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Original Article

"Voices from the Ward": Exploring the social and emotional experiences of adolescents and young adults in psychiatric inpatient care

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Abstract

Objectives: This study explores the lived experiences of adolescents and young adults in a Nigerian psychiatric inpatient setting, focusing on the interplay of cultural beliefs, stigma, coping mechanisms, and systemic barriers. The aim is to inform the development of culturally sensitive, family-centred, and systemically supported interventions for this vulnerable population.

Methods: An Interpretative Phenomenological Analysis design was employed to examine the experiences of 28 participants aged 13 to 28 years diagnosed with various mental health conditions. Data were collected over nine months through in-depth semi-structured interviews. The analysis involved an iterative process incorporating reflexivity, member checking, and validation to ensure credibility and contextual relevance.

Results: The findings revealed evolving understandings of mental health, as participants transitioned from culturally rooted misconceptions to biomedical frameworks. Social relationships were significantly shaped by stigma-induced isolation, shifting familial roles, and mixed peer interactions within the hospital environment. Participants employed various coping mechanisms, including reliance on spirituality and creative outlets, but highlighted the unmet need for structured psychological support. The therapeutic environment was both a source of safety and a challenge, with participants navigating overcrowding, lack of privacy, and inconsistent interactions with staff. These narratives underscored the complex interplay of cultural beliefs, systemic barriers, and individual resilience in shaping mental health experiences.

Conclusion: The study highlights the need for culturally tailored psychoeducation, family-centred interventions, and systemic improvements in mental health care for adolescents and young adults in resource-constrained settings. Expanding access to structured psychological support and enhancing therapeutic environments are critical to fostering sustainable recovery and improving care outcomes.

Keywords: Adolescents and young adult mental health; cultural stigma and coping strategies; interpretive phenomenological analysis; Nigeria; psychiatric inpatient care

Adolescence and young adulthood represent critical developmental periods marked by significant physical, psychological, emotional, and social transitions. Mental health conditions during these life stages are widespread and, if left unaddressed, can have profound and lasting impacts on educational achievement, interpersonal relationships, social functioning, and long-term quality of life.[1,2] Globally, it is estimated that approximately 14% of adolescents live with a mental health condition, with depression, anxiety, and behavioural disorders among the leading causes of illness and disability in this group.[3,4] A recent meta-analysis by Polanczyk et al.[5,6] further revealed that nearly one in five adolescents worldwide

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experience a diagnosable mental disorder, yet most cases, particularly in low- and middle-income countries (LMICs), remain undiagnosed and untreated. The treatment gap is especially acute in resource-constrained settings, where mental health services are either unavailable or underutilised due to systemic and cultural barriers.

While there is growing global recognition of the importance of early intervention in youth mental health, research exploring the lived experiences of adolescents and young adults has predominantly emerged from high-income countries (HICs). In these contexts, studies consistently highlight the critical role of supportive therapeutic environments, positive staff–patient relationships, structured therapeutic activities, and peer support networks in promoting emotional stability, self-esteem, and recovery among young individuals undergoing psychiatric care.[7–9] For instance, evidence from HICs indicates that a sense of belonging within therapeutic communities and early integration of structured psychoeducational interventions significantly enhance mental health outcomes during hospitalisation.[9–11] These environments also tend to promote patient autonomy, emotional expression, and a developmental approach to recovery, which aligns with the broader goals of adolescent mental health care.

However, the applicability of these findings to LMIC contexts remains limited. Psychiatric inpatient facilities in countries such as Nigeria operate within vastly different systemic, cultural, and economic conditions. Severe workforce shortages, inadequate funding, overcrowded wards, and the absence of developmentally appropriate interventions are persistent challenges.[12–14] In Nigeria, for instance, mental health services are characterised by a psychiatrist-to-population ratio of fewer than 0.15 per 100,000, compared to a global average of 4.5 psychiatrists per 100,000 people.[13] Additionally, mental health stigma remains deeply entrenched in many Nigerian communities, influencing care-seeking behaviour, treatment adherence, and family involvement.[10,14] Traditional beliefs, which often attribute mental illness to supernatural causes such as curses, spiritual attacks, or ancestral punishment, continue to shape public perceptions and responses to psychiatric conditions.[15]

Despite this complex landscape, limited research has directly explored the experiences of adolescents and young adults within Nigerian psychiatric inpatient settings. Most existing studies have either focused on adult psychiatric populations or examined community-based mental health interventions, offering little insight into the specific developmental, social, and emotional needs of young people in institutional care.[3,5] Furthermore, while the role of stigma and spirituality has been acknowledged in prior studies, few have systematically explored how these factors interact with systemic inadequacies—such as overcrowding, lack of privacy, and inconsistent staff engagement—to shape young people's coping strategies and mental health trajectories over time.

What is presently known on this subject?

- Adolescents and young adults in low- and middle-income countries (LMICs) face significant mental health challenges due to cultural stigma, systemic inadequacies, and limited access to therapeutic interventions, with little research focusing on their experiences in psychiatric inpatient settings.

What does this article add to the existing knowledge?

- This study provides a comprehensive exploration of the lived experiences of adolescents and young adults in a Nigerian psychiatric inpatient setting, highlighting the interplay of cultural beliefs, stigma, coping mechanisms, and systemic barriers.

What are the implications for practice?

- The findings inform the development of culturally sensitive, family-centred, and systemically supported mental health interventions, offering actionable strategies to improve care and outcomes in resource-constrained settings.

This study seeks to address these critical gaps by offering an in-depth exploration of the lived social and emotional experiences of adolescents and young adults in a Nigerian psychiatric inpatient context. Using an Interpretative Phenomenological Analysis (IPA) approach, the research investigates how participants make sense of their mental health conditions, how cultural and systemic barriers influence their recovery processes, and how they deploy coping mechanisms within an often-constrained therapeutic environment. In doing so, this study aims to inform the design and delivery of culturally sensitive, family-centred, and systemically supported interventions that respond to the unique realities of mental health care in LMICs, contributing to a more equitable and contextually grounded understanding of global mental health care needs.

Materials and Method

Research Design

This study adopted an interpretive IPA design to explore and interpret the lived experiences of adolescents and young people with mental illness. IPA is rooted in phenomenology, hermeneutics, and idiography, focusing on understanding how individuals make sense of their experiences within their unique contexts.[16] The design is particularly suitable for exploring under-researched phenomena, such as the emotional and social challenges faced by young Nigerians with mental illness, and it enables the researcher to delve deeply into participants' subjective interpretations.[17]

IPA emphasises a double hermeneutic process, where participants make sense of their lived experiences, and the researcher interprets these understandings within broader sociocultural and theoretical frameworks.[18] This approach is well-suited for the current study, as it allows for the examination of individual experiences while also recognising the influence of societal and cultural contexts, such as the pervasive stigma surrounding mental illness in this context.[19,20]

The study design integrates qualitative, inductive methods to provide a rich, holistic understanding of the participants' lived realities. By focusing on adolescents and young people, this design acknowledges the developmental and social complexities of this group, aiming to generate actionable insights that could inform culturally sensitive mental health interventions. The interpretive nature of IPA ensures that the research goes beyond descriptive accounts, capturing the deeper meanings and implications of participants' experiences.[20] This design lays the groundwork for subsequent sections on data collection and analysis, where the methodological rigour and ethical considerations that underpin this study are elaborated.

Study Setting and Participants

The study was conducted at a large regional psychiatric hospital located in South-Eastern Nigeria. This facility serves as a primary mental healthcare provider for a population of over 20 million people, making it an ideal site for exploring the lived experiences of adolescents and young adults with mental illness. The hospital's role as a central hub for psychiatric care in the region ensured access to a diverse pool of participants undergoing treatment for various mental health conditions.

Participants were recruited through purposive sampling, a strategy designed to include individuals with direct experiences of the phenomenon under investigation who could provide rich, detailed accounts of their lived realities.[21] Recruitment was facilitated in collaboration with medical officers and senior nurses acting as gatekeepers. These gatekeepers identified eligible participants, distributed invitation letters and participant information sheets, and maintained communication between the researcher and participants. This approach effectively addressed potential challenges related to accessibility, rapport-building, and ensuring participant suitability for the study.[22]

A total of 28 participants were recruited, comprising 16 males and 12 females (Table 1). Participants ranged in age from 13 to 28 years, representing a developmental spectrum across adolescence and early adulthood. Inclusion criteria required participants to have a clinical diagnosis of a mental illness, to be actively receiving treatment as either inpatients or outpatients at the psychiatric hospital, to possess sufficient insight into their condition to provide informed consent, and to have proficiency in English to facilitate effective communication during interviews.

While purposive sampling is appropriate for IPA studies, it is recognised that this method carries the potential for sampling bias, as participants who are more articulate or available may be over-represented.[20] Efforts were made to minimise this bias by working closely with gatekeepers to ensure a diverse range of participants regarding age, gender, diagnosis, and duration of admission. Nevertheless, as with most qualitative research, the findings may not be statistically generalisable but are intended to offer deep, contextualised insights.

Table 1. Participants' demographic information

Participant ID	Sex	Age (years)	Diagnosis
P1	Female	13	Anxiety
P2	Male	13	Depression
P3	Male	14	Substance use disorder
P4	Female	14	Bipolar
P5	Female	15	Schizophrenia
P6	Male	15	Mood and personality disorder
P7	Male	13	Anxiety
P8	Female	14	Depression
P9	Female	15	Substance use disorder
P10	Male	16	Schizophrenia
P11	Male	17	Bipolar
P12	Female	18	Mood and personality disorder
P13	Male	19	Depression
P14	Female	20	Anxiety
P15	Male	21	Substance use disorder
P16	Female	22	Schizophrenia
P17	Male	23	Bipolar
P18	Female	24	Mood and personality disorder
P19	Male	25	Depression
P20	Female	26	Anxiety
P21	Male	27	Substance use disorder
P22	Female	28	Schizophrenia
P23	Male	27	Bipolar
P24	Female	26	Mood and personality disorder
P25	Male	15	Depression
P26	Female	14	Anxiety
P27	Male	13	Substance use disorder
P28	Female	13	Bipolar

Participant demographic information including ID, sex, age at the time of study, and primary mental health diagnosis.

Data saturation was closely monitored during data collection. After 25 interviews, the research team observed that interviews were no longer yielding substantially new themes, with subsequent interviews largely reinforcing previously identified patterns. Three additional interviews were conducted to confirm saturation and enrich the richness of data.[23]

Data Collection

Data collection took place over a nine-month period between March 2022 and December 2022. This extended timeframe was necessary to recruit a diverse sample, navigate logistical challenges, and ensure participants' emotional readiness to engage in the research.

Table 2. Interview guide

Primary question	Prompts
Can you describe your experiences within the psychiatric hospital?	o How would you describe the support you have received here? o What aspects of the environment have been helpful or unhelpful? o How do you feel about your interactions with staff and peers?
How do you perceive and manage distress related to your mental health?	o What emotions or thoughts do you commonly experience? o How do you cope when feeling distressed? o What role do family, friends, or spiritual practices play in your coping strategies?
What kinds of social challenges, if any, have you faced as a result of your mental health condition?	o Have your relationships with family or friends changed in any way? o How do you feel others treat you because of your condition? o Are there any attitudes or behaviours you have found difficult to deal with?
What role does the therapeutic environment play in your well-being?	o How do the facilities, activities, or resources here affect your recovery? o What changes would you recommend improving this environment? o How do interactions with staff and peers influence your emotional and social well-being?
What suggestions do you have for improving mental health care for adolescents and young adults?	o What types of support or services would make the biggest difference for people in your situation?

Semi-structured, in-depth interviews were used as the primary method of data collection. This approach allowed flexibility in exploring participants' lived experiences while maintaining alignment with the study's key objectives.[21,18] Interviews were conducted by the lead author, a trained qualitative researcher with expertise in mental health and qualitative methodologies, ensuring consistency in the interview process and the quality of the data collected.

Each participant was interviewed once. Interviews were typically conducted after participants had been admitted for at least two weeks, once they had stabilised sufficiently to engage meaningfully in the study. This timing was carefully considered to balance ethical sensitivities around participants' emotional states while ensuring that their reflections captured both their initial reactions to admission and emerging experiences within the therapeutic environment. Conducting interviews beyond the immediate post-admission period aimed to reduce the influence of acute distress and adjustment processes on participants' narratives, although it is acknowledged that perceptions might continue to evolve over longer hospital stays.

All interviews were conducted in private consultation rooms within the psychiatric hospital to ensure confidentiality, comfort, and a conducive environment for participants to share their experiences. Each session lasted between 60 and 120 minutes and was audio-recorded with participants' informed consent.

An interview guide was developed to facilitate a comprehensive exploration of participants' experiences. It included open-ended questions and prompts designed to encourage detailed, reflective responses. The guide covered areas such as participants' understanding of their mental health conditions, emotional and social challenges, and coping strategies.[24] The questions were designed with reference to relevant literature and aligned with the study's conceptual framework. In addition, the draft guide was reviewed by two external experts: a clinical psychologist with extensive experience in adolescent mental health and a senior academic in qualitative research methods. Both experts provided feedback on question clarity, cultural sensitivity, and developmental appropriateness. Minor revisions were made based on their suggestions, particularly around wording and sequencing to ensure age-appropriate engagement and reduce the risk of psychological distress.

Adolescents aged 13–17 years participated with parental or guardian consent, although interviews were conducted privately to maintain autonomy and encourage candid responses.

The extended data collection period allowed for flexibility in scheduling interviews around participants' treatment plans and hospital routines. Emotional distress occasionally emerged during interviews, and participants were given the option to pause or terminate the session if needed. Gatekeepers, including medical officers and senior nurses, provided support where necessary and helped maintain ethical safeguards throughout the study.[22,25,26]

All interviews were transcribed verbatim and checked for accuracy against audio recordings to ensure data integrity. Transcripts were anonymised, with unique participant IDs assigned to protect confidentiality. Digital data were stored on password-protected devices, and physical documents were securely locked, following data protection protocols.[23]

A sample of the interview guide used during data collection is outlined in Table 2, highlighting the primary questions and associated prompts.

Ethical Considerations

This study adhered to established ethical principles to safeguard participants' rights, autonomy, and well-being. Ethical approval for the study was obtained from the Research Ethics Committee of the Federal Neuropsychiatric Hospital, Enugu on 15 February 2022 (Approval Number: REC/2022/045), ensuring compliance with the Declaration of Helsinki[23] and guidelines for research involving vulnerable populations.[26]

All participants received detailed information about the study's purpose, procedures, potential risks, and benefits. Adolescents aged 15–17 years provided assent alongside parental or guardian consent, while participants aged 18–35 years provided informed consent independently. Participants were explicitly informed of their right to withdraw at any time without repercussions, ensuring voluntary participation and autonomy.[21]

Confidentiality and anonymity were maintained by replacing participants' names with unique IDs in all records and publications. Audio recordings and transcripts were securely stored on password-protected devices, and hard copies of consent forms were kept in a locked cabinet. Identifying information was removed from all transcripts to further protect participants' identities.[22]

To ensure psychological safety, interviews were conducted in private, quiet spaces within the psychiatric hospital. Participants could pause or terminate the interview if they felt distressed. Gatekeepers, including medical officers and nurses, were available to provide immediate support if necessary. Referrals to mental health services were arranged for participants requiring additional assistance.[23] Adhering to ethical principles for working with vulnerable populations, the researchers avoided judgment, respected privacy, and were prepared to stop interviews if participants became distressed.[27]

Cultural sensitivity was prioritised by using culturally appropriate language and conducting interviews in English, Nigeria's dominant language. The researcher's familiarity with the cultural context fostered trust and openness, ensuring participants felt comfortable sharing their experiences.[21]

All data were securely stored, with digital files protected by passwords and physical documents kept in locked storage. Data will be retained for the duration specified by institutional guidelines before being securely destroyed. Findings will be reported transparently, ensuring participants' voices are authentically represented while maintaining confidentiality. These measures underscore the study's commitment to ethical integrity and participant welfare.

Data Analysis

The data analysis adhered to the IPA framework, which is well-suited for exploring the lived experiences of individuals and the meanings they ascribe to these experiences.[18] This iterative and reflexive process ensured a comprehensive and contextually grounded understanding of the participants' narratives.

Step 1: Data familiarisation: The first step involved repeated listening to audio recordings and meticulous reading of interview transcripts. This immersion allowed the research team to identify preliminary patterns and familiarise themselves with the nuances of participants' narratives. Field notes taken during interviews enriched the contextual understanding of the data, providing additional insights into tone and non-verbal cues.[16]

Step 2: Initial coding: An inductive approach was applied, focusing on staying close to participants' accounts to avoid imposing predefined categories. Key phrases or segments of text that captured significant experiences or meanings were highlighted and coded, such as 'feeling judged' or 'prayer provides comfort.' These initial codes helped capture both shared and unique aspects of the participants' lived experiences.[17]

Step 3: Developing themes: The codes were grouped into broader themes that reflected shared patterns across participants while preserving individual nuances. For instance, codes like 'shame from the community' and 'feeling abandoned by friends' were combined under the theme *Stigma and Isolation*. The themes were iteratively refined during research team discussions to ensure they authentically represented participants' experiences.[18]

Step 4: Interpretative analysis: Themes were further explored to interpret participants' narratives within their broader sociocultural and institutional contexts. The double hermeneutic process—participants making sense of their experiences and researchers interpreting these understandings—was central to this stage. For example, the interplay between spirituality and coping was analysed in the context of societal beliefs about mental illness.[19]

Step 5: Validation and reflexivity: To ensure the credibility of findings, themes were reviewed and validated by the research team. Reflexive journaling was maintained throughout the process to document potential biases and ensure transparency in the interpretation. Member checking with participants confirmed the accuracy of key findings and reinforced their relevance to the lived experiences shared during interviews.[28–30]

Step 6: Synthesis and presentation: The final step synthesised the themes and subthemes into a coherent narrative, incorporating direct participant quotes to illustrate findings. The presentation of findings balanced descriptive accounts with interpretative insights, aligning with the principles of IPA to provide a nuanced understanding of participants' lived experiences.[18,20]

Ensuring Rigour

To ensure the rigour and trustworthiness of the study, several strategies were employed, aligning with established qualitative research standards.[28,29]

Credibility: Credibility was enhanced through prolonged engagement with participants and their narratives. The longitudinal design of the study allowed for a comprehensive understanding of participants' lived experiences, capturing the evolution of their perspectives over time.[16] Member checking was conducted with participants to ensure that interpretations of their experiences were accurate and reflective of their realities. Participants reviewed summaries of their interviews and provided feedback or corrections, aligning with recommendations for enhancing credibility in qualitative research.[28]

Dependability: Dependability was ensured by maintaining a detailed audit trail, documenting each stage of the research process, including recruitment, data collection, and analysis.[30] Reflexive journaling by the lead researcher supported dependability by recording methodological decisions and their rationale. This process enabled the research team to reflect on their positionality and potential biases throughout the study.[31]

Transferability: Transferability was supported by providing rich, detailed descriptions of the participants' contexts, including their sociocultural and healthcare environments. This approach allows readers to assess the applicability of the findings to similar populations or settings.[32] Verbatim quotes from participants were included to enhance the contextual richness of the findings, enabling a deeper understanding of their lived experiences.[16]

Confirmability: Confirmability was achieved through triangulation of data sources and perspectives, including interviews, field notes, and contextual observations, to corroborate the findings.[32,33] Regular peer debriefing sessions among the research team facilitated critical discussions, challenging assumptions and interpretations to ensure that the findings were firmly grounded in the data.[30]

Authenticity: The study prioritised authenticity by faithfully presenting participants' voices and ensuring that their lived experiences were accurately represented.[29] The iterative process of analysis allowed for nuanced interpretations that captured both shared and unique experiences among participants, aligning with the principles of interpretative phenomenological analysis.[18,34,35]

Research Team

The research team was led by AN, a clinician researcher and senior academic with extensive experience in mental health care and qualitative methodologies. AN conducted the majority of interviews and oversaw all stages of the research process, ensuring methodological rigour and ethical adherence. JO, an experienced qualitative researcher with a background in general nursing and familiarity with the study setting, supported participant recruitment and conducted several interviews.

Both researchers maintained detailed reflexive journals to document observations, decisions, and potential biases, fostering critical self-awareness throughout the study. Regular debriefing sessions were held to discuss data collection processes, emerging themes, and challenges, ensuring a collaborative and iterative approach to analysis. To mitigate any influence their presence might have on participants, the team carefully considered the dynamics of gender, age, and professional roles during interviews. This reflexivity helped establish a rapport with participants, facilitating open and candid discussions.[36]

The reporting of this research adhered to the COREQ framework[37] to ensure transparency and completeness in the presentation of qualitative findings. The team's reflective approach and robust methodological framework enhanced the credibility and depth of the study findings.

Results

The findings from this IPA revealed four overarching themes: *evolving understandings of mental health, navigating social relationships, coping with distress,* and *the therapeutic environment as a mixed experience*. The longitudinal nature of the study provided rich insights into how participants' understanding of their mental health, coping mechanisms, and social relationships shifted over time.

Evolving understandings of mental health captures the transition from initial confusion and cultural interpretations of mental illness to a more nuanced understanding influenced by healthcare providers and personal reflection. *Navigating social relationships* reflects the challenges of stigma, shifting familial dynamics, and the dual role of peers as both a support system and a source of tension within the hospital. *Coping with distress* highlights the reliance on spirituality, the expressed need for structured psychological support, and the development of personal and peer-based strategies. Finally, *the therapeutic environment as a mixed experience* explores the dichotomy of the hospital as a place of safety and stability but also a source of stress due to overcrowding and mixed interactions with staff.

Table 3 summarises these themes, their subthemes, and associated codes with illustrative examples, providing a detailed framework for understanding the participants' lived experiences.

Theme 1: Evolving Understandings of Mental Health

Participants' interpretations of their mental health conditions changed over the course of their stay, influenced by cultural beliefs, personal reflections, and interactions with healthcare providers.

Table 3. Themes, subthemes, and codes

Themes	Subthemes	Codes with examples
Evolving understandings of mental health	1.1: Early confusion and misinterpretation	*"curses or punishment," "angered spirits," "unexplained brain issues"*
	1.2: Gradual clarity through interaction	*"doctor explained it's like a sick brain," "understanding stress as a factor," "not my fault"*
Navigating social relationships	2.1: Isolation and stigma from home	*"friends no longer visit," "community views me as cursed," "feeling abandoned"*
	2.2: Peer relationships within the hospital	*"support from peers," "shared understanding," "fights over shared resources"*
	2.3: Shifting familial roles	*"parents visit weekly," "father avoids contact," "shame from relatives"*
Coping with distress	3.1: Spirituality as a foundation	*"prayer helps me calm down," "god gives me hope," "scripture reading for clarity"*
	3.2: The desire for structured support	*"need for counselling," "lack of coping skills," "wish for therapy sessions"*
	3.3: Creative and peer-based strategies	*"writing poems to express emotions," "drawing as a relief," "talking to a roommate"*
The therapeutic environment as a mixed experience	4.1: Safety and routine	*"feeling safe here," "predictable daily routines," "shelter from external judgment"*
	4.2: Overcrowding and lack of privacy	*"too many people in one room," "noise makes it hard to think," "no private spaces"*
	4.3: Mixed interactions with staff	*"one nurse always checks on me," "some staff are rude," "doctors don't have time"*

Themes represent overarching patterns, subthemes provide detailed insights, and codes include direct examples from participant narratives to illustrate these findings.

Sub-theme 1.1: Early Confusion and Misinterpretation

At the start of their treatment, many participants described confusion about their conditions. For many, these interpretations were heavily shaped by cultural narratives that attributed mental illness to spiritual or supernatural causes. Beliefs about curses, spiritual punishments, or ancestral anger dominated the initial narratives of several participants. For instance, some believed their illness was caused by curses or spiritual punishments.

> *"My uncle told me someone must have done something bad to me. That's why I started thinking maybe it's true."* (P2, Female, 14)
>
> *"They say my family angered some spirits, and now this is happening to me. I don't know if it's true, but it makes me scared."* (P10, Male, 15)

For others, the lack of accessible information about mental health further compounded their confusion. Many participants described being handed medication without a clear explanation of their diagnosis or treatment plan.

> *"I know it's something about my brain, but I don't know why it happened or how it can be fixed. No one explains it to me."* (P7, Male, 16)

This initial uncertainty often led to feelings of helplessness and distrust in the treatment process. Participants expressed frustration at being caught between the spiritual explanations provided by their families and the biomedical interventions offered by the hospital.

Sub-theme 1.2: Gradual Clarity Through Interaction

As participants spent more time in the hospital, some began to gain clarity about their conditions. Empathetic conversations with doctors and nurses played a significant role in shifting participants' understanding from spiritual to medical frameworks. Healthcare providers who used relatable analogies or avoided overly technical language were particularly effective.

> *"The nurse explained that my brain gets tired just like my body. She said it needs rest and help to recover. That made me feel like it wasn't something to be ashamed of."* (P12, Female, 17)

However, the transition to a biomedical understanding was not uniform. Many participants continued to grapple with conflicting explanations, especially when their families reinforced spiritual interpretations.

> *"Even though the doctor said it's about stress and my brain, my parents still tell me to pray more. It's hard to believe one thing when everyone at home believes another."* (P6, Female, 15)

The lack of consistent messaging about mental health left some participants feeling caught between two worlds, unsure of which narrative to adopt.

Theme 2: Navigating Social Relationships

The interplay of stigma, family dynamics, and peer interactions significantly shaped participants' social experiences.

Sub-theme 2.1: Isolation and Stigma from Home

Participants frequently discussed the stigma surrounding mental illness in their communities, describing how it led to feelings of abandonment and isolation. Many participants felt judged by friends and family, who distanced themselves after learning of their hospitalisation.

> *"I used to have so many friends, but now none of them talk to me. It's like they're afraid of me."* (P5, Female, 16)

For younger participants, the rejection from peers was particularly painful, as they longed for social connections but felt constrained by societal attitudes.

> "*People back home call me names. They say I'm cursed. I try to explain, but they don't listen.*" (P11, Male, 14)

The hospital environment provided some relief from these societal pressures, offering a space where participants felt their condition was normalised.

> "*At least here, people don't look at me like I'm crazy. We're all in the same boat, so it feels better.*" (P8, Male, 15)

Sub-theme 2.2: Peer Relationships Within the Hospital

Interactions with peers in the hospital were both supportive and challenging. Many participants found comfort in sharing experiences with others who understood their struggles, fostering a sense of solidarity.

> "*It's easier to talk to people here because they know what I'm going through. We help each other when it gets tough.*" (P17, Female, 17)

However, overcrowding and competition for resources often led to conflicts, which heightened stress for some participants.

> *"There are too many of us in one room. We fight over small things, like who gets the best spot to sit. It makes me anxious."* (P13, Male, 16)

Despite these challenges, participants emphasised the importance of peer connections in their recovery journey.

Sub-theme 2.3: Shifting Familial Roles

Family dynamics evolved over the course of participants' treatment. For some, family members became more supportive as they began to understand mental illness better.

> "*At first, my mum didn't know what to do, but now she comes every week and brings me snacks. It makes me feel loved.*" (P6, Female, 15)

Conversely, other participants described feeling abandoned by their families, who distanced themselves due to stigma or a lack of understanding.

> "*My dad hasn't come to see me once. I think he's embarrassed that I'm here.*" (P9, Male, 18)

These shifting roles often left participants questioning their place within their families and contributed to feelings of instability.

Theme 3: Coping Within the Therapeutic Environment

Participants described various coping strategies that were deeply influenced by their cultural beliefs, personal resilience, and, critically, the characteristics of the hospital environment itself. While the psychiatric facility offered a degree of safety and stability, systemic challenges such as overcrowding, limited privacy, and mixed interactions with staff also significantly shaped participants' coping mechanisms and emotional well-being.

Sub-theme 3.1: Spirituality as a Foundation

For many participants, spirituality was a central pillar of their coping strategies. Prayer, scripture reading, and religious reflection provided comfort, a sense of agency, and hope amidst the uncertainty of their hospitalisation.

> "*Every night, I pray and ask God to heal me. It gives me hope that one day I'll feel better.*" (P19, Male, 17)
>
> "*Reading the Bible calms me when my mind is racing. It reminds me that I'm not alone.*" (P4, Female, 14)

The spiritual practices often compensated for the emotional gaps left by an overstretched and occasionally impersonal hospital system. However, participants also recognised the limitations of relying solely on spirituality to address the psychological and emotional complexities they faced.

> "*Praying helps me feel better, but it doesn't stop the bad thoughts from coming back. I wish there was something more.*" (P20, Male, 15)

Thus, while spirituality remained a vital source of hope, many participants yearned for more tangible, structured forms of psychological support from the therapeutic environment.

Sub-theme 3.2: The Desire for Structured Psychological Support

Despite the emotional safety that the hospital environment sometimes provided, participants strongly articulated the need for structured psychological interventions such as counselling, emotional skills training, or therapy groups. Many felt that medication alone was insufficient to address their emotional distress and that the absence of therapeutic support left them feeling isolated during moments of acute need.

> *"They give us medicine, but that's not enough. I need someone to teach me how to deal with my feelings."* (P14, Female, 16)

> *"When I'm upset, I don't know what to do except sit by myself. I wish someone could show me how to handle it."* (P3, Male, 15)

This unmet need was compounded by the challenges within the therapeutic environment itself, such as the scarcity of trained mental health professionals and the limited availability of private spaces for emotional expression. Overcrowding, in particular, made it difficult for participants to find quiet moments for reflection or to seek help when feeling overwhelmed.

> *"There are too many people in one room. It's noisy all the time, and I can't think or rest properly."* (P13, Male, 16)

> *"Sometimes I just want to cry, but there's nowhere to go to be alone. It's frustrating."* (P2, Female, 15)

Thus, while the hospital aimed to offer stability, its environmental constraints often undermined participants' coping efforts and highlighted the urgent need for more holistic and developmentally appropriate psychological services.

Sub-theme 3.3: Creative and Peer-Based Strategies Amidst Environmental Challenges

In response to the limitations of both the therapeutic environment and available psychological support, participants independently developed creative and peer-based coping strategies. Writing, drawing, and poetry became powerful outlets for emotional release and self-expression, helping participants manage their internal struggles amidst the crowded and overstimulating hospital setting.

> *"When I feel overwhelmed, I write poems. It helps me let out my feelings without having to talk about them."* (P16, Female, 17)

Peer support also emerged as a vital buffer against environmental stressors. Participants found strength and understanding through relationships with fellow patients, often describing how shared experiences created a sense of solidarity and mutual encouragement even when physical resources were scarce.

> *"Talking to my roommate helps a lot. He knows exactly how I feel, and we encourage each other."* (P18, Male, 16)

Although these strategies were largely self-initiated, they proved crucial in mitigating some of the distress caused by overcrowding, lack of privacy, and the emotional toll of hospitalisation.

Sub-theme 3.4: Mixed Interactions with Staff and Their Impact on Coping

Participants' experiences with hospital staff varied considerably, influencing their emotional coping and overall sense of well-being. Positive interactions, characterised by empathy and attentiveness, were critical in reinforcing participants' emotional resilience.

> *"There's one nurse who always checks on me. She makes me feel like I matter."* (P6, Female, 17)

Conversely, negative interactions—such as being dismissed, shouted at, or treated insensitively—often exacerbated participants' feelings of distress, helplessness, and alienation.

> *"Some staff just shout at us to be quiet. It makes me feel like we're not important to them."* (P19, Male, 16)

These experiences significantly shaped participants' perceptions of the hospital environment as either a source of support or a stressor, further underscoring the pivotal role of staff attitudes and behaviours in facilitating or hindering effective coping.

Discussion

This study critically explored the lived experiences of adolescents and young adults in a Nigerian psychiatric inpatient setting, revealing how cultural beliefs, stigma, systemic inadequacies, and individual coping strategies intertwine to shape mental health journeys. The findings are consistent with, but also extend, previous research from other LMICs, highlighting both shared and context-specific dynamics.

The theme of *evolving understandings of mental health* highlights the persistent tension between traditional cultural interpretations of mental illness and emerging biomedical frameworks. Similar patterns have been documented in Ethiopia, where many patients initially attributed mental illness to supernatural causes before gradual shifts occurred through therapeutic engagement.[38–41] In Kenya, Mutiso et al.[42] observed that culturally embedded beliefs often coexist with biomedical understandings, creating internal conflicts for patients. Our findings reinforce the importance of culturally sensitive psychoeducation delivered early in treatment, a need echoed across LMICs.[43]

Participants' experiences of stigma and isolation resonate with findings from South Africa, where adolescents with mental illness reported profound social exclusion and discrimination, exacerbating emotional distress.[40,44–47] Similarly, research in Uganda by Kigozi et al.[48] highlighted how stigma from both community and family members undermined young people's recovery trajectories. In this study, participants often found temporary reprieve in the hospital environment, though tensions within overcrowded wards introduced new relational challenges. These findings suggest that while inpatient settings can buffer external stigma, they must actively foster supportive peer environments to maximise their therapeutic potential.[49]

A notable contribution of this study lies in illuminating how coping strategies were inseparably linked to the characteristics of the therapeutic environment. Participants' reliance on spirituality mirrors findings from Ghana, where Ofori-Atta et al.[50] identified prayer and faith healing as primary coping mechanisms among psychiatric patients. However, our findings extend this understanding by demonstrating that spirituality, while essential, was insufficient for managing complex emotional needs. The expressed desire for structured psychological support echoes calls from studies in Zimbabwe and Uganda for more accessible, developmentally appropriate therapies for young people.[44,48]

Crucially, the role of psychiatric nurses emerged as pivotal in shaping patients' coping experiences. Compassionate, attentive nursing staff reinforced emotional resilience, while dismissive interactions exacerbated feelings of neglect. This finding aligns with Semrau et al.'s[41] study in Ethiopia, where positive nurse-patient interactions predicted better emotional outcomes. Psychiatric nurses, therefore, are uniquely positioned to bridge gaps in psychological support through consistent emotional engagement, active listening, and psychoeducation.

To strengthen their role, psychiatric nurses require targeted training in trauma-informed care, culturally sensitive communication, and adolescent development. Training in brief psychological interventions such as problem-solving therapy, motivational interviewing, and basic cognitive behavioural strategies could equip nurses to provide structured emotional support alongside medication management.[51,30] Nurses could also facilitate structured group sessions focused on coping skills, emotional regulation, and stigma resilience, which have shown promising outcomes in South African adolescent populations.[40]

Furthermore, psychiatric nurses can empower patients by involving them in care planning, reinforcing autonomy, and nurturing self-efficacy. Research from LMICs consistently demonstrates that patient-centred approaches, where young people actively participate in decision-making, are associated with better engagement and recovery outcomes.[52] In this study, participants voiced a need for greater involvement in their emotional care, suggesting an opportunity for nurses to adopt participatory models of practice.

The systemic challenges identified—overcrowding, lack of privacy, limited psychological services—mirror conditions reported in mental health facilities across LMICs.[53–56] Addressing these infrastructural barriers is critical; however, even within resource constraints, psychiatric nurses can play an active role in advocating for patients' needs, creating micro-environments of safety, and championing incremental improvements in therapeutic engagement.[57]

In sum, this study not only reinforces existing knowledge about the lived experiences of young psychiatric inpatients in LMICs but also highlights the critical, often underutilised, role of psychiatric nurses in fostering emotional resilience and recovery. Investment in nurse-led psychological interventions and training could offer a scalable, culturally adaptable strategy for improving adolescent and young adult mental health outcomes in resource-constrained settings.

Limitations and Strengths

This study has some limitations that should be considered when interpreting the findings. Firstly, the research was conducted within a single psychiatric hospital in Southern Nigeria, limiting the generalisability of the findings to other regions or healthcare settings. Cultural and systemic differences across Nigeria may influence how adolescents and young adults experience mental health challenges and access care. Furthermore, the reliance on self-reported data introduces potential biases, such as social desirability bias, where participants may have adjusted their responses to align with perceived expectations of the researcher.[18] Some participants may have also struggled to articulate their experiences fully due to emotional distress or discomfort discussing mental health.

The study's nine-month longitudinal design provided valuable insights into evolving experiences but may not have been long enough to capture post-discharge trajectories or the sustainability of coping mechanisms. Future studies with extended follow-ups could offer a more comprehensive view of recovery processes.[28]

Despite these limitations, the study has notable strengths. The use of IPA allowed for an in-depth exploration of the participants' lived experiences, providing a nuanced understanding of the interplay between cultural beliefs, stigma, and coping mechanisms.[18] The longitudinal approach captured the dynamic nature of recovery, an area often overlooked in cross-sectional studies. By focusing on adolescents and young adults, a demographic frequently underrepresented in mental health research, the study addresses a critical gap in the literature.[1] The integration of cultural contexts, such as spirituality and familial roles, enhances the relevance of the findings to LMIC settings.[6,14] The rigorous data collection and validation processes, including member checking and reflexivity, ensured that the findings were credible and grounded in participants' narratives, further strengthening the study's contribution to the field.[30,31]

Implications for Practice

The findings of this study highlight the intricate interplay between individual, familial, cultural, and systemic factors that shape the mental health experiences of adolescents and young adults in a Nigerian psychiatric inpatient setting. These insights lead to actionable, yet context-sensitive recommendations aimed at improving care delivery and outcomes for this vulnerable population.

A critical barrier to recovery identified in this study was participants' reliance on cultural and spiritual narratives to explain their mental health conditions. Psychoeducational programmes must therefore incorporate culturally tailored explanations that acknowledge spiritual frameworks while introducing biomedical perspectives in relatable terms. For instance, analogies such as describing mental illness as a “tired brain” or a “storm that needs calming” can reduce shame and promote acceptance. Collaborating with religious leaders and traditional healers to deliver these messages may help bridge the divide between local belief systems and formal mental health care, fostering community trust and engagement. These strategies, however, must be supported by sustainable policies and investment in culturally competent mental health education materials and training for providers.

The dual role of families as both sources of support and stigma highlights the need for targeted family-centred interventions. In practice, this could include the development of structured family engagement programmes embedded within routine inpatient care comprising psychoeducational sessions, family therapy, and facilitated dialogue. In resource-constrained settings, training a small cadre of psychiatric nurses and social workers to lead these sessions could be a cost-effective approach. Partnerships with NGOs, local government, and faith-based organisations could also assist in mobilising funding and human resources for outreach and community education components.

Participants also expressed a strong desire for structured psychological therapies, which remain largely unavailable in most Nigerian inpatient facilities due to workforce shortages and limited funding. Scalable models such as task-shifting, where non-specialist health workers are trained to deliver evidence-based psychological interventions like problem-solving therapy or brief cognitive behavioural therapy, should be piloted and evaluated. These interventions are cost-effective and have shown feasibility and success in other LMICs. Integrating routine psychological assessments at admission, using brief validated tools, could further help prioritise care and match patients with available support based on need.

Participants’ use of creative and peer-based strategies also suggests opportunities for institutionalising low-cost, high-impact interventions. Art, writing, and music therapy can be implemented using inexpensive materials and facilitated by trained volunteers, nurses, or occupational therapists. Establishing structured peer-support groups with rotating peer facilitators or mentorship models can foster community and resilience. Hospitals could consider creating 'well-being corners' in wards stocked with basic resources (journals, drawing kits) to encourage self-expression and mindfulness, even in the absence of dedicated therapists.

Systemic improvements to the therapeutic environment are essential. Overcrowding, noise, and lack of privacy were key stressors. While large-scale infrastructural reform may require national-level funding and long-term planning, small-scale initiatives—such as designating ‘quiet hours’, creating makeshift privacy zones with partitions, or reconfiguring shared spaces to reduce sensory overload—can offer immediate relief. Advocating for modest increases in ward budgets and staff training funds may also help facilitate incremental but impactful change. Psychiatric nurses can be trained in trauma-informed care, communication, and environmental stress-reduction strategies to create more emotionally supportive micro-environments.

Finally, addressing stigma through public education and policy is paramount. National and regional mental health policies must prioritise anti-stigma campaigns tailored to adolescents and families. Collaboration with schools, media outlets, faith-based groups, and community influencers can amplify these efforts. Mobile outreach units and digital platforms may also be leveraged to reach rural and underserved populations. Long-term success requires the integration of these efforts into national adolescent health strategies, mental health budgets, and school-based well-being programmes.

Implications for Research

This study highlights critical areas for future research in adolescent and young adult mental health within LMICs. First, longitudinal studies are needed to track recovery trajectories post-discharge, focusing on the sustainability of coping mechanisms and the impact of reintegration into communities, where stigma remains a significant barrier.

Research should also evaluate the effectiveness of culturally tailored psychoeducational interventions that integrate traditional beliefs with biomedical models. Comparative studies could assess how such approaches influence mental health literacy and treatment adherence. The role of spiritual and community leaders in reducing stigma and facilitating acceptance warrants further exploration.

Further investigations into family-centred interventions—such as family therapy or psychoeducational workshops—are essential to understanding how families can transition from being sources of stigma to supportive actors in recovery. There is a need to assess the feasibility and scalability of structured psychological therapies, such as cognitive-behavioural and group therapies, in resource-constrained settings.

Creative and peer-support strategies also require more evidence. Evaluating the impact of structured creative therapies, such as art or music programmes, and formalised peer-support groups on long-term outcomes would provide valuable insights. Finally, innovative community-level stigma reduction campaigns—including digital platforms and participatory approaches—should be investigated for their effectiveness in improving mental health literacy and help-seeking behaviours.

Conclusion

This study highlights the complex and evolving experiences of adolescents and young adults in a Nigerian psychiatric inpatient setting, illuminating how cultural beliefs, systemic barriers, social dynamics, and personal resilience interact to shape mental health journeys. It contributes novel insights into how inpatient environments are both therapeutic and challenging, providing safety and structure while also intensifying distress due to overcrowding, lack of privacy, and inconsistent staff interactions.

The findings strongly suggest that mental health interventions in LMICs like Nigeria must move beyond a one-size-fits-all approach and instead adopt context-specific, culturally grounded, and developmentally appropriate strategies. Integrating spirituality into psychoeducation, engaging families in recovery, and empowering psychiatric nurses to take on psychosocial roles are practical, evidence-supported routes toward improving care quality.

From a policy perspective, these findings reinforce the urgency of investing in youth mental health as a national priority. Mental health policies must explicitly include adolescent populations and commit to financing training, infrastructure, and service innovations tailored to their unique needs. Implementation of cost-effective, scalable interventions, such as task-shifting models for psychological support and community-led stigma reduction can help address current service gaps while ensuring sustainability.

Moreover, psychiatric nurses should be recognised and supported as key change agents. Their dual role as providers of care and advocates for patients positions them to influence institutional culture, foster therapeutic relationships, and lead creative solutions in under-resourced settings. Training and mentoring frameworks, alongside formal inclusion in mental health policy design, would help maximise their impact.

Ultimately, by acknowledging and addressing the intersection of cultural, familial, environmental, and systemic factors, mental health services can better support the recovery, dignity, and empowerment of young people. This study provides a critical foundation for future interventions, research, and policy reform aimed at building inclusive, compassionate, and effective mental health systems in Nigeria and across other LMICs. Such systems must not only address immediate clinical needs but also create the conditions for sustainable emotional wellbeing and social reintegration, ensuring that all young people, regardless of circumstance, are given the chance to thrive.

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