruiting the participants. Given that the research has been designed to only accommodate participants who were in a recovery stage and where they were able to have a meaningful conversation with the researcher, a lot of patients who did not meet the inclusion criteria were denied the opportunity to participate despite their willingness to do so. In my reflection, although I was feeling fulfilled at that stage for gaining entry to the target group, I also felt guilty for not giving everybody an equal opportunity to participate in the study. During my reflection, I realised that such action could be equated to stigmatization for those patients who were not allowed to participate in the study. Moreover, I realised that calling those patients that were nominated by the units' managers one after the other to either a counselling room or nurses' station to give them the invitation letters and other necessary information about the research could have helped to conceal the information from others, thus averting any stigmatising view that may be attached to it. While the above experience may seem to have worked against the interest of some vulnerable persons, the experience helped me to understand how much the mentally ill people crave for human relationship. Such cravings were reiterated by the first person I interviewed after the recruitment who repeatedly said, and I quote, "I am so happy to have this discussion today, it has been long since I had one on one chat with people". What this implies is that this vulnerable group of people always want to talk to someone about their feelings.

Reflexive note of first interview

The first interview I conducted with a male participant was a bit difficult for me. The interview started fine as I introduced myself to the participant and explained to him all he needed to know about the research. I also sought his consent to allow me to record the interview with my voice recorder; the reason for audio recording was explained to him which he granted permission following my assurances that his identity will not be revealed in any part of the research work. This made him feel much more relaxed and the interview proceeded smoothly. Not long after the interview commenced the participant's mother came into the interview room and insisted that I must not record her son's voice. Her fear was that I could make the interview public either on the radio, television or pages of newspapers and thereby letting everyone know that her son is mentally ill. This is typical of Nigerian society where most families do everything possible to hide the identity of any of their members that has mental illness. However, thinking about this, the woman's fear and reactions could be justifiable given that Nigerian media and movie industries often paints ugly pictures of people who are living with mental illness. For her, she thought I was going to use the son's data and identity to shoot films or make television or radio news. However, I made effort to make her understand that it wasn't what she thought. Even the son did his very best to convince the mother, and she accepted our explanations and allowed us to proceed with the interview. Although she accepted, she never rested as she continued to check on the son in the interview room, thereby interfering with the interview. She recurrently repeated what she said the first time she came in and we continued to reassure her of the confidentiality. She almost tried to regulate the kind of information the son gave during the interview because she felt the son could give some information that might implicate him. Her interferences made the interview disjointed and a lot of vital information could have been withheld by the interviewee as his mother was almost monitoring the kind of information her son gave.

On reflection, I realised the importance of maintaining and sticking to ethical principles when conducting a research. Consent is one of the important aspects of ethical principles that can protect a researcher in any study that involves human beings. Despites the woman's threat to report me to her family, I was not deterred because the interviewee as an adult consented to be interviewed and audiotaped. Again, this incident helped me to appreciate the importance of confidentiality when research involves human beings. A breach in the confidentiality agreement can adversely affect both researcher and the participants because releasing participants' information without his or her consent can cause distress to the person. Also, the researcher can stand the risk of being sued by the participant for a breach of confidentiality. The woman's threat to report me to her family if I publicise her son's identity with the information, I collected from him made me more careful with the issue of confidentiality throughout the process of the fieldwork.

3.4 **Analytical Framework**

While some schools of thought have conceptualised qualitative analysis as craftsmanship (Brinkmann, 2012), others view it as detective work (Patton, 2014). However, regardless of the different meanings ascribed to it, qualitative data analysts aims to identify concepts and themes that emerge from the data which, when clustered together provides suitable explanations or answers to research questions (Srivastava & Hopwood, 2017). To achieve an accurate analysis of qualitative data, a skilful interpretation and proper handling of the data generated through participants' interviews is required, but this relies on a systematic and rigorous process (Holloway, 2009). Many scholars (Braun & Clarke, 2006; Patton, 2002), have over the years provided qualitative researchers with many well-known texts outlining general procedures for carrying out qualitative data analysis, including; interpretative phenomenological analysis, content analysis, conversational analysis, and thematic analysis. The application of each of these analytical procedures is always informed by a number of factors including the type of topic the researcher wishes to explore, the research questions, who makes up the participant group, the theoretical stand and context of the research (Braun & Clarke, 2014).

In this study, thematic analysis, sometimes referred to as theme analysis (Meier *et al.,* 2006), was adopted for the analysis of the data generated through the interviews with the young adults. Although thematic analysis and interpretative phenomenological analysis (IPA) are both qualitative analytical methods that seek to identify patterns in data, IPA is believed to be theoretically bound (Braun & Clarke, 2006) which makes it difficult for non-realists to use. At this point, it is necessary for me to acknowledge my own theoretical positions and values with respect to qualitative research. I do not think there is only one ideal theoretical framework or method for conducting an analysis of qualitative data. When undertaking quality research, it is important that there is conformity of methods with the researcher chosen methodological approach (Braun & Clarke, 2006). The theoretical versatility of thematic analysis gives researchers the freedom to apply the method of analysis in any way they want to. Furthermore, as a new qualitative researcher I found thematic analysis more suitable for my level given that it does not require detailed theoretical and technological knowledge unlike, for example, IPA, grounded theory and discourse analysis. Braun and Clarke (2006), recommend thematic analysis for every qualitative researcher given that it offers a more accessible form of analysis particularly for people who are new to engaging in qualitative research. The above recommendation informed my decision to use thematic analysis to analyse the data gained from the interviews of 16 participants.

3.4.1 Thematic Analysis

According to Holloway and Todres (2003), qualitative methods are diverse, multifaceted and nuanced and thematic analysis should be seen as a foundational method for its analysis. Thematic analysis has been described as a systematic approach for identifying, analysing and presenting patterns or themes as they emerge within interview data (Braun & Clarke, 2006). It is suggested that thematic analysis is the first analytical method that every qualitative researcher should become familiar with, as it provides them with the fundamental skills for conducting several other forms of qualitative analysis (Holloway & Todres, 2003; McLeod, 2012). Although its usefulness is highly acknowledged, thematic analysis is still regarded as a poorly defined and rarely recognized method of data analysis (Roulston, 2001). Nevertheless, thematic analysis has become the most commonly used method of data analysis in qualitative studies (Braun & Clarke, 2014; Clarke, 2006; Fereday & Muir-Cochrane, 2017). In recent times wide application of this analytic method could be attributed to the attempts made to systematically develop a thematic method in order to improve robustness in social researches (Braun & Clarke, 2006).

Critics of thematic analysis (Boyatzis, 1998) argued that it is not a specific method per se, but a tool to be used across different methods. Similarly, Ryan and Bernard (2000) align their views with Boytzis (1998) by locating thematic coding as just a process performed within a major analytic method, rather than an independent analytical approach. Ryan and Bernard (2000) described it as a poorly developed method, in that it does not appear to exist as an analytical approach in the same way others do, for example, narrative analysis, content analysis, interpretative phenomenological analysis, conversational analysis. Conversely, Braun and Clarke (2006), argue that thematic analysis should be considered as an independent method of data analysis. To achieve this, the principles and systematic steps as outlined by Braun and Clarke (2006) were followed. This involved using the following six phases: - familiarization with the data, coding, searching for themes, reviewing themes, defining and naming themes, and writing up.

3.4.1.1 Familiarization with the data

This is common to all forms of qualitative analysis. After the interviews were conducted, and audio recorded, I transcribed each interview verbatim (see appendix ii) with utmost carefulness, trying to minimise grammatical ambiguity (Braun & Clarke, 2006). Rubin and Rubin (2012) emphasised the importance of accuracy and maintaining the originality of participants' words in this phase, as any slight alteration in their words, even where a comma is placed, can change the meaning. While this phase can be difficult and time-consuming, (Ghiyasvandian *et al.*, 2014), it is also highly valuable as it provides the researcher the first opportunity to get familiarised with the content of the text. Also, in order to gain a deep understanding of the text, the researcher needs to immerse himself in the interview transcripts. (Javadi & Zarea, 2016) recommend that researchers should engage in active and frequent reading of the transcripts so that they will become familiar with every aspect of their interview data. Also, at this stage preliminary patterns are often formed by reading the topics brought to the fore by the participant and possible connections in the data (Rubin & Rubin, 2012; Saldana & Saldaña, 2015). Hence, ignoring any part of the text may lead to missing some of the important aspects of the data. In order to check the accuracy of the transcript I listened to the audio recording again while comparing it with what I had written. Once I felt confident, I had accurately recorded what they had said in writing I was then able to move onto the next stage of the analytic process.

3.4.1.2 Generating Initial Codes

After I had read and familiarised myself with the data, I then generated the initial list of ideas that appeared to be emerging from the data and what were points of interest about them. I then went on to producing initial codes from the data. Hence, this phase involved searching and identifying portions of the text that I believed were relevant to the research questions, identifying meanings in these segments of text and giving them a code. Going through this process enabled me to organise my data into significant groups and assign initial codes to the data. This was done manually and systematically from the overall set of data, with equal attention being paid to all data in order to identify the relevant aspects that may or may not be repeated in the data. To code the data, I used coloured pens or highlighters to indicate potential patterns and I made notes in the margin of the transcript. The codes were then collated together within each transcript. This was done by copying extracts of data from the individual interview transcript and then collating the codes together in another computer files.

3.4.1.3 Searching for Themes

Themes are usually sought from the codes and this begins after all data have been initially coded and collated (Javadi & Zarea, 2016). With the long list of the different codes identified across the data set, the researcher will gradually bring similar codes under a set and give a name to each set with a concise explanation written separately for each (Saldana, 2015; Clarke & Braun, 2013). I analysed the codes I had generated, keeping watch for how different codes may combine to form a central theme. To do this, I used visual representations to help in sorting the different codes into themes. According to Braun and Clarke (2006), some initial codes form themes, while others may form subthemes, and some are codes that do not belong to any theme and may be discarded. At this point, I collated themes and sub-themes, and data extracts that had been coded in relation to them to make sense of the meaning of the individual theme. Finally, in order not to leave anything out at this stage, I looked in detail at all the extracts to ensure that themes I had identified held as they were or whether some themes needed to be combined, refined, separated or even discarded.

3.4.1.4 Reviewing Themes

In this phase, the researcher tries to relate parts of the whole data set. It involves checking and rechecking the themes at every level against the initial codes and at some point, also against the original text segments. This is actually about the refinement of themes and it begins when the researcher has come up with a set of main themes, while looking out for those themes that could be divided into two. At this stage two basic principles, internal homogeneity and external heterogeneity are worth considering (Patton, 1990). This means that data in the theme should be meaningfully related to each other and there should be clear and recognisable difference between themes.

Understanding that this phase involves two processes of reviewing and refining themes, I carried out the first process of the review during the coding of data extracts. To do this, I read all the collated extracts for each theme and further consider whether they appear to form a coherent pattern. I then moved on to second process which involved trying to establish if the theme itself was problematic or whether some of the data extracts within the theme did not fit well. To do this I reworked the themes in order to create a new theme, while those extracts that did not seem to fit well in the new theme were discarded entirely from the analysis. Immediately I became satisfied that the main themes adequately captured the essence of the coded data and once the main theme was confirmed, I then moved on to the level two.

A similar process was carried out in the second level of review, but in relation to the entire data set. Here I considered the authenticity of the respective themes in relation to the data set and I also checked whether the main themes correctly reflect the meanings as captured in the data set as a whole. According to Braun and Clarke (2006), in this phase, the researcher will re-read the entire data to ascertain whether themes work in relation to the data set and also code any additional data within themes that was omitted in earlier stages of coding. After I confirmed the themes, I then moved to another phase of the analysis. In this phase the researcher usually needs to go back for a further review of the themes that do not fit the data set, and this process is continued until a thematic map that adequately fits the data set is achieved (Ghiyasvandian *et al.,* 2014). It is argued (Braun & Clarke, 2006) that the possibility exists, that the researcher may identify some potential new themes in the course of this review which he may wish to start coding if he finds them interesting. However, Braun and Clarke (2006) warn that as coding data and generating themes may seem to be endless, it is imperative also to be careful not to get carried away by endless recoding. This warning is issued in light of there being no clear guidelines on when to stop, but it may be appropriate to stop if refinements are no longer yielding anything new or substantial (Rubin & Rubin, 2012; Saldana, 2015).

3.4.1.5 Defining and Naming Themes

In this phase the researcher conducts and writes a detailed analysis of each theme, establishing the essence of each theme and constructing, some concise and informative names for the various themes (Clarke & Braun, 2013). This started after I was satisfied, I had identified relevant themes from the data. I defined and further refined the themes that emerged from the analysis and analysed the data within them. This stage also involved ascertaining the essence of each theme and identifying what aspect of the data each theme captures. In order not to have a theme that was too complex and diverse, I went back to the collated data extracts for each theme and tried to organise them into a clear, consistent and coherent narrative.

For each theme, I conducted and wrote a detailed analysis, as well as identifying the story that each theme told. As a matter of importance, I considered how this story fits into the broader overall story about the data in relation to the research questions. This ensured that there is not too much overlap between themes. As part of the refinement, I checked whether or not a theme contains any sub-themes, and this helped me to clearly define what the themes were and what they were not. To confirm this, I tried to see whether I could describe the scope the content of each theme in a couple of sentences. According to Clarke and Braun (2013) if the researcher cannot do this, then the themes may need further refinement. These processes led to the emergence of the following themes; (1) Being mentally ill (2) Hopelessness (3) Fear of the unknown (4). Violence and vulnerability (5) Spirituality, religion and faith

3.4.1.6 Producing the Report

Producing the report begins as soon as the themes are fully worked out and this involves the final analysis and writing up the findings. The task of writing up a thematic analysis demands that the researcher tells the complicated story of his data in a convincing way and the merits and trustworthiness of his analysis (Braun & Clarke, 2006). Hence, I have tried to ensure that the analysis provides a concise, clear, logical, and non-repetitive mind capturing account of the story the data tells within and across all themes. In the write up, sufficient evidence of the themes is provided to demonstrate the essence of the theme. In this write up, I go further than simply offering a description of themes by making arguments in relation to the research objectives.

3.5 **Authenticity and Trustworthiness**

Researchers are always charged with the obligation of justifying to the research community that they have followed thorough procedural steps that can guarantee the quality of their findings (Choudhuri *et al.*, 2004). Although this applies to both quantitative and qualitative methods, the techniques for achieving validity and trustworthiness respectively are different (Williams & Morrow, 2009). Unlike qualitative research, there is an established and agreed language in quantitative research that allows for a shorthand way of communicating with other researchers about the validity and reliability of the study (Choudhuri, Glauser & Peregoy, 2004; Ponterotto, 2005). Ponterotto (2005) argues that applying such language in qualitative research will make little or no sense owing to the fact that often there is a vast difference in their epistemological underpinnings, processes, and procedural paradigm. Nevertheless, ensuring authenticity and establishing trustworthiness in qualitative research by using the terminology that all researchers are familiar with is significantly important (Williams & Morrow, 2009).

However, qualitative research has often been criticized for a lack of scientific rigor that might ensure its authenticity and trustworthiness for guarantying the quality of its findings (Pandey & Patnaik, 2014). Polit and Beck (2012) described authenticity as the ability and the extent to which the researcher expresses the feelings and emotions of the participant’s experiences in a faithful manner. Silverman (2013) suggests, reporting this using a descriptive approach, will enhance readers’ understanding of the essence of the experience through the participants’ interviews.

To further ensure trustworthiness in qualitative research, (Graneheim & Lundman, 2004, p. 106) suggest that “participants should be given the opportunity to go through the interpretation given to the experience he/she shared with the researcher.” However, Burnard, *et al.* (2008) warns that while involving participants in the verification of data analysis could be helpful, researchers should also be mindful of its pitfalls. They explain that as data is collected at a given time during the study, and when considered at a different temporal point and as interpreted data, the participant which is the originator of the data might offer a different meaning to it. Burnard *et al*. (2008) therefore argued that this might not be practicable, because presenting research findings to a non-academic audience might be challenging. Additionally, Warne and Mcandrew (2010) suggest returning the interpreted data to participants could raise conscious awareness that was previously denied by the participant, and consequently, may have the potential to cause distress. For these reasons, and including distance and time constraints, I could not return the interpreted transcripts to the participants.

In this study, authenticity and trustworthiness was ensured through several means. One of the ways used to maximize authenticity and trustworthiness was through the right choice of research paradigm and epistemological position. Presenting the research paradigm and epistemology that rightly supports a study is an essential criterion of rigour in qualitative research (Bishop & Holmes, 2013; Zitomer & Goodwin, 2014). This was accomplished by providing a rational for using the chosen methodology. Secondly, using an audio voice recorder during the participants' interviews helped me to capture a comprehensive account of the participants' lived experience without missing anything. This also helped me to manage subjectivity during the data analysis process as participants' voices were transcribed verbatim into a written text without omission. Thirdly, the use of reflexivity throughout the study process helped me maintain credibility of the findings as it helped me to identify my personal background, perceptions and values and made sure they did not influence the participants' data. The application of the most appropriate methodology and my epistemological and ontological position as outlined above and strict adherence to the rules of the analytical approach employed have led to the emergence of a number of themes which are presented in the next chapter.

Chapter 4 : Findings

4.1 Introduction

This chapter presents the research findings and clearly outlines how each theme relates to the research objectives. According to Braun and Clarke (2006), final analysis and write-up of the report begins after themes are fully worked out. The essence of the write-up in a thematic analysis is to shine more light on the complicated story of research data in a way which directly reflects the research objectives (Braun & Clarke, 2006). In this study, thematic analysis was used to analyse the data and a number of themes emerged. The themes are; (1) Being mentally ill (2) Hopelessness, (3) Fear of the unknown (4) Violence and vulnerability (5) Spirituality, religion and faith. Table 4.1 below represents the demographic information of the research participants. For confidentiality, the participants' real names were removed and replaced with pseudonyms.

Table 4.1 Participants' Demographic information

Pseudonyms	Sex	Age	Duration of diagnosis	Distance: Home to hospital
Unice	Female	28	4 years	35 miles
Chinye	Female	26	4 years	29 miles
Iboko	Male	23	8 months	11 miles
Ozo	Male	29	18 months	15 miles
Madi	Male	28	2 years	20 miles
Chinwe	Female	22	5 years	13 miles
Chukus	Male	28	5 months	6 miles
Ngba	Male	21	8 months	15 miles
Tochi	Male	27	13 months	8 miles
Anya	Male	28	3 years	27 miles
Agbo	Male	30	1 year	35 miles
Ugo	Male	27	3 months	11 miles
Ezi	Male	26	4 years	7 miles
Okey	Male	23	2 years	10 miles
Onuji	Female	29	4 years	8 miles
Amara	Female	28	5 years	25 miles

Table 4.2 below presents the identified themes and the sub-themes attached to each.

Table 4.2 Themes and sub-themes

Themes	Subthemes
Being mentally ill	Mental illness as an abnormal brain or abnormal illness. Mental illness is an embarrassment Mental illness is like being in another world
Hopelessness	Being caged/Loss of roles Self-critical Loss of confidence in the treatment Lack of support
Fear of the unknown	Uncertainty about treatment Uncertainty about the future Stigmatization impacting marriage, work, social life
Violence and Vulnerability	Physical abuse Verbal/Psychological and/or Emotional abuse
Spirituality, and religion faith	Praying to God to promote mental wellbeing Reading and professing the words of God

The figures below (4.1, 4.2, 4.3, 4.4, and 4.5) are thematic maps for each of the themes and its sub-themes presented in this chapter.

4.1.1 Theme 1: Being Mentally Ill

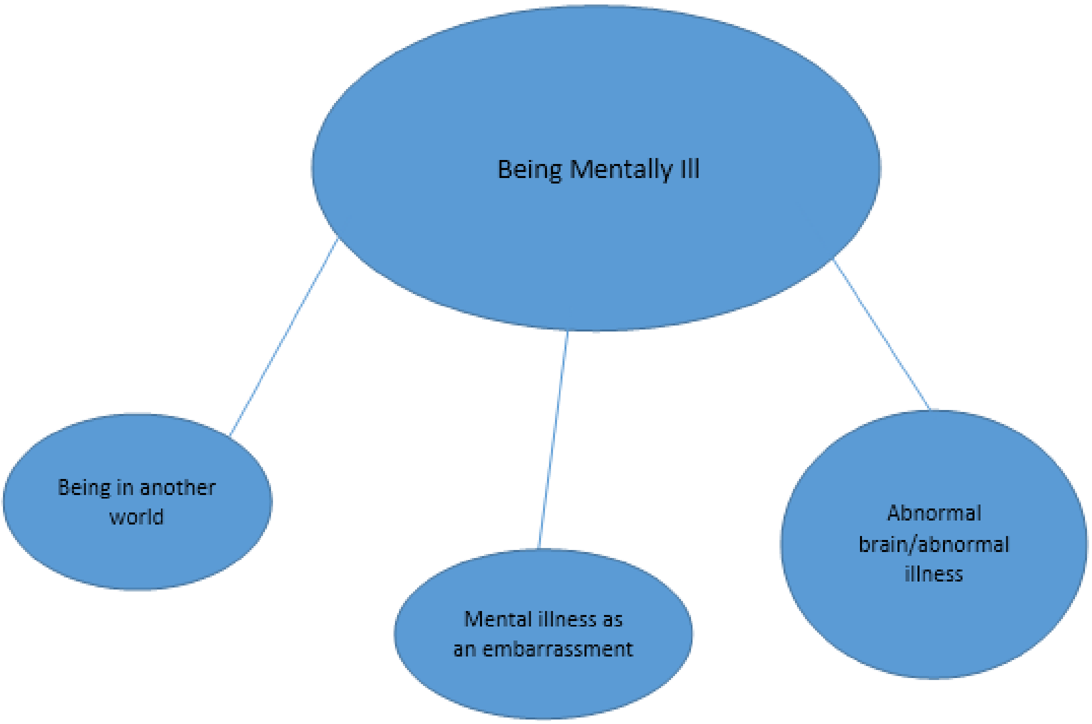

Figure 4.1 Theme 1

This theme encapsulates the meanings each of the participants attached to mental illness based on their lived experiences. The meanings they gave to mental illness reflected their experiences and can influence their behaviours and outcomes of the illness. Almost all of the participants verbalised the illness as having had long lasting effects on their lives. Participants showed their readiness to narrate their stories beginning with the first episode of their illness. Within their narratives, participants used different terminologies to refer to mental illness, using words and phrases such as; *'mental illness, sickness of the brain', 'illness of the brain', 'problem of the brain', and 'the madness'*. In this report and the rest of the work, the above phrases will continue to be used in some places in place of mental illness in order to maintain authenticity of participant data.

Within the above theme, regardless of the terminology used to refer to their mental illness, participants ascribed different meanings to it. These meanings represent their subjective perceptions of mental illness. Illness perception is described as an *"organised cognitive representations or views which patients hold about their illness"* (Petrie *et al*., 2008, p. 560). Petrie *et al*. (2008) further suggested that patients' perception of their illness can influence their helping seeking behaviours because it represents their personal beliefs about the illness. In this study, among the meaning participants attached to their experience of living with illness of the brain is that;

"Mental illness is an abnormal brain **Chuku,** *abnormal illness* ***(Amara),*** *it is an embarrassment, and it is like being in another world"* ***(Unice).***

Drawing from their interviews, it was obvious that some participants derived meanings from the time they became aware of their diagnoses.

For example, **Unice** said, *"this illness has taught me many lessons and has changed my orientation about life".*

Reflection following 5th interview

My 5th interview was with ***Unice****, a lady who looked very bright, beautiful and well dressed. In fact, during recruitment I almost skipped her because I believed her to be one of the members of staff working in outpatient unit. During the interview, I engaged her in a discussion regarding her experience of living with mental illness, the moment I opened a discussion about her mental health problem, this lady who was looking happy and bright immediately became moody. It took her a while before she started responding to me. This participant continued to narrate her experiences, but at one point her mood changed again, and she became emotional and started crying saying "I know that God hates me and that is why He allowed this to happen to me." I became emotional too, but I controlled my emotion. Consequently, I paused the interview and gave her some minutes break. On coming back, she wanted to continue with the interview. During my reflection I realised that if I had allowed my emotion to control me, I would not have been able to handle the situation and we probably not have been able to complete the interview.*

Also, their experiences at the places of healing (religious, traditional and hospitals), the community, family and the impacts of the illness on their lives may have influenced those meanings they attributed to mental illness. These meanings form the sub-themes which reinforce the theme as highlighted above. Each sub-theme is discussed below.

4.1.1.1 Mental Illness is an Abnormal Brain/Abnormal Illness

Some participants described their illness with reference to having an ‘abnormal brain’ and ‘abnormal illness’. Experiencing mental illness in this way appeared to influence their beliefs about self and their capabilities. For example, **Iboko** said;

“I think I have an abnormal brain which resulted to abnormal illness. I can’t do anything for myself again…. I can’t even remember anything”. It is really a bad sickness which goes and comes back. (p. 5)”

Chukus said;

“Hmmm, from my experience so far I think I have an abnormal brain because if it is ordinary sickness I would have recovered since I started taking my drugs. In fact, I am just tired (p. 5).”

Amara; a female participant also said;

“What brought me here is that I was in school I didn’t read very well because my brain scattered. It made me believe that I have abnormal brain because my class mates were doing very well. Another thing that made me believe that I have an abnormal brain is that ever since I started taking medications for this illness I have not witnessed any improvement despite the fact that my sister who is a nurse told me that she knew some people who had similar problem but after taking their medications for some periods they got healed.” I also know one girl in my school that had the same problem before but now she is fine and has got married with kids. I think her case is different from my own.” (p.1)

When sharing these experiences participants’ facial expressions showed deep emotion. Drawing from the statements above, it is obvious **Amara, Iboko and Chukus** already have a negative cognitive representation of their illness. However, believing they have abnormal brains may result in self-stigma, and is likely to have some psychological connotations. Believing they had an abnormal brain may have led to them interpreting their illness as being incurable. According to learning theory (Bandura, 1977), individuals learn to think or behave in a particular way because of their day to day experiences. With reference to the above quotations, having received treatment for a period of time without any positive outcome may have reaffirmed that **Iboko** and **Amara** have an *‘abnormal brain’* which resulted in mental illness and cannot be cured. Also, their inability and lack of strength to do certain tasks for themselves may be a further confirmation of their *‘abnormal brain’*. Such beliefs could generate more anxiety and also lead to feelings of worthlessness, low self-esteem, and loss of self-confidence further compromising their mental wellbeing.

4.1.1.2 Mental Illness is an Embarrassment

Within this sub-theme, about seven participants repeatedly verbalised the embarrassing nature of their illness. From the participants' interviews, mental illness was considered synonymous with embarrassment. Some of them linked the embarrassment of their mental illness to the symptoms of the illness, while others attributed it to the side effects of their medications. Perhaps more evident, was the attitudes of society, family and friends towards them that led to or reinforced the embarrassing nature of the illness.

For example, **Unice**, a female participant, consistently used the word *'embarrassment'* in relation to her illness.

Unice said;

"Huuuu! Yeee, I could remember, I am not forgetting all that, considering this mental illness with a whole lots of embarrassments and surprises, but where do I start to talk about all the embarrassments I have got because of my illness, is it the beatings I received from my family members, the nurses and doctors or the Rev. Father who referred us to this place? In fact, everything about this illness is embarrassing. The remembrance of this sends me to my early grave" (p. 1,2)

Reflection on Unice’s disclosure of abuse

When Unice disclosed to me that she had been beaten by family members and Rev. father I became angry. My anger was stirred more, and I became emotional when she mentioned that nurses and doctors beat her frequently, but she doesn’t have anybody to report to. I held my tears because I thought allowing my tears to flow could look unprofessional and would also worsen her own emotions. Moreover, she could lose her confidence in me as a researcher and as a human being. Not knowing who to report her problems to sounds like someone who was helpless and hopeless. Personally, I felt misrepresented by my co-nurses who joined the doctors in such unethical behaviour. Even if others engage in such barbaric behaviours, the nurses and doctors who are trained and entrusted with the responsibility of caring and protecting mentally ill people should be an advocate for them. However, Unice’s story helped me to appreciate how vulnerable mentally ill persons can be in an environment where there is no existing or implementable policy to protect their rights. With Unice approval, I reported the incidence of physical abuse to the unit manager who promised to investigate the matter take necessary disciplinary measure against the perpetrators. While this barbaric behaviour was reported to the unit manager with Unice’s approval, I also felt encouraged in carrying out this study because the knowledge gathered from this study will be shared with staff at the hospital, and it has also shown me another area of mental health practice that needs more work.

Unice took a few moments before she started responding to me, allowing herself time to think about and recall the embarrassment she had experienced as a result of her illness and to consider how she felt about it. Coming from a society where mental illness is deeply stigmatised, and the person diagnosed with the illness being treated as an outcast, Unice may have linked such experiences with her embarrassment both of the illness and having to talk about it. Whilst narrating this part of her story Enice’s facial expression was one of pain perhaps reflecting the emotionality in experiencing mental illness. As a young adult whose ego is still developing, anything that may constitute embarrassment may affect her personality formation (Erikson, 1968). Although Erikson identified several psychosocial stages of development, he particularly emphasised the importance of social factors in the personality development.

In another statement **Unice** indicates it is her own lack of knowledge that has contributed to her embarrassment. She said;

"It becomes too embarrassing when not knowing much about the brain and what goes on in the brain and before you know it, you have started taking drugs about it (p.3)"

Unice may have believed having a better understanding of how the brain works could have prepared her for taking medication. Such embarrassing feelings affected Enice's social interactions, perhaps compromising her mental wellbeing. Unice stated;

"it was embarrassing, you know what that could mean, if I go out, I don't mingle as before….at a point I started seeing my inner most mind as my best friend and I started keeping everything to myself" (p.3)

Poor knowledge of mental health issues has been identified as a factor hindering young adults' mental wellbeing (Guner, 2014). With regard to the embarrassment of being mentally ill, **Chuku,** stated;

"Mental illness is a bad and an embarrassing sickness because it takes one out of his house and people will begin to see you as a wayward person. It makes one to remove everything he has at home to the market place, picking rubbish on the street and people will start saying the sickness has taken him to market place which indicates that the person is incurable." (p.3)

Chuku's realisation that he once removed his belongings from the house to the street made him feel embarrassed. However, that feeling of embarrassment is contextualised when Chuku talks about what he knows about mental illness. Referring to how society regards a mentally ill person who goes on the street carrying some of their belongings is a reflection of a cultural belief about mental illness, this behaviour being regarded as a measure of the illness and it being incurable. Several participants talked of direct encounters they had within their respective societies and, sadly how they were treated; stigmatised, discriminated against, disrespected and abused by family members and significant others. Stigmatisation against mentally ill individuals has been critically investigated in existing studies (Kinderman *et al.*, 2006; Güner, 2014), but none of those studies reported how it constituted embarrassment for the stigmatised person. **Agbo;** said;

"I feel embarrassed when people start running away from me because of my illness. I also feel embarrassed when I start recounting what I did" (p. 3)

Okey stated;

"If I am staying with friends and we are chatting, before I know it some of them will start telling me you are mad! You are mad!! Once they make such statements I loss self-confidence. And anywhere I go, even when I am walking on the road some people will be making the same comments and this embarrasses me." (p.6)

Such experiences, together with their pre-knowledge about societal beliefs regarding mental illness are all factors that may have influenced the meaning they attribute to their mental illness. For some the embarrassing nature of mental illness was associated with the side effects of drugs. **Tochi** said;

"I always feel weak, dizzy and sometimes I sleep in the public place. It is very embarrassing for one to be sleeping every time in the public place and I know it is because of my drugs. Sometimes I think of stopping the drugs because the embarrassment is too much" (p.4)

While **Iboko** stated;

"In fact, my wish then was just to stop taking the drugs because the side effects were very embarrassing" (p.1).

And **Okey** suggested;

"Yes, most times if I take the drugs during bed time, I won't be able to sleep. Also, it makes me to laugh when I am not supposed to laugh and frown my face when I am supposed to laugh. And you know this can be very embarrassing because people even those that didn't know that I have mental illness do look at me somehow and it is very embarrassing." (p. 2)

Chinwe talked about;

"The injection they were giving me use to cause my tongue to stick out and turning my head. Sometimes I even sleep in the public place and people will be asking me why am I sleeping in the public place? In fact, I feel so embarrassed!.......I once stopped my medications because of this particular problem, and I felt better, but sometimes I started feeling somehow ill again which made them to bring me here." (p.6)

Medical treatment is always seen as a way of helping a person recover from the symptoms of mental illness. However, medication is not without its own problems (APA, 2006). Analysing the participants' interviews, it is evident that the side effects of their prescribed medication complicates the existing symptoms of mental illness and causes further embarrassment. Feelings of embarrassment were strongly associated with their medication and this was already influencing their decision to discontinue their treatment. Stopping medication to feel better and be free from the embarrassment it causes could invariably affect their mental wellbeing as relapse may occur. Feelings of embarrassment can also create social problems which may compromise their wellbeing by limiting their ability to freely socialise within wider society. As a way of addressing the social issues related to mental illness, some of the participants suggested societal acceptance and reintegration would be helpful.

For example, **Amara**, said;

"I want people to show us love and see us as normal people and their fellow human beings, endure us and live in harmony with us (p.4)".

This was supported by other participants; Anya, Onuji, and Okey. The attitudes of those around them can either help them overcome the emotionality of their perceived embarrassing situation or it could also worsen their problems.

4.1.1.3 Being in Another World

Mental illness was also described by some of the participants as 'being in another world'. Being in another world is an important metaphor which participants used to describe their negative experiences of living with mental illness. This description was impacted by different events and activities that played out in their problems affecting their wellbeing and influencing the way they perceived mental illness. Being aware of their mental illness, finding themselves in a strange environment and/or confined in a specific place, being isolated from family, friends and society, having to take medication with potent side effects, and losing their roles could have influenced the meaning they attributed to their mental illness. For example, **Unice** stated how she felt she was in another world with reference to the injection she received;

"Mental illness is like a struggle to manage one's deepest wounds in secret because you don't want to give the world another chance to discriminate against you… Mental illness is like living in your own world, you feel like you are trapped in a reality that's not your own. Mental illness is waking up every day from the same nightmares, waking up to another nightmare. Mental illness is being in a world where you must face your problem alone without anybody to help you. You know you need help, but you can't look for help because you feel you could expose your problem to people and they will start to avoid you. Yes, the first time I went to the hospital I was forced to do so, it wasn't my decision. Then I was given this injection that has to do with the brain, and I was like being confused and was like what is happening, and it was as if I am in another world, throughout that day I lived in a different planet because I did not know anything that happened around me." (p.3)

Unice did not want to involve anyone in her problem because she does not want to expose herself to discrimination, but at the same time she did not find it easy facing her problems *'alone'*. Again, Unice was not involved in the decision-making process regarding her treatment and no pre-information regarding what to expect and what not to expect from the drugs was offered. Lack of consent and unexpected side effects of the drugs exacerbated Unice's negative experience of her hospital treatment. **Unice** further said;

"When the nurse gave me the injections, to my greatest astonishment, I was so down, and I couldn't sit up nor open my eyes even to see anything. It was so painful, and I started feeling as if they inserted something in my body and I couldn't do certain task again (p.2)."

Other participants also associated their mental illness with the experience of being in another world. **Onuji** said;

"This sickness is terrible, at a time I started feeling like I was in another world because I wasn't always myself, I am always absent minded, and I lost interest in everything, and I didn't have anyone to associate with because I lost all my friends. I was just there all alone living in my own world." (p. 5).

Similarly, **Chinye** stated;

"I was just in my own world. I was totally disconnected, no friends, classmates, I was so restricted and caged. My head was always flooded by uncontrollable thoughts (She became emotional and started crying). All I needed at that time was to go home, I wouldn't mind coming from home to receive my treatment." (p.4)

Finding themselves in an unfamiliar environment, where everyone and everything looks strange, and being disconnected from family and friends could be a source of anxiety, a state often connected with depersonalisation (Barker et al. 2003). Describing themselves as being in another world might be a way of expressing their discomfort at being in a psychiatric hospital. **Okey** stated;

"I feel I am in another world. I am caged here, I sleep, wake up here and do everything here. I can't do anything when I want to do it. Nobody to talk with, the only people I see here are those that are mad. They make some silly noise like birds and animals. I don't like here." (p. 8)

For Okey, being admitted to hospital restricted his movements. This was a serious issue for Okey because he lost his freedom and could not do the things he used to do at his own convenience. According to Okey, the behaviours of other patients in the hospital made him uncomfortable and may have contributed to his feeling of being *'caged' and/or 'being in another world'*.

The perceived meanings the participants' associated with mental illness were influenced by their lived experiences of, and being treated for, mental illness, as well as cultural and environmental factors. However, those meanings were also found to be negatively impacting on their wellbeing.

4.1.2 Theme 2: Hopelessness

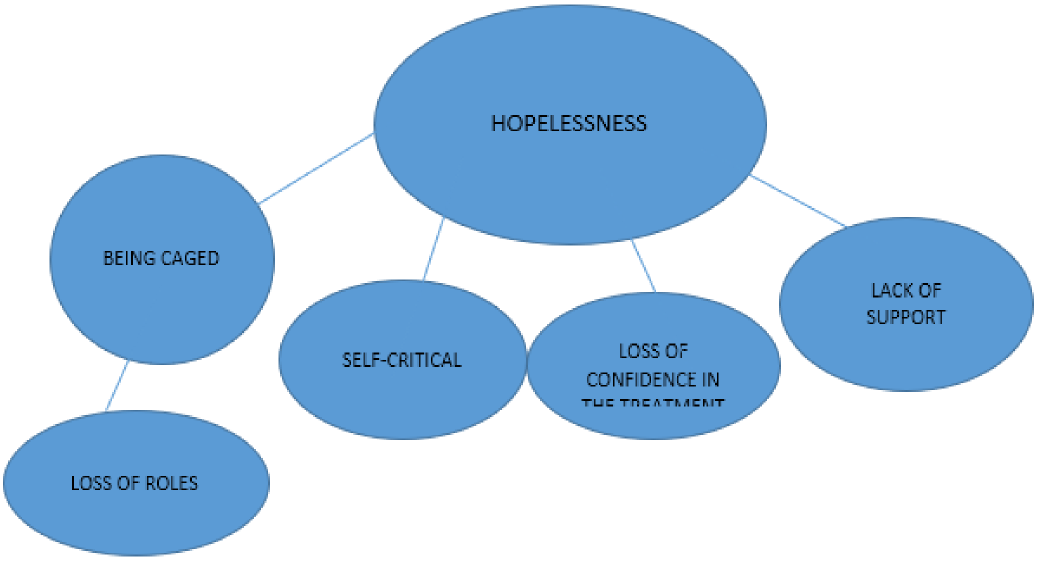

Figure 4.2 Theme 2

The study established that participants experiencing mental illness had associated feelings of hopelessness. Hopelessness is an emotion that contributes to or is the result of low mood and can negatively affect the way one perceives oneself and circumstances (Liu *et al.*, 2015). Hopelessness can be a powerful influence on people's behaviour as it may influence an individual's view of their future (Liu *et al.*, 2015). Seligman (1975) suggested helplessness leads to hopelessness.

In this study feelings of hopelessness led participants to lose interest in important events or activities that mattered to them before they had become ill. When an individual becomes hopeless, the person may no longer value things that were once important and is often associated with a lack of inspiration, helplessness, powerlessness and abandonment (Viñas

Poch *et al.*, 2004). Hopelessness has been strongly associated with suicide (Klonsky *et al.*, 2012). Feelings of hopelessness can be initiated through a variety of factors. The following sub-themes highlighted the various origins of hopelessness for those participating in this study.

4.1.2.1 Being caged/loss of roles

Many participants expressed how worried they were over their confinement in hospital. For some, such feelings of confinement gave rise to feelings of hopelessness as they were not able to do anything for themselves and there was no defined period when they would be discharged home. Ozo stated;

"I am not happy that I am sick because all my mates are out there working very hard to make the ends meet. Some have travelled to other countries in search of greener pasture. My mates have all gone to China, India, Ghana, Cameroon, and South Africa to go and make money for themselves, but here I am tied down, sleeping and waking up every now and then in the same place just because they said I smoke marijuana. I am tired of this situation; how long will I continue to be tied down like this?" (p. 1)

Reflection on confinement in the hospital environment

Doing this project has revealed to me through the eye of the participants how it feels to be confined in an environment. From the interview, I realised that participants see it as a punishment for a sickness they are being accused of having rather than a method of treatment. These participants feel it is a way of tagging them and they feel stigmatised which worsens their condition. In a confined place, patients lose their role function and feel their self-worth and self-esteem is destroyed. I also realised that there was no age-related programme that was specifically designed to meet the needs of the young adults. Even at admission, no consideration was giving to age, which means in the male ward everyone is admitted there irrespective of their age and the same thing goes for the females. Putting them in such an environment could encourage withdrawal because their views about life and issues of life may not be the same due to age differences.

On my reflection, I realised that considering a person's age on admission and making sure that every young patient is admitted in the unit where other young adults are found can make them feel at home and mingle well among themselves. Also, deigning some an age-oriented programme to meet the needs of young adults may improve their experience whilst in hospital.

Finding himself in an environment where he sleeps and wakes every day without being allowed to leave the hospital left Ozo feeling resentful; as a young adult he values the freedom of movement which his contemporaries can enjoy. Ozo questions when he will be able to leave the hospital, but to no avail. His quotation suggests he was completely ignorant of his length of stay in hospital, and not being sure of when he might expect to be discharged could give rise to a sense of hopelessness. He feels that his condition does not require keeping him in the hospital. **Ozo** goes on to explain;

"I am tired of been tied down here because they said I smoke marijuana. Yes, it is true that I smoke marijuana, but you know the mental problem from marijuana is different from other mental illness." (p.2)

Ozo clearly displayed his feelings of frustration and loss of hope when he said;

"All my mates are out there making serious money for themselves, but here I am wasting yet I can't even tell how long I am going to be here p.1)."

The perception that he is already falling behind his mates due to his illness seemed to have further depleted his sense of hope. This appears to have affected his interest in staying in the hospital for treatment, as he constantly mentioned that he is 'tired of the hospital' and he prefers to 'go home and be receiving his treatment from home'. **Ozo** expressed how hopeless he feels which could be a risk factor of suicide. His statements were full of regrets and feelings of frustration, because he believes that he is a failure;

"I see myself as nothing now, I see myself as nobody, as a dead person because I cannot associate with any man or woman here in the hospital and nothing is working for me. How can I achieve anything being in here? Will I be here and build houses, buy cars or help my younger ones?" (p. 4)

Similar to Ozo, Anya's feelings of frustration and hopelessness were also evident in his narrative. **Anya** explained;

"It is about this sickness, I feel so restricted in this place, and I can't do anything for myself in this place….is this how I am going to end up? How do I continue my business when I cannot even cross the gate? If I wasn't here for the past two months, I would have achieved so many things in my business. I must say I am losing a lot of things in my business. Imagine a business man who all of a sudden stop going to his shop for a couple of months, the person is going to lose so much from the business. And I don't have anybody to take care of the business for me. I am not feeling happy because I was supposed to be discharged yesterday, but they didn't

discharge me. I am now confused because I don't know when they are going to discharge me …. I am tired of the whole thing. I can't continue like this." (p.1)

Just like Ozo, Anya's feelings of hopelessness were deepened by his disconnection from his business due to the restriction of his movements. From his statement, having someone to stand in for him for the period of hospitalisation could have instilled hope in him. Not being sure of when he will be discharged suggests he has not been involved in his treatment plan and this further affected his feelings of hopelessness. Having someone to try to address these concerns with him could help allay his anxiety and instil hope. Another participant, **Ezi,** expressed his frustration and sense of hopelessness;

"What provokes me most is the way I am being restricted here in the hospital and, even at home I can't do anything on my own, and I am not sure when it is going to end. I can't do anything with my life again, I could not go to school, do business or work. I am always fighting with my family because they don't allow me to do things when I want it. I am getting tired of such life." (p. 2)

Ezi's confinement and restriction of his freedom does not only provoke him, it makes him 'tired of living'. Both at home and in hospital, he is not always allowed to do the things he would like to do. While it appears Ezi wants to do things for himself, those around him prevent this. Not being allowed to be functional is likely to result in negative thoughts and subsequent feelings of worthlessness.

4.1.2.2 Self-critical

Self-criticism is typically experienced as negative internal thoughts about oneself or, more specifically, about one's behaviours or attributes (Powers *et al.*, 2007). The participants clearly demonstrated in their narratives that they no longer believe in themselves. This could be a marker of hopelessness which has an immediate negative impact and might have a future impact on their mental wellbeing if not properly addressed. In this sub-theme, participants expressed self-criticism. Unice appears to have lost confidence in self, was self-critical and no longer appeared to believe in herself;

"I am a star, I sing, dance and perform on stage, and I want to be a known star. When I was in secondary school I used to dance, but now I can't sing or dance, I can't even make the correct moves again. I feel inferior and withdrawn, I feel sorry for myself, and I feel ashamed of coming to the public. Most times I even regret coming to the psychiatric hospital" (p. 6).

Unice still recognises and has a passion for her talents and dreams, but feels she is no longer able to perform adequately, and her sense of self has been crushed by her illness. Unice might be thinking that since she has presented herself to a psychiatric hospital, it is likely that everybody will know about her illness and she will be stigmatised. Unice feels 'ashamed' when she comes into contact with the public to perform, believing people may misinterpret her dance moves and performances as signs of her mental illness. This is understandable considering the Nigerian environment where Unice lives, as due to multiple cultural beliefs which encourages stigmatisation, people easily link or interpret every action or moves made by anyone who has had a diagnosis of mental illness to the same problem. These thoughts are likely to have eroded her confidence making her feel inferior and ashamed of performing on stage as she once did. Unice; questioned her existence and expressed regrets for coming to a psychiatric hospital in the first place. At this stage, she became very emotional and started crying saying;

"It is like God hates me and I have become tired of everything. Most times I even regret coming to a psychiatric hospital. I wish I could die now because I am nothing". (p.6)

When a person begins to question his/her existence or start verbalising a lack of confidence in self, it simply reinforces their state of hopelessness and again introduces the risk of suicide.

Similar to Unice's narrative, **Chinye** revealed her frustration and self-criticism which lead to her attempting suicide;

"I just realised that I am a fraudster because I have been claiming what I am not. Since my primary school days, I have always presented myself as a very intelligent girl and people see me as such and respect me for that, but now I have been exposed. People now know me as a fraudster because I cannot remember any of those things, we did in primary school anymore. My head is blank, I can't even remember my name. Nobody is as bad as me, I have a very bad personality. With this kind of personality, I cannot make it in life. How do I practice as a medical doctor since I cannot remember any single thing we did in school in the past? Whenever I am in the midst of mates, I feel so ashamed of myself because I don't have any contribution to make in a discussion…. I feel blank in my head. I have tried to start all over again to learn how to read and understand yet I cannot still understand what I read. And I have asked myself, who else is like me? Every other person except me remembers everything they did in school in the past. Why am I so different from others? I have decided to leave school and look for something else to be doing or better still be a housewife because the whole of these things is not giving me any hope…. (p.5)

Chinye also continued;

"I felt that my own world has ended, I no longer have interest on anything again and I felt my life has been shattered already. Because I was a very pretty and intelligent girl which everyone admires but when I had this problem, I felt so bad, I felt that I have disappointed my parents, siblings and I was the cause of every mistake made by anyone in my family. I concluded that all hope was gone, I am not going to actualise my dream of becoming a medical doctor. How do I complete my medical school when all my mates have all left me behind?" (p.2)

As a young adult who was in the early pursuit of her career and suddenly became mentally ill, Chinye found her situation very challenging. The initial interruption in her medical education as a result of her illness, losing contact and connections with class mates, peers and friends may have created anxiety in her. Being admitted and confined to a hospital environment may have instigated a sense of helplessness followed by a state of hopelessness. Being uncertain of her future could have depleted Chinye's hopes in such critical period of her life. Accepting that her life has been shattered was a clear reflection of her state of hopelessness. **Chinye** further stated;

"I felt I was causing my parents and siblings a lot of pains. At a time, I started having suicidal thoughts because no hope was left in me again. I even jumped from a 2-storey building but God saved me from the accident, and I didn't die in it, I only sustained ankle joint injury which I am still managing till now. It was after the accident that my orientation changed, and I started having a rethink on the whole problem. I advised myself and decided to do everything possible not to allow myself to be ruined by this problem." (p.4)

Acceptance of failure in life made Chinye feel that she had disappointed everyone in her family and her failure was causing serious pain for her parents and siblings and was responsible for every mistake anyone made. Living with guilt and seeing herself as a worthless person led her to attempting suicide.

4.1.2.3 Loss of confidence in the treatment

Treatment under normal circumstances is designed to restore wellness in a sick person. Anything short of restoration of wellness in a sick individual could discourage or deter the service user from continuing with the treatment (APA, 2006). Under this code, the majority of the participants expressed lack of confidence in their treatment and this also contributed to their state of hopelessness. **Unice** stated;

"And for the fact that I was coming from another hospital I believed that they don't know my history very well, I wasn't comfortable with the health professionals, but I was persuaded by

my mother. The injection I received weakened me', I felt so 'dizzy' and 'could not open my eyes to do anything at home'. Even with the medication I wasn't getting myself like the former place. Everything turned out to what I suspected initially. Apart from this, I was more uncomfortable when I went back to the hospital for the second prescription, but it wasn't the same woman that attended to me on the first day that was there again. When I asked, they told me the woman has been transferred to another section. It was now a guy and when the guy gave me injection, although before the injection I was already saying in my mind that I won't take the injection. However, I also said if I take the injection and it improves my condition the more then I will continue to take it because when I started taking the tablets in the first prescription, I started feeling better and getting some flesh. As I now received the injection, it was something else, so painful and I said no! No!! I won't take this injection again and they brought tablets and I said no! No!! I don't need any more. You people hate me and want to kill me with this (p. 3)".

Coming from another hospital, this participant faced the difficulty of establishing trust and confidence in the health professionals. Unice doubted and did not believe that the health professionals in her new place of treatment would be able to help her that much given that they did not know her history as much as staff did at the former clinic. Having this belief appeared to influence her mindset towards the treatment. She talks of the injection *'weakening'* her and the medication not having the same effect as it did in 'the previous place'. Her confidence was further compromised when she went back hoping to still meet the *'first woman that attended to her on the first day'*, only to discover that the woman had left the unit. Unice was not comfortable with a male nurse attending to her and doubted his competency. Unice made up her mind prior to receiving the injection, that if having the injection gives her bad feelings, she will never have the medication again. Unfortunately, the experience was not good for Unice, and this was evidenced by her reaction and verbal attack on her parents and the nurse. She believed that the injection was a deliberate attempt to kill her which indicates a mistrust of everyone. She also alleged that everyone *'hates her'* and that was the reason they brought her to the hospital to *'be killed with injections'*. Believing that everyone hates her impacted negatively on her emotions, leading to a lack of trust both on care givers and the medications, ultimately leading to loss of hope in the treatment. Trying to find out if participant had preference for either a male or female nurse and/or involving her in treatment decisions could have alleviated some of the stress she was exposed to.

For Iboko and Tochi, the improvement they experienced in their mental health as a result of their treatment instilled hope and encouraged each of them to continue with the treatment. **Iboko** stated;

"I was talking anyhow, even fighting anybody I see around me, so my people brought me here so that they will heal me. When I came, I started receiving treatment, I was first admitted at the emergency unit where they gave me some drugs. After taking the drugs I noticed that I was adding weight seriously and was also causing me body pains and weakness, but they changed the drugs for me after I complained to them. So, when I started taking the new drugs then I started feeling better and that is why they asked me to transfer to this unit. This is where they transfer those that are recovering to." (p.7)

Tochi suggested;

"I was already feeling frustrated and hopeless because the drugs I was taking was not helping me….it caused me some side effects, but after I complained to the doctors and they changed those drugs, everything normalised, now I am feeling better (p.5)."

The above quotations indicate Iboko and Tochi became hopeful when they started noticing an improvement in their mental health. This suggests that service users become hopeless when their treatment does not meet their expectations. For Iboko and Tochi it could be suggested that apart from the medication itself their condition became ameliorated after being given a listening ear when they complained about the side effects of the medication. Keeping lines of communication open with service users could facilitate the instilling of hope as it creates opportunity to develop a therapeutic relationship (Martin & Chanda, 2016).

4.1.2.4 Lack of Support

Lack of support was seen to have influenced their state of hopelessness. Participant talked of feeling hopeless when they could not get support from families, friends and health professionals. A good support system for an individual living with mental illness can assist in stabilizing the emotional state of the individual (Davidson *et al.*, 2006). In this sub-theme most of the participants felt they were not supported and that this was affecting their wellbeing. **Okey** said;

"My father is late, it is only my mother that is left now, and it is my elder brother that is sponsoring me in school. Most times if I ask my brother for my school fees and feeding money, he wouldn't give me the money that time, and he wouldn't say a word to me. His silence gets me provoked me and makes me hopeless (p.6)".

Okey felt unhappy not because the brother could not provide for his needs, rather he always becomes worried when his brother refuses to respond to him. For Okey, even if his brother lacks sufficient funds, getting assurances from him could establish a level of hope in him. Okey lives in suspense as he doesn't know what his brother's silence means. Whether it means yes, or he feels that okey is disturbing him with demands for money. Okey's condition is worsened because the illness has had much impact on him that he cannot do any vigorous job again as to make money for himself. Okey further stated;

"On the other hand, my condition cannot allow me to engage in a hard labour. If I do any hard work, it worsens my condition and I will break down. I don't even know where to start now, I don't know! Sometimes I cry for myself because my life is frustrated already. I don't know who to go to again for financial assistance (p.4)."

Okey seemed to have lost hope both in self and others. He was beginning to see his life as hopeless and worthless. His inability to get support from the elder brother and significant others made him to remember how much his illness has affected his survival ability. However, from his statement, it seems what he needed in the absence of other things was emotional support. Encouraging words and assuring him that everything will be fine could reduce his feelings of hopelessness. For Okey, his brother's silence may further exacerbate his vulnerability as it could prompt him to think that he has become a liability and a burden on the family. Similarly, Tochi believes that all his mates who receive support from their families are doing well and have got ahead of him. This thought can be demoralising. While Tochi may be aware that his mental illness caused his set back, his utmost worries was how to begin life again because he cannot access any support from his family;

"So many things really bother my life now. For instance, most times I start thinking about how to begin my life. I don't have any business or job I am doing to earn a living and no body to go to for help. Most of my mates who get support from their families are all doing very well today but here I am today wasting away (p.4)"

This could be challenging for him as a young adult who is just starting life and has the added complication of mental illness. Tochi is worried because he feels that nothing is left of him, he feels stranded and hopeless because he does not know how and where to start life again, he is anxious because he feels that all his mates are ahead of him. Many of those participating in this study believed, their mental illness has stripped them of their roles and their social positions are already threatened because of the hardships the illness brought upon them.

4.1.3 Theme 3: Fear of the Unknown

Figure 4.3 Theme 3

This study highlights that the life of a mentally ill young adult is full of uncertainties. The findings also suggest that due to the experience of mental illness and the accompanying lack of knowledge in relation to both short-term and long-term outcomes, the young adults are constantly fearful. Fear of the unknown seemed to be compounding their problems because it consistently builds on their already existing anxiety. Fear is an induced feeling of insecurity which always occurs when one perceives dangers or threat to his or her safety (Olson, 2006). Within this theme it is suggested that uncertainty is inherent in mental illness and this predisposes people to ask questions of themselves which they often find difficult answer or accept. Under this theme, several sub-themes emerged.

4.1.3.1 Uncertainty about Treatments

Under this sub-theme, some participants expressed their fears over the uncertainties surrounding treatments and cures for mental illness. It is possible that some of them developed their fear because of their illness experience or what they had learned about mental illness within their socio-cultural setting before they became ill. Most of their expressions are related to uncertainties in relation to treatment. For example, **Tochi** said;

"Having a sickness that you cannot predict its cure is the worst thing one can ever experience because it keeps one in a continuous thinking and you will continue to live in fear every minute of your life. Even now, I am as confused as anything and I don't even know what to believe again about this sickness. Even though the nurses keep telling me that I will be fine, but many people believe that mental illness is a permanent condition which gets cured and reoccurs after a period of time. That is why I get confused and worried about what to expect, I just have to be taking my drugs". (p.5)

Tochi's worries seemed to have been influenced by what he learned from people within his community. In Nigeria, people interpret mental illness according to their cultural and religious beliefs. It is common to hear people say mental illness has no cure or treatment, and it will be present throughout life. People tend to internalise such beliefs which often influences their attitude towards treatment. Although the nurses tried to reassure Tochi in order to allay his anxiety and enable him to continue with his treatment, he seems to have imbibed the idea of no permanent cure for mental illness. Tochi may doubt the effectiveness of his treatment because he also expressed worries over the prolonged treatment he has had, but his problem was still there, and he was getting *"fed up".*

Similarly, Amara anxiously expressed her concern over the uncertainties surrounding the treatment of mental illness. Amara was first taken to a traditional healer where a number of incantations were conducted on her, but she did not like the traditional healing method rather she prefers orthodox methods. Although Amara showed preference for orthodox medicine, she also confessed that she was not too sure if it could permanently cure her illness. Her fear of not being sure of what treatment outcomes would be seemed to have affected her adherence to medication. Amara confirmed that she discontinued her medications on two occasions which resulted in relapse. She said, "she has seen people living with her kind of problem, but they never get well even after all the treatments". It could be argued that apart from Amara's experiences with her treatment to date, her fear could also have a link to what she has been observing in society. Amara said she had been observing what happened to others and this appeared to have also reinforced her fears. Amara suggested that the fear she developed over treatment uncertainties was already affecting her wellbeing and could affect her future if not properly managed as it would continue to exacerbate her depressed mood. Amara confessed the situation 'bothers her much and gives her sleepless nights' which is the opposite of what is required for a mental wellbeing.

Other participants' highlighted fear regarding the uncertainties associated with treatment for mental illness. For instance**, Ugo** said;

"Hmmm! Mental illness is a very bad sickness because it comes and goes. It makes one to remain in a perpetual fear because it keeps me in suspense. When I first had this illness, I never conceived in my mind that it could last up to two weeks, but as time went on, I discovered that the situation wasn't what I thought initially. I have had this problem for more than a year. Even with the treatments, nothing seems to be working. Most times, the whole thing makes me to doubt if this can be cured at all. But on second thought, I have just decided to be taking my drugs and that is all." (p.3)

Okey stated;

"When I talked to one of my aunts about my plans to stop drugs, she advised me not to stop the drugs that I will get better someday. Then I asked her how long will the someday be? This is the same question I have been asking myself. Since 2011 I started taking these drugs till now, my sickness never ceased, and I will be asking myself what kind of sickness is this that does not respond to treatment? (p.5)"

While Ugo has decided to continue taking his medications regardless of his believe that mental illness has no permanent cure, such decisions cannot be without fear and doubt. Ugo expressed how anxious he becomes whenever he conceives that it is likely he is going to be on drugs for life. However, Okey's concern about the uncertainties of his treatments seems to be derived from his years of treatment without any positive outcomes. The long-term treatment he has under gone without any improvement in his mental health has given him reason to doubt the efficacy of the treatment. Perhaps, Okey thinks stopping medications could save him from problematic side effects of those medications.

4.1.3.2 4.1.3.2 Uncertainty about the Future

Participants expressed their worries about the future considering the negative impact the illness has had on them. Their anxieties revolve around the concerns that their illness came at a time when they were supposed to be laying foundations for their futures. Most of the participants dropped out from school or were unable to commence any meaningful career that could lead a promising life. While participants were experiencing the negative impacts of the illness, they were also worried about the future. For example, they highlighted how the illness caused their restricted movements, weakened their bodies, and caused their forgetfulness. They believed their mental illness has affected every aspect of their lives. **Chuku** stated;

"Well! Even though I try my best every day to pull through this whole struggle, but I must say that this is not easy. I still find it difficult to come to term with this kind of illness that makes

one to wallow in anxiety because you don't know what your fate will be next. I no longer function very well. I have dropped all my activities, and I can't read or write now. The illness has forced me out of school, and I can't even sleep well now. Not only this, I found it difficult doing some domestic works on my own such as fetching water, washing my clothes and dishes. If this continues like this, what is going to be my fate in the future? Even though they keep telling me that I will be fine. But on the second thought, what if this sickness doesn't get cured? How am I going to face my tomorrow? My instinct always tells me that with this mental illness, my future has been badly severed. The thought of my future bothers me so much." (p.6)

Anya reported;

"This illness is such a difficult situation that even the person living with it cannot tell what the next moment hold. You are living in this moment, but you can't tell what your next moments will be. Sometimes I am tempted to ask myself, what if I don't get better again. What happens to my future life? And so many other thoughts. For instance, now, I have spent some weeks already in this hospital, if I was not here for the past 5 weeks, I would have achieved so many things. I must say I am losing a lot in my business. I spend the whole of my time thinking about my future since everything seems to have slipped off my hand. The worst part is that I don't even know when this my problem will end." (p.8)

Chinye also stated;

"I was still in the medical school when I started feeling this sickness, since 2009 till now I have been having the same illness. Although sometimes I feel as if I am cured but after some periods it comes back, so because of this, my life seems disjointed because it never allowed me to concentrate and pursue my goal as a young lady. I lost concentration in my study, I could not understand anything whenever I am reading my book and I lost interest on everything. So, after considering all these most times I feel like taking my life because I think this thing is not going to end anytime soon." (p.3)

This also reflects loss of roles and fear of uncertainty about the future. Okey also said;

"Since I started having this sickness, each time I do hard or stressful work it affects me. Even if I am on my drugs and I try to engage myself in some stressful jobs like too much reading, digging ground or climbing of trees, it triggers my sickness. And I have been asking myself, is this how I am going to continue for how long? How am I going to fend for myself tomorrow since this sickness has crippled my life like this? Sincerely, I am not sure if I am ever going to function well again." (p. 9)

During the interviews participants made comments regarding one impact of mental illness on their lives being a ‘loss of roles’. Undoubtedly, loss of role appeared to result from symptoms of the illness, hospitalisation and the side effects of medication. Loss of roles instigated a fear of unknown in the participants, generating a high level of anxiety. For example, **Agbo** said;

“This condition bothers me very much because I see myself as someone who does not have a future. I have spent most of my life in this sickness, believing that I will be fine, but what I don’t get understand is whether I will be fine again in life? Each day I wake up, I ask myself the same question, unfortunately there is no answer to it. I don’t know how to start life again. That is why I said this sickness has really destabilised me.” (p. 4)

While reiterating this part of his interview Agbo frowned indicating his emotionality when expressing his fear. It could be argued Agbo is using his present situation to mirror his future, but nothing is giving him hope about the future. Saying that he does not know how to begin life again is sign of fear for the future which may cause him more anxiety. Likewise, **Chinwe** said;

“I stay awake every night thinking about my problem, and my future. I told my doctor last time that I am seeing things and I don’t know whether it will affect my education, although it is already affecting it (p.6).”

Chinwe expressed concern over her present condition and fear over the uncertainties surrounding her illness. She highlighted how her illness presently does not allow her to do anything, even to read or write because she cannot understand or articulate her points when writing and this worries her. Chinwe feels she does not have the potential to continue with her education. **Tochi** also verbalised her uncertainties;

“So many things really bother my life. For instance, most times I start thinking about how to begin my life. I don’t have any job or business that I am doing to earn a living and nobody to go to for help.” (p.7)

This participant expressed his hopelessness and anxiety regarding his future. Tochi highlighted that he was discharged a few months ago and he now comes to the hospital as outpatient. The period following discharge from hospital can be a challenging time for individuals (Niimura, Tanoue and Nakanishi, 2016). According to Tochi, his discharge was like starting a new, being faced with the challenge of how to begin his life again. Tochi was fearful of how to begin his life. Not having a job or business to earn a living was the greatest source of his anxiety.

4.1.3.3 Stigmatization

Within this sub-theme, participants expressed a fear instigated by stigma. Findings revealed stigma influenced the young adults' fear of the unknown, with participants commonly expressing worries over their chances of getting married, gaining employment or re-establishing friendships. Participants seemed to have internalised the stigma evident within wider Nigerian society regarding those who are mentally ill. While impact of stigma on their lives was clearly evident, the data suggests concerns for this in their future lives. Participants' considered their mental illness as a limitation to their future lives, as they thought of themselves as second class citizens who are worthless. **Okey** anxiously said;

"I always bother whether any girl will accept to marry me or whether I will be able to get any job considering my condition now. Anytime I go to church, school or any other public place, I always think that people are talking about me because of my sickness (p.4)"

From his statements, it is possible that nobody talks about him or his illness, but he appears to have internalized societal stigma which is now making him not believe in himself. Okey lives with the fear that he may not be able to secure job or woo any girl since everybody now knows him as a mentally ill person. Similarly, **Amara** said;

"While I was growing up I had so many wishes such as becoming a medical doctor, getting married and start having my own children but all my dreams have been shattered. I didn't eventually become a medical doctor instead I ended up as an ordinary school teacher. I couldn't even continue with the teaching job because of my illness. In the aspect of marriage, here I am very fat without a husband at my age and all my age mates have all got married with children and good jobs. So, each time I look at my condition, fear grips me because I don't know whether I will still be able to secure any employment again or be accepted in my former place of work. I also worry if any man will accept me knowing that I have mental illness." (p. 3)

In the above quotation stigmatization is evident. Amara is obviously aware and worried about the immediate impact of her mental illness, but at the same time she is worried about its potential impact on her future life. While there appears to be some acceptance of not achieving her dreams, Amara also has fears about her future possibilities due to both her illness and the stigma attached to it. Being aware of the negativity associated with mental illness she questions her chances of achieving certain life goals such as securing a job, getting married and living what she perceives to be a fulfilled life. Unice also expressed a similar concern stating;

"Stigmatization is really going to be an issue for me. Growing up as a child in this society, I know that mental illness is a highly stigmatized illness in our society. The thought of it gets me more worried because it's definitely going to affect me in my dream career. As I mentioned before, I used to sing, dance and perform on the stage before I had this problem, in fact I had the dream of becoming a star in music, but I must tell you, the way I feel now I doubt if I will still be able to do all that again. All my fans would have lost interest and hope in me because of my mental illness. Also, personally I have the belief that I won't be able to sing, dance or make the correct or right moves again. And I am concerned that people would always mistake my dancing moves for signs of my mental illness when performing on stage." (p.6)

From the above quotation it appears Unice was aware of the stigma associated with mental illness even before she was diagnosed of mental illness perhaps indicating internalized stigma. Although she was willing and had the enthusiasm to develop her talent, this was compromised when she perceived people not being interested in her performance due to her history of mental illness. She also feared that some of her regular moves and facial expressions during a performance might be misinterpreted by other people.

Chinwe also said,

"In terms of marriage I can't even tell whether I will be to marry even though I so much desire to marry. I worry about it a lot but there is nothing I can do in terms of that (p.6)"

This is an expression of uncertainty and fear; not knowing what to expect in terms of getting married, whether she will be able to or not. Chinwe saw her mental illness as a potential threat to her future expectations, given that she believed she would be stigmatised.

4.1.4 Theme 4: Violence and vulnerability

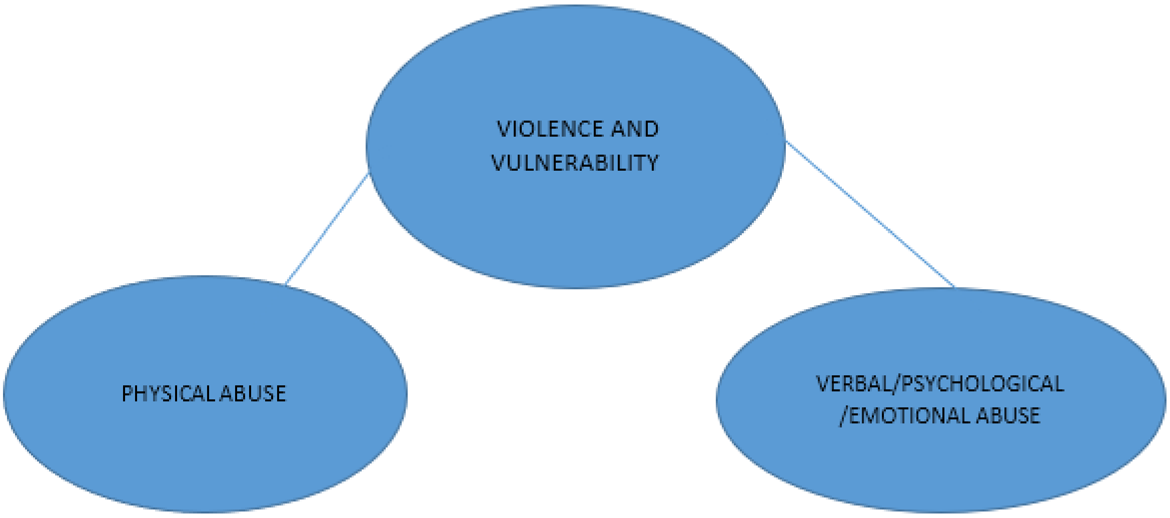

Figure 4.4 Theme 4

The term vulnerability describes the state of being exposed to the possibility of being abused or attacked physically, verbally, emotionally, sexually, financially and psychologically (Kurs & Grinshpoon, 2018). This theme captured aspects of the participants' lives which revealed how vulnerable those experiencing mental illness can be. Participants told of their experiences of violent attack from relatives, health professionals and/or significant others, when they were mentally ill. In the main such violent attacks took the form of physical and/or verbal abuse, each of these sub-themes being presented below.

4.1.4.1 Physical Abuse

Although currently there seems to be no consensus definition of violent behaviour (Varshney, *et al.*, 2015), the WHO (2002) noted violence as a "deliberate use of physical force, threatened against a person or group of persons that either results in, or has a high likelihood of, resulting in injuries, death, psychological harm, mal-development or deprivation" (Krug *et al.*, 2002). The issue of violence against people who are mentally ill is not new due to the common belief that such people are violent to self and others; a belief that reinforces stigmatisation (Choe *et al., 2014)*. In this study, participants talked about how the illness predisposed them to dehumanisation, violent attack, including physical beatings, by families and others. As a result of these negative experiences, participants had feelings of rejection, held beliefs of being hated and many of them wishing and willing to leave their homes to find a place where they could feel safe, an important component of basic human needs (Maslow, 1943). Most of the participants within this study talked about how they felt when they were violently attacked, dehumanised, beaten up, starved, and pushed out of the house in the middle of the night by those who were supposed to protect them from such adversities. According to Maslow, the absence of physical safety due to war, natural disaster, family crisis, child abuse, the affected individuals could experience psychological distress or transgenerational trauma. Participants also expressed how they felt powerless to defend themselves, but instead wished to leave the house to find a place where they could feel safe. For example, Amara said;

"Oh! It is really affecting me. Even my sister that I live with in her house flogs me always, telling me that I am mad, and I am not supposed to live in a house where human beings are living. Sometimes she pushes me out of her house in the night and I will be walking about. I have been locked out of her house several times in the middle of the night. She makes me think I am the cause of my problem and I feel so bitter about it. I even feel bitterer whenever I see my age mates and school mates with their spouses and kids looking very good and I will be wishing I am in their shoes. It makes me to remember that I suppose to be in my own house by now and not my sister's house. All I want is to be loved, my sister and others should endure me and my characters." (p.2)

Amara was dehumanised by her own sister who was supposed to ensure her safety. *'Flogging'* her made Amara consider the option of leaving the house to go to an unknown destination and/or locking her out of the house in the middle of the night, could expose her to several dangers. Such dangers may include homelessness, exposing her to rapists, unwanted pregnancy, sexually transmitted diseases, drug abuse, road traffic accident, and suicide.

Reflection on the emotionality of Amara's story

As a researcher Amara's story was both emotional and poignant, helping me to reconnect to things I have observed in Nigeria, but struggle to make sense of. In my teenage days when I started accompanying my mother to some of the local open markets in my community and neighbouring communities, I observed that some mentally ill women were pregnant, and some with their newly born babies and people always gathering to watch them as they pick up rubbish in the market and streets, feeding their babies with all kind of dirty foods and water. As a young boy I was never curious to ask how they became pregnant, but as I got older, I began to wonder how do these people become pregnant if they are not married? And even if they were married, do their spouses come to sleep with them on the street since some *of them have lived on the street for a long time and cannot trace their homes again. Amara's story helped me to realise that some of those pregnant and breastfeeding mentally ill ladies may have been in a home where domestic violence was a feature, where they were dehumanised and driven out of their homes as a result of their mental illness and they ended up on the streets where men took advantage of them.*

While her story helped me to realise how some mentally ill people become vulnerable to some dangers, I felt very bad because of the inhuman treatments the sister meted out to her. I felt worst after I have left the interview venue as I felt I did not do anything to help Amara address what she had experienced in her sister's house. I felt that Amara was open with me about the domestic violence because she hoped to get some help from me. On reflection I felt that I should have, with her permission, reported the incident to the nurse manager who would further investigate the case of domestic violence and take appropriate actions to stop the abuse.

However, regardless of my inability to proffer a solution to her problem, this has helped me to have a better understanding of how mentally ill people become vulnerable to many dangers and it also made me think of the need for patients' relatives to be educated on the implications of their actions against their mentally ill relatives.

During my interview with Amara her non-verbal communication, the frown on her face and the exclamation, 'OH!' as she narrated her experiences, may have reflected her emotional pain as a result of reiterating her sister's behaviours towards her. According to Freud (1963), painful past events can be kept in the pre-conscious or unconscious, but if the former can be brought back to conscious awareness, then the emotionality of the event will be awoken. This can be difficult to assess in a research interview, but Amara's reactions when talking about her negative experiences indicated that perhaps the emotionality attached to the events were awakened and therefore brought to consciousness (Freud, 1963). However, from her statement, what Amara wanted was to be 'loved' and in staying with her sister she might have believed this need could be met. With reference to Maslow's hierarchy of human needs, the need for love and belongingness takes precedence over some other needs, hence it was captured in the pyramid of human motivation as the third human need. Amara needed to be accepted by her family and feel loved. However, the behaviour of her sister had the opposite effect as it made her feel hated, unaccepted and rejected. In addition to the violence, Amara's sister also made her believe she is the cause of her own problem, causing her to feel under pressure to consider leaving the house to go elsewhere, to feel safe or perhaps to no longer be a burden on the sister. Amara mentioned that she had been locked out of the house in the middle of the night several times. While this does not constitute physical violence, it equates to abuse and increases her vulnerability, as it may well have exposed her to sexual abuse, unwanted pregnancy, sexually transmitted infections, drug abuse and suicide. Moreover, this could have added to her emotional and psychological distress thereby worsening her problems. Similarly, **Unice** also spoke of family violence;

"I wasn't in peace with anyone in my family, I insult my parents anyhow. Sometimes I even think of staying away from my family because I was totally beaten by my parents and my siblings, reverend fathers and others. I felt hated and rejected. Even the first time I was brought to this hospital I was flogged till my brain became hot. Each time I remember the experience, I feel very sad, it takes me to my early grave." (p.5)

Parents and siblings are supposed to be a strong source of succour to a person having any form of emotional or psychological problem, but this was not the case for Unice. She attributed her most difficult experiences to the lack of peace which existed between her and family members, including her parents. This is because she was always under threat of, and sometimes experienced violent attacks from parents and siblings, making her feel that everyone in the family hated her and her presence irritated them. Like Amara, Unice considered the option of staying away from her family in order to be free from the domestic violence meted out on her. Although Unice said she had 'insulted her parents', I did consider if this could have been an act of self-defence or if it was a trigger for her family's violence towards her. As previously stated, people wrongly assume that those who are mentally ill are violent or aggressive, however, there is often a reluctance to investigate the cause of aggressive behaviour and/or to consider it within a given context. For example, Unice might have insulted her parents in response to their violence as a way of trying to exert her right to protest at being maltreated and marginalised.

Whilst Amara and Unice talk of family abuse other participants, including Unice, discussed their experiences of violence on the part of spiritual fathers and health professionals. Unice told of a time when she had once been beaten by a reverend father and, while she was on an admission ward, doctors and nurses used to *'beat hell out of her'*. Although Unice did not mention the reason why they beat her, the issue that remains is it is unethical and amoral for people to do this, especially those who hold positions of trust. It is a violation of human rights (Hoop *et al.,* 2008). The violent behaviours of her parents, siblings, the reverend father and care givers seem to have left Unice with a strong sense of mistrust of others. From her verbal and non-verbal communication during interview it was apparent Unice was still hurting from these experiences. When she spoke of these incidents, she became emotional and her face contoured, as though in physical pain, and she said, "each time I remember the experience, I feel very sad, it takes me to my early grave". Her verbal and non-verbal communication are in keeping with someone who might be depressed and perhaps worrying regarding the possibility of suicide.

Domestic violence was not just confined to the female participants', **Chukus** also reiterated a similar story;

"My younger brother who is an engineer is always beating me with his hands, telling me that I should stop that madness. He abuses me with all kind of negative words, calling me different names. And I am always quiet because I can't do anything, I can't fight back but not that I like the beating, of course nobody would like to be beaten. I know myself, I know what I am passing through and I know how I struggle to get money. Within me I know how I feel about the beatings and I know that I am mad and that is why if my mother and my younger brother are beating me, I will just relax without fighting back." (p. 2)

Chukus's young brother and his mother were both involved in the violence towards him. According to Chukus, while beating him his younger brother always asked him to stop *'this madness'.* Arguably, this could imply that they are insinuating that he might be faking his illness, or they believed that by beating him, the mental illness could be cured. He mentioned that he never fought back whenever his younger brother attacks him physically, but that does not mean he enjoys the physical beatings. However, while he does not like the maltreatment meted out on him, he chooses to remain defenceless, as he is fearful if he retaliates his family will withdraw their supports from him. This could also be equated to Seligman's theory of learned helplessness in which people learn to be helpless in their situation even if they have the means to help themselves (Seligman, 1979). Feeling of helplessness stems from a person's previous efforts to help himself in which he feels it was fruitless, hence he concludes that it is futile to make similar efforts. This was reiterated in Chuku's statement when he said *"I know myself, I know what I am passing through"* ……….and I know how I struggle to get money. *"Within me I know how I feel about the beatings and I know that I am mad."* and *that is why if* *my mother and my younger brother are beating me, I will just relax without fighting back".* Living with mental illness appears to have stripped Chuku of his self-confidence and made him feel intimidated and defenceless.

In another interview, Chinwe was able to share her experiences of domestic violence. Chinwe sounded very angry and hurt while sharing her experiences during interview stating;

"This my condition makes me feel intimidated somehow. For instance, my hair, the middle of my hair was cutting and everyone in my family started telling me that is because of my sickness. And it was as if all of them ganged up against me and were forcing me to cut my hair, but I told them 'no' that I don't want to cut my hair again because I have been cutting it. And I said to myself, how long will I continue to cut my hair? I told them no, I am not cutting it again, yet they continued to force me. And I think they thought my illness is making my hair to fall off, but I told them it could be dandruff. Most times, they force me to do things that I don't want to do. Some months ago, I had a very bad experience with them because of my hair. One fateful morning like that before I could wake up, they ganged up and came to my room and held me down and finally forcefully cut my hair, but I couldn't do anything. I even had a serious problem with them this morning before I came to the hospital, but I still insist that I don't want to cut the hair again." (p.1)

Although in her story Chinwe never mentioned that she was beaten by her parents or siblings, it was clear that she experienced physical abuse in another form, the forceful cutting of her hair, which affected the relationship she had with her family and ultimately her mental wellbeing. The actions of her mother and siblings towards her were a form of physical abuse. Even though Chinwe was mentally ill she ought to have been given the right to make some decisions regarding her own body. The family members' overshadowing attitudes towards her could have left a kind of negative impression that they are taking advantage of her health condition. During the recounting of this experience Chinwe looked angry and emotional. It was not clear to Chinwe whether the cutting of her hair as insisted by the family was a form of traditional treatment for her mental illness or if they thought her hair could be part of the causes of her mental illness. There is an ancient belief in Nigeria in which people with coiled hair from birth are regarded as people possessed by an evil spirit called *"OGBANJE"* which they believed to be responsible for mental illness and other misfortunes including untimely deaths. Therefore, to avert such dangers, rituals are usually conducted leading to the cutting of the hair in order to free the person. For certain religious groups, this is usually done by their religious leaders in their place of worship.

Whatever their motive for cutting her was, it appeared this incident had direct effect on Chinwe's emotional state, as it made her attribute the intimidation to her illness, stating; *"my family members are always making me feel as if I am the cause of my problem and it makes me feel depressed."* This kind of behaviour is obviously not what the participant, who is already having emotional problem, needed at that time. Seeking her consent and working in accordance with Chinwe's needs could make her feel respected, supported and loved at a time when her confidence is low. However, 'ganging up' against her and forcefully holding her down to cut her hair was the antipathy of this. Apart from feeling intimidated, Chinwe felt defenceless, unprotected, hated and believed the family to be her worst enemy. This was reiterated when she mentioned that *"her greatest problem is her family".* Chinwe wished that she was married so that she would have someone to be discussing her problems with. These actions on the part of her relatives are in keeping with coercive treatment, sometimes considered as a coded way of infringing the human rights of those that are wrongly diagnosed with mental illness by use of the medical model (Livingston & Boyd, 2010). While Chinwe had her own beliefs regarding the cause of her hair problem and how this could be solved, but these were overshadowed by her family which amounted to intimidation and abuse.

In addition to Chinwe's problem with her family, two other participants, Okey and Madi, reported to have experienced physical attacks in the hands of their immediate families and relatives. Okey and Madi were coerced and forcefully taken to a place of treatment without their consent or any prior explanation of the arrangement. **Madi** said;

"What brought me here is that I was in my house sleeping and one of my uncles came and knocked at my door before I could wake up to open the door, they have already broken the door and forced themselves into my room. They asked me what is happening to me and I replied them "nothing is wrong with me" they now gathered with some other youths and insisted that I must follow them to somewhere and I asked them where are they taking me to please, I need to know? Nobody was ready to respond to my question instead they jointly forced me into their car and brought me here. And that was how I found myself here." (p. 1)

The facial expression of the participant as he was narrating his experience showed that the action of his uncle and others did not go down well with him. Such approach could be described as a typical example of a forceful admission or coerced treatment. Madi saw their invasion into his room while he was still sleeping as an attack on his person. It is possible that his uncle and others may have acted that way claiming Madi had been behaving in an unusual way, but regardless of their reasons, as an adult Madi deserves to be involved in any decision regarding his health and his decision should be respected. As Madi was asleep in bed when they forced their way in, he might have felt intimidated, defenceless and unprotected, his human right has been infringed by his uncle and others. Confining him to hospital posed a huge restriction on his freedom of movement, which can also be interpreted as another form of abuse.

Okey talked of potential abuse from those deemed as professionals looking after him when he was admitted to hospital;

"I know I was not sick, and I never told anybody I am sick. I believe I am normal, but they claimed that I am sick and forced me here. Immediately they injected me I realised that I was sick. I did not resist them because I was afraid of being beaten or starved if I resist their advice, or they might abandon me. That was why I kept quiet and followed them, but within me, I am not happy (p. 2)".

Okey's story is similar to Madi's story, both of them recognised they were not sick, but nobody was ready to listen to them. People with mental illness are often disregarded, ignored, and/or shunned by those allegedly providing care for them (Ye *et al.*, 2016). This is a common attitude towards those with mental illness in Nigeria (Ukpong & Bs, 2010). This may have stemmed from the erroneous belief by some Nigerians that people who have mental illness are most unlikely to engage meaningfully in discussions (Gureje *et al.*, 2005). This clearly demonstrates how voiceless those living with mental health problems can be. This kind of stereotyping can place individuals with mental illness under unnecessary victimisation (De Passos *et al.,* 2013). Regardless of Okey and Madi telling their relatives they were fine and needed no treatment, their voices were ignored, and they were forcefully taken to hospital, highlighting the level of authority people exercise over their relatives who are experiencing mental illness in Nigeria (Ukpon & Abasiubong, 2010). Although Okey felt 'sad' about what had happened, he did not resist the attack on his person because he was afraid that they could 'beat him up', 'starve him' or 'abandon him'.

4.1.4.2 Verbal Abuse

The data generated from the participants' interviews in this study demonstrate the abuse people living with mental illnesses experience extends beyond physical and sexual abuse. Going through the participants' stories, it could be argued that verbal abuses give rise to both physical and emotional or psychological abuses. Physical attack seems to always start with verbal attack, the perpetrator using it to gain control of their victims. Under this sub-theme, most of the participants recounted how they experienced continuous verbal abuse such as name calling, belittling, insulting, embarrassing, threatening, yelling or cursing inside and outside of their homes. It is noteworthy that emotional/psychological abuse appears to be inherent in both verbal and physical abuse, as they both have the potential to negatively impact a person's ego or personality. This was evidenced by the participants who experienced physical and verbal abuse also expressing how such experiences affected them emotionally. For example, Chinwe said;

"Ever since this my problem started, I have been hearing so many things that I don't even know where to start telling you. They call me different names; mad girl, crazy person, useless person, they shout at me anyhow, and most time if I talk or ask them questions, they don't even respond to me and when they do, they respond with harsh voice. This makes me feel as if I am the cause of my problem." (p.5)

Generally, family and friends are expected to provide a support system for their relative who may be experiencing emotional problems. However, for Chinwe this was not the case, as those whom she was supposed to take succour from became her abusers. The relationship between verbal abuse and emotional problem was evident, as Chinwe told how such abusive words and name calling made her feel depressed. Calling her a *'useless person'* undermined Chinwe's self-confidence and self-esteem and led to self-blame. Not responding to Chinwe's conversations or questions may have further impacted negatively on her emotion, making her feel rejected, hated and unworthy. **Chinwe** went on to say;

"There is this particular statement which my mother and my siblings are always making about me. They said that I am slimming down and each time they make the statement I always become very angry with them. For instance, I wanted to go to church yesterday and she made the same statement, immediately I started feeling so depressed and I couldn't go to church again. I have told my mother and my siblings that I don't like such words, but they wouldn't stop. People are always saying all kinds of words about me, but their own attitude is nothing to write home about, but they will be seeing my own attitude as the worst. They can't even endure what I have endured (p.5)."

Telling her that she is 'slimming down' by her mother and siblings could be a way of letting her know that she is not feeding well again. However, this was interpreted in a negative way by Chinwe, as she saw the statement as being judgemental and derogatory. The meaning given to the statement by her may not be the same as the intention of the source of the statement, her mother and siblings. Regardless of intention of meaning, Chinwe's expression of how such a judgmental statement made her feel depressed speaks volumes of the negative impacts such judgemental or condemning statements may have on the emotional wellbeing of those living with mental illness. Chinwe said; *"the statement is not my problem, but the way they say it, makes me depressed and it also makes me feel as if I am the cause of my illness."* This draws attention to the importance of choice of words and the phrasing of statements when addressing individuals with mental illness. Perhaps Chinwe would not have found the statement offensive if it was framed in a non-judgemental way. Similarly, **Onuji** said;

"When I am talking to my husband he will seem not to be interested or listening to what I am saying especially if we are sleeping and I try to wake him up to accompany me to go and ease myself. He will not listen to me and sometimes he will talk or respond to me with harsh voice. If I tell him that I want to go and ease myself or sleep, he does not listen to me. Most times he will tell me ah! Sleep if want to sleep and leave me to rest. Once he reacts that way, I always find it difficult to sleep again." (p. 6)

For Chinwe and Onuji close relatives appeared to be the major players in verbally abusing them. In the case of Onuji, although her husband was the only relative who was always around, it could be deduced that she did not find his presence very supportive. A supportive relationship should be able to address both the physical and emotional needs. Ignoring Onuji's needs could be construed as neglect and further affect her emotions. Also, responding to her 'with harsh voice' each time she calls for her husband's support could be interpreted to mean so many things; it could indicate a sign of hatred, unworthiness, or she is becoming a burden to him. Onuji confessed that she always experiences difficulty in sleeping whenever the husband speaks to her in that way, indicating the level of impact such behaviour had on her emotional wellbeing.

Chukus also an example of verbal abuse;

"My people abuse me with negative words, calling me different names such as good for nothing, mad person, crazy person. Sometimes, if they are doing family meeting, nobody invites me and if I try to join in the meeting, everyone will stand against me. This makes me feel like an outcast. I do want to contribute in the meeting, but they won't let me join them (p.3)."

Amara also experienced verbal abuses from her close relatives;

"My sister calls me all sorts of names; mad person, wayward and so many things. She tells me that I am mad, a crazy girl and I am not good to live in a house. All I wish is to be loved. Let them endure me, live in harmony with me. They should see me as their fellow human being, and I need their support (p.4)."

These participants were verbally abused by their own family members. Calling them such names is derogatory and dehumanising and could lead to making them feel isolated and depressed. While the above participants have experienced verbal and emotional abuse from their own family members, Unice and Okey also talked of health professionals and other members of the society being involved in abusing those experiencing mental illness verbally and emotionally. **Unice** said;

"I feel even worse when I try to approach any of the doctors regarding my condition and they ignore me. Sometimes I wish I could die because no doctor is listening to me. What I thought that could have helped me was to go home because someone giving me attention or listening ear could have helped me, but it wasn't possible because I was on admission. Even when I told my doctor this morning about my feelings, he didn't even say a word to me. (p.7)

Reflection on ignoring someone

I never realised the implications of ignoring or snubbing someone until Unice mentioned that she felt like dying after the health care professionals ignored her and could not give any answer or explanations to her concerns. On hearing that, I felt guilty of the same offence because at some points in my practice as a nurse I have ignored patients either because I felt they are asking too many questions, or their concerns were irrelevant. Hence, it is likely that those health care professionals may have unintentionally ignored Unice or they felt she was asking too many questions. However, regardless of whether it was intentional or unintentional, Unice's experience has opened my eyes to the emotional implications of ignoring someone and especially those who are already having emotional difficulties. The doctors and nurses did not provide an answer or explanation to her health concern and this made her feel irrelevant, devalued, and her self-esteem was lowered, hence she wished to commit suicide. On reflection, I realised the importance of attending to every concern raised by someone who is experiencing mental illness.

When Unice realised that her condition was not improving, even when taking regular medications and the side effects of which were overwhelming her, she began to look for someone to discuss it with. During the interview, participants commented that they were being "ignored" and nobody was ready to listen to them. "Not being listened to" is synonymous to being ignored. Ignoring has been described as a silent way of abusing someone emotionally (Porcere *et al.,* 2006). Unice felt "let down", "frustrated", "ignored" as she battled with the uncertainties surrounding her condition and the worsening side effects of her medications, but without response to her questions or explanations being provided by the health care providers. Their actions made Unice feel irrelevant which further lowered her self-esteem. However, her story offers good insight into how such unethical behaviours on the part of health professionals can negatively influence people's experiences of mental health care. Mental health care should be predicated on therapeutic relationships, with listening and hearing the patient's story being important components when developing such relationships (McAndrew & Warne, 2010). Unice had an urge to talk to a doctor about her feelings, but this was a difficult thing to achieve as she believed nobody was listening to her. This response by the doctors left her feeling worse, Unice stating; *"this made me feel worse than before."* The facial expression of the participant as she shared her story indicated the pain, she experienced for being ignored by those whom she was looking to for support. As a consequence of such attitudes on the part of professionals', Unice considered leaving the hospital environment to go where she felt attention may be given to her and where she might perhaps have felt more valued. In the case of Okey he provided a lengthy description of how he felt emotionally abused whenever his family ignores him. Okey said;

"The issue of my school fees and feeding money has to be looked into. I know money is not easy to get but at least whenever I ask them for the money, they should try to tell me something whether to wait till tomorrow or next and not to keep quiet at me. Being mute at my request gets me worried as I would not know what they have in mind. Also, as I am still in school, anytime I ask them for money and they do not have it at hand, they should try to tell me some good words that will make me feel cared for and loved and give me hope so that if I am going back I will go with happiness." (p. 2)

Whereas he needed money from family to sort out school and personal needs, it was not his paramount need. He considered emotional support more important. Not receiving the money was not the cause of his emotional problem but his brother's muteness over his request got him worried as he wondered what could be on his brother's mind. Also, his fate was kept in suspense. Instead of giving Okey some assurances and sweet words which could instil hope into him as they may not have the money at the moment, he was allowed to battle with uncertainties which affected his emotions. Okey experienced verbal abuse from friends and others. For Okey, the problem was related to his diagnosis of mental illness, he stated;

"one of the major challenges I have experienced and which I am still experiencing today is that whenever I am staying with friends and we are chatting, before I know it, some of them

will start telling me you are mad! You are mad!! Even though I can't say whether they are joking with it or not, but the truth is that it makes me feel depressed because I don't know whether they are aware that I am mentally sick. Anywhere I go, even when I am walking on the road some people make the same comments and it gets me irritated (p, 5)."

Being diagnosed with a mental illness predisposed Okey to peers' verbal abuse which also affects his emotional state. Although Okey was not sure if his friends were joking with him whenever they tell him 'you are mad', such statements make him 'depressed' and perhaps make him question if he is accepted or welcomed among his peers, or if what he was saying did not make sense. Knowing that Okey has mental illness, his peers could have been more careful with their choice of words while talking with him. Telling him that he is mad is akin to name calling which made him withdraw from the discussion. Perhaps, he considered himself not worthy to be in the mist of his peers because of his mental illness. This could have future implication on his self-esteem and confidence, enough to compromise his ability to associate freely with friends.

It was particularly touching to listen to their accounts of violence attack/abuse and at some points I became speechless not only because they were abused, but because of the people who were involved. The involvement of health care professionals, siblings, parents, friends and reverend fathers in attacks/abuses of young adults who are mentally ill was unacceptable inhumanity. Participants felt insecure because they believed they had lost the empathy of important people in their lives. When reiterating thee incidents, participants seemed to have lost hope in their relationships with those people. Hence, they were desperate to leave their homes, hospital or stop identifying with friends. This created further emotional turmoil which affected their mental wellbeing. Emotional instability seems to be grounded in the young adults' experiences of abuse. Although each of the participants experienced abuse in different ways, common to their experiences is the emotionality of being abused. Every participant, regardless of whether he/she was attacked verbally, physically, *or "being ignored or not being listened to"*, expressed how such actions caused them to feel depressed. *"Being ignored or not being listened to"* had similar emotional effects on them as other forms of abuse.

4.1.5 Theme 5: Spirituality, and Religion Faith

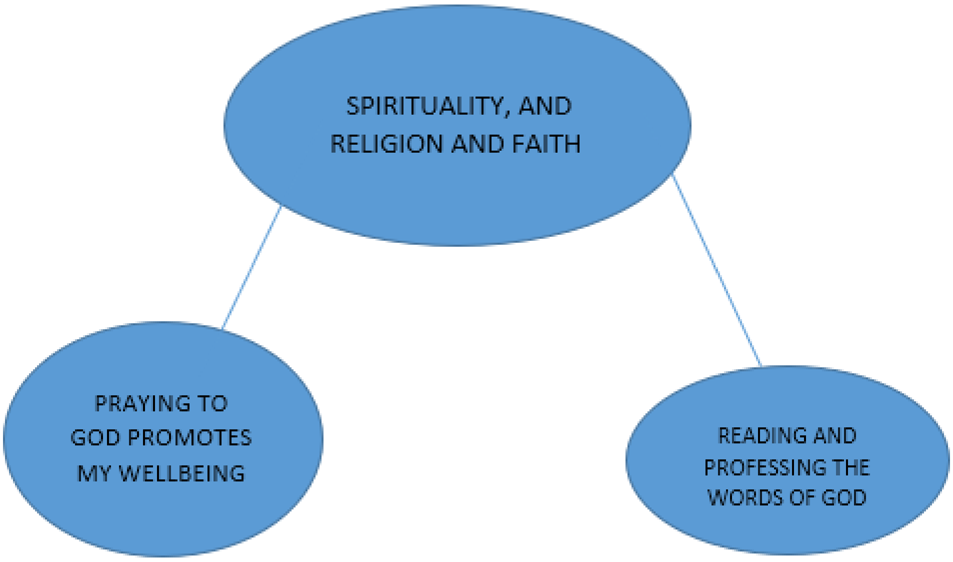

Figure 4.5 Theme 5

This theme captures participants' expressions of their spiritual and religious beliefs. From the data collected it is obvious there is a hidden power in their prayers, religious books and slangs which re-energised the participants, instilling hope and promoting their wellbeing. This was particularly a strong theme, as every participant openly and freely shared how they found solace and support by praying, reading their bibles, singing praises to God, and professing their connectivity with the supreme God. Reading the bible and professing biblical words provided calmness and served as a source of hope for them. Some of the participants stated they needed both their medication and prayers to feel better, while others were only concerned about what God can do for them in their illness. However, some participants appeared to no longer believe in the power of prayer. This theme was divided into two relevant sub-themes.

4.1.5.1 Praying to God Promotes Wellbeing

While participants' stories in general revealed the relevance of spirituality and religious beliefs in promoting their wellbeing, some of them specifically talked about the solace and support they were able to draw from the words of prayers. For instance, Chukus said;

"Even though there are other methods of treatment for this my sickness, but I don't believe in some of them especially native doctors (traditional healers) who use all sort of things on human beings in the name of finding solutions for a problem. I can only take my drugs and pray to God so that my sickness will go. Most times, people tell me that I should reject anything that

is wrong with me through prayers and I should be shouting "Amen". And I discovered that each time I say Amen! Amen!! And Amen, my sickness always disappears." (p.3)

Chukus found prayers and saying 'Amen' were very therapeutic because of the strengths he draws from it. Acknowledging that other methods of treating mental illness exist, but detesting them all apart from medication and prayers, Chukus tells how much he values medication and words of prayer. Apart from his medication, echoing or responding with *'Amen'* to prayers was found helpful because his 'sickness always disappears' and he feels better whenever he says *'Amen'*. This could be seen as combined therapy which includes; pharmacotherapy and prayer-therapy (Whitford & Olver, 2011). Chukus may not have responded so well to his medication alone without prayers, and as a consequence, there is an overarching need to find a way of supporting his spiritual life. Madi was another participant who shared his experiences with regard to the strength he draws from his prayers and spiritual practices. He stated;

"Since I started suffering from this my sickness, I never allowed myself to be overwhelmed. I am always praying to God to help me in this my condition. I have a personal relationship with God and because of this I can say that my belief is what has been keeping me strong. They do call everyone out every morning to be prayed for. Even when I am about to go to bed I also pray though I don't shout, most times I pray in my heart saying God you know why you brought me from my mother's womb, do not allow my condition to overwhelm me. So, each time I pray I feel as if God is sitting beside me and listening to my request. Through prayers I believe I can have a conversation just like I am having with you now and that makes me feel that God is interested in my case. That is why every time you will see me lying on the bed here, I don't go out because if I go out and see the kind of people I mix up with, it makes me to feel very bad and I will be asking God why me? Why am I here? And I will be praying to God to help me." (p.4)

Although Madi affirmed that the journey through his mental illness has not been smooth, he refused to be overwhelmed by it. He acknowledged that prayers have been his source of strength, supporting him throughout difficult times. Believing that God has been in his life since his birth could be the reason why he continually prays to God for strength and healing. He believed that if God was the one who masterminded his birth that same God would not allow him to be overwhelmed by his health challenge. It could be assumed this belief has reinforced his inner strength which helped him through the difficult times. Regardless of this, it seems Madi never liked the joint Morning Prayer where everyone is asked to come out of their bedrooms to a particular spot for the prayers. He suggests this is because it predisposes him to seeing faces or mixing with people he does not like. Not liking those faces was because he does not see himself to be suffering what others are suffering perhaps due to the way they behave, he feels he has recovered from his own illness and should not be made to join with those whose symptoms are still obvious. He also prefers having quiet time with God, perhaps because he feels more satisfied when he prays privately. Not willing to pray or mix with other patients could be misinterpreted by professionals to mean social withdrawal or isolation without exploring other factors pertinent to his behaviour.

In another scenario, participants' experiences portrayed a situation where they recognised the relevance of their prayers and other religious practices to promote their wellbeing, but the environment and method of treatment they were exposed to seemed not to be helpful. This prompted their urge to leave the hospital. For example, **Chinye** said;

"I knew that I wasn't stable enough to go home, but I wasn't comfortable again in the hospital, so I pretended before the doctors so that they would think that I am due to be discharged and this finally worked for me. But God helped me, as soon as I got home, I started praying and my mother involved a member of our church, a prayer group and reverend father who were helping me with prayers, but I did not stop my medication. Before I knew it, I started feeling better, I then realised that while my first episode was terrible it was because I did not know God then and I couldn't pray." (p.6)

Prayers were experienced as one of the key factors for feeling good mentally. Although, as important as it was for this participant to pray, she did not feel supported by the environment because of the restriction placed on her movement. Chinye felt as though she was caged and restricted in the hospital and this hindered her from praying, hence she wished to leave the hospital. Leaving the hospital seemed to have helped her reconnect with her spiritually. On discharge Chinye immediately engaged in prayers with her family and others. The therapeutic effects of such prayers boosted her wellbeing. Despite her strong zeal for prayer, she never stopped her medication, rather she used both prayers and medication in the form of combined therapy. The recovery she experienced when she combined both medication and prayers helped her to appreciate the difference between when she felt unable to communicate with God and when she could. The keen interest she showed regarding her medication and her spiritual life by not choosing one over the other is an indication of their relevance in sustaining her mental health. Drawing from Chinye experience, it would appear pharmacotherapy and spiritual therapy should exist simultaneously and neglecting one of these could compromise utilization of the other. Similarly, **Ezi** suggested;

"I have been in this hospital for a long time, but I am not getting better. I just want to go to my aunt's house because she sells medicines because I am tired of the drugs I receive in this hospital. When I was in her house, she used to give me medication and prays for me and each time she gives me medication and prays for me I always get myself." (p.3)

Ezi indicates that neither his pharmacological need nor his spiritual needs were met while in hospital. It could be suggested that not having his spiritual needs met led to loss of confidence in his medication and prompted his reason for opting to leave the hospital and go back to his aunt's house. Although Ezi did not offer an explanation as to why he could not pray in hospital, one interpretation might be he felt restricted in the hospital making it difficult for him to express his religious practices in a way that satisfied him. It could be argued that nobody prays for him in the hospital or prayers were not always offered the way his aunt does it, hence he was eager to leave the hospital to his aunt's house. Having spent some time in his aunt's house previously, Ezi affirmed that during that time, his sickness usually goes, and he feels better whenever his aunt gives him her own medication with some words of prayer. This could be interpreted to mean that his aunt says the prayer in a way that addresses his needs which in turn encourages him to have faith in his medication. Hence, understanding patients' mode of prayers or encouraging them to recite their prayer in their own unique way may encourage them to adhere to medical orientated treatment.

Amara was another participant who suggested being in hospital had not given her the freedom to express her faith and this prompted her wish to leave the hospital. **Amara** said;

"At a time, I felt like leaving the hospital. I felt like going to church to pray to God so that I will be mentally fit." (p.7)

Although Amara did not mention specifically whether or not staff at the hospital were meeting her medical needs, she did indicate her dissatisfaction with her spiritual life while in the hospital. Being in a psychiatric hospital where her movements were restricted made it impossible for her to go to church as was her usual practice. The prayers she was able to access in the hospital did not meet her needs, and because of this Amara was not satisfied spiritually. Amara believed leaving the hospital could offer her the opportunity to go to church and part take in those rituals that would enable her to feel mentally good. She believes that total recovery from her illness does not depend solely on medication, but going to church to communicate with God, prayers and her relationship with God, were just as important for her mental wellbeing. Similarly, Onuji also made a decision to leave hospital because she felt the prayers in the hospital were not meeting her needs. **Onuji** stated;

"I normally go to pastor every evening and the pastor prays for me, but it seems the prayer is not working. I just want to leave this psychiatric hospital and go back to my family." (p.4)

For **Okey,** prayers and beliefs in God discouraged him from adhering to his medication;

"I got frustrated at a time to the extent that I discontinued my medication. The reason for stopping my medication is that sometimes I will be asking myself, since 2011 I started taking these drugs till now my sickness never ceased and I will be asking myself; what kind of sickness is this? Sometimes I pray and pray and tell myself that I will not take this drug again, with faith I believe that I am healed." (p.3)

Okey's feeling of frustration regarding the ineffectiveness of his medication is understandable, as he was unable to recognise any improvement since starting on medication. This prompted him to discontinue his medication at some point. Hence, Okey considered divine healing as an alternative to his medications. Implicit in this, is Okey's affirmation that at some point he tried to rely more on his religious faith than his medication. Okey also affirmed that at times he prays and tells himself that by having faith he will be healed, and because of this he is not going to take medication again. Using faith and prayers in the place of medication could be described as risky and poor use of spirituality and religious faith in addressing mental illness. Research evidence suggests that while religious beliefs and spirituality may serve as an important source of hope in mental illness, it could interfere with treatment adherence (Zagożdżon & Wrotkowska, 2017). In contrast to the above participants Sam stated;

"I feel happy here. Why I feel happy is because early every morning we always pray together, and they will give us advice. In fact, I am comfortable here and I will be here till the doctor asks me to go home (p,3)."

Although Sam expressed his happiness with his treatment and his readiness to remain in the hospital until his doctor asks him 'to go home', he specifically talked of his happiness and strength being drawn from the morning prayers they attend every morning. Sam's experience demonstrates the impact of meeting the spiritual needs of those with mental illness can have on their commitment to medical orientated treatments and their overall wellbeing.

The evidence provided in this theme by participants clearly illustrated how prayer formed an integral part of their survival strategies. From their comments, prayer was seen as one of the major factors that helped them stay on their medications. Hence, most of the participants strongly affirmed that their prayers are as important as their medication. Participants who felt that their prayer needs were not met opted to leave the hospital to where they felt such could be achieved. For most participants, prayer is a form of therapy because of the emotional support it offered them and the instillation of hope. Hence, some of them felt apart from their medications, communicating with God provided relief for them, hence they said both medication and prayers are all important for their mental wellbeing.

4.1.5.2 Reading and Professing the Words of God

This sub-theme captures the participants' beliefs of how they had positive experiences when staying close to their religious books and memorising the chapters and verses that promoted their spirituality and instilled hope. The participants verbalised how relieved and supported they felt when they read and quoted particular portions in their religious books. For the participants' reading those words gives them a sense that God is speaking directly to them and was experienced as a strong source of hope among this group of participants. For example, **Madi** suggested;

"And I never thought that this my present condition can affect my future because I know that 'He (God) that is in me is greater than he (God) that is in the world'. I know myself and I know what the God says in the bible concerning my problem, even though I fall a hundred times I know I can rise more than two hundred times. So, I don't believe that this little thing can affect me in anyway, I know the God I serve, and I know where I am heading to. Reading the scriptures gives me a lot. If I am reading my bible, sometimes it is like a burden is lifted off my mind and I can experience a lot of hope, comfort and peace of mind. For me all I need is my drugs and God to feel better even though I am been caged here, it makes it really difficult for me as I no longer participate in my church activities, but I still believe that if I do the right thing like not quarrelling with anybody, stay on my own, meditate on my own, pray on my own, study the word of God on my own and take my medication that I will be fine again."(p.6)

Being a religious and a spiritual person was seen to be advantageous in dealing with mental health issues. The strong ties Madi maintains with God may account for his acquaintance with some quotations from the bible. Quoting inspirational passages from Christian religious books appeared to reinforce Madi's spirit to remain strong. Those quotations from his religious books appeared to amplify his hope and strength, helping him to ignore the some of the challenges associated with his mental illness. While battling with his illness, Madi was able to anchor his faith on those religious words, maintaining his present illness cannot affect his future. Madi believes medication and words of God to be the only treatments he needs to deal with the challenge of his mental illness. Similar to Madi, **Ugo** also puts his faith in God and Christian teachings, stating;

"Well, life is all about decision and again, I am a child of God. The bible says if you are a child of God, old things have passed away, all things have become new. Also, in life, everyone has his or her orientation or plans for life. I have so many things, I would have joined so many things, but my principle is that if my plans are not going the way I want it, I will not continue because it is not the will of God and that is how I live my life. And I believed that since I became a born-again Christian, know whom Christ is and what the bible says, there are some certain things I can never believe in this life and there are some certain things that can never stop me. For instance, now, I cannot believe that my sickness is incurable, or somebody used charm on me." (p.4)

Ugo expressly and repeatedly confirmed how his commitment to God has reinforced his strength. Looking back, he realised that ever since he became a born again 'child of God', no challenge has ever surmounted him, hence, his present mental illness was no exception. He used what he had read in the bible to instil hope into himself. Also, his Christian beliefs made him more sceptical about superstitious beliefs. Being 'rooted in the bible and a born-again child of God' implies that he no longer holds the cultural belief that, mental illness is as a result of, an evil spell, ancestral curse, evil spirit or charms from wicked people, as commonly held by many Nigerians (Ukpong & Abasiubong, 2010). In other word, his believe in Christian God changed his orientation about the causes of mental illness. Also, his belief in God gave him a strong reason to believe that his mental illness can be cured. **Amara** also saw herself as a 'child of God', stating;

"I feel very happy whenever I remember that I am a child of God by making. I preach the word of God to people every morning whether they like it or not, even in the night I shout it very well so that people will hear it. That makes me feel at peace with God." (p.3)

Remembering that she is a child of God made Amara happy and gave her the conviction that God will heal her someday. Also preaching to people about God was a way of finding 'peace with God' and maybe in her life.

Finally, and in keeping with Madi and Ugo, Chinye spoke of how her coming to know God helped her cope with her second episode of mental illness. **Chinye** said;

"After my second episode, I realised that the reason why I could not cope well in my first episode was because I did not know God as much as I know Him now. I could not find the word of God to console myself in the time of distress. Before I knew it, I started withdrawing from my family and friends and I no longer go to school or associate with anybody... I became so

depressed even to the point that I attempted suicide when I fell from one storey building, but God saved me, and I only sustained an ankle injury." (p.6)

Comparing her experiences during the first episode and the second episode of illness helped her to appreciate the usefulness of the words of God. Chinye confirmed that not knowing or being close to God during her first episode of illness was experienced as the cause of her inability to cope well, because she could not find a chapter in the bible to take succour. However, being close and knowing God during her second episode gave her the opportunity to know some passages in the bible which offered her some emotional and spiritual support to cope with the mental illness.

Similar to the importance of prayer, the comments of the participants provided evidence of how reading and memorizing some passages of their bible was a source of help to them. Participants suggested they always feel relieved whenever they recite a passage in the bible. Although none of the participants were able to explain how familiarity with the bible helped them, they all felt reading and quoting passages boosted their moods. For the participants, reading the bible made them feel connected with a higher being who has power over their problem. Participants anchored much of their hopes on those motivational words because they found them very comforting. Although some expressed their happiness for the emotional support and instillation of hope they got through reading and reciting their bibles, others regretted their inability to know and quote some inspirational passages in the bible. Hence, they alleged that was responsible for their bad experiences with the mental illness during their previous episode.

4.2 **Summary**

According to young adults in this study the experience of mental illness affected different areas in their lives. The findings showed that there are areas of similarity and dissimilarity in their experiences. Being mentally ill was construed differently with some young adults describing it as an 'embarrassment', 'living in another world', having an 'abnormal brain' or 'abnormal illness'. Hopelessness and fear of the unknown are two overlapping themes that emerged from the study. From comments made by all of the young adults, several factors were associated with feelings of hopelessness and fear of the unknown; the illness itself and its treatment, the cultural environment with regard to the hospital and wider society, attitudes of families and society at large, loss of roles and economic constraint. Also, physical and emotional abuse dominated young adults' experience of mental illness. Families, health professionals and society at large were documented as the real perpetrators of abuse. Amidst their mental illness and its challenges, prayers and reciting the bible served as a good resource for emotional support, the instillation of hope and improved self-esteem. Notwithstanding the benefits of spirituality and religious faith, there were some aspects that demonstrated negative practice in relation to faith and spirituality. Apart from the positive impacts of spirituality and religious faith on their mental wellbeing, most young adults also mentioned how accepting them back into society, showing them love and care, and providing support, including financial support, to enable them to get back to their businesses and careers were considered imperative for their mental wellbeing. These findings are discussed in detail in the next chapter.

Chapter 5 Discussion

5.1 Introduction

The exploration of the lived experiences of 16 young adults diagnosed with mental illness and receiving treatment in a Nigerian psychiatric hospital has yielded a significant amount of data which has been analysed and organised into what, for the participants, are important themes. Within this chapter, the discussion will focus on the emergent themes and how they directly addressed the study aim and objectives and provide a platform for informing an improved clinical practice. This chapter will also contextualise the findings within the existing literature, with attention being given to the areas of similarity and/or divergence and would acknowledge the fact that participants in the reviewed studies are not all young adults. This chapter goes further to demonstrate the importance and credibility of this research by illustrating its unique contributions to knowledge.

The five most relevant themes from the study that are discussed in this chapter include; (1) Being Mentally Ill (2) Hopelessness (3) Fear of the Unknown (4) Violence and Vulnerability (5) Spirituality, and Religion Faith.

5.1.1 THEME 1: Being Mentally Ill

One of the major findings of this study, and an important one with regard to the provision of mental health care, was the meanings the young adults attributed to their mental illness. Young adults had trouble and struggled while trying to articulate and make sense of their mental illness. This is consistent with the study of McCann *et al*. (2012) in which young adults were reported to have struggled while trying to make sense of their conditions. However, in this study, although similar issue was recorded but young adults were able to describe their mental illness using phrases and words such as mental illness, sickness of the brain, illness of the brain and problem of the brain. More specifically, some of the young adults interpreted their mental illness equating to having an *'abnormal brain', 'an embarrassment' and being 'in another world'*

5.1.1.1 An Abnormal Brain and Abnormal Illness

Many of the young adults who participated in the study equated their mental illness to having an 'abnormal brain' and/or an *'abnormal illness'*, with both phrases being used interchangeably. The meaning they attributed to their mental were influenced by external factors such as culture, symptoms of the illness, previous exposure to mental illness and contact with people who have had a similar illness. While some of the participants used the phrases abnormal brain/abnormal illness to portray this as the casual factor of their mental illness, others related the words to the effects of their mental illness and its impact on their lives. The language used would suggest participants associated a biological connotation with their mental illness, but there was also a cultural influence.

In Nigeria there is a popular belief that some families are cursed with abnormal brains which makes them more prone to mental illness (Okpalauwaekwe *et al.,* 2017). Others believe that those who suffer from mental illness are people who have weaker brains and cannot withstand any form of stress (Okpalauwaekwe *et al.,* 2017). While a *'weaker brain'* would need further definition and explication, an inability to cope with stress, is in keeping with Western notions of this being a major cause of mental illness in young adults (Elliott *et al.,* 2011; Naeem *et al*., 2012; Gomez-de-Regil *et al.,* 2014). For the participants in this study while they were cognisant of the reality of their mental illness and its consequences, especially with regard to how it affected their general functioning, they were not able to understand why and how their mental illness had developed. However, participants tried to make sense of their illness based on, the duration of their illness, symptoms they experience, its impact on their lives, and the type of treatments they received. In trying to articulate their mental illness in this way, it was evident socio-cultural forces came into play. Patients referred to how their communities and wider society regards people with mental illness. Lasebikan (2016) suggests the way in which patients describe and make sense of their symptoms is an important indicator of the way in which culture affects mental illness, with symptom presentation varying among cultures.

In Nigeria, 'brain fog syndrome' was first described and conceptualised among the Yoruba sub-culture as cognitive impairment because it was believed to be responsible for; disruption of sleep, lack of concentration, and short memory among high school and university students (Ola *et al*., 2009). Within this study, evidence shows that symptoms of mental illness do not only vary across cultures, but also among those experiencing them. Young adults construed their illness symptoms as being different from their peers. This could simply be regarded as the uniqueness of their experiences. McCann *et al.* (2012) had similar finding in which you adults acknowledged that their circumstances were different, and the researchers concluded that it shows the uniqueness of their experience. Also, much like McCann *et al*.'s study, young adults based their understanding upon the fact that their symptoms have persisted for a long time and/or the illness prognosis being poor compared to what they have observed in others. By and large in the both studies, comparing their situations with those of their peers had similar implication. Firstly, such comparison gave young adults in this study the reasons to think they have 'abnormal brains' different from others which they believed to be the reason for their ‘abnormal illness’. Similarly, participants in McCann *et al*.’s (2012) resorted to questioning their identity with some asking themselves about why they are different and why they could not be the same as other persons in their age group.

Furthermore, evidence inherent in this study also suggests that the way young adults made sense of the meaning of their mental illness was largely influenced by the pre-existing knowledge they have gathered over time about mental illness. Having listened to stories about mental illness and associating with friends who have had similar problems, but who have recovered following a short period of treatment, participants were further convinced that their own illness was not ordinary, hence linking it to abnormal brains with abnormal illness. Nevertheless, this may have to do with how people interpret scenarios.

Ordinarily, one would expect that observing a positive prognosis of a similar illness in other individuals would be a source of strength for coping with their own conditions, but that was not the case here. For some young adults in this study it only increased their anxiety of having to deal with the hurdles of living with mental illness throughout their life time because for them such illness is not curable. Similar to the findings of Ola *et al*. (2009), young adults in this study also misconstrued the impacts of their mental illness as evidence of their abnormal brains, with some of them believing that their inabilities to compete with peers in school and achieve day to day tasks as a clear indicator of this. Some of the young adults shared their experience of not being able to perform simple tasks or them taking longer than necessary to accomplish them.

McCann *et al*. (2012) have reported a similar finding, whereby young adults believed their condition to be beyond an ‘ordinary mental illness’ because they felt what they were encountering was much more challenging than a brief period of emotional problems which their peers encountered. Interpreting their inabilities to do certain day to day tasks led participants in this study to believe they had *‘abnormal brains’* suggesting a knowledge deficit of what mental illness in terms of its causes, treatment and prognosis. Participants did not know what treatments were available for their illness or how mental illness might impact on general wellbeing.

Consequently, the young adults experienced intense anxiety emanating from their inability to come to terms with their mental illness. Equating mental illness to having an abnormal brain and/or abnormal illness also appears to have had an influence on their beliefs about self and their capabilities. Participants’ inability to perform their usual daily tasks, retain information and function well, were practical markers they used to differentiate self from their peers.

Additionally, the long duration of their treatment without obvious sign of recovery partly informed their description of mental illness as an *'abnormal brain resulting in abnormal illness'*. This resonates with the assertion that illness perception is a product of a cluster of factors including; what the individual believes caused the illness, how long it may last, what could be the consequences of the illness on the person's life, the associated symptoms, and how the illness could be controlled or cured (Petrie & Weinman, 2006). Experiencing mental illness in this way appears to have implications for the individuals' attitude to and compliance with treatment. Regarding attitude and compliance, treatment was problematic for young adults as three of them expressed their distrust of mental health professionals, partly as a consequence of believing their problems are inborn and cannot be cured with medication. This finding is also consistent with the report of (McCann *et al.,* 2012) in which recovery was conceived as an unachievable task due to lack of knowledge regarding their illness and not being able to explain why their own illness was different from their peers. More significantly in this study is the feeling of shame and embarrassment young adults experienced for having an abnormal personality different from others. Some participants (for example Unice and Amara) described having a mental illness as an embarrassment'.

5.1.1.2 Mental Illness is Like Being in Another World

Just like other sub-themes, this sub-theme encapsulated what the young adults said it felt like to live with mental illness. People who have had experience of mental illness always seem to differ in their description or interpretation of what it feels like to live with mental illness, however, this also indicates the uniqueness of the experience. In previous studies, young adults described their mental illness in various ways with some describing it as a *'mystery', 'lost life'* (Guner, 2014), *'a vortex of hell, a nightmare', 'tornado' and 'devil'* (woodgate, 2006). Mental illness has also been described as a mediator of social relationships (McCann & Clark, 2004). All these reflect the stigma still evident towards mental illness. In this study, young adults likened their mental illness to being in *'another world'*. Hence trying to convey or relay to the understanding of others the difficulties of living and managing a mental illness. One of the important findings in relation to this subtheme is that even when the young adults knew they had a problem and require the help of others, they preferred to remain alone and isolated because they were afraid of being identified as a person with mental illness. This finding is in keeping with McCann *et al.* (2012) who reported that young adults isolated themselves from others to avoid exposing their mental illness and losing their relationships with them.

Likewise, in this study, avoiding others was considered to be a strategy to save themselves the embarrassment and shame associated with mental illness, and to prevent them losing the relationships they have with significant people. Erikson’s theory of psychosocial development highlighted that at stage 6, Intimacy Vs Isolation (18 to 40 years), the urge to form intimate relationships with people committed to love is always the top priority of an individual, and failure to achieve this may lead to isolation, loneliness and depression (McLeod, 2013). In light of this, it could be argued that there is a complex interaction of age-related factors and illness related factors. Not only were the participants in an age range whereby developing intimate relationships would have been important to them, they also had to contend with the impact of their mental illness and its associated shame and embarrassment which had the potential to hinder their relationships with others.

Another finding in this study suggests the way young adults felt about their mental illness was also mediated by method of treatment, containment, and medications itself. Young adults detested being restrained against their will during the acute stage of their illness. Restraint was considered punitive and very distressful. Although it was meant to be therapeutic and corrective, the outcome was contrary to its objectives. Recounting and reflecting on their experiences, the participants found restraint stressful, as they felt restricted, caged and disconnected from family and friends. This is consistent with Mayer *et al*.’s (2010) findings who, when exploring the experiences of a group of service users who were exposed to sedation, seclusion and restraint, reported that they detested restraint and seclusion as methods of containment and treatment, because they found it very distressful and also a violation of their human rights as it hindered their freedom of movement and communication. Likewise, in this study, young adults felt controlled, restricted, caged and could not enjoy their usual freedom of movement and association. Staying in a secluded place all alone without having contact with friends and/or family can be emotionally traumatising. Having to remain in a room, sleeping and waking every day in the same place was like being in another world.

Not only did the young adults feel disfranchised, they also believed their human rights had been infringed, as they could not do anything at will. In an environment with no functional Mental Health Act that protects those who are mentally ill, there remains a high risk of inappropriate containment, treatment and abuse of human rights. Participants appeared to be left to their own fate which partly influenced their description of being in another world. Some young adults also felt they were coerced and there was no room for them to get involved in their treatment. Involving the participants in their own treatment plans may have given them a sense of belonging and allayed their anxiety. Mayer *et al.* (2010), suggested that mental health service providers should be sensitive to the expressed needs of service users and where possible, patient’s preference for containment and treatment should be further discussed with them and their choices should be respected. This was an issue of concern for some participants in this study, as some of them preferred to be treated in the comfort of their homes or through outpatient service. Some of these issues bothering on treatments and impacts of mental illness appeared to have affected their hope of recovery. Hope as a theme is discussed in detail in the next section.

5.1.1.3 Mental Illness as an Embarrassment

Embarrassment typically happens when an individual feels he/she has failed to meet an acceptable social standard, leading to negative self-evaluation (Varshney *et al.*, 2015). In this regard, it could be argued that embarrassment is a social construct predicated on what society has judged to be a social standard. In this study, some of the young adults epitomized the meaning of mental illness being that of an embarrassment. This reflects the many issues young adults had faced whilst living with their mental illness. Embodying mental illness as an embarrassment was seen to have a direct association with the way they conceptualized mental illness as having an abnormal brain/abnormal illness. The young adults who construed their illness as an abnormal brain/abnormal illness felt embarrassed and were ashamed to identify with their peers because it portrayed them as having weaker brains and being different from their peers. In addition, participants pointed out several other issues including; symptoms, impact of the illness, adverse effects of their medication, attitudes of people, and cultural/societal interpretations of mental illness which constituted the embarrassment they experienced.

The impacts of mental illness have been widely researched (Rusch *et al.*, 2005; Gureje *et al.*, 2006; Bradshaw *et al.*, 2014) with many describing mental illness as an illness that affects every aspect of a person's life including their emotions, cognition, and behaviours. Participants in this study felt embarrassed as they remembered occasions where the symptoms of their illness made them act irrationally, such as dancing in public places, carrying lots of rubbish through the streets and speaking meaningless words. Moreover, some of the young adults felt a deep sense of guilt and embarrassment when they thought that they might have said or done something not socially acceptable during the acute stage of their illness. This reiterates the findings of McCann and Clark, (2004) and resonates with Erikson (1963) theory of human development. Erikson (1963) suggests that during the young adult stage (18 to 40 years), people seek to establish intimate and loving relationships with other people, but if anything interrupts the success of this stage it can result in isolation, loneliness and depression. For some of the participants this feeling was worsened by the actions of some family friends who avoided them, with some running away on sighting them, because they believed them to be dangerous and could harm them. This demonstrates the existent stigma in our society. Stigmatisation is fundamental to embarrassment, the latter often resulting from the internalisation of the former (Quinn *et al.*, 2015). Implicit in this situation, were the occasions where young adults participating in this study were openly and verbally stigmatised and embarrassed by their peers by refusing to allow them to join in a friendly conversation, calling them derogatory names such as *'mad'* or *'crazy person'*.

On a close analysis of mental illness been epitomized as an embarrassment, there are several reasons to justify it and these are contained in the data. In what appears to be a complex interaction of several factors including; how society regards and treat people with mental illness (Abdullah & Brown, 2011), and the cultural beliefs about mental illness (Bakare, 2014), the young adults were often pre- occupied with a sense of shame and embarrassment. Consequently, some of the participants in this study appeared to live under duress, trying to impress the society to which they belong and maintain their social status and self-esteem. However, this was not an easy task for them as most of the young adults seemed to have internalised the stigma. The implication of this was their self-confidence was compromised with several of the young adults becoming self-critical. This study showed that young adults were always self-conscious in a bid to ensure that how they speak, move, look, or laugh in the public domain do not portray the characters of a mentally ill person. This is particularly pertinent for young adults being in their transitional stage and in the early stage of their careers, therefore anything that interferes with their self-confidence and self-esteem is likely to have a negative impact (Ticusan, 2012).

Inherent in this study, was the fact that some young adults believed that ever since their illness started, they no longer felt able to exhibit their talents or skills in public due to fear of being identified and castigated as a 'mad person' because of their gestures. In other words, their self-confidence and self-worth were eroded, costing them their skills and talents. It could also be suggested that mental illness as an embarrassment may be long lasting remaining a problem in the life of the affected individuals. This assertion is predicated on the facts that some participants alleged some friends, family members and other members of the public continue to make some kind of gestures and utterances which are mocking or making jest of them because of their illness. However, some of the young adults also admitted that they were not sure if those gestures were meant as a caricature of them and also some of the verbal utterances could be a joke. Nevertheless, negative words or gestures have the potential to reinforce internalised stigma which can be experienced as shame and embarrassment. This study is also suggesting while people might recover from the symptom of their mental illness, its impact can be long lasting. This was reiterated by one of the participants (Chuks) who said that he 'has recovered but he has not recovered in his mind'. This is a metaphorical statement that could have several meanings. One such meaning could be that of internalised stigma which will continue to produce shame and embarrassment about having been mentally ill.

Furthermore, young adults did not find their medications very effect. The adverse effects of their medications were noted as being partly the cause of their embarrassment. Although such medication was meant to address the symptoms of their illness, achieving this was not without side effects, the latter accounting for the embarrassment of the young adults. Some of the participants recounted occasions where their medication had a paradoxical effect. Sometime, their medication diminished their symptoms, but the side effects of the medication produced worse symptoms which embarrassed them. For example, some participants said medication made them fall asleep in public places in the broad daylight, others said it caused their tongues to stick out, they had blurred vision, and/or loss of memory. Such embarrassment interfered with their social life. This finding is similar to that of Guner (2014), who established that young adults' social lives were compromised when they were heavily medicated. Others said they were not comfortable taking the medication, as it would be an embarrassment if their peers found out they were being treated for mental illness. An earlier study by McCann and Clark (2004) reported that young adults noted their mental illness and the side effects of their medications as a *'destroyer'* of social relationships with some of them going into hiding in a bid to conceal their illness, preserve their social status and maintain their friendships with people. In this study, findings showed that the shame and embarrassment brought about by adverse effects of medication, encouraged medication non-adherence. When the young adults felt embarrassment by their medications and this became unbearable, they considered stopping the medication. The implication of this was young adults experienced relapse, which caused them to be re-admitted in the hospital.

Although most of the causes of shame and embarrassment experienced by young adults seem to revolve around symptomatology, the impact of mental illness, side effects of medication and cultural issues surrounding mental illness. However, data from this study also demonstrates unsupportive attitudes and rude behaviour exhibited by some health professionals, spiritual leaders, and family members was partly responsible for the shame and embarrassment experienced by the young adults. Participants reported that there were occasions where they were abused by some professionals, reverend fathers and family members. They also recounted occasions when they asked the health professionals questions regarding their mental illness, but they were ignored, and it was *'embarrassing'* for them. The above actions made the participants feel humiliated and embarrassed. Also, the shame of been beaten and bullied publicly appears to have a lasting emotional effect on them as some of the young adults had the feeling that their peers and friends may have watched when they were bullied. This action trampled on their ego resulting to low self-esteem and the memory of such humiliation affected their social life.

Although, different things constituted the sense of embarrassment on the part of the participants, one commonality appeared to be the anxiety it generated. Living under duress, being self-conscious and losing self-confidence is a source of concern that needs to be addressed simultaneously while treating those who experience mental illness, as it could hinder the recovery process. For some of the participants experiencing such anxiety couple with their primary mental illness made them feel as if they were in another world.

5.1.2 THEME 2: Hopelessness

Loss of hope is another important theme that emerged in this study. Although, a number of research reports have identified an association between mental illness and hopelessness, (McCann & Clark, 2004; Pokharel & Lama, 2016; Zubair *et al.,* 2016), little has been written about how people with mental illness develop a sense of hopelessness. Central to the concept of hope is having expectations, goals, viable dreams and positive views for the future (Connell *et al.,* 2012). Hopelessness is conceptualised as a powerful emotion resulting from a negative assessment of one's circumstances. This often results in low mood and may negatively affect how an individual perceives self, his/her situation, others and wider society (Panagioti *et al.*, 2012). Loss of hope was commonly reported in this study with the majority of the participants demonstrating a sense of hopelessness. Their mental illness and its methods of treatment adversely affected how they appraised their present circumstances and future hopes. The sense of despair, entrapment and hopelessness in their mental illness was so profound that some of the young adults had considered suicide. There were occasions when the young adults felt they had lost sight of those things that instil hope, thus leading to a state of hopelessness. These feelings were influenced by several factors including; the methods of treatment, containment, prognosis and other social factors. These factors were organised into sub-themes, strengthening the overall theme.

5.1.2.1 Being Caged and Loss of Roles

A feeling of being caged was a cause for many young adults to feel hopeless. While hospitalisation is generally considered an important aspect of managing individuals who are experiencing mental illness (Papoulias *et al.,* 2014), new evidence in this study is suggesting that such practice can lead to feelings of resentment depending on the arrangement. Although the admission of the majority of young adults in this study was voluntary, their experiences were by all defined by seclusion. Consequently, most young adults expressed displeasures with their hospital admission, with some describing the situation as 'being in a cage'. This experience is similar to the finding of Ghafari *et al.* (2014) who found people with chronic illness experienced being in the hospital as being in a cage.

Similarly, Mayers *et al*. (2010) reported young adults expressed concerns over their experiences of seclusion and restraint during hospitalisation and described it as a punitive, rather than therapeutic intervention. As established in this study, young adults experienced their hospitalisation as disenfranchisement, due to their confinement which did not only restrict their freedom of movement but denied them their basic human rights such as; freedom of association, communication, work and the right to decide how to be treated. From this description, it would appear the hospital environment was not therapeutic. Papoulias *et al*. (2014) suggested social relationships, communication, a sense of belonging and a home like environment as being central components of a therapeutic environment. While hospitalised the young adults felt disconnected from families, friends, and from a familiar environment where they were used to carrying out their normal daily activities. Not having any familiar faces to communicate and share their problems which made them feel abandoned, helpless and more anxious. In a study by Mayers *et al.* (2010), patients reported feeling distressed during hospitalisation because they were separated from their families, friends and familiar environment. Having a family member, friend or being in an environment familiar to young adults would have given them some sense of security and expectation. This aligns with the definition of hope whereby it involves having expectations (Barut *et al.,* 2017; Connell *et al.*, 2012). Helplessness leads to hopelessness (Seligman, 1972). For the participants in this study, losing sight of what they had been hoping for would have left them with a sense of helplessness which eventually could have led to hopelessness. Pokharel *et al.* (2016) suggest hopelessness result from a negative appraisal of a system. The importance of family and friends in the discourse of a strong support system for people experiencing mental illness has been widely researched, with many echoing families and friends as being the key to achieving this (Griffiths *et al.*, 2011; Kuwabara *et al.*, 2007). Apart from the social support such relationships provide, it also gives the individual a sense of belonging which further reassures them that they have people who may be able to help them.

Barut *et al.* (2017), recently found a strong correlation between a sense of belonging and hope. The young adults in this study identified a need to be part of the outside world and maintain communication and connections with family and friends. While this finding is in keeping with the findings of Barut *et al.*'s (2017) study, there is divergence. While participants in Barut *et al.*'s (2017) study believed a sense of belonging is best achieved by being part of a family, friends, peer group, or a group of other people with mental illness, young adults in the current study did not see other people with mental illness as an important group to associate with, rather they saw other people with mental illness in the same environment to be irritating.

Again, loss of roles was associated with confinement, and this was acknowledged by most participants. Young adults felt that their confinement in the hospital with unfair restriction placed on their freedom of movement and activities prompted a disengagement from their normal roles and functions, such as attending to their businesses, schooling, looking after their children and nuclear families. Having been disconnected from the outside world, it became impossible for them to have insight into what was happening outside the hospital environment, creating further anxiety. This situation also appeared to have reduced their ability to see beyond their present illness and appear hopeless, with most of them concluding that their peers/contemporaries have *'left them behind'*. Some of the young adults also feared that they may never be able to compete with their peers again in terms of achievements. This finding is consistent with that of (Kuwabara *et al.*, 2007) in which young adults recovering from mental illness felt they have lost so many things and they are many steps behind their peers. Feelings of hopelessness also appeared to be a response to not being able to establish an expected date for their discharge, with most of them concluding that their lives have become useless. The uncertainty that surrounded their length of stay in the hospital added to their anxiety. This suggests that health care providers were not in regular communication with the participants, who remained ignorant of their length of stay in the hospital. Mayers *et al*. (2010) had a similar finding whereby participants reported inadequate communication between them and care providers thereby keeping them in dark cornea throughout their period of hospitalization. This finding brought to fore the importance of communication and role functions in the management of mental illness.

In service users' movement, communication was noted as an important factor, with service users demanding to be involved at every level in their care (Cohen, 1998). Involving people in their care has many positive implications for wellbeing. Apart from the patient enjoying the privilege of knowing what is happening in their own health trajectory, it equally gives them a sense of belonging which improves self-esteem and can instil hope which in turn may contribute to their wellbeing (Barut *et al.,* 2017). Moreover, McCann and Lubman, (2012) acknowledged the centrality of communication with the service users confirming that steady communication with care providers lead to satisfied patients.

Similarly, a person's role functions were identified as a key factor for mental wellbeing in this study. This is akin to the WHO (2004) definition of mental health whereby positive feelings and positive functioning are considered central to mental health. For the participants in this study, these important key factors for mental wellbeing were hindered. Although they realised their abilities and were willing to engage in their respective roles and use their skills and talents, their confinement and restriction in the hospital made it difficult for them to work productively and be able to contribute to their communities. Not being productive or contributing to their communities created a sense of hopelessness and low self-esteem. Implicit in this is that young adults considered their lives as being 'useless' and equated themselves to 'a dead person' with many saying, it is better they die now than living a meaningless life. This statement portrays their suicidal intension. Studies (Connell *et al.,* 2012; Barut *et al.,* 2016; Pokharel *et al.,* 2016) found a strong link between hopelessness and suicide. This therefore calls for more proactive measures in dealing with mental health issues. This may involve a review of the way mental illness is been managed. Currently in Nigeria, treatment of mental health issues is based on a narrow medical ideation with little or no attention being given to other factors that could further compromise their mental health.

Additionally, one of the findings from this study relates to current practises in Nigerian psychiatric hospitals that does not seem to have any therapeutic component. As a consequent, most young adults in this study showed preference for treatment at home where they can maintain touch with families, friends, and attend to their personal roles and feel a sense of belonging. Psychiatric treatment in the comfort of patients' home is now a common practice in most western countries such as UK (Johnson, 2013), however it is yet to be adopted in mental health services in developing countries like Nigeria. Nevertheless, there are conditions in which treating patients in the hospital is inevitable. Considering this, the concerned authorities and policy makers should focus on policies that would improve the wellbeing of people while on admission wards, with special consideration being given to patients' freedom and maintaining frequent contact with their natural environment. Firstly, health care providers should be trained to be sensitive and observant to patients' needs and try to prioritize them.

Part of being sensitive to patients needs is carefully listening to patient's stories and involving them in the planning of their care. In a study by McCann and Lubman (2012) participants felt satisfied with health professionals because they were given listening ear and professionals were approachable and supportive.

On the contrary, young adults in this study indicated care providers did not listen to their concerns and contributions and believed they were not *'sensible enough'* as to make any rational decisions. Making sure the individual does not lose contacts with the outside world, particularly in relation to their roles and functions, is also important. The finding in the current study suggest that separating or disengaging young adults from their occupation, roles, vocations and functions reduces their self-confidence, causing them to become self-critical and, at times renders them hopeless. Therefore, considering the complexity of this issue, adopting any admission plan that would acknowledge service users' roles and functions will help to improve their wellbeing while in the hospital.

5.1.2.2 Self-Critical

This study reveals a high level of self-criticism among young adults experiencing mental illness which appears to link to other behavioural issues that endangered the wellbeing of young adults. Self-criticism is a concept that has been widely researched in mental health with different findings emerging (Dinger *et al.*, 2015; Luyten *et al.*, 2007; McIntyre *et al.*, 2018). Initially, findings focused on the positive aspect of self-criticism, with some believing that self-criticism is a pre-condition for self-improvement and growth (Blatt *et al.*, 2010). This assertion was premised on the idea it is only when one courageously looks inwardly and identifies his/her flaws and accept/own them, that the individual will be able to take actions to correct or minimize mistakes thereby becoming a better person (Blatt *et al.,* 2010). While the above assertion may be right, the narrative may not be the same when mental health issues are present. Evidence emerging from the current study suggests self-criticism as one of the major causes of feelings of inadequacy, lack of confidence, low self-esteem and hopelessness. This is in keeping with other research whereby findings showed self-criticism is highly and likely to involve a more negative than positive impact (Shahar, 2016). Likewise, other researchers (Zahn *et al.*, 2015; Zuroff *et al.*, 2016; McIntyre, Smith & Rimes, 2018) recently implicated self-criticism in a variety of mental illnesses including; feeling of inadequacy, hopelessness, anxiety, eating disorders, substance abuse, personality disorder and suicide. However, the available literature is confusing about whether self-criticism is a cause or effect of mental illness.

In this study, although self-criticism was a prevalent issue because of its negative impact on the wellbeing of the young adults, it was difficult to establish whether self-criticism was a cause or effect of their mental illness. Shahar (2016) suggested that self-criticism could be a cause or effect of mental illness. This point may have been buttressed by (Dunkley *et al.*, 2012) who suggested growing up in a critical or emotionally abusive family was a strong predictor for an individual to become self-critical and it is likely to cause depression and other emotional problems. In light of this, it could be argued that self-criticism may be the actual cause of mental illness for some of the young adults. In this study, female young adults (Chinye) confirmed that as a child growing up, she never enjoyed parental love or care and attributed this experience as playing a part in the cause of her mental illness. A documented evidence also suggests that childhood experience of a person could have a huge impact on his/her mental health status later in later life (Fryers, 2013).

Nevertheless, other evidence documented in this study of young adults also suggests that self-criticism could emanate during the course of mental illness and its management. For some participants their mental illness and the process of hospitalisation played a significant role in the way they perceived and evaluated themselves. Where self-criticism exists, there is always an uncompromising demand for high standards in performance and achievement. For those who are not able to meet such high standards they may become hostile and derogatory toward the self and/or result in feelings of inadequacy (Shahar, 2016). Participants in this study who were not able to meet their set goals were left feeling unfulfilled and defeated. According to Zahn *et al.* (2015) a self-critical individual looks at everything from a negative perspective and prefers to accept the negative aspect of an event, attributing its positive aspects to others (Warren *et al.*, 2016). The young adults in this study accepted their mental illness as their own fault. This may have initiated feelings of guilt, resulting in self-directed anger in the form of self-abuse, with two of the young adults expressing they have attempted suicide and others expressing suicidal intensions. Zuroff *et al.* (2016) explained that as part of expressing one's feeling of guilt and inadequacy, the self-critical persons resort to self-abuse, condemning oneself and being harsher and unkind toward self than the individual would ever be to others. Participants' feeling guilty was occasioned by different factors including the belief that their inability to go out and work and earn a living was caused by themselves and it was affecting everyone around them. Other participants were concerned about their underperformance and lack of contribution to their family, believing that they were not living a life commensurate with their age, level of education and position in the family, giving rise to feelings of inadequacy. Appraising themselves negatively based on their inabilities to achieve the high standard goals they had set, left most of the young adults with a sense of failure, feelings of inadequacy, worthlessness, and hopelessness. This is in keeping with the study of Zahn *et al.* (2015) who found decreased self-worth, inadequacy and hopelessness co-occurring and a consistent symptom of those diagnosed with mental illness.

Regarding the above, a lack of knowledge appeared to have played a role in this situation. The young adults participating in this study lacked knowledge regarding the impact of their mental illness. Having knowledge of their mental illness could have helped them to realise that the symptoms of their illness, especially during acute stage, and/or the effects of their medication are likely to interfere with their cognition and could hinder their ability to engage in any meaningful roles. Their inability to realise that they were not in control of their illness or its management was the basis for owning negative outcomes and may have fostered their feelings of inadequacy and decreased self-worth. The feeling of inadequacy demonstrated by participants reflected their helplessness and inability to carry out certain tasks instigating a sense of hopelessness in them. Kannan and Levitt (2013) suggest self-critical persons do not only feel inadequate or have a sense of failure, but they also feel they cannot possibly live up to their standards or expectations. This is also evidenced in this study as some participants confirmed that they are not able to do what they used to do, and this would remain the situation in the future. This may indicate they have lost their will power or self-confidence. Other participants believed they never had what it takes to be successful or they had lost their skills and felt helpless.

According to Seligman (1972), repeated exposure to uncontrollable and aversive environmental stimuli leads gradually to the belief that the aversive situation is inescapable, and a sense of helplessness ensues. This implies that helplessness is learned by individuals (Liu *et al.*, 2015). They further explained that, it is the causal attribution formed by individuals in response to a negative life experiences that influence their feelings of hopelessness and may likely leads to depression. The young adults felt helpless due to their restriction in the hospital; it made them believe they had lost everything and did not know if they would ever regain their freedom and have control over their lives again. This situation could be construed as hopeless.

From the above findings, it could be argued that this poses a serious implication for the future lives of the young adults. As highlighted by Shahar (2016), one of the features of self-criticism is the fear of failure and/or disapproval by others. Hence, not wanting to fail or be disapproved of by others frightened and/or discouraged the young adults from engaging in their usual tasks or trying new tasks, thereby reinforcing their hopelessness and threatening their future. Given that feelings of inadequacy and guilt are both common features of self-criticism (Shahar, 2016) and hopelessness being rooted in the former (Zahn *et al*., 2015), it could be suggested self-criticism could be an indicator of suicide. Hopelessness and feelings of guilt have been strongly linked to suicide by the previous studies (Connell *et al.*, 2012; Barut *et al.*, 2016; Pokharel et al. 2016). In this study, although it was acknowledged that only two participants agreed that they have attempted suicide, many other young adults individually expressed their suicidal thoughts, with some of them saying they are 'tired of life' and 'it is better they die because life has become meaningless for them'.

A study in US by DeVylder *et al.* (2015) suggested that most completed suicides started with negative verbal expressions. Considering this, the management of young adults with mental illness should consider procedures that will address self-criticism. Healthcare providers need to be knowledgeable about self-criticism and its relationship with loss of hope. More importantly, having established a link between self-criticism and suicide, it is crucial that healthcare providers are trained to be sensitive towards young people who are self-critical and watch out for signs of suicidality.

5.1.2.3 Loss of Confidence in the Treatments

This study has also provided insight on how young adults receiving treatment for their mental illness lost their confidence and trust in their treatment. Although the aim of treatment for mental illness is to help alleviate symptoms and restore wellness (APA, 2006; Corrigan *et al*., 2014), the lived experiences of young adults suggests that this significant goal is not always achievable. Their loss of interest and confidence in their treatments was as a result of their negative experiences; ranging from ineffectiveness of the medication, side effects of the prescribed drugs, poor relationship between healthcare providers and service users, to duration or long length of time on the treatment. These factors have been identified in previous research (Bener *et al.*, 2013; Pareek *et al.*, 2013; Rao *et al.*, 2017) and were found to be the reasons why most patients fail to comply with their treatments. However, none of these studies reporting reasons for patients' non-compliance with treatments pursued the idea of how this may also constitute hopelessness for the service user. It is common for people to feel discouraged and loose interest in treatment if it is not meeting their needs or expectations. For instance, Okey was one of the participants who discontinued their medications because he felt it was not effective. Nevertheless, while hopelessness dominates this theme, factors relating to treatment that constitute hopelessness for young adults should be properly addressed.

While drug inefficacy, medication side effects, long term treatment and negative attitudes on the part of some healthcare providers may seem the principal factors that led to the young adults decline in interest and confidence in their treatments, strong evidence exists that lack of knowledge about their problems and its treatment played a central role. Implicit in this was the young adults' concerns over their prolonged period of treatment without any significant positive impact on their wellbeing. This finding is consistent with Guner (2014) who reported that participants were unsure about the course of their treatment. Medication ineffectiveness constituted a state of helplessness for the participants. Not knowing what to expect again from their treatment lead to a sense of hopelessness. This constituted a serious concern for the young adults with many of them concluding that their mental illness has no cure. Consequently, most young adults considered it more or less a waste of time to remain in a treatment that does not offer them any kind of relief in terms of their illness, with some of them preferring to remain medication free. This concurs with other studies of (Adelugba *et al.*, 2016; Pareek *et al.*, 2013) who found that inefficacy of medication is one the major reasons for non-adherence to treatment. Preferring to be medication free was also connected to the overwhelming side effects of their medication. A number of studies (Bener *et al.*, 2013; Rao *et al.*, 2017; Velligan *et al.*, 2017) reported side effects of medication as one of the reasons why people loss interest and confidence in their treatments.

Dealing with the overwhelming side effects of medication was a complex issue for them, in addition to their limited knowledge about their medications. These and other uncertainties surrounding their treatment led them to questioning the relevance of such treatments, and the consequential loss of confidence and trust in them. The decision to discontinue their treatment and to leave the hospital is indicative of their frustration and sense of hopelessness triggered by their negative experiences of treatment. Bearing the above in mind, efforts to strengthen young adults' confidence and build their hope in treatment should be a priority. Those experiencing mental illness need to be involved and well informed about their diagnosis, treatment and prognosis from the point of admission to the hospital. Unfortunately, this is not usually the case in Nigerian psychiatric hospitals. The experience of young adults suggests that the basic information that could have boosted their knowledge of mental illness and its treatment, such as the type of drugs often prescribed, its expected side effects, the duration of treatment, were not provided hence the young adults were left to battle with many uncertainties. (Tabler *et al.*, 2014) suggested that providing patients with relevant information and education about their mental illness is a central principle of mental health care. This was absent for the young adults' taking part in this study.

Although the young adults showed a strong interest in understanding their situation, they were not always given a listening ear. Implicit in this was how young adults recounted the negative attitudes of some health care providers towards them. The negative attitudes of some doctors and nurses towards the young adults each time they asked questions regarding their problems and medications indicated poor patient-professional relationships. Such attitudes may prompt emotional instability in the person seeking support. In a functioning relationship, the patients communicate their experiences and share important data, thoughts and feelings with their care givers who listen and observe closely to the patients' expressions of needs (Martin & Chanda, 2016). The reviewed literatures (Mayers *et al.,* 2010; Day *et al*., 2011; Guner, 2014) also established that patients felt unsupported and unsatisfied because doctors and nurses did not maintain good communication with them. Being ignored or not getting the desired response from the nurses or doctors made the participants feel abandoned. This is very worrisome considering that such attitudes of staff members have been reported elsewhere to contribute to loss of trust and lack of confidence in treatment among patients with mental problems (Rao *et al*., 2017). Acknowledging the negative implications of staff's negative attitudes regarding the wellbeing of young adults, suggests the need for a more therapeutic relationship between the health care providers and young adults. (Choy & Ismail, 2017) suggested that a cordial patient-staff relationship enhances patients' confidence in their treatment thereby helping them to keep hope alive. A similar study by McCann and Lubman (2012) involving young adults with mental illness also reported that participants felt happy and satisfied with their treatment because clinicians were *'youth-friendly'*. Working with the young adults and getting them involved in their own care plans could instil their trust in the care providers. It has been reported that when young adults were involved their treatment and therapies it facilitated their recovery, as a therapeutic dialogue was established with the young adults (McCann & Lubman, 2012).

There were other instances in this study where some young adults explained how trust and confidence eluded them because they were transferred to another care provider who was entirely new to them. Such unexpected change of treatment plan resulted in an overwhelming challenge to them, as they were not sure of the new person's skills and behaviours. Moreover, participants felt that there is relevant information about their health which the initial care provider has, but which the new staff might not know. Hence, young adults at that point were not hopeful about their mental health needs being met. The effect of such change was evidenced in the young adults' refusal to receive injections and other treatments from the new staff, indicating their lack of trust and confidence in the treatments and the practitioners. Acknowledging the role of trust or mistrust in building or destroying hope is important, and health care providers should always adopt an approach that could enhance confidence and trust of the young adults in their treatment for mental illness. This study provides evidence indicating the overarching role of trust/confidence in achieving hope that would help young adults to adhere to their treatment. This is in keeping with (Ozag, 2006) who established a strong relationship between trust and hope. The implication is that, trust and confidence reduce perceptions of threats and harm and encourages constructive and goal-determined responses from the affected individuals. Lack of trust/confidence heightens perceptions of threats and harm and reduces hope (Ozag, 2006). Yet hope is believed to be an enhancer of one's sense that he/she can cope with a problem. However, hope is not achievable without adopting such measures that can help to build young adults' trust and confidence during treatment. One of such measures identified in this study is to always involve the young adults in planning their own care. This is one of the key components of the service users' movement (Lakeman *et al.*, 2007).

Moreover, looking at this from a social perspective, and apart from it being the right of a patient to know his diagnosis and make choices regarding treatment, there are other benefits that are attached to it. Involvement of service users in their own care empowers them to be in control of their health. It also helps to cements the relationship between the service user and care provider which is important for building trust and confidence (Lewis, 2014). Evidence emerging from young adults' accounts of their problems also indicates lack of knowledge about their mental illness and its treatment constitutes part of their challenge. These includes; not knowing how the brain works, what to expect when they take their medications and how long will they need to be in receipt of treatment. Therefore, considering these issues raised by the participants, their involvement in care planning could provide opportunity for them to learn more about their mental health its treatment. In addition, engaging young people in their care planning may make them feel important, recognised, respected and supported which will in turn enhance their hope.

5.1.2.4 Lack of Support

This sub-theme provides an insight into the role of lack of support in young adults' experience of hopelessness. Having found loss of hope being a serious issue for young adults, there is also evidence suggesting that lack of support plays a role in their mental illness. The issue of lack of support and its impacts on the wellbeing of people living with mental illness have also been reported elsewhere (Carless & Douglas, 2008; Harandi *et al.*, 2017; Kinoshita *et al.*, 2013; O'Connor *et al.*, 2014). However, most of the studies reporting lack of support only looked at it from a relational perspective, only few of these studies throw a beam light on the impacts of lack of economic support, and the studies did not focus on young adults.

The evidence emerging from the young adults' lived experiences of mental illness suggests lack of economic support is part of a major challenge young adults' face either during or after hospitalization. McCann and Clark (2004) found hopelessness in young adults living with mental illness could often be related to lack of income. This is understandable considering their age as young adults places so much responsibilities on them. Being a young adult requires that the individual must start an independent life, begin a career, form and maintain intimate relationships, as well as lots of other responsibilities (Keller *et al.,* 2007). Living with mental illness as a young adult has been shown to pose a threat to achieving or meeting those responsibilities (Addington *et al.*, 2018). Mental illness is known to have many negative impacts on the socio-economic life of individuals (Bradshaw *et al*., 2014; Guner, 2014). Evidence in this study supports the above findings. The evidence also suggests that the impact could be more intense for young adults due to the responsibilities associated with this age range. Participants felt that their lives have been truncated and their ability to meet those expectations had been thwarted since they did not believe they were able to carry on with their business or work. In Guner's (2014) study participants considered their lives as a *'lost life'* because life had been unbearable for them. This was an expression of loss of hope related to their mental illness. Their sense of despair and hopelessness seemed to have worsened by some age-related characteristics. For instance, early adulthood can be a critical stage characterised by competition, with hopes and expectations often placed on them by family and society (Keller *et al.,* 2007). When a person becomes mentally ill these hopes and expectations might be thwarted, with young adults perceiving themselves as a failure and disappointment to families and society.

Similar findings were reported by Kuwabara *et al.* (2007) who stated participants expressed serious concern about meeting parents' expectations. Also, the competitive character inherent in their age group further worsened their hopelessness. For instance, it is common for young adults to compete with their peers either in school, business, skills acquisition and relationships and other achievements. Accordingly, the young adults repeatedly talked about their losses in business, achievements and their 'backwardness' in other aspects of life due to their mental illness. However, participants were aware that their mental illness was responsible for their economic difficulties and the tension generated from the thought that they have fallen behind peers made them feel more frustrated and hopeless. This also created an impression that for them it would not be possible to still meet up with their peers, reinforcing their hopelessness.

Nevertheless, it was evident in the young adults' interviews that their sense of hopelessness resulting from a lack of support comes from two major factors. Firstly, their inability to engage in their usual tasks occasioned by the overwhelming impact of their mental illness and long stay in hospital brought an economic woe upon them. This appears to be in keeping with the theory of social selection/drift which holds that mental illness is responsible for socio-economic inequality and not vice-versa (Elstad, 2001; Chandola *et al.*, 2003; Charles, 2007). Although, some young adults were keen to be engaged, the long-term admission to hospital denied them access to their businesses and other activities that could provide economic stability. Despite the fact that studies have shown that work is one of the major determinants of mental health and a social integrating force that is highly valued (Stuart, 2006), the facility where the young adults are been treated in Nigeria did not recognise its therapeutic importance. Being restricted within the hospital did not only deny the young adults the opportunity to integrate into society, but also denied them the freedom to work to support themselves and contribute to their families. Not having this opportunity may have eroded their self-confidence and self-worth which are the key factor for hopelessness. Working productively to support oneself and contributes to one's family or society is identified as a key component of mental health (Arbesman & Logsdon, 2011), therefore in the case of young adults participating in this study, one of the key determinants of mental wellbeing was missing.

Secondly, the negative impacts of being disengaged from work or business manifested in long term effects on the participants. This evidence emerged as young adults who were already discharged to the outpatient department also reported concern about their financial incapacitation. This is understandable because the same young adults who experienced the impact of mental illness, including the protracted hospitalisation, are discharged to a society without any form of empowerment. The significance of this finding is that young adults experiencing mental health problems understand recovery to be more than the mere disappearance of symptoms. For the young adults, recovery should affect every aspect of their lives including their economic life. It is not enough to conclude that a young adult has recovered from mental illness by the mere disappearance of symptoms. This reiterates Guner's (2014) findings where those living with mental illness conceptualised recovery as a lack of symptoms and ability to work, earn enough money to be self-sufficient, get married, and become part of a social circle or community. For instance, some participants when asked if they have recovered from their mental illness, admitted that they had recovered, however they also said that they had not recovered in their minds. This is a metaphor which if analysed could have several meanings including their sense of hopelessness. It may also relate to the fact that most of them complained that their businesses and other sources of income have suffered abandonment and/or been shut down due to their illness and protracted hospitalisation, and wished they had access to a grants or funds to help them start a new life. However, grants or funds were not accessible to the young adults despite the fact that most of them showed the willingness to get back to work or business. The thought of not knowing where to access funds to start their 'new life' reinforces their sense of hopelessness. Given that hopelessness is a psychological issue which can cause or result from mental illness (Ebenuwa & Obiunu 2011), it could be suggested young adults' psychological problems will continue to occur if the risk factors are not resolved from admission till discharge.

From the above findings, it can be reasoned that Nigeria's mental health care system is lacking in rehabilitation. Current literature about Nigeria's mental health care reveals it only reflects the narrow medical model which does not take account of other ways to resolve emotional needs (Ukwuka *et al.*, 2016). The irony of this is that the health care system ends up creating psychological problems while trying to manage psychological problems. Young adults come to hospital to have their mental health challenges addressed but go home with feelings of hopelessness resulting. Lack of a rehabilitation programme and other palliative measures limits the Nigerian mental health care system Adopting a more broad-based model could help to manage young adults' mental illness more holistically.

Based on the above findings, rehabilitation programmes and palliative care should be extended to cover the economic needs of the young adults. Such programmes have to be planned and implemented from the time of admission, through treatment, to discharge and follow up. As part of a rehabilitation and palliative care programme for young adults experiencing hopelessness due to economic challenges resulting from their mental illness, treatment approaches that will not encourage long time disconnection from their business or work place should be adopted. For example, young adults want to be treated in their homes where they can feel relaxed, have freedom of movement and maintain their normal life style. This will not only encourage contact with their businesses or works, but it will also help them to maintain contact with their natural environment. Additionally, where long term treatment in hospital is inevitable, young adults should be engaged in skill acquisition during their stay and where possible they should be engaged in some paid work such as cleaning, washing, trimming of flowers to help them earn some cash for themselves. Stuart (2006) in his study found employment to be an important stepping stone to recovery for people with serious mental illness. Apart from saving money to support themselves after discharge, earning money may give them a sense of fulfilment and improve their self-image which will in turn instil hopes in them. Again, young adults who will be hospitalised on a long-term basis for their mental illnesses are also asking for special funds to be set aside in the form of grants or loans to help them re-establish themselves on discharge. This kind of arrangement is common in western countries such as UK (NHS, 2018), however this is not currently available in Nigeria.

5.1.2.5 Conclusion

Loss of hope in mental illness reflects many issues young adults experienced in the course of living with and having their mental illness treated. Many issues arising from the illness itself and its treatment contributed to the sense of hopelessness felt by the participants. Within their perceived hopelessness they reported; being caged, having loss of roles, being self-critical, loss of confidence in their treatment and lack of support. While hopelessness manifests as a product of young adults' mental illness and its treatment, it also demonstrates a perception on the part of young adults being responsible for their psychological problems. This means, hopelessness can be a cause or effect of psychological problems. The implication of not taking measures to avert any sense of hopelessness arising from mental illness and its treatments may result in psychological problem continuing in young adults. More concerning the evidence presented link hopelessness with the risk of attempting or committing suicide among young adults. In addition, lack of hope means lack of expectation, and this may be encouraging young adults to discontinue their treatment. Bearing all these in mind, the mental healthcare providers in Nigeria psychiatric hospitals should adopt methods and programmes of care that can instil hope and address other psychological problems in young adults.

5.1.3 THEME 3: Fear of the Unknown

Fear of the unknown is another important theme that emerged from this study data. It encapsulates several issues that occupied the minds of the young adults throughout the period of their mental illness and which they could not find an answer or solution to. This reflected the emotionality of living with mental illness especially as a young adult. Uncertainties relating to mental illness reflects many issues impacting on their present and future life. It also related to unclear issues about treatments of mental illness as experienced by the young adults. This theme does have some overlaps with the previous theme of hopelessness in that some of the factors inherent in a sense of hopelessness feature in fear of the unknown. Fear of the unknown in mental illness can sometimes be difficult to understand as it can be a cause or an effect of mental illness. As garnered in this study, fear of the unknown curbs young adults' ability to undertake actions that could ameliorate both their present and future wellbeing. This overarching theme is discussed under the following subthemes; uncertainties about treatment, uncertainties about their future and stigmatisation.

5.1.3.1 Uncertainties about Treatment of Mental Illness

Fear of the unknown as captured in the main theme is the result of several uncertainties that surround mental illness and its treatment. The evidence in this finding appears to suggest uncertainty in illness occurs when there is an inability to cognitively construct the meaning of illness and related events. An earlier model of uncertainty in illness by Mishel (1988) posited that uncertainty exists when there is insufficient knowledge to make decisions. Whereas this assertion resonated well with the finding of this study, there is also evidence to suggest that chronic illness exacerbate the chances of uncertainty. However, (Wright *et al.*, 2009) suggested uncertainty can exist in both acute and chronic illness, as it occurs due to an individual's inability to cognitively construct meaning which may manifest as a cognitive stressor. Consequently, the person may experience a sense of loss of control and a perceptual state of doubt which changes over time.

Although young adults were still adhering to their treatments, they had doubt about the treatability of their mental illness. Their constant doubts over the treatability of their mental illness and what could be their fate if the treatments fail, ultimately defined the morbid fears young adults experienced. It is understandable for people to feel anxious or fearful if faced with a situation they feel they do not have control over. Although young adults were zealous about their recovery from mental illness, fear of not being sure about how much their medication and other treatments can help them to recover their mental health constrained their treatments. This aligns with Woodgate (2006) who also reported living in the shadow of fear is the essence of young adult's experience of living with mental illness. Living in the shadow of fear was not only associated with this issue, but also related to fear of return of their symptoms despite being treated which in turn interfered with their treatments. This means there was an element of uncertainty in not knowing whether their treatments can ameliorate their symptoms. Nevertheless, underlying young adults' fear in relation to treatments was their inability to get a clear answer to questions and doubts that have occupied their thinking. In other words, having insufficient information about how the treatment can help partly constituted the uncertainties which predisposed them to fear. This finding aligns with (Carleton, 2016) who posited that uncertainty is a perceived absence of information at any level of consciousness concerning a particular situation. This is reinforced in a study by Murphy *et* *al.* (2015) involving young adults with mental illness found uncertainties about treatments as a problem and linked it to participants' insufficient knowledge about their mental illness.

Although Carleton (2016) affirms that uncertainty results from perceiving situations with insufficient knowledge, in the current study uncertainties regarding treatments was associated not only with inadequate knowledge, but other factors came into play. These includes; previous exposure to people who developed mental illness before them, the socio-cultural belief about mental illness and its treatments, and already garnered personal experience from their own illness. All these factors were noted to have had some influence on the way they experienced and understood their illness. For instance, some of the participants' communities believe mental illness has no cure, others believed that mental illness has no permanent cure, leaving them with doubt about the treatability of their mental illness. However, regardless of these beliefs, there is evidence to suggest that young adults internalized them and influences how they think about mental illness. These and other socio-cultural beliefs appeared to have fuelled the uncertainties regarding their treatments for mental illness. The doubt which they have internalised is responsible for their fear of the unknown about their treatment.

Furthermore, having been in the hospital had exposed them to professional knowledge which believes that mental illness can be cured with the right treatments and medications. Young adults restated that although doctors and nurses reassured them about the treatability of their mental illness, their personal experiences so far did not appear to be confirming to the professionals' assurances. This is because from their self-appraisal, the treatments do not seem to have had any positive impacts on them regardless how long they had been on it. Hence, young adults were not sure of what to expect from their treatments. Their confusion was heightened as they brought to memory what they had observed in their respective communities about people with mental illness who never got permanently cured even with treatment.

On reflection, although some participants acknowledged that doctors and nurses reassured them of being cured of their mental illness, it cannot be guaranteed that all participants got the same professional knowledge. However, the professional knowledge may not have been enough as to let the young adults know how long they might need to continue with treatment. Murphy *et al*. (2015) reported that young adults who experienced fear of the unknown in relation to their treatments, associated it with their limited knowledge about them. In another study Anderson *et al.* (2013) reported that participants were uncertain about the treatability of their mental illness as they had little or no knowledge about their illness. In the current study, some young adults, for example Unice and Ugo, mentioned that one of their greatest challenges is their lack of knowledge about their illness and its treatments. Although young adults showed resilience in their efforts to remain and receive the required treatments for their mental illness, some of them were nevertheless plagued with the lack of knowledge and fear of the unknowns.

Significant in every uncertainty is the morbid fear that is inherent in it (Carleton *et al.*, 2007). This was found very challenging by the young adults in this study as it disrupted their ability to confront their situation and mitigate its possible future negative impact. When an individual is faced with threatening situations, one of two physiological reactions or responses, fight and flight, are involved (Öhman, 2008). The person either stays to fight the threat or flees in an effort to avoid it. In the case of the participants, these two physiological responses manifested. While some of the young adults reluctantly decided to accept and adhere to their treatments despite their fear, others discontinued their treatment several times which resulted in relapse and re-admission to the hospital. Woodgate (2006) reported similar findings. However, more significantly in the current study, is the continuous negative impact fear had on the young adults. The fear did not only impede their efforts towards ensuring continuity of their treatments, but it also affected their cognitive ability to take decisions that could alleviate their overall wellbeing. Given that fear is the basic cognitive process of all anxiety disorders (Carleton *et al*., 2007; Clark & Beck, 2010), it therefore implies that the young adults could have lived and battled with anxiety as a secondary diagnosis throughout their periods of treatments. Fear and anxiety are known to be interrelated and an emotional issue. Anxiety also interfered with young adults' sleeping pattern as they were always awake ruminating over the uncertainties of their treatments. The impact of this on their wellbeing could persist or even worsened if the situation if it is not acknowledged and addressed properly. Not being informed about their mental problems and a lack of counselling as part of their treatment were stated by the young adults as being responsible for their fear and uncertainties about their treatments (Unice, Amara, Ugo, and Onuji). If health care providers, including the nurses and doctors, find more time to talk with the young adults about their mental illness and their treatment uncertainties and fear will be more readily addressed it on time.

5.1.3.2 Uncertainty about the Future

Significant in the finding of this study were the young adults' feelings of loss of control over both their present and future life. Such feelings were not unconnected with their past experiences. Using their past and present experiences to appraise what the future may look like caused confusion for some of the young adults. For some young adults, although they were aware that they have a mental illness, they were not sure if their illness was going to last for a long time and/or whether their illness would limit the actualization of their goals. Others already had a rigid view about their illness, with some of them believing they had been diagnosed with a mental illness and it was going to remain a hindrance, stopping them from living their lives to the fullest. These beliefs prompted uncertainty among the young adults regarding their future lives.

Uncertainty occurs in a situation where there is limited knowledge (Wakeham, 2015). Therefore, uncertainty about the future as experienced by the young adults occurred because they were confronted by a threatening situation in which their current knowledge could not give a definitive interpretation with regard to its course, prognosis, and future consequences. Living with a illness which its cause is not truly known and its treatment and prognosis are not predictable was so challenging that some of the young adults decided to settle for 'nothing'. Settling for nothing implies not knowing what to believe about their problems and wellbeing. Looking critically at the uncertainty experienced by the participants, it does appear that it brings more uncertainty. This is because, the level of uncertainty expressed by some young adults in relation to the treatment of their mental illness, appears to be a foundation for uncertainty regarding their future. While the young adults were still struggling to resolve or find an explanation to address the uncertainty they perceived about their treatments, their attention was already drawn to the potential impact on their future lives. In essence, the study demonstrates a state of uncertainty occurring between the participants present state of ambiguity and the more future orientated unpredictability. Therefore, any effort to contain uncertainty in the first stage could help to avert subsequent uncertainties and ensure improved mental stability for the young adults, given that uncertainty has been observed as one of the major sources of fear and anxiety.

Worthy of acknowledgement is the role of knowledge deficit in the existence of uncertainties. Wakeham (2015) suggested uncertainty often exist where there is lack of knowledge about a particular phenomenon. Accordingly, the uncertainties expressed by the young adults are not unconnected with the insufficient knowledge they had regarding their mental illness and its prognosis. As acknowledged in the previous themes, participants had insufficient knowledge about mental illness, and some described this as their greatest challenge. A lack of knowledge with respect to illness and its related uncertainty was well described by Mishel (1988).

Although Mishel's model listed a number of issues that give rise to uncertainties in illness, all seemed to be embedded in knowledge deficit about the prevailing condition. The model suggests in the experience of illness, ambiguity concerning the state of the illness, complexity regarding treatments and system of care, lack of information about the diagnosis and seriousness of the illness, and unpredictability of the course of the illness and prognosis all interact in a complex manner to precipitate uncertainty in illness (Mishel, 1988). Whereas this model maybe regarded as a social construct, each of its components did manifest in the uncertainties expressed by the young adults in this study. In order to have a clear view of their present and future situation, young adults resorted to questioning their illness, doubting its treatments and considering the possibility of them functioning or being relevant again in society. For instance, some of them asked *"what kind of illness is this that does not respond to treatment?'* Others said, *'I don't think I will be able to function again as to complete my education, do any work to support myself and family or even marry again'*. This ultimately defines the cognitive representation they hold about their mental illness. However, as demonstrated in by the quotation uncertainty is subjective. Being subjective means that the level of uncertainty each young adult experienced or expressed was dependent on his or her level of knowledge about the existing situation. This also depends on the cognitive ability of each young adult to interpret events related to their illness. This was observed in the way they expressed the uncertainty differently.

More significantly, apart from knowledge deficit being an important factor in experiencing uncertainty in mental illness, it is also observed that duration of experience with mental illness manifested as an important determinate of how young adults expressed their fear of uncertainty. This was justified through the way and manner young adults expressed hope and hopelessness differently. Young adults who have had their diagnosis and treatment for a longer period of time were more negative about the future. It could be suggested that their years of negative experiences, coupled with prolonged treatment with no positive outcome, was responsible for their pessimistic outlook. In contrast, people with a shorter period of mental illness and in the early stages of their treatment were more optimistic about their future. This finding is in contrast to those of (Sweeney *et al.*, 2015) who reported that fear was particularly acute in participants who were experiencing mental illness for the first time because they did not understand what was happening to them.

Having difficulties in assigning credible possibilities to outcomes of their mental illness had many implications for the participants. One implication was that, young adults lived in enduring, emotional and confusing situations. This was observed as some of the young adults kept saying, they are 'just confused because they do not what to expect again'. Also, when young adults thought they were failing to take control on their future, they resorted to assigning a negative identity to themselves; believing that they were ‘not good for anything and never would be’, thereby lowering their self-esteem more. The finding also presents an element of fear of stigmatization in the future. This concurs with other findings Woodgate, 2006; McCann *et al.,* 2011) in which fear of being stigmatized was a major concern for the participants.

5.1.3.3 Stigmatisation

There has been consistent reporting on personal experiences of stigmatization and its distressing impact on people with mental illness (Martin *et al*., 2009). However, the finding in the current study appears to be slightly different from those in the existing literature. Fear of stigmatization emerged as one of the major issues facing the young adults while battling with mental illness. This appears to be slightly different from other findings in the sense that most previous studies focused on the immediate impact stigmatization had on the affected individuals, rather than the impact of anticipated fear. For instance, Sweeney *et al*. (2015) reported evidence of a climate of fear, while Woodgate (2006) suggested young adults who had a diagnosis of mental illness lived in the shadow of fear. These phrases have no explicit meaning, but certainly, it demonstrates the uncertainties that surrounded their illness which could include fear of future stigmatization and its negative impacts on their future prospects. However, the clearer finding that is common among the participants in the current study and the studies cited above is the decision taken by participants to withdraw from friends so that their relationships will not be affected.

Conversely in this study, although young adults reported experiences of stigmatization influencing some of them to hide their diagnosis and service use from friends, it does appear that the immediate consequences of stigmatization were not their major concern. Young adults were more concerned about the future consequences or threats of such stigma on their lives. The fear of future societal rejection may have been complicated by the fact that mental illness has a negative social image (Ahmedani, 2011). In this study, even though some of the young adults were hopeful of their recovery, they were also concerned the stigma would continue and affect their future lives. Therefore, young adults had the overt fear that their diagnoses could have a more damaging impact on their future lives than it is already doing. This finding resonated with previous findings (McCann & Clark, 2004; McCann *et al.*, 2012), who reported that young adults were fearful of being discriminated against by others who might know or suspect they had mental illness. In this study, fear of stigmatization occupies a central place in explaining fear of the unknown as experienced by the participants. This is because stigmatization is a known consequence that accompanies a diagnosis of mental illness (Henderson, Evans-Lacko & Thornicroft, 2013) and by the implication has both short- and long-term negative impacts. The short-term impact includes the loss of friends and discrimination when one is experiencing the illness (Woodgate, 2006; Sweeney *et al*., 2015), which in this study caused participants to go into hiding in a bid to save their relationships and maintain some respect. The long-term impact includes the fear that even if they eventually get healed, the illness will leave an indelible mark (stigma) which will continue to work against their future endeavours. The young adults believed everyone around them knew and would remember that they once had a diagnosis of mental illness. This is especially common in Nigerian society where there are multicultural and religious practices which influence the way Nigerians understand and address issues pertaining to mental illness (Adewuya & Makanjuoal, 2008).

In Nigeria, mental illness is highly stigmatized (Ssebunnya *et al.*, 2009), most people believing it runs in a family, it is a curse or punishment from the gods or possession by evil spirits, and it is not curable (Bakare, 2014). Others believe that once one is diagnosed with mental illness the person has become unproductive in life, and people with mental illness are dangerous (Bakare, 2014). Accordingly, it is arguable that these misplaced notions have become part of the beliefs of young adults about mental illness so as soon as they were diagnosed, they immediately internalized the stigma. Subsequently, the experience of stigma while living with mental illness served to consolidate the already internalized stigma to further complicate their situation. Moreover, having been in a society where people with mental illness are maltreated, disrespected, denied their right and above all experiencing social distancing (Stuart, 2006), young adults were always grappling with the fear of facing such challenges and humiliation. This was demonstrated by a couple of participants (e.g, Ozo, Chinye, Anya, Unice, Ugo) who expressed fear of the possibility of achieving or attaining a certain goal, believing that their illness had left a ‘bad mark’ on them which will continue to work against their lives. For instance, having accepted the notion that mental illness runs in a family some young adults questioned the probability of them getting married. Others doubted if they will still be able to pursue their chosen careers knowing that society has already formed a negative impression about their productivity. Furthermore, others were concerned about the possibility of being employed again given that society always regard people with mental illness as dangerous and would not want to associate with them. This finding is also similar with that of Sweeney *et al.* (2015) who explains inequalities towards those who have been diagnosed with mental illness are often subjected to.

Furthermore, it could be argued that the overt fear of the possible impacts of stigma on their future lives was much influenced by the idiosyncrasy of the age of participants in this study.

Having mentioned in the previous sections that young adults constitute the age at which an individual starts to take up some responsibilities, seek employment, live independently and develop intimate relationships the threat from stigmatisation presents a huge challenge.

Apart from the above, the negative implication of fear of stigmatisation is observed is concerning. Firstly, although participants appear to have prepared themselves in anticipation of the inevitable future impacts of stigma on their lives, they did so in a negative way. It made them feel that they are not good enough so that even when they had the opportunity to explore their illness and its prognosis, they were not interested. Secondly, the fear that they may not be able to attain their goals in life was presented as a constant source of anxiety. Such anxiety has been reported as a severe cause of mental distress (Sayce & Morris, 2007).

Furthermore, fear of stigma affected the young adults' confidence, and this kept them from trying certain things. Most of them could not boldly engage in certain activities or even make themselves available for other jobs when the opportunities arose because they do not always conceive the possibility of being accepted for the role. They were always afraid that not everybody will give them attention because of their known mental illness. For instance, one of the participants (Unice) who said she used to sing and dance to entertain her audience, said she can no longer do it because of the fear that people might misinterpret her moves and link it to her mental illness. Another one (Ugo) also said that he does not have the confidence any more to approach a girl he likes and express his feelings, because of the fear of being stigmatised. On another occasion, some young adults in an attempt to avoid the future impacts of stigma on their lives resorted to concealing their problems and medications from friends and significant others. Apart from the above implications, it is important to note that stigmatisation could have permanent psychological implications on the individual if the cause is not addressed. Breaking the circle of fear will involve educating and counselling the young adults in order to challenge some of the superstitious beliefs they garnered from the wider society. Additionally, some of the participants sometimes were in need of love, acceptance and support from their families and communities. Acceptance in this context is central to good mental health (Gilburt *et al.*, 2008; Slade, 2010). The sense of acceptance in the young adults will not only grant them inner joy, but also increases their confidence which will in turn encourage them to engage in various activities without the fear of stigmatization. In this regard, families and society need to be educated on the issues of mental illness and informed about the importance of their support, love and acceptance of any members of their family who may be living with mental illness. Discriminating against people with mental illness both at family and societal level will constitute an abuse of human right.

5.1.4 THEME 4: Violence and Vulnerability

The majority of participants in this study reported cases of violent attack against them when they were in the acute stage of their mental illness. Acts of violence acts towards people with mental health problems appear to be the result of bias, with some people, including families and health care professionals, accusing them as the main perpetrators of violent acts (Passos *et al.,* 2013). In the above section, it was noted that people with mental illness are often stigmatized because of the societal perception that they may be dangerous and violent. It could be argued that this long-standing superstitious beliefs about individuals with mental illness fuels these acts of violence as people could hide under such beliefs and be committing such inhuman acts against the mentally ill persons. Nevertheless, this study as in other studies (De Passos, Stumpf and Rocha, 2013; Kamperman *et al.*, 2014) there is evidence to suggest people with mental illness are more vulnerable to abuse from the family members, health professionals and society at large. This is discussed under two subthemes; physical and verbal/emotional/psychological abuse.

5.1.4.1 Physical Abuse

Evidence within this study demonstrates young adults living with mental illness were frequently abused physically, therefore suggesting people living with mental illness are vulnerable to physical abuse. This finding aligns with the findings of other studies (Passos *et al.,* 2013; Kamperman *et al.,* 2014) in which high rates of abuse against people with mental illness were reported, the researchers concluding this group of people are at greater risk of physical abuse than the public. Although, none of these studies specifically studied young adults with mental illness, stigmatisation and prejudice appears to be a common factor occasioning physical abuse against people with mental illness (Abasiubong *et al.,* 2007; Adewuya & Makanjuoal, 2008; Ukpong & Abasiubong, 2017; Okpalauwaekwe *et al*., 2017). Stigmatisation and prejudice influence how people judge or react towards those living with mental illness. The common misconceptions society holds about mental illness include, but are not limited to, persons with mental illness are dangerous, they do not have the capacity to make decisions for themselves, they are the cause of their problems, they are suffering because of their evils, and it is not curable (Varshney *et al.,* 2015). Choe *et al.* (2014) suggest that such beliefs do not only reinforce stigmatization but can also fuel acts of violence and abuse against people with mental illness. For example, in this study a few participants example (Amara, Unice, Chinwe and Ozo) spoke of the involvement of family, friends, a reverend father and healthcare professionals in abuse of young adults with mental illness.

Interestingly, and contrary to commonly held belief about people with mental illness being violent, the current finding suggests that individuals with mental illness are more likely to be victims than perpetrators of violence. This finding also aligns with other studies *(*De Passos *et al.,* 2013; Kaur *et al.*, 2009) which had evidence that led to the conclusion that people with mental illness are always more of the victims than being the perpetrators of violence in the society. This assertion was justified through the substantial evidence that emerged in this study. Young adults individually recounted occasions when they were *'beaten up, slapped, flogged, locked out of their houses or pushed out of their houses in the late hours of the night, and starved'*. Others also talked about how they were intimidated and forced into doing things against their will. Such things included; forceful treatment or hospitalization, cutting their hair and persuasion to do things against their wish. Some of the participants were also subjected to other forms of ill treatment such as being chained and/or locked in the house. Although it is not clear why such inhuman acts were meted out on them, it does depict stigmatization and prejudice. Chaining or using iron shackles to restrain individuals with mental illness is a common practice in African countries (Arias *et al.,* 2016; Asher *et al.,* 2017; Human Right Watch, 2012; Read *et al.,* 2009). This is often done with the intention of restraining them from wounding other family members or appearing in public places and causing injuries to others. Similar acts also take place in the hospitals, the kind of seclusion method applied to the young adults did not only constitute physical abuse, but also emotional abuse as it denied them both the freedom of movement and freedom of association.

Mental illness being a widely stigmatized health challenge, occasioned by several misconceptions (Kelvin *et al.,* 2007; Abiodun *et al.,* 2008; Henderson *et al.,* 2013), people easily commit such heinous acts due to the false beliefs they hold about mental illness. This is typical of Nigerian society, with violent attack and abuse of human rights against people with mental illness is often reported. Further, some of the young adults in this study reported being *'flogged' and 'beaten'* by their relatives or traditional healers. Although the motive behind such actions was not stated by the participants, however, Abasiubong *et al.* (2007) in an earlier Nigerian study explained that some people take such actions with the intension of driving away the evil spirit they believe is possessing the affected individuals. Whether there is truth in such a belief is not clear, but the truth remains that such actions amount to physical violence and abuse of mentally ill individuals. Examples of this are evident in this study, with two participants stating their families always beat them up, asking them to *'stop the madness'*. Another participant shared a similar experience involving a reverend father and a traditionalist. Such beatings may be carried out as a way of a cure for the madness or as a punishment for being possessed by evil spirit. However, there is also evidence to suggest that families and friends' actions towards the young adults were a deliberate act of abuse. For example, starving them, and pushing a person out of their house, especially in the late hours of the night, is an act of physical abuse that is likely to expose them to more dangers such as sexual assault, drug abuse or even suicide. Although none of these was reported, other studies in Nigeria have reported high rates of drug abuse, sexual abuse and suicide among people with mental illness (Abayomi *et al.*, 2013).

Furthermore, participants felt they were physically abused when they were forced to go to traditional healers and/or hospital for treatment. Although, treatment of mental illness in Nigeria is provided on voluntary basis, there appears to be forced treatment. Many of the young adults spoke of how they were persuaded and forced to go to a place of healing and/or hospital without their consent. Perhaps, such action was taken by their relatives in order to help the young person, but none-the-less such actions could be construed as abusive. Courtesy demands regardless of their health status adults should be involved about whatever decisions are taken regarding his health. This is one of the main objectives of the service user movement (Lewis, 2014). However, this was not recognised by families and health professionals dealing with the young adults participating in this study, thus, reflecting the common misconception that people with mental illness do not have the capacity to make decisions. The implication of this was evident as some young adults, for example Ozo and Chuks, resisted their relative's action to take them to a place of treatment. Unfortunately, such an attempt to resist the relatives' actions only earned them more beatings, leading them to believe that they are not in control of themselves.

The mental health system in Nigeria is such that it gives families excess power over the person who is mentally ill, even in relation to finance (Ndetei *et al.*, 2007). Accordingly, the affected person does not usually have the opportunity to make their own contribution towards their affairs. However, it is typical of adults to rebuff certain decisions if they do not consider it favourable for themselves, and this was the case with some participants in this study. When some of the participants tried to rebuff their family's decision over their illness, this was misinterpreted as being aggressive. The consequence was that their relatives usually mobilize other youths to forcefully take them to the place of treatment against their wish. Looking critically into such actions against the young adults, it could be argued that the defensive actions the mentally ill person put up against an unfavourable decision or action towards them are often misconstrued as being aggressive and dangerous. When the person who is mentally ill cannot launch a defensive action, it may indicate they are afraid of losing the support they get from the family and friends, or simply afraid of being attacked by this group of people; as were the young adults in this study.

A similar scenario was also experienced by the participants while in the hospital. Apart from the restriction placed on their freedom of movement while on admission which also amounted to physical abuse, a number of young adults, for example Unice and Amara, also recounted how the healthcare professionals joined in mistreating them. This finding highlights the vulnerability of people with mental illness regardless of the situation they are in. These people do not only face the attacks from the families and society, but also from the doctors and nurses. In Nigeria this situation may be the result of not having a functional law or policy that protects the rights or interests of individuals living with mental illness. There is an expectation that the role of health care professionals is to protect and advocate for those in their care with mentally ill, however the opposite was the case for some young adults participating in this study.

The physical violence experienced by the participants subjected them to emotional and psychological distress because they felt intimidated and stigmatised by all. The fear of being attacked either by family members, healthcare professionals and others, left them in a state of constant anxiety. According to Maslow (1943), the absence of physical safety due to war, natural disaster, family crisis, and child abuse, the affected individuals could experience psychological distress or trans-generational trauma. This assertion reflected much of the young adults' experiences. As part of protecting and guaranteeing the safety of young adults living with mental illness in Nigeria, there is a need to further educate families and the public about mental illness and how to care for individuals with such illness.

5.1.4.2 Verbal/Emotional Abuse

The result from this study documents verbal and emotional abuse experienced by the young adults with mental illness and the perpetrators of such abuse. Ordinarily, much attention is given to physical abuse, with verbal and emotional abuse being silent in the discourse of abuse of people with mental illness. However, that does not rule out the fact that verbal and emotional abuse of people with mental illness appears to be on the increase (Teasdale *et al.,* 2014; Thornicroft *et al.,* 2007). The reason for such neglect of verbal abuse may relate to the misconception that verbal abuse does not have consequences for a person's mental health (Gadit, 2011). Additionally, while physical abuse is more likely to leave wounds or injuries on the bodies of the abused persons, verbal and emotional abuse do not leave such evidence, hence making it difficult to be detected by any third party. However, for the participants in this study verbal abuse seems to be the most prevalent kind of abuse, a finding in keeping with other studies (Karni-Vizer & Salzer, 2016). Other similarities between the current study and the study of Karni-Vizer and Salzer (2016) include the following: Families are mostly reported as the main perpetrators of verbal abuse, followed by friends and others. Secondly, verbal abuse was mostly in the form of name calling, such as 'you are mad', *'you are crazy', 'you are good for nothing'*. Apart from name calling, other verbal abuse in the form of offensive language was used when; yelling, scolding, threatening, screaming, making judgemental and critical comments.

Regardless of the differences in the description of physical and verbal abuse, the both forms of abuse manifested similar consequences on the recovery process of young adults. Although some of the young adults only experienced physical abuse, the fact that most of those physical attacks happened publicly, they felt embarrassed and ashamed. Feelings of embarrassment and shame are typical examples of emotional problems (Tangney, 2002). Also, as discussed in the above sections, the feeling of resentment created in the young adults when they were subjected to inhuman acts was enough to cause them emotional pain. This was evident in one participant's interview, when she talked emotionally of remembering such embarrassment and shame saying, it *'takes her to an early grave'*. This statement implies that she has suicide ideation whenever she remembers all those inhuman acts meted on her. This further suggests that the emotional effects of physical abuse could be worst and long lasting than its physical impact.

Likewise, the young adults felt embarrassed and ashamed when they were publicly abused verbally. However, regardless of the commonality in the embarrassment and shame felt in both forms of abuse, the abusive words which featured in verbal abuse appeared to be more covertly hostile than the physical violence. As earlier stated in this subtheme, verbal abuse leaves no physical evidence unlike the physical or sexual abuse, however its emotional consequences appear to be as devastating as those of physical abuse. Verbal abuse is in the form of spoken words, is likely to be assimilated or internalized by those being abused, the negative words remaining in their memories and continuing to torment them. (Teicher *et al.,* 2006) also reported significant emotional distress in a verbally abused group of young adults, concluding that the emotional harm caused by verbal abuse could be worse than that of physical abuse. Moreover, verbally abusive words have been reported to be strongly related to emotional exhaustion and depersonalization (Sprigg *et al.,* 2007). This could even be worse for people who are already self-critical. For example, in this study the young adults recounted how judgemental and critical comments made them feel as if they were *'the cause of their own problems'*. Others reported that they felt depressed when judgemental and critical comments were made about them. This suggests that physical and verbal abuse can also be experienced as emotional abuse. Also, emotional abuse may occur simultaneously with physical and verbal abuse. This implies that the perpetrators of physical and verbal abuse are also those who initiate emotional abuse knowingly or unknowingly.

Nevertheless, the emotional abuse experienced by young adults in this study was not limited to the effects of physical and verbal abuse. There were occasions when young adults felt they were snubbed, ignored, or being excluded from a discussion or gathering. According to transactional analysis theory, ignoring is the worst thing you can do to human being (McLeod, 2013). Porcere *et al.* (2006) described it as a refusal to acknowledge or see an individual and his/her personal needs by those in the position of control. This could basically be described as a covert way of banishing or sending someone away (Porcere *et al.*, 2006). The act of snubbing or not listening was mostly the behaviour of healthcare professionals and family members. However, it is important to note that ignoring creates the same feelings as being physically abused because it triggers the same region of the brain as physical pains (Karakurt & Silver, 2013). Doctors and nurses behaving in this way worsened their negative experience of the mental illness. However, snubbing or not listening to the young adults appeared to have a more negative impact on the young adults when health care providers were involved. For instance, some participants emotionally pointed out that they felt like dying when doctors and nurses ignored their questions regarding their mental illness. Wishing to die after being snubbed by care providers was an expression of the emotionality of such silent action. Perhaps, young adults felt belittled, disrespected or embarrassed. It is also possible that ignoring or not responding to their questions left them with feelings of helplessness and hopelessness. Those who were snubbed or ignored by their own family members reported feelings of depression and sleepless night. Snubbing or ignoring has been cited as a silent way of abusing someone emotionally (Karakurt & Silver, 2013). Theoretically, in terms of transactional analysis, ignoring is the worst thing you can do to somebody because of the emotional it precipitates (McLeod, 2013).

Being excluded from friends and family discussions or gatherings also had an emotional impact on the young adults. Apart from the embarrassment and shame such action caused them, it also left them with feelings of insecurity and being unloved. The young adults may have believed that such gatherings or discussions were used to discuss them and their illness, hence their exclusion and consequent anxiety.

In summary, the findings within this theme suggest young adults with mental illness in Nigeria as a vulnerable group, who need the protection and support of their families, friends and healthcare professionals, rather than being condemned by such people. Although, there is evidence (Rueve & Welton, 2008) suggesting it is the stress mental illness produces in families that leads to aggression and violence against the affected individuals. However, evidence also abounds regarding culture and stigmatization being the primary cause of violence acts against people with mental illness (De Passos, Stumpf & Rocha, 2013; Varshney *et al.*, 2015). But regardless of the cause, the findings of this study suggest an important need for family psycho-education. Such interventions have been found effective elsewhere (Lucksted *et al.*, 2012; Reinares *et al.*, 2010). Such interventions may enlighten families and friends of the importance of loving and providing support for those experiencing mental illness. As evident in my findings, participants expressed their need to be loved, accepted and supported by families and society. Love is considered an emotion needed for self-esteem and self-actualization. This implies that every individual needs to have a sense of acceptance, belonging and love for him/her to achieve self-esteem and attain self-actualization (Maslow, 1943).

In Nigeria healthcare professionals should also be made to undergo further training to familiarise themselves with such theories in order to engender new understandings and new skills to better support people with mental illness. Above all, it is imperative for Nigeria to have an effective mental health policy that would protect people's rights and ensure the safety of young adults with mental illness.

5.1.5 THEME 5: Spirituality, and Religious Faith

Spirituality and religious faith played a central role in the recovery from mental illness among the young adults. The findings demonstrate religion and spirituality are used as coping strategies among young adults with mental illness. There is a wealth of existing literatures (Dein *et al.*, 2012; Geppert, 2009; Koenig, 2007; Koenig *et al.*, 2012; Nolan *et al.*, 2011; Pearce *et al.*, 2015; Salsman *et al.*, 2005) reporting a positive relationship between spirituality/religious faith and mental health. In the literature relating to young adults' mental illness, this study is among the first to report the relevance of spirituality and religious practice among young adults living with mental illness, specifically pointing out areas of importance in their faith that positively influenced their wellbeing. Evidence emerging from young adults' experiences revealed the majority of them used spiritual beliefs and religious activities to cope better with their daily challenges. Praying, reading and professing the words of the bible and other religious books promoted their wellbeing, instilled hope and made them feel more positive about life. Relevance of prayers and bible readings as a good resource for managing mental illness is discussed in detail below.

5.1.5.1 Praying to God Promotes My Wellbeing

Contrary to commonly hold views about religion and mental illness (APA, 2013), evidence emerging from this study indicates that spirituality/religious faith is a strong source of hope and promotes strength and resilience for young adults with mental illness. As part of their coping strategies, praying was found to have a positive impact on their recovery and general wellbeing. This contrasts with some previous assumptions in which religion was stereotyped as a defence against childish helplessness (Jones, 2007), or diagnosed as a form of mental illness (APA, 2013). Young adults in this study provided evidence that clearly illustrated how prayers formed an integral part of their survival strategies. For them, prayer is a therapy that they believed should be combined with their medications.

Although it was revealed in the participants' interviews that some of them have had experience of other non-western treatment methods, including herbalists and native doctors, before coming to the hospital they did not find them helpful. Utilizing non-orthodox methods of treating mental illness, has been reported in previous studies in Nigeria (Abdulmalik & Sale, 2013; Adeosun *et al.*, 2013; Aghukwa, 2012; Aniebue & Ekwueme, 2009; Lasebikan *et al.*, 2012; Odinka *et al.*, 2014 Oyewunmi *et al.*, 2015), all of them suggesting people with mental illness often have their first contact with non-orthodox treatments before accessing western treatments. However, in the present study evidence indicates that young adults did not independently seek non-orthodox treatments, but this action was taken on the suggestion and/or persuasion of their relatives. Nevertheless, when comparing their experiences, the majority of participants expressed a dislike for every other treatment method but verbalised an expressed acceptance for prayers and medications. Prayers were particularly considered more effective over other non-western treatment as it offered them emotional relief whenever they say their prayer or echoed Amen to prayers. In the few studies available regarding young adults' mental illness, only two studies (Guner, 2014; Hailemariam, 2015) report young adults with mental illness perceive prayers as one of the facilitating factors for their recovery. However, a larger body of literatures (Chidarikire, 2012; Geppert, 2009; Hefti, 2011; Pargament & Lomax, 2013; Simão, Caldeira, & de Carvalho, 2016) identifies the positive effects of spirituality and religious faith on people experiencing emotional or psychological challenges. Most importantly, the findings of these studies indicate prayers were frequently reported to be effective in the management of anxiety, depression and other emotional issues. Likewise, in the current study, evidence inherent within the young adults' subjective accounts highlights numerous emotional and psychological benefits they derive from prayer.

Although it is not totally clear how prayers worked in helping the young adults, their personal accounts showed that talking and invoking the name of God in prayers, either individually or collectively, earned them a sense of connectedness to God whom they considered a higher being. For some young adults, that feeling of connectedness with the higher being is presumed a source of strength, as it instilled hope in them thereby enhancing their emotion wellbeing. For others, the feeling of connectedness strengthened them, thereby encouraging them to believe they could overcome their mental health issues. This suggests that prayers enhanced their resilience helping them to cope with the daily stress and difficulties of living with mental illness. Given the fact that the participants were already battling with hopelessness, fear of the unknown and other emotional issues that increased their anxiety, connecting with a higher being through prayer strengthened their sense of self-confidence, self-esteem and elevated their hopes. Connecting with a higher being may have also given them a sense of being loved by the divine. The feeling of being loved by a supernatural being may be particularly important given that the young adults were already plagued by stigmatization, discrimination and shame. Through prayers they secured an attachment to God who perhaps at that time was more accessible than mortal beings (family, friends, health professionals), and one which provided a positive self-attribution reinforcing personhood. Moreover, the positive effect of prayer was experienced beyond the alleviation of negative emotions.

Coming together every morning to pray fostered the young adults' social life as such a gathering usually gave them the opportunity to interact with one another. For some participants this particularly element of their care contributed to their satisfaction with the care services and their willingness to remain in treatment. This might suggest religious involvement is an important way of social networking for young Nigerian adults with mental illness. This supports the finding of Pargament and Cummings (2010) who suggested people with mental illness who engaged more in public religious activities reported a larger network of social relationships with more social support. Notwithstanding the positive social impacts of such religious gatherings, two participants (Chinwe & Madi) did not appreciate the social benefits of such a gathering on the ground that they did not like 'the faces and behaviours of other patients that often attend the same prayers. This may be regarded as stigmatization among patients themselves. This type of stigmatization in a religious group is different from the one described by (Huguelet *et al.*, 2006) in which people with mental illness are found to experience indifference from their religious group. Two of the young adults in this study verbalised stigmatization and discrimination on their part against others during prayer meetings. Nevertheless, both forms of stigmatization during religious gatherings had similar negative impacts including, attempting to withdraw self from such a group and those individuals affected may have felt spiritually unsatisfied.

Another significant finding within this study is prayers as a determining factor for compliance and satisfaction with professional treatments, especially for those in the hospital. Inherent in this was how some of the participants affirmed that their prayers are as important as their medications. Prayer was construed as a form of therapy because of the emotional support it offered the participants. Hence, some of the young adults believed apart from their medications, communicating with God provided relieve hence, they believed medications and prayers are both important for their wellbeing. Those whose prayer needs were met adhered to and expressed a willingness to complete their treatments. However, participants who felt that their prayer needs were not met opted to leave the hospital and go to where they felt such can be achieved. It is important to note that such a decision to leave the hospital on account that their spiritual needs were not met does not indicate preference for spiritual healing over orthodox treatments. Therefore, this finding differs slightly from previous findings regarding the practice of non-orthodox treatment for mental illness in Nigeria (Odinka *et al*., 2014; Oyewunmi *et al.,* 2015), Ethiopia (Hailemariam, 2015), Ghana (Arias *et al*., 2016), and Uganda (Nsereko *et al.,* 2011) in which high patronage of non-orthodox treatments was reported and linked to peoples' preference for it over western treatments.

In this study, although young adults practiced spirituality and religious faith, they never regarded it as a standalone treatment for their mental illness, rather it was always perceived as a co-factor for their mental wellbeing. The decision to comply with their medications and prayers is understandable, given that medications and prayers played different important roles in their recovery. Whereas medications helped to alleviate the symptoms of their mental illness, prayers proved important for the young adults' psychological/emotional wellbeing. Hence, the young adults talked of their need for prayers as much as medications, therefore suggesting the need to achieve a balance between biological and spiritual needs in order to maintain emotional/psychological stability. Nevertheless, this finding supports some aspects of previous findings in Nigeria reporting people with mental illness often place more value on non-western treatments first, however, where western treatments are inevitable, most patients would prefer to combine the two treatments (Jack-Ide *et al.,* 2013). Although, young adults did not appreciate the benefits of any other non-western treatments and did not show their willingness to patronize any of such methods as a standalone treatment, prayers were remarked as important in conjunction with their medications for their recovery. The young adults who did not feel satisfied with prayers attributed it to the manner in which prayers were being conducted; on daily basis while on the admission ward. Firstly, it was a general prayer made for everybody without any due consideration to the individual's denomination and the prayers did not contain all the rituals as they used to observe it in their various churches. Obviously, such could pose a challenge to meeting their needs, given that participants are from different church backgrounds, therefore, it is likely that each participant may have a particular pattern of praying in their churches. Moreira-Almeida *et al.* (2006) in defining religion recognized the idiosyncrasy in religion when they defined it as an 'organised beliefs system, practices, rituals, symbols designed to promote closeness to the supernatural being'. It is therefore imperative that these things are taken into consideration while offering prayers in order to satisfy people's spiritual needs. Bringing all of them under one umbrella of prayer may not satisfy everyone's religious and spiritual needs. This simply implies that, individualization is important when considering spiritual/religious needs of patients just as it is in other forms of therapy. For this reason, working in collaboration with patients' religious and spiritual leaders who may have to visit those during the acute stage of their illness to pray together with them could be construed as an important aspect of mental health care.

Although prayers demonstrated a good resource for coping in mental illness, evidence also recognises negative application of spirituality and religious faith, hence justifying an earlier claim that in relation to mental health both have merit and demerit (Chidarikire, 2012). A negative application of religious faith was demonstrated by some participants who confirmed that they have at some point during their illness discontinued their medications and relied on their religious faith. This group of participants equally reported having relapsed which brought them back to the hospital. Nevertheless, this does not mean that prayers cannot have a positive effect on their emotional health, it simply suggests that prayers cannot be a standalone treatment for mental illness.

5.1.5.2 Reading and Professing the Words of God

Similar to prayers, this study also identified reading and professing the words of God as being helpful. This finding has not been reported in any other study relating to young adults lived experience of mental illness. Evidence within this study demonstrates how young adults who engaged in reading the scriptures and other religious books experienced emotional relief beyond prayer. Reading and professing the written words in their religious books provided the young adults with a focus of what to live for.

Although young adults acknowledged they were diagnosed with a mental illness and were also aware of the damage such illness may cause both in their present and future lives, remembering the promises of God as contained in religious scriptures gave them inner strength and instilled hope. In practical terms the young adults described their faith as a source of strength and comfort throughout their period of mental illness. However, this might suggest while there could be health benefits intrinsic in religious faith, identifying a specific area of religious faith that impacts specifically on one’s spirituality and assisting such individual to make the best of it is paramount. Evidence in this study suggests being acquainted with one’s religious teachings is a needed prerequisite to enjoying health benefits inherent in it. Young adults who maintained strong ties with God through the reading of the bible and other religious books relating to their beliefs expressed hopefulness, demonstrated resilience and were more positive about their lives. However, this was seen to have worked in different ways for different participants. For some young adults, reading or listening to and meditating on some specific verses or passages in Christian books elevated their mood and instilled hope in them. For others, what worked for them was not just acquainting themselves with bible passages, but also having the conviction that they were living according to the scriptures, such as not quarrelling or fighting with people, living in peace with everyone, avoidance of alcohol, smoking, fornication, stealing and anything condemned by their faith. In this regard, having a positive self-appraisal about their relationship with God appears to have boosted their confidence and avoided the feelings of guilt. Also, preaching the words of God to others and being benevolent to people was spiritually and religiously fulfilling for some of the participants. Perhaps doing all that earned them the feeling that they have impressed God and they are in good term with God, therefore dispelling every feeling of guilt. This concurs with the finding of Pargament (2010) who argued for two kinds of religious coping; positive and negative coping. He explained that positive coping involves benevolent religious appraisal, forgiveness and living according to the principles of a person’s religion.

In contrast, not observing the teachings of their religion could mean disobedience to God and might leave them with feelings of guilt. Such feelings have been associated with poor mental wellbeing (Milstein *et al.*, 2010). This point was further buttressed through the comments of some participants who compared their experiences in two different episodes of their mental illness and had a strong reason to believe that the emotional trauma they experienced during the first episode was far worse than the second episode. Accordingly, these individuals felt they were not acquainted with God. They believed a deficit of such emotional support from verses in the bible, as it was not part of their lives, they little resource to support self during a time of emotional distress despite their religious affiliation. The same participants also felt they were not close to God and were not observing their religious teachings, generating a sense of guilt, as they resorted to calling themselves ‘sinners’ and believing that their mental illness was a form of punishment for their sins. Perceiving spirituality and religious faith in this manner constituted negative religious coping and its consequences were noted to include psychological and emotional instability and has the propensity to cause suicide. Implicit in this, is the fact that one out of the two participants who exhibited such negative religious coping attempted suicide and the second person had expressed suicidal intent.

This finding resonates with other studies (Ellison *et al.,* 2009; Koenig, 2009) who found negative religious coping involves activities and beliefs such as linking negative events to God’s punishment, venting anger at God, and feeling discontent with one’s religious. However, the same participants affirmed knowing or being close to God and being acquainted with inspirational/emotion lifting chapters and verses in the bible made a difference in their second episode of mental illness, hence reiterating the relevance of religious faith and spirituality in mental illness. This was also mirrored by other participants who implied that knowing God and being acquainted with all the inspirational passages in the bible did not only enhance their emotional wellbeing, but also helped them to maintain resilience while managing their illness. Reading those words and reciting them from time to time acted as a reminder about the promises of God concerning their lives, thus giving them more reasons to be resilient and optimistic about life. This is particularly important for the young adults, given that positive assurance words and talking therapy are recommended for people in other countries experiencing some emotional problems (National Institute for Health and Care Excellence, 2014). Reading, listening and meditating on the scriptures was equated to having a direct conversation with God by most of the young adults. For them, reading or listening to those words made them feel as though they were having one on one conversation with God. Such scripture passages appeared to be representing God Himself and each of the young adults believed that such words addressed their condition directly. For some young adults, such spiritual and religious practices helped them to allay their anxiety, increase their emotional strength, and avoided feelings of bitterness. Others confirmed that they felt blessed and comforted by God whenever they read any parts of their religious books addressing their emotions, hence providing inner peace and reduced anxiety. This is a positive outcome for the participants given that this study has identified hopelessness, fear of the unknown and other issues generating anxiety among the young adults. While psychological counselling was not made available to them, reading, listening or meditating using religious books compensated by addressing their hopelessness and allayed their morbid fear of the unknown.

In addition to the above, the importance of one's familiarity with his or her religious teachings was acknowledged. Participants who demonstrated more familiarity or more acquaintance with their religious books did not express hopelessness or fear of the unknown. These participants were also more optimistic about their future regardless of the fact they were aware of their mental illness but being knowledgeable of what their religious books said about such situations gave them the courage to believe their illness would not destroy their futures. This finding is similar to other studies (Chidarikire, 2012; Arias *et al.,* 2016) where faster remission and recuperation from mental illness was reported among those who were more religious minded. Using religion and spirituality to enhance one's emotional and personal mood represents a positive way of utilizing spirituality and religious faith, however (Blanch, 2007) argued that understanding issues in this manner cannot change the reality surrounding the problems. Although, the negative application of religious faith and spirituality sometimes compromises its usefulness (Pargament & Lomax, 2013), having a higher purpose made a difference in the young adults' ability and willingness to persevere in difficult situations and adhere to their medications.

Also significant in the study is the finding that all the positive impacts associated with religious faith and spirituality was experienced as a palliative measure. This further put the curative capacity of religious faith and spirituality in doubt and also challenges its reliability as a single treatment for mental illness. This finding conflicts with those of other studies (Barke *et al.*, 2011; Gureje & Lasebikan, 2006; Hailemariam, 2015; Nsereko *et al.,* 2011; Read *et al*., 2009; Hailemariam, 2015; Nsereko *et al*., 2011; Ae-Ngibise *et al.,* 2010; Barke *et al.,* 2011; Crawford & Lipsedgey, 2004; Gureje & Lasebikan, 2006; Read *et al*., 2009; Estrin, 2013; Carey, 2015) in Africa countries such as Nigeria, Ghana, Ethiopia, Togo and Uganda, where people with mental illness do not engage with biomedical treatments instead turning to spirituality/religious faith as the only means of treating their illness. The role of palliative spirituality and religious practice in mental health has been demonstrated both in the previous literature (Behere *et al.*, 2013; Hefti, 2011; Simão *et al*., 2016) and in this study. The emotional support, improved self-esteem, instillation of hope, and dispelling of fear and anxiety achieved by the young adults through prayers and the reading and listening to the words of God clearly defines religiousness and spirituality as palliative. This was reflected in some of the young adults' interviews who equated prayers and the words of God to their medications and stating they only needed their medications, prayers and the words of God in order to feel fine. In the light of this, prayers and the word of God (spirituality and faith) should be considered as a form of therapy that could be administered alongside medications when treating young adults with mental illness.

Although, in recent times, there was a call for spiritual and traditional healers to be officially and fully integrated into the mental health care system by some researchers (Gureje & Lasebikan, 2006; Horton, 2007; Saraceno *et al.*, 2007; Gureje *et al.*, 2015; Arias *et al.*, 2016) in Nigeria and Ghana, such recommendation was based on the level of patronage of faith and traditional healers by those with mental illness. Meanwhile, the patronage of spiritual and traditional healers was linked to the fact the majority of people have superstitious beliefs about the causes of mental illness and would often choose to seek help through traditional and spiritual means. Additionally, the profound lack of medical resources is partly the reason for the recommendation of initiating a partnership between spiritual/traditional healers and biomedical treatments as a way of ensuring that care is provided for those living with mental illness (Patel, 2011).

While the findings from this study also suggest the integration of spirituality and religious faith in the treatment of mental illness, the idea slightly differs from the previous studies. Previous studies undertaken in Nigeria (Gureje & Lasebikan, 2006; Horton, 2007; Saraceno *et al.,* 2007; Adefolaju, 2014; Gureje *et al.*, 2015) suggested the integration of traditional/spirituality/religious faith in the management of people with mental illness is based on different reasons. For instance, it is believed that non-orthodox treatment is in response to the peoples' beliefs (Oyedeji *et al.*, 2004; Falayi, 2014), it is affordable, accessible and considered efficacious for the people (Adefolaju, 2014)A, and therefore, it should be officially recognised and funded in order to encourage people to consider both treatment approaches. A more pragmatic view of this issue indicates poor government policies on mental health, lack of trained professionals, inadequate treatment facilities and the high cost of services perpetuate the high patronage of non-orthodox healing in Nigeria (Gureje *et al.*, 2015). It has been suggested that integrating the two treatment options would help to close the existing gap in Nigerian mental health care system (Gureje *et al.*, 2015). Making traditional/faith healing a recognised option of treatment for the purpose of augmenting the deficit in the mental care system of Nigeria and also for its curative benefits, rather than its palliative benefits as experienced by the young adults in this study may be useful (Gureje *et al.*, 2015).

Just like psychological therapies or counselling, spiritual or religious faith as a type of therapy played a significant role in allaying anxiety, instilling hope, boosting self-esteem and preparing the mind of young adults to accept the reality of their mental illness. However, caution should be taken when encouraging patients to practice spirituality and religious faith, given that negative religious coping strategies have been documented both in this study and in previous literature (Pargament & Lomax, 2013).

Although certain aspects of the young adults religious coping were considered to be negative, the benefits of spirituality and religious faith cannot be disregarded. Addressing this may necessitate the involvement of religious teachers in the management of people who are experiencing emotional problems. Also, meeting the spiritual and religious needs of every mentally ill young adult should be seen as an important role of care giving with specific emphasis on identifying the aspects of patients' religious faith that benefits him/her most. Furthermore, as evidenced in this study, methods of containment in the hospital posed a threat to participants' being able to express and practice their religious faith which may have indirectly affected their overall wellbeing. Some young adults felt that their method of restraint in the hospital did not allow them to fully explore their religious values. Being restricted in the hospital was mostly reported as preventing them from participating in their church activities where they could have had more time to communicate with God in their own religions' style. Hence some young adults were eager to leave the hospital, so they could have the freedom to practice their faith. This might be suggesting the need to have a mental health care system that would encourages the practice of religious faith and spirituality as a form of therapy while during their admission to a mental health resource.

5.2 **Summary**

This chapter has critically discussed the findings of this study exploring the lived experience of young adults with mental illness. Against a backdrop of existing literature, the findings of this study have provided new insights from the previously under researched African population, and more specifically the Nigerian population, thus demonstrating my unique contributions to knowledge. In the existent literature social support, being valued and having a sense of belonging, communication, clinicians being approachable and adopting a broad-based approach to care were considered important issues in enhancing the mental wellbeing of young adults experiencing mental illness.

However, in addition to these this study also identified getting answers to their questions, good understanding of their illness, financial empowerment, retention of role function, personal freedom, regular contact with families, friends and business, sense of being loved and acceptance by the society, assurance of economic support, treatment at one’s home and more importantly prayers and reading of religious books, as being particularly important to young adults diagnosed with mental health problems in the Nigerian context. The development of this knowledge will be important for achieving the much-needed mental health care reform in Nigeria. This study has revealed several factors impacting emotional instability in young adults living with mental illness. These include; attitudes of professionals, families, society and the associated lack of support; the illness itself and subsequent consequences, for example their ability to work and/or continue their business; a disruption to their usual lifestyle, for example not being able to carry out their religious practices; and some of the treatment procedures. Most importantly is the fact that the current practice of mental health care in Nigeria is lacking in terms of making sure those factors identified are appropriately addressed. Hence, the mental wellbeing of young adults is continuously hindered.

In view of the findings of this study, there is a special need for a treatment approach that supports young adults’ continuous pursuit of their goals in terms of; education, work, careers, relationships, skills and other personal developments. Also, considering the important roles spirituality and religious faith played in allying their anxiety, providing emotional support and instilling hope in them, any reform of the system must find a way of incorporating these two aspects of Nigerian life fully into the treatment plan of young adults experiencing mental illness. Most young adults felt dissatisfied with the level of spiritual and religious practice while in the hospital. Moreover, there were cases of human right abuses against the young adults living with mental illness, hence, reform at the policy level, requires enacting laws that protect human rights of young adults living with mental illness. Finally, findings suggest the need for policy makers to identify plans for helping to resolve losses, in terms of education, work and business, in order that young adults who have experienced mental illness may resume their chosen careers and subsequently their hopes and dreams. The next chapter will conclude this thesis by stating what has been achieved, contribution to knowledge, implications of the study, limitations, reflection and plans for future studies.

Chapter 6 Conclusion

6.1 Introduction

The aim of this study was to explore Nigerian young adults' lived experience of their mental health problems and to ascertain how they may have affected their mental wellbeing. The key objectives of this study were to explore young adult's lived experience of their mental health problems, to understand how young adult's lived experience of their mental health problems affect their mental wellbeing, to extrapolate what the enablers would be for promoting their mental wellbeing, to consider the above in terms of improving mental health care in Nigeria and to contribute original knowledge to the small body of knowledge regarding mental health in Africa and preventing mental ill health. To achieve this, a phenomenological research was used as this is an appropriate methodology where knowledge is poorly understood.

This final chapter will outline the key findings of this research based on the key research objectives, the implications for practice, and the study limitations. This will be followed by a reflective account of the whole processes of doing PhD, and finally, the contribution of the study to knowledge will be presented.

6.1.1 Key findings in relation to the study objectives

To Explore Young Adult's Lived Experience of their Mental Health Problems

This thesis has offered an in-depth exploration of how mental illness is experienced by young adults in receipt of treatment in a Nigerian psychiatric hospital. Several key issues that are potentially significant in mental health practice and social care have been illuminated. The study of young adults' lived experiences of mental illness revealed that most of the participants had encountered challenging situations, involving multiple factors and protracted worries.

To Understand how Young Adult's Lived Experience of their Mental Health Problems Affects their Mental Wellbeing

Those who felt that they had an abnormal brain which is more susceptible to mental illness also felt it is not curable. Certain factors such as culture, impact of the illness and what they have observed from those who have a similar illness all influenced their thoughts about mental illness not being curable. The consequence of this was that such individuals appeared reluctant in accepting treatment as they believed the illness has no cure and they had to live it. Conceiving mental illness in this way contributed to their isolation through their withdrawal from others as they believed the illness made them a lesser human being. The consequences of such beliefs led the participants to describe their mental illness as *"mental illness is like being in another world" and "mental illness is an embarrassment"*. Being an embarrassment also reflected how shameful they felt when recalling that they may have acted irrationally during the acute stage of the illness. It also reflected the way they were treated publicly without regards or respect for their human dignity by families and friends. Additionally, some of the participants believed that they were recognised as individuals with a mental illness, prompting self-stigmatizing behaviour and reinforcing their withdrawal from society.

Loss of hope in mental illness and fear of the unknown are other important themes that were highlighted in this study. These two themes overlapped in that they both revealed how different factors were associated with the illness; the system of treatment and socio-economic factors interacted to create anxiety for the young adults, further complicating their mental illness. Hopelessness was occasioned by the use of seclusion in the hospital, the young adults describing this experience as being 'caged' and leading to loss of roles thereby affecting their social and economic life. Other factors impacting their sense of hopelessness included; lack of support, self-criticism and loss of confidence in relation to their treatment. Fear of the unknown, and the consequential state of not feeling safe, arose through a number of uncertainties that emerged during the course of their mental illness. There was uncertainty about treatment, uncertainty about their future and fear of stigmatization. The latter was a serious source of anxiety as most of them were concerned that having a history of mental illness could affect their chances of completing their education, getting married, and securing employment.

Vulnerability as a result of persecution towards the mentally ill young adults is an important theme as it revealed how young Nigerian adults with mental illness were bullied and abused, physically, verbally, and emotionally. These abuses were committed by families, friends, health professionals, religious leaders and others. The young adults in this study felt vulnerable as most of them lacked the mental and physical capacity to fight back or resist some unfavourable decisions taken by others on their behalf. Those who had the capacity to fight back or resist, feared that their families and friends might withdraw their support from them, suggesting their vulnerability. The outcome of such abuses on their mental wellbeing was emotional and psychological instability further complicating their condition.

To Extrapolate What the Enablers Would be for Promoting their Mental Wellbeing

Treatment at young adults' own home or through the outpatient unit was preferred to being hospitalised. Young adults felt that receiving treatments in their own homes would not only ensure that they retain their freedom of movement but would also enable them to maintain contact with family and friends and retain their role functions. Additionally, the feeling of being at home would help to allay their anxiety.

Young adults also felt that being loved and accepted by family and wider society could facilitate their recovery and improve their wellbeing. This simply suggests that this group of individuals need to be protected rather than being discriminated against and abused. One of the most effective means of achieving this is to ensure their protection is embedded in mental health policies in Nigeria and that such policies are enacted.

Also, the young adults wished that they could access financial support from either their families or significant others that would enable them to get back to their businesses and careers after being discharged from the hospital so as to be achieve a level of financial independence and security. This is important given that recovering from mental illness should be seen beyond the disappearance of signs and symptoms.

Spirituality and religious faith and their relevance in coping with mental illness was another important theme arising from this study. This had two important subthemes; Praying to God as a means of promoting wellbeing; and reading and professing the words of their religious books. The young adult’s data regarding their spiritual and religious beliefs demonstrated the power of their prayers, religious books and slangs as they ‘re-energised’ the participants, instilling hope and promoting their wellbeing. This was particularly important given that young adults were already besieged by hopelessness and fear, hence their spiritual and religious involvement demonstrated a major source of hope and support for them. Also, praying, reading their bibles, singing praises to God, professing the words in the bible gave them a feeling of connectedness with the supreme God whom they believed had the power to alleviate their condition. Additionally, praying and reading religious books gave them a sense of calmness and helped them to remain in treatment. Also important in this finding is the fact that participants did not see spirituality and religious faith practices as a stand-alone treatment for their mental illness, but rather they affirmed that they needed both their medication and prayers to feel better. The relevance of spirituality and religious faith as presented in this study suggests there is potential to use them as a form of therapy that could be used in combination with medication if they are properly harnessed.

Although, young adults despised other traditional ways of treating mental illness and did not see spiritual and faith practice as a standalone treatment for mental illness, meeting their spiritual and faith needs was paramount to completing their course of treatment in the hospital.

Accordingly, young adults who opted to leave the treatment facilities or refused their medications were those who felt that their spiritual and religious needs were not completely met, perhaps due to the way it was always organised in the hospital. They needed their prayers and spiritual practices in the hospital to align with the traditions of their various faith and some of them wished to have one on one prayer with their spiritual leaders. However, given the fact that health professionals may belong to other faith groups different from patients' own, it may be difficult for them to meet such needs. This therefore calls for collaboration with religious leaders where and when necessary in the care of young adults with mental illness in order to close any existent disparity in the hospital meeting spiritual needs. This collaboration will not only ensure young adults do not wish to leave the hospital but might also bring them inner peace and prompt them to continue with other more contemporary treatments.

6.1.2 Implications of Study

6.1.2.1 Implications for practice

Having explored the lived experience of Nigerian young adults with mental illness with my key interest being in ascertaining impact of this and what the enablers would be for promoting their mental wellbeing and preventing mental ill health, some important issues have been unveiled.

This subjective account of experiencing mental illness is particularly important given the challenges people with mental illness face both in Nigerian society and within the healthcare system. This study is the first explorative study that has given voice to young adults with mental illness in Nigeria. Expert by experience, acknowledging lived experience as valuable as clinical or professional expertise (Lakeman, McGowan and Walsh, 2007), is a new concept in Nigerian mental health clinical practice. The importance of introducing such a concept needs to be acknowledged as it provides that receiving in-patient care the opportunity to put their illness into context, prompt appropriate treatment and has the potential to improve services. In addition, it will give service users a sense of being respected, listened to and supported as an individual. It is also such feelings that will enhance mental wellbeing.

Another important implication of this study derives from the finding about anxiety resulting from hopelessness and fear of the unknown on admission to hospital. These emotional issues mainly emerged during their hospitalization. For instance, their incarceration led to loss of roles, fear centred on uncertainty about the effectiveness of their treatment and being stigmatized. Sadly, for some of the young adults, these emotional issues were further complicated by the snubbing attitudes of some health professionals. In this regard, health care professionals need to take account of how their attitudes and behaviours contribute to the emotional problems experienced by young adults during hospitalization. Such negative attitudes and behaviour on the part of doctors, nurses and other health professionals need to be challenged, with their unacceptability highlighted within hospital policy.

Not knowing anything about their mental illness and its treatment made it difficult for the young to predict the outcome of their illness and how it might impact their futures. This remained a source of anxiety for the young adults which continually interfered with their recovery and wellbeing. Having health care professionals taking time and talk to them about their mental illness or be able to provide them with a simple booklet that answers frequently asked questions would help to allay some of their anxiety and enhance their wellbeing. Ignoring such important issues would likely increase their anxiety which could further complicate treating their primary diagnosis or cause new mental health problems. In light of this possibility it is paramount that healthcare staff address underlying issues young adults experience as part of their mental health problems.

Thirdly, in this study, spirituality and religious faith was identified as an important resource for coping with mental illness among young adults. Prayers and reading of the bible and other religious texts instilled hope in the young adults, thus helping them to allay their anxiety and a boost of their self-esteem. This actually demonstrated as an antidote for hopelessness, fear and anxiety that dominated the experience of the young adults. Health care practitioners' need to be aware of this as their involvement in assisting service users to have their spiritual and religious needs met could contribute to the success of medical treatments. Most of the young adults confessed that they need their prayers and their bibles as much as they need their medications, implying hospitalization that does not meet a service user's spiritual and religious may lead to non-adherence to treatment and/or the person wanting to leave the hospital. Accordingly, this finding suggests an integration of spirituality and religiosity into the care plan of young adults with mental illness and should be individualised and aligned with their traditional way of practicing their religion. While this may be difficult for health professionals to do given, they may not be acquainted with the traditional way of religious practice for every service user, it would require the involvement of religious leaders to carry out the religious rituals.

6.1.3 Implication for Policy

This study has raised an important issue regarding policy in the mental health care system of Nigeria. The findings in this study highlighted a number of human rights abuses against young adults living with mental illness. Their illness made them vulnerable to physical, verbal and emotional abuse. It also predisposed them to stigmatisation and discrimination. Also, human rights abuses took place in the clinical environment involving the health care professionals, relatives and significant others as the perpetrators without any report of them. With such violations of human rights happening to people with mental illness, the lack of mental health policy in Nigeria urgently needs addressing. The Nigerian government need to urgently develop and implement a functional policy that will protect the human rights and preserve the human dignity of people with mental illness.

The second implication for policy focuses on economic and social rehabilitation. Evidence revealed by the young adults demonstrated the challenges they face in getting back to their careers after discharge from hospital. Their mental illness coupled with their long-term hospitalization interrupted their economic and social lives, with most of them losing their jobs, businesses and skills There is a need for policy makers to enact policies that provide a whole system approach to recovery from mental illness, encompassing the maximising young adults' quality of life through social inclusion and encouraging independence and autonomy in order to restore hope and leading to a successful life in the community. As the majority of the young adults faced challenges starting their careers after they were discharged home due to unavailability of funds, policy maker should ensure availability of funds for people recovering from mental illness in order for them to re-engage with their studies and/or businesses and be able to make a valuable contribution toward society as well as having hope for their future.

6.1.4 Limitations of the Study

The first limitation of this study relates to sample and religion/ethnicity. The study included 16 young adults, and all were drawn from one cultural and religious group, and therefore are not representative of the Nigerian population of young adults who experience mental health problems. However, qualitative research places emphasis on the specifics of an experience, whilst providing readers with sufficient information about the research context to be able to make their own judgement about the transferability of its outcomes (Whitehead, 2004; Koch, 2006). To address this contextual information ranging from descriptions of interview settings to processes used for recruitment, data collection, analysis and write up were systematically presented throughout the thesis.

The inclusion criteria for this study stated participants must have recovered from their illness to a level by which they would be able to engage constructively in discussion with the researcher. As I have been based in the UK while undertaking my PhD and had not previously worked at the hospital where the interviews took place, I was reliant on gatekeepers (doctors and nurses), those who have knowledge of potential participants as they are in their care, to help with recruitment. Using such a process can be problematic in terms of bias as those clinicians may have nominated patients they liked most, or they knew would give account of the service, at the exclusion of others who may have been relevant for the study as well. However, using gatekeepers can prevent burdening those who are not at the time stable enough to engage in a constructive discussion, and if doing so may have experienced negative repercussions further compromising their mental health.

6.1.5 Personal Reflection on My PhD Journey

I know I have passion for education, but I never knew I could have the opportunity to further my education to PhD level due to perceived financial constraints. However, winning an unexpected Federal Government Scholarship to pursue my postgraduate studies including master’s and PhD in any University of my choice in the world made me to believe that it is good to have a burning desire for something even if the reality does not seem possible. Although winning a scholarship to pursue my postgraduate education to PhD level brought much joy to me and my family, I was besieged by anxiety.

From being happy to being anxious. Remembering that I had a heavy task before me without some commensurate skills to face it gave me much concern. Although I had completed a master’s programme in the UK but deep down in my heart, I knew that experience was not enough to undertake a PhD, especially given that its originality and contribution of new knowledge is key to achieving a successful PhD. However, I told myself that doing a PhD is a form of training as I am embarking on this journey in order to be mentored and coached to know what I do not know now. If I already have all the knowledge, I would not have the need to apply to study for a PhD and with this thought, my anxiety was reduced.

Going for my visa application was another moment of anixety. Getting a student visa was not a big deal because I had sponsors (TETFund/Ebonyi State University). When I received my visa, it suddenly dawned on me that I was going to be separated from my wife and my little daughter who was barely 6 months old, and I had become very attached to her. This constituted another source of anxiety, but I knew I had to leave them to pursue my career further. On the 23rd June 2015 I finally said good bye to them with smile on my face, but tears in my heart and my eyes.

Now, UK here I come, Manchester here I come, University of Salford here I come, PhD here I come.

Being a first year PhD student for me was characterized with many hurdles, uncertainties and anxieties. Although I had managed to draft a 5000-word proposal which was submitted before I was offered admission to study a PhD, I was still not sure how the whole thing was going to lead to a new knowledge. Before arriving in the UK, my supervisors had already scheduled our first supervision meeting, I was seriously overwhelmed by several uncertainties; how is the meeting going to be? Will my supervisors be friendly? What if they ask me questions on the topic, I have indicated interest in and I cannot answer correctly they might begin to look at me as someone who may not be capable to pursue a PhD. They might lose interest in supervising me. To my greatest surprise, during my first meeting with my supervisors, I was greeted with hospitality, the supervision meeting turned into a counselling session, and I met with people who were ready to mentor me to help me achieve my dream. During our discussion, the way they talked to me, how they outlined what I would be doing, how to do it and when to do certain things, made the process look simpler. However, nothing was actually removed from the task, but at least I was able to regain a little of my confidence.

Fear and anxiety gripped me again after I attended an orientation meeting organised for new postgraduate students. In that meeting, a lot of policy issues relating to the PhD and students' progression were discussed. Firstly, we were made to understand that for postgraduate research students we are expected to have an annual progression assessment during the first and second year before viva in the final year. The policy went on to explain that a student is expected to withdraw from the programme and step down to Mphil or master's programme if he or she fails to pass the assessment after a repeat examination. At this point the fear of failing and withdrawing from my programme became overwhelming. The only question that was going through my mind throughout that period was, what if I am withdrawn from the programme what will be my fate? What will my sponsor say? What about my job? How am I going to look before my family and friends? How am I going to face the shame? I will become a disappointment to my employer/sponsor and my family. This anxiety and fear remained part of my thinking throughout my first and second year. Nevertheless, I must confirm that being anxious and fearful of the task ahead had a positive impact on my study, the fear of failure and withdrawing from my study awoken the resilient spirit in me and I stayed active throughout my study. What I learnt from this is that fear or anxiety can sometimes serve as a positive factor to achieving one's goal. By the end of my first year I had acquired more skills for the task ahead. I had my Interim Assessment and the process was successful. It is was then time to go and do my fieldwork in Nigeria.

What is the source of fear this time?

The fear in relation to my fieldwork was interviewing young adults who are mentally ill. Although I am a trained nurse I have only had a few months experience of working with mentally ill people during my undergraduate days. Also, during my childhood, if our parents or senior siblings want to scare us or make us to stop crying, they would say they are going to call the mad person to come and beat us. Hence my mind was dominated with this stereotypical belief that people with mental illness are dangerous and violent. This belief remains common today, to the point where some of my close friends made jest of me planning to involve people with mental illness as my study population. Some friends told me to buy a helmet to protect my head since I am going to be interviewing mad people. Although for them, it was a joke, it actually reflects what Nigerian society, previously including me, think about individuals with mental illness. And this is where my reflection is derived.

In all sincerity, working with this group of people was an interesting and exciting experience for me. Interacting with them during recruitment, interviews and after the interviews greatly influenced my usual perception about them as I discovered that they were friendly, cooperative, open minded and appreciative. I listened to a group of people who had stories to tell, but no one to listen to them because of stereotyping they were exposed to. I saw people who desired having human relationships but were deprived of this because of stigma. I saw people who were always emotional because of their situations, but who had no shoulder to lean on. I concluded that families, society, individuals, government, policy makers and health professionals, including the nurses, have not done much to protect and improve the welfare of people with mental illness. Although there were occasions during the interviews when some of them became angry and some shed tears, those were the only signs of the emotionality of their situation which is a strong message that they need supports rather than being discriminated against. Hence, I begin to see people with mental illness as individuals who require psychological, emotional, physical, social, financial and spiritual support, rather than being regarded as dangerous and violent people.

6.1.6 Contributions to Knowledge

The aim and objectives of this study have been clearly accomplished with the following new knowledge emerging from it.

First and foremost is an exploration of young Nigerian adults' lived experience of mental illness does not exist within global mental health literature. Hence, this thesis being the first of its kind has provided evidence upon which further research can be built, eventually informing future reform regarding mental health care provision for young adults who have mental illness in Nigeria.

In particular, this study provides a clear understanding of how hopelessness and fear of the unknown can co-exist when a person experiences mental illness and how this impact on the wellbeing of young adults.

One of the key findings in this study is hopelessness in young Nigerian adults diagnosed with mental illness. Hopelessness as a co-existing characteristic of mental illness is a challenging issue that has been reported in many other studies. However, what other studies failed to report was an understanding of how it occurs from a service user perspective. As part of this study's contribution, factors and events that precipitated hopelessness in young Nigerian adults living with mental illness were revealed. Deficit knowledge of what mental illness is, and its possible treatments compromised their ability to predict the illness prognosis hence leaving them in the state of hopelessness. This state of despair was further intensified by prolonged prescribed treatment without commensurate positive outcomes on their wellbeing. Two major precipitating factors hopelessness was associated with were hospitalization and a perceived lack of support after discharge from hospital. Hospitalization caused a disconnection between young adults and their natural environment; families, friends, wider society, and above all disengaging from their businesses and role functions, the latter often providing structure in their lives. Such disconnections precipitated a sense of despair with many of the young adults, believing that they had lost everything and now have lower status than their peers. Some of the participants also exhibited a sense of despair when they believed that there would be no financial support to help them re-engage their previous lives after discharge from hospital.

This study offers new knowledge regarding the probability of young adults developing anxiety as a secondary diagnosis when being admitted to a Nigerian psychiatric hospital which could hinder recovery.

Secondary anxiety can result from hopelessness and fear of the unknown, in this instance resulting from an inability to understand their mental illness and events and factors associated with both the illness and its treatment. In Nigeria the treatment of mental illness focuses on resolving symptoms, rather than taking a holistic approach to addressing the mental health problems of young adults. In doing this, relationships, education and careers are often ignored, and this can vicariously lead to secondary anxiety relating to the young adults' futures. Secondary anxiety is not always acknowledged by health professionals in Nigeria. Taking cognisance of anxiety that develops while living with and being treated for mental illness is paramount in ensuring effective and sustainable recovery. The long-term implications of such anxiety are its ability to continue to manifest, hence hindering total recovery. The consequence is that young adults will continue to have their mental wellbeing compromised, and in Nigeria the possibility of hospitalisation.

Additionally, the role played by the health facility in creating a sense of hopelessness and fear of the unknown suggests that the methods of treatment in Nigeria could be a precipitating factor for psychological instability while trying to treat a psychological problem. In light of this, it can clearly be suggested that a shift in mental health practice in Nigeria is needed, especially where young adults are concerned. Taking account of those background factors which are likely to precipitate anxiety remains a key role when care planning for young adults with mental illness. To address this issue effectively and prevent any possible recurrence of mental illness, professionals treating mental illness in young adults need to look beyond arresting symptoms and adopt more holistic care plans for young adults. To achieve this, young adults in this study highlighted a number of enablers to allay anxiety and improve recovery and mental wellbeing. These include; provision of treatment at the patient’s natural home, adoption of treatment plans for young adults that would ensure they retain their role functions even during admission, young adult-oriented skill acquisition while in hospital, financial support and societal integration after discharge from the hospital. They also identified a listening ear, counselling and satisfaction of their spiritual and/or religious needs as important aspects of the recovery process. More importantly, getting them involved in developing their treatment plans to ensure the enablers of recovery are present is paramount.

This study provides a unique useful basis for collaboration between health professionals and religious/spiritual leaders in the Nigerian mental health care system.

While spirituality and religious faith were noted as a huge source of hope and emotional support this needs to be incorporated into the everyday practices of health professionals, perhaps through adopting a well-defined model for such collaboration. There have been previous recommendations on integration of non-orthodox practices into mental health care, however, the basis for such recommendations and the model of integration recommended by previous authors were challenged. For example, studies undertaken in Nigeria by Gureje and Lasebikan (2006); Horton (2007); Saraceno *et al.* (2007); Gureje *et al*. (2015) suggested an official recognition of non-orthodox healing. Such a suggestion was made in light of participants showing a preference and higher patronages for non-orthodox treatment, wanting it to be a standalone treatment. However, none of the previous studies recognised clearly articulated the need for an integrated model. Also, in Ghana, the model of collaboration recommended by Arias *et al*. (2016) suggests that patients can remain in the prayer camps and have their medication administered there. Such recommendation was based on the fact their study found that most patients with mental illness in Ghana prefer living and seeking help in prayer camps rather than being hospitalised.

However, in the current study, it is conclusive that young adults did not see spirituality/religious faith as an alternative treatment, rather it was experienced as a form of therapy and an enhancing factor for their medical treatment. Findings also showed that all young adults detested going to live in traditional or spiritual healing centres (such as the prayer camps evident in Ghana), with most of them showing preference for admission to the hospital on condition that their spiritual needs would be adequately met. This therefore suggests the need for a collaboration that would allow patients to remain in the hospital for as long as their treatment lasts with their spiritual and religious leaders visiting the hospital from time to time to address any spiritual or religious needs. This will not only ensure that patients remain in hospital to complete their course of treatment, but it would also enable health professionals to deliver more holistic care. This is important given that in Arias *et al.'s* (2016) study the overall welfare of people with mental illness was said to be challenged by ineffective collaboration between prayer camps and biomedical practitioners in Ghana's mental care system. Arias *et al.* (2016) suggested collaboration was difficult as prayer camp staff had strong beliefs in spirituality/religious faith more than biomedical explanatory models of mental illness, hence putting them in charge of patients in their prayer camps and not guaranteeing their adherence to biomedical treatments. Based on the findings of this and Arias *et al.'s study,* it can be suggested that even though the need to incorporating spirituality or religious faith practice into biomedical practice is complex the idea is gathering momentum in Africa, but modalities for developing such collaborations may differ for different African countries. If such a model is to be effective it needs to be tailored according to age, religion and culture of the patients.

This study provides a basis for developing spirituality/religious faith as a form of therapy.

One of the significant contributions of this study is that it has brought the role of spirituality/religious faith in the management of mental illness to the fore. Whenever the subject of the treatment of mental illness is discussed in African countries, for example in Nigeria, there is always a tendency for those involved to see non-orthodox medicine (traditional and spiritual/religious faith) as a treatment option. This African phenomenon has been challenged by the outcomes of this study as the young adults did not consider spiritual/religious practice as a standalone treatment for their mental illness. Young adults were unanimous about the instillation of hope, emotional relief, calmness and a sense of connectedness they experienced each time they said their prayers, read their religious books or remember that God is with them. None of the participants reported being cured through spiritual/religious practice alone. Therefore, while spirituality/religious faith could serve as an important coping strategy for people living with mental illness, it should not be considered as a standalone treatment option, but rather a form of therapy that is integral to other treatments. Being a form of therapy suggests that it can be administered alongside other therapies or treatments as combined therapy. This new knowledge became prominent as the young adults in this study clearly stated that they need their spiritual/religious practices as much as they need their medication. This new understanding of the therapeutic role of spirituality/religious faith offers a new reference point for discussion on its place within mental health care.

The study has provided a basis for expanding the existing models of treatment used in psychiatry

This contribution to knowledge derives from the overall findings. The study in general shows that the biomedical model which dominates the Nigerian mental health care system is inadequate to manage the needs of young adults with mental illness holistically. This is due to a number of issues that influenced young adults' mental wellbeing, either positively or negatively, being relate to psychological, sociological, and spiritual/religious factors. Based on this, adoption of a broader and a multifaceted model in mental health practice in Nigeria would more effectively address the needs of those who use such services and would address many of the concerns raised in this study.

6.1.7 The Future Plans

The research presented in this thesis has revealed a number of issues that are particularly important for clinical practice and policy improvement to enhance the overall wellbeing of young adults with mental illness. However, as important as those findings are, none of the research findings have been disseminated. Therefore, as part of my work in the immediate future I have planned to disseminate the relevant findings through publishing in academic journals and books and undertaking conference presentations and seminars. It is also my intension to disseminate this thesis by including it in University of Salford electronic archives, ensuring these findings are made freely available globally to any person who may be interested.

Moreover, while this research had unveiled findings relevant for clinical practice and policy improvement, there are also some issues emanating from this study which deserves further exploration. Such issues include, but are not limited to, exploring the lived experiences of mental illness of young adults from other religions and ethnic groups in Nigeria to further establish the relevance of spirituality and religious faith within their recovery from mental illness. Secondly, owing to the issues raised about hopelessness and fear of unknown and potential association with secondary anxiety, I am keen to explore how some of the precipitating factors to these issues can be addressed to ameliorate these conditions occurring. I am hoping to achieve this through postdoctoral studies. Again, future research should also seek to explore the willingness of both health professionals and religious leaders to work in collaboration in hospital settings for the purpose of meeting the spiritual and religious needs of young adults who are experiencing mental illness.

6.1.8 Conclusion

This study has offered good insight into how Nigerian young adults' experience their mental health problems and how this affects their lives and ultimately their mental wellbeing. Regarding its originality, no previous studies have examined the lived experiences of Nigerian young adults with mental illness. Having used phenomenology to explore this new area, five core themes have been identified which are significant to healthcare practice and policy making. These include; being mentally ill, hopelessness, fear of the unknown, violence and vulnerability, and spirituality, religion faith. As challenging as these issues raised by young adults are, they have clearly identified a need for restructuring and improvement in the care and management of young adults with mental illness. The outcomes suggest urgent evaluation of current mode and modality of treating young adults with mental illness in Nigeria hospitals. In general, evaluation and improvement within practice and policy need to focus on ensuring that issues that precipitate hopelessness, fear and anxiety among young adults while living with and being treated for mental illness are properly addressed through holistic care plans and policy documents. More emphasis within the clinical area is needed to ensure that young adults' understanding of their mental illness, and expectations of their futures are properly addressed and to explore ways of making sure that they maintain contact with their role functions, natural environment, and things that instil hope in them. Additionally, while spirituality and religious faith were a huge resource for coping with mental illness, there was no proper arrangement in place for meeting their spiritual/faith needs while in the hospital. In that regard, findings suggest collaboration between health professionals and religious leaders to ensure that such a gap in the care of young adults is closed and more appropriate mental health care is delivered.

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APPENDICES

7.1 Appendix I- Summary of the journal articles

Title of Paper, Authors & Place of origin	Type of Research/ Qual/Quant + Method e.g. cross-sectional study; grounded theory	Target group No. of Participants Gender Age Ethnicity	Aim/ Focus	Method of Data collection	Method of Data Analys
Andersson *et al.*, (2013). Help-seeking behaviour, barrier to care and experiences of care among persons with depression in Eastern Cape, South Africa.	Quantitative study – A cross sectional study.	977 patients aged 18 – 40 years participated	To understand the barriers to care and patients' experiences of care among people with depression	Questionnaire	SAS 9.3 an 19.
Biddle *et al.*, (2006). Young	Qualitative study	23 young adults 16-24 years with	To explore young adults' perceptions of	Semi-structured interviews	Thematic ar

adults' perceptions of GPs as a help source for mental distress.		different mental illnesses	GPs as a source of help mental distress		
Day *et al.*, (2011). Child and adolescent service experience (CHASE): Measuring service quality and therapeutic process in South London.	Quantitative Approach –A cross sectional study	132 young people aged 8 – 18 years	To develop a robust measure of young people's mental health service experience derived from their own accounts and priorities.	Structure Questionnaire	T. Test was analyse the
Elliott *et al.*, (2011). Subjective accounts of the causes of mental illness in the USA.	Qualitative study-Phenomenological approach	50 inpatients aged 18 years and above with various mental illnesses in western USA.	To explore patients' perceptions regarding the nature and causes of the condition that brought them into the hospital	Semi-structured interviews	Thematic an

Gomez-de- Regil (2014). Causal Attribution and Illness Perception: A Cross Sectional Study in Mexican Patients with Psychosis.	Quantitative Method- Cross sectional study.	Sixty-two psychotic patients aged 16 – 45 years.	To identify the most common factors psychotic patient, attribute their illness to. Secondly, to assess the association between causal attribution and illness perceptions.	Questionnaire	Spss
Guner P. (2014). Illness perception in Turkish schizophrenia patients: A qualitative explorative study.	Qualitative methods- An explorative study	9 Turkish patient aged 18 years and older participated in the study	To understand what it is like to have schizophrenia.	Semi-structured interviews	Thematic ar

Hailemariam K. W, (2015). Perceived causes of mental illness and treatment seeking behaviours among people with mental problems in Gebremenfes Kidus holy water site.	Qualitative study – A case study	25 participants with various mental illness	To assess the perceived causes of mental illness and treatment seeking behaviours among patients who attend the holy water sprinkling religious practice in the holy site in Ethiopia.	Semi-structured interviews	Thematic ar

Kuwabara *et al.* (2007). A qualitative exploration of depression in emerging adulthood: disorder, development and social context. United Stated of America.	Qualitative study – phenomenological study	15 participants with depression were interviewed	To examine the lived experience of emerging adults with depression with focus on their treatment seeking, development and social context of their illness	In-depth interviews	Thematic analysis	The following themes emerged; interruption to identity; healthcare (access to care to care, stigma, lack of effective treatment, uncertainty and fear); relationship and role transition	The participants wer recruited from outside psychiatric facilit hence there is no doub that a very importan aspect of their live experience may hav been omitted
McCann and Lubman, (2012). Young people with depression and their satisfaction with the quality of care they receive from a primary care youth mental health service.	Qualitative Approach (A phenomenological analysis).	26 young people aged 16 – 25 years and being diagnosed with depression.	To examine how satisfied young people with depression are with the quality of care they receive from clinicians of a primary care service for young people with mental health problems.	Semi-structured interviews	Thematic analysis	The following themes emerged; First, clinicians being youth-friendly, secondly, clinicians adopting a broad-based style of care illustrate that their use primarily of psychosocial therapies and the judicious use of antidepressant medication is received favourably by youth. Thirdly, care facilitating recovery highlight that clinicians' youth-friendly and broad-based approach enables a therapeutic dialogue to be established with the young	One of the limitations t this study is that it is qualitative study, and th results are context boun to the participants an the context in which th study took place. Secondly, recruitmen through key clinician may have produced a atypical sample o engaged young peopl with a different level o satisfaction wit clinicians than those wh were less engaged wit service.

						people, contributing to recovery from depression.	
Mayers *et al.*, (2010). Mental health service users' perceptions and experiences of seduction, seclusion and restraint.	Qualitative study-ethnography	43 patients aged 25 – 60 years from 17 service points in western Cape town in South-Africa participated.	To explore the perceptions and experiences of a group of service users who have been exposed to seclusion, sedation and restriction	Focus group and semi-structured questionnaire.	Descriptive statistics and content analysis approach.	Inadequate communication, infringement of their human rights, method of containment was not friendly, and it caused them so much distress	The use of servic providers as th interviewers may hav influenced th participants' responses.
McCann *et al.* (2012). The experience of young people with depression: a qualitative study in Australia.	Qualitative study-interpretive phenomenological analysis	26 young people with depression aged 16 – 25years	To explore the experience of young people with depression	Semi-structured interview	Thematic analysis	The following themes emerged; struggling to make sense of their situation, spiralling down, withdrawing, and contemplating self-harm or suicide	The main limitation c this study is tha recruitment from a yout mental health servic might have produce participants who hav not been admitted in psychiatric hospital
Murphy *et al.* (2015). A qualitative study of antipsychotic medication experiences of youths. Canada.	Qualitative study-interpretive phenomenology	18 youths aged 13 – 26years	To explore the lived experience of youth who are prescribed antipsychotics	Semi-structured interviews	Thematic analysis	Ambivalence, desires for alternatives, gaps in support.	The researchers did nc specifically request c have access to medica records to verif diagnoses or specifi names of antipsychotic Participants reporte

							both a wide range medication includin antipsychotics, as well a diagnoses an symptoms. This ma have affected the ability to accuratel identify all th medication they wer prescribed and experiences wer specific t antipsychotics. Mor also, there is a possibilit that recall, and response may have been affecte by the illness and sid effects of th medication.
McCann & Clark, (2004). Embodiment of severe and enduring mental illness: finding meaning in schizophrenia. Australia.	Qualitative study- descriptive phenomenology	9 young adults with schizophrenia participated.	To explore how young people with schizophrenia experience their illness as an embodied phenomenon and find meaning in the illness	Unstructured interviews	Thematic analysis	The emerged themes include; Illness as a catastrophic experience, illness as a mediator of social relationship, medications side effects as burdensome	
Naeem *et al.*, (2012). Views of depressed patients	Qualitative study – Ethnographic approach.	9 patients aged 18 years and older diagnosed of	To elicit the patients' knowledge and perceptions of	Interviews	Thematic analysis.	Patients had little knowledge of mental illness in general and	The patient who wer interviewed are thos who had alread

in Pakistan concerning their illness, its causes and treatments.		depression were recruited for the study.	depression, its cause and treatments and their views about nonpharmacological treatments.			depression in particular. They believed that mental health problems are caused by stress or trauma and that only medicine could help them. Patients had no knowledge of the role's psychologists or psychotherapy.	presented t psychiatrists fo treatment. They migh have had different view from other people wh suffer from the sam problem and had no sought assistance o might have done so fro other healt professionals or thos outside the traditiona health system, such a faith healers.
Watsford *et al.*, (2013) Exploring Young People's Expectations of a Youth Mental Health Care Service in Australia.	Qualitative approach	20 young people aged 12 – 24 years with moderate mental illness in Mexico.	To understand young people's expectations of a mental health care services	Semi-structured interview	Data was analysed using thematic analysis	They showed lack of knowledge of what to expect from a mental health services and hopelessness was also expressed	The study involve young people only fro one youth mental healt service in one state Australia. Secondly th interviews wer relatively short as th majority of the youn people were brief wit their responses
Woodgate (2006). Living in the shadow of fear: adolescents' lived experience of depression.	Qualitative Study-Hermeneutic phenomenology	14 young people aged 14 – 18 years diagnosed of depression from two major outpatient adolescent's	To gain an understanding of what it was like to be a young person living with depression	Open ended interview was used for data collection	Thematic analysis.	Living in the shadow of fear emerged as the essence of the adolescents' experiences and ultimately defined what was like to live with depression	The sample populatio was mainly composed o female adolescent hence the outcome o this study was not a tru representation

		treatment centres in a major city in Western Canada.					adolescents' experience of depression.

7.2 **APPENDIX II -** Sample of Participants' Transcripts

TRANSCRIPT 1
PARTICIPANT'S NAME: EUNICE
AGE: 26
SEX: FEMALE
EDUCATION: UNIVERSITY
TRIBE: IGBO

Introduction:

Interviewer: My name is Mr. Nwedu Aaron Beryl. I am a nurse and I am A lecturer at Ebonyi State University Abakaliki. I am also doing my PhD study currently at the University of Salford United Kingdom. As part of my study, I am required to carry out a field work, to collect data from young adults receiving treatment from a Nigerian psychiatric hospital.

Please, I would like to know you too.

Interviewee: my name is Eunice C. U., I am from Imo State, I have a degree in linguistic and Igbo Language from Imo State University. I am of age, between 25 and 30 years.

Interviewer: Do you know where you are? Do you know the name of this place?

Interviewee: hmmm, yea; I could remember, am not forgetting all that, considering this mental illness with a whole lot of embarrassments and surprises. At least I can say that this is federal neuro-psychiatric hospital Enugu as my memory will remind me. We both laughed.

Interviewer: what actually brought you here?

Interviewee: Formerly, this is not my first place of taking the medications but as time goes by, I started being stimulated with what that goes on. I finally saw myself here, my parents and guidance, my family brought me to this hospital for treatment upon the fact that I was acting and behaving somehow. But where I was first given treatment, I was not taking the medications and because of that …..Maybe I started having the effects of what that could occur when one discontinues doctor's order or something like that and I started over reacting, being hyper active because I stopped the drugs. Even when I came to this hospital that was the same complaints most of the nurses and doctors were giving about me. They said that my behaviours should be moderate. And for the fact that they don't know my history very well, I wasn't getting myself 100 percent like the former place I was taking to. Although by the grace of God, this time around I am cooperating and am getting myself (her facial expression did not show it).

Interviewer: ok, can I ask you this? You have been hearing about mental illness and you may have been told by the doctors and nurses that you have a mental illness. what has the experience been like?

Interviewee: yes, I have been hearing it and I have been told that I have mental illness but it very embarrassing to live with such illness (she shook her head and frowned while she was making the comment), very embarrassing and overwhelming. Mental illness is like a struggle to manage one's deepest wounds in secret because you don't want to give the world another chance to discriminate against you… Mental illness is like living in your own world, you feel like you are trapped in a reality that's not your own. … Mental illness is waking up every day from the same nightmares, waking up to another nightmare. Mental illness is being in a world where you must face your problem alone without anybody to help you. You know you need help, but you can't look for help because you feel you could expose your problem to people and they will start to avoid you. Yes, the first time I went to the hospital I was forced to do so, it wasn't my decision. Then I was given this injection that has to do with the brain, and I was like being confused and was like what is happening, and it was as if I am in another world, throughout that day I lived in a different planet because I did not know anything that happened around me.

Interviewer: your statement about how you felt when you were first injection shows you least expected that, please can you tell more about that experience?

Interviewee: first of all, one thing you should know about mental illness is that education in this part of the world, especially in the rural areas does not give account of the brain or study the brain very well whereby you will be exposed to how the brain works and things like that. So it becomes too embarrassing when not knowing much about the brain or what goes on in the brain and before you know it you have started taking drugs about it. This will definitely trigger you off and out. Unlike that of the physical body, that of the brain is something different. Like in my secondary school, I wasn't taught about the brain till my graduation, it was just from personal research that I got some information on that yet there was no elaborate information. When I became sick, then I was given this drug that has to do with the brain, and I was like been confused and was like what is happening? ….in fact, ever since I started having this mental illness my life remained shapeless…. living with this illness is like being in another world (she frowned while saying it).

Interviewer: do you mean you were confused when you started taking the drugs?

Interviewee: yes of course! So many things, I don't even know how to describe them even up till now I am still confused…..So I was now believing that the only thing that will help me is to be taking the drugs, since everybody is now preaching to me to be taking the drugs, they have been hammering on it, so I have to grow up and nothing else (with her face frowned).

Interviewer: Although you said you have not received an elaborate knowledge on brain functions, I noted that already but from your experience what do you think that contributed to your mental illness?

Interviewee: emmmm; sorry! Like I know like I can remember, I started feeling withdrawn and depressed during my level five in secondary school, then I was keeping a boyfriend and I was as well the brightest student in the school so eventually I was accused of emmmm of emmmm of abortion, I can say accuse because it was a false accusation. Before I could know it so many decisions were taken, I wouldn't know, things like that subtraction and additions and before I could know it I started being depressed, ill function as well, I couldn't mix up with people, I started isolating myself, I couldn't go on to share things on my mind with my mother like before. At that point I now see my inner most mind as my best friend.

Interviewer: could it mean that you started keeping things to yourself?

Interviewee: yes, I started keeping everything to myself and my mum was the next person I have then, and no longer my boyfriend, my school mates or my studies or any other thing. So, you know what this could mean. The boyfriend of a thing and every other thing shattered. It was embarrassing, you know what that could mean if I go out I don't mingle as before…. I will say a limited resource of livelihood and heart break still contribute to my mental illness………The fact is that this illness has affected every aspect of my life including my social life……someone who use to give me letter from my boyfriend now gave me a letter for another girl from my boyfriend. In fact, heart break and everything and I couldn't do anything

Interviewer: did the letter come when you were already experiencing depression?

Interviewee: yes, I have started experiencing it a little bit, although when the accusation now came, I took a decision not to go to anyone. I was like what is the cause of this? Most times what I decide to affect me, I don't know what to do, another person may be telling you what is happening in your mind, as all these things were happening, my boyfriend got married and I was like when am I going to stand on my ground to tell this story? So mental illness can come in different ways. Even when all these things were happening, I never knew it was a mental illness, not until my mum said there is a way am behaving and she wants to take me to a reverend father, it was the reverend father that recommended and referred us to federal medical centre Owerri where I met one woman like that on psychiatric cases, she gave me drugs, she gave me injections and I was like telling them that I never told anybody that I wanted to go to the hospital and I don't think I need hospital attention. So when the nurse gave me the injections, to my greatest surprise and astonishment, I was so down after I received the injection and I couldn't sit up and I was lying on my mother's laps until after about 45minutes drive to our home. I couldn't open my eyes and I wasn't seeing so well even to enter my house, little by little I laid down. So, when night came I had the tablets, the next morning I had other tablets and next morning……, I now saw that I was becoming a little bit strong. When

I noticed that I was getting little bit okay I stopped the drugs. When my mother asked me why I am not taking the drug I told her that when they bring second drugs then I will start taking it. When we went back to federal medical centre Owerri for the second drugs I discovered that it wasn’t the same woman that attended to me the first time that was there again. When I asked they told me the woman has been transferred to another section. It was now a guy and when the guy now gave me injection, although before the injection I was already saying within my mind that I won’t take the injection however, I also said if I take the injection and it improves my condition the more then I will continue to take it because when I started taking the tablets I was getting myself and getting some flesh. But when I now received the injection, it was something else, so painful and I said no no! I won’t take this injection again and they brought tablets and I said no no! I don’t need any more.

Interviewer: so, you got scared by the injection?

Interviewee: yes, it was so painful, and I started feeling as if they inserted something in my body and I couldn’t do certain tasks again.

Interviewer: what did you think about the painful injection?

Interviewee: it is not like the first one! I got scared because it was very painful unlike the first one. And I was like you brought me here to kill me. If anybody tells me to take the drugs again, I will hate that person (this she said with frowned face). So, before I could know it I have got admitted already in the hospital and since then I have been on it.

Interviewer: you have received treatment from the onset from the hospital, in your own view what do you think about treatment of mental illness?

Interviewee: treatment? I don’t really know! I have not reached 80% good health wise.

Interviewer: I mean as a lay person having mental illness, what is your experience so far about treatment of mental illness?

Interviewee: hmmm, for the fact that I have had an experience of feeling good before, I can say it is better, and presently as am talking I am feeling a little bit relieved. So will say it is better because it makes me feel good, unlike before I now enjoy food, I have peace of mind, I go to bed and sleep very well and now I can relate freely, and I can now behave like a child of God.

Interviewer: you said something about relating freely, was there any time you weren't relating freely?

Interviewee: hmmm, that was the time I wasn't taking my drugs. But naturally, before it started, I was okay.

Interviewer: having experienced this since 2004, from that time what are the experience/s that you had passed through which you wouldn't want again?

Interviewee: my mother's death (Eunice was very cold at the remembrance of this incident) and not being able to get appointment.

Interviewer: regarding your mental health problem, what are the ugly experiences you have had as a result of this problem?

Interviewee: I can't read, I wasn't in peace with my family, I insult my parents anyhow sometimes I even think of a way of staying away from my parents, ah! I was totally beaten by parents, siblings, reverend fathers and others. Even the first time I was brought to this hospital I was flogged till my brain was hot.

Interviewer: how do you always feel each time you remember this?

Interviewee: Ah! Each time I remember it I feel very sad, it takes me to my early grave (participant was very unhappy while sharing this) …..it feels so sad to remember all that but what can I do? I have got to endure it.

Interviewer: as a young person with experience of mental illness, is there any time you think your problem can affect your future?

Interviewee: yea! So many of the time, even as at 2014 and 2015 in fact so many of the times I wanted to commit suicide (she was very unhappy) …..because whenever I look into my past and my present, it doesn't give me the feeling that my future will be better. I have battled with this illness since 2004

Interviewer: which aspect of your life do you think your mental health problem has affected?

Interviewee: I am a star, I sing, dance and perform, I want to be a known star, when I was in secondary school I used to dance but now I can't sing or dance, I can't make the correct or right moves anymore, I feel inferior and withdrawn, I feel sorry for myself, I feel ashamed of coming to the public. Most times I even regret coming to the psychiatric hospital in the first place. I don't really know.

Interviewer: do you mean you are regretting for coming to the hospital? But you know it is only in the hospital that you can receive a proper treatment, don't you know it can get worst if you stay at home without treatment?

Interviewee: I never knew, just that it was the reverend father that referred me to such a woman and he was like if I continue to take the drug he will be there for me spiritually and otherwise, analysing things and harnessing the word and eventually it turned bad, before I know it things changed, that woman was transferred, the reverend father is probably at home and my mum is dead, so where do I start? Feeling frustrated, eventually Eunice started crying and saying that I feel that God just wanted to punish me with all these.

Interviewer: with your experience so far in this illness what are the things that have hindered your wellbeing?

Interviewee: sleep, most of the time I don't sleep.

Interviewee: What normally causes your sleeplessness?

Interviewee: You know that time that I started receiving injection without tablets, I was not able to sleep very well before I knew it I was relapsing, but this time around I am getting enough sleep, I prefer to go back to the former place where I was first treated because then I did not know the importance of the drugs, I was always going back to my house after receiving the drugs. Here this time around, they are now getting used to me. In 2014/2015, the drugs they were giving to me wasn’t corresponding to my body and I was like what is happening? And I couldn’t talk to anybody, it was just something else, nobody to talk to and before I could know it workers went on industrial action.

Interviewer: That time you were feeling that the drugs are not helpful, what was in your mind|?

Interviewee: Ah! I wished I could die because no doctor was listening or attending to me. So, I was thinking of killing myself.

Interviewer: In that situation of not receiving what you expected, what do you think that could have helped you?

Interviewee: What I thought that could have helped me was to go home because, someone giving me a listening ear could have helped me, but it wasn’t easy. I needed a counsellor or psychologist to work on my emotions, another thing that could have helped me is that, had it been that my mother was alive, she would have gotten some important information from my folder at the first place where I was treated and take it to the new to enable them know the kind of drugs I was taking. But because they did not know much about my case they just diagnosed and before I knew it, they have started giving me drugs and I started dying again. I strongly believed that the drugs I received from the former place are not the same thing with what I am getting here. So, I will feel better if they can allow me to go and get some information about the drugs at owerri. But even when I told the doctor this morning, he was not listening to me. Also, I am feeling like being caged in my brother’s house where I am staying at the moment, seriously caged!

Interviewer: Please can you explain more what you mean by feeling that you are being caged?

Interviewee: Eventually I am the one who cooks for everyone, does all the domestic jobs and taking care of myself as a lady. You know it is not easy for a lady to take care of herself, I am also working now, even though I don’t get much money from it, but it is hectic as well and other things too.

Interviewer: Do you in anyway wish that you have time to go out

Interviewee: Yes! Of course, what will I wish myself if not good?

7.3 APENDIX III- Ethical approval by Research Ethics Committee, University of Salford, United Kingdom

University of
Salford
MANCHESTER

Research, Innovation and Academic
Engagement Ethical Approval Panel

Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

17 June 2016

Dear Aaron,

RE: ETHICS APPLICATION HSCR16/21 – An Exploration of the perceptions of young adults (18-30) diagnosed with mental illness and being treated at a Nigerian Psychiatric Hospital regarding their mental health problems.

Please be aware that Ethical approval from Salford is subject to subsequent approval from 1) the Research Ethics Committee; and 2) the Medical Director (or his/her nominee), at the Federal Neuro-psychiatric hospital, Enugu, Nigeria. Please provide details of these approvals prior to commencing fieldwork/data collection.

Otherwise, based on the information you provided, I am pleased to inform you that application HSCR16/21 has been approved.

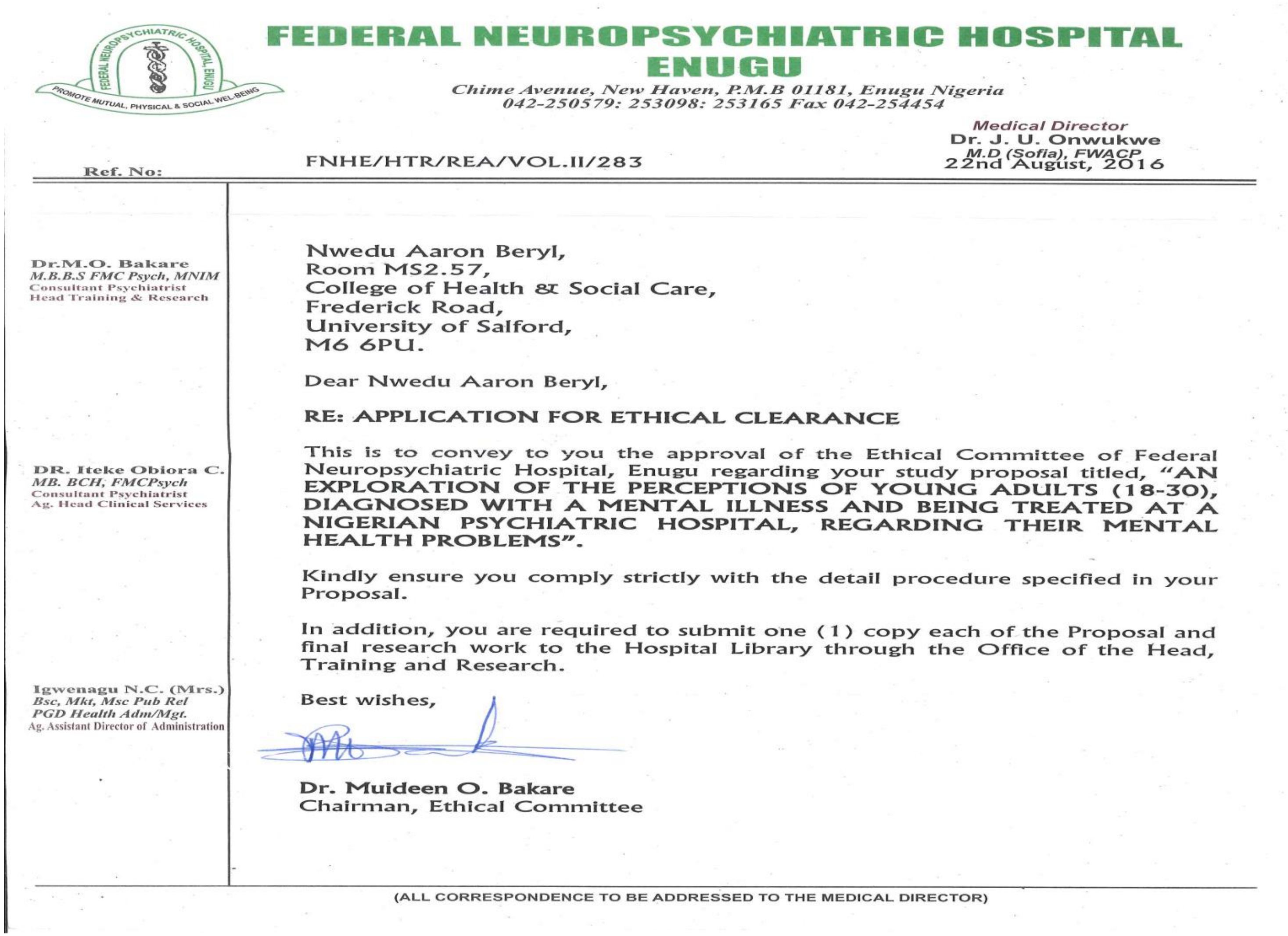
If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

A Clark

Andrew Clark
Deputy Chair of the Research Ethics Panel

7.3.1 APPENDIX IV- Ethical by Research Ethics Committee, Federal Neuro-Psychiatric Hospital Enugu, Nigeria.



FEDERAL NEUROPSYCHIATRIC HOSPITAL
ENUGU
Chime Avenue, New Haven, P.M.B 01181, Enugu Nigeria
042-250579: 253098: 253165 Fax 042-254454

Medical Director
Dr. J. U. Onwukwe
M.D (Sofia), FWACP

Ref. No: FNHE/HTR/REA/VOL.II/283

22nd August, 2016

Dr.M.O. Bakare
M.B.B.S FMC Psych, MNIM
Consultant Psychiatrist
Head Training & Research

DR. Iteke Obiora C.
MB. BCH, FMCPsych
Consultant Psychiatrist
Ag. Head Clinical Services

Igwenagu N.C. (Mrs.)
Bsc, Mkt, Msc Pub Rel
PGD Health Adm/Mgt.
Ag. Assistant Director of Administration

Nwedu Aaron Beryl,
Room MS2.57,
College of Health & Social Care,
Frederick Road,
University of Salford,
M6 6PU.

Dear Nwedu Aaron Beryl,

RE: APPLICATION FOR ETHICAL CLEARANCE

This is to convey to you the approval of the Ethical Committee of Federal Neuropsychiatric Hospital, Enugu regarding your study proposal titled, **"AN EXPLORATION OF THE PERCEPTIONS OF YOUNG ADULTS (18-30), DIAGNOSED WITH A MENTAL ILLNESS AND BEING TREATED AT A NIGERIAN PSYCHIATRIC HOSPITAL, REGARDING THEIR MENTAL HEALTH PROBLEMS".**

Kindly ensure you comply strictly with the detail procedure specified in your Proposal.

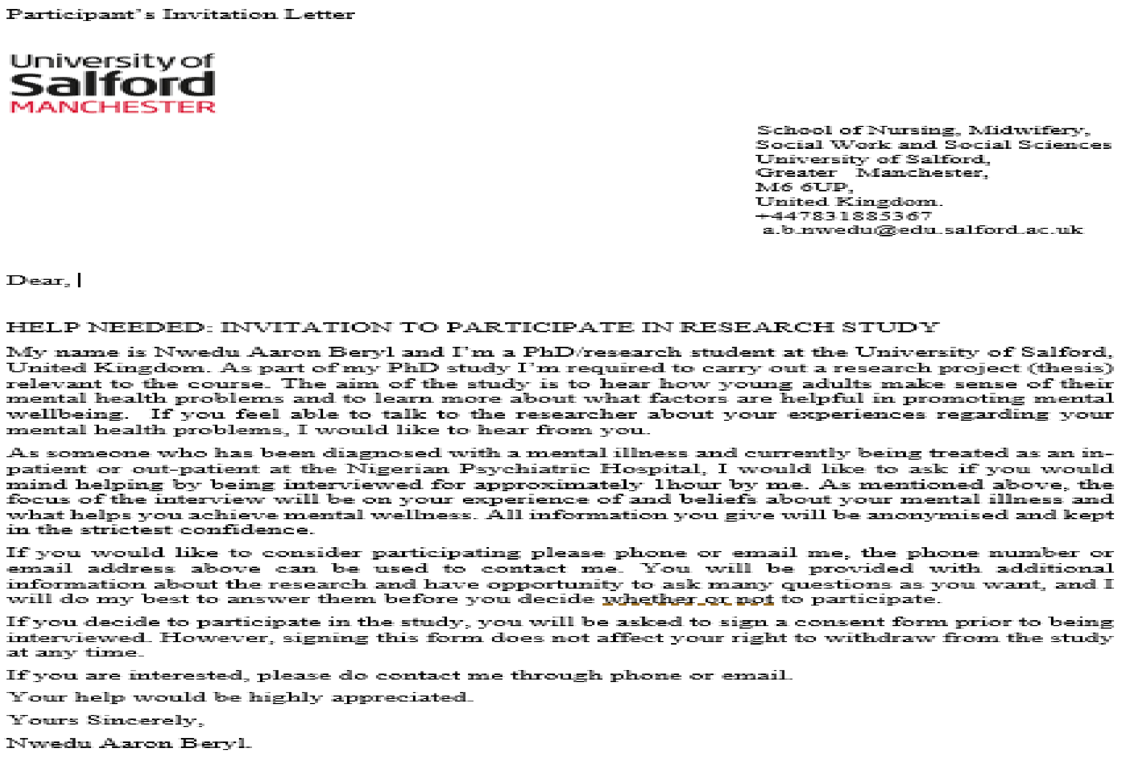
In addition, you are required to submit one (1) copy each of the Proposal and final research work to the Hospital Library through the Office of the Head, Training and Research.

Best wishes,

Dr. Muideen O. Bakare
Chairman, Ethical Committee

(ALL CORRESPONDENCE TO BE ADDRESSED TO THE MEDICAL DIRECTOR)

7.3.2 APPENDIX V – Participants' Invitation Letter



Participant's Invitation Letter

University of
Salford
MANCHESTER

School of Nursing, Midwifery,
Social Work and Social Sciences
University of Salford,
Greater Manchester,
M6 6UP,
United Kingdom.
+447831885367
a.b.nwedu@edu.salford.ac.uk

Dear, |

HELP NEEDED: INVITATION TO PARTICIPATE IN RESEARCH STUDY

My name is Nwedu Aaron Beryl and I'm a PhD/research student at the University of Salford, United Kingdom. As part of my PhD study I'm required to carry out a research project (thesis) relevant to the course. The aim of the study is to hear how young adults make sense of their mental health problems and to learn more about what factors are helpful in promoting mental wellbeing. If you feel able to talk to the researcher about your experiences regarding your mental health problems, I would like to hear from you.

As someone who has been diagnosed with a mental illness and currently being treated as an in-patient or out-patient at the Nigerian Psychiatric Hospital, I would like to ask if you would mind helping by being interviewed for approximately 1hour by me. As mentioned above, the focus of the interview will be on your experience of and beliefs about your mental illness and what helps you achieve mental wellness. All information you give will be anonymised and kept in the strictest confidence.

If you would like to consider participating please phone or email me, the phone number or email address above can be used to contact me. You will be provided with additional information about the research and have opportunity to ask many questions as you want, and I will do my best to answer them before you decide whether or not to participate.

If you decide to participate in the study, you will be asked to sign a consent form prior to being interviewed. However, signing this form does not affect your right to withdraw from the study at any time.

If you are interested, please do contact me through phone or email.

Your help would be highly appreciated.

Yours Sincerely,

Nwedu Aaron Beryl.

7.3.3 APPENDIX VI - Participant Information Sheet

University of Salford MANCHESTER

Study Title: An exploration of the perceptions of young adults (18-30), diagnosed with a mental illness and being treated at a Nigerian Psychiatric Hospital, regarding their mental health problems.

Aim of the study

The aim of this study is to learn more about the perceptions of the mentally ill young adults of their mental health problem and, what factors would promote their mental wellbeing.

What is the purpose of the study?

The purpose of the study is to learn from those who are using mental health services about how they view their illness and which factors promote or hinder mental wellbeing. It is hoped that the findings of this study will have an impact on the way young people who experience mental illness are cared for.

Why have I been invited?

You have been invited to take part in this study because you met the inclusion criteria for this study which includes; the participant must be within the age range of 18 to 30 years, must have been diagnosed with mental illness and he/she is currently receiving treatment either as inpatient or outpatient. You are also invited because your doctor and/or nurses in charge of the ward/clinic have confirmed that you might be willing to share your perceptions regarding your mental health problem and factors that promote or hinder your mental wellbeing.

Do I have to take part?

No, taking part in this study is entirely voluntary. It is up to you to decide. I will describe the study and go through this information sheet with you. Once you have had chance to read and/or go through the information in this leaflet and asked questions you can make a decision about participating. If you do decide that you would like to participate. I will then ask you to sign a consent form to show you have agreed to take part. However, you are free to withdraw within two weeks after the interview without giving any reason. If you withdraw, nobody will mind, and it will not affect the standard of treatment you receive.

What will I have to do if I take part?

You will be expected to take part in a face to face interview which will last for 1hour. Before the interview starts, we will agree on a name you would like to be called to protect your anonymity. The interview will not interfere with your treatment. During the interview I will be asking you a number of questions in relation to your perceptions regarding your mental health problem. The interview will be audio recorded; to enable the researcher to transcribe the oral discussion into a written form so it is easier to analyse at a later date and any identifying information can be removed. You can ask to have the audio recorder stopped at any time and you can take a break at any time. Your identity will not be mentioned anywhere in the study. The audio recorded information will be destroyed immediately after the researcher has extracted the information, he needs from it.

Expenses and payments

Refreshments will be provided during the period of this interview. Your cost of travel will also be taken care of, if the need arises that you have to transport yourself to the place of interview.

What are the possible disadvantages and risks of taking part?

I do not foresee any disadvantages or risks to you in taking part in this study. However, I know sometimes talking about mental health problems can be distressing. For this reason, a short time of approximately 15 minutes will be allocated at the end of the interview to check out how you are feeling.

If you think you might need further longer term support the researcher will arrange this with the appropriate people who already provide care. The 15 minutes at the end of the interview will be off the record and not form any part of the research.

What are the possible benefits of taking part?

I cannot promise the study will help you personally, but the information generated from the study may be used to improve mental health provision in Nigeria.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed by me. If you have a concern about any aspect of this study, you should ask to speak to me. I will do my best to answer your questions and my contact details are given at the end of this document. If you remain unhappy and wish to complain formally you can do this by contacting my supervisor or the Research Centres Manager through the contact details given below.

Supervisor; Dr. Susan McAndrew (Mental Health), mcAndrew@salford.ac.uk, 016129xxxx

Research Centres Manager Mr Anish Kurian, G.08 Joule House Acton Square, University of Salford, M5 4WT a.kurien@salford.ac.uk 0161 295 5276

Will my taking part in the study be kept confidential?

All information collected about you during the research will be kept strictly confidential and any information about you which leaves the hospital will have your name address and any other identifying facts removed so that your identity will remain anonymous. During the interview, your information which will be audio recorded and researcher's notes will be kept safely. Individual participant research data will be anonymous and given a research code known only to the researcher. A master list identifying participants to the research codes data will be held on a password protected computer accessed only by the researcher. Likewise, the audio recordings will be downloaded onto the researcher's password protected computer. Consent forms will be stored in a locked cabinet, within locked office accessed only by the researcher and all electronic data will be stored on a password protected computer known only by researcher. The data collected will only be used for the completion of my thesis leading to the PhD. The only people authorized to access this data are the researcher and his supervisor. This data will be deleted from the computer and hard copies and audio recordings destroyed immediately after the study has been completed.

The only situation where confidentiality will be breached is if you report criminal activity and/or something that is harmful to self or others. I am duty bound to report such situations to the appropriate manager.

What will happen if I don't carry on with the study?

You have the right to withdraw from the study within two weeks after the interview without giving reason and without anybody penalising you. If you withdraw from the study all the information and data collected from you will be destroyed and your name removed from the study files.

What will happen to the result of the research study?

The result of this study will be used to produce a PhD thesis, I will also present the findings at conferences and write articles for publication in professional journals for anybody, including you, to ready and learn from this study. In my thesis, presentations and publications your anonymity will be protected.

Who is organising or sponsoring this research?

The University of Salford, United Kingdom is the organiser of this research, while Ebonyi State University in collaboration with Tertiary Education Trust Fund Nigeria is the sponsor of the study.

Contact the researcher:

If you have any questions about the research, you can contact me; +447831885367, +2348037390568

Email: a.b.nwedu@edu.salford.ac.uk

Thank you for your interest and support. You can seek further clarification or ask me questions if necessary.

7.3.4 APPENDIX VII - Research Participants’ Consent Form

University of Salford
MANCHESTER

CONSENT FORM

Title of study: An exploration of the lived experience of young adults (18-30), diagnosed with a mental illness and being treated at a Nigerian Psychiatric Hospital, regarding their mental health problems.

Name of Researcher:

Please complete and sign this form after you have read and understood the study information sheet (V2 10/05/2016). Read the statements below and delete either yes or no, as applicable.

1. I confirm that I have read and understand the study information sheet (V 2, dated 10/05/2016), for the above study. I have had opportunity to consider the information and ask questions which have been answered

Yes/No

satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw within two weeks after the interview, without giving any reason, and without my rights being affected.

Yes/No

3. If I do decide to withdraw, I understand that the information I have given will be destroyed. The time frame for withdrawal is 2 weeks after my interview

Yes/No

4. I agree to being interviewed, and the interview being audio-recorded

Yes/No

5. I understand that my personal details will be kept confidential and not revealed to people outside the research team. However, I am aware if I reveal anything related to criminal activity and/or something that is harmful to self or others, the researcher will have to share that information with the appropriate authorities

Yes/No

6. I understand that my anonymised data will be used in the researcher's thesis and other academic publications and conference presentations. Yes/No

7. I agree to take part in the study: Yes/No

Name of participant ____________________ Date ____________________ Signature ____________________

Name of person taking consent ____________________ Date ____________________ Signature ____________________