

Research Article

Resilience Mediates the Stigma-Depression Relationship Among Physically Disabled Persons in Osun State, Nigeria

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Abstract

The current study aimed to test the hypothesis that perceived stigma will be related to depression, and that this relation will be mediated by resilience among physically disabled people in Osun State, Nigeria. A cross-sectional correlational design was employed. Two hundred physically disabled people (64% women, mean age 22.79 years, SD = 4.33) were recruited from healthcare facilities and disability support organisations. Participants completed depression (PHQ-9), perceived stigma, and resilience scales. The PROCESS macro (Model 4; Hayes, 2022), with 5000 bootstrap samples, was used to test mediation. Perceived stigma was positively correlated with depression and negatively correlated with resilience, while resilience was negatively correlated with depression. Stigma retained a significant direct pathway to depression after resilience was entered into the model ($c' = .1697$, $SE = .0397$, 95% CI [.0915, .2479]), accounting for roughly 60% of the total effect, while resilience mediated the remaining 40% (indirect effect $B = .1128$, $BootSE = .0288$, 95% CI [.0573, .1705]). Stigma and depression are partially mediated by resilience in this population, indicating that stigma-reduction and resilience-building interventions, delivered together rather than as separate programmes, may be more effective in promoting the mental wellbeing of physically disabled Nigerians.

Keywords: Perceived Stigma, Resilience, Depression, Physical Disability, Nigeria.

INTRODUCTION

Depression is a major public health issue; it is estimated that over 280 million people around the world suffer from depression (World Health Organization, 2023). This burden is not shared evenly: physically disabled people carry a disproportionate share of it, and this is felt most acutely in low-resource settings such as Osun State, Nigeria, where rehabilitation services, assistive devices, and disability-rights protections remain limited. People with physical disabilities are much more likely to have depression than the general population (Li & Mitra, 2019), and these factors are linked to physical disability (e.g., mobility, chronic pain, dependence, unemployment, discrimination, and social isolation) (Kumar et al., 2024). A study in Nigeria reported a depression prevalence of 20% for persons with lymphatic filariasis, over 42% for tertiary hospital patients, and 89.9% for those with leprosy or Buruli ulcer (Ossai et al., 2024). An estimated three times as many persons with disabilities as persons without disabilities have mental health problems.

Stigma, comprising awareness or internalisation of negative societal attitudes regarding a devalued attribute such as physical disability (Goffman, 1963), is an especially potent risk factor for depression. Stigma involves public misconceptions, pity, avoidance, and discrimination that frame disability as a deficit (Shakespeare, 2018). A systematic review of 60 studies found the same positive association between the sense of being stigmatised and depression for multiple stigmatised groups, such as those with physical disabilities (O'Donnell et al., 2024). Stigma and social exclusion in terms of pejorative labelling and exclusion have been associated with depression, low self-esteem, and suicidal ideation among persons with disabilities in Nigeria (Amaechi et al., 2023; Ossai et al., 2024). In addition to Nigeria, disabled elderly in Ibadan who had not received informal care were much more likely to be depressed (Gureje et al., 2006), and stress burden in general has been shown to predict psychiatric disorder throughout life in young adults (Turner & Lloyd, 2020), indicating that chronic disability-related strain builds up to depressive illness.

A scoping review of the manifestations of stigma for persons with physical disability revealed that stigma awareness was found to negatively impact psychosocial functioning, such as in relation to self-efficacy and quality of life (Ju et al., 2023). In adults with mobility impairments, higher perceptions of stigma correlated with higher depression and lower life satisfaction (Bogart et al., 2018); in individuals with spinal cord injuries, higher perceived stigma was associated with poorer psychological adjustment (Ditchman et al., 2013). A strong association between stigma of all forms and poor mental health, such as depression, has been confirmed by meta-analytic studies (Mak et al., 2007; Rueda et al., 2016). The connection between stigma and depression is less well understood.

Resilience, the ability to sustain or recover positive psychological functioning during stress and adversity (Masten, 2014), is a possible intervening variable. Resilience is not a lack of stress, but one's ability to adjust to intense stress; it involves internal factors like optimism and coping skills, as well as external factors like social relationships (Luthar et al., 2000; Southwick et al., 2014; Windle, 2011). The Stress-Adaptation Model (Lazarus & Folkman, 1984) proposes that stigma is appraised as threatening, triggering stress responses that can lead to depression when experienced

for long periods, while resilience influences this process and can help to build coping resources to counteract it. The buffering hypothesis of Cohen and Wills (1985) also states that psychological resources including resilience buffer the harmful impact of stress by changing appraisal and increasing coping skills. Negative attitudes towards disability tend to lead to reduced self-confidence, social withdrawal, formation of negative self-schemas (Scambler, 2009), and increased risk for depression, thus undermining the very things that make up resilience.

In line with this protective role, resilience has been found to be associated with reduced depressive symptoms and increased life satisfaction among adults with physical impairments (Catalano et al., 2011), and resilient disabled individuals have been found to be able to manage stress and maintain optimism despite facing discrimination and environmental challenges (Li & Wu, 2017). The evidence on the role of resilience as a mediator is growing elsewhere in the world, but not Nigeria. The relationship between stigma and depression was partially mediated in physically disabled persons by resilience with a mediation effect of 0.18 (Liu & Zhang, 2021) and 0.19 (Kumar et al., 2024) respectively. Abolghasemi (2025) found resilience as a mediator between internalised stigma and social functioning in adolescents with physical disabilities, and Ji et al. (2024) found psychological resilience as a moderator between stigma and depression in chronically ill patients. In an actor-partner interdependence model, Chen et al. (2024) found a significant indirect effect of resilience on depression among older disabled adults and their caregivers, mediated by perceived social support. A separate study of adults living in the community with physical disabilities in China showed that self-stigma had a positive predictive effect on depression, with social participation and self-esteem as additional mediators (Scientific Reports, 2025), and Zhao et al. (2022) found that the chain mediating effect between disability and post-stroke depression was significant, with perceived social support and resilience as the two mediators between them. Thus, the relationships between the various variables in this network are interconnected, with resilience playing a pivotal role.

The role of resilience in the network of relationships is emphasised, with activities-of-daily-living disability being associated with lower resilience and reduced social coping (Na & Yang, 2022). The sources of this evidence are mostly from Western or Asian contexts (Kumar et al., 2024), with limited literature available on the disabled person in Nigeria specifically (Adeworan, 2019). However, predictors for common mental disorders were identified by Gbadegesin and Ikwuyatum (2024) in Ibadan Metropolis, and the mediating role of resilience in the pathway of stigma-depression has not yet been studied within the local context. This gap is important because interventions that target an understanding of the mechanism have the potential of being ineffective if they do not target the right mechanism: if stigma negatively affects mental health primarily through a reduction in resilience, then resilience-building programmes should be emphasised; if the pathway is primarily direct, then anti-stigma advocacy should be emphasised. The question of the relative merits of the two routes can only be answered by a study that tests both at the same time for a Nigerian population.

This is a pertinent question in Nigeria because physical disability brings with it

a host of challenges. Access to specialised health care and disability rehabilitation services, as well as the provision of assistive devices, are largely constrained to few urban centres, with lower income and rural disabled people being left out and with inadequate social welfare provisions. The disadvantages of mobility limitations, chronic pain, dependence, and the feeling of being a burden continue, with culture and religion attributing disabilities to misfortune, curse, and/or punishment that may exacerbate the shame and avoidance that gives rise to perceived stigma.

The socio-cultural landscape in Osun State, characterised by a predominantly Yoruba population with strong extended-family and faith-community networks, creates a complex and often contradictory environment. While these networks can serve as sources of social support, they are also the vessels through which deeply ingrained cultural beliefs, such as "ayanmo" (destiny), curses, or punishment from ancestors or spirits, are transmitted, directly impacting how physical disability is perceived and experienced (Etieyibo & Omiegbe, 2016; Ajuwon, 2017; Abubakar, 2024). This duality is crucial for understanding both the vulnerability to depression and the potential pathways for resilience.

Within the same time frame, Nigerian society has also continued to have strong extended-family and faith-community networks: relatives who take on caregiving roles, church and mosque groups that organise practical and emotional support, and communal decision-making structures that can absorb some of the shock of acquiring a disability. These networks, in principle, can serve as protective factors and as a source of resilience that operates differently from the individual-level coping resources emphasised in much of the Western resilience literature. Yet it is an empirical question whether this is true here as it is elsewhere, and whether the same religious and communal structures that offer support also carry the misfortune-based framings of disability described above.

The WHO's International Classification of Functioning, Disability, and Health (ICF) provides a framework for understanding that disability is not merely a physical condition but an outcome of the dynamic interaction between a health condition (e.g., a mobility impairment) and contextual factors, including social, cultural, and environmental barriers (Sulaiman et al., 2021). In this light, the physical limitations and social barriers faced by individuals in Osun State are not isolated from mental health. Indeed, a representative study of elderly Nigerians in the broader South-Western region (including Ibadan, near Osun) demonstrated that functional disability was strongly associated with an increased likelihood of suffering from major depressive disorder, particularly when coupled with unmet social care needs (Gureje et al., 2006).

Determination of the process through which resilience is the mechanism through which mental health is harmed, or whether it is more damaging through anti-resilience (stigma) pathways, has a direct impact on the current allocation of limited mental-health resources in Nigeria between anti-stigma advocacy and psychosocial skill-building programmes. The study thus explores the possibility of mediation of the relationship between perceived stigma and depression among physically disabled people of Osun State, Nigeria. We hypothesised that perceived stigma would be negatively correlated with resilience, which would be negatively correlated with

depression, and that there would be a substantial direct pathway between perceived stigma and depression mediated by the relationship between perceived stigma and resilience.

RESEARCH METHODS

The design of this study was cross-sectional correlational. A total of 200 physically disabled persons were conveniently sampled from the various healthcare facilities and disability support organisations in Osun State, Nigeria, comprising those with mobility disabilities, amputees, and others with physical disabilities. Mean age was 22.79 years ($SD = 4.33$, range 17-41); 68.0% were aged 25 or below. There were 64.0% females and 36.0% males of the total population. Most respondents were Christian (64.5%), Yoruba (84.0%), and single (85.0%). In the education category, 74.5% were with SSCE while 25.5% were with OND, of which 35%, 33.5%, and 31.5% were in employment, unemployed, and self-employed respectively.

Depression was measured using the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) which was rated on a scale from 0 (not at all) to 3 (nearly every day). The scale demonstrated acceptable reliability in this study ($\alpha = .737$). Lee's (2007) 29-item Perceived Stigma Scale ($\alpha = .796$ in this study; range 1-4, strongly disagree to strongly agree) was used, with items such as "People discriminate against me because I have a disability." The 11-item Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) was used to measure resilience with a 5-point scale, with the item "I maintain a hopeful outlook" having an alpha of .795.

Ethical clearance was granted by the Institutional Review Board (IRB) of the Federal University of Health Sciences, Ila-Orangun; and permission was granted by the management of the healthcare facilities and disability support organisations involved in the study. Trained research assistants explained the intention and procedure of the study to each potential participant, and informed consent was secured in both written and/or witnessed thumbprint form. No coercion was involved, no negative consequences resulted from undesirable answers, and confidentiality of individual answers was assured. Where possible, questionnaires were self-administered; where a respondent's disability impacted their ability to read or write, a research assistant read the items and recorded the response.

The respondents had to meet the following inclusion criteria: (1) physical handicaps, (2) age 17 years or older, and (3) willingness to participate. Respondents with severe cognitive impairment that would make self-report difficult were not included. After discarding questionnaires with missing items and invalid response patterns, 200 questionnaires were retained for analysis. Data were analysed in SPSS version 25. Demographic and study variables were summarised using descriptive statistics, and scale reliability was tested using Cronbach's alpha. Pearson correlation statistics were used to investigate the correlations between perceived stigma, resilience, and depression. Mediation was tested with the PROCESS macro for SPSS (Model 4; Hayes, 2022) using 5000 bootstrap samples for bias-corrected confidence intervals, with perceived stigma as the independent variable, resilience as the mediator, and depression as the outcome. P-values of $\leq .05$ were considered significant.

RESULTS AND DISCUSSION

The demographic description of the respondents is provided in Table 1 below. The mean age was 22.79 years ($SD = 4.33$); most respondents were female (64.0%), Christian (64.5%), Yoruba (84.0%), and single (85.0%). Table 1 shows the demographic characteristics of the respondents ($N = 200$).

Table 1: Demographic Characteristics of Respondents ($N = 200$)

Variable	Category	n	%
Age Group	≤25 years	136	68.0
	26-35 years	61	30.5
	36-45 years	3	1.5
Gender	Male	72	36.0
	Female	128	64.0
Religion	Christianity	129	64.5
	Islam	64	32.0
	Traditional	7	3.5
Ethnicity	Yoruba	168	84.0
	Igbo	10	5.0
	Hausa	9	4.5
	Others	13	6.5
Marital Status	Single	170	85.0
	Married	13	6.5
	Separated/Divorced/Widowed	17	8.5
Academic Level	SSCE	149	74.5
	OND	51	25.5
Employment	Employed	70	35.0
	Unemployed	67	33.5
	Self-employed	63	31.5

Acceptable reliability was obtained for all three scales: depression $\alpha = .737$, perceived stigma $\alpha = .796$, resilience $\alpha = .795$ (Table 2). Mean depression score was 12.51 ($SD = 5.81$, range 0-27); mean perceived stigma was 66.13 ($SD = 10.76$, range 29-94); mean resilience was 30.26 ($SD = 8.99$, range 11-49).

Table 2: Reliability and Descriptive Statistics for Study Scales

Scale	Items	Cronbach's α	Mean	SD
Depression	9	.737	12.51	5.81
Perceived Stigma	29	.796	66.13	10.76
Resilience	11	.795	30.26	8.99

The severity of depression was very variable, with 6.0% reporting minimal, 29.5% mild, 27.0% moderate, 23.5% moderately severe, and 14.0% severe (Table 3), reflecting a high proportion of respondents with at least minimal depressive symptoms. The distribution of depression severity is shown in Table 3:

Table 3: Depression Severity Distribution

Severity	n	%
Minimal	12	6.0
Mild	59	29.5
Moderate	54	27.0
Moderately Severe	47	23.5
Severe	28	14.0
Total	200	100.0

The results of zero-order correlation (Table 4) supported the mediation hypothesis because they showed that perceived stigma positively correlated with depression and negatively correlated with resilience, while depression negatively correlated with resilience.

Table 4: Correlations Among Study Variables (N = 200)

Variable	1	2	3
1. Perceived Stigma	-		
2. Resilience	-.618**	-	
3. Depression	.523**	-.532**	-

Note. ** $p < .01$.

The results of mediation analysis (Table 5; Figure 1) showed that the increase in perceived stigma was significantly associated with the decrease in resilience ($a = -.5168$, $p < .001$), and the decrease in resilience was significantly associated with the increase in depression ($b = -.2182$, $p < .001$). The indirect effect of stigma on depression through resilience was significant ($B = .1128$, $\text{BootSE} = .0288$, 95% CI [.0573, .1705]), representing roughly 40% of the total effect ($c = .2825$, $p < .001$). The results showed partial mediation, with the mediation effect not found when resilience was directly added to the model, but the direct effect was still significant ($c' = .1697$, $p < .001$). The model explained 34.4% of the variance in depression, $R^2 = .344$, $F(2, 197) = 51.659$, $p < .001$.

Table 5: Mediation Model Depicting that Perceived Stigma is Associated with Depression, with Resilience as a Mediator

Path	Coeff.	SE	t / BootSE	95% CI
Stigma → Resilience (a)	-.5168	.0467	$t = -11.069^{***}$	[-.6089, -.4247]
Resilience → Depression (b)	-.2182	.0474	$t = -4.600^{***}$	[-.3118, -.1247]

Stigma → Depression, direct (c')	.1697	.0397	t = 4.280***	[.0915, .2479]
Stigma → Depression, total (c)	.2825	.0327	t = 8.635***	[.2180, .3470]
Indirect effect (a × b)	.1128	.0288	BootSE	[.0573, .1705]

Note. N = 200. ***p < .001. R² = .344, F(2, 197) = 51.659, p < .001.

Figure 1. Mediation model showing resilience as a mediator between perceived stigma and depression.

These results build upon a growing body of evidence that resilience is one way by which stigma negatively affects mental health. The positive association between stigma and depression is similar to the findings of O'Donnell et al. (2024), who conducted a systematic review across five groups of people with stigma and found that these groups reported increased depression scores, and to the finding by Saia et al. (2024) that among the 149 participants who were people with disabilities, there was an association between depression and the stigmatised group of persons with disabilities, which included those using a wheelchair. Nigerian research also found a positive association between stigma and disfigurement-related isolation and depression, anxiety, and pain among persons affected by lymphatic filariasis (Ossai et al., 2024). The strength of association is also similar to Liu and Zhang's (2021) finding of a significant correlation between stigma and depression among physically disabled people.

Stigma is part of a negative association with resilience, which reinforces the idea that stigma decreases psychological resources, not just that they exist alongside low resilience. Disabled people may develop negative self-schemas (Scambler, 2009), negative appraisals (resilience is not possible), and internalise negative societal attitudes that may lead to social withdrawal and doubt about abilities. This aligns with Liu et al. (2021), who found that stigma was negatively associated with resilience among physically disabled people, and is also consistent with previous research which found that the relationship between caregiver burden and internalised stigma among mothers with children with disabilities was mediated by resilience.

The negative relationship between resilience and depression is consistent with the protective effects of mental health through emotion regulation, problem-focused coping, and maintaining a positive self-concept (Akbar, 2025; Mira et al., 2023). Resilient people are likely to evaluate stressors as less threatening and maintain a sense of purpose even in the face of limitation, which may account for why these stressors were less associated with depressive symptoms in this sample.

Resilience was found to account for about 40% of the total effect in the relationship between stigma and depression, building on Liu and Zhang (2021), Kumar et al. (2024), and Abolghasemi (2025) in the Nigerian context. The shares of mediation for perceived social support and resilience for post-stroke depression were 10% and 6% respectively, with a further 7% chain effect (Zhao et al., 2022); there appears to be an especially salient role for resilience in disability-related, rather than illness-related, stigma. It also aligns with the overall pattern that self-stigma is associated with depression via psychosocial pathways (e.g., social participation, self-esteem), suggesting that resilience sits within a larger constellation of psychosocial factors that are depleted by self-stigma (Scientific Reports, 2025).

The partially mediated pathway identified in this study cannot be fully understood without considering the unique cultural and religious dynamics of Osun State. The "misfortune-based" framings of disability that fuel stigma are often perpetuated within the same socio-cultural structures that provide resilience resources. For instance, while a deep and widespread belief in a transcendent being and a strong faith community can foster "spirituality as resilience," providing meaning, hope, and a sense of purpose in the face of adversity (Adebusoye et al., 2025; Agbawodikeizu et al., 2022), it is also within these systems that disability is sometimes interpreted as a "curse from the gods" or divine punishment for an ancestor's transgression (Chukwu et al., 2019; Fubara-Manuel, 2022).

Similarly, the extended family, which is celebrated for offering practical care and financial support (Onalu & Nwafor, 2021), can also be a primary source of internalised shame and exclusion for an individual whose physical condition is seen as a family embarrassment. This dual function signifies that resilience in this context is not merely an individual psychological trait, but a relational and socially negotiated process, often forged within the very cultural and spiritual frameworks that also oppress. This challenges the individualistic model of resilience scales like the CD-RISC and underscores the need for culturally integrated, rather than purely secular, interventions.

The indigenous philosophy of Ubuntu, which emphasises interconnectedness, communalism, and the idea that "a person is a person through other people," offers a crucial lens for understanding resilience in this population (Adesehinwa et al., 2025; Eromosele, 2021). In this framework, well-being is a communal responsibility, and recovery from adversity is achieved through relational healing and collective support (Mokhwelepa & Sumbane, 2027). This is operationalised in the Nigerian context through the reliance on family networks, religious congregations (such as the Aladura churches which have direct support programmes for the "handicapped"), and community-level acts of solidarity (Akindolie, 2020; Onalu & Nwafor, 2021). These collective coping strategies, which include joint prayer, shared storytelling, and the pooling of resources, represent an understudied but vital pathway to resilience that is distinct from the individual-centred optimism and problem-solving measured by conventional scales.

The continued significant direct effect of stigma on mental health controlling for resilience suggests that stigma also has indirect effects on mental health, such as social isolation or lower self-esteem (Link & Phelan, 2001), and aligns with Ji et al.'s (2024) finding that psychological resilience can moderate, rather than mediate, the path between stigma and depression, and sometimes strengthen it. In reality, the pattern here indicates that anti-stigma activities, which involve challenging negative disability stereotypes and fostering positive ones of disability, coupled with activities that help build resilience resources as outlined by Akbar (2025) and Chen et al. (2024), should be a consideration in reducing depression among physically disabled Nigerians.

The cultural and religious environment in Nigeria may add to stigma-related alienation by fostering misconceptions such as disability as punishment or misfortune, but may also provide resources for resilience, such as extended family

networks, religious coping, and community solidarity. This dual role marks a departure from the individualist framing of resilience common in much of the Western literature, where measures such as the CD-RISC were developed and normed around constructs like personal self-efficacy, optimism, and problem-focused coping (Connor & Davidson, 2003).

In a collectivist, family- and faith-centred setting such as Osun State, resilience appears to be produced and sustained relationally, through the obligations of kin, the practical support of religious congregations, and community-level acts of solidarity, rather than through individual psychological traits alone. This may be a qualitatively different resilience pathway from the one typically reported in Western or East Asian samples (Kumar et al., 2024; Liu & Zhang, 2021), even where the numerical strength of the stigma-resilience-depression pathway observed here resembles those studies; the mechanism generating resilience, and not only its statistical size, may be culturally distinct, and a scale built around individual coping may under-capture the collective forms of resilience operating in this context. The same religious and family structures that supply support can simultaneously reinforce the misfortune- or punishment-based framings of disability that feed stigma, so the two functions are not easily separated in practice.

The potential influence of other social factors locally identified, such as food security, housing quality, green space, and exposure to violence (Gbadegesin & Ikwuyatum, 2024), is likely to play a role in this pathway too and should be incorporated into future models.

These findings indicate that the two prongs of intervention identified above work best as a single, integrated strategy rather than as parallel, unconnected programmes. Structured psychosocial interventions like coping-skills training, cognitive reframing of adversity, peer mentoring by disabled persons who have successfully adapted, and vocational/livelihood support to regain a sense of competence might be expected to strengthen this set of resources measured at the level of resilience in this study. Interventions at the level of stigma, such as public awareness campaigns, disability-inclusive media representations, disability-equality training for healthcare workers as discussed by Amaechi et al. (2023), and enforcement of existing disability-rights legislation, could decrease the discriminatory treatment perceived by respondents in this sample. However, the direct effect of stigma was still large even after controlling for resilience, and therefore, resilience-building efforts are not likely to be enough; efforts to address the social context of disabled people's lives (beyond their coping resources) are also important.

The findings of this study strongly suggest that mental health prevention programmes for physically disabled Nigerians would be most effective as a single integrated strategy. For example, an intervention could be designed where community-level stigma reduction efforts, such as engaging religious and traditional leaders to reframe disability as a human condition rather than a spiritual punishment, are coupled with individual-level resilience training delivered within existing community structures. This training could include culturally adapted cognitive reframing, but also, critically, a strengths-based peer-mentoring component (e.g., "BOLD Hearts Network" model) where disabled individuals share their narratives of

successful adaptation (Farouk et al., 2026; Fubara-Manuel, 2022). Furthermore, the reliance on spirituality as a resilience mechanism suggests that resilience-building interventions should explicitly incorporate and support spiritual coping, such as through faith-based counselling, rather than offering a purely secular alternative. By embedding psychosocial support within the existing family and community networks that are central to the Nigerian experience, this integrated model would directly address the direct and indirect pathways (40% of the effect) through which stigma leads to depression, as identified in this study.

Even though the PHQ-9 was used in this sample to screen for depression, other instruments have been used to screen for depression in the physically disabled population, and depression was found to have independent explanatory value in this population in addition to perceived stigma and resilience.

These conclusions are tempered by some limitations. The sample is convenience-based and represented major healthcare facilities and disability support organisations of a single metropolitan area, and was skewed to include mostly young, single, Yoruba respondents, limiting the generalisation to older disabled Nigerians, rural residents, or other ethnic and religious groups. The cross-sectional design does not allow for causal direction to be established; although the theoretical model states that stigma precedes resilience and depression, causal pathways in the opposite direction or in a reverse/reciprocal direction (depression increasing sensitivity to stigma and a further decrease in resilience) cannot be ruled out. There may also be social-desirability bias with the use of self-report measures, especially in regards to a stigma-sensitive topic. Future research could examine whether the pathway towards resilience identified in this study also captures the directionality of the relationship, and support the generalisability and directionality of the pathway further with a probability sampling method and objective measures of resilience and/or informant-rated measures of resilience as Ji et al. (2024) did elsewhere, or test whether resilience itself moderates the relationship with stigma and depression.

CONCLUSION

The relationship between perceived stigma and depression in physically disabled people in Osun State, Nigeria, exists in a partially mediated way, with resilience accounting for about 40% of the effect of perceived stigma on depression, while a significant direct effect of perceived stigma on depression remains. Based on these findings, mental health prevention programmes for physically disabled Nigerians should combine community-level stigma reduction, such as public education campaigns, engagement of religious and traditional leaders, and enforcement of disability-rights legislation, with individual-level resilience training, such as coping-skills programmes, cognitive reframing, and peer mentoring, delivered as a single integrated intervention rather than as separate, unconnected activities, since resilience alone is unlikely to offset the sizeable direct effect of stigma on depression found in this study. The study also adds to a literature that is otherwise dominated by samples from the West and Asia, and provides the first Nigerian evidence that the pathway of stigma-resilience-depression is similar across cultural contexts but with possibilities for local adaptation of intervention.

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