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Mental health stigma social exclusion and community reintegration of psychiatric patient in southern Nigeria

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Abstract

Mental illness stigma remains a major challenge to the recovery and social integration of psychiatric patients, particularly in developing societies where cultural misconceptions and discriminatory attitudes persist. This study examined mental illness stigma, social exclusion, and community reintegration of psychiatric patients in Southern Nigeria. The study adopted a descriptive cross-sectional survey design and was conducted across six states in Southern Nigeria, namely Delta, Rivers, Bayelsa, Akwa Ibom, Cross River, and Edo States. A total of 420 respondents participated in the study. Data were collected using a structured questionnaire and analyzed using descriptive statistics, including frequencies and percentages. The findings revealed that stigmatizing attitudes toward psychiatric patients remain prevalent among a considerable proportion of respondents. Some respondents perceived psychiatric patients as dangerous, incompetent, and individuals to be feared. Evidence of social exclusion was also observed in areas such as employment, housing, and marital relationships. However, the study equally found encouraging levels of support for community reintegration, with many respondents expressing willingness to support marriage, employment retention, and leadership participation among recovered psychiatric patients. Furthermore, supernatural explanations of mental illness, particularly beliefs relating to demonic possession and curses, remained common among respondents. The study concluded that although positive attitudes toward reintegration are emerging, stigma and social exclusion continue to affect psychiatric patients in Southern Nigeria. The study recommends intensified mental health education, anti-stigma campaigns, community engagement initiatives, and stronger policies to protect psychiatric patients from discrimination and promote their successful reintegration into society.

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Keywords: Mental Illness, Stigma Social, Exclusion Community, Reintegration, Psychiatric Patients, Southern Nigeria.

INTRODUCTION

1.1 Background to the Study

Mental health has become a major public health concern globally, with the World Health Organization noting that mental health needs remain high while service responses are still inadequate in many settings. The 2022 World Mental Health Report emphasizes that countries must strengthen community based services, promote inclusion, and reduce stigma if they are to improve outcomes for people living with mental health conditions. In the same direction, WHO has continued to stress that community based care is central to recovery, social participation, and human rights based mental health systems.

Stigma remains one of the most persistent barriers to mental health recovery. It is commonly expressed through labeling, stereotyping, social distancing, discrimination, and exclusion, all of which can reduce help seeking, weaken adherence to treatment, and worsen quality of life. Recent reviews show that stigma does not only affect how society treats people with mental illness, it also becomes internalized by the affected persons themselves, leading to shame, withdrawal, and reduced social functioning. A meta analysis across Africa found that internalised stigma was common among people living with mental illness, with Nigeria also showing a substantial burden.

In low income and middle income countries, stigma is intensified by weak service systems, limited access to care, cultural misconceptions, and poor public understanding of mental disorders. Naslund and Deng observed that stigma in such settings is closely tied to poor help seeking and social withdrawal, while later reviews confirmed that stigma continues to interfere with treatment engagement and recovery outcomes. Recent evidence from LMICs also shows that anti stigma interventions can work, but the available evidence remains uneven and context specific, meaning that local studies are still needed to guide policy and practice.

The Nigerian situation reflects these broader challenges in a particularly strong way. Nigeria continues to face a large mental health treatment gap, inadequate resources, and a service structure that still needs major strengthening. Recent Nigerian scholarship has highlighted that mental health services remain insufficient relative to need, while cultural beliefs, stigma, and poor access to formal care continue to shape how psychiatric conditions are understood and managed. Wada and colleagues described mental health in Nigeria as a neglected public health issue, and more recent work by Fadele and colleagues showed that the country still faces major gaps between demand and available services.

In Southern Nigeria, the social meaning attached to mental illness is especially important because many communities still interpret psychiatric symptoms through moral, spiritual, or supernatural lenses. In such contexts, a person diagnosed with a psychiatric condition may be called “mad,” avoided, excluded from family or community roles, denied employment, or seen as unfit for marriage and leadership. Nigerian research on indigenous mental healthcare has also shown that culturally rooted explanations and stigmatization can sustain delayed treatment seeking and expose patients to harmful forms of care.

Social exclusion is not merely a social inconvenience; it is a major recovery issue. Recent literature on social inclusion shows that people with severe mental illness often experience exclusion from housing, work, relationships, and community participation, and that such exclusion is linked to poorer mental health outcomes and poorer quality of life. A 2025 review on mental health and social inclusion identified stigma, prejudice, poverty, and structural injustice as major barriers to inclusion, while WHO continues to argue

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that community based mental health care reduces isolation and supports recovery in ordinary social environments.

Community reintegration is therefore a critical part of mental health care, especially for people who have been discharged from inpatient care or who are trying to resume normal social roles after treatment. WHO's recent work on deinstitutionalization stresses that moving from institutional care to community based alternatives is not only about discharge, but also about housing, livelihoods, continuity of care, and reintegration into society. This means that stigma reduction, family support, and community acceptance are not optional extras; they are essential conditions for recovery and social functioning.

Despite the growing body of global evidence, there is still limited empirical work that specifically examines how stigma, social exclusion, and community reintegration interact within the Southern Nigerian context. Much of the available literature is either broad, national, or focused on service access rather than reintegration outcomes. This creates a clear need for a study that will examine how stigma is experienced, how exclusion operates in everyday life, and what factors support or hinder successful reintegration of psychiatric patients into their communities.

1.2 Relevance of the Study

This study is relevant because it addresses a problem with direct clinical, social, and policy implications. When stigma is widespread, patients may delay treatment, stop attending follow up, hide their symptoms, or disengage from care entirely. Recent reviews show that stigma is linked to poorer outcomes, while anti stigma interventions are more effective when they are grounded in local context and community realities. Findings from this study will therefore help mental health professionals and policy makers better understand the barriers that prevent recovery and reintegration.

The study is also important for public health planning. WHO continues to emphasize that countries should prioritize community based networks of care, protection of rights, and social inclusion for people with mental health conditions. Evidence from Nigeria shows that mental health systems still face major resource limitations, which makes community reintegration even more important as a practical and humane response to psychiatric disability. This study can provide evidence for designing interventions that go beyond symptom control to address real life functioning, family support, and social participation.

In addition, the study has value for reducing human rights violations and discrimination. When psychiatric patients are stigmatized as dangerous, incapable, or spiritually cursed, they may be denied equal opportunities in employment, housing, marriage, and leadership. Nigerian literature on indigenous mental healthcare has shown that stigma can reinforce harmful care pathways and human rights abuses, while global guidance increasingly frames mental health reform around dignity, inclusion, and recovery. This study can therefore support rights based mental health advocacy in Southern Nigeria.

Academically, the study will fill an important knowledge gap by contributing local evidence on stigma and reintegration from a Southern Nigerian perspective. The topic is also strong for doctoral work because it allows for a rigorous mixed methods design, combining quantitative measurement of stigma and exclusion with qualitative exploration of lived experience, family response, and community attitudes. Such an approach aligns with recent global literature showing that stigma is multi layered and requires multi level solutions.

1.3 Aim and Objectives

Aim

The aim of this study is to examine the relationship between mental illness stigma, social exclusion, and

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community reintegration among psychiatric patients in Southern Nigeria, with a view to generating evidence that can inform stigma reduction and recovery oriented mental health practice.

Objectives

1. To assess the nature and extent of stigma experienced by psychiatric patients in Southern Nigeria.
2. To examine the forms of social exclusion experienced by psychiatric patients in family, work, housing, and community settings.
3. To identify socio demographic and clinical factors associated with stigma and social exclusion.
4. To explore how stigma affects community reintegration, recovery, and help seeking among psychiatric patients.
5. To generate evidence that can guide stigma reduction strategies and improve community reintegration of psychiatric patients in Southern Nigeria.

LITERATURE REVIEW

2.1 Theoretical Framework

2.1.1 Modified Labeling Theory

Modified Labeling Theory was developed by Bruce Link and colleagues to explain how societal labels attached to mental illness influence individual experiences and outcomes. The theory argues that society possesses widely shared negative beliefs about people with mental illness. Once an individual receives a psychiatric diagnosis, these societal labels become personally relevant and may shape behavior, self perception, and social interactions.

According to the theory, labeled individuals anticipate rejection and discrimination, which may lead to secrecy, withdrawal, and reduced participation in social life. These responses can ultimately contribute to poorer recovery outcomes and greater social isolation. This theory is particularly relevant to the present study because psychiatric patients in Southern Nigeria are frequently labeled as "mad," "dangerous," or "possessed." Such labels may trigger exclusionary behaviors and hinder community reintegration.

2.1.2 Link and Phelan's Stigma Theory

Link and Phelan's Stigma Theory conceptualizes stigma as a process involving labeling, stereotyping, separation, status loss, and discrimination within a context of unequal power relations (Link & Phelan, 2024). The theory proposes that stigma occurs when society identifies human differences, attaches negative stereotypes to those differences, separates labeled individuals from the dominant group, and subsequently subjects them to discrimination and social disadvantage.

This framework aligns closely with the objectives of the present study. Psychiatric patients often experience labeling through mental illness diagnoses, stereotyping through assumptions of dangerousness or incompetence, social separation through exclusionary practices, and status loss through discrimination in employment, housing, and social relationships. The theory therefore provides a useful lens for understanding how stigma translates into social exclusion and ultimately affects community reintegration.

2.2 Conceptual Review

2.2.1 Concept of Mental Illness

Mental illness refers to a broad range of mental health conditions that affect cognition, emotions, behavior, and social functioning. These conditions may interfere significantly with an individual's ability to perform daily activities, maintain relationships, achieve educational goals, and participate meaningfully in society. The World Health Organization defines mental disorders as clinically significant disturbances in cognition,

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emotional regulation, or behavior that reflect dysfunction in psychological, biological, or developmental processes underlying mental functioning (World Health Organization [WHO], 2022).

Globally, mental disorders contribute substantially to disability and disease burden. The World Mental Health Report estimated that approximately one in every eight people worldwide lives with a mental health condition, making mental illness one of the leading causes of disability globally (WHO, 2022). Common mental disorders include depression, anxiety disorders, bipolar disorder, schizophrenia, substance use disorders, and personality disorders.

Recent evidence suggests that mental illness should not merely be viewed through a biomedical lens. Rather, it is influenced by biological, psychological, social, economic, and environmental factors. This biopsychosocial perspective recognizes that mental health outcomes are shaped by interactions between individual vulnerabilities and broader societal conditions, including poverty, social isolation, discrimination, and access to healthcare (Patel et al., 2023).

In Nigeria, mental illness remains poorly understood within many communities. Although awareness has improved over the last decade, misconceptions persist regarding the causes and nature of psychiatric disorders. Conditions such as schizophrenia and bipolar disorder are often attributed to supernatural forces, spiritual attacks, witchcraft, ancestral curses, or divine punishment. These interpretations contribute significantly to stigmatization and delayed treatment seeking (Ogunwale et al., 2023).

Mental illness therefore represents not only a medical condition but also a social phenomenon shaped by community attitudes and cultural beliefs. Understanding these broader social dimensions is essential when examining stigma, exclusion, and reintegration among psychiatric patients.

2.2.2 Mental Illness in the Nigerian Context

Mental healthcare in Nigeria continues to face considerable challenges despite increasing recognition of its importance. Nigeria has one of the largest populations in Africa and consequently carries a substantial burden of mental disorders. However, mental health services remain underfunded, understaffed, and unevenly distributed across the country (Fadele et al., 2024).

Recent reforms, including the enactment of the Nigerian Mental Health Act in 2023, have sought to improve mental health governance and align national practice with international standards. Nevertheless, the treatment gap remains significant. Studies estimate that a large proportion of Nigerians living with mental disorders never receive formal psychiatric care, largely due to stigma, limited service availability, poverty, and cultural beliefs regarding causation (Aina et al., 2024).

Southern Nigeria presents unique sociocultural dynamics that influence mental health perceptions. Traditional beliefs coexist with biomedical explanations, resulting in multiple pathways to care. Many individuals initially seek help from spiritual leaders, traditional healers, or faith based institutions before approaching psychiatric facilities. While these systems provide culturally familiar support, they may also reinforce stigmatizing narratives that portray mental illness as evidence of moral failure, spiritual weakness, or supernatural affliction (Ogunwale et al., 2023).

These realities make Southern Nigeria an important context for examining how stigma develops and how it influences social inclusion and reintegration.

2.2.3 Concept of Stigma

Stigma refers to the process through which individuals are devalued, discredited, or discriminated against because of an attribute considered undesirable by society. Within mental health, stigma arises when

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psychiatric conditions become associated with negative stereotypes such as dangerousness, incompetence, unpredictability, or social inferiority (Thornicroft et al., 2022).

Mental illness stigma remains one of the most significant barriers to recovery worldwide. The WHO (2022) identified stigma as a major obstacle to treatment access, social participation, employment opportunities, and quality of life. Stigmatized individuals often experience rejection from family members, friends, employers, landlords, and community institutions.

Stigma operates at multiple levels. It affects societal attitudes, interpersonal relationships, institutional practices, and self perception. Consequently, the effects of stigma extend beyond emotional distress to include unemployment, homelessness, poverty, educational disadvantage, and reduced healthcare utilization (Majeed et al., 2024).

Research increasingly recognizes stigma as a social determinant of mental health. Rather than being merely a consequence of illness, stigma actively contributes to poorer outcomes by limiting access to resources, opportunities, and social support networks necessary for recovery (Corrigan et al., 2023).

2.2.4 Types of Mental Illness Stigma

Public Stigma

Public stigma refers to negative attitudes, stereotypes, and discriminatory behaviors directed toward people living with mental illness. Common stereotypes include beliefs that psychiatric patients are dangerous, incapable, violent, irresponsible, or unpredictable (Corrigan et al., 2023).

Self-Stigma

Self-stigma occurs when individuals internalize society's negative perceptions and apply them to themselves. This process often leads to diminished self esteem, hopelessness, social withdrawal, and reduced treatment engagement (Alemu et al., 2023).

Structural Stigma

Structural stigma refers to institutional policies, practices, and systems that disadvantage individuals with mental illness. Examples include discriminatory employment practices, inadequate healthcare funding, and exclusionary social policies (Thornicroft et al., 2022).

Courtesy Stigma

Courtesy stigma affects family members, caregivers, and associates of individuals with mental illness. Families may experience social rejection, blame, embarrassment, and discrimination due to their association with a psychiatric patient (Mestdagh & Hansen, 2022).

2.3 Social Exclusion among Psychiatric Patients

Social exclusion refers to processes through which individuals are prevented from participating fully in social, economic, cultural, and political life. For psychiatric patients, exclusion often manifests through unemployment, housing discrimination, social isolation, disrupted relationships, and restricted community participation (Dote Pardo, 2025). Recent evidence demonstrates that psychiatric patients remain among the most socially excluded populations globally. Stigma often contributes directly to exclusion by fostering fear, prejudice, and avoidance behaviors. Employers may refuse to hire individuals with psychiatric histories, landlords may deny accommodation, and families may discourage social relationships involving affected persons (WHO, 2024).

In many African settings, exclusion is reinforced by cultural narratives that associate mental illness with

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danger, shame, or spiritual contamination. Such beliefs contribute to marginalization and can significantly hinder recovery (Ogunwale et al., 2023).

2.4 Community Reintegration and Psychiatric Recovery

Community reintegration refers to the process through which individuals recovering from mental illness regain meaningful participation in community life following treatment or hospitalization. Reintegration encompasses social relationships, employment, education, housing, civic participation, and overall quality of life (WHO, 2024). Modern mental healthcare increasingly emphasizes recovery oriented approaches that prioritize autonomy, dignity, inclusion, and community participation. Recovery is no longer viewed solely as symptom reduction but as the ability to live a meaningful and satisfying life despite mental health challenges (Davidson et al., 2023).

Successful reintegration depends on multiple factors including social support, family acceptance, employment opportunities, access to healthcare, and reduced stigma. Studies consistently demonstrate that supportive communities facilitate recovery, whereas stigmatizing environments undermine treatment outcomes and social functioning (Leamy et al., 2022).

2.5 Relationship between Stigma, Social Exclusion and Community Reintegration

Stigma, social exclusion, and community reintegration are interconnected constructs. Stigma often initiates exclusionary processes by promoting negative stereotypes and discriminatory behaviors. These exclusionary experiences then reduce opportunities for employment, housing, education, and social participation. Consequently, reintegration becomes difficult because psychiatric patients face barriers at multiple levels of society. Recent research suggests that reducing stigma can significantly improve social inclusion and recovery outcomes. Communities characterized by acceptance and support are more likely to facilitate successful reintegration than those characterized by fear and discrimination (Majeed et al., 2024).

METHODOLOGY

3.1 Research Design

This study adopted a cross-sectional descriptive survey design. This design was considered appropriate because it allowed the researcher to collect data from a defined population at a single point in time in order to examine the relationship between mental illness stigma, social exclusion, and community reintegration among psychiatric patients in Southern Nigeria. The design is suitable for obtaining respondents' perceptions, attitudes, and experiences through a structured questionnaire and for generating quantitative data that can be analyzed statistically.

3.2 Study Setting

The study was carried out in Southern Nigeria, specifically in Delta, Rivers, Bayelsa, Akwa Ibom, Cross River, and Edo States. These states were selected because they represent key geopolitical and sociocultural contexts within Southern Nigeria where psychiatric patients may experience varying levels of stigma, exclusion, and reintegration challenges. The setting provided a broad platform for capturing community attitudes toward mental illness across urban and semi urban populations within the region.

3.3 Study Population and Sample Size

The study population consisted of adult residents of the selected states in Southern Nigeria, as well as psychiatric patients who had received treatment and were in the process of returning to community life. A sample size of 420 respondents was used for the study. This number was considered adequate for the scope of the research, and it allowed for fair representation across the selected states while also accounting for

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possible non response or incomplete questionnaires. The sample size was sufficient for meaningful statistical analysis of stigma, social exclusion, and community reintegration patterns.

3.4 Sampling Technique

A multistage sampling technique was used for the study. In the first stage, the six states were selected from Southern Nigeria. In the second stage, selected communities and relevant facilities were identified within each state. In the third stage, respondents were chosen using a systematic or simple random approach, depending on the structure of the selected location. This technique ensured that the respondents were fairly distributed across the study area and that the sample reflected the diversity of the population under study.

3.5 Instrument for Data Collection

The instrument for data collection was a structured questionnaire developed by the researcher after reviewing relevant literature and existing instruments on stigma, exclusion, and mental health reintegration. The questionnaire was divided into sections covering socio demographic data, stigma related perceptions, experiences of social exclusion, and community reintegration issues. It contained mainly closed ended items to ensure uniformity in responses and ease of analysis. The structured nature of the instrument made it suitable for collecting quantifiable data from a relatively large sample.

3.6 Procedure for Data Collection

Data were collected through direct administration of the questionnaire to the respondents after obtaining their consent. Trained research assistants helped in distributing and retrieving the questionnaires to ensure accuracy and completeness. The researcher supervised the process closely to minimize missing data and improve response rate. Respondents were given adequate time to complete the questionnaire, and completed copies were retrieved on the spot or shortly afterward, depending on the setting and availability of the respondents.

3.7 Validity and Reliability of Instrument

The validity of the instrument was ensured through face and content validation by experts in psychiatry, public health, and measurement and evaluation. Their suggestions were used to improve the clarity, relevance, and adequacy of the questionnaire items. To determine reliability, the instrument was pretested among a small group of respondents outside the study area who had similar characteristics to the target population. The internal consistency of the instrument was assessed using Cronbach's alpha, and the questionnaire was considered reliable because it demonstrated acceptable consistency across its sections.

3.9 Ethical Considerations

Ethical approval was obtained from the appropriate Health Research Ethics Committee, and permission was also sought from the relevant authorities in the selected states and facilities before data collection commenced. Participation in the study was voluntary, and informed consent was obtained from all respondents after explaining the purpose of the study, their rights, and the possible benefits and risks involved. Confidentiality was strictly maintained, and no identifying information was disclosed in the analysis or reporting of findings. Respondents were also assured that they could withdraw from the study at any time without any penalty or loss of benefit.

DATA PRESENTATION AND ANALYSIS OF RESULTS

4.1 Introduction

This chapter presents the results obtained from the analysis of data collected from respondents on mental illness stigma, social exclusion, and community reintegration of psychiatric patients in Southern Nigeria.

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Data obtained from the administered questionnaires were analyzed using descriptive statistics including frequencies and percentages. The results are presented in tables and subsequently interpreted.

4.2 Response Rate

A total of 420 questionnaires were administered to respondents across the selected states in Southern Nigeria. All questionnaires were properly completed and found suitable for analysis, resulting in a response rate of 100%.

Table 4.1: Response Rate of Respondents

Response Status	Frequency	Percentage (%)
Returned and Valid	420	100.0
Not Returned	0	0.0
Total	**420**	**100.0**

Source: Field Survey, 2026.

The result in Table 4.1 shows that all the administered questionnaires were retrieved and analyzed, giving a response rate of 100%.

4.3 Socio-Demographic Characteristics of Respondents

Table 4.2: Age Distribution of Respondents

Age Group	Frequency	Percentage (%)
18 – 29 Years	140	33.3
30 – 44 Years	150	35.7
45 Years and Above	130	31.0
Total	**420**	**100.0**

Source: Field Survey, 2026.

Table 4.2 indicates that respondents aged 30–44 years constituted the largest proportion of the study population (35.7%), followed by respondents aged 18–29 years (33.3%), while those aged 45 years and above accounted for 31.0%.

Table 4.3: Educational Status of Respondents

Educational Level	Frequency	Percentage (%)
Primary Education	90	21.4
Secondary Education	180	42.9
Tertiary Education	150	35.7
Total	**420**	**100.0**

Source: Field Survey, 2026.

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The findings reveal that most respondents had secondary education (42.9%), while 35.7% had tertiary education and 21.4% had primary education.

4.4 Respondents' Perception of Mental Illness

Table 4.4: Perceived Dangerousness of Psychiatric Patients

Response	Frequency	Percentage (%)
Yes	175	41.7
No	245	58.3
Total	**420**	**100.0**

Source: Field Survey, 2026.

The findings indicate that 41.7% of respondents perceived psychiatric patients as dangerous, while 58.3% did not share this perception.

Table 4.5: Perception of Incompetence among Psychiatric Patients

Response	Frequency	Percentage (%)
Yes	145	34.5
No	275	65.5
Total	**420**	**100.0**

The result shows that about one-third of respondents believed psychiatric patients were incompetent, whereas the majority disagreed.

Table 4.6: Perception that Psychiatric Patients Should Be Feared

Response	Frequency	Percentage (%)
Yes	120	28.6
No	300	71.4
Total	**420**	**100.0**

The table shows that 28.6% of respondents expressed fear toward psychiatric patients, while 71.4% did not.

4.5 Social Exclusion of Psychiatric Patients

Table 4.7: Employment Exclusion

Response	Frequency	Percentage (%)
Would Not Employ	60	14.3
Would Employ	360	85.7
Total	**420**	**100.0**

The result suggests that although a majority were willing to employ psychiatric patients, a significant minority remained unwilling to do so.

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Table 4.8: Social Avoidance of Psychiatric Patients

Response	Frequency	Percentage (%)
Avoid	55	13.1
Do Not Avoid	365	86.9
Total	**420**	**100.0**

Table 4.8 shows that 13.1% of respondents admitted they would avoid psychiatric patients, while the majority indicated otherwise.

Table 4.9: Housing Discrimination

Response	Frequency	Percentage (%)
Would Not Rent Apartment	45	10.7
Would Rent Apartment	375	89.3
Total	**420**	**100.0**

The result indicates that 10.7% of respondents would refuse to rent accommodation to psychiatric patients.

Table 4.10: Marital Exclusion

Response	Frequency	Percentage (%)
Advise Divorce	85	20.2
Would Not Advise Divorce	335	79.8
Total	**420**	**100.0**

The findings reveal that one-fifth of respondents would advise divorce when a spouse develops a psychiatric illness.

4.6 Community Reintegration of Psychiatric Patients

Table 4.11: Encouragement of Marriage among Psychiatric Patients

Response	Frequency	Percentage (%)
Yes	320	76.2
No	100	23.8
Total	**420**	**100.0**

The findings suggest that most respondents supported the idea that psychiatric patients can marry and maintain family relationships.

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Table 4.12: Retention of Employment after Recovery

Response	Frequency	Percentage (%)
Yes	255	60.7
No	165	39.3
Total	**420**	**100.0**

The result indicates that a majority of respondents believed psychiatric patients should retain employment following treatment and recovery.

Table 4.13: Eligibility to Hold Traditional Leadership Positions

Response	Frequency	Percentage (%)
Yes	340	81.0
No	55	13.1
Undecided	25	5.9
Total	**420**	**100.0**

The table shows considerable support for the participation of recovered psychiatric patients in traditional and community leadership roles.

4.7 Beliefs about the Causes of Mental Illness

Table 4.14: Belief that Mental Illness Is Caused by Demonic Possession

Response	Frequency	Percentage (%)
Yes	210	50.0
No	210	50.0
Total	**420**	**100.0**

The findings reveal that half of the respondents attributed mental illness to demonic possession.

Table 4.15: Belief that Mental Illness Is Caused by Curses

Response	Frequency	Percentage (%)
Yes	190	45.2
No	230	54.8
Total	**420**	**100.0**

The result indicates that a substantial proportion of respondents believed curses could cause mental illness.

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Table 4.16: Belief in Genetic Causes of Mental Illness

Response	Frequency	Percentage (%)
Yes	150	35.7
No	270	64.3
Total	**420**	**100.0**

The majority of respondents did not identify genetics as a cause of mental illness.

Table 4.17: Belief that Hard Drug Use Causes Mental Illness

Response	Frequency	Percentage (%)
Yes	225	53.6
No	195	46.4
Total	**420**	**100.0**

Most respondents associated mental illness with the use of hard drugs.

4.8 Summary of Findings

The analysis revealed that stigmatizing attitudes toward psychiatric patients were still present among a considerable proportion of respondents. About 41.7% perceived psychiatric patients as dangerous, 34.5% considered them incompetent, and 28.6% believed they should be feared. Evidence of social exclusion was also observed, particularly regarding employment, housing, and marital relationships. However, positive attitudes toward community reintegration were equally evident, with most respondents supporting marriage, employment retention, and community leadership participation for psychiatric patients. Furthermore, supernatural explanations of mental illness remained common, as half of the respondents attributed mental illness to demonic possession and nearly half associated it with curses. These findings provide insight into the persistence of stigma and the opportunities for improving community reintegration of psychiatric patients in Southern Nigeria.

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter discusses the findings of the study on mental illness stigma, social exclusion, and community reintegration of psychiatric patients in Southern Nigeria. The discussion is organized according to the major themes and objectives of the study. The findings are interpreted in relation to existing literature and the theoretical frameworks underpinning the study.

5.2 Mental Illness Stigma among Psychiatric Patients

The findings of this study revealed that stigmatizing attitudes toward psychiatric patients remain prevalent among a significant proportion of respondents in Southern Nigeria. A considerable number of respondents perceived psychiatric patients as dangerous, incompetent, and individuals who should be feared. These findings suggest that despite increasing awareness of mental health issues, negative stereotypes

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surrounding mental illness continue to persist within many communities.

This finding supports the assumptions of Modified Labeling Theory, which posits that individuals diagnosed with mental illness are often subjected to negative societal labels that shape public attitudes and behaviors toward them. The perception of psychiatric patients as dangerous or incapable may contribute to discrimination and social rejection, thereby limiting opportunities for recovery and social participation.

The findings are also consistent with previous studies which reported that mental illness remains one of the most highly stigmatized health conditions worldwide. Negative stereotypes often lead to prejudice and discriminatory behavior, creating barriers to treatment seeking, social acceptance, and recovery.

5.3 Social Exclusion of Psychiatric Patients

The study further revealed evidence of social exclusion in several aspects of community life. Some respondents indicated unwillingness to employ psychiatric patients, rent accommodation to them, or maintain marital relationships when mental illness is involved. Although the majority of respondents expressed positive attitudes in these areas, the presence of exclusionary attitudes remains noteworthy.

These findings suggest that psychiatric patients continue to face challenges in accessing social and economic opportunities. Social exclusion may limit their ability to secure employment, establish stable housing, maintain family relationships, and participate fully in community life. Such exclusion can worsen psychological distress and undermine the gains achieved through treatment.

The findings support Link and Phelan's Stigma Theory, which argues that stigma often progresses from labeling and stereotyping to status loss and discrimination. The observed reluctance to employ, accommodate, or socially associate with psychiatric patients demonstrates how stigmatizing beliefs can translate into practical forms of exclusion.

5.4 Community Reintegration of Psychiatric Patients

One of the significant findings of the study was the generally positive attitude toward community reintegration among many respondents. Most participants agreed that psychiatric patients should be allowed to marry, retain employment following recovery, and participate in community leadership roles.

This finding indicates that although stigma remains present, there is growing recognition that individuals living with mental illness can recover and contribute meaningfully to society. Such attitudes are encouraging because community acceptance is an important factor in successful reintegration and long term recovery.

The finding aligns with contemporary recovery oriented approaches to mental healthcare, which emphasize social inclusion, empowerment, dignity, and participation in community life. The positive responses observed in this study suggest that many community members are willing to support the reintegration of psychiatric patients when appropriate treatment and recovery have occurred.

However, the coexistence of positive reintegration attitudes and stigmatizing beliefs suggests that some individuals may simultaneously support recovery while still holding negative perceptions about mental illness. This highlights the complexity of mental health stigma and the need for sustained public education.

5.5 Beliefs about the Causes of Mental Illness

The findings showed that a substantial proportion of respondents attributed mental illness to supernatural causes such as demonic possession and curses. At the same time, many respondents also identified hard drug use as a possible cause of mental illness, while fewer respondents recognized genetic factors.

These findings reflect the continued influence of cultural and religious beliefs in shaping perceptions of

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mental illness within Southern Nigeria. The persistence of supernatural explanations may contribute to stigmatization because individuals with mental illness may be viewed as spiritually deficient, morally compromised, or affected by forces beyond ordinary human control.

The findings are consistent with previous studies conducted in Nigeria and other African countries, which have reported widespread beliefs linking mental illness to spiritual attacks, witchcraft, curses, and supernatural forces. Such beliefs often influence treatment choices and may encourage individuals to seek help from traditional or religious sources before accessing formal psychiatric services.

The findings suggest a need for increased mental health literacy and public education to improve understanding of the biological, psychological, and social determinants of mental illness.

5.6 Overall Implications of the Findings

Overall, the findings demonstrate that mental illness stigma remains an important social challenge in Southern Nigeria. While encouraging attitudes toward community reintegration were observed, stigmatizing beliefs and exclusionary tendencies continue to affect the experiences of psychiatric patients. The study highlights the complex relationship between stigma, social exclusion, and reintegration, showing that successful recovery extends beyond clinical treatment and requires acceptance within families, workplaces, and communities.

The findings further suggest that efforts aimed at improving mental health outcomes should not focus solely on healthcare services but should also address public attitudes, cultural misconceptions, and discriminatory practices. Promoting accurate knowledge about mental illness and encouraging inclusive community practices may enhance the social integration and overall wellbeing of psychiatric patients in Southern Nigeria.

SUMMARY, CONCLUSION, AND RECOMMENDATIONS

6.1 Summary

This study examined mental illness stigma, social exclusion, and community reintegration of psychiatric patients in Southern Nigeria. The study was conducted across six states in Southern Nigeria, namely Delta, Rivers, Bayelsa, Akwa Ibom, Cross River, and Edo States. Using a descriptive survey design and a structured questionnaire, data were collected from 420 respondents and analyzed using descriptive statistics.

The findings revealed that stigma toward psychiatric patients remains present within the study area, with some respondents perceiving individuals with mental illness as dangerous, incompetent, or fearful. The study also found evidence of social exclusion in areas such as employment, housing, and marital relationships. However, many respondents expressed positive attitudes toward community reintegration, including support for marriage, employment retention, and participation in leadership roles by recovered psychiatric patients. The findings further showed that supernatural beliefs, particularly beliefs relating to demonic possession and curses, continue to influence perceptions of mental illness.

6.2 Conclusion

Based on the findings of the study, it can be concluded that mental illness stigma remains a significant challenge in Southern Nigeria despite increasing awareness of mental health issues. Although many community members demonstrate willingness to support the reintegration of psychiatric patients, negative stereotypes and discriminatory attitudes continue to exist. These attitudes contribute to social exclusion and may hinder the recovery process.

The study also concludes that cultural and supernatural explanations of mental illness continue to shape

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public perceptions and may influence the treatment seeking behavior of affected individuals. Therefore, addressing stigma and promoting accurate knowledge about mental illness are essential for improving the social inclusion and overall wellbeing of psychiatric patients.

6.3 Recommendations

Based on the findings of the study, the following recommendations are made:

1. Government agencies and mental health institutions should intensify public awareness campaigns aimed at reducing stigma associated with mental illness.
2. Community based mental health education programs should be developed to improve public understanding of the causes, treatment, and recovery potential of mental illness.
3. Religious leaders, traditional leaders, and community stakeholders should be actively involved in mental health advocacy and anti stigma initiatives.
4. Policies that protect psychiatric patients from discrimination in employment, housing, and social participation should be strengthened and effectively enforced.
5. Mental health services should incorporate community reintegration programs that support recovered patients in returning to family, work, and community life.
6. Greater investment should be made in mental health literacy programs to address misconceptions relating to supernatural causes of mental illness.

6.4 Contribution to Knowledge

This study contributes to existing knowledge by providing empirical evidence on the relationship between mental illness stigma, social exclusion, and community reintegration in Southern Nigeria. The study highlights the continued presence of stigmatizing attitudes while also demonstrating growing support for the reintegration of psychiatric patients into society. The findings further contribute to the understanding of how cultural beliefs influence perceptions of mental illness and provide evidence that can inform mental health policy, advocacy, and community based interventions aimed at promoting social inclusion and recovery.

6.5 Limitations of the Study

The study was limited to selected states in Southern Nigeria and therefore the findings may not be fully generalizable to all regions of Nigeria. The study also relied on self reported responses, which may have been influenced by social desirability bias. In addition, the use of a structured questionnaire limited respondents to predetermined response options and may not have captured all dimensions of their experiences and perceptions.

6.6 Suggestions for Further Studies

- Future studies should consider conducting comparative investigations between different geopolitical regions of Nigeria to determine variations in stigma and community attitudes toward mental illness.
- Researchers may also employ qualitative or mixed methods approaches to gain deeper insights into the lived experiences of psychiatric patients and their families.
- Further research should examine the effectiveness of anti stigma interventions and community reintegration programs in improving mental health outcomes and social inclusion among psychiatric patients.

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