

GENDER DIFFERENTIALS IN THE PERCEPTION OF MENTAL ILLNESS AMONG THE YORUBA OF OGUN STATE, NIGERIA

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Abstract

Mental illness presents lots of challenges especially in Nigeria. There are various cultural factors that influence perceptions of people about mental illness. Although studies exist on perceptions of mental illness, little attention has been paid to gender differences. This study therefore examined gender differentials in the perception of mental illness among the Yoruba people of Ogun State, Nigeria. Labelling theory provided the theoretical framework. Nine hundred and sixty seven adults were randomly selected. Five In-depth Interviews were conducted among caregivers of people living with mental illness (those who are receiving treatment and those who have recovered) and nineteen Key Informant Interviews were conducted among orthodox practitioners and traditional healers. The study revealed that there were significant differences between men and women in the perception of mental illness. Stigmatisation and gender discrimination among People Living with Mental Illness (PLWMI) should be eradicated through government actions, advocacy and education.

Keywords: *Gender differentials, Mental illness, Treatment, Perception, Ogun State*

Introduction

Globally, good health has been recognised as one of the core life-sustaining needs that are crucial for building a nation (Smith, 2013 and World Health Organisation, 2015). The World Health Organisation conceptualises health as a complete state of physical, social and mental well-being and not just the non-existence of a disease or illness (World Health Organisation, 1948). Physical health refers to the biological aspect of health; it connotes functional and metabolic efficiency of an individual. Social health refers to the health of an individual as it relates to his or her ability to interact with others and thrive in social settings. Mental health is a term used to describe the level of emotional well-being

or absence of mental disorder. The physical, social and mental health of a person are interrelated and interconnected (Elegbeleye, 2013).

Mental health is an integral part of an individual's capacity to live a life of fulfillment, including the ability to maintain social relationships and to make day-to-day decisions (World Health Organisation, 2005). However, mental illness explains the disorder generally characterised by deregulation of mood, and behaviour of either male or female. Mental illness has gotten to an alarming rate globally. Approximately, 500 million people have a mental illness globally with the majority living in developing countries (World Health Organisation, 2013). World Health Organisation reported that 25 to 38 million people had schizophrenia and epilepsy respectively, over 90 million people suffered from drug and alcohol problem and over 150 million persons had depression at any point in time, and around one million persons commit suicide annually (World Health Organisation, 2013). This figure is projected to increase by 15 percent in the year 2030 (World Health Organisation 2014). However, the prevalence rate of mental illness in Nigeria is 20 percent. The high prevalence of mental illness has a significant emotional burden on individuals, families, and society (Mental Health Leadership and Advocacy Programme, 2012).

The concept of gender is a structural determinant of mental health and mental illness. The relationship between gender and mental health is complex and it contains a core contradiction (Gelder, Lopez-Ibor, Andreasen, 2000; Gureje, 2010). Majority of the female-dominated cases are results of specific diagnoses (specifically depression, fear, nature and eating abnormalities). Patel, Kirkwood, and Pednekar (2006) identified the existence of societal effects in mental illness. They establish that poverty (characterised by poor earnings, inability to make ends meet), marital status and tobacco usage significantly contribute to greater proportions of psychological disorder.

For Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen and Kendler (1994), global rates of mental illness experienced by men are the same for women. However, remarkable gender differences (GD) occur in the forms of mental illness. Financial status, traditional expectations, and societal support vary by masculinity and femininity, and they influence on persons' susceptibility to mental illness. Epidemiological reviews propose that women in matrimony are more

affected by matrimonial conflict than married men and men are more expected to be affected by occupational-related stress. This development has much to do with masculinity and femininity roles and expectations in the world. Male and female differences in mental health will not be abridged until women's mental health is considered (Avotri and Walters, 1999). Male and female differences occur in form of help-seeking for mental illness. Masculinity and femininity prejudice also takes place in the management of mental illness (World Health Organisation, 2014). The interferences obtainable for averting and treating the psychological disorder in developing nations are quite limited (World Health Organisation, 2012).

Holistically, what one culture may consider as a mental disease or abnormal behaviour may be seen as normal in another culture. This dissimilarity in conception shows bias in the definition, identification and management of a mentally ill individual. There is often disagreement and lots of debate on how to understand mental illness in developing countries across different cultures. Among the Yoruba of Southwest Nigeria, mental illness is referred to as '*arun opolo*', psychosis as '*iwin* or *were*' and mental retardation as '*ode* or *odoyo*' (Jegade, 2005 and Jegede, 2010). The Yoruba people attributed its causes to four sources namely, natural sources (accident or drug induced), supernatural or mystical (due to the wrath of the gods), preternatural source (due to witches) and hereditary sources (Jegade, 2010). There is the categorisation of mental illness into three – '*were*' '*amutorunwa*' (mental illness that is inborn); '*were iran*' (hereditary mental illness) and '*were afise*' (afflicted mental illness).

Recognition of mental illness is by careful assessment of cultural customs, values and beliefs within the individual's society. However, societal attitudes, beliefs and successful treatment of mental illness play a vital role in determining health-seeking behaviour. Kabir, Iliyasu, Abubakar and Aliyu (2004) affirmed further that the role of the society in the prevention and treatment of patients with mental illness cannot be overemphasized. Culture of the people affects their health and social relationships. Culture influences the people's perception, attitudes and behaviour in the treatment of mental illness (World Health Organisation, 2007)

In Nigeria, there are different conceptions concerning health and disease. For instance, Ola-Aluko and Edewor (2002) argued that the society socialised a Nigerian woman into a culture of female subordination as in most other patriarchal (male-controlled) cultures of the world. In another study, Aniebue and Ekwueme (2009) revealed that socio-cultural practice such as male dominance (patriarchy) and the stigmatising nature of mental illness, in which women are possibly more susceptible than men could explain the observed gender differences in health-seeking behaviour of people living with mental disorder. There is prevalent stigmatisation of mental disorder in Nigeria. However, attitudes to mental illness are driven by ideas of the stigma involved in seeking psychiatric help.

In most Yoruba communities due to its patriarchal (male dominance) nature, when a man suffers mental illness, it is traced to the wicked people in his extended family who do not want him to succeed in life. A woman on the other hand due to her subjugated position is not seen in the same light when she suffers a mental illness. Her case is traced to her committing atrocities such as acts of promiscuity or witchcraft and other harmful activities such as wickedness against a rival wife or husband's concubine.

Globally, mental health is the most neglected component of health despite the availability of effective and affordable treatments. Mental illness presents lots of challenges in developing countries. Such problems include stigma and lack of information about mental health in the society. One in four will suffer a mental illness but will they get the care and treatment they need? (British Broadcasting Corporation, 2016). In spite of the encumbrance of dysfunctional behaviour and the resulting level of anguish for persons, efforts to address it continue to be disappointing. This poor effort is because of low budgetary resources, inadequate psychiatric professionals, the existence of competing and conflicting mental health care system needs and the stigma involved in seeking psychiatric assistance. Attitude to mental illness reflects in the bigotry of societal interaction with people suffering from mental illness. One main health problem for women is that of mental condition. A variety of studies revealed that women are excessively afflicted by mental health challenges and that their susceptibility is related to marital status, labour and roles in the world. Major proposed reasons were: nurturing children and taking care of the house is frustrating; the role of

housewife is somewhat amorphous and indiscernible; when a married woman works she is in a less pleasing position than the married man and expectations challenging women are vague and diffuse.

Statistics from the United Kingdom National Morbidity Survey of 2000 shows the categories of demographic characteristics of mentally challenged people. It reveals that individuals who are separated or divorced or single are more prone to mental disorder (Singleton *et. al*, 2001). An evaluation of the association between marital status and mental health revealed that women in matrimony do experience an increased rate of mental illness than married men, although single women display rates of mental illness akin to or even lesser than the rates revealed for single men

Halgin and Whitbourne (2003) admit that some psychiatric conditions have strikingly diverse degrees of occurrence and frequency in women and men, but they are ambiguous about whether these variances are real or attributable to many partialities. Numerous literatures shows gender variations in help-seeking behaviour among people that are mentally ill. Women are more likely seek for help, whether professional or quack, than men (Clarrochi, Wilson, Deane and Rickwood, 2003). In contradiction, another study in rural Australia showed that men would try to find assistance if they agonized from mental health challenges. The study observed male and female variances, for example, males have advanced preference signal for seeking assistance from psychologists than females do (Clarke, 2010). On the other hand women had constantly higher proportions of suicidal efforts and post-traumatic stress condition compared to men.

Gender-specific risk causes of mental illness that affect women comprise centre violence, socioeconomic shortcoming, low returns and income disparity, low or subservient social status and position and incessant obligation for the care of others. The high pervasiveness of sexual violence to which women are open to and the resultant high rate of Post-Traumatic Stress Disorder (PTSD) succeeding such viciousness make married women the leading single collection of women affected by mental illness.

Majority of the articles on mental health published examined the approaches towards people living with mental illness (PLWMI) from

European and other technologically advanced western countries (Barke, Nyarko and Klecha, 2011). There is little information about the understanding of and approach to mental illness in sub-Saharan Africa (Gureje *et al.*, 2005). A more current study among residents of three states in South western Nigeria revealed the widespread negative understandings and perception of mental disorder (Gureje *et al.*, 2005). There is paucity of knowledge about the extent to which socio-cultural factors affect perceptions of mental illness and utilisation of mental health care services. This study attempted to examine the influence of gender differential on perception of causes and treatments of mental illness amongst the people of Ogun state Nigeria.

Labelling theory

During the 1960s and 1970s and till date, labelling theory was very prominent. Labelling theory had its origin in the book 'suicide' written by French Sociologist, Emile Durkheim (1858-1957). Labelling theory proposes that individuals get labels based on the way others assess their propensities or behaviours. Furthermore, it is the theory of self-identification and conduct of persons may be prejudiced by concepts that are employed to describe or classify them. Labelling theory is concerned with social roles that the general public offers for abnormal behaviour termed social stigma. Social roles or functions are necessary for organisation and functioning of the society.

The term 'mentally ill' was applied to labeling theory in the year 1966 by Thomas J. Scheff. Scheff claimed that mental illness is a sole manifestation of social influence. He submitted that the world views certain activities as abnormal and to come to positions with and comprehend those activities frequently exacts the label of mental illness on those who display them. The label of 'mentally ill' may assist a person seeking help regarding medications. Studies have shown that expectations of labelling could have a substantial adverse effect. It can cause patients to withdraw from the general public. They come to forestall and recognise undesirable social responses to them, and this possibly damages the value of life (Bruce, 1987; Bruce, Francis, Elmer, Patrick and Bruce 1989; Bruce, Link, Jo and Phelan, 1999).

In relation to labelling theory, the purpose of the reactions of others to a specific group is deviance. Deviance does not insinuate the superiority of an action which an individual commits but the consequences of the

presentation of the instructions and sanctions of the criminals. However, Durkheim emphasised mostly on the society than the individual. The world describes the person in a specific manner, and it creates predictions about human attitudes. Given this, the Yoruba conceptualises mental disorder from a traditional viewpoint and tags the person as 'were' when his conduct is of non-conformity with the accepted culture, particularly when such attitude is on the extreme.

The labelling theory is quite relevant in evaluating mental illness among the Yoruba especially as it affects women. Mental illness is mostly labelled as something that is profoundly spiritual, and for a woman, it must be that the gods are punishing her for some wrongdoing such as witchcraft or promiscuity including her refusal to engage in some cultural or traditional rites as may be demanded of her by her family members. This label invariably clearly explains why among the Yoruba, women are more likely to be assigned appropriate diagnosis due to how such mental illness may have been labelled which is also a reflection of the peoples' perception, attitudes, and cultural beliefs.

Methodology

Research design and Study area

This study utilized both cross-sectional and exploratory design. It adopted triangulation of both quantitative and qualitative methods of data collection. Qualitative research tools were In-Depth Interview (IDI) and Key Informant Interview (KII) guides while quantitative research tool was structured questionnaire.

The study location was Ogun State in South-western Nigeria. It is predominantly a homogenous group of Yoruba extraction, made up of six dialectical sub-ethnic groups of: Egba, Ijebu, Remo, Egbado (also called Yewa), Awori and Egun. The state capital is Abeokuta. The Yoruba tradition and belief about causes of mental illness to include witchcraft makes Ogun State relevant as a traditional Yoruba state with a high female population. Psychiatric hospitals and Local Government Areas (LGAs) which were selected for this study included:

1. Department of Psychiatry, Federal Medical Centre, Abeokuta (Abeokuta South Local Government Area);
2. Department of Psychiatry, Olabisi Onabanjo University Teaching Hospital, Sagamu (Sagamu Local Government Area);

3. Aro Neuropsychiatric Hospital, Abeokuta (Abeokuta North Local Government Area); and
4. Lantoro Community Psychiatry, Abeokuta (Abeokuta South Local Government Area).

These hospitals and Local Government Areas (LGAs) were purposively selected. The criteria used in the selection of the psychiatric hospitals are:

- i. The presence of amenities for psychiatric patients
- ii. The availability of psychiatric patients

The traditional healers in Ogun State were communicated through local and state associations.

Study participants

The respondents for the study were drawn from adults (male and female), 18 years and above, Yoruba and permanent residents in the study location. The opinions of relatives of people living with mental illness, community leaders and psychiatric health workers were obtained through in-depth interviews (IDIs) and Key informant interviews (KIIs).

Data collection and Sampling Techniques:

Data collection involved a triangulation of quantitative and qualitative methods. Questionnaire was administered to 967 respondents while in-depth interviews and Key informant interviews were conducted in each of the selected institutions. Multistage sampling procedure was adopted, which involved purposive selection of Ogun state due to the presence of specific mental health facilities, especially the first generation Neuropsychiatric Hospital, Aro and the place of the state in the history of psychiatry in Nigeria

The instruments used for data collection were structured questionnaire, in-depth interview and key informant interview guides designed for each group of participants. Interviewers' discretions were however allowed for the qualitative methods. Several measures were taken to ensure that the research instruments were precise and reliable for validity. The instruments were translated into Yoruba language for ease of administration to respondents not versed in English language. The reliability of the data from the pilot study was done using Cronbach's Alpha correlation coefficient. The overall reliability result was 0.893 which means that instrument had a high percentage of significant reliability.

Data Analysis

The quantitative data were analysed at the Univariate level through descriptive statistics such as frequency and percentage while chi-square tests and ANOVA were used to determine the association between the variables measured. Qualitative data was analysed through transcription of recorded interviews and discussions. The recordings done in Yoruba were translated into English language, and transcribed for subsequent analysis. The transcriptions were compared with the notes taken during data collection. The data collected were content analysed and thematically organized. Information obtained was reported as phrases in quotes from the recorded expressions of participants. Internal validity was achieved by using data from all the three sources, and by presenting views from different participants to support the research objectives.

Limitations of the Study

The research was carried out among only one language group in Nigeria. Other ethnic groups could have dissimilar interpretations of mental disorder. Though, the study was conducted in both Federal and State-owned mental health facilities, the result may not be adapted to the rest of the country because it was conducted in Ogun State only.

Results

Table 1: Perception of Mental Illness by Gender

Characteristics	Gender Differentials		Total	χ^2	Df	P-value	
Knowledge of mental illness	Male	Female		248.17	1	<	P<0.05
Has knowledge	179(55.8%)	494(99%)	673(82%)	2		0.00001	SIGNIFICANT
Does not have knowledge	142(44.2%)	5(1%)	147(18%)				
Sources of knowledge about mental illness				11.439	6	0.0757	P<0.05 SIGNIFICANT
Friends	59(18.4%)	88(17.6%)	147(17.9%)				
Parents/Relatives	60(18.7%)	105(21%)	165(20.1%)				
The media	101(31.5%)	112(22.4%)	213(26%)				
Hospitals	62(19.3%)	134(26.9%)	196(24%)				
Christian faith healing centre	11(3.4%)	16(3.2%)	27(3.3%)				
Islamic faith healing centre	7(2.2%)	10(2%)	17(2.1%)				
Traditional healers	21(6.5%)	34(6.8%)	55(6.7%)				
Causes of Mental illness				16.858	3	0.0008	P<0.05 NOT
				5			

Natural	102(27.6%)	122(24.4%)	224(27%)					
Supernatural	109(44.7%)	219	328(40%)					SIGNIFICANT
Hereditary	87(18.6%)	(43.9%)	187(22.8%)					
Preternatural	23(9.2%)	100(20%)	81(9.9%)					
		58(11.6%)						
Perceptions about whether mental illness affects males more than females				15.996	2	0.0003		P<0.05 SIGNIFICANT
More males are affected	110(34.2%)	241	351(42.8%)					
More females are affected	160(50%)	(48.2%)	361(44%)					
Can't say		201(40.2%)						
Commonness of Mental illness								
Childhood	5 (1.6%)	9(1.8%)	14(1.7%)	32.368	3	<0.00001		P<0.05 SIGNIFICANT
Adolescence	78 (24.3%)	73(14.6%)	151(18.4%)					
Older adulthood	67(20.9%)	193(38.7%)	260(31.7%)					
Any age	171(5.3%)	224(44.9%)	395(48.2%)					
Curability of Mental illness				43.340	1	<0.00001		P<0.05 SIGNIFICANT
Curable	237(72%)	454(91%)	691(81.8%)					
Not Curable	84(28%)	45(9%)	129(18.2%)					
Where Mental illness can be cured				39.243	3	<0.00001		P<0.05 SIGNIFICANT
Psychiatric hospitals	160(50%)	349 (70%)	509(62%)					
Traditional healers	87(27.1%)	63(12.6%)	150(18.3%)					
Church	51(15.9%)	66(13.2%)	117(14.3%)					
Mosque	23(7.2%)	21(4.2%)	44(5.4%)					
Mental illness as a stigmatized condition				6.882	2	0.0320		P<0.05 SIGNIFICANT
Stigmatised disease	157(48.9%)	269(54%)	426(57.6%)					
Not a	120(37.3%)	144(28.9%)	264(17.8%)					
Stigmatised disease	44(13.7%)	86(17.2%)	130(24.6%)					
Can't say	100.0	100.0						
Total	321(39.1%)	499(60.9%)	820					
Number))						

Source: Author’s Computation, 2016

Here we examine the opinion or perception of the respondents about mental illness which involves their knowledge, possible causes of mental illness, awareness, and its sources gender commonly affected and the place for the cure among others. The respondents whose opinions was

sought regarding mental illness were 39% males and 61% females. Table 4.4 shows that 99% of females were aware of mental illness, only 55.8% of males were aware of it.

The qualitative data collected indicated the perception of mental illness in a more robust way. Participants' perceptions about mental illness were generated from their being cognizant of the illness. The qualitative data on the perception of mental illness was mainly sub-divided into four parts which included the definition, causes, gender differentials and attitude towards people living with mental illness (PLWMI).

Noticeably, participants did not explain or describe their awareness in the same manner. Highlighted here are excerpts that clearly illustrate by definition the consciousness of participants about mental illness:

As Yoruba people, we know mental illness as 'were'. It is also called 'Alaaganna'. As for me, mental illness means to misbehave in the society **(Traditional healer, Sagamu Local Government Area, KII).**

Another Traditional healer had a different opinion on the definition of mental illness. This was his position:

From experience what we call mental illness is 'Arun opolo'. In this case, the person has run mad **(Traditional healer, Abeokuta North Local Government Area, KII).**

However, a Psychiatrist had a different view of mental illness. He said:

Mental illness is a health condition that is characterised by changes in thinking, mood or behaviour associated with impaired functioning **(Psychiatrist, Abeokuta South Local Government Area, KII).**

A Social Worker also gave the definition of mental illness as follows:

Mental illness is when an individual is not in conformity with the norms and values of society regarding behaviour **(Social Worker, Sagamu Local Government Area, KII)**

Although all the participants in the study areas are knowledgeable about mental illness, they gave different definitions. This definition is a reflection of the saying that no single definition is accepted universally by scholars in the field.

Perception of mental illness by participants was not only found on the meaning they attributed to the disease, occasionally this meaning could be an outcome of the perceived causes. There was no restriction of the local name to the familiar 'were' as it is known. Others have re-

conceptualised the local name by the causes and described it as ‘*Arun opolo*’.

With regard to the sources of knowledge of mental illness, for male respondents, 18.4%; 18.7%; 31.5%; 19.3%; 3.4%; 2.2% and 6.5% got their information of mental illness from friends; parents/relatives; media; hospitals; Christian faith healing centre; Islamic faith healing centre and traditional healers respectively. In contrast, female respondents, 17.6%; 21%; 22.4%; 26.9%; 3.2%; 2% and 6.8% got their information of mental illness from friends; parents/relatives; media; hospitals; Christian faith healing centre; Islamic faith healing centre and traditional healers respectively.

In relation to the causes of mental illness, for male respondents, 27.6%; 44.7%; 18.6% and 9.2% attributed the causes of mental illness to natural; supernatural; hereditary and preternatural respectively. On the other hand, 24.4%; 43.9%; 20% and 11.6% of female respondents attributed the causes of mental illness to natural; supernatural; hereditary and preternatural respectively.

The exact cause of mental illness is unknown. Causes of mental illness among the Yoruba include natural, supernatural, spiritual, environmental, heredity and offences committed and attacks from enemies (Aluko, 2006). These causes substantiate the opinions of the Key Informant Interviews (KII) and In-depth Interview (IDI) respondents. Here are the opinions of some of the respondents regarding the causes of mental illness.

‘Were’ in Yoruba is caused by ‘were’ ‘amutorunwa’ (mental illness that one is born with), ‘were’ ‘iran’ (mental illness that is hereditary) and ‘were’ ‘afise’ (mental illness due to affliction) (Traditional healer, Abeokuta South Local Government Area, KII).

Another participant stated that:

The primary cause of mental illness is the breaking of a taboo in the family. In Yorubaland, it is called ‘ewo idile’ (Traditional healer, Abeokuta North Local Government Area, KII).

A respondent stated that:

“Omo odun mejo ko’gbodo ya were bi koni taye ninun” (Translated thus; “A child of eight years or less must not be affected by mental illness without supernatural causes”). Mental

illness is not meant for children except adults (Caregiver, Abeokuta North Local Government Area, IDI).

Despite the differences that exist among the participants on the meaning of mental illness, they all seem to agree on causes of mental illness. In view of the above explanations, it is clear that the precise cause of mental illness is not known. Also, it is clear that mental illness is as a result of the combination of biological, cultural, and social factors.

With regard to perceptions whether mental illness affects males more than female respondents, 34.2% of male respondents reported that more males are affected than females while 48.2% of female respondents reported that more males are affected than females. Conversely, 50% of male respondents reported that more females are affected than males while 40.2% of female respondents reported that more females are affected than males.

There are different opinions on gender differences in mental illness. The following excerpts from KIIs attest to such differing opinions on mental illness.

Concerning drug abuse, we have 95% men and 5% women. Women are also prone to depression (Psychiatrist, Abeokuta North Local Government Area, KII).

Another participant stated that:

Mental illness is more common in females than males. The ratio is 15:5. The age range is between 18 and 35 years which is as a result of a loss of loved ones, separation or divorce (Social Worker, Abeokuta North Local Government Area, KII).

Thus, it is believed that male and female are affected by mental illness in one way or the other. However, the proportion of females to males influenced by mental illness varies.

Women are more likely to be in psychotherapy than men (American Psychological Association, 2013). Over the years, findings have shown that females have a significantly higher risk of frequent mental distress.

According to the male respondents towards commonness of mental illness, 1.6%; 24.3%; 20.9% and 5.3% reported that mental illness is common to childhood; adolescence; older adulthood and any age respectively. On the contrary, 1.8%; 14.6%; 38.7% and 44.9% reported that mental illness is common to childhood; adolescence; older adulthood and any age respectively.

Findings revealed that in curability of mental illness, 72% of male respondents indicated that mental illness is curable while 28% do not accept that mental illness is curable. However, for female respondents, 91% indicated that mental illness is curable while 9% do not support that mental illness is curable.

In consideration of where mental illness can be cured for male respondents, 50%; 27.1%; 15.9% and 7.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively. On the other hand, for female respondents, 70%; 12.6%; 13.2% and 4.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively. With regard to mental illness as a stigmatized condition, for male respondents, 50%; 27.1%; 15.9% and 7.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively. In contrast, for female respondents, 70%; 12.6%; 13.2% and 4.2% reported that mental illness could be cured in psychiatric hospitals; traditional homes; church and mosque respectively.

The rate of response by respondents on the attitude to mental illness was moderately impressive particularly among the caregivers/families of people living with mental illness. The following excerpts from KIIs and IDIs attest to this.

When my daughter committed homicide that was when I brought her to the psychiatric hospital where we eventually discovered that she has a mental illness. She is getting better, but I am scared of taking her home so that she won't kill another person in the family (Caregiver, Abeokuta South Local Government Area, IDI).

On the other hand, a Psychiatrist expressed the following view:

Three to four of our patients in this hospital have been neglected here. When we contacted their families, we were told that they were no more members of the family. Mental illness has brought a big shame to the family. We have been rehabilitating them for some time now (Psychiatrist, Abeokuta North Local Government Area, KII).

All the participants reported stigma as an example of the reaction of people towards them. There is the belief that stigmatisation and discrimination are the most critical challenges they face. These attitudes

are the most fundamental problems people living with mental illness (PLWMI) often go through.

The gender differentials on the perception of mental illness significantly related with awareness of mental illness ($\chi^2= 248.172$), sources of knowledge ($\chi^2= 11.439$), causes of mental illness ($\chi^2= 16.8585$) and that it affects more males than females ($\chi^2= 15.996$). It is also significantly related with the commonness of mental illness ($\chi^2= 32.368$), curability of mental illness ($\chi^2= 43.340$), where mental illness can be cured ($\chi^2= 39.243$) and mental illness as a stigmatized condition ($\chi^2= 6.882$). This shows that there was a significant relationship between the gender differentials and perception of mental illness.

Discussion of Findings

The discussion of the research findings shows the aspect of the data collected that are unique, supported by literature and contribute to knowledge by extending the literature. This discussion covers other sub-themes such as perception, definition, and causes of mental illness, availability, access, choice, utilization of mental healthcare services in the study area, gender preference of mental healthcare professionals and gender role in decision-making in the management of mental illness.

The Yoruba terminology for mental illness is a vast knowledge; the term '*were*' was used by Jegede (2002), Erinoshio (2010) and Olugbile, Zachariah, Kuyinu, Coker, Ojo and Isichei (2009). As earlier observed by Jegede (2005, 2010) and Erinoshio (2010), indigenous knowledge of the illness informed the local name, based on the causes of the illness. Similarly, the Yoruba people also viewed '*were*' as '*Àrun Opolo*' symbolising 'brain syndrome'. Another local name ascribed to the illness among the Yoruba in Nigeria is '*Alaaganna*'. However, there has not been any comprehensive sociological investigation of the etiology of the illness in this study area.

The results obtained and analysed in this study showed that there was a significant association between perception of mental illness and gender. Available data revealed that mental illness is known widely among the Yoruba of Ogun State, Nigeria, with the majority of the respondents (78%) being aware of the illness. The perception of mental illness varies by gender. Invariably, gender differences exist in the study area. Knowledge is very vital to practice. What you are not aware of, you may never practice except by mistake. Stereotypes and biases against people

living with mental illness are prevalent in the world. The statistical analysis demonstrates that knowledge of mental illness is significantly associated with gender. This finding is contrary to the apriori expectation, as found in Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, and Kola (2005) who posted that poor knowledge of mental illness was common in Ogun, Osun and Oyo States in Nigeria.

Sources of mental illness had a significant association with gender. Respondents' knowledge of mental illness emanates from seven sources, which include friends, parents/relatives, media, hospital, Christian faith healing centers, Islamic faith healing centers and traditional healers. The media had the highest percentage of sources of information on mental illness. Invariably, the media have put a lot of effort towards the creation of awareness about mental illness. However, this is contrary to the findings of Ackkard and Neumark-Sztainer (2001) who posited that parents and health care providers are key sources of health-related information.

Further findings from this study revealed that causes of mental illness had a significant association with gender. Most females (43.9%) and males (44.7%) believed in mystical factors as one of the leading causes of mental illness. This result is in line with the findings by Adewuya and Makanjuola (2008) and Adewuya and Oguntade (2007). This finding was corroborated by some responses in the qualitative data collected. According to a study carried out by Ahmed, Sun, and Nazar (2015), people all over the world have diverse explanatory viewpoints concerning the nature, sources, and interventions for mental illness. The belief in the mystical forces is strengthened in day-to-day cosmology in Nigeria. Health is observed as being underpinned by spiritual dimensions (Oluwole, 1995; Gureje *et al*, 2005; Ojua and Omono, 2012). This view is similar to the findings of Ukpong and Abasiubong (2010) and Ani, (2004) that the ascription of mental illness to mystical causality is not limited to the illiterates.

Results show that 34.2% of male respondents reported that more males are affected than females while 48.2% of female respondents reported that more males are affected than females. Conversely, 50% of male respondents reported that more females are affected than males while 40.2% of female respondents reported that more females are affected than males. However, the result showed that gender differences exist in

the perception and treatment of mental illness. Traditionally, people are not interested in discussing mental illness in Nigeria (Bakare, 2014).

Findings from this study revealed that there are significant gender differences in the commonness of mental illness. Results also suggest that mental illness affects anyone irrespective of age and gender. This result is similar to the findings by Steel, Marnane, Iranpour, Chey, Jackson, Patel and Silove (2014). It is also in line with the results of Susuman (2010) to that a minimum of one person is mentally ill at one point or the other. According to Patel, Flisher, Hetrik and McGorry (2007), mental illness affects persons at any phase of life. The result further showed that there are significant gender differences with regard to the perceived curability of mental illness. This result is in line with the findings of Oyewunmi, Olabode, Oluwole, and Ayannike (2015) and World Health Organisation (2003). Qualitative data corroborated this position.

There were differences between men and women with regard to where mental illness can be cured. Male (50%) and female (70%) believed that mental illness could be cured effectively in psychiatric hospitals. However, this is contrary to the findings of Hailemariam (2015); Adewuya and Makanjuola, (2009); Aneibu and Ekwueme (2009) and Kabir *et. al.*, (2004) who observed that the most preferred treatment of mental illness is spiritual/traditional healers. In Nigeria, it is evident that religious conviction demonstrates an imperative role in the health belief system of the people. The study conducted by Jack-Ide, Makoro and Azibiri (2013), revealed that sacred/spiritual mode of care provide the trust with God being 'in charge' and having the supremacy to defeat every single underhandedness spell from an adversary. Due to the perceived causes (supernatural) of mental illness, the traditional experts and spiritual therapists are the single persons to assist the patients getting respite from the disorder (Ganesh and Udoh, 2012).

Conclusion

This study concluded that gender differences largely influenced the perception and the choice of treatment of mental illness.

Recommendations

1. Stakeholders like Governments, international organisations, NGOs and women groups should outline ways for women to

participate in formulation and implementation of mental health policies, and programmes of rehabilitation of the mentally ill, especially women.

2. The Populace should be enlightened and educated on the effects of stigmatisation of the People Living with Mental Illness (PLWMI) irrespective of the gender.

Ethical Considerations

Participants were selected based on principle of confidentiality of data, beneficence to participant, Non-Maleficence to participants and Voluntariness. Institutional approval was obtained from ethical committee in Aro Neuropsychiatric Hospital, Abeokuta with approval Number PR003/16 and Federal Medical Centre, Abeokuta with approval number FMCA/470/HERC/05/2016.

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