

Research Article

Mental Health Help-Seeking Sources Among Nigerian Adolescents and Their Associated Factors

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Abstract

Mental health challenges among adolescents in Nigeria remain under-addressed, with low help-seeking rates influenced by stigma, poor awareness, and limited family and school support. This study examines mental health help-seeking sources among adolescents in the Federal Capital Territory (FCT), Abuja, and identifies factors associated with the use of formal and informal support systems. A descriptive cross-sectional design was used, involving adolescents (10–19 years) from public and private secondary schools, and teachers, across urban and rural FCT. Multistage sampling techniques were utilized to select participants while quantitative data was collected via structured questionnaires from 424 adolescents, and 50-teachers and data analysed using SPSS v28. Results showed that 53.1% of adolescents reported using formal/professional sources of mental health help, while 46.9% relied on informal/non-professional sources. Adolescents primarily sought help from parents (41.3%), school counsellors (27.4%), teachers (12.5%), and friends (11.8%). Urban school location significantly predicted formal help-seeking (AOR = 2.165, $p = 0.003$). Christian adolescents were more likely to seek formal help compared to Muslims (AOR 2.29; $p=0.002$). Higher father's education strongly predicted formal health-seeking, particularly tertiary education (AOR 5.39; $p<0.001$). The findings highlight the influence of socio-demographic and contextual factors on adolescents' help-seeking behaviour and underscore the need for strengthened institutional, familial, and community-based mental health support systems.

Keywords

Adolescents, Mental Health Help-Seeking, Family Support, School Support

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1. Introduction

Adolescence is a pivotal developmental period marked by rapid physical, emotional, and psychological transitions. While this stage holds the promise of growth and exploration, it also presents substantial mental health challenges. Globally, up to 20% of adolescents experience mental health conditions, yet the vast majority, particularly in low- and middle-income countries (LMICs), lack access to appropriate care. [1-3] In Nigeria, mental health services remain scarce and stigmatized, with adolescents often relying on informal networks; particularly families, schools, and community figures as their first point of support.

School systems are key social environments that shape help-seeking behaviours among young people. Studies show that adolescents are more likely to seek mental health support when they perceive emotional closeness, trust, and open communication within families and school settings. [4] In the Nigerian context, however, limited mental health literacy and pervasive stigma undermine these support structures. For instance, secondary school students in Lagos demonstrated low awareness and understanding of mental health conditions such as schizophrenia. [5], reflecting the broader educational gaps in youth mental health.

Schools can play a transformative role in bridging the mental health treatment gap by acting as accessible platforms for early intervention and referral. Similarly, in India, lay counsellor-delivered problem-solving interventions within schools showed sustained improvements in adolescent mental health over 12 months. [6, 7]

However, despite the promise of school-based models, cultural and systemic barriers persist. In sub-Saharan Africa, traditional and faith healers often serve as default providers of mental health care due to limited access to formal services and widespread mistrust in the health system. [8] This underscores the need for culturally sensitive, community-anchored interventions that integrate schools as key players in mental health promotion. Lessons from other country contexts, such as the US and India also illustrate the value of leveraging trusted community actors [9, 10].

Importantly, stigma and unmet needs continue to deter adolescents from seeking help. In countries like India and Bangladesh, stigma is a dominant barrier, often leading to silence and internalization of distress. [11, 12] Similarly, across Asia and Europe, many adolescents report unmet mental health needs, further pointing to systemic inadequacies in service provision. [13] The prevalence of mental illness among youths in Ogun State, Nigeria, was found to be severe, with schizophrenia being the most prevalent type and substance use disorder moderately prevalent [14].

In Nigeria, evidence on adolescent mental health has largely focused on prevalence, stigma, and awareness, with limited empirical attention to *where adolescents seek help* and the factors influencing their choice of formal versus informal support. There is also a scarcity of studies comparing help-

seeking patterns across urban-rural settings and public-private school contexts within the same population. This gap limits context-specific planning for adolescent mental health services, which this study seeks to address in the Federal Capital Territory, Abuja. This study, therefore, seeks to examine mental health help-seeking sources among adolescents in the FCT.

2. Materials and Methods

2.1. Study Design

This study employed a descriptive cross-sectional design, utilizing quantitative approaches to provide a comprehensive understanding of mental health help-seeking sources among Nigerian adolescents and their associated factors. The quantitative component involved structured questionnaires to assess levels of mental health awareness, help-seeking behaviours, and associated factors.

2.2. Study Settings

The study was conducted in the Federal Capital Territory (FCT), Abuja, Nigeria, covering both urban and rural area councils, including Abuja Municipal, Bwari, Gwagwalada, Kuje, Abaji, and Kwali. This diverse geographical coverage allowed for comparative analysis between urban and rural settings, as well as across public and private secondary schools.

2.3. Study Population

The study focused on two main groups: adolescents aged 10–19 years attending public and private secondary schools in the FCT, and teachers from the selected schools. These groups were included to provide a broad understanding of adolescent mental health help-seeking, drawing on both the students' experiences and the insights of those responsible for offering institutional and supportive guidance.

2.4. Sampling Techniques

A multistage sampling technique was used to ensure representativeness across school types and geographical locations.

- 1) Stage 1: Stratification of area councils into urban and rural categories.
- 2) Stage 2: Random selection of public and private secondary schools from each stratum.
- 3) Stage 3: Random selection of classes Junior Secondary School (JSS) to Senior Secondary School (SSS) within each school.
- 4) Stage 4: Systematic random sampling of eligible students within selected classes.
- 5) Teachers were selected based on availability and role in student support.

2.5. Sample Size

A total of 424 adolescents were included in the study, determined using standard sample size calculation for population-based surveys, considering a 95% confidence level, 5% margin of error, and an estimated 50% prevalence of mental health awareness from prior studies [15]. Additionally, 50 teachers (two from each of the 25 sampled schools) were purposively recruited for quantitative survey.

2.6. Data Collection Procedure

Quantitative data were gathered through a standardized and pre-tested questionnaire administered to adolescents, and teachers. The adolescent questionnaire was a structured, pre-tested, self-administered instrument designed to assess mental health awareness, help-seeking behaviours, and associated factors. It included sections on socio-demographic characteristics, exposure to mental health information, perceived mental health status, preferred sources of help (formal and informal), and associated factors. The questionnaire was administered to 424 adolescents aged 10–19 years enrolled in selected public and private secondary schools. Participants completed the questionnaire during school hours under the supervision of trained research assistants, who provided guidance where necessary. For younger adolescents or those requiring clarification, questions were read aloud and explained without influencing responses. Completion took approximately 20–25 minutes, and all responses were recorded anonymously to ensure confidentiality. Mental health awareness was measured by adolescents' reported exposure to and sources of mental health information; help-seeking behaviour was assessed by self-reported sources of support, categorized into formal and informal; and mental health status was measured using self-perceived mental health and reported emotional distress. Although validated international scales were not used, the questionnaire was expert-reviewed, pre-tested, demonstrated acceptable reliability. All respondents including students and teachers completed the questionnaires and constituted the final analytic sample. Participation took place during supervised school sessions, and all eligible individuals who assented/consented completed the survey; no formal refusals were recorded. Missing data were minimal (<5%).

2.7. Operational Definitions

- 1) *Mental Health Help-Seeking*: Any action taken by an adolescent to obtain support, advice, or treatment for emotional, psychological, or mental health concerns.
- 2) *Formal (Professional) Help-Seeking*: Seeking mental health support from trained health professionals or institutions, including hospitals, clinics, psychiatrists, psychologists, or other qualified medical personnel.
- 3) *Informal (Non-Professional) Help-Seeking*: Seeking mental health support from non-medical sources such as

parents or caregivers, friends, teachers, school counselors, religious leaders, or traditional healers.

- 4) *Family Support*: Emotional, informational, or practical assistance provided by parents or caregivers, including openness to discussing mental health issues and encouragement to seek help when needed.

2.8. Eligibility Criteria

Inclusion Criteria:

- 1) *Adolescents*: Currently enrolled in selected secondary schools, aged 10–19 years, willing to provide assent.
- 2) *Teachers*: Currently serving as guidance counsellors or designated mental health support staff in sampled schools.

Exclusion Criteria:

- 1) Adolescents with severe cognitive impairments that hinder comprehension. They were identified through school records and preliminary screening by teachers and trained research assistants. They are unable to comprehend or respond meaningfully to questionnaire items.
- 2) Non-consenting individuals.

2.9. Validity and Reliability

Content validity were established through expert review by public health and mental health researchers to ensure clarity, relevance, and appropriateness of the items for Nigerian adolescents. The instrument was subsequently pre-tested among a small sample of adolescents and teachers from schools outside the selected study sites who had similar characteristics to the study population. Feedback from the pilot testing was used to refine question wording and structure. Internal consistency reliability was assessed using Cronbach's alpha, which yielded acceptable coefficients ($\alpha \geq 0.70$) across key questionnaire domains, indicating good reliability.

2.10. Data Analysis

Quantitative data were analysed using IBM SPSS version 28. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize socio-demographic characteristics and key variables. Bivariate and multivariate logistic regression analyses were performed to identify factors associated with help-seeking behaviours and mental health awareness, with results presented as odds ratios (OR) and 95% confidence intervals (CI). Triangulation of data across adolescents and teachers, enhanced the credibility and internal validity of findings. Data were checked for completeness at the point of collection. Missing data were minimal (<5%) and handled using listwise deletion during analysis, as the proportion was small and unlikely to bias the results.

Ethical Considerations

The study received ethical approval from the relevant institutional review board. Written informed consent was obtained from parents and adult participants, while assent was obtained

from adolescents under 18 years. Participation was voluntary, and respondents were assured of confidentiality and anonymity. Data were stored securely, and only de-identified information was used for analysis. Participants showing signs of distress during interviews were referred to available mental health services. The study adhered to the principles of beneficence, non-maleficence, and justice in research conduct.

Risks and Benefits Disclosure

Participation posed minimal risk, and respondents could opt out at any time. While no financial incentives were provided, participants contributed valuable insights toward understanding the mental health help-seeking sources among Nigerian adolescents.

3. Results

Distribution of Adolescents' and Teachers' Socio-Demographic Characteristics by School Type

Table 1 presents the socio-demographic characteristics of adolescents and teachers by school type (private and public) among 424 adolescents and 50 teachers. Most participants were aged 14–16 years (67.2%), with females (59.2%) more represented than males. The majority were in senior secondary school (89.6%) and resided in urban areas (56.4%). Ethnically, Yoruba (30.4%) and Igbo (29.7%) adolescents predominated, while Christianity (63.7%) was the most common religion. Nearly half of the respondents had 3–4 siblings (48.1%) and were middle children (47.9%). Regarding parental education, most fathers had tertiary education (39.4%), followed by secondary education (30.7%).

Table 1. Distribution of Adolescents' Socio-Demographic Characteristics by School Type.

Parameter	School Type		Overall n (%) (N=424)
	Private n (%) (N=231)	Public n (%) (N=193)	
Adolescents' Socio-Demographic Characteristics			
Age			
10 - 13 years	25 (5.9%)	19 (4.5%)	44 (10.4%)
14 - 16 years	166 (39.2%)	119 (28.1%)	285 (67.2%)
17 - 19 years	40 (9.4%)	55 (13.0%)	95 (22.4%)
Gender			
Male	81 (19.1%)	92 (21.7%)	173 (40.8%)
Female	150 (35.4%)	101 (23.8%)	251 (59.2)
Education Level			
Junior Secondary School	18 (4.2%)	26 (6.1%)	44 (10.4%)
Senior Secondary School	213 (50.2%)	167 (39.4%)	380 (89.6%)
Area of Residence			
Urban	143 (33.7%)	96 (22.6%)	239 (56.4%)
Rural	88 (20.8%)	97 (22.9%)	185 (43.6%)
Ethnicity			
Others	35 (8.3%)	37 (8.7%)	72 (17.0%)
Igbo	73 (17.2%)	53 (12.5%)	126 (29.7%)
Yoruba	67 (15.8%)	62 (14.6%)	129 (30.4%)
Hausa	56 (13.2%)	41 (9.7%)	97 (22.9%)
Religion			
Christianity	158 (37.3%)	112 (26.4%)	270 (63.7%)

Parameter	School Type		Overall n (%) (N=424)
	Private n (%) (N=231)	Public n (%) (N=193)	
Islam	73 (17.2%)	81 (19.1%)	154 (36.3%)
Number of siblings			
None	13 (3.1%)	7 (1.7%)	20 (4.7%)
1 - 2 Sibling	81 (19.1%)	54 (12.7%)	135 (31.8%)
3 - 4 Siblings	107 (25.2%)	97 (22.9%)	204 (48.1%)
5 or more Siblings	30 (7.1%)	35 (8.3%)	65 (15.3%)
Birth position in the family			
First Child	79 (18.6%)	55 (13.0%)	134 (31.6%)
Middle Child	113 (26.7%)	90 (21.2%)	203 (47.9%)
Last Child	39 (9.2%)	48 (11.3%)	87 (20.5%)
Father Highest education			
No Formal Education	31 (7.3%)	22 (5.2%)	53 (12.5%)
Primary	38 (9.0%)	36 (8.5%)	74 (17.5%)
Secondary	65 (15.3%)	65 (15.3%)	130 (30.7%)
Tertiary	97 (22.9%)	70 (16.5%)	167 (39.4%)

Table 2 shows clear differences between private and public-school teachers. Most private school teachers had 1–10 years of teaching experience (62.1%), whereas the majority of public-school teachers had over 10 years of experience (76.2%).

Overall, more than half of the teachers (54.0%) had above 10 years of experience. In terms of location, most teachers worked in rural areas (64.0%), with rural representation higher in private schools (72.4%) than in public schools (52.4%).

Table 2. Teachers' Socio-Demographic Characteristics by School Type.

Parameter	Private n (%) (N=29)	Public n (%) (N=21)	Overall n (%) (N=50)
Years of Teaching Experience			
1 – 10 years	18 (62.1%)	5 (23.8%)	23 (46.0%)
Above 10 years	11 (37.9%)	16 (76.2%)	27 (54.0%)
Location			
Urban	8 (27.6%)	10 (47.6%)	18 (36.0%)
Rural	21 (72.4%)	11 (52.4%)	32 (64.0%)

Sources of Mental Health Consultation or Treatment Among Adolescents

Figure 1 shows the distribution of sources of mental health consultation or treatment among adolescents. A total of 225 respondents (53.2%) reported consulting medical professionals or hospitals, while 101 (23.8%) sought help from religious

institutions. Traditional healers were consulted by 71 adolescents (16.7%). A smaller proportion, 27 respondents (6.3%), indicated that they did not seek any form of consultation or treatment.

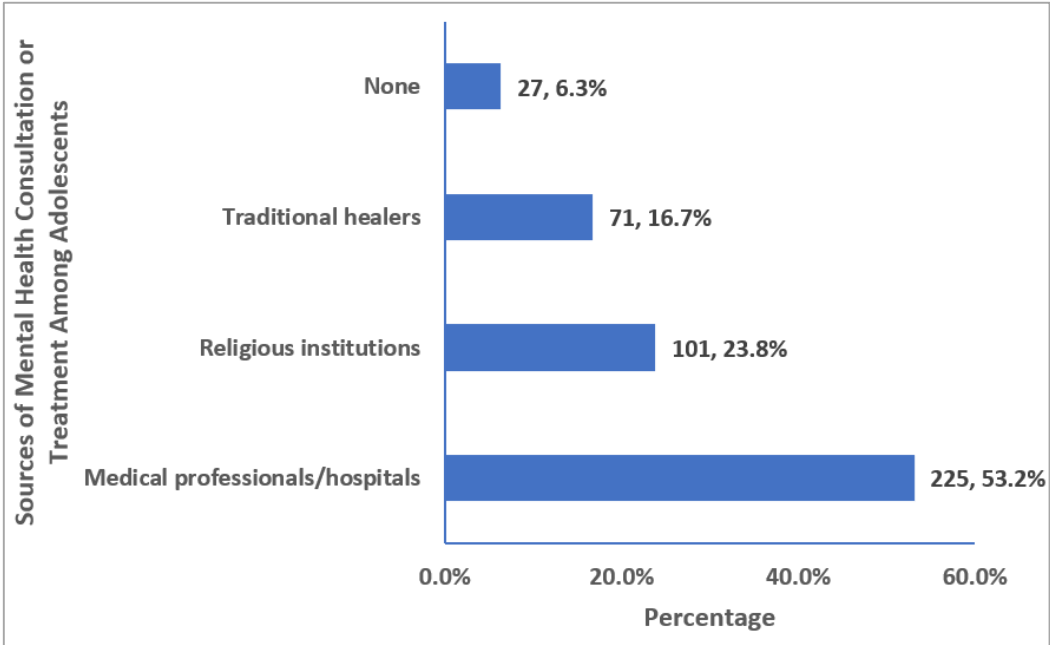


Figure 1. Sources of Mental Health Consultation or Treatment Among Adolescents.

Adolescents' Exposure to Mental Health Information

Table 3 presents data on adolescents' exposure to mental health information through different channels. A large majority of respondents reported infrequent exposure to mental health content across all platforms. Specifically, 75.4% of adolescents said they rarely view or listen to mental health programs, 87.5% reported rarely reading mental health content, and 76.9% said they seldom hear mental health topics on the radio or online.

Table 3. Exposure to Mental Health Information.

Parameter	Frequency (N=424)	Percentage (%)
Frequency of viewing/listening to mental health programs		
Not frequent	320	75.4
Frequent	104	24.6
Frequency of reading mental health content		
Not frequent	371	87.5
Frequent	53	12.5

Parameter	Frequency (N=424)	Percentage (%)
Frequency of hearing mental health topics on the radio/online		
Not frequent	326	76.9
Frequent	98	23.1

Primary Sources of Mental Health Information among Adolescents

Figure 2 illustrates the various sources from which adolescents obtain information about mental health. The internet emerged as the most common source, cited by 166 (39.2%), indicating a firm reliance on digital platforms for mental health awareness. This was followed by schools, with 104 (24.5%), highlighting the role of educational institutions in disseminating knowledge about mental health. Friends and family were also significant sources, accounting for 80 (18.9%) and 72 (17.0%) respondents, respectively, suggesting the importance of peer and familial support systems. Meanwhile, other sources were minimal, with only two respondents (0.4%) identifying them as a source of information.

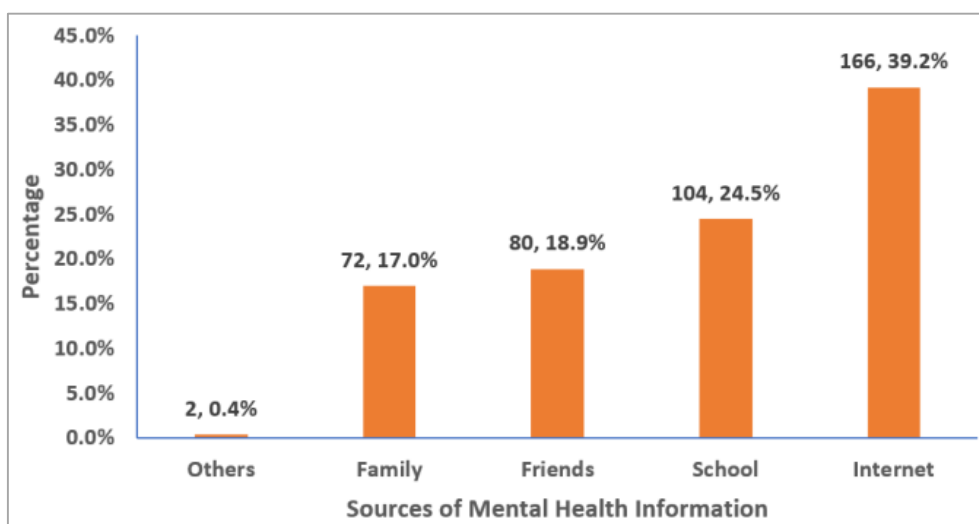


Figure 2. Primary Sources of Mental Health Information among Adolescents.

Source of Support When Feeling Overwhelmed or Anxious

Figure 3 illustrates the preferred support sources when individuals feel overwhelmed or anxious. The most common

source is "Parent" (53, 41.3%), followed by "School counselor" (116, 27.4%). Other significant sources include "Teacher" (175, 12.5%) and "Friend" (3, 11.8%). Less frequently chosen are "Online resources" (50, 6.4%) and "Others" (27, 7.0%).

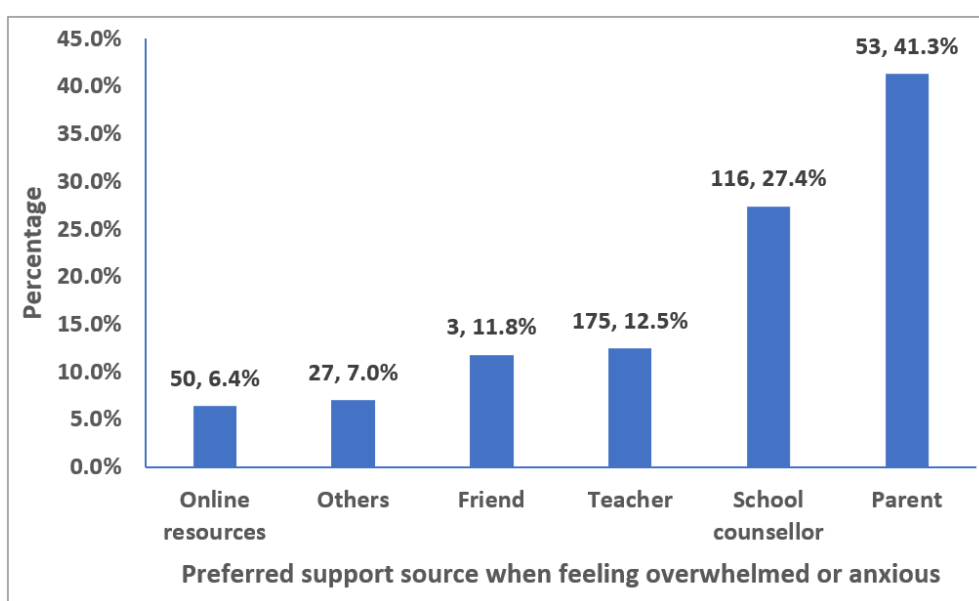


Figure 3. Source of Support When Feeling Overwhelmed or Anxious.

Improvements for Enhancing Mental Health Support

Figure 4 illustrates the distribution of respondents' perceptions on various improvements needed to enhance mental health support in schools, categorized by school type. Overall, the most identified improvement was the provision of mental health workshops, reported by 42% of respondents (24% pri-

vate, 18% public). This was followed by the need for counselors, mentioned by 37% of all respondents (20% private, 17% public), and access to external resources, noted by 26% overall (12% private, 14% public). Support groups were the least frequently mentioned improvement, with only 26% of respondents overall identifying it (15% private, 11% public).

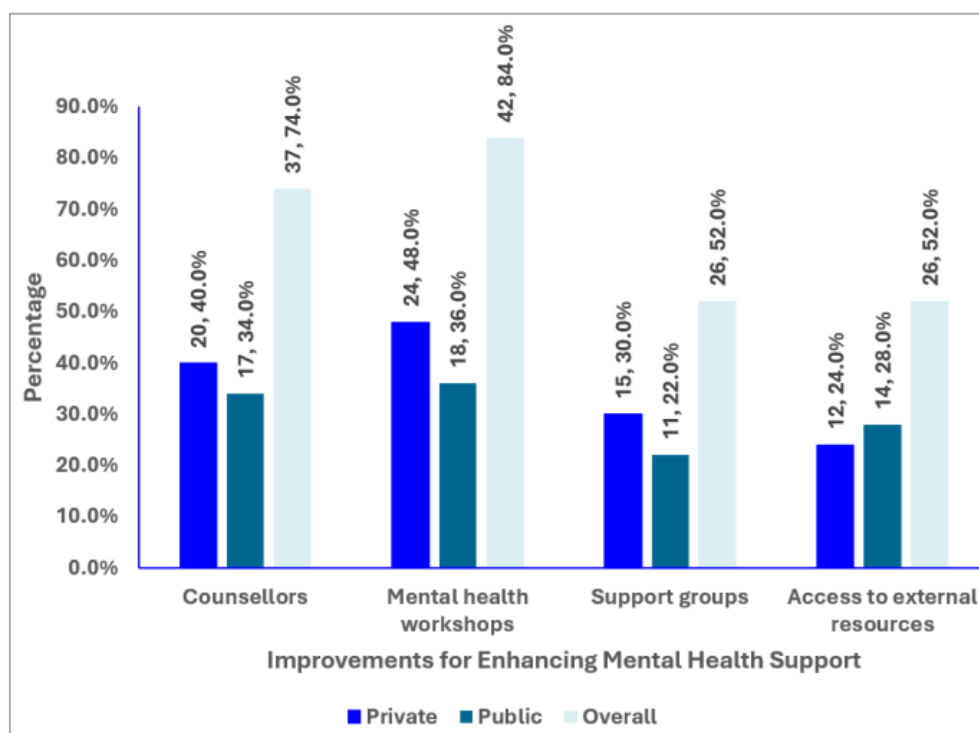


Figure 4. Improvements for Enhancing Mental Health.

Teachers' Access to Mental Health Resources and Their Perception Toward Mental Health in Schools

Table 4 presents the distribution of teachers' access to mental health resources and their perceptions regarding mental health in school settings across private and public schools, with a total of 50 participants. Nearly half of the teachers reported having no access to mental health resources or training to support students: 15 (51.7%) from private schools, 10 (47.6%) from public schools, and 25 (50.0%) overall. The difference between school types was not statistically significant ($X^2 = 0.082$, $p = 0.774$). Despite limited access to resources, a large majority of teachers perceived mental health awareness as very important in schools, 23 (79.3%) from private schools, 18 (85.7%) from public schools, and 41 (82.0%) overall. Only a small proportion considered it not important, including 6 (20.7%) private, 3 (14.3%) public, and 9 (18.0%) overall, with

no significant difference by school type ($X^2 = 0.338$, $p = 0.561$). Similarly, most teachers reported being very comfortable addressing mental health topics or concerns with students: 21 (72.4%) from private schools, 16 (76.2%) from public schools, and 37 (74.0%) overall. The remaining 13 (26.0%) indicated they were not comfortable, with no significant variation between school types ($X^2 = 0.090$, $p = 0.764$). However, when asked whether they felt adequately trained to identify and support students with mental health needs, notable differences emerged. While 22 (75.9%) private school teachers felt adequately trained, only 9 (42.9%) of their public-school counterparts shared this sentiment. Overall, 31 (62.0%) teachers felt adequately trained, while 19 (38.0%) did not. This difference between school types was statistically significant ($X^2 = 5.632$, $p = 0.018$).

Table 4. Teachers' Access to Mental Health Resources and Their Perception Toward Mental Health in Schools.

Parameter	School Type		Overall n (%) (N=50)
	Private n (%) (N=29)	Public n (%) (N=21)	
Do you have access to mental health resources or training to support your students?			
No	15 (51.7%)	10 (47.6%)	25 (50.0%)
Yes	14 (48.3%)	11 (52.4%)	25 (50.0%)

Parameter	School Type		Overall n (%) (N=50)
	Private n (%) (N=29)	Public n (%) (N=21)	
X ²	0.082		-
p-value	0.774		-
Perception of Mental Health			
How important do you think mental health awareness is in the school setting?			
Not important	6 (20.7%)	3 (14.3%)	9 (18.0%)
Very important	23 (79.3%)	18 (85.7%)	41 (82.0%)
X ²	0.338		-
p-value	0.561		-
How comfortable are you in addressing mental health topics or concerns with students?			
Not comfortable	8 (27.6%)	5 (23.8%)	13 (26.0%)
Very comfortable	21 (72.4%)	16 (76.2%)	37 (74.0%)
X ²	0.090		-
p-value	0.764		-
Do you feel adequately trained to identify and support students with mental health needs?			
No	7 (24.1%)	12 (57.1%)	19 (38.0%)
Yes	22 (75.9%)	9 (42.9%)	31 (62.0%)
X ²	5.632		-
p-value	0.018*		-

Source: Field Survey *Significant at $p < 0.05$

Factors Associated with Adolescent Mental Health Help-Seeking Sources

Table 5 illustrates the factors significantly associated with mental health help-seeking sources among adolescents in Nigeria. Out of the total respondents, 53.1% sought formal/professional sources of mental health help, while 46.9% used informal/non-professional sources. Adolescents attending urban schools were significantly more likely to seek formal/professional mental health help (AOR = 2.165; $p = 0.003$). Similarly, individuals of the Yoruba ethnic group were significantly less

likely to use formal sources compared to those of other ethnicities (AOR = 0.459; $p = 0.028$). Christian adolescents were more likely to seek formal help than their Muslim counterparts (AOR = 2.288; $p = 0.002$). Adolescents with 3–4 siblings had higher odds of using formal help sources compared to those with none (AOR = 4.533; $p = 0.031$). Father's education played a significant role: adolescents whose fathers had secondary education (AOR = 2.503; $p = 0.022$) and tertiary education (AOR = 5.385; $p < 0.001$) were more likely to seek formal/professional mental health support.

Table 5. Bivariate and Multivariate Logistic Regression Analysis of Factors Associated with Mental Health Help-Seeking Sources Among Adolescents in Nigeria.

Variable	Informal/Non-Professional	Formal/ Professional	COR (95% CI)	p-value	AOR (95% CI)	p-value
Mental Health Help-Seeking Sources	199 (46.9)	225 (53.1)	-	-	-	-

Variable	Informal/Non-Profes- sional	Formal/ Profes- sional	COR (95% CI	p-value	AOR (95% CI)	p-value
Age						
10 - 13 years	14 (7.0%)	30 (13.3%)	Ref.	-	-	-
14 - 16 years	153 (76.9%)	132 (58.7%)	0.403 [0.205-0.791]	0.008*	0.576 [0.265-1.254]	0.165
17 - 19 years	32 (16.1%)	63 (28.0%)	0.919 [0.428-1.972]	0.828	2.335 [0.930-5.858]	0.071
Gender						
Male	87 (43.7%)	86 (38.2%)	Ref.	-	-	-
Female	112 (56.3%)	139 (61.8%)	1.256 [0.852-1.851]	0.251	1.266 [0.805-1.990]	0.307
Education Level						
JSS	18 (9.0%)	26 (11.6%)	Ref.	-	-	-
SSS	181 (91.0%)	199 (88.4%)	0.761 [0.404-1.435]	0.399	0.598 [0.271-1.320]	0.203
Type of school						
Private	109 (54.8%)	122 (54.2%)	0.978 [0.667-1.434]	0.909	1.212 [0.757-1.942]	0.423
Public	90 (45.2%)	103 (45.8%)	Ref.	-	-	-
School Location						
Urban	92 (46.2%)	138 (61.3%)	1.845 [1.253-2.716]	0.002*	2.165 [1.300-3.604]	0.003*
Rural	107 (53.8%)	87 (38.7%)	Ref.	-	-	-
Residence area						
Urban	106 (53.3%)	133 (59.1%)	1.268 [0.863-1.864]	0.226	0.886 [0.537-1.463]	0.636
Rural	93 (46.7%)	92 (40.9%)	Ref.	-	-	-
Ethnicity						
Others	24 (12.1%)	48 (21.3%)	Ref.	-	-	-
Igbo	60 (30.2%)	66 (29.3%)	0.550 [0.301-1.004]	0.052	0.507 [0.248-1.038]	0.063
Yoruba	71 (35.7%)	58 (25.8%)	0.408 [0.224-0.745]	0.003*	0.459 [0.229-0.919]	0.028*
Hausa	44 (22.1%)	53 (23.6%)	0.602 [0.320-1.134]	0.116	1.130 [0.523-2.443]	0.756
Religion						
Christianity	114 (57.3%)	156 (69.3%)	1.686 [1.131-2.512]	0.010*	2.288 [1.347-3.886]	0.002*
Islam	85 (42.7%)	69 (30.7%)	Ref.	-	-	-
Siblings number						
None	16 (8.0%)	4 (1.8%)	Ref.	-	-	-
1 - 2 Sibling	68 (34.2%)	67 (29.8%)	3.941 [1.252-12.403]	0.019*	3.025 [0.775-11.812]	0.111
3 - 4 Siblings	86 (43.2%)	118 (52.4%)	5.488 [1.772-16.996]	0.003*	4.533 [1.150-17.867]	0.031*
5 or more	29 (14.6%)	36 (16.0%)	4.966 [1.496-16.484]	0.009*	4.143 [0.961-17.863]	0.057
Birth position						
First Child	73 (36.7%)	61 (27.1%)	0.590 [0.342-1.018]	0.058	0.602 [0.311-1.164]	0.132
Middle Child	90 (45.2%)	113 (50.2%)	0.886 [0.533-1.474]	0.642	1.126 [0.623-2.036]	0.695
Last Child	36 (18.1%)	51 (22.7%)	Ref.	-	-	-

Variable	Informal/Non-Professional	Formal/ Professional	COR (95% CI)	p-value	AOR (95% CI)	p-value
Father education						
No formal	37 (18.6%)	16 (7.1%)	Ref.	-	-	-
Primary	47 (23.6%)	27 (12.0%)	1.328 [0.625-2.823]	0.460	1.259 [0.541-2.932]	0.593
Secondary	62 (31.2%)	68 (30.2%)	2.536 [1.285-5.006]	0.007*	2.503 [1.140--5.493]	0.022*
Tertiary	53 (26.6%)	114 (50.7%)	4.974 [2.543-9.729]	<0.001*	5.385 [02.430-11.934]	<0.001*

Source: Field Survey *Significant at $p < 0.05$

4. Discussion

The findings from this study shed light on the multifaceted and context-dependent nature of mental health help-seeking patterns among Nigerian adolescents. Although over half of adolescents in this study sought help from formal sources such as hospitals or professionals, a significant proportion still relied on religious institutions, traditional healers, or family and friends as primary support channels. In rural Nigeria, where psychiatric services are sparse and stigma remains entrenched, these informal routes become a default system. This pattern is consistent with findings across low- and middle-income countries (LMICs), where informal help is the norm due to stigma, limited access, and cultural beliefs. [13, 16] The continued reliance on informal help-seeking pathways reflects limited availability, accessibility, and acceptability of formal mental health services, particularly in rural and public-school settings. This underscores the need for school-centered mental health policies that position schools as primary entry points for early identification, referral, and prevention.

The role of family, particularly fathers' education level, was found to be more likely associated with formal help-seeking behavior. Adolescents whose fathers had tertiary education were more likely to access professional support. However, only few of adolescents reported that their parents openly discussed mental health. This suggests that intergenerational literacy plays a vital mediating role. However, only few of Nigerian parents in this study reported "talking openly about mental health", revealing a critical area of intervention. Parents are the first points of contact and can model positive emotional regulation. Yet, parents often lack the knowledge or tools to fulfill this role. This aligns with Indonesian and Bangladeshi findings where parental education and family communication significantly predict adolescents' willingness to seek formal help. [12, 17] Evidence from Nigeria show that Parental education and open communication strategies was predicts adolescent mental health behaviors. [18, 19]. However, the extremely low percentage of

Nigerian parents who openly discussed mental health exposes a critical intervention point. Internationally, family-based interventions show promise. In Chile's "Skills for Life" program. [20] and India's lay-counsellor models. [7], parent engagement and psychoeducation helped increase adolescent resilience and service uptake. [1] The role of parental education and family communication in shaping help-seeking behaviour indicates the need for family-centred mental health policies. Government and school authorities should support parent-focused psychoeducation programs, school-parent engagement forums, and community sensitization initiatives to reduce stigma and improve early help-seeking among adolescents.

This study reveals a dual reality, private schools are more proactive in implementing mental health programs, while public schools face resource constraints despite willingness to collaborate. Teachers in private schools were more likely to feel adequately trained compared to public school teachers, even though most teachers in both settings consider mental health support important. Private schools had better-trained teachers and more proactive programs. Similar urban-rural and public-private disparities were found in Eswatini, where urban teachers exhibited significantly higher depression literacy than their rural counterparts. [21] To address this, countries like Kenya have embedded mental health modules into national curricula. [22], while India's PRIDE initiative trains non-specialist lay counsellors to deliver school-based interventions with proven impact. [6] The observed public-private and urban-rural disparities highlight inequities in access to trained personnel and services. Policies should prioritize capacity building for teachers in public and rural schools, including continuous professional development, standardized training in basic mental health identification, and clear referral pathways to formal services.

Adolescents in urban areas were significantly more likely to seek formal help. Adolescents in urban areas of Nigeria may be significantly more likely to seek formal help due to better availability of health facilities, greater exposure to health information, and reduced stigma associated with help-seeking. Urban environments often provide easier access to hospitals, counselling centres, and social services, which is more likely

associated with increases in formal support utilisation. This pattern aligns with a study which reported that urban youths have higher mental-health service utilisation due to improved awareness and service density [23]. These comparisons suggest that structural advantages and increased health literacy in urban settings play a key role in shaping help-seeking behaviours among adolescents. Although not directly assessed in this study, mobile mental health units and telehealth services are recommended as potential strategies to address the observed urban–rural disparities and limited access to formal mental health services among adolescents. These approaches may enhance reach and continuity of care, particularly in underserved and resource-constrained settings. Mobile clinics and telepsychiatry have shown success in rural India and Bangladesh, enabling access despite geographical barriers. [10, 12] These solutions are scalable and cost-effective, especially when supported by local governments and NGOs.

Alarming, media and school content played a minimal role in informing adolescents about mental health. This lack of exposure significantly limits awareness and help-seeking behaviours. While the internet was the most common source of mental health information in this study, school-based sources lag behind. In rural areas with poor digital access, schools must take a leading role in disseminating knowledge. This information gap echoes in studies from Lagos, Nigeria and India which contributes to stigma and misinformation. [5, 11].

Religious affiliation was significantly associated with help-seeking behavior. Christian adolescents were significantly more likely to seek formal help than Muslims. This echoes findings in other African contexts, where Christian denominations are more open to medical models of mental health, while Islamic communities may lean toward spiritual or traditional healing routes. Moreover, the lower rate of formal help-seeking among Yoruba adolescents suggests that ethnic norms and culturally grounded interpretations of mental illness may shape help-seeking preferences. This finding reveals the need for culturally competent interventions that engage community leaders, religious heads, and traditional authorities in mental health promotion. These findings mirror trends in other African and Asian settings where Islamic communities may favour traditional or spiritual approaches. [4, 16] Culturally sensitive programs that work with rather than against these religious paradigms, such as mental health training for imams and pastors are crucial. These leaders can help bridge worldviews, demystify biomedical care, and direct youth toward appropriate resources.

5. Limitation

This study has some limitations. First, the cross-sectional design limits causal inferences; however, theoretical frameworks were used to strengthen interpretation. Second, self-reported data may be subject to social desirability bias, which was minimized through anonymous surveys and trained interviewers. Third, findings may not be generalizable beyond the

FCT, though inclusion of both urban and rural schools improves transferability. Fourth, this study is subject to selection bias, as participants were recruited exclusively from in-school adolescents attending public and private secondary schools in the FCT. Consequently, out-of-school adolescents who may have different or higher mental health risks and distinct help-seeking patterns were excluded, limiting the generalizability of the findings to the broader adolescent population. Lastly, while measurement tools were adapted and pre-tested, they may not capture all nuances of mental health experiences. To enhance validity, a mixed methods approach with triangulation across students, parents, teachers, and professionals was employed.

6. Conclusions

This study provides empirical evidence on the sources of mental health help-seeking among Nigerian adolescents and the factors associated with their choice of formal versus informal support. While over half of respondents reported using formal services, help-seeking behaviour was significantly shaped by contextual and socio-demographic factors, particularly urban school location and father's level of education. These findings suggest that structural access, socio-economic positioning, and family literacy play a more decisive role than school type alone in determining adolescents' engagement with professional mental health services..

Strengthening school-based mental health systems through structured mental health education, routine screening, and targeted training for teachers, especially in public and rural schools—is essential. At the family and community levels, improving parental mental health literacy and engaging religious and community leaders can help reduce stigma and facilitate timely referral to appropriate services. From a policy perspective, the results support the integration of adolescent mental health into national education and health policies, with deliberate investments in adolescent-friendly services, task-shifting approaches, and digital or mobile mental health platforms to improve access in underserved areas. A coordinated, multisectoral approach that links schools, families, communities, and the health system is necessary to reduce inequities and sustainably improve adolescent mental health outcomes in Nigeria.

Abbreviations

FCT	Federal Capital Territory
LMICs	Low- and Middle-Income Countries
SPSS	Statistical Package for the Social Sciences
OR	Odds Ratio
AOR	Adjusted Odds Ratio
CI	Confidence Interval
JSS	Junior Secondary School
SSS	Senior Secondary School

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Author Contributions

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Data Availability Statement

The data supporting the findings of this study were generated through structured questionnaires administered to adolescents and teachers across selected secondary schools in the Federal Capital Territory (FCT), Abuja. Due to ethical restrictions, particularly the need to protect the confidentiality and anonymity of adolescent participants and school personnel, the datasets are not publicly available. De-identified data may be made available upon reasonable request from the corresponding author, subject to approval from the institutional ethics committee and in accordance with data protection guidelines.

Conflicts of Interest

The authors declare no conflicts of interest.

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