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Exploring Coping and Barriers to Mental Health Help-Seeking Among Unemployed Adults with A History of Suicide in Adamawa State, Nigeria

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ABSTRACT
Mental health problems, particularly suicidal attempts, remain a major public health concern among young people in low-resource settings, including Nigeria, where access to formal mental health services remains limited. This study explored coping strategies and barriers to mental health help-seeking among unemployed adults with a history of suicidal attempts in Adamawa State, Nigeria. A phenomenological qualitative design was employed. Participants who met the study eligibility criteria were purposively recruited from the three senatorial zones of Adamawa State, and 11 participants aged 18–45 years who completed the in-depth interviews were included in the final analysis. Data were collected through audio-recorded in-depth interviews, transcribed verbatim, and analysed using Braun and Clarke's thematic analysis, with NVivo software used to facilitate data management and coding. Participants experienced substantial reliance on informal coping mechanisms, including engagement in daily activities as a means of distraction, social withdrawal, religious practices and culturally based remedies, while some reported seeking information or support through online and artificial intelligence resources. However, participants reported using them, but their accounts did not indicate effective relief or reliable substitution for professional care. Formal mental health services were rarely utilized and were generally sought when distress became severe. Participants identified several barriers to help-seeking, including stigma and fear of social labelling, cultural expectations of self-reliance, financial constraints, negative experiences or perceived negative attitudes from healthcare providers, and delayed recognition of mental health needs. The findings suggest that participants experienced substantial reliance on informal coping mechanisms within the context of socio-cultural, economic, and health-system barriers to formal mental health care. The study recommends strengthening community-based mental health awareness, reducing stigma, improving the affordability and accessibility of services, and enhancing the quality and acceptability of mental health care to facilitate timely help-seeking among vulnerable young people.

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INTRODUCTION

Suicidal behavior remains a major global public health concern, with substantial consequences for individuals, families, and communities. The World Health Organization (WHO) estimated that approximately 727,000 people died by suicide in 2021, with 73% of these deaths occurring in low- and middle-income countries (LMICs). Suicide was the third leading cause of death among people aged 15–29 years globally, while a previous suicide attempt is an important risk factor for subsequent suicide (World Health Organization [WHO], 2025a). Beyond mortality, people who survive suicidal behavior may continue to experience psychological distress, stigma, interpersonal difficulties, and challenges in accessing appropriate mental health support. These concerns are particularly important in LMICs, where mental health systems continue to experience substantial gaps in financing, human resources, and access to quality services (WHO, 2022, 2025b). Recent WHO evidence further indicates that persistent shortages of financial resources, skilled mental health workers, and quality services continue to limit the capacity of many countries to meet population mental health needs.

Mental health help-seeking is a multidimensional process that extends beyond the decision to consult a health professional. It involves recognizing psychological difficulties, interpreting them as requiring assistance, deciding whether to disclose them, identifying an acceptable source of support, and successfully accessing care (Rickwood et al., 2005). Among young people, this process may be influenced by perceived stigma, concerns about confidentiality, limited awareness of available services, preference for self-reliance, difficulties communicating emotional experiences, and concerns about how family members or peers may respond (Gulliver et al., 2010; Radez et al., 2021). Mental health-related stigma is particularly important because it can influence both the willingness to disclose psychological difficulties and the decision to seek professional assistance. A systematic review and meta-analysis found an association between mental health-related stigma and reduced active help-seeking (Schnyder et al., 2017). Similarly, Clement et al.

(2015) demonstrated that stigma can operate across several stages of the help-seeking process, including recognition of a problem, disclosure, and engagement with professional care.

In Nigeria, mental health help-seeking occurs within a complex sociocultural environment in which biomedical, religious, traditional, and community-based explanations of psychological problems may coexist. Earlier community-based research demonstrated that knowledge and attitudes concerning mental illness in Nigeria were influenced by beliefs about its causes and manifestations (Gureje et al., 2005). More recent evidence indicates that cultural interpretations continue to shape pathways to mental health care. Jidong et al. (2021) found that Nigerian participants held diverse understandings of mental health conditions, including spiritual and traditional explanations, and that these beliefs influenced perceptions of appropriate treatment and the use of traditional healing. Such findings indicate that help-seeking decisions cannot be adequately understood without considering the cultural meanings attached to psychological distress and the sources of support that individuals regard as legitimate.

Evidence from northern Nigeria further illustrates the influence of culturally embedded beliefs on pathways to care. Aghukwa (2012), in a study of psychiatric patients and their families in Kano, found that religious healing was commonly used before psychiatric treatment and that beliefs concerning supernatural explanations of mental illness were associated with delays in seeking psychiatric care. However, religious and spiritual practices should not be viewed solely as barriers to professional care. Religion and spirituality may provide meaning, hope, emotional support, and mechanisms for coping with distress (Koenig, 2009). The important issue is therefore how religious and other informal sources of support interact with professional care and whether they facilitate or delay access to appropriate mental health services.

Coping following suicidal behavior may similarly involve a range of responses shaped by individual circumstances and social environments. Individuals may draw on interpersonal relationships, religious beliefs, meaningful activities, and other sources of emotional support, while others may withdraw or avoid discussing their experiences. Evidence from Ghana demonstrates the complexity of these responses. Asare-Doku et al. (2017), in a qualitative study of families following a suicide attempt, identified social support, spirituality, and avoidance among the ways participants responded to the experience, while stigma and shame also influenced their coping. Although the study focused on families rather than attempt survivors themselves, its findings demonstrate the importance of examining suicidal behavior within the wider social and cultural environment in which coping and support occur.

The relationship between coping, socioeconomic circumstances, and help-seeking is particularly relevant among unemployed young people. Unemployment may occur alongside financial insecurity, uncertainty about the future, restricted opportunities, and pressures associated with expectations concerning education, employment, independence, and family responsibilities. Nigeria's Labour Force Survey reported an overall unemployment rate of 5.3% in the first quarter of 2024, with rates of 8.4% among people aged 15–24 years and 7.5% among those aged 25–34 years (National Bureau of Statistics [NBS], 2024). These figures provide national context rather than an estimate for unemployed young people in Adamawa State or for the precise 18–35-year age range of the present study. For young people experiencing significant psychological distress, socioeconomic difficulties may interact with interpersonal, cultural, and service-related factors to influence how distress is interpreted and managed. Unemployment should therefore not be regarded as a direct or single cause of suicidal behavior; rather, it represents one component of the broader social and economic context within which multiple risk and protective factors may operate.

Importantly, recent evidence from Adamawa State indicates that suicidal behavior among young people is already a documented concern. Iweama et al. (2024) examined suicidal ideation and attempts among 616 undergraduate students recruited from universities, colleges of education, and polytechnics in Adamawa Central Senatorial Zone. The study reported suicidal behavior in 34.9% of participants and identified significant associations involving factors such as sex, depression, hopelessness, perceived burdensomeness, and thwarted belongingness. The authors emphasized the need for mental health services and early identification and intervention for young people in Nigeria**.** This study provides important quantitative evidence concerning the burden and correlates of suicidal behavior in Adamawa State. However, its population consisted of tertiary institution students and its cross-sectional quantitative design was primarily concerned with prevalence and associated factors. It did not explore the lived experiences of unemployed young people who had survived a suicide attempt, their subsequent coping strategies, or the factors influencing their decisions to seek or not seek professional mental health support.

Recent Nigerian evidence also indicates that experiences of suicidal behavior and pathways to support are influenced by broader cultural and interpersonal contexts. Jidong et al. (2024), using mixed methods involving patients, family caregivers, clinicians, and members of the public, examined perspectives on self-harm and suicidal ideation in Nigeria. The qualitative component included patients with a history of self-harm and suicidal ideation, family caregivers, and clinicians. The findings highlighted the influence of cultural and religious beliefs on help-seeking and identified family members and close friends as important sources of support**.** However, the study was not specifically focused on unemployed young people in Adamawa State, nor did it center specifically on coping and barriers to professional mental health help-seeking following a suicide attempt.

Consequently, an important gap remains in the Adamawa literature. Existing local evidence has established the presence and correlates of suicidal behavior among young people, particularly tertiary students, but there is limited qualitative evidence concerning how unemployed young people who have experienced a suicide attempt understand and manage their subsequent psychological distress**.** In particular, little is known about the coping strategies they employ, the sources of support they consider acceptable, and the social, cultural, economic, and service-related factors that facilitate or hinder professional mental health help-seeking. This distinction is important because findings from tertiary students cannot necessarily be generalized to unemployed young people, whose socioeconomic circumstances, daily stressors, social expectations, and access to support may differ substantially. Moreover, quantitative evidence identifying associated factors does not necessarily explain how individuals experience those factors or how they influence everyday coping and help-seeking decisions.

Understanding these experiences requires attention not only to the availability of mental health services but also to how young people interpret psychological distress, whom they trust, how they cope, and what influences their willingness or reluctance to seek professional assistance. Qualitative inquiry can provide this contextual understanding by allowing

participants to describe their experiences and meanings in their own words and by identifying barriers and coping processes that may not be adequately captured through quantitative measures. Such evidence is particularly relevant for developing mental health services that are culturally responsive, socially acceptable, and accessible to young people who may remain disconnected from formal care.

Therefore, this study explored coping strategies and barriers to mental health help-seeking among unemployed young people with a history of suicide attempts in Adamawa State, Nigeria. The study sought to understand how participants managed psychological distress following their experiences, the formal and informal sources of support they used, and the factors that facilitated or hindered their engagement with professional mental health care. By generating context-specific evidence from the perspectives of affected young people, the study contributes to a more nuanced understanding of coping and help-seeking following suicidal behavior and provides evidence that may inform culturally responsive mental health interventions and support services for unemployed young people in Adamawa State.

MATERIALS AND METHODS

Design

A phenomenological qualitative design was employed to explore the lived experiences of unemployed youth with suicidal attempts in Adamawa State, Nigeria. This enabled the researcher to explored participants' personal experiences, perceptions, coping strategies, and experiences of seeking mental health support within their social, cultural, and socioeconomic context.

Participant Selection and Setting

The study population comprised unemployed youth aged 18–45 years who had experienced a suicidal attempt and had resided in Adamawa State for at least six months before the study. Participants were purposively selected from the three senatorial zones based on their ability and willingness to provide detailed information concerning their experiences of suicidal attempts, coping strategies, and mental health help-seeking behaviours.

The age range was adopted to capture young adults within the economically active population who may experience considerable pressures related to employment, financial independence, family responsibilities, and socioeconomic expectations. The study therefore used 18–45 years as its operational definition of youth in accordance with the population targeted by the research and the socioeconomic context of the study setting. While unemployment refers to the absence of regular and stable paid employment, with participants either actively seeking employment or willing to obtain regular employment.

This study was conducted in Adamawa State, located in the northeastern region of Nigeria, specifically in the selected urban and rural areas of the state. It is a state in the North-East geopolitical zone lying on the sahel belt between latitudes 8^0N and 11^0N, longitude 11.5^0E and 13.5^0E occupying a land mass of about 42,000sq Km. Adamawa shares international borders with Cameroon to the east and borders with Gombe, Borno, and Taraba States within Nigeria. Its strategic location influences various socio-economic, cultural, and environmental dynamics impacting the lives of its residents, especially the youth.

The state has a population estimated at over five million, comprising diverse ethnic groups such as the Fulani, Kilba, Bata, and other minority groups, contributing to a rich cultural heritage. However, the region has experienced challenges like high unemployment rates, low educational attainment, poverty, and periodic security disruptions due to insurgencies. These conditions contribute to socio-economic vulnerabilities among the youth, many of whom struggle with limited access to employment and social support networks.

Adamawa State is predominantly rural, with agriculture as the primary economic activity. Despite this, the agricultural sector provides limited formal employment opportunities, leading to a high rate of youth unemployment. In recent years, there has been an increase in urban migration as youths search for better opportunities in the state's capital, Yola, and other urban centers like Mubi and Numan. However, this migration has not adequately addressed unemployment issues, with many young people experiencing financial instability, psychosocial stress, and limited access to mental health services.

These socio-economic and environmental factors create a complex context for studying suicidal attempts, as unemployment, poverty, and insecurity may contribute to mental health challenges. The study is focus on Adamawa's unemployed youth offers insights into understanding how these unique conditions shape mental health outcomes and highlights the need for targeted interventions that address the underlying socio-economic and psychological needs of this vulnerable population.

Instrument for Data Collection

Ethical approval for the study was obtained from the Research and Ethics Committee of the Adamawa State Ministry of Health with reference number **S/MOH/1131/1**.

Before each interview, the researcher or trained research assistants explained the purpose and procedures of the study, the voluntary nature of participation, potential risks and benefits, confidentiality arrangements, and the participants' right to decline to answer any question or withdraw from the study without penalty. Written informed consent was obtained from each participant before the interview commenced.

Because the study addressed sensitive experiences relating to suicidal attempts and mental health, interviews were conducted individually in a private and quiet setting that promoted confidentiality and participant comfort. The interviewer maintained a non-judgmental and supportive approach throughout the interviews. Participants were not pressured to discuss issues that caused significant discomfort or distress, and interviews could be paused or discontinued according to participants' wishes.

The interviews were conducted in English, Hausa and/ Fulfulde according to participants' language preference and lasted approximately 30–60 minutes. With participants' permission, all interviews were audio-recorded. Brief field notes were also made immediately following interviews to document relevant contextual observations and reflections.

Qualitative Rigor

Qualitative rigor was ensured through the application of credibility, transferability, dependability, and confirmability. Credibility was strengthened by using verbatim quotations and careful engagement with participants' responses to accurately reflect their experiences. Transferability was enhanced through a detailed description of the study setting and participants, allowing the findings to be applied to similar contexts. Dependability was ensured by clearly documenting the research process from data collection to thematic analysis, while confirmability was achieved by maintaining an audit trail of transcripts, recordings, and coding to ensure that

findings were grounded in participants' narratives rather than researcher bias.

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Data Analysis

All interviews were audio-recorded and transcribed verbatim. Interviews conducted in Hausa were translated into English during the transcription process, with care taken to preserve the meaning and context of participants' responses. The transcripts were reviewed against the audio recordings to ensure accuracy before analysis.

The data were analyzed thematically using an iterative process. The researcher first read the transcripts repeatedly to achieve familiarity with the data. Meaningful statements and relevant segments of the transcripts were then assigned initial codes. Similar codes were compared and grouped into broader categories, from which preliminary themes and sub-themes were developed.

The emerging themes were repeatedly reviewed against the coded extracts and the complete transcripts to assess their coherence, distinctiveness, and relevance to the study objectives. The analysis was primarily inductive, allowing patterns and meanings to emerge from participants' accounts while remaining guided by the research objectives.

NVivo software, version 14**,** was used to organize the transcripts, codes, categories, and thematic materials. NVivo served as a data-management and coding tool, while interpretation and development of themes remained the responsibility of the researcher. Relevant verbatim quotations were selected to illustrate the themes and preserve participants' voices in the presentation of the findings. Participant codes rather than names were used to maintain confidentiality.

RESULTS AND DISCUSSION

Table 1: Socio-Demographic Variables of Participants (N=15)

Code	Age (Years)	Gender	Level Of Education	Marital Status	Residential Setting	No Of Dependents	Monthly Income (₦)
001	28	M	Tertiary	Married	Urban	5	50,000-100,000
002	23	M	Secondary	Single	Rural	3	<50,000
003	38	M	Tertiary	Married	Rural	7	<50,000-100,000
004	39	M	Tertiary	Married	Urban	4	50,000-100,000
005	35	M	Primary	Married	Rural	4	50,000-100,000
006	33	F	Tertiary	Married	Urban	2	50,000-100,000
007	35	F'	Secondary	Married	Rural	5	< 50,000
008	26	M	Tertiary	Married	Rural	4	<50,000
009	22	F	Secondary	Divorced	Urban	2	<50,000
010	22	F	Tertiary	Widow	Rural	2	<50,000
011	24	M	Secondary	Single	Rural	4	<50,000
012	25	M	No formal Education	Single	Urban	2	>100,000
013	32	F	Secondary	Widow	Rural	5	50,000-100,000
014	37	M	Tertiary	Single	Rural	4	<50,000
015	37	M	Tertiary	Married	Urban	6	<50,000

Participants were aged 22–39 years and included more males than females. Educational attainment ranged from no formal education to tertiary education, with tertiary education being most common. Most participants were married, lived in either rural or urban areas, and had between two and seven dependents. Monthly income varied, although several participants reported earning less than ₦50,000. Overall, the participants represented diverse demographic and socioeconomic backgrounds.

Table 2: Coping Strategies of Unemployed Youth with A History of Suicidal Attempts (N=15)

Themes	Sub-themes	Excerpts
Engagement in menial work	Assistance from others; resource management and economizing	*I always visit one of the medicine shop closed to my house to assist the owner with cleaning and dispensing drugs to his customers (007). I follow farm owners to their farms especially during harvest to get food from the little left over to enable me feed my children and myself (006).*
Self-reliance	Managing emotional distress independently; limiting dependence on others; developing personal resilience	*I used to engage in activities just to get myself distracted from the whole issues." (P010). Am no longer seeking help from anybody for any problem because many people, even family members, misunderstood me anytime I told them what I was going through."* (P004).
Social withdrawal	Withdrawing from social interaction; distancing from unsupportive relationships; seeking solitude	*Feel like going somewhere to sit down alone and not to talk to anybody."* (P007). *"Am no longer seeking help from anybody for any problem because many people, even family members, misunderstood me anytime I told them what I was going through."* (P004)
Religious and cultural coping	Seeking comfort through faith; cultural self-management; drawing strength from religious teachings	*"Sometimes I comfort myself by believing that God provides everything. But when the situation persists, I leave the house to distract myself to ease the pressure."* (P001). *"In my culture, we are bound to manage our things by ourselves without inviting any third party to avoid spreading. Even going to the hospital is believed to be exposing my weakness."* (P003). *"Religion encourage us to be resilient in many situation and as such, I only seek for help only when situation get out of hand."* (P008).
Use of online resources	Seeking information and problem-solving through the internet and artificial intelligence	*Yes, one of my colleagues advised me to search for solutions from artificial intelligence and online resources, which I did but did not get better."* (P003).
Formal mental health help-seeking	Family-facilitated access to mental health services	*My parents were convinced to bring me to the hospital after attempting to end my life for rescue…"* (005)

The findings indicate that Participants described several ways of coping with emotional distress, including engaging in productive activities, managing difficulties independently, withdrawing from others, drawing comfort from religious and cultural beliefs, and using online resources. Some participants also described seeking professional care, particularly when their distress became severe. These accounts suggest that participants used a combination of personal, social, religious, and informal strategies to manage their difficulties, although their experiences varied.

Table 3: Barriers to Mental Health Help-Seeking Among Unemployed Youth with A History of Suicidal Attempts (N=15)

Themes	Sub-themes	Excerpts
Stigma and Community Perceptions	Fear of social labelling, rejection and community gossip.	*"Anytime people see you around a psychiatric hospital, they assume you are mad and spread damaging stories in the community. That's why I prefer to resort to prayers, because God understands my problems."* (P002). *"In my culture, we are bound to manage our things by ourselves without inviting any third party to avoid spreading. Even going to the hospital is believed to be exposing my weakness."* (P003).
Distrust of Health Workers and Services	Concerns about confidentiality; negative interpersonal experiences with health workers	*"Yes, the attitudes of some health workers toward patients, such as divulging confidential information and shouting at*

Themes	Sub-themes	Excerpts
		them, discourage people from seeking help." (P011).
Cultural and Religious Beliefs.	Self-management; fear of exposing vulnerability; religious endurance	*in my culture, we are bound to manage our things by ourselves without inviting any third party to avoid spreading. Even going to the hospital is believed to be exposing my weakness." (P003). Religion encourage us to be resilient in many situation and as such, I only seek for help only when situation get out of hand." (P008)*
Financial constraint	. Inability to afford care; dependence on available financial resources.	*You can only go to the hospital or herbalist when you have money now. If I visit someone that will help me, will he offer those help for free?"* (P001).
Preference for informal support	Reliance on trusted friends and close social relationships	*I have one of my primary school friends whom I always call for advice whenever I feel unusual."* (001).

The findings indicate that participants largely managed emotional distress through informal coping methods such as engaging in activities to distract themselves, isolating from others, finding comfort in religious and cultural beliefs, and occasionally turning to online or AI-based resources, while professional mental health services were seldom used and mainly sought only when their condition became critically severe.

DISCUSSION

The findings on barriers to mental health help-seeking show that stigma and community perceptions were important influences on participants' decisions regarding professional care. Participants expressed fear of being labelled, judged, or discussed negatively if they were seen accessing psychiatric services. One participant stated, *"Anytime people see you around a psychiatric hospital, they assume you are mad and spread damaging stories in the community. That's why I prefer to resort to prayers, because God understands my problems"* (P002). This account demonstrates that stigma may influence help-seeking before an individual reaches a health facility. The fear was not simply about the experience of receiving treatment but also about being identified publicly as someone seeking psychiatric care. This finding is consistent with Schnyder et al. (2017), whose systematic review and meta-analysis found an association between mental health-related stigma and reduced active help-seeking. Clement et al. (2015) similarly showed that stigma can affect several stages of help-seeking, including recognition of difficulties, disclosure, and engagement with professional care.

Distrust of health workers and services was another reported barrier. Participants expressed concerns about confidentiality and negative interpersonal treatment within health facilities. One participant stated, *"Yes, the attitudes of some health workers toward patients, such as divulging confidential information and shouting at them, discourage people from seeking help"* (P011). This finding should be understood as the participant's reported experience or perception and not as independent evidence that health workers generally engage in breaches of confidentiality or disrespectful treatment. Nevertheless, the perception is important because trust is fundamental to mental health care. Individuals experiencing psychological distress may need to disclose highly personal information, and concerns about confidentiality can make such disclosure difficult. In a setting where participants already expressed fear of stigma and community exposure, concerns about privacy may further reduce confidence in formal mental health services.

Cultural and religious beliefs also emerged as a barrier to professional help-seeking. One participant explained, *"In my culture, we are bound to manage our things by ourselves without inviting any third party to avoid spreading. Even going to the hospital is believed to be exposing my weakness"* (P003). Another participant stated, *"Religion encourage us to be resilient in many situation and as such, I only seek for help only when situation get out of hand"* (P008). These accounts indicate that expectations of privacy, self-management, resilience, and endurance may discourage participants from disclosing psychological difficulties or seeking professional assistance at an early stage. This finding corresponds with Jidong et al. (2021), who reported that cultural and spiritual interpretations influence understandings of mental health and pathways to care in Nigeria. It also complements Aghukwa's (2012) findings from northern Nigeria concerning the influence of religious beliefs on psychiatric help-seeking.

The findings therefore highlight an important overlap between coping and barriers. Religion and culture appeared as a coping resource in Table 2 but also as a barrier in Table 3. This is not contradictory. Rather, it indicates that the same cultural and religious resources can have different effects depending on how they are experienced. Faith may provide hope and emotional strength, while an expectation to endure difficulties privately may delay professional care. Similarly, cultural values may promote resilience while discouraging disclosure. This dual role reinforces the need for mental health interventions that respect cultural and religious beliefs without assuming that all culturally based coping practices have the same consequences for help-seeking.

Financial constraints constituted another barrier to mental health help-seeking. One participant stated, *"You can only go to the hospital or herbalist when you have money now. If I visit someone that will help me, will he offer those help for free?"* (P001). This account illustrates how financial insecurity may influence whether professional care is considered accessible. Among unemployed young people, limited or unstable income may affect the ability to meet the direct and indirect costs associated with healthcare. Although the National Bureau of Statistics (2024) provides national unemployment estimates rather than figures specific to the study population in Adamawa State, participants' accounts demonstrate how economic circumstances can shape mental health help-seeking at an individual level. When financial

resources are limited, informal support and self-management may appear more attainable than formal healthcare.

Preference for informal social support was another barrier-related theme identified in the study. Participants described relying on trusted friends and other close relationships for advice and emotional support. One participant stated, *"I have one of my primary school friends whom I always call for advice whenever I feel unusual"* (P001). This finding indicates that participants did not necessarily reject support altogether; rather, they often preferred support from people with whom they already had established trust. This is consistent with Al-Shannaq and Aldalaykeh (2023), who identified family and friends as important sources of emotional and psychological support among young people. It also agrees with Jidong et al. (2024), who found that family members and close friends were important sources of support among people experiencing self-harm and suicidal ideation in Nigeria. However, reliance on informal support may become a barrier when trusted individuals are unable to provide the level of assistance required or when individuals do not progress from informal support to appropriate professional care.

The findings also suggest that professional mental health care was sometimes accessed only after distress had become severe. One participant reported, *"My parents were convinced to bring me to the hospital after attempting to end my life for rescue"* (P005). This account suggests that family members may become the principal drivers of professional care when an individual's distress reaches a critical level. It also indicates that formal mental health services may be approached reactively rather than as part of early intervention. Within Rickwood et al.'s (2005) help-seeking framework, several barriers identified in this study—including stigma, self-reliance, cultural expectations, financial difficulties, and distrust—may interfere with the progression from recognition of distress to disclosure and professional service utilization.

Overall, the findings show a close relationship between the coping strategies and barriers identified in this study. Participants often relied on strategies that were immediately available and familiar to them, including menial work, self-reliance, solitude, religion and cultural practices, and online resources. These strategies may provide temporary emotional or practical benefits, but they do not necessarily address the underlying psychological difficulties associated with suicidal behavior. At the same time, stigma, concerns about health services, cultural expectations, financial limitations, and reliance on informal relationships may make professional care less accessible or less acceptable. The findings therefore suggest that help-seeking among unemployed young people should be understood within the wider social and economic context in which their coping takes place.

The findings have implications for mental health service provision in Adamawa State. Efforts to improve professional help-seeking should address the stigma associated with psychiatric services and the fear of being labelled or exposed within the community. Mental health education at community level may help improve understanding of psychological distress and encourage earlier use of appropriate services. Health services should also strengthen confidentiality and respectful communication, given the concerns expressed by participants about privacy and health-worker attitudes. Such measures may improve trust and make formal mental health services more acceptable to young people who are already reluctant to disclose their difficulties.

Interventions should also recognize the importance of religion, culture, family, friendship networks, and other informal sources of support. Rather than attempting to replace these existing resources, culturally responsive mental health programs could build on their supportive aspects while creating clearer pathways to professional care. Engagement with appropriate community and faith-based stakeholders may help reduce stigma, improve recognition of psychological distress, and encourage timely referral when individuals require professional assistance. Such an approach would acknowledge the realities of participants' coping strategies while reducing the likelihood that severe psychological distress is managed exclusively through self-reliance or informal support.

Finally, the financial difficulties reported by participants indicate the need to consider affordability and accessibility when designing mental health services for unemployed young people. The emergence of internet surfing and artificial intelligence as a coping strategy also suggests that digital platforms may increasingly form part of young people's information-seeking behavior. However, digital resources should complement rather than replace professional assessment and care, particularly for individuals with a history of suicide attempts. Overall, the findings indicate that improving mental health help-seeking among unemployed young people in Adamawa State requires more than simply increasing the availability of services. It requires attention to stigma, cultural expectations, financial realities, interpersonal trust, confidentiality, and the informal coping resources through which young people already attempt to manage psychological distress.

CONCLUSION

Coping and help-seeking were shaped by interconnected personal, social, cultural, religious, and economic factors. Mental health services for unemployed young people should recognize existing coping and support systems while addressing stigma, confidentiality concerns, affordability, and barriers to timely professional care. Culturally responsive approaches that strengthen appropriate referral and linkage to professional mental health services may improve access to care among this population.

STRENGTH

A key strength of the study lies in its ability to uncover the complex and often overlooked interplay between coping behaviors and help-seeking barriers among unemployed youth with suicidal and attempts, revealing how informal coping mechanisms such as religion, social relationships, distraction, and survival activities simultaneously function as both adaptive responses to distress and substitutes for professional mental health care.

LIMITATION

This study is based on participants' subjective narratives within a specific context, which may not fully capture the diversity of coping experiences and help-seeking behaviors among unemployed youth in other settings or allow for broader generalization of the observed patterns

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