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From Distress to Care: A Contextual-Ecological Framework for Psychological Help-Seeking in South-East Nigeria

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Abstract

Background: Large gaps between psychological distress and use of professional mental-health care persist in Nigeria, but conventional explanations often isolate stigma, literacy, beliefs, or service scarcity as separate barriers. Such accounts under-specify how distress is interpreted, negotiated within relationships, routed through plural care systems, and converted or not converted into actual service use. This conceptual paper develops the Contextual-Ecological Distress-to-Care (CEDC) Framework for South-East Nigeria. Approach: The framework was developed through a purposive, iterative conceptual synthesis of recent help-seeking theory, Nigerian and sub-Saharan African empirical evidence, and Nigerian mental-health policy and service literature, with foundational South-East Nigerian studies retained where uniquely informative. Framework: CEDC conceptualises help-seeking as a recursive six-stage pathway: distress emergence and recognition; explanatory appraisal and meaning-making; disclosure and relational negotiation; pathway selection and sequencing; conversion of intention into access; and engagement, continuation, switching, and re-entry. These stages are shaped simultaneously by individual, relational, religious-cultural, service, socioeconomic, digital-information, and policy environments. Professional psychological care is treated as one pathway within a plural ecology rather than an inevitable endpoint. Contribution: The framework integrates sociocultural meaning with material access, distinguishes intentions from realised service use, and models switching between professional, primary-care, faith-based, traditional, family/community, digital, and no-care pathways. It generates testable propositions and stage-specific intervention targets for counselling psychology, primary care, community partnerships, and mental-health policy. The framework requires prospective empirical validation across South-East Nigerian states and other pluralistic, resource-constrained settings.

Keywords: psychological help-seeking; mental health services; South-East Nigeria; pathways to care; culture and religion; ecological framework; global mental health

1. Introduction

Mental-health help-seeking is often treated as a discrete individual decision: a person experiences symptoms, decides whether professional care is desirable, and either uses a service or does not. Recent evidence supports a more complex account. Across sub-Saharan Africa, systematic reviews identify interacting knowledge, attitudinal, sociocultural, logistical, treatment-related, policy, and service-system barriers, while pathways to care commonly involve movement among formal and informal sources of support (Komu et al., 2025; Williams et al., 2025). A 2026 systematic review of help-seeking interventions likewise distinguishes attitudes, intentions, and behaviour and shows that improvement in one outcome does not guarantee change in another (Bora et al., 2026). Help-seeking therefore cannot be reduced to a stable preference or intention.

Nigeria illustrates this complexity. The National Mental Health Act 2021 and the 2023 National Mental Health Policy represent important policy developments, yet recent analyses continue to document workforce shortages, concentration of specialist services, financing constraints, uneven primary-care integration, and weak coordination (Damul et al., 2026; Fadele et al., 2024; WHO Regional Office for Africa, 2025). The Act provides a rights-oriented legal framework, but legislation alone cannot make care geographically available, affordable, trusted, or culturally responsive (Federal Republic of Nigeria, 2022; Damul et al., 2026). Nigerian implementation studies demonstrate that task-shared mental-health care can be strengthened through primary care, training, supervision, and digital peer support, while also showing that medication stock-outs and weak referral systems can constrain implementation (Adewuya et al., 2025; Iheanacho et al., 2024).

South-East Nigerian evidence adds a distinctive sociocultural dimension. Foundational studies indicate that biomedical, spiritual, and traditional explanations and care preferences may coexist, and that pathways are not necessarily exclusive (Ikwuka et al., 2016b; Odinka et al., 2015). In a non-clinical South-East sample, biomedical care was strongly preferred, yet spiritual and traditional pathways were also endorsed; a related study found ideological barriers involving mental-health literacy and cultural interpretation to be strongly perceived alongside systemic and financial constraints (Ikwuka et al., 2016a, 2016b). Clinical research on schizophrenia also linked sociocultural interpretations and first-contact choices with delays before psychiatric presentation, although findings from severe mental illness should not be generalised uncritically to all psychological distress (Odinka et al., 2015).

Recent Nigerian research reinforces the need to move beyond a beliefs-only explanation. Qualitative evidence from multiple Nigerian cities shows that spiritual explanations,

traditional healing, and stigma are embedded within broader social contexts (Jidong et al., 2021). In Ibadan, help-seeking for severe mental illness has been described as occurring within relational “ecologies of care,” in which families weigh accessibility, affordability, quality, and perceived efficacy across biomedical, faith-based, and traditional options (Read et al., 2026). The CLERIC studies similarly show that willingness among religious leaders to collaborate with formal services can coexist with non-referral when structural limitations, trust deficits, livelihood concerns, and bidirectional knowledge gaps remain unresolved (Adewuya et al., 2026; Oladipo & Adewuya, 2026).

Ebonyi-specific evidence remains useful but heterogeneous. General health-seeking research in Ishiagu identifies cultural and social influences on care decisions; research among young adults in Ebonyi has examined mental-health messaging and help-seeking; and inpatient qualitative work has documented stigma and service-related challenges among adolescents and young adults (Ebulum, 2026; Nwedu et al., 2025; Onuoha et al., 2024). These studies do not provide a population-level basis for claiming predictors of professional psychological help-seeking across Ebonyi or the South-East. They instead strengthen the case for a conceptual model that can organise heterogeneous evidence without overstating its scope.

This paper develops the Contextual-Ecological Distress-to-Care (CEDC) Framework for adult psychological help-seeking in South-East Nigeria. It treats help-seeking as contingent, relational, recursive, and structurally conditioned: distress must be recognised, interpreted, negotiated, connected to a meaningful source of care, and converted into actual access before engagement can occur. The framework contributes by integrating individual intentions with relational negotiation and plural care pathways; separating pathway preference from the material conversion of intention into service use; and modelling continuation, discontinuation, switching, and re-entry after first contact. It is proposed as an empirically testable framework for South-East Nigeria and, with contextual adaptation, other pluralistic and resource-constrained settings.

2. Psychological Help-seeking: Concept and Boundaries

Professional psychological help-seeking refers here to purposive efforts to obtain assessment, counselling, psychotherapy, or related mental-health support from trained professionals or appropriately trained formal health providers. This definition is narrower than general health-seeking and broader than psychiatric service use alone. In Nigeria, professional mental-health care may be encountered through psychologists, counsellors, psychiatrists, nurses, social workers, or trained primary-care personnel, including services

supported by mhGAP-based integration (World Health Organization [WHO], 2023; Iheanacho et al., 2024). The distinction matters because much Nigerian evidence concerns psychiatric treatment for severe mental illness rather than counselling or psychological therapy specifically.

Formal and informal help should nevertheless not be treated as mutually exclusive. South-East Nigerian and wider Nigerian studies show that people may endorse or use biomedical, faith-based, traditional, family, and community resources in combination or sequence (Ikwuka et al., 2016b; Jidong et al., 2021; Odinka et al., 2015; Read et al., 2026). A person can consult a pastor and later a psychiatrist, use prayer alongside medication, disclose to family before approaching a counsellor, or move away from formal care after a disappointing encounter. The analytically useful question is therefore not simply “formal or informal?” but how the pathway is assembled over time and what moves a person toward, away from, or between sources of care.

The CEDC framework also distinguishes help-seeking attitudes, intentions, and realised behaviour. The Theory of Planned Behavior treats intention as a proximal determinant of behaviour, but reviews of adult mental-health help-seeking show that most applications focus more heavily on intentions than observed service use and that structural constraints can weaken the intention-behaviour relationship (Adams et al., 2022; Ajzen, 1991). Recent intervention evidence similarly demonstrates that improvements in attitudes or intentions do not automatically produce equivalent changes in actual behaviour (Bora et al., 2026). This distinction is especially important where services are scarce, costly, distant, poorly signposted, or distrusted. Help-seeking is therefore conceptualised as a process rather than a single endpoint. Its possible outcomes include professional care, delayed care, informal or faith-based support, traditional care, self-management, no care, or combinations of these. It also includes re-entry after disengagement. This wider process definition permits the framework to examine not only whether care was sought but where the pathway stalled, diverted, switched, or resumed.

3. South-East Nigerian Context

Available mental-health help-seeking evidence from South-East Nigeria is uneven across the five states of the geopolitical zone. The regional literature is strongest for pathways to psychiatric care and sociocultural interpretations of severe mental illness, while direct population-level research on professional psychological help-seeking among adults is limited (Ikwuka et al., 2016a, 2016b; Odinka et al., 2015). This unevenness requires cautious use of evidence: findings from Enugu-based services, schizophrenia samples, students, young

adults, or one Ebonyi community should inform propositions without being represented as estimates for the entire zone.

One recurring feature of the evidence is explanatory pluralism. South-East Nigerian studies show that biomedical, spiritual, social, and traditional interpretations can coexist rather than forming mutually exclusive belief systems (Ikwuka et al., 2016b; Odinka et al., 2015). Wider Nigerian qualitative work similarly documents supernatural or spiritual explanations alongside engagement with biomedical care and highlights the continuing role of traditional healing and religious support (Jidong et al., 2021). The implication is not that religion or indigenous healing necessarily obstructs professional care. Instead, explanatory models can shape which symptoms are considered serious, what kind of expertise seems appropriate, and whether different providers are approached sequentially or simultaneously.

Help-seeking is also relational. Family members and other trusted actors may recognise deterioration, finance care, recommend a provider, accompany a person, discourage disclosure, or redirect care toward a familiar religious or traditional setting. Read et al. (2026) show in Nigerian and Bangladeshi urban communities that treatment decisions for severe mental illness are embedded in relational “ecologies of care,” while recent Nigerian studies of faith-based integration identify both willingness to collaborate and structural or relational obstacles to referral (Adewuya et al., 2026; Oladipo & Adewuya, 2026). The relevant unit of analysis is therefore often wider than the individual.

Stigma and mental-health literacy remain important but should not be treated as self-sufficient explanations. Meta-analytic evidence links help-seeking self-stigma particularly strongly with attitudes and intentions, while recent mental-health literacy research indicates that recognition, stigma, help-seeking efficacy, and knowledge of care options are related but distinct constructs (Cresswell-Smith et al., 2026; Lien et al., 2024; Yu et al., 2023). Nigerian evidence among undergraduates also links health literacy and knowledge with help-seeking attitudes, although such findings cannot be assumed to represent the general adult population (Osiesi et al., 2025).

The material service environment determines whether perceived need can become use. Recent reviews across sub-Saharan Africa identify distance, transport, cost, waiting time, scarcity of services and professionals, and weak referral systems among recurring access barriers (Komu et al., 2025). Nigeria-specific analyses similarly describe shortages and implementation gaps, while task-sharing studies demonstrate that primary-care integration can increase front-line capacity when training, supervision, medications, and referral systems are supported (Adewuya et al., 2025; Damul et al., 2026; Iheanacho et al., 2024). Thus, a

favourable attitude toward professional help may remain behaviourally irrelevant when there is no feasible pathway to a trustworthy service.

Nigeria's policy environment creates an additional ecological layer. The National Mental Health Act 2021 establishes a contemporary legal framework for mental-health governance and rights, while the 2023 National Mental Health Policy places renewed emphasis on a public-health approach and integration (Federal Republic of Nigeria, 2022; WHO Regional Office for Africa, 2025). Yet implementation remains uneven, and recent policy analysis cautions that normative reform has not eliminated financing, workforce, coordination, and service-delivery constraints (Damul et al., 2026). The framework therefore treats law and policy as enabling conditions whose practical effects depend on implementation.

Finally, digital environments may alter pathways by changing how distress is named, information is obtained, and services are encountered. Nigerian primary-care implementation has used mobile tools and digital peer-support systems to support providers, and recent help-seeking intervention literature identifies online and multicomponent strategies as potentially useful, while also showing that evidence is dominated by high-income settings (Adewuya et al., 2025; Bora et al., 2026). Digital access is consequently modelled as a cross-cutting resource rather than assumed to be universally available or sufficient.

4. What Existing Theories Explain and Miss

The CEDC framework draws from established theories but is not reducible to any one of them. The Theory of Planned Behavior (TPB) explains how attitudes, subjective norms, and perceived behavioural control contribute to intentions and behaviour (Ajzen, 1991). In mental-health help-seeking, this is valuable because stigma, perceived usefulness of professional care, social approval, and perceived control can shape intention. Yet a scoping review found that TPB studies in adult mental-health help-seeking largely emphasized intentions and were concentrated outside Africa, leaving uncertainty about how well intention-centred models explain realised service use under strong structural constraints (Adams et al., 2022). CEDC therefore retains intention-related mechanisms but places them within a longer pathway.

Andersen's Behavioral Model of Health Services Use distinguishes predisposing, enabling, and need factors and remains useful for understanding why perceived or evaluated need does not translate equally into service utilization (Andersen, 1995). Its strength is the explicit recognition of enabling resources. For the South-East Nigerian context, however, a more processual account is needed to show when family negotiation, spiritual meaning-

making, provider sequencing, and pathway switching occur. CEDC converts broad domains into stage-specific mechanisms rather than treating them only as background determinants.

Levesque et al.'s (2013) patient-centred access framework conceptualizes access as an interaction between characteristics of services and people's abilities to perceive, seek, reach, pay, and engage. This directly informs CEDC's separation of perceived need and intention from the conversion of intention into access. CEDC extends this logic by making explanatory appraisal, relational negotiation, and plural pathway selection explicit before access, and by modelling switching and re-entry after engagement.

Pathways-to-care research is especially important in South-East Nigeria because it focuses on first contact, sequencing, and delay. Regional studies show that psychiatric pathways may involve biomedical, traditional, and faith-based providers and that care choices can be associated with treatment delay (Ikwuka et al., 2016b; Odinka et al., 2015). A recent sub-Saharan review confirms the importance of multiple local health-system pathways (Williams et al., 2025). CEDC broadens this tradition beyond severe mental illness and first psychiatric contact by including recognition, disclosure, intended professional help-seeking, non-use, continuation, switching, and re-entry. Finally, emerging "ecologies of care" work emphasises that help-seeking is embedded in relationships, material conditions, and local care systems rather than being determined by beliefs alone (Read et al., 2026). CEDC shares this relational orientation but contributes a staged mechanism: distress recognition, meaning-making, relational negotiation, pathway selection, conversion into access, and engagement/re-entry. The framework thus integrates TPB's intentional processes, Andersen's enabling conditions, Levesque's access interface, pathways-to-care sequencing, and ecological relationality into a recursive model tailored to plural care environments.

5. Conceptual Development Approach

This article uses an evidence-informed conceptual analysis rather than a systematic or scoping review. The purpose of the literature was to develop, challenge, and specify theoretical constructs, not to estimate pooled effects or provide exhaustive coverage of every study. Literature was identified purposively and iteratively through searches of PubMed, publisher databases, and official Nigerian and WHO sources, with emphasis on publications from 2021 to 2026. Foundational older studies were retained when they provided uniquely relevant South-East Nigerian evidence on pathways to care, sociocultural interpretation, or treatment delay.

Three evidence streams were prioritized. The first comprised general theories and reviews of adult mental-health help-seeking, including work on the Theory of Planned Behavior, health-service utilization, access to care, stigma, mental-health literacy, and help-seeking interventions (Adams et al., 2022; Andersen, 1995; Bora et al., 2026; Levesque et al., 2013; Lien et al., 2024; Yu et al., 2023). The second comprised empirical evidence from South-East Nigeria where available, followed by wider Nigerian and sub-Saharan African evidence on pathways, explanatory models, faith/traditional care, service barriers, and relational decision-making (Adewuya et al., 2026; Ikwuka et al., 2016a, 2016b; Jidong et al., 2021; Komu et al., 2025; Odinka et al., 2015; Read et al., 2026; Williams et al., 2025). The third comprised Nigerian legislation, policy, workforce, and implementation evidence (Damul et al., 2026; Federal Republic of Nigeria, 2022; Iheanacho et al., 2024; WHO Regional Office for Africa, 2025).

Conceptual development proceeded by asking where existing models locate key mechanisms and where empirical Nigerian evidence reveals mechanisms that are poorly represented. Recurrent constructs were then organized temporally into six stages and ecologically into seven cross-cutting contextual layers. The staged sequence is not intended to imply a fixed linear process. Instead, it is a heuristic architecture that permits looping, skipping, parallel pathways, exit, and re-entry. The model itself is therefore a theoretical proposal, not an empirically validated causal model.

Because the literature is uneven, claims are scope-limited. Findings from schizophrenia studies are used to illustrate possible pathway mechanisms, but not to characterize all psychological distress. Findings from Lagos or Ibadan are used as Nigerian comparative evidence rather than as direct evidence for South-East Nigeria. Ebonyi-specific studies are included when relevant, but are not treated as representative of the whole region. These boundaries are essential to the framework's validity and identify where empirical testing is most needed.

6. From Distress to Care: The Contextual-Ecological Distress-to-Care Framework

The Contextual-Ecological Distress-to-Care (CEDC) Framework proposes that professional help-seeking emerges from six linked but recursive stages: (1) distress emergence and recognition; (2) explanatory appraisal and meaning-making; (3) disclosure and relational negotiation; (4) pathway selection and sequencing; (5) conversion of intention into access; and (6) engagement, continuation, switching, and re-entry. Seven ecological layers, individual resources and identities; family and relational systems; community and religious-cultural systems; health-service organization; socioeconomic conditions; digital-

information environments; and law, policy, and governance can influence more than one stage simultaneously.

The central proposition is that professional psychological care is neither the default nor the inevitable endpoint. At each stage, an individual can remain in self-management, move toward family or community support, enter faith-based or traditional care, approach primary care, seek specialist mental-health care, combine pathways, or delay action. This architecture makes it possible to distinguish three analytically different forms of non-use: non-recognition of need, selection of a different pathway despite recognised need, and failure to convert a professional-care intention into actual access. These forms require different interventions.

Figure 1. Contextual-Ecological Distress-to-Care (CEDC) Framework

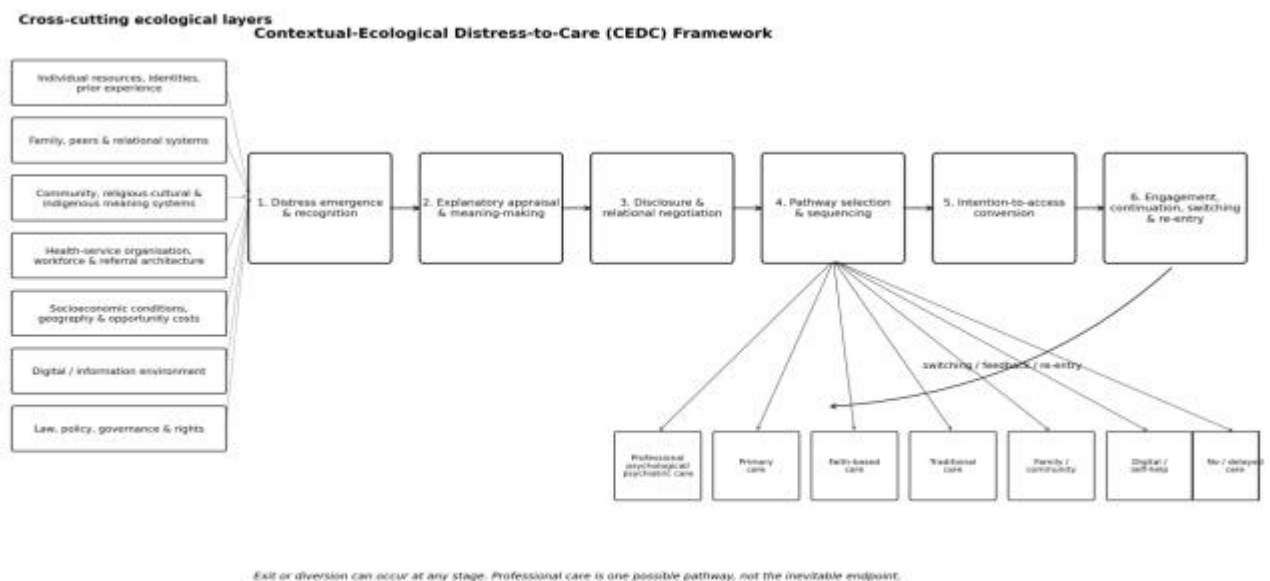


Figure 1 summarises the framework, including the six stages, cross-cutting ecological layers, plural care options, and feedback/re-entry loops.

Note. The proposed framework is conceptual rather than empirically validated. The six stages are recursive; exit, diversion, combination of care sources, switching, and re-entry can occur. Professional psychological/psychiatric care is one possible pathway rather than the inevitable endpoint.

6.1 Stage 1 – Distress emergence and recognition

Stage 1 concerns whether distress becomes recognizable as a problem that warrants help. Psychological distress may begin as sadness, anxiety, sleep problems, irritability, bodily symptoms, impaired concentration, social withdrawal, loss of functioning, or other experiences that are not immediately labelled as a mental-health problem. Mental-health literacy influences recognition, but recent scholarship cautions that literacy is more than diagnostic knowledge; it also includes beliefs about management, stigma, help-seeking efficacy, and knowledge of available support (Cresswell-Smith et al., 2026; Lien et al., 2024).

Recognition is threshold-dependent. People can normalize distress as an expected response to financial strain, bereavement, interpersonal conflict, illness, unemployment, academic pressure, or other adversity, particularly when functioning remains partly intact. The framework, therefore, distinguishes distress presence from perceived need. This distinction is supported by wider help-seeking research showing that clinical indicators of need and self-perceived need do not always align, and by Nigerian evidence showing that mental-health knowledge remains uneven (Fadele et al., 2024; Komu et al., 2025). Recognition may also be influenced by family members who notice behavioural change before the person identifies a problem.

In South-East Nigeria, older schizophrenia research showed that sociocultural interpretations of symptoms were associated with first-contact choices and treatment delays (Odinka et al., 2015). Although these findings cannot be generalised to common mental distress, they illustrate a broader mechanism: the way symptoms are noticed and interpreted can influence when and where help is sought.

Stage 1, therefore, contains at least four processes: symptom noticing, attribution of significance, appraisal of severity or functional impact, and recognition that help may be beneficial. Interventions at this stage should emphasize culturally intelligible mental-health literacy, recognition of functional impairment, and practical information about available help rather than only diagnostic labels. The 2026 intervention review found that psychoeducation and mental-health-literacy interventions can improve help-seeking outcomes, especially when combined with other strategies, supporting the value of recognition-focused intervention while also indicating that knowledge alone is insufficient (Bora et al., 2026).

6.2 Stage 2 - Explanatory appraisal and meaning-making

Once distress is recognized, it must be interpreted. Stage 2 concerns explanatory appraisal and meaning-making: what is happening, why it is happening, whether it is controllable, and what kind of help fits the explanation. The framework assumes explanatory pluralism rather than a binary opposition between biomedical and indigenous beliefs. South-East Nigerian studies provide strong evidence for this approach. Ikwuka et al. (2016b) found that participants could endorse biomedical, spiritual, and traditional pathways concurrently, while Odinka et al. (2015) linked magico-supernatural conceptualizations of schizophrenia with particular help-seeking patterns. Jidong et al. (2021) similarly reported spiritual-causation beliefs and the perceived relevance of traditional healing in a multi-city Nigerian qualitative study that included Enugu. These findings indicate that people can hold layered explanations in which stress, social conflict, biology, spirituality, morality, and interpersonal relations are not necessarily mutually exclusive.

Meaning-making is also dynamic. Explanations can change after a conversation with family, a religious leader, a clinician, or a traditional practitioner, and after a treatment succeeds or fails. Read et al. (2026) found uncertainty and plural explanations among families seeking help for severe mental illness; decisions were shaped by perceived efficacy, cost, and quality as well as beliefs. Oladipo and Adewuya (2026) likewise found that Nigerian religious leaders often held pluralistic rather than strictly anti-medical explanatory models. The implication is that professional help-seeking does not require complete abandonment of spiritual or cultural explanations. It requires that professional care become sufficiently compatible with the person's working model of the problem.

The framework, therefore, treats explanatory appraisal as a "fit" problem. A provider is more likely to be considered when the provider's perceived competence matches the assumed cause and desired form of remedy. Professional psychological care may be seen as fitting interpersonal, emotional, traumatic, behavioural, or stress-related explanations, while a pastor may be selected for spiritual threat or moral conflict, and a traditional healer may be selected for culturally specific causal narratives. Multiple providers may be chosen sequentially or simultaneously when multiple explanations coexist. Intervention at Stage 2 should avoid contempt for non-biomedical meaning systems. Evidence from the CLERIC programme suggests that epistemic disrespect and bidirectional knowledge gaps can weaken collaboration between religious and health sectors (Adewuya et al., 2026; Oladipo & Adewuya, 2026). Culturally responsive counselling and public communication should therefore create explanatory bridges: acknowledging the person's interpretation, clarifying

what professional care can address, and identifying safe opportunities for complementary referral without endorsing harmful practices.

6.3 Stage 3 - Disclosure and relational negotiation

Stage 3 concerns disclosure and relational negotiation. Recognition and meaning do not automatically become autonomous action because help-seeking often unfolds within relationships. A person must decide whether to disclose distress, to whom, and with what anticipated consequences. Family members, spouses, peers, clergy, elders, and other trusted figures may then validate, minimize, reinterpret, finance, redirect, or block a proposed pathway. Stigma is especially relevant at this stage because disclosure creates social exposure. Yu et al. (2023) found that public stigma was strongly related to self-stigma of help-seeking and that self-stigma had a stronger association with help-seeking attitudes and intentions after accounting for public stigma. Nigerian evidence likewise identifies stigma as an important barrier, but its operation is context-dependent rather than uniform (Jidong et al., 2021; Komu et al., 2025). Anticipated reputational harm may be particularly important when services are visibly identifiable as psychiatric or when communities are socially dense, and confidentiality is uncertain.

Relational negotiation can facilitate care as well. Families can recognize deterioration, provide transport or money, accompany the person, recommend a trusted provider, and support treatment adherence. Recent Nigerian ecologies-of-care research emphasizes that help-seeking for severe mental illness is often a family-organized process rather than an individual act (Read et al., 2026). Religious leaders can also act as trusted gatekeepers. The CLERIC study found substantial readiness among many religious leaders to collaborate with mental-health systems, while also identifying a gap between stated willingness and actual referral behaviour (Adewuya et al., 2026). This means that relational actors can be either bridges or bottlenecks depending on knowledge, trust, resources, and referral infrastructure.

The framework, therefore, proposes that subjective norms should be unpacked into concrete relational processes. “What others think” is not enough. It matters who controls money, who has authority, who is trusted to interpret symptoms, who knows where services are located, and whose approval is needed for continued care. Gender, age, marital status, economic dependence, and household structure may alter these relationships, but the framework does not presume a fixed direction without empirical testing. Interventions at Stage 3 should therefore include more than individual anti-stigma messaging. Family-inclusive psychoeducation, confidential entry points, peer navigation, clergy referral partnerships, and clear communication about privacy may reduce relational friction. Where

safe and desired by the service user, involving trusted supporters may help convert recognition into action. Conversely, services must preserve autonomy where family or community involvement is coercive, stigmatizing, or unsafe.

6.4 Stage 4 -Pathway selection and sequencing

Stage 4 concerns pathway selection and sequencing. After distress has been interpreted and relationally negotiated, a person or family selects a source or combination of sources of help. The CEDC framework distinguishes at least seven possibilities: professional psychological or psychiatric care; primary health care; faith-based care; traditional care; family/community support; digital or self-help; and delayed or no care. These are not assumed to be exclusive. Plurality is well documented. South-East Nigerian community research showed simultaneous preferences for biomedical, spiritual, and traditional options (Ikwuka et al., 2016b). Among patients with schizophrenia, first contact with faith or traditional healers was common and associated with particular causal interpretations and delays to psychiatric care (Odinka et al., 2015). More recent Nigerian evidence suggests that plural care remains active but that motivations are not reducible to belief: families consider cost, access, perceived quality, previous outcomes, and provider trust (Read et al., 2026).

Pathway selection should therefore be modeled as a comparative judgment among feasible options rather than a binary choice between formal care and non-care. A pastor may be geographically closer, socially trusted, available outside office hours, and willing to accept non-cash support. A private clinician may be preferred but unaffordable. A public facility may be cheaper but distant or perceived as stigmatizing. A digital resource may offer privacy but lack diagnostic or crisis support. A family may choose self-management first and escalate later if symptoms worsen. These comparative attributes can shift over time.

The framework also distinguishes pathway selection from sequencing. The first choice may not be the final choice. Treatment failure, worsening symptoms, new information, financial exhaustion, or referral can move people from one sector to another. Williams et al. (2025) found complex pathways across local health systems in sub-Saharan Africa, while Read et al. (2026) documented movement across biomedical and non-biomedical providers. The CEDC framework therefore includes arrows between pathways and back to earlier stages of appraisal, because a new care experience can change beliefs about cause, efficacy, stigma, and need.

Intervention at Stage 4 should focus on safe navigation rather than assuming that public education will eliminate plural care. Referral literacy is critical: people need to know what kinds of providers offer which forms of care, when specialist intervention is indicated, and where affordable services can be found. Faith and traditional providers who are willing to collaborate can be engaged in recognition and referral while safeguarding human rights. The CLERIC findings suggest that collaboration must be bidirectional, with clinicians also developing competence in respectful engagement with religious meaning systems (Adewuya et al., 2026; Oladipo & Adewuya, 2026).

6.5 Stage 5 - Conversion of intention into access

Stage 5 is the framework's central distinction between intention and realized access. A person may have recognized distress, accepted a psychological explanation, obtained family support, and selected professional care, yet still fail to reach a service. The conversion of intention into access depends on the interaction between personal capabilities and the organization of services. Levesque et al. (2013) conceptualized access through the relationship between service characteristics, approachability, acceptability, availability/accommodation, affordability, and appropriateness, and people's abilities to perceive, seek, reach, pay, and engage. This logic is especially useful in Nigeria, where recent reviews identify distance, transport costs, service scarcity, workforce shortages, waiting time, unaffordability, weak referral systems, and inconsistent treatment resources as major barriers (Damul et al., 2026; Komu et al., 2025). Structural barriers can therefore suppress professional service use even where attitudes and intentions are favourable.

The South-East Nigerian evidence supports separating ideological from instrumental barriers. Ikwuka et al. (2016a) found that ideological barriers were perceived strongly, but instrumental barriers involving system and financial impediments were also substantial. The conceptual implication is not to rank one class of barrier permanently above another. Instead, CEDC proposes a conjunctive mechanism: professional help is more likely when perceived legitimacy and practical accessibility coincide. If either is very low, the pathway can fail.

Nigeria's primary-care integration studies show that the conversion barrier can be modified. The HAPPINESS intervention used mhGAP-based, mobile-supported primary-care integration and demonstrated high implementation adoption and fidelity, with clinical improvements among patients whose records were available for analysis (Iheanacho et al., 2024). The MeHPriC programme in Lagos trained hundreds of primary-care workers and improved knowledge, attitudes, and reported practice, yet qualitative findings still identified medication stock-outs and limited referral networks (Adewuya et al., 2025). These studies

suggest that bringing care closer to communities can improve reach, but local infrastructure, supervision, medicines, referral destinations, and public awareness must be addressed together.

Affordability deserves specific attention because it includes more than consultation fees. Transport, lost work time, repeated visits, medication, childcare, accompanying relatives, and opportunity costs can all affect conversion. Confidentiality also functions as an access condition: a nearby service may still be unusable if clients fear recognition by staff or community members. Language and provider fit may similarly turn nominal availability into practical inaccessibility.

Digital pathways can reduce some reach barriers, but only under certain conditions. Mobile-supported implementation has shown feasibility in Nigerian service delivery, while recent international intervention evidence indicates that online and multicomponent approaches can improve some help-seeking outcomes (Bora et al., 2026; Iheanacho et al., 2024). However, digital options still depend on device access, data costs, privacy, literacy, language, accessibility, and reliable onward referral. CEDC therefore treats digital access as an ecological modifier rather than an automatic solution. The intervention implication is that campaigns to improve attitudes should be paired with service-navigation and access reforms. Increasing willingness to seek care without expanding affordable, confidential, and geographically reachable services risks producing an “intention surplus” in which demand rises but cannot be met. Stage 5 makes that failure visible and measurable.

6.6 Stage 6 - Engagement, continuation, switching, and re-entry

Stage 6 begins at first contact and concerns whether care becomes sustained engagement, discontinuation, switching, combination, or later re-entry. Initial attendance is therefore not the endpoint of help-seeking. The quality and meaning of the first encounter can reshape subsequent beliefs, trust, family support, and future pathway choices. Appropriateness is central. Levesque et al. (2013) emphasised that access includes the fit between services and needs, not merely physical entry. In mental-health care, perceived respect, therapeutic alliance, confidentiality, explanation of treatment, waiting time, side effects, cost, and perceived improvement can all affect continuation. Komu et al. (2025) identified treatment-related concerns, including prior negative experiences and medication concerns, alongside structural barriers in sub-Saharan Africa. Nigerian qualitative research similarly suggests that dissatisfaction can occur across biomedical and non-biomedical sectors, producing movement between them rather than permanent loyalty to one system (Read et al., 2026).

Stage 6 also captures the consequences of disrespect. The CLERIC research indicates that negative interactions between professional and religious sectors can undermine trust, while clinicians' lack of religious literacy can be experienced as a relational barrier to collaboration (Adewuya et al., 2026; Oladipo & Adewuya, 2026). At the individual level, a client who feels that a clinician dismisses deeply held spiritual meanings may disengage even if the clinical intervention is technically appropriate. Conversely, a faith or traditional provider who recognizes danger signs and refers respectfully may support continued professional engagement. Continuation is also affected by material sustainability. A service may be affordable for one visit but not for repeated sessions. Psychological treatments can be especially vulnerable where insurance or public provision is weak, and travel is costly. Recent Nigerian policy analysis continues to identify financing and service-capacity constraints despite legal reform (Damul et al., 2026). The framework, therefore, treats engagement as repeated access rather than a single successful conversion.

Switching is not necessarily a failure. It can represent adaptive navigation when a service is ineffective, harmful, inaccessible, or mismatched. The clinical and policy concern is whether switching occurs with continuity, safety, and appropriate referral or through fragmented trial-and-error that delays effective care. CEDC consequently allows feedback from Stage 6 to Stage 2 (new meaning-making), Stage 3 (new family advice), Stage 4 (new pathway selection), and Stage 5 (new access constraints). Interventions at Stage 6 should therefore include continuity planning, clear referral communication, respectful discussion of clients' explanatory models, affordable follow-up, monitoring of adverse experiences, and mechanisms for re-entry after dropout. Service quality is itself a help-seeking intervention because trustworthy experiences influence future willingness within families and communities.

6.7 Cross-cutting ecological layers and interactions

The six stages are surrounded by ecological layers that operate across the pathway. Individual resources include symptom severity, prior service experience, literacy, income, gendered expectations, coping preferences, and perceived efficacy. Relational systems include family authority, emotional support, financial control, peer influence, and caregiving. Community and religious-cultural systems include stigma, moral narratives, spiritual explanations, trust networks, and indigenous understandings of distress. A health-service organization includes workforce, location, opening hours, referral pathways, provider attitudes, medicines, counselling availability, and continuity. Socioeconomic conditions include poverty, employment, transport, insecurity, and opportunity costs. The digital-information environment includes social media, online misinformation, digital literacy, tele-

support, and service-navigation information. Law and governance include rights protections, financing, regulation, primary-care integration, and state-level policy implementation (Damul et al., 2026; Federal Republic of Nigeria, 2022; WHO Regional Office for Africa, 2025).

These layers are deliberately cross-cutting because the same factor can influence several stages. For example, stigma can inhibit symptom labelling, disclosure, attendance, and continuation; family resources can shape recognition, pathway selection, payment, and follow-up; and service scarcity can influence both perceived behavioural control before help is sought and actual conversion after a professional pathway has been chosen. This multi-stage action differentiates contextual factors from one-off “predictors.”

The framework also allows interactions. Improved mental-health literacy may have little effect if no service is reachable, while service expansion may be underused if the service is not trusted or recognised as relevant. This interaction logic is consistent with the 2026 help-seeking intervention review, which found that multicomponent approaches can be more effective than isolated information strategies and that the evidence base remains dominated by high-income settings (Bora et al., 2026). In South-East Nigeria, future interventions should therefore be designed around combinations of stage-specific bottlenecks rather than a universal assumption that awareness alone is the key problem.

7. Testable propositions

The CEDC framework is intended to generate empirical tests rather than to function only as a descriptive diagram. The following propositions specify relationships that can be examined quantitatively, qualitatively, longitudinally, or through mixed methods. They are hypotheses derived from the synthesis and should not be treated as already established causal findings.

Proposition 1: The association between psychological distress and professional help-seeking will be mediated by perceived need, such that symptom severity will predict service use more strongly when distress is recognised as requiring external help. This proposition follows from evidence that recognition and mental-health literacy are linked to help-seeking attitudes but do not map perfectly onto clinical need (Cresswell-Smith et al., 2026; Lien et al., 2024).

Proposition 2: Explanatory pluralism will be more predictive of pathway sequencing than any single causal belief. Individuals who simultaneously endorse psychological, biomedical, social, and spiritual explanations are expected to show greater use of multiple or

sequential care sources than those with more exclusive explanatory models. South-East and wider Nigerian evidence supports the coexistence of multiple explanatory and treatment preferences (Ikwuka et al., 2016b; Read et al., 2026).

Proposition 3: Family and trusted-network endorsement will moderate the relationship between professional help-seeking intention and actual service contact. Strong professional-care intentions should be more likely to become service use when key relational actors provide approval, information, transport, money, accompaniment, or referral support.

Proposition 4: Help-seeking self-stigma will exert its strongest effects at disclosure and pathway-selection stages rather than only at symptom recognition. This proposition is consistent with meta-analytic evidence linking self-stigma more strongly than public stigma to help-seeking attitudes and intentions (Yu et al., 2023).

Proposition 5: The effect of favourable attitudes toward professional psychological care on actual service use will be moderated by service accessibility. Where distance, cost, waiting time, or provider scarcity are high, positive attitudes and intentions will show weaker associations with realized use. This proposition integrates TPB with access evidence (Adams et al., 2022; Komu et al., 2025; Levesque et al., 2013).

Proposition 6: Prior satisfactory encounters with any trusted formal provider will increase the probability of future professional help-seeking, whereas disrespectful, stigmatising, or ineffective encounters will increase switching, discontinuation, or diversion to alternative pathways. This proposition should be tested prospectively because cross-sectional satisfaction measures cannot establish temporal direction.

Proposition 7: Religious leaders' referral behaviour will depend jointly on their mental-health literacy and the perceived accessibility and trustworthiness of receiving services. Training alone will therefore have smaller effects where referral destinations are scarce, costly, or perceived as disrespectful. Recent Nigerian CLERIC findings provide a strong empirical basis for this hypothesis (Adewuya et al., 2026; Oladipo & Adewuya, 2026).

Proposition 8: Primary-care integration will reduce the intention-to-access gap more effectively when community awareness, provider competence, supervision, medicines, and referral pathways are strengthened together. Nigerian implementation studies support the feasibility of primary-care integration but also document residual system constraints (Adewuya et al., 2025; Iheanacho et al., 2024).

Proposition 9: Digital mental-health information will improve recognition and navigation only when users have sufficient digital access, privacy, literacy, and confidence in available services. Digital exposure without viable referral options will increase knowledge more reliably than completed professional service use.

Proposition 10: The pathway from distress to professional care will differ across gender, age, socioeconomic position, urban-rural location, and prior treatment experience because these characteristics alter relational authority, stigma exposure, resources, and service reach. The framework predicts heterogeneity rather than a single population-average pathway.

Proposition 11: Multisector referral arrangements linking primary care, psychological services, and willing faith/community actors will reduce pathway fragmentation and time lost between first help-seeking and effective professional care, provided that collaboration is rights-based, bidirectional, and supported by functioning services.

Proposition 12: Re-entry after dropout will be more likely when services preserve respectful contact, provide clear re-access routes, and address the original reason for disengagement. This proposition shifts research from one-time “utilisation” toward longitudinal engagement trajectories.

8. Intervention and practice implications

The practical value of CEDC is that interventions can be matched to the point at which a pathway is most likely to stall. At Stage 1, mental-health literacy initiatives should improve recognition without implying that all distress requires specialist treatment. Recent literature conceptualizes mental-health literacy as broader than symptom recognition alone and includes knowledge, stigma reduction, and help-seeking efficacy (Cresswell-Smith et al., 2026; Lien et al., 2024). Messaging should therefore include what kinds of difficulties merit support, what services exist, and how to reach them. At Stage 2, culturally responsive practice requires curiosity about explanatory models rather than attempting to replace spiritual or indigenous interpretations with biomedical explanations. Nigerian evidence supports plural explanations and shows that religious leaders themselves may hold mixed explanatory models (Jidong et al., 2021; Oladipo & Adewuya, 2026). Counsellors and psychologists can explore how different meanings affect risk, treatment expectations, and willingness to combine forms of care while maintaining evidence-based and rights-respecting boundaries.

Stage 3 suggests involving relational networks when appropriate and consented to. Family members can assist with recognition, transport, financing, adherence, and referral, but they can also amplify stigma or redirect pathways (Read et al., 2026). Interventions should therefore strengthen supportive lay referral without treating family involvement as automatically beneficial. Confidentiality safeguards remain essential, particularly where anticipated social exposure discourages disclosure. At Stage 4, referral collaboration with faith and traditional providers should focus on safety, reciprocal respect, and clearly defined referral thresholds rather than symbolic partnership. The CLERIC studies demonstrate both willingness to collaborate and the importance of addressing livelihood concerns, trust, and bidirectional knowledge gaps (Adewuya et al., 2026; Oladipo & Adewuya, 2026). Collaboration should not legitimize harmful practices; it should create earlier routes to professional assessment while respecting the social legitimacy of community actors.

Stage 5 requires system strengthening. Primary-care integration, task-sharing, supervision, medication availability, referral pathways, and affordable community services can reduce the gap between willingness and actual access (Adewuya et al., 2025; Iheanacho et al., 2024; WHO, 2023). Digital support may complement these mechanisms, but it should not substitute for service availability or assume universal connectivity (Bora et al., 2026). At Stage 6, services should monitor the first-contact experience, therapeutic relationship, perceived usefulness, affordability, and reasons for discontinuation. CEDC predicts that a poor initial encounter can trigger switching to another provider or withdrawal from care, whereas trusted and culturally responsive encounters can strengthen continuation. Practice improvement should therefore evaluate engagement and re-entry, not only initial attendance.

9. Policy and Systems Implications

Nigeria's policy environment is more favourable to rights-based mental-health reform than it was a decade ago. The National Mental Health Act 2021 establishes a legal framework for mental-health and substance-use services and rights protection, while the 2023 National Mental Health Policy adopts a broader public-health orientation (Federal Republic of Nigeria, 2022; WHO Regional Office for Africa, 2025). Yet recent policy analysis concludes that implementation remains constrained by underinvestment, workforce shortages, weak coordination, and incomplete service integration (Damul et al., 2026). The CEDC framework helps translate this policy-practice gap into observable pathway failures. First, rights must become reachable services. State-level implementation should prioritize primary-care integration, community-based psychosocial care, and referral networks so that a legal entitlement is not undermined by distance or scarcity. Second, financing reforms should consider repeated psychological care and not only medication or hospital treatment. Out-of-

pocket costs can block conversion from intention to access even when services technically exist (Damul et al., 2026; Komu et al., 2025). Third, workforce policy should include psychologists, counsellors, psychiatric nurses, social workers, and trained non-specialist providers rather than relying exclusively on psychiatrists.

Fourth, governance should recognize plural community actors without abandoning rights standards. Faith and traditional providers are already part of real-world pathways, and recent Nigerian evidence indicates potential for collaboration, but referral relationships require mutual trust, clear boundaries, training, and functioning destination services (Adewuya et al., 2026; Oladipo & Adewuya, 2026). Fifth, mental-health information systems should capture more than hospital attendance. Useful indicators would include referral source, first contact, time to professional care, dropout, re-entry, and transitions between sectors. Such data would allow policymakers to identify where along the distress-to-care pathway people are being lost. Finally, South-East states should avoid assuming that national policy implementation will occur uniformly. Service mapping, local referral directories, community partnerships, and state-specific implementation research are needed because geography, workforce, faith networks, urbanization, and institutional capacity vary within the zone. The framework is therefore compatible with national reform but designed for subnational adaptation.

10. Research agenda

The immediate research priority is empirical validation. A first programme of work should develop or adapt measures for each stage: distress recognition and perceived need; explanatory models; disclosure and relational approval; pathway preferences and actual first contacts; intention-to-access barriers; and engagement, switching, and re-entry. Existing help-seeking scales can be useful, but the framework requires measures of actual pathway behaviour and access conditions rather than intentions alone. Prospective designs are especially important. Cross-sectional studies cannot determine whether stigma preceded non-use, whether family advice changed after service contact, or whether dissatisfaction caused switching. A cohort beginning with adults reporting significant distress could record recognition, intentions, first contacts, service reach, and pathway changes over six to twelve months. Event-history or sequence analysis could then examine time to professional care and common pathway trajectories.

Qualitative work should investigate how adults describe the point at which distress becomes “a problem,” how explanatory models change, how families negotiate provider choices, and what makes professional care acceptable or unacceptable. Comparative work across Abia, Anambra, Ebonyi, Enugu, and Imo would test whether the framework travels

across different service and community environments. Research should also examine gender, age, socioeconomic position, rurality, disability, and prior service use as potential sources of pathway heterogeneity.

Implementation studies should test stage-matched interventions. Examples include mental-health-literacy plus navigation interventions for Stages 1 and 5; family-supported referral for Stage 3; bidirectional clergy-clinician collaboration for Stages 3 and 4; primary-care task sharing for Stage 5; and continuity/re-entry interventions for Stage 6. Hybrid effectiveness-implementation designs would be particularly useful because they can examine both clinical outcomes and whether the delivery system actually changes access. A further priority is measurement of professional psychological help-seeking specifically. Much Nigerian literature concerns psychiatric care or mental-health services broadly, and severe mental illness is overrepresented in the South-East pathway literature. Future research should distinguish psychologists, counsellors, psychiatrists, primary-care providers, faith providers, traditional practitioners, digital resources, and informal networks. Without that differentiation, it is difficult to determine whether barriers concern professional psychological care in particular or formal health services in general.

11. Strengths and limitations of the conceptual analysis

This conceptual analysis has several strengths. It integrates recent global help-seeking scholarship with Nigeria-specific evidence and retains foundational South-East Nigerian studies only where they illuminate mechanisms not yet replaced by newer local evidence. It explicitly distinguishes attitudes, intentions, access, and sustained engagement, and it avoids portraying faith or traditional pathways as simple proxies for ignorance. The framework also generates propositions that can be tested rather than remaining a purely descriptive list of barriers.

The limitations are equally important. The South-East Nigerian evidence base is uneven and contains substantial work on schizophrenia, severe mental illness, students, and clinical populations. Evidence on community-dwelling adults seeking psychologists or counsellors specifically is much thinner. Some recent Nigerian evidence used to elaborate relational and faith-based mechanisms comes from Lagos or Ibadan and may not transfer directly to the South-East. The conceptual synthesis was purposive rather than systematic, so it does not claim exhaustive coverage or formal quality appraisal of all eligible studies. Finally, CEDC is a proposed framework: its stages, interactions, and propositions require empirical validation, and future evidence may show that some stages overlap, occur in different orders, or need to be subdivided.

12. Conclusion

Professional psychological help-seeking in South-East Nigeria is unlikely to be explained adequately by a single barrier, belief, or intention. The proposed Contextual-Ecological Distress-to-Care Framework argues that distress becomes professional care only when a series of conditions align sufficiently: the distress is recognized as requiring help; its meaning permits professional care to be considered; disclosure and relational negotiation do not block action; a professional pathway is selected; practical conditions permit access; and the first encounters support continued engagement. At any point, people may delay, divert, combine sources of care, switch providers, or re-enter later. This staged and ecological view reframes the policy problem. Mental-health literacy without services, services without trust, and legal rights without affordable access are all incomplete solutions. The framework, therefore, calls for linked interventions across recognition, relationships, pathway navigation, primary-care accessibility, culturally responsive practice, and continuity. Its value now depends on empirical testing. Prospective, cross-state, and mixed-method research can determine whether the proposed stages and mechanisms explain real-world help-seeking better than intention-focused or barrier-list approaches and can identify where intervention is most likely to convert distress into timely, acceptable, and sustainable care.

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Table 1. Existing theories/models and the contribution of the CEDC framework

Theory/model	Useful constructs	Limitations for South-East Nigeria	CEDC extension
Theory of Planned Behavior (Ajzen, 1991; Adams et al., 2022)	Attitudes, subjective norms, perceived behavioural control, intention.	Often stops at intention; does not adequately represent plural care, family gatekeeping, service scarcity, or switching.	Retains intention mechanisms but embeds them within recognition, relational negotiation, access conversion, and re-entry.
Andersen Behavioral Model (Andersen, 1995)	Predisposing, enabling, and need factors shaping service use.	Broad domains do not specify when meaning-making, sequencing, or relational decisions occur.	Reorganises enabling and need factors into stage-specific mechanisms across a time-sensitive pathway.
Patient-centered access framework (Levesque et al., 2013)	Approachability, acceptability, availability, affordability, appropriateness; abilities to perceive, seek, reach, pay, engage.	Access begins after need is perceived and does not fully specify plural explanatory models or pathway switching.	Uses access as the Stage 5 conversion mechanism while adding earlier meaning/relational stages and later switching/re-entry.
Pathways-to-care approaches (Ikwuka et al., 2016b; Williams et al., 2025)	First contact, sequencing, delays, multiple provider sectors.	Often centred on severe mental illness and eventual psychiatric contact.	Extends pathway analysis to common distress, professional psychological care, no-care outcomes, and longitudinal re-entry.
Ecologies of care (Read et al., 2026)	Relational, material, and local-system embedding of treatment decisions.	Strong contextual account but not a staged decision architecture for testing where pathways stall.	Adds six recursive stages, explicit transition points, and stage-specific intervention targets.

Table 2. CEDC stages, mechanisms, evidence, barriers/enablers, and intervention levers

CEDC stage	Core mechanisms	Representative evidence	Typical barriers/enablers	Intervention levers
1. Distress emergence & recognition	Symptom noticing, perceived severity, functional impact, mental-health literacy, perceived need.	Cresswell-Smith et al. (2026); Lien et al. (2024); Bora et al. (2026).	Normalisation, low recognition, stigma; enabling literacy and service knowledge.	Context-sensitive literacy, functional-impairment cues, clear service information.
2. Explanatory appraisal & meaning-making	Psychological, biomedical, interpersonal, spiritual, moral, and indigenous explanations; explanatory fit.	Ikwuka et al. (2016b); Jidong et al. (2021); Odinka et al. (2015); Read et al. (2026).	Explanatory mismatch; provider seen as irrelevant; plural explanations can also widen options.	Culturally responsive assessment, explanatory bridges, respectful discussion of faith/indigenous meanings.
3. Disclosure & relational negotiation	Disclosure, family/peer/clergy advice, stigma, confidentiality, authority, financing.	Yu et al. (2023); Read et al. (2026); Adewuya et al. (2026).	Anticipated shame, family opposition, secrecy; supportive family or gatekeepers can enable care.	Confidential entry points, family/peer navigation where consented, clergy referral partnerships.
4. Pathway selection & sequencing	Comparison and ordering of professional, primary-care, faith, traditional, family/community, digital, or no-care pathways.	Ikwuka et al. (2016b); Williams et al. (2025); Read et al. (2026).	Provider trust, cost, proximity, prior outcomes, cultural legitimacy.	Referral literacy, safe cross-sector referral, service directories, rights-based collaboration.
5. Intention-to-access conversion	Availability, reach, affordability, provider fit, waiting time, referral, digital access, opportunity costs.	Levesque et al. (2013); Komu et al. (2025); Damul et al. (2026); Iheanacho et al. (2024).	Distance, cost, workforce shortage, weak referrals, confidentiality concerns; primary-care integration can enable access.	Task-sharing, affordable community care, navigation, referral strengthening, supervision, medicines, privacy safeguards.
6. Engagement, continuation, switching & re-entry	First-contact experience, trust, perceived effectiveness, cost sustainability, therapeutic relationship, continuity.	Komu et al. (2025); Read et al. (2026); Adewuya et al. (2026); Oladipo & Adewuya (2026).	Disrespect, poor fit, adverse experience, repeated costs; respectful, effective care enables continuation.	Continuity planning, shared decision-making, re-entry routes, culturally responsive care, monitoring dropout.

Table 3. Testable propositions and suggested empirical designs

Proposition	Mechanism	Suggested empirical test
P1	Perceived need mediates the association between psychological distress and professional help-seeking.	Prospective cohort; symptom severity, perceived need, and verified/diary-recorded service contact.
P2	Explanatory pluralism predicts multiple or sequential care pathways better than any single causal belief.	Latent-profile or sequence analysis of explanatory-model measures and provider contacts.
P3	Family/trusted-network endorsement moderates the intention-to-service-use relationship.	Longitudinal survey with network support, intention, and actual attendance.
P4	Self-stigma acts most strongly at disclosure and pathway-selection stages.	Stage-specific mediation model; stigma, disclosure, intention, first contact.
P5	Service accessibility moderates the effect of favourable professional-care attitudes on realised use.	Multilevel study linking individual attitudes to travel time, cost, service availability, and attendance.
P6	Satisfactory prior formal-care encounters increase future professional help-seeking; negative encounters increase switching or disengagement.	Prospective service-user cohort with experience quality and subsequent pathway tracking.
P7	Religious leaders' referral behaviour depends jointly on mental-health literacy and trust/accessibility of receiving services.	Clergy survey plus referral logs; interaction analysis; qualitative process evaluation.
P8	Primary-care integration reduces the intention-to-access gap most when supervision, medicines, referral pathways, and community awareness are strengthened together.	Hybrid effectiveness-implementation or stepped-wedge study.
P9	Digital information improves recognition/navigation only when digital access, privacy, literacy, and viable referral options are sufficient.	Digital intervention study measuring knowledge, navigation, and completed referral.
P10	CEDC pathways vary by gender, age, socioeconomic position, rurality, disability, and prior treatment experience.	Stratified cohort or mixed-method comparative pathway analysis.
P11	Rights-based multisector referral arrangements reduce pathway fragmentation and delay to effective professional care.	Quasi-experimental referral-network evaluation with time-to-care outcomes.
P12	Respectful continuity and explicit re-entry routes increase return to care after dropout.	Longitudinal service cohort or implementation trial focused on dropout and re-engagement.