University of HUDDERSFIELD

AN EXPLORATORY STUDY OF THE LIVED EXPERIENCES OF WOMEN WITH MENTAL ILLNESS IN SOUTHWEST OF NIGERIA

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<u>Dedication</u>

This piece of work is dedicated to my husband, Deji. Abegunde, and my children, Adedoyin, Akinbobola and Imisioluwa. Thank you for your motivation and love, which gave me the courage to endure this extensive journey. I love you all dearly!

Abstract

Background: Women with mental illness experience the burden of the symptoms of their illness and other challenges related to the illness. In addition, many of these women are mothers and the illness affects their motherly role and abilities. There is limited understanding of women's experiences of mental illness in the southwest of Nigeria. This study investigated how these women with mental illness live their everyday lives. The focus of the study also extended to the exploration of lived experiences of mothers living with mental illness in the same part of Nigeria. I believe the findings may provide an additional understanding of their experiences and strategic ways of providing care for this group of women.

Aim: The current study explored the lived experiences of women and mothers with mental illness in southwest of Nigeria. Also, the study examined the women's experiences of accessing mental health services.

Method: The hermeneutics methodological approach outlined by Gadamer (1900/2002), was found useful in this study. The approach supports the interpretation of participants' subjective experiences for a greater understanding. Participants were recruited through purposive sampling, and data collection was conducted in two phases. Phase one examined the lived experiences of women and the second phase looked at the everyday activities of 26 mothers. All the participants were receiving treatments for mental illness in two mental hospitals in the southwest of Nigeria. A semi-structured interview method was used to collect data from the 46 participants. The thematic analysis proposed by Braun and Clarke (2013) was used to analyse the datasets because of its compatibility with the study design.

Result: Phase one findings identified three main themes as experiences of being diagnosed with mental illness, the impacts of mental illness on participants, and their views about mental healthcare provision. Phase two findings revealed the effects of mental illness on mothers, the themes that emerged from the second data collection included the reliance on the support of others, effects of mental illness on children, views about services delivery and the unmet needs of mothers with mental illness. Each of the themes has subthemes which are discussed comprehensively in this thesis.

Conclusion: To improve mental health services, there is a need to revise the mental health policies in Nigeria. The findings suggest the need to provide parenting support for mothers with mental illness. Care of people with mental illness should include economic and psychosocial interventions.

Copyright statement

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Terminology

Aladura: These are Prophets or Prophetesses who claim to derive their spiritual power through prayer. They use prayer, 'holy water', 'anointing oil', or soap and fasting and foretelling are included as methods of healing.

Alangana: It is an idea representing a cultural interpretation of mental illness among the Yoruba ethnic group. It is commonly used for people who suffer from mental illnesses. Other words used for such individuals who suffer acute episodes of mental illness with the same meaning are '*asinwin*', '*olode-ori'*, '*were*', '*Jawejura*' and many others.

Alasotele: Someone who has spiritual gifts to predict impending misfortunes or evil that has happened. They possess the power to tell the nature of the misfortune, the causes and how it will happen but lack the ability to cure or prevent the danger from happening.

Alawoku: Yoruba people believe there is no permanent cure for mental illness. The illness is believed to be completely incurable because the afflicted person is controlled by spirits. The word '*alawoku*' is a word which stigmatises, and ridicules a person with mental illness even if the person is not showing symptoms of the illness.

Aisan idile: This is the concept used among the Yoruba speaking people to express illness they believe is hereditary. They believe that mental illness can be inherited either from a mother or father. It is one of the major considerations for approval among families of the intending couples to refuse or consent to their marriage. In the Yoruba context, the spouse of a woman who has a history of mental illness after marriage can end the union with the belief of protecting their unborn children from inheriting the illness from the wife.

Arun opolo: Mental illness is generally referred to as '*arun opolo'* meaning brain disease. Yoruba speaking people believe strongly that with mental illness, it is difficult to think, work and interact well with others if the brain is affected.

Babalawo: Babalawo means someone with gifts of divination and who knows secrets and is able to predict the future. 'Baba' means father in Yoruba language, but the profession is not restricted to men as several women are also involved in herbal healing practices and Shrine Priests. It is the belief among the Yoruba people that Babalawo served as the intermediary between humans and Deities. They are consulted for guidance whenever an important decision is to be made. Babalawo is believed to have the power to heal diseases through

herbal mixtures or sacrifice. Other words such as '*Adahunse'* or '*Onisegun'* are used to refer to people who use herbs to cure diverse illnesses.

Dalemosu: A 'Dalemosu' among Yoruba people is a term used in stereotyping women who are or have divorced or separated from their spouses on the grounds of adultery, chronic illness such as leprosy or mental illness and infertility to live in her parents' house. The social stigma of being a "Dalemosu" affects the woman and her family.

Ebi: Ebi means family in the Yoruba language. It encompasses more than two generations founded on patrilineal and matrilineal kinship principles. In Yoruba culture, people are identified by their families, not by their direct parents. That is, *agbo ile Ibo loti wa*, meaning which family are you from? Then, Olori-ebi means the oldest person in the family, usually a man, the one who makes the final decision on family issues.

Elewon: This simply means a prisoner who is or has served punishment to correct wrongdoings. It is also used for a person who has finished serving their jail terms. However, an ex-prisoner may face challenges of re-integrating into society because of stigmatisation. The scars of being an ex-convict include social and economic problems.

Igbeyawo (Marriage): It is the cultural practice among the Yoruba people to seek spiritual guidance or investigate the family history or lineage when a man and woman want to come together as husband and wife. Marriage in Yoruba culture is more than the union of the intended people going into marriage, but involves the two families coming together as one family after the marriage has been contracted.

Olodumare: Olodumare is regarded as a spiritual being endowed with power and knowledge which transcends human imagination. Yoruba people believe that Olodumare created and rules the physical and spiritual world with his incomparable power. Another word for Olodumare is '*Olorun*' who is believed to control human destinies.

Orisha: Orisha is a supernatural entity through which Yoruba speaking people communicate with Olodumare. It is believed that there are 401 (okanlenirinwo) Orishas in Yoruba land. Some are believed to have been in existence before the physical planet was created. They believed that there are some orishas that live in heaven with Olodumare (*ara orun*) while there are some who are sacred beings and live here on earth (*irunmole*).

<u>**Chapter One – Introduction**</u>

This study was conducted to add more information to the existing knowledge of women living with mental illness in southwest Nigeria. It is based on the limited knowledge about the daily life activities of this specific group of women. The chapter opens discussion on mental illness by providing the definition and the nature of the illness. Methods of assessing and diagnosing mental illness, its advantages, and critique are stated. The chapter then looks at the prevalence of mental illness on three levels: globally, in Africa, and in Nigeria. The burdens of mental illness and challenges in alleviating the impact of mental illness are discussed. It is presented separately to show the magnitude of mental illness problems, especially in Nigeria. In this chapter, I discuss the background of the study, the study population, and the need to conduct the study. Information on the cultural values of the study population are stated, followed by the research questions, aims and objectives. The structure of the thesis is then presented.

<u>**Mental illness definition**</u>

Mental health is defined by the World Health Organization (WHO, 2003, p. 7) as:

> "*a state of well-being whereby individuals recognise their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. Mental health is about enhancing competencies of individuals and communities and enabling them to achieve their self-determined goals*".

The notions of mental health include subjective well-being, intergenerational dependence perceived self-efficacy, independence, capability, and ability to realise one's intellectual and emotional latent state (WHO, 2003), but mental illness makes it difficult to achieve because it is an illness that affects a person's mood, thinking and behaviour (Arlington, 2013; WHO, 2020). It is a health problem that can affect anyone in society regardless of age, gender, social class, culture, or ethnicity (Mental Health Foundation, 2016; Ridlo & Zein, 2018). Mental illness represents health conditions such as "*depression, bipolar disorder, schizophrenia, anxiety, dementia and post-traumatic stress disorder*" (WHO, 2019, p. 19).

<u>**Diagnosis of mental illness**</u>

Mental illness is diagnosed through scientific methods. The Oxford Concise Medical Dictionary (2020, p. 154) describes diagnosis as "*the process of determining the nature of a disorder by considering the patient's signs and symptoms, medical background, and when necessary – results of laboratory tests and X-ray examinations*". According to Apter (2019) and First et al. (2021), the methods of diagnosing mental illness by health care professionals are the

Diagnostic and Statistical Manual for Mental Disorders (DSM) proposed by the American Psychiatric Association (APA), and the WHO International Classification of Diseases (ICD). While ICD is used for training, the DSM-5 provides a more recent representation of the classification of and information around mental illness (APA, 2013; Regier et al., 2013 Muller, 2014).

The DSM: its utility and critique

There are different versions of the DSM (that is DSM, 1-5); the changes were caused by advancements in science and to reduce the suffering associated with mental illness (Aluja et al., 2021; Khoury et al., 2014; Regier et al., 2013). Each edition of the DSM brings out different information that is helpful to identify and treat people with mental illness as presented in the DSM-IV-TR: "*The purpose of the DSM-IV is to provide clear descriptions of diagnostic categories in order to enable clinicians to diagnose, communicate about, study, and treat people with various mental disorders*" (DSM-IV, 2000, p. xxxvii).

Studies have identified that a benefit of the DSM has been the relief it provides for people diagnosed and living with mental illness (Khoury et al., 2014; Probst, 2015). The DSM provides insight into symptoms and illness, identifying them as real experiences as opposed to personal failings or weaknesses, as formerly believed in ancient times (Apter, 2019; Khoury et al., 2014). Individuals with mental illness could receive treatments for their illness (Clark et al., 2017; First et al., 2021), and could be helped in developing and improving clinical interventions for mental illness through research (Khoury et al., 2014; Regier et al., 2013).

On the other hand, the DSM was critiqued for not considering factors such as cultural, psychological, political, and societal influences in people's lives that might understandably and predictably cause mental illness (Clark et al., 2017; Engel 1980; Sarafino & Smith, 2011). It was stated that the DSM legitimised medical science to strengthen the professional interests of private organisations (Lafrance & McKenzie-Mohr, 2013; Jacob et al., 2013). For example, the pharmaceutical industry was criticised for gaining financial benefit by using the DSM to diagnose people because many persons who received the diagnoses of mental illness are treated with pharmaceutical products (Cosgrove & Krimsky, 2012; Cosgrove and Wheeler, 2012; Greenberg, 2013). Pharmacological treatment is associated with DSM diagnosis; it was stated that most of the medicines cause health problems such as diabetes, heart disease and obesity, and reduced life span (Frances, 2013; Greenberg, 2013).

Furthermore, it was argued that the DSM could not establish the same diagnosis across clinicians and across time points for the same individual (Blashfield et al., 2014; Kirk et al., 2015). Another problem of the DSM was that it creates more illness from normal life. For example, when the DSM was first published in 1952, 108 categories of mental illness were proclaimed and this increased to 354 in the 1994 DSM IV version (Greenberg, 2013; Pilgrim, 2014). It has been argued that the emphasis on genetic causal factors may increase the beliefs that people with mental illness have unpredictable and dangerous behaviour because genes provide important information about the inherent nature of a person (Khoury et al., 2014; Malla et al., 2015). Therefore, it may cause stigma, labelling, and discrimination against individuals with mental illness with devastating effects (Frances, 2013; Rusch et al., 2010).

Mental illness related stigma, stress and coping theory

Mental illness is associated with stigma, which may happen in an aggressive or subtle way, it is argued that stigma has deleterious effects on individuals who experience it (Link et al., 2004). Stigma, as stated by Goffman (1963), is "*bodily signs designed to expose something unusual and bad about the moral status of the signifier*" (Goffman, 1963, p. 1). Goffman further stated that the essence of stigma is "*deeply discrediting*" to individuals, who experience it (Goffman, 1963, p. 3), and "*victims*" may be blamed for their "*otherness*" (Porter, 2002, p. 62). Studies reveal that many people with mental illness are stigmatised, isolated, and labelled in society (Link & Phelan, 2001; Parker, 2012). Stigma reduces the self-esteem and social network of people with mental illness (Hampson et al., 2020; Sharac, et al., 2010). It exposes people with mental illness to stress and distress that further affects their health (Major et al., 2013; Matthews & Gallo, 2011; Williams & Mohammed, 2009).

Social stress theory emphasises that individuals can be exposed to social stressors. Individuals with stressful exposure have limited resources to cope or reduce stress (Aneshensel 1992; Schwartz and Meyer; 2010). To explain how people respond when they experience discrimination, Lazarus and Folkman (1986) defined transactional stress theory as how an individual reacts when confronted with a stressful situation, as a result of interaction one has with his or her environment. Lazarus and Folkman (1986) went further to state that it is a situation when affected individuals assess the situation as ''*significant for his or her well-being in which the demands tax exceed available coping resources*'' (Lazarus and Folkman, 1986, p. 63). This can be linked to Selye's (1976) General Adaptation Syndrome (GAS) where a person may respond to stressors by either resisting or adapting to the stressor. Many individuals with mental illness experience stigma and discrimination in employment, housing, and education (Corrigan and Watson, 2002, Heinshaw,2010) including structural stigma instantiated in policies and programmes that lead to further deprivation (Gerich, 2014).

A lack of resources to resist stress from society's stigma results in many people with mental illness adopting avoidance coping methods, withdrawing from social activities, and not seeking treatment (Abiri et al., 2016; Beckers & Craske, 2017; McNeill & Galovski, 2015). However, some individuals may use personal resources to reduce stress while others rely on social support to reduce stress where personal resources are insufficient to cope with stressful events (Berjot & Gillet, 2011).

Global prevalence of mental illness

Studies show an increase in the number of people experiencing mental illness worldwide (Brooks et al., 2020; Carlson et al., 2019). In 2017, the number of people reported to have been affected by mental illness was estimated at 792 million which is about 10.7% of the global population (Ritchie & Roser, 2018), and women are more affected than men (McManus et al., 2016; Ritchie & Roser, 2018; WHO, 2019). From the statistics, the number of women affected with depression was 41.1% compared with 29.3% of men suffering from the illness (WHO, 2019). The study conducted in Singapore identified 7.2% of women against 4.3% of men who were suffering from depression (Picco et al., 2017). Similarly, Abel and Newbigging (2018) discovered a higher percentage of women (20.7%) with mental illness than men (13.2%) in the UK.

Factors contributing to the increase in the prevalence of mental illness include social inequalities (Algeria et al., 2018; Knapp and Wong, 2020; Macintyre et al., 2018), demographic changes (Lancet, 2018; Richteret al., 2019), and different events happening in the world such as Covid-19 (Pierce et al., 2020; United for global mental health, 2020; Winkler et al., 2020). An increase in the prevalence of mental illness was said to have increased the high suicide rates globally (Bachmann, 2018; Brådvik, 2018; Office for National Statistics, 2019). Contrary to views about the increase in prevalence, it was argued that it may not be an increase in the prevalence of mental illness, but that more people are accessing treatment because of reduced stigmatisation about people with mental illness (Hall et al., 2019; Prasad et al., 2016).

Global burden of mental illness

Studies conducted on the global burden of disease reveal that mental illness has disabling effects (Lynskey and Strang, 2013; Whiteford et al., 2013). Mental illness (especially depression) is one of the six diseases that mostly causes disability (Hay, 2017; Ridlo & Zein, 2018). The findings of Vigo et al. (2013) on the global burden of mental illness stated the years lived with disability (YLDs) represented 32.4% and 13% for disability-adjusted life-years

(DALYs). It was stated that the impact of mental illness was more on people aged between 10–29 years (Whiteford et al., 2013).

The economic burden of mental illness is in three categories: direct, indirect, and tangible costs (Chong et al., 2016). The direct economic burden of mental illness includes diagnostic tests, hospital inpatient, outpatient care, prescription cost, and transportation cost including rehabilitation care (Kleine-Budde et al., 2014; Trautmann et al., 2016; WHO, 2020). Indirect costs of mental illness are described as productivity losses due to disability and premature death. People with mental illness have higher mortality risks than people without the illness (Charlson et al., 2014; Ilyas et al., 2017; Jin & Mosweu, 2017), with their life expectancy reduced by almost 10 to 20 years as compared to the people without the illness (WHO, 2016). The indirect costs include unemployment, sick leave, hospital admission, including the loss of productivity for caregivers (Castro, et al., 2014; Maske, et al., 2016). Furthermore, mental healthcare professionals report higher rates of burnout, reduced enthusiasm for work, emotional exhaustion, and a low sense of achievement (Popa et al., 2010; Luciano & Meara, 2014). Intangible costs are difficult to quantify, it refers to pain, emotional distress, low quality of life, and other problems experienced by individuals living with mental illness and their families which are difficult to quantify (Anders et al., 2013; Chong et al., 2016). Labelling, discrimination, and the stigma of being diagnosed with mental illness are parts of the problems of having the illness (Corrigan & Watson, 2002; Vass et al., 2015).

In comparison with the general population, people with mental illness appear to have an increased risk of developing physical illness (such as osteoporosis). This is because of low bone mineral density problems, smoking, reduced physical activity, and vitamin and calcium deficiency associated with mental illness (Javaid & Holt, 2008) or caused by antipsychotics (Gracious et al., 2012; Steardo et al., 2020). Studies have shown that poor physical health in people with mental illness is the result of disparities in health care provision, access, and utilisation of services by individuals with mental illness (Bland & Martin, 2016; Stubbs et al., 2015; Wang et al., 2019; Wey et al., 2016).

Mental illness is associated with sexual abuse and unwanted pregnancy, sexually transmitted infections, and interpersonal violent crime (Azbel, Wickersham, Grishaev, et al., 2013; Lundberg, Johansson, Okello et al., 2012). Homicide and suicide are also among the burdens of mental illness (Doku, 2016; Mars et al., 2014; Nwagu, 2016). Mental illness can lead to poverty, social isolation, reduced productivity, and lower quality of life in people who experience the illness compared to the general population (Ådnanes et al., 2019; Funk et al., 2012; Petkari & Pietschnig, 2015). The challenges posed by mental health problems worldwide lead to treatment gaps or disparities in healthcare of people with mental illness

(Hunter, Hunter, Rice, Kraemer & Oyman, 2014; Carter-Pokras & Baquet, 2002; Schwartz & Meyer, 2010). Social factors and allocation of resources adds to the problem, and most mental illness remains undiagnosed and untreated (Miranda et al., 2008; Gustavsson et al., 2011; Wittchen et al., 2011). The result is an elevated prevalence of mental illness, comorbidity, poverty, and untimely death (Junkka et al., 2020; Kohn et al., 2018; McAllister et al., 2018).

Mental healthcare in African countries

According to the WHO (2016), mental and substance misuse illnesses are increasing with 80% of affected people living in Africa. It was stated that many people (from 75% to 90%) with mental illness in the African continent do not receive treatments (Flisher, 2018). The treatment gap contributes to an increase in the burdens of mental illness in Africa (Juma et al., 2020; Wainberg et al., 2017). The population growth of African nations was 49% while the years lost to mental illness disability was stated as 52% (Sanhoh et al., 2018).

Many factors have been identified as causes of mental illness in Africa such as frequent civil conflicts, war, and the violation of human rights (Betancourt et al., 2018; Gupta & Zimmer, 2018; Kwobah et al., 2017). It includes domestic violence, increasing poverty, unemployment and deprivation (Duthe et al., 2016; Monteiro, 2015), and natural disasters (Morganstein & Ursano, 2020; Sharma et al., 2017). Additionally, many African nations do not control their borders, and the drug traffic syndicates use the opportunity of uncontrolled African borders to create transit points to carry out illicit drug trade (Ducan, 2018; International Drug Policy Consortium, 2020). Consequently, these drugs are consumed by the local population, which has created a big problem in Africa, resulting in an increase in the mental illness prevalence rate (Asiedu, 2019; Eligh, 2019). It was explained that many African countries do not have an alcohol control policy, which has encouraged illicit alcohol production, uncontrolled advertisements and sales of alcohol. The implications of a lack of alcohol policy in many Africa nations include excessive alcohol consumption and some of the alcohol is adulterated, which may also cause health problems (Ferreira-Borges et al., 2017; UNODC, 2020).

Studies show that methods of treating mental illness that are inexpensive are available such as medications and psychosocial therapies (Barry et al., 2013; Levin & Chisholm, 2016). However, African nations experience challenges that make it difficult to achieve cost-effective treatments and reduce the wide treatment gap that exists in the continent. The mental health care system in Africa is characterised by inadequate funding, resulting in a lack of enough resources (e.g., medications) to reduce the burden of the illness (Chisholm et al., 2019; Monteiro, 2015; Rathod et al., 2017). Most of the medicines for treating mental illness are not always available in many African mental health hospitals (Barbui et al., 2017; Keynejad et al.,

2017). When the medicines are available, they are difficult to afford by many people (Hopwood et al., 2021). Explanations for the treatment gap in Africa include a shortage of health professionals such as psychiatrists. For example, the ratio of medical staff in Africa was 1.4 per 100000 people against 9.0 health professionals per 100000 of the population on a global average (Sankoh et al., 2018). The problem of limited health workers is tremendous in countries that have experienced war such as Sierra Leone where 0.02 mental health specialists are available to 100000 of the population (Alemu et al., 2012; Wurie et al., 2016). Inadequate funding and a limited number of health workers has increased the unmet needs of people with mental illness in Africa.

The outcome of the Mental Health Atlas survey carried out in 2014 by the WHO showed that the number of people accessing care in Africa was 14 per 100000 of the population compared with 1051 per 100000 of the global average. Reasons for the treatment gap include the low level of mental health literacy in many African communities (Hanlon et al., 2014; McCann et al., 2016), including the inability of health professionals to collaborate with traditional and religious healers to ensure individuals that need mental health care can receive treatment (Green & Colucci, 2020; Nyame et al., 2021). In terms of geographical location, mental health facilities in many African nations are inaccessible to the population that needs the services (Rathod et al., 2017; Sosso & Philippe, 2016). As well, many people with mental illness may not access care because of the stigma and discrimination that they will experience in the community (Nwagu, 2016; Yoder et al., 2016). Moreover, many African nations do not have adequate statistics regarding the prevalence of mental illness to help in planning and making decisions about treatment strategies, indicating low priority for mental health (Allen et al., 2014; Docrat et al., 2019; Marais & Petersen, 2015).

The methods of assessing and diagnosing mental illness used in African nations are developed in western society, which may well not be suitable to assess mental illness in the African setting because of cultural differences (Brissos et al., 2011; Gopalkrishnan 2018). It is argued that the western assessment tool does not consider the gender role differences that are valued in Africa (Bolton et al., 2002; Vlassoff, 2007). Importantly, the health care system in Africa is over-stretched by treatments of both infectious and non-communicable illnesses such as cancer, diabetes, heart diseases and typhoid (Moussavi et al., 2011; Ngo et al., 2013). Thus, the weak health system lacks the capacity (human resources and funds) to provide optimum treatment for the increasing population of people with mental illness (Erskine et al., 2017; Petersen et al., 2017). The implications for the majority of people with mental illness, who are not accessing treatments include an increase in disability and premature death in African nations.

The mental health system in Nigeria

Situated on the Gulf of Guinea, Nigeria is one of the seventeen countries in West Africa, sharing a border with countries such as Benin, Niger, Chad and Cameroon (The commonwealth, 2021). It occupies 924,000 square kilometres of land (The commonwealth, 2021). It is the country with the largest population in Africa with an estimated population of over 219,000, 000 people, and gained independence in 1960 from British rule. Its climate varies, arid in the north and has a tropical climate in the centre (Middle belt) and equatorial in the south (The World Factbook, 2021). The country has different ethnic groups with different languages and traditions (Ogunyemi & Bada, 2020; The World Factbook, 2021), but the major tribes are Hausa, Ibo and Yoruba (Central Intelligence Agency, 2019; National Population Commission, 2006). Hausa people are in the north, and the eastern region of the country is home to Ibo people while the southwest is occupied by Yoruba language-speaking people, popularly known as Yoruba (Awogbade 2004; Ayodele, 2016; Barber, 2013). Health problems in Nigeria include malaria, fever, and water contact diseases such as schistosomiasis (Oguonu and Edelu, 2016; Oyeyemi et al., 2020). In addition to physical illnesses such as cancer and diabetes, mental and substance misuse illnesses are also present among people in Nigeria (Labinjo et al., 2020; Ugochukwu et al., 2020).

The mental health care system in Nigeria is provided under three tiers of government: primary, secondary, and tertiary (Adefuye 2011; Asuzu 2008; Pharm Access Foundation, 2015). The primary healthcare duties are to provide interventions for people at the community level. Health professionals in primary healthcare are nurses, community health workers, and midwives. They are permitted to prescribe specific medications in limited quantity, to review treatments and to make a care plan for people accessing care at local level. The head of staff in primary care are mostly community health workers and their activities are supervised by medical doctors. The primary healthcare services are provided by Local Government Authorities (Country Policy and Information Note, 2018; Federal Ministry of Health, 2008). The duty of secondary mental healthcare services is to support primary healthcare services for early treatments and to avoid mental health problems becoming severe. At the same time, people can access treatments at the secondary level through a referral from the primary care level, likewise, secondary healthcare can refer individuals with mental illness for treatments at the tertiary level (Anyebe et al., 2019). Complex and specialist treatments and rehabilitation services are provided at the tertiary level. Services at the tertiary level are the responsibilities of the federal government which includes making policies and regulations that guide the country's mental health care services. Teaching and specialist hospitals (standalone mental hospitals) are provided by the federal government at the tertiary level for sustainable recovery.

The structure of mental healthcare services in Nigeria is aligned with the WHO standard (WHO, 2006; MedCOI, 2017). If the system is followed properly, individuals with symptoms of mental illness will have easy and quick access to care from the primary care level which is at the grassroots.

There are no national statistics on the prevalence of mental illness in Nigeria (Abdulmalik et al., 2016; Ugochukwu et al., 2020), but studies from each region of the country provided insight into the level of mental illness in the country. For example, the result of Adewuya et al (2018) household survey in Lagos completed by 11,246 participants showed that 20.9% of the participants had depression. In the eastern part of the country, 52.3% of the study participants were said to suffer from depression (Stanley & Chinwe, 2020). Likewise, in the northern area of Nigeria, the outcome of a ten-year study conducted by Said et al. (2015) found that 18% of 8606 people attending health care were receiving treatments for mental illness.

In Nigeria, similar to the global context, mental illness is associated with different problems such as impairments and reduced social engagements. There is a risk factor to some physical illnesses, which cause untimely death, and reduced access to economic opportunity (Oloniniyi et al., 2019; Tunde-Ayinmode et al., 2012). While mental illness is commonly known for its impact on health and wellbeing, it also related to severe financial losses due to high costs of treatment, and impaired ability to work (Taboola et al., 2018; Fakorede et al., 2020).

Nigerian mental health policy and practice

The mental health policy in Nigeria was developed in 1991, and efforts to revise it have not been successful (Anyebe et al., 2019; Osain 2011; Suleiman, 2016), which can be interpreted as meaning a low priority for mental health care in the country. Nigeria has not been able to achieve cost-effective interventions for mental illness because of poor health system governance (Adeloye, et al., 2017; Uneke et al., 2012). The mental health system is characterised by inadequate financing (Abdulmalik et al., 2019). The fund allocated to mental health care in 2018 was 3.9% (The world Factbook, 2018) while South Africa meets the 5% recommended by the WHO (Docrat & Lund, 2019). Furthermore, a large proportion of the allocated funds is spent on buildings and staff salaries rather than curative services (Abdulmalik et al., 2019; Adefuye, 2011; MhLAP 2012). Arguably, the low investment in mental health care in the country increases the treatment gap as many people cannot access the services easily (Ikwuka et al., 2016). In Nigeria, treatment costs are paid by patients and their families on an out-of-pocket basis (Agboola et al., 2018; Enaohwo et al., 2014; Olugbile et al., 2013). Thus, individuals who cannot afford treatment costs may use alternative treatments or not treat their illness at all. While the symptoms of their illness may become worse, it may also lead to untimely death.

Nigeria's mental health system is known for its shortage of mental health professionals (Abdulmalik et al., 2016; Okechukwu, 2020). Inadequate information about mental health problems also extends to the mental health workforce. However, the number of specialist staff was stated as 0.02, psychologists were 0.09, and the ratio of nurses was 0.19 per population (Jack-Ide and Uys, 2013; Offiong and Chung, 2013). The limited number of health professionals cannot meet the increasing demand of the population. This statistic suggests that many people who need mental health care services may not receive it. People that are able to access the services may not have all their needs met because of limited health professionals who may be overwhelmed by the demand of the large population. It was stated that lack of incentives contribute to many mental health care professionals going into other fields of practice (Akande, 2004; Jack-Ide, Uys, & Middleton, 2013; Oladeji & Gureje, 2016). Limited numbers of trained mental health staff make the early identification, treatment of mental health illness, and the promotion of comprehensive health programmes difficult to achieve in rural areas of Nigeria (Abdullahi, 2018; Jack-Ide, Uys and Middleton, 2013).

There are eight mental health specialist hospitals that are run by the government in Nigeria. They are not well distributed across the country; all the hospitals are built in urban areas (Abdulmalik et al., 2013; Jack-Ide et al., 2012). Since mental health hospitals are not available within convenient proximity, it makes it difficult to identify and treat mental health illnesses early. Accessing care in urban areas often leads to additional expenses being incurred by inhabitants in rural areas and this may delay visits to health care settings (Abdulmalik et al., 2016; Agboola et al., 2018).

Studies show that there is insufficient awareness about mental illness in Nigeria, which has contributed to stigmatisation of people experiencing the illness (Abdulmalik et al., 2019; Armiyau 2015; Atilola and Olayiwola 2011). Individuals experiencing symptoms of mental illness lose their personal identity as soon as they are diagnosed. It leads to stigmatisation, exclusion, and poverty (Adeosun et al., 2014; Lasebikan and Aremu, 2016). People who experienced severe symptoms of mental illness and who suffered repeated episodes of mental illness are labelled '*were', 'olode-ori'* or '*jawejura*', meaning they cannot be cured of their illness (Jegede, 2005). When individuals with mental illness are labelled with derogatory names, it is believed that full recovery from mental illness is not possible. Some people lose hope for their family members, they abandon and expose them to violations which further increase their suffering and premature death (Adeosun et al., 2014; Audu et al., 2013). The stigma also extends to the family of the person experiencing mental illness as the family is viewed by the general public as an extension of the patient's deviance while the children of the ill parent may experience shame and embarrassment in society (Atilola and Olayiwola, 2011). It is difficult for individuals with mental illness to secure or maintain employment in

Nigeria because of the widespread misconception about mental health issues. It is believed that they are dangerous and that their cognitive ability and judgment can never be trusted (Adeosun et al.,2013; Oyewunmi et al., 2015).

The stigmatisation of people with mental illness is not just limited to the general public but also extends to health professionals (Sheikh et al., 2015; Ubaka et al., 2018). Many messages from the media not only reinforce stigmatisation but create hostility for persons with mental illness (Oduguwa et al., 2017; Oluwole et al., 2016). In order to avoid being labelled, people with mental illness may prefer to conceal their illness from relatives by way of reducing their social interaction or withdrawal (Abdullah and Brown, 2011; Gureje et al., 2005). Where secrecy is not possible, some of the people yield to social or self-stigma because of discriminations experienced from society (Adewuya et al., 2011; Mosanya et al., 2014). The stigmatisation, abuses, and violation of human rights experienced by persons with mental illness indicate a lack of protection and provision for people with mental illness in Nigeria (Gureje et al., 2015; Oshodi et al., 2014).

The challenges confronting mental health practice in Nigeria can be linked back to the outdated mental health policy and the ineffective implementation of the existing policy. Insufficient funding and lack of statistics about mental illness in the country have hindered taking evidence-based decisions and planning which raises questions about equitable access to care for the service users.

Background to the study

Prior to undertaking this research project, I worked in English hospitals with women who experienced mental illness. Initially, I was sceptical about doing the job because of my cultural perceptions concerning mental illness and people that have the illness. However, I accepted the job after much persuasion from friends, after all, it would provide income and take me out of boredom.

Working in the mental health sector changed my assumptions that people with mental illness are violent and harmful. Rather, I saw people with mental ill-health as individuals that needed care and support just like persons with physical illness. As a support worker, my duties involved assisting patients during mealtimes, consultations with doctors and other health personnel, and observing them during physical activities including vocational training periods. These activities promoted interaction between the women and I and I gained more confidence each time I was on duty, and on several occasions, I also took patients outside the hospital premises for social activities.

Even though I worked in a mental health care hospital, I did not have the intention of doing the work for a longer period or pursuing more knowledge in the area of mental health and mental illness. The motivation to have an understanding of the lifeworld of women with mental illness began in 2014 during a holiday to Nigeria. On my way home from the airport, I witnessed a scene that has remained unforgettable for me. A woman was maltreated (beaten with a stick) for taken a 100-hundred-naira (£0.40) loaf of bread from a seller to eat, which I believed was done to survive hunger. I was troubled watching the woman in that situation but to others who present at the scene, it was a better way of teaching her a lesson, and a few of them helped the bread seller to pursue the woman. My driver who actually directed my attention to the incident shouted: '*efi egba na, ena dada, egba lonje were, teba na daradara koni lobe mo*' (she needed to be beaten thoroughly, that is what a mad person deserves, beat her so that she does not go to the bread seller's shop again). Perhaps she could have made a positive contribution to her community if not for her mental illness. Many questions, which I was unable to get answers to kept coming to my mind: where was her family? What would happen to her next? Why was she not treated for her illness?

During my five-week holiday, I saw persons (male and female) with mental illness. Seeing many people in distress caused by mental illness, I realised that my working in mental hospitals in northwest England was more than just earning income. It was a preparation to make a difference in the lives of many people suffering from mental illness in my community by making their voices heard through research. Then, how can I understand these women's situation without asking them? As stated, "*those that are marginalised in the society have a clearer understanding of their problems that need to be investigated and have had experiences that provide a more appropriate foundation for knowledge than those of dominant groups*" (Wylie, 2004, p. 339). For this purpose, the present study was designed to develop a greater understanding of women's experiences of living with mental illness in southwest Nigeria. Hearing directly from the women who experienced mental illness will provide a new understanding of living with this condition. The voices of women who are willing to share their experiences may inform the delivery of mental health services in Nigeria whereby, the benefits will extend to many people experiencing the illness.

The cultural background of the study population

Southwest Nigeria is occupied by the Yoruba which comprises of six states (Awogbade 2004). The inhabitants of the six states are involved in agricultural activities including arts, hunting, pottering, and craft specialisation (Vaughan, 2000; Intelligence Agency, 2019). Religion constitutes an important part of the Nigerian culture; in the north are Hausa people who are mostly Muslims and practice Islamic religion while in the south, Christianity is widely practiced

by Ibo and Yoruba people (Kitause & Achunike, 2013; Obasohan, 2015). There is a common belief among the Yoruba that the physical and spiritual world exists and is controlled by divine power (God), that this spiritual being controls everything including health (Atanda, 2007; Fadamiro & Adedeji, 2016). This belief is pervasive among the Yoruba, as it is demonstrated in their everyday activity. They believe that health and illness are by divine intervention (Adegoke, 2010; Okeke et al., 2017).

The Yoruba culture is a highly collectivist one. There is a strong sense of family and cultural value and family traditions which appreciate collective nurturing, benefits, loyalty, and unity. It is also common to have hierarchical and patriarchal family structures (Elegbeleye, 2005; Fadipe, 1970; Familusi, 2012). Within families as well as between extended families, there is a high interdependence, where everyone in the family is expected to support other (extended) family members (Akintan, 2013; Familusi, 2012). Although the family is normally considered as very helpful and protective, it also has its disadvantages such as a lack of privacy and extensive financial obligations (Ayanrinde and Bamigbola, 2009; Ojeda et al., 2013). The Yoruba idea of family (ebi) is more than just immediate family members, they try to include the extended family, and those who marry into the family are adopted (Abdul, 2014). Age and gender are revered in the Yoruba culture. The oldest man (Olori-Ebi) in the extended family is well respected and honoured. He makes all the decisions and manages the affairs of the whole family (Abdul, 2014; Fadipe, 1970; Gbadegesin, 1991). It is acceptable for a Yoruba man to marry more than one wife at the same time or over the course of his life. It is however expected that a woman can have only one husband and one marriage in her lifetime (Fasoranti & Aruna, 2007; Olabode, 2009; Sofola, 1973).

The patriarchy of the Yoruba culture is very apparent, and the male supremacy placed over women is acknowledged and manifested in the differences in gender expectations and responsibilities (Aluko, 2015; Akintan, 2013; Odebode, 2009). This was demonstrated when women's status in Yoruba culture was described: "*the Yoruba nation like many other African societies is essentially patriarchal; hence men are understood to be more privileged than women …. Men show superiority over women*" (Familusi, 2012, p. 300). Men are likely to engage more in work that brings more financial gain into their family, and they make most of the decisions for their family. The culture accepts a man to make major decisions without the consent or support of his wife and to protect his family from any danger. In contrast, women are likely to be at home and looking after their children or involved in petty trading (their income is perceived to be supportive at best), and they also help their husbands in farming activities (Oyewole, 2016; Mudau & Obadire, 2017). Men have more advantageous positions when it comes to inheritance than women, even if women may be older (Aluko, 2015). Although economic hardship has reduced the limitations placed on women financially, many women are

now engaging in different jobs that were exclusively occupied by men in the past (Oyewale, 2016). However, the impact of the patriarchal system is still much felt in the Yoruba community.

In Yoruba culture, men and women are expected to have different styles of communication. Women are expected to talk quietly or maintain silence in most situations and carry the burden of maintaining peace while for men it is acceptable, and at worst, excusable, for men to be tough, assertive and non-inclusive (Elegbe and Nwachukwu, 2017). This patriarchal system and religious beliefs are also true for the Ibo (Omadjohwoefe, 2011; Ugorji, 2009).

The need for the study

The lack of routine statistics made it difficult to know the number of people with mental illness in Nigeria (Abdulmalik et al., 2016; WHO-AIM, 2006). However, there is evidence that women constitute parts of the population suffering from mental illness in the country (Adeponle et al., 2017; Lasebikan et al., 2012). Many women with mental illness are mothers and studies show the possibility of children of mothers with mental illness, developing the illness (Dean et al., 2010; Mattejat & Remschmidt, 2008; Murphy et al., 2018). It has been demonstrated that mental illness is a risk factor for physical illnesses such as diabetes and heart diseases and leads to untimely death (Ilyas et al., 2017; WHO, 2020). Mental illness affects people's income and quality of life (Chong et al., 2016; Jin & Mosweu, 2017).

Although there are studies on the experiences of caregivers of people with mental illness, some studies are based on the perspectives of health professionals. However, knowledge on the experience of women who are living with mental illness is limited in the southwest of Nigeria. With the numerous effects of mental illness on health, it becomes necessary to understand the lifeworld of this group of women because it is an experience that can change people's life.

The study's aims and objectives

The current study aims to explore the lived experiences of women with mental illness in southwest Nigeria. The objectives of the first phase of the study were to:

1. Explore the lived experiences of women with mental illness

2. Understand their views about health services provision, and

3. Identify their views about mental and social needs.

The emergent themes from the analysis of data from the women's interviews led to another set of interviews on mothers with mental illness. Phase two of the current study examined experiences of mothers with mental illness in order to:

1. Have an understanding of the lived experiences of mothers with mental illness
2. Explore the mothers' views about mental health services provisions, and
3. Find if they have unmet health and social needs.

Structure of the thesis

This study has nine chapters, with chapter one being the introductory chapter of this thesis. It explains the definition of mental illness, the prevalence and burden of mental illness to individuals and society on three levels: global, the African continent, and Nigeria. The need for the present study was stated, including the study population and the background to the study.

Chapter two demonstrates the steps taken to identify the relevant studies reviewed, such as designing the research question and developing the inclusion and exclusion criteria to search for the reviewed studies. The process also includes searching for literature electronic in databases, identification, retrieval, appraisal and the synthesis process.

Previous literature related to lived experiences of women and mothers living with mental illness identified in chapter two were reviewed in chapter three. The review of the existing literature helps to identify gaps in the knowledge of women and mothers with mental illness in southwest Nigeria. It provides an opportunity to relate the present study within the setting of the existing literature.

Chapter four discusses the methodological approach and philosophical positions that guided the study and helped to answer the research questions and to achieve its aims and objectives. The reasons for locating the study within interpretive and relativist perspectives are stated. This chapter also provides an overview of phenomenology as a methodology and different philosophies in phenomenology are explained. In addition, adopting the hermeneutical phenomenological perspective to conduct the study for the in-depth knowledge of participants' experiences was stated. The compatibility between hermeneutics and thematic analysis methods was discussed. It discusses the use of the thematic analysis method to identify themes that present study participants' experiences from data generated.

The data collection process used in the study is explained in chapter five. It begins with obtaining approval for the study followed by the identification and recruitments of the study participants. It mentioned the role of gatekeeper and access to participants. Reasons for

choosing face-to-face and the semi-structured method of interviewing was explained. Different stages of Braun & Clarke (2013) thematic analysis techniques of identifying themes were stated to enhance the trustworthiness of the study. Also, the ethical principles that guided the study were explained in the chapter and I reflected on my field experience during the data collection.

Chapter six discusses the findings from the interviews for phase one of this study. The chapter explains how participants perceived their mental illness and methods of managing their illness. It explains social, religious, and cultural factors that increased participants' experiences of mental illness. Views of participants regarding the mental care services were stated.

The findings from the second phase of this study are discussed in chapter seven. It was informed by the findings from phase one of the study. It explains the burden of mothers with mental illness who have to manage the symptoms of their illness and care for their children simultaneously. Findings revealed that participants were over-burdened with financial problems, and lack of strength to provide for the needs of their children. The chapter explains how the lingering effects of participants' mental illness affected their children in their adulthood. Lastly, problems of accessing mental healthcare facilities by participants were stated.

In chapter eight, the main findings of the present study are discussed and situated within the broader literature and theory. The chapter explains how gender, culture, and structural factors had further put participants in a more vulnerable and disadvantaged position. It explains a lack of equity and rights to access care because of ineffective implementation of the national mental health policy, leading to marginalisation of people with mental illness. A conceptual model was developed based on the study's findings.

Chapter nine is the concluding chapter of this thesis. The chapter summarises every segment of the thesis including reviewed literature, methodological approach, research process, and findings. It states the study's original contribution to knowledge. The implications of the research findings were stated and followed by recommendations. The strengths and weaknesses of the study were explained and finally, the areas for further research are stated.

Chapter Two - Literature review

This chapter seeks to identify and appraise existing literature with the aim of identifying the gaps in research knowledge of women's experiences of living with mental illness. The review of existing literature was conducted by using systematic review (SR) principles. SR is a method peculiar to the quantitative approach, whereby a comprehensive search is conducted to identify relevant studies related to the topic of interest (Hansen & Trifkovic, 2013). Following a systematic approach will promote transparency and improve the breadth of the literature review.

The integrative review method will be used to review existing literature related to the topic of interest. It allows the review of both qualitative and quantitative research simultaneously in order to have a holistic understanding of a phenomenon (Boland et al., 2017; Toronto & Remington, 2020; Soares et al., 2014). Findings of the integrative review can be used in clinical settings to guide practice for its scientific evidence and likewise in social care for providing a deeper understanding of a phenomenon of interest (Denney & Tewksbury 2013; Souza et al. 2010).

The chapter consists of five main sections. The first section is called *design and search methods*. This section states the steps taken to identify the literature reviewed in chapter three. It includes developing the research question, searching electronic databases to retrieve studies related to the topic under investigation. Then, the various steps taken to identify the reviewed studies are stated, including the appraisal of the selected studies.

Design and search methods

This section discusses steps taken to find the reviewed literature and it will be presented under six headings: literature search strategy, inclusion and exclusion criteria, a literature search on electronic databases, search results and selecting relevant studies, critical appraisal of the selected studies and data synthesis.

Literature Search strategy

The first step undertaken was to develop strategies to search for potential studies. As recommended, it involves designing a research question and retrieving information from multiple databases (Cooper et al., 2018; Templier and Pare, 2015). Searching for information from different sources will provide adequate and efficient coverage on the topic under investigation (Bramer et al., 2017; Grewal, Kataria and Dhawan, 2016). There are acronyms

such as PICO and SPIDER that are used as a guide to developing research questions. The PICO tool generates a greater number of results than the SPIDER framework, but it relates to quantitative research (Methley et al., 2014). The SPIDER framework is designed to identify qualitative and quantitative studies or mixed research designs (Methley et al., 2014). SPIDER framework produces greater specificity for every database and sensitivity to the search terms. The SPIDER acronym refers to "*sample, phenomena of interest, design, evaluation, and research*" (Cooke et al., 2012, p. 1435).

In the current study, the components of the SPIDER framework are women and mothers (as sample) while the phenomenon of interest is schizophrenia, a mental illness. The design stands for a method of collecting data used in the studies, such as interviews or questionnaire methods, evaluation refers to views and attitudes, and research which can be qualitative or quantitative in approach. Inclusion and exclusion criteria were developed to search for potential studies. The research was developed using the SPIDER acronym. The research question is: what are the experiences of women living with mental illness? Following the formation of the research question, the next step was to develop the inclusion and exclusion criteria to facilitate the identification and selection of relevant studies.

Inclusion and exclusion criteria A literature search of different electronic databases will generate large studies; therefore, it is important to choose studies that are relevant to the research question and exclude those that are not as suggested by Boland et al. (2017) and Oliver (2012). The inclusion criteria for the reviewed literature included:

- Primary research studies,
- Studies that have an abstract, published with full text and in the English language,
- Studies with sampled women were 18 years or above with mental illness in accordance with the DSM or ICD diagnostic criteria,
- Studies that focused on the perspectives of women,
- Peer-reviewed journal articles
- Studies that included men with mental illness were added for their relevance,
- Quantitative and mixed-method studies were included if the sample included women with experiences of mental illness.

Studies were excluded:

- For lack of sufficient information to assess the trustworthiness,
- If the studies were not written in English,
- Where there was limited applicability to the review. For example, studies conducted on experiences of caregiver or health professionals.

The inclusion criteria included studies from both quantitative and qualitative methodology because understanding can be acquired from the two research paradigms (Hammarberg et al., 2016; Hannes & Macaitis, 2012; Lawrence, 2014).

Literature search on electronic databases

The search terms derived from the SPIDER framework were used to conduct a preliminary search on electronic databases. First, a literature search was conducted on Google Scholar and Summon (the university of Huddersfield's search engine). Phrases or sentences such as "experiences of mothers with mental illness, views of women with mental illness, perceptions of women with mental healthcare services" were used with the two search engines because they do not support the use of Boolean operators. The initial result generated on Google Scholar was 23,200. After a five-year timeframe was applied, the number was reduced to 890 articles. The reason for limiting the search to five years was to allow up-to-date information to be retrieved as recommended (Aveyard, 2019; Beller et al., 2013). Likewise, a preliminary search on Summon produced 3015 results, it was narrowed to 738 by refining the search and introducing a five-year timeline, and the inclusion criteria was applied. Additionally, African Journals online (AJOL) was accessed for potential studies published in African countries. The number of studies identified through AJOL was 147 studies.

The search was extended to different databases in order to generate sufficient literature for the review, "*information retrieval is an essential component of the systematic review process*" (Wade et al., 2006, p. 92). A broader approach was used since mental illness is usually studied in nursing, psychiatry, psychology, public health, and social work. The literature search was conducted without narrowing the search terms to a specific methodology. The electronic databases assessed were Cumulative Index to Nursing and Allied Health (CINAHL); Medline; Science Direct; Scopus; PsychINFO; PubMed, and web of science. The search terms were used in conjunction with Boolean operators to search and retrieve studies on database search engines. Boolean operators (AND, OR, NOT or AND NOT) are words used in databases to retrieve information (Ely and Scott, 2007; Machi & McEvoy, 2016). For example, when two search terms were combined using 'AND' the search generated articles that mentioned the

search terms. Using 'OR' broadened the search and identified more literature compared to when 'AND' was used. When the term 'NOT' was used to combine words, it generated articles containing the first search word, thus narrowing the search. Hence, it saves time that may be used to eliminate irrelevant studies (Ely and Scott, 2007; Jesson et al., 2011).

The keywords and related literature were incorporated into the search strategy. The following search terms were used (experiences OR perspectives OR views) AND (women OR mother OR motherhood OR Mothering OR parenting) AND ("mental illness" OR "mental problem" OR "serious mental illness" OR "mental disorder") AND ("service use" OR "treatment" OR "healthcare delivery" AND "barriers" OR "Challenges"). This strategy was used to eliminate inappropriate hits from search activities. In place of mental illness, search terms such as depression, bipolar disorder, anxiety and schizophrenia that were sensitive enough to generate studies specific to the aim of the review were combined with other search terms. By combining the search terms on Medline, 61137 studies were generated. The studies retrieved from PsycINFO were 1867, PubMed produced 3058 results, and 5432 hits from CINAHL. The number of studies retrieved from Scopus database was 3690 and 2173 studies from the Web of Science. An advanced search was conducted, the search resulted in 1265 hits in Medline, 115 records from PsycINFO, and 2894 records from PubMed. The CINAHL search engine produced 260 records through advance searching while 1024 were recorded from the Web of science, and 651 hits from Scopus.

Furthermore, I undertook a secondary search of reference lists of retrieved studies and followed related articles. The purpose of performing this activity was to ensure that relevant studies that may have been missed during the search of the electronic databases may be included in the review as recommended (Boland et al., 2017; Vassar et al., 2016; Wright et al., 2014). Email alerts were set on different journals (such as Academia, and African Journals online) to keep up to date by receiving emails when studies related to the topic were published. Whilst studies relevant to the topic of investigation on a global level can be received from the Academia journal, AJOL would send a notification for empirical research published in Africa only.

Search results and selecting relevant studies

The literature selection process is an essential part of a literature review, the process is used to eliminate studies that appear in more than one database (Bramer et al., 2017). Also, it helps to determine relevant studies that will be included in the review among a plethora of literature identified (Levy & Ellis, 2006; Petticrew & Roberts, 2006). The following steps were taken to select the reviewed literature in the present study. The electronic database search generated

a total of 7984 studies and 18 from a back-chaining search, bringing the total numbers of studies identified to 8002. To select relevant studies to the review, duplicates were removed, and 732 records remained. The titles and abstracts of the remaining 732 were read to determine whether they were relevant to the topic under investigation. Through the process of reading the titles and abstracts, 368 records were excluded for not meeting the inclusion criteria. Studies that did not relate to the review aims and did not address women's views of mental illness were not selected. The remaining 61 studies were selected and screened to know if they met the inclusion criteria. Another 27 studies were excluded at the data extraction phase because they did not meet the inclusion criteria, in total 34 studies were reviewed. Of the 34 literature, two studies (Halsa, 2018; Thoits, 2016) were not peer-reviewed but included because of their relevance.

The literature selection procedure was documented using Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) proposed by Moher et al. (2009). PRISMA was designed with the focus on reporting the process of conducting the reviews of Randomised Controlled Trials (RCTs). It can also be used as a method of reporting systematic reviews of other types of research (Aveyard, 2019; Fink, 2014). It promotes transparency in reporting how literature was searched and helped to assess the strengths and weaknesses of the investigation (Moher et al., 2009). Thus, figure 2.1 presents the selection process of the reviewed literature using the PRISMA flow diagram.

Stage	
Identification	Records of studies identified: 8002. African Journals on Line (AJOL). 147 CINAHL 260 Citation tracking 18 Google Scholar 890 Medline 1265 PsycINFO 115 PubMed 2894 Scopus 651 Summon 738 Web of Science 1024
Screening	Records after duplicate removed 732
	Records screened based on title and abstract: 368
Eligibility	61 full text articles assessed for eligibility, using CASP appraisal tool → Studies not meeting eligibility criteria
	Another 27 studies were excluded after appraisal → Studies not meeting eligibility criteria
Included	34 studies included in the literature review

Figure 2.1. The PRISMA Flow diagram demonstrating reviewed literature selection

Critical appraisal of the selected studies

Selected studies were evaluated to reduce the potential for bias (Cohen & Crabtree, 2008; Joyner et al., 2018), and to determine their standard and relevance (Aveyard, 2019; Petticrew & Roberts, 2006). The studies appraisal was performed by using the Critical Appraisal Skills Programme (CASP) tools. The CASP was first developed to critically appraise the quality of quantitative studies, it consists of 12 questions (Harrison et al., 2017). However, it was argued that the tool for examining trustworthiness and relevance in quantitative studies may not be appropriate for qualitative research, considering the diversity of methods that exist in qualitative research studies (Dixon-Woods et al., 2004). For this purpose, the Public Health Resource Unit (PHRU) (2006) published a structured approach of CASP tools to appraise the

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quality of qualitative research methods design. The PHRU Critical Appraisal Skills Programme (CASP) was considered effective to appraise qualitative studies, as it promotes transparency. It shows the strengths, weaknesses, and applicability of the reviewed studies (Harrison et al., 2017). The CASP tool for evaluating the quality of qualitative study comprised of ten questions that addressed different aspects of a study. For example, it asks for clarity of aims, the appropriateness of a qualitative methodology, ethical issues, and clarity of findings (Atkins et al., 2008). The PHRU (2006) CASP tools were used in appraising the quality of the reviewed qualitative studies.

It was suggested that the gold standard of appraising the quality of a study does not exist in integrative review because of the different approaches used to conduct qualitative and quantitative studies. The inclusion of different designs in the integrative review method has been critiqued because it causes bias and lacks accuracy in the outcome of the synthesis (O'Mathuna, 2000). To overcome this challenge, methodological features of each study included in the integrative review are examined to assess the study's quality and to reduce bias (Whittemore & Knafl, 2005). The quality of a study is described as "*the extent to which the study design, conduct, and analysis systematically avoid or minimize potential sources of bias*" (Conn & Rantz, 2003, p. 323). The assessment criteria stated in the CASP tools to appraise the quality of qualitative study were used as guidelines to check the standard of the 27 qualitative studies included. The quality of selected studies can be evaluated by scoring their methodological features. A total score of 10 was allocated for each article with a 3-point scale (A=low, B=moderate, C= high) was assigned for the studies' methodological rigour. Studies that scored from 9 to 10 were believed to have a low risk of bias and grouped under category A. Studies that received between 6 and 8 had a moderate risk of bias and were in category B. Articles that were assigned to category C scored lower than 6 which meant they had a high risk of bias (see table 1, appendix 1).

The quality of the five quantitative and two mixed methods studies included in the review was assessed by using CASP tools designed for a quantitative study. It consists of 12 questions as shown in table 2. It was used to assess the studies' methodological flaws, biases, validity and reliability of the literature and provides the opportunity to draw conclusions. Studies that scored between 9 and 12 were rated and given a rating of category A. Category B had scores of between 6 to 8, while studies grouped in category C, scored below 6. Detailed information on evaluating the quality of quantitative studies included is demonstrated in appendix two.

The studies have clear aims, sampling strategies, and methods of collecting data. The analytical process was clearly described and suitable for the design of the studies. They provided clear findings and clinical implications of their findings including the areas of further

research. The relationship between the researcher(s) and participants was provided in fourteen studies. Good reflexivity was found in 10 studies and three authors maintained a field journal. More information about the characteristics of the included studies is presented in appendix 3. Overall, all of the studies were retained and analysed regardless of the score. As suggested by Whittemore & Knafl (2005), the reason for assessing the quality of the reviewed literature was not to eliminate studies thought to be of low quality but to have a background in which to consider the results of the analysis. It was further stated that publication space restrictions may have contributed to limitations in describing processes for promoting rigour in some of the studies which were believed to be of low quality (Whittemore & Knafl, 2005). Ethical issues were documented in all of the studies, piloting was found in four studies (Afe et al., 2017; Biringer et al., 2016; Burke et al., 2016; Saavedra et al., 2016).

Data synthesis

In total, 34 studies were included in the review, out of which there were five quantitative studies (Afe et al., 2017; Buchman-Wildbaum et al., 2017; Ibrahim et al., 2016; Tesfaw et al. 2020, Thoits, 2016). The mixed-methods design (such as questionnaire and interview) studies were two (Makanjuola et al., 2016; Strand et al., 2020) while the remaining 27 studies used qualitative research methods. Studies that included health professionals' perspectives were two (Hailemariam et al., 2017; Iseselo & Ambikile, 2017) and two multi-site studies (Kisa et al., 2016; Makanjuola et al., 2016) were included. The review included 12 studies that included only women in their sample while the remaining 22 pieces of literature included men.

The interpretive thematic synthesis method proposed by Thomas and Harden (2008) was used to develop an understanding and interpretation of themes across the reviewed literature in the present study. Thematic synthesis enables researchers to stay close to the results of the primary studies and allows individuals conducting studies' review to synthesise them in a transparent way, and helps researchers in facilitating the clear production of new concepts (Thomas and Harden, 2008). The Thomas and Harden (2008) thematic analysis has three stages: reading the studies for understanding and coding, organising the codes into related areas to form descriptive themes, and analysing the generated themes. Steps taken during the data synthesis included grouping the studies together based on their aims and findings. The next step was reading each study several times to develop new insights and applying definitive coding of the results within the studies to develop descriptive themes. The themes were arranged together based on their findings to answer the review research question. During the analytical process, new interpretations were generated and all of the data across different studies were compared, in order to explore the universality of women's experiences across countries.

The five themes with subthemes were identified, the main five themes are perceived causes of mental illness, four studies were reviewed under this theme. The second theme was the negative effects of mental illness, managing the effects of mental illness, mothering with mental illness, and barriers to accessing mental health services. The perceived causes of mental illness among individuals diagnosed with mental ill-health were examined by four studies. Two subthemes emerged from the negative effects of mental illness: stigmatisation and domestic violence. The number of articles that investigated mental illness stigma reviewed in the study was six and three studies on domestic violence experienced by women with mental health problems. Another seven papers explored the different methods used by individuals with mental illness to manage the symptoms of their illness. Studies on experiences of mothers living with mental ill-health were ten, while four articles related to barriers to accessing mental health services were included in the review.

Summary

The methods used to search, identify, and select current literature on experiences of women with mental illness were presented in this chapter. Methods of evaluating the quality of the selected studies and method of analysing the literature to generate themes and subthemes across the selected studies to present women's experiences of mental illness were also explained. The next chapter will present the findings from the thematic analysis of the studies.

Chapter Three - Findings of the literature review

The data analysis identified five main themes: perceived causes of mental illness; negative effects of mental illness; experiences of mothering with mental illness; managing the effects of mental illness; and barriers to accessing mental health services. Additional studies were included for deeper understanding of the findings.

Perceived causes of mental illness

Individuals having a mental illness, without a doubt, will find meanings and interpretations of their illness. The following studies contribute to the knowledge about causes and meaning women attribute to their mental illness from different settings. Araten-Bergman et al. (2016) conducted a study in Israel with a heterogeneous sample of 18 participants (11 men and 8 women). The findings of the study yielded multiple explanations; the most widely reported was that causes of mental illness among the participants (11) were spiritual causes. The remaining seven participants believed in genetic factors and trauma from stressful life events. The theoretical framework for the study was appropriate, and the qualitative methods used allowed participants to provide more information about their experiences. However, attributing the causes of mental illness to spiritual problems by a large number of participants can be explained as the over-representation (14 out of 18) of people from ethnic groups who have a strong belief in Judaism. Judaism is a religion concerning referencing the supernatural being (God). Those who practice it believe that God protects and also punishes people for their sins in different ways including mental illness to correct their disobedience (Gribetz, 2016; Levitin, 2012). The majority of the participants (13 out of 18) had only elementary and high school education. In addition to religious or cultural factors, the low level of participants' educational status may have contributed to questioning how they perceived the causes of their mental illness. The finding provides an understanding of the influences of religion and cultural background on the meaning and interpretation of health and illness.

Makanjuola et al. (2016) included people from three African countries (Ghana, Kenya, and Nigeria) to understand the meaning and causes of their mental illness. Mixed methods of conducting research (such as semi-structured interviews and questionnaires) were used by the authors to achieve a greater understanding of their 85 participants. Similar to Araten-Bergman et al. (2016), participants gave multiple explanations regarding the causes of their mental illness. The majority of the participants (70%) stated supernatural causes such as witchcraft and spiritual attack. The remaining 30% reported biopsychosocial factors such as genetic, stressful events, and alcohol problems (Makanjuola et al., 2016). Participants were

recruited from traditional healing centres; I argued that the recruitment process may have contributed to the high percentage of participants who held supernatural beliefs regarding the causes of their mental illness. Secondly, it was a mixed-method design study that involved a quantitative method and the recruitments took place in three countries, I suggest that more participants should have been enrolled in the study to justify the quantitative approach method.

Similar to Makanjuola et al. (2016)'s use of mixed methods of enquiry, interview and questionnaires were adopted by Nohr et al. (2019) to carry out their research projects. Using a mixed method approach (interviews and questionnaires), helped to substantiate participants' claims. The 14 who participated in the study were six males and eight women. As identified by the authors, participants' mental illness was caused by social and environmental problems. Participants reported the use of excessive alcohol consumption to reduce their anxiety concerning their inability to meet their family's exhaustive demands because of low economic conditions (Nohr et al., 2019). Cuban people have a culture of excessive alcohol consumption which may have influenced participants' choice of coping with stressful events. The absence of supernatural causation of mental illness can be interpreted as the non-involvement of the Santena people in the study. The Santena are the African-Cuban ethnic group that believe in worshipping deities, practices spiritual healing and ritualistic process (Fortes-Lima et al., 2018).

In the inner-city of Johannesburg in South Africa, Ntshingila et al. (2016) conducted a phenomenological study with eight women with borderline personality disorder (BPD). Trauma from childhood experiences, such as loneliness, sexual abuse, and living in an environment associated with a high crime rate was reported by participants to have caused their health problems (Ntshingila et al., 2016). A holistic approach for treating women with BPD was recommended by the authors because of the different adverse conditions they had been exposed to. The study was conducted by women's healthcare providers through purposive sampling. The selection process and participants' relationships with their healthcare providers might have affected the women's responses. Findings of the two studies (Nohr et al., 2019; Ntshingila et al., 2016) strengthened the evidence that the causes of mental illness are not limited to biological problems alone, but include social and environmental influences.

Negative effects of mental illness

The analysis of ten of the primary studies reviewed looked at the adverse effect of mental illness. The findings highlighted the unpleasant experiences the women with mental illness had from others which is called negative effects of mental illness. This theme has two

subthemes which are stigmatisation and domestic abuse as which will be discussed in this section.

Stigmatisation

Research shows that individuals with mental illness do experience stigma and differential treatment from others. The stigma experiences are in different forms as identified by Burke et al. (2016) in the UK. The 12 individuals who participated in the study reported being humiliated, ignored, and excluded from social activities by family and friends. As discovered by Burke and colleagues, stigma experience was received by participants from their health professionals. Participants reported being treated differently from others without mental illness (Burke et al. 2016). Contrary to the claims made by Burke et al. (2016)'s participants, what they referred to as differential treatments may be usual procedures that everyone accessing the services must follow. On the other hand, the severity of the symptoms of participants' mental illness which was not considered in the study, may be the reason for being avoided by others, for fear of being attacked.

Likewise, the quantitative study of Buchman-Wildbaum et al. (2020) in Hungary was on mental illness stigma. People (200) with different diagnoses of mental illness were included in the study. It involved 66.5% women and 33.5% men who reported stigmatisation and being treated differently in the workplace. Participants reported that a lack of social support and stigma contributed to their low educational status and employment problems they experienced (Buchman-Wildbaum et al., 2020). I suggest that the presence of physical illness together with mental illness may have contributed to participants' unemployment and lack of higher education attainment reported by 80% of the sample.

The experiences of mental illness stigma discovered in the studies of Burke et al. (2016) and Buchman-Wildbaum et al. (2020) were limited to participants only. However, participants in Huggett et al. (2018) study in England reported: "*hierarchy of stigma*" (p. 386). A situation where the sample (a mainly white ethnic group) were stigmatised and avoided by family members, friends, and service providers. The stigmatisation attitudes from the public were said to extend to family members of the participants (Huggett et al., 2018). Also, Huggett et al. (2018) sample who participated in the focus group discussion reported the level of stigma received from the public depended on the types of mental illness. Individuals with severe mental illness symptoms were said to receive more negative attitudes than persons with mild or low symptoms. However, it was a focus group study; individual interviews could have been more insightful and present an individual's experience.

Ibrahim et al. (2016) survey study in Nigeria investigated people's experience of mental illness stigma and its social implication. The experience of 370 individuals (males constituted 56.5%

and females were 43.5%) suffering from mental illness was considered. As identified by the authors, 65% of the participants stated they experienced stigma and 22.5% were discovered to have a higher level of internalised stigma with suicidal thoughts. The consequences of public stigma on the participants included a delay in accessing medical treatment, isolation, and loss of income. The findings have contributed to knowledge, but the modifications made to the standardised measuring instruments may compromise its validity. The findings might be different if the original version of the questionnaire was used. A greater understanding of participants' stigmatisation experiences might be achieved if different research designs that allowed participants to speak about their experiences in their own terms were used.

The findings of Tesfaw et al. (2020) quantitative study in Ethiopia corroborate with Ibrahim et al. (2016). Among the 409 persons (62.3% male and 37.7% female), with mental health problems that took part in the research, 69% had been discriminated against at work, and 65% reported that their opinions were not taken seriously. Overall, the percentage of women who reported experience of stigma was higher than men (2.4% against 1.0%). It was also discovered that women participants had higher internalised stigma compared to their male participants, that is, 2.89% compared to 1.85% (Tesfaw et al., 2020).

In Tanaka et al (2018), participants' families were identified as the main source of stigma by denying the participants access to medical care, isolated, or being tied down and not protected. The 39 participants constituted 66.7% were male and 33.3% were female who reported been physically and financially abused by family members and experienced unemployment problems because of stigmatisation. Additionally, Tanaka et al. (2018) discovered participants had reduced social contact with people which resulted in the loss of opportunities and poverty that had increased the participants' distress. The authors failed to distinguish the effects of mental illness stigma on men and women in their findings, however, it provided valuable insight into the participants' experiences. The unemployment status can be linked to the general unemployment rate in the community where they live. On the other hand, it may be their mental illness that made them reside in a low economic area. Additionally, the symptoms of their mental illness could have made it impossible for them to be efficient and safe at work.

The literature presented in this section examined the experience of stigmatisation and its effects on people with mental illness. The findings established the claim of scholars (Corrigan & Watson, 2002; Link & Phelan, 2001) who stated that mental illness attracted stigma irrespective of background. The settings were different, but all the studies' findings established stigma as a universal issue and harmful to the wellbeing of people experiencing it. What is

different, is the extent and degree to how mental illness stigma affects the lives of individuals who experience it.

Domestic violence

Intimate partner violence (IPV) among women with mental illness was a common phenomenon. However, studies in this section provide more information about factors associated with IPV other than the women's mental illness.

Afe et al. (2017) cross-sectional survey study was conducted in Nigeria to understand the factors that put women with mental illness at greater risk of experiencing IPV. The sample consisted of 79 women who had been diagnosed with severe mental illness (SMI). The findings of the study showed that 73% of the participants had an incident of IPV. The most frequently reported form of IPV was verbal abuse (71%) followed by physical abuse (51%), and sexual assault (24%). Out of the 51% of the participants who reported physical abuse, 41% reported sustaining injuries from the incident. The lower socio-demographic and socioeconomic status of the participants were identified as factors that contributed to the women's abusive relationships (Afe et al., 2017). Higher prevalence of IPV was identified in women with partners who were both under 40 years. Unemployed women or those who had low income were found to experience more IPV (Afe et al., 2017). The authors found a lack of income to support the financial burden of mental illness as part of the reasons for IPV. They concluded that health professionals should extend their services from medication treatments to social intervention and help their clients to increase their financial status. The findings added to what is known about women with mental illness and experience of IPV. It was discovered that employment significantly supported and enhanced the recovery of people living with mental illness. However, the higher percentage of IPV recorded in the study can be linked to predetermined survey questions (yes or no answers) that only allowed participants to respond positively or negatively.

The study of Vranda et al. (2019) extended the argument by exploring the attitude of women with SMI concerning IPV. This study was carried out in India with 100 women receiving treatments in a mental health clinic. Of the 100 sample, 62 reported experiences of IPV, 38 refused to disclose their IPV experience to their services providers. Only ten women were found to have voluntarily shared their IPV with health professionals because of pain and trauma from the experience. The remaining 52 women who concealed their IPV experience said they were quiet about their domestic abuse to avoid punishments from their partners after disclosure. They were ashamed of their IPV experience to become known in the community.

Moreover, the women were not sure if they would be protected from their abusive partners. The presence of their partners during the consultation with their service providers was stated to be a hindrance to the disclosure of their IPV experiences (Vranda et al., 2019).

Experiences of women with mental illness and society's view about the health condition were the focus of Islam et al. (2018)'s study. This phenomenological study was conducted with 10 women living with a diagnosis of mental illness in Bangladesh. Physical, emotional, and sexual assaults from partners were reported by participants. Findings showed that IPV was culturally viewed as a method of correcting women's 'bad' behaviours by their spouses or an appropriate way of controlling women with mental illness. Self-harm and becoming violent against family members were discovered as a means of showing annoyance against the ill-treatments by women who experienced IPV (Islam et al., 2018). Women who suffered IPV were said to experience emotional trauma that worsened their mental illness symptoms. The authors recommended psychosocial intervention as a means of correcting cultural practices regarding IPV against all women. The findings enriched understanding of women with mental illness experiences through the use of mixed qualitative methods (interview and focus group discussions). Notwithstanding, the study was conducted by the women's health professionals who selected and interviewed them, the health professionals' position may have interfered with the study's findings.

Managing the effects of mental illness

The use of medication as a means of controlling the symptoms of mental illness has been established through many studies including Lee et al. (2020) and Yeisen et al. (2017). The study of Lee et al. (2020) was conducted in the USA with 28 participants (10 men and 18 women) living with mental illness. Participants acknowledged the usefulness of the medication in managing their illness's symptoms, but its side effects hindered their social functioning. In Norway, Yeisen et al. (2017) discovered similar findings from their study sample which consisted of 14 women and seven men. The claim of Lee et al. (2020) was supported by Yeisen et al (2017) findings as participants reported reduced symptoms of mental illness through medication and also suffered from stiffness, sedation, and tiredness including drooling caused by medication side effects (Yeisen et al. 2017). In addition to a physical illness suffered from the effects of antipsychotic medication, participants reported that health professionals often misinterpreted the medication side effects as signs of relapse and caused them to be isolated from others. Lack of understanding about their mental illness was said to have caused violence in the community by the people who misinterpreted symptoms of the illness as an attempt to attack them. The two studies included people with different mental illnesses with

different levels of recovery. Their prescriptions differed and the participants may not respond to adverse effects of medication in the same way. However, the findings suggested that the role of medication in recovery is multifaceted, highlighting different experiences among people with mental illness.

Other than medication, religious activities such as prayer were identified by Tuffour et al. (2019) among participants. The 12 participants (nine women and three men) were identified as a Black African minority group in England. Participants spoke about their religious belief as a coping strategy that helped them to integrate back into their community. The authors agreed that religious belief and spirituality may help participants psychologically. They also identified the negative influence of this coping method on their treatments such as not taking their medication regularly, and believing they were cured of their mental illness (Tuffour et al., 2019). The study failed to distinguish between religiosity and spirituality in the context of coping with mental illness. Participants were living with their family members which might influence their coping mechanism.

Coping methods such as employment, physical exercise, accessing information about mental illness and spending time with family and friends were identified by Biringer et al. (2016). This hermeneutic phenomenological study involved 10 participants in Norway who spoke about the benefits of their coping strategies such as reduced aggression, relieved inner tensions, and reduced illness symptoms and sleeping problems. Participants were purposively selected by their healthcare providers who were also the authors of the study. The relationship between the authors and the participants may have influenced the impressive responses provided by participants. The findings of Saavedra et al. (2016) relating to employment as a coping mechanism against mental illness aligned with the outcome of Biringer et al. (2016) study. Saavedra et al. (2016) study was conducted in Spain with 21 participants. Out of the 21 participants, one had never been to school, two had completed higher education, while others had elementary or high school education. Only three participants were unemployed while the remaining 18 people were employed or trying to go back to a paid job. Improvements in financial condition, social interaction, and reduced symptoms of mental illness were discovered among participants that were employed (Saavedra et al. 2016). Those that were employed were reported as having low income and work-related stress while unemployed participants explained the difficulties in securing a job. The low income reported can be argued as the result of their low educational status which may not qualify them to get a highly-paid job. Again, the study was conducted in a low economic area in Spain with a high rate of unemployment. Thus, their inability to secure work may be due to the general unemployment situation in their environment rather than their mental illness.

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Using tolerance and challenging stigma against discriminatory attitudes from others as coping strategies were the findings of Mora-Rios et al. (2016) in Mexico City. The qualitative study involved 23 individuals (constituting 12 women and 11 men) with experience of mental illness. Tolerance means withdrawal or resigning to a situation while challenging methods indicates resisting unpleasant circumstances. Participants who challenged people's discriminatory attitudes towards them said they educated others about mental illness to change their perceptions concerning people suffering the illness. The coping methods used by the participants may be an indication of their recovery level from mental illness. Participants that used the withdrawal method may likely be at a low level of recovery with minimal interaction, and with the possibility of having their self-esteem and self-efficacy eroded by the negative actions from others. The finding has an important implication for health providers to increase mental health awareness. However, the authors failed to specify the coping method used by the different gender included in the study.

The methods of managing the effects of mental illness identified by Thoits (2016) especially in relation to others was different from the findings of other studies in this section. This quantitative study took place in the USA with 9282 samples which consisted of 60.6% of women and 39.4% of men with mental illness. From the participants' demographic, 89% experienced severe mental illness and 94% were impaired by their mental illness. It was discovered that 77% of the participants used a deflecting strategy, that is, not accepting that they were suffering from mental illness. I argued that participants who rebuffed a mental illness diagnosis may not be aware of their psychological problems. Again, it is likely they were suffering from mid or low symptoms of mental illness or had not received treatment for mental illness. Alternatively, participants who rebuffed having mental illness, provided a communally desirable answer rather than uttering a true belief about themselves. Moreover, it was a survey study where answers had been predetermined. Using different research methods (such as interviews) could have provided more knowledge about participants' claims.

In all, the findings of these studies demonstrated different ways people used to cope with the adverse effects of living with mental illness. The method employed by individuals may be determined by available resources and the level of their recovery. The coping strategy for individuals may change with time.

Mothering with mental illness

Motherhood is accompanied by challenges and opportunities; this is not exceptional for mothers with mental illness. Research shows that they experienced additional challenges because of their mental health. The three subthemes related to experiences of mothering with

mental illness are unpredictable absence, fear of condemnation, and difficulties with child discipline. The subthemes are discussed below to provide an understanding of the challenges associated with mothering with mental illness.

Unpredictable absence

Bartsch et al. (2016) in Australia focused on the experiences of 12 mothers with bipolar disorder (BPD). The authors discovered the mothers' difficulties in maintaining daily routines of caring for their children (such as preparing meals and household chores) and a stable social network with other parents. The mothers attributed the challenges experienced to hospital admissions. They reported that hospitalisation made them physically unavailable to respond to their children's needs. To overcome this challenge, mothers in the study were said to utilise dialectical behaviour therapy (DBT) skills to assist them in their parenting roles. However, the Bartsch et al. (2016) sample were highly educated mothers who experienced mid symptoms of BPD. Therefore, accessing DBT training might not be difficult for them compared to other mothers with severe symptoms of mental illness or mothers without access to DBT training provision. Furthermore, the studies examined parenting experiences across different child developmental stages but failed to present mothers' challenges that are prominent at different stages of child development.

Similarly, Klausen et al. (2016) study showed the effects of regular admission to mental health hospitals on participants' motherly role. This qualitative study was conducted in Norway with 10 mothers experiencing anxiety disorder and depression. Mothers in Klausen et al. (2016) study reported the hindrances in their motherly role as they were physically distanced to their children to identify and meet their needs. However, the study failed to investigate the severity of the participants' mental illness that may warrant hospital admission. The views of mothers in Connerty et al. (2016) regarding hospital admission were different from Klausen et al. (2016). An understanding of how eight mothers with anxiety and depression cared for their children after being discharged from the hospital was examined in Australia. The mothers disclosed that the hospital setting was supportive and protective compared to the community environment (Connerty et al. 2016). Further, mothers in this study reported difficulties in managing the symptoms of their mental illness and caring for their children simultaneously. Making decisions and accessing support services in the community was regarded as a difficult and additional task (Connerty et al., 2016). While mothers in Klausen et al. (2016) preferred community treatment, Connerty et al. (2016) were satisfied with hospital admission. The differences in the experiences of mothers in Klausen et al. (2016) and Connerty et al. (2016) regarding hospital admission could be explained in relation to age differences. Children in Connerty et al. (2016) were new born babies and stayed together with their mothers in a

hospital environment. The support given to mothers in Connerty et al. (2016) may be usual treatments for all mothers with new babies irrespective of health challenges. Meeting the needs of children with the age range of four to sixteen years (as in Klausen et al., 2016) may pose a challenge to mothers on hospital admissions.

In addition to hospital admission for treatments, mothers with mental illness may experience a problem in caring for their dependent children because of fatigue, lack of concentration, and demotivation. This was discovered by Rampou et al. (2015) in South Africa in a qualitative study with 10 mothers with serious mental illness (such as depression, schizophrenia, or bipolar disorder). The authors found that their participants were unable to provide their children's basic needs regularly due to the effects of antipsychotic medication. The findings of Rampou et al. (2015) demonstrated other issues such as lack of social support and financial insufficiency that may further increase the distress of mothers with mental illness.

Fear of condemnation

The hermeneutic study of Blegen et al. (2016) in Norway revealed the experiences of 10 mothers receiving mental health care. Findings showed that the mothers concealed their feelings to avoid being considered as not good enough mothers. Though the mothers were encouraged to seek help for their parenting role, the fear of being stigmatised prevented them accessing support. They preferred to struggle in silence and appear to be well, rather than lose custody of their children. It was concluded that health care providers should be compassionate to build trust and strengthen mothers with mental illness to talk about their concerns (Blegen et al., 2016). The power and control relationship that exists between participants and their health professionals may have created gaps and difficulties for participants to express their feelings. Challenges experienced by mothers in Halsa (2018) were similar to the Blegen et al. (2016) sample. Halsa (2018) study was carried out with 14 participants in Norway using the semi-structured interviewing method. Mothers in these two studies share similarities such as choosing not to ask for support and hide their distress to avoid been labelled as dangerous mothers and problems with Child Protection Services. However, only mothers in Halsa (2018) practised intensive mothering like mothers without mental illness to avoid stigma. While Halsa, (2018) added to the knowledge about the experiences of this group of mothers, it failed to investigate the parenting support available to the participants or whether their mental illness impacted their ability to access support.

Contrary to the findings of other studies (Blegen et al., 2016; Halsa, 2018), women in the study of Hine et al. (2019) showed the need for self-awareness by mothers with mental illness. The constructivist grounded theory of Hine et al. (2019) was carried out with 17 mothers with

mental illness in Australia. As discovered by the authors, the mothers were aware of their strengths and needs, and they recognised that they did not need to follow rigid and traditional methods of parenting. Findings show that mothers in Hine et al. (2019) were able to achieve the balance in their motherly role and their mental illness by prioritising their needs. Different from mothers in Blegen et al. (2016) and Halsa (2018) studies, Hine et al. (2019) participants accessed both formal and informal parenting support. Mothers in Hine et al. (2019) were familiar with mental health services, which may have facilitated their access to support and claim to have had a positive experience of parenting with mental illness. Additionally, Hine et al. (2019) study sample was recruited through social media which automatically restricts the sample to mothers who have access to the internet and are technologically literate. I argued further that the findings may have been different if another sampling method had been used. These findings show that supporting mothers with mental illness reduces the stress of meeting parenting roles and managing their mental health problems. The outcome of Awram et al. (2017) qualitative study further emphasised the importance of providing support for mothers with mental health problems. Awram et al. (2017) study took place in Australia with 10 mothers suffering from mental illness. With the support of health professionals and practical support from relatives, the mothers were able to meet the need of their dependent children. The educational courses received by Awam et al. (2017) sample from their services providers helped them to develop strategies of meeting their parental responsibility and their recovery needs. While it can be argued that these mothers were women with reduced symptoms of mental ill-health, support and resources played an essential role in their recovery and motherhood.

Difficulties with child discipline

It is common for mothers with mental illness to link their limited parenting skills to their mental health problems (Strand et al., 2020). The 15 parents (10 mothers and five fathers) that participated in the research of Strand et al. (2020) in Sweden explained their inability to control their children's bad behaviours to inadequacies in their parenting skills. The parents lacked confidence, unsure whether they were correcting or provoking their children to anger with their parenting strategy. The finding shows the effects of parents' mental illness on children's wellbeing. It contributed to the knowledge of the topic under investigation, but the questionnaire used in the study was not explicitly structured and piloted. The questionnaire reliability may need to be established in a wider context. In a similar vein, a study by van der Ende et al. (2016) in the USA examined strategies for parenting by parents with mental illness. The 27 parents (eight fathers and 19 mothers) that took part in the research stated their parental role was restricted because of the mental illness that caused them to have hospital admissions. van der Ende et al. (2016) found that the mothers had parenting problems such

as an inability to set boundaries and a lack of time spent with children for leisure activities because of distraction caused by their mental illness.

Motherhood involves taking responsibilities for caring for their children. The reviewed literature on mothers with mental illness provides insight into different aspects of motherhood that can be affected by mental illness. It includes unpredictable absences due to hospital admission that may not allow mothers to physically present to nurture their children. When mothers are physically available, they may lack the energy to provide daily routines of meeting the needs of their dependent children because of medication side effects. Additionally, mental illness may prevent mothers giving their children appropriate and consistent discipline.

Barriers to accessing mental health services

An investigation into the understanding of factors affecting people with mental illness to access mental health care services was carried out by Hailemariam et al. (2017) in Ethiopia. The 50 people recruited into the study consisted of 17 people who were receiving medical treatment at the time of conducting the study. Another 10 people who had never accessed mental health facilities were included, 12 individuals who had stopped utilising mental health services, and 11 health professionals were included, to provide more understanding. Of the 39 service users, 22 were women. Hailemariam et al. (2017) found that the geographical location of the mental health hospital, poverty, inconsistent supply of medication, and the duration of mental illness as challenges to accessing care. The inclusion of people with mental illness at different stages of utilising mental health services illuminated the findings. The study design method also allowed participants to freely express their opinions. However, the study excluded people who did not speak the Ethiopian national language (Amharic), so the experiences of the excluded group could have provided additional information.

The aim of Iseselo & Ambikile (2017) in Tanzania was similar to Hailemariam et al. (2017). An in-depth interview was conducted with 11 individuals with mental illness while, the authors used focus group discussion with seven health workers relating to their perspectives about mental health service provisions. The findings of Iseselo & Ambikile (2017) were consistent with Hailemariam et al. (2017). Iseselo & Ambikile (2017) participants reported irregular supplies of medication in government hospitals. The high cost of medication in private pharmacies was discovered to make it difficult for participants to maintain treatments. Though nurses were included in the study, more information about the situation may have been provided if psychiatrists or pharmacists were interviewed. Secondly, the study was conducted in one region, research may have produced different findings in other districts of the country. In

addition to a shortage of medication supply, the study of Kisa et al. (2016) with 77 service users in three low-income countries (Liberia, Nepal and Uganda) discovered other factors contributing to poor access to medical treatments. Findings of the multi-site study included stigma, poverty, and lack of social support from families. Furthermore, participants reported distance to hospital, overcrowding, and health workers unfriendly behaviour as barriers to seeking treatments (Kisa et al., 2016). The study was concluded with the recommendation that health providers should address the barriers identified by the participants to improve the services. The three countries were located in the southern region, so different findings may be discovered in different areas of low-income countries with different settings. Nevertheless, the study of Kisa et al. (2016) highlighted the challenges experienced by participants in accessing care.

The findings of a qualitative study of Memon et al. (2016) were different from other studies (Hailemariam et al. 2017; Iseselo & Ambikile, 2017; Kisa et al., 2016). It examined the challenges experienced by individuals with mental illness in receiving medical care. In England, Memon et al. (2016) conducted focus group discussions with 26 participants (13 men and 13 women) from black and minority ethnic groups. Language created a communication problem between participants and their service providers, causing a potential barrier for participants to access information about services. Memon et al. (2016) found cultural factors as another barrier to utilisation of medical care. First, it was difficult for the participants to agree that they had a mental illness. Secondly, participants' choice of health professionals meant they spent a long time waiting for medical treatments. The value of Memon et al. (2016) research was that health professionals in England were called to understand the culture and values of the minority groups to improve their access to health care. However, the study included people from different ethnic minority groups, and challenges associated with the specific group were not explored. The findings may not have represented the views of everyone in the focus group discussion.

<u>Strengths and limitations of the review</u>

It is necessary to consider the strengths of this review. It incorporated the experiences of women with mental ill-health from a variety of backgrounds and circumstances. It included studies from different methodological approaches to have comprehensive information about women's experience of mental illness. The review of the 34 studies provided an understanding of women and mother's experiences of mental illness. The use of systematic methods to identify and select reviewed studies enhanced the transparency and rigour of the integrative synthesis. All included studies were of high or medium methodological quality, there were no

studies assigned to category C. However, some of the qualitative studies did not provide enough details in relation to researcher reflexivity which is important in qualitative research. Furthermore, the studies varied according to the demographic details provided, which limits the extent to which findings of the integrative synthesis can be applied to different ethnic or social groups.

Evidence gap

The findings covered many areas of women's experiences of mental illness such as meaning and interpretation of mental illness, how it affected their lives, coping strategies and challenges experienced in accessing treatments. Studies in Nigeria have contributed to the experiences of women with mental illness in general, such as the quantitative study of Afe et al. (2017) that investigated the risk factors for IPV among women with mental illness. The cross-sectional survey study of Ibrahim et al. (2016) examined the experiences of stigma and the mixed design study of Makanjuola et al. (2016) explored how mental illness is perceived by persons experiencing it.

The review identified a gap in the research literature. Afe et al. (2017) narrowed the study to the experience of IPV only, while the study of Ibrahim et al. (2016) was designed to only consider the stigmatisation experience among women with mental illness. Makanjuola et al. (2016) limited the study to how men and women with mental illness perceived the causes of their illness. However, none of the studies examined their participants' needs or perceptions of mental health services. The findings of the review showed a gap in the knowledge of mothers with mental illness in Nigeria. There are many mothers in Nigeria who exist in a state of persistent tension with their mental illness. It is important to understand their experience, in order to know how it is similar or different from mothers with mental illness from different settings. Therefore, a new study is needed to fill the gap in the literature relating to the experiences of women and mothers with mental illness in southwest Nigeria.

The current study

The current study was set to fill the gap of knowledge concerning the experiences of women and mothers with mental illness. This study will reflect on the different aspects of women's life to have a deeper understanding of their experiences. Qualitative methods will be used in order to achieve a good comprehension of women's experiences. The current study will use the qualitative method because it will produce unanticipated insights into women's subjective experiences instead of using predetermined answers. Findings from the study may be helpful to create a supportive environment for women with mental illness in Nigeria. It will contribute

to the cumulative knowledge about women and mothers' experiences of this condition. This study will be a two-phase project with the first phase centred on women's experiences of mental illness. The second phase will examine mothers' experiences of mental illness and the care of their children. Collecting data for women and mothers with mental illness separately will help to explore the experiences of the two groups of women in detail. As stated in chapter one pages 29-30, the objectives of the current study will be to understand from participants' view the meaning of living with mental illness, their unmet needs (if there are any), and views about mental health services provision. Experiences of mothering with mental illness will be explored in phase two of the study, which will include how the mothers' illness had affected their family especially their children.

Summary

Findings revealed that women with mental illness have knowledge about their illness which includes circumstantial factors and spiritual beliefs in addition to biomedical descriptions. Likewise, they have different ways of coping with their illness. It was discovered how mental illness placed additional burdens on mothers in performing their motherly responsibilities for their children. The analysis of the reviewed studies showed the gap in knowledge in the area of women and especially mothers with mental illness in Nigeria. The current study was designed to fill the vacuum created by the paucity of research studies on the lived experiences of this group of women. The next chapter will look at different approaches for conducting a research study and will choose the most appropriate method for the current study.

Chapter four – Methodology

This chapter four provides explanations of ideas about knowledge, reality, truth and how these ideas can be examined through different epistemological and ontological perspectives. Then it highlights the differences between qualitative and quantitative approaches and justifies the methodological approach adopted for the present study. It also discusses the origin of phenomenology by also describing how it became a widely accepted approach of conducting qualitative research studies. The methodology section first discusses the differences between the two phenomenological approaches (descriptive and interpretive) and then describes the present study within the interpretive existential hermeneutic approach. This chapter is concluded by stating the chosen method of data analysis and its suitability with the adopted interpretive approach used to conduct the study.

Research paradigm

In research, the paradigm is explained, as the philosophical assumptions and principles that guide the understanding of researchers about the world in which they live. It provides the guidelines on the type of study to be conducted, how to carry out the study, and the method for interpreting the study (Denzin and Lincoln, 2000; Lincoln, Lynham and Guba, 2011; Mackenzie & Knipe, 2006). As defined, paradigm is "*a way of thinking about and making sense of the complexities of the real world*" (Patton, 2002, p. 69). Epistemology and Ontology are explained in terms of people's idea about the world and how their worldview influenced by what they believe as reality (Creswell and Clark, 2011).

Epistemology is the method of obtaining knowledge about the world, it is a way of establishing understanding about a phenomenon and to what extent people can claim that knowledge (Bryman, 2016). Willig (2013) explained it as "*the nature of knowledge itself, about its scope and about the validity and reliability of claims to knowledge*" (Willig, 2013, p. 4). Whilst epistemology is about the understanding of the world, ontology concerns the study of being and existence (Mills & Birks, 2014), that is, "*what reality exists out there*" (Harper and Thompson, 2012, p. 87). There are many world views (like positivism, post-positivism, interpretivism and pragmatism) that can be used for obtaining knowledge about a phenomenon (Gray, 2016; Kaushik and Walsh, 2009; Schwandt, 2007). This study is limited to the discussion of positivist and interpretivist worldviews of structuring and organising the research.

The Positivist epistemological stance concerns the study of natural science (Bryman & Bell, 2015; Silverman, 2010). It provides the basics of how many quantitative research methods such as questionnaires, surveys, experiments are used to generate knowledge (Petty et al., 2012; Tolley et al., 2016). Positivists believe in an objectivist idea of reality; they have the opinion that the objective method is the only way to establish a fact. They emphasise that "*the external world itself determines, absolutely, the one and only correct view that can be taken of it, independently of the process or circumstances of viewing*" (Kirk &Miller, 1986, p. 14).

The second epistemological perspective is interpretivism (constructivism) which uses qualitative methods to gain knowledge of social phenomena. Interpretivism is linked to a relative ontological stance. It rejects the idea that truth can be achieved by only objective methods and independent of human consciousness (Dowling, 2007; Gray, 2016). The reality that can be gained through objective methods is advocated by positivists. Interpretivists argue that meaning and interpretations given to an event by human beings, comes from their consciousness (as immanent from human beings) rather than the "*out-there-ness*" asserted by positivists (Willig, 2013, p. 4).

Quantitative methods are guided by a realistic ontological perspective. People who hold the realistic view of the world are of the opinion that truth can be gained from only a single version, by obtaining knowledge which is through scientific methods only (Silverman, 2010). On the other hand, interpretivists share the relativism perspective. They argue that multiple understandings of a phenomenon exist, and they can be achieved through different methods (Sarantakos, 2013). Relativists claim that people perceive and experience the same phenomenon in different ways, hence, more than one perspective of an event can be made (Laverty, 2003; Willig, 2013). Positivists use objective methods to conduct an inquiry of a phenomenon. They produce data that can be measured for accuracy, and to represent large populations (Sarantakos, 2013). On the other hand, interpretivists are concerned with understanding, meaning, interpretation of an event, its effects on people's lives, and to have knowledge of individuals' actions and behaviour arising from their experiences (Silverman, 2010). To have this deeper understanding, interpretivists look beyond the data but seek to relate experiences within an individual's culture and society (Lincoln et al., 2011).

Quantitative methods are used to produce knowledge on the basis of knowledge that is known, it could be about trends in world population fertility, morbidity and mortality, and other events (Bryman 2016). Yet, a deep understanding of people's experiences, actions and health behaviour is still missing. Because of highly standardised tools and the measurable terms with predetermined questions and responses used in quantitative research designs, it limits the scope of the research (Tolley et al., 2016). However, interpretivism's epistemological position

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have turned away from positivist concepts to provide the foundations upon which qualitative research methodologies have evolved. Interpretivists disagree with the idea that objective methods are the only way of achieving reality. It is stated that multiple realities exist and unlike quantitative methods, the subjectivity of people while experiencing a phenomenon could be recognised (Mills & Birks, 2014). Relativists believe in more than one version of reality because the experience of a phenomenon varies, depending on the environment and the position of individuals experiencing the event (Schmidt, 2018). They state that:

> "If there are always multiple interpretations of reality that exist in people's minds, then there is no process by which the ultimate truth or falsity of the constructions can be determined" (Polit & Beck, 2008, p.15).

The aim of this study was not to quantify relationships or to test hypothesis but to holistically explore the experiences of women living with mental illness. To achieve a deeper understanding of the topic, the lived experiences of the participants will be investigated. The present study will take an interpretive epistemological stance that seeks an understanding of an event from people's perspectives. This study is located within relativism ontological positions which says that experience is subject to multiple interpretations, not just a single truth. I believe that women in the southwest of Nigeria may experience mental illness differently than the women living in other parts of the world because of different social settings and resources available to manage the situation.

Adopting interpretive methodology will enable research participants to construct their own accounts of reality that they experience within a given culture and time. The research design that aligns with interpretive and relativism perspectives is a qualitative approach. The qualitative method which is associated with interpretivism is a bottom-up approach, where broad understandings of a phenomenon are gained from individuals' views and subjective meanings (Creswell and Clark 2011). In qualitative research design, new understandings are derived from the individuals who have knowledge of the phenomenon, because of their experiences they perceived from the events and as there is no prearranged response by the researchers.

Qualitative approaches

There are different approaches in qualitative methodology such as ethnography, grounded theory, and phenomenology (Bryman, 2016; Gray, 2018). Ethnography is well-suited for anthropological studies as it seeks an understanding of the experience of a group of people in a community, rather than the individual's experience (Hammersley & Atkinson, 2007; Wall, 2015). Ethnography provides greater insight into people's way of life such as language, culture, values, specific religious practice, even protests or natural disasters (Hammersley &Atkinson, 2007; Jerolmack and Khan, 2014; Murchison & Coats, 2015). This qualitative

approach (ethnography) was considered inappropriate for the present study, because the aim was to examine the individual experience of mental illness, but not to provide records of social events in a community.

Grounded theory (GT) is another qualitative methodology that was considered but not chosen because of the sampling method. Though researchers started with purposive sampling at the initial stage by using GT, this was changed to theoretical sampling as the data collection progressed to analyse the views of the people (Corbin and Strauss, 2008). Recruiting participants to a grounded theory study ends only when data saturation is reached (Sbaraini et al., 2011). In the GT approach, researchers start with few questions and then later additional interview questions are developed for the analysis of data (Charmaz, 2001; Chun-Tie, et al., 2019). Other variations of GT methodology that supports the knowledge of pre-existing literature has been developed (Charmaz, 2014; Corbin and Strauss, 2008), but the review of existing literature before data collection was not supported by Glaser and Strauss (1967). As stated by Glaser and Strauss who proposed the grounded theory, "*an effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study*" (Glaser and Strauss, 1967, p. 37). Existing literature was reviewed at the beginning of this study to get foreknowledge of the subject area and to understand where new knowledge is needed. Secondly, an interview guide was developed before data collection to provide structure during the interview process. Thus, GT was counted as unsuitable for the present study.

After the non-suitability of ethnography and GT approaches, I considered phenomenology. This is a qualitative approach that concerns people's understanding of a phenomenon (Dowling, 2007; Grbich 2013). The theoretical sampling that is peculiar to GT is not necessary in phenomenological studies. Conducting phenomenological research is not limited to gaining the understanding of people's feelings but requires the researcher to engage with the research participants and understand their views and social situation. It is about what is important to participants in a particular situation and sometimes they may have ways of getting out of the situation (if it is unfavourable one) or may need support. These are the features that make a phenomenological study of great importance while making the voices of the less privileged heard (Sloan & Bowe, 2014). Phenomenology values the prior knowledge of existing literature (Drake, 2010) and my prior understanding about women's experiences of mental illness have a great impact on this study. The methodology allows research questions to be designed before the commencement of the interview. Phenomenology is considered the most appropriate approach to achieve a comprehensive understanding of the study participants' experiences because it acknowledges the individual's subjective experiences and opinions (Davidsen, 2013; Lopez & Willis, 2004). Compared to ethnography that seeks the collective experience of people in a community, the phenomenology enables researchers to explore the

individual experience of research participants. This study is guided by phenomenological principles, because the approach recognises the subjective lived experiences and opinions of the people who are being investigated.

<u>Phenomenology as a chosen methodology</u>

Phenomenology originated to reject the scientific method of presenting human experiences (Smith, 2013). The structure of experience involves '*intentionality*', which means, being consciousness of something (Roche, 2013, p. 1). Brentano (1874, cited in Roche, 2013), described intentionality as, '*inner perception'*, which is, human beings consciously directing their intention to objects around them (Roche, 2013, p.1). As explained by Brentano (1874), the object can exist in physical or perceived in our minds from consciousness. Whilst physical objects can be seen and touched, mental objects exist in people's minds, and human beings have the mind to describe, judge and react to the object they perceive. According to Brentano, phenomenology can be used to complement scientific methods when it comes to the human experience because:

> "There exists a world of people, whose distinguishing characteristics include the 'possession' of individual consciousness. There exists a world of numerous subjective unities of experience, called Selves or Persons" (Roche, 2013, p. 6).

Husserl was concerned that social events were investigated independently, without the people experiencing the phenomena. This prompted him to propose an approach for exploring '*things as they appear*" to people in their consciousness not as measured in the scientific method (Smith 2013, p. 20). Husserl's phenomenological philosophy was influenced by Brentano's '*intentional inexistence'* idea (Kaufer & Chemero, 2018, p. 18). In *Logical Investigation*, Husserl (1900, 1970) described intentionality as a process where a person purposefully directs his attention on the matters of study. According to Husserl, it is phenomenology that unveils the feelings and thoughts that happen inwardly (Cilesiz, 2010; Van Manen, 2014). There are two classical distinguishable practices in phenomenology, one of them is transcendental phenomenology, which is a pure description of lived experience as proposed by Husserl and interpretive, which is about interpretations of experience as proposed by Heidegger (Davidsen, 2013; Lopez and Willis, 2004).

Transcendental (Husserlian) phenomenology

Husserl's phenomenological philosophy is based on a reflexive method, which is about the pure description of people's experiences (Matua & Van Der Wal, 2015). It explores an event from the perspective of people who experience it (first-person account), to offer accounts of "*time, body, space and relations*", as experienced by the people who are affected by the phenomenon (van Manen, 2014, p. 71). His aim was to understand experience within its primitive origin, without interpreting or theorising it. To achieve a pure description of an experience, Husserl said the evidence must be from immediate experience:

> "Since I am striving toward the presumptive end, genuine science, must neither make nor go on accepting any judgment as scientific that I have not derived from evidence, from experiences in which the affairs and affair-complexes in question are present to me as they themselves" (Husserl, 1999, p. 130, cited in Van Manen, 2014, p. 89).

From Husserl's point of view, how the object is consciously perceived, and the meaning derived from the lived experience (Erlebnis) are of potential interest (Van Manen, 2014). For further illustration, Husserl called what is experienced in consciousness noema and the act of perceiving the object as noesis (Moustakas, 1994). For example, in the present study, the mental illness experienced by the study participants can be referred to as noema and the experience of having a mental illness as noesis. The subject who consciously perceived the object does not occupy a principal position in Husserl's descriptive phenomenology (Grbich, 2012). This was made manifest in his famous phrase, "*the things themselves*" (*zu den Sachen*) and the development of transcendental phenomenology (Langdridge, 2007, p. 16). In Husserlian transcendental phenomenology, the main idea is to give a reflective account of experience (Earles, 2010; Plotka, 2011). A situation where a person transcends his or her subjectivity (transcendental 'I') to reflect on experience that was retrospectively perceived. This method of presenting an experience was described as "*God's eye view*" (Langdridge, 2007, p. 16).

To achieve the required level of reflection necessitates the process of bracketing, also known as *epoche*. Husserl offered the epoche as a method of describing an experience without interpreting it, as we cannot interpret what was given but describe it (Chan, Fung and Chien, 2013; Moustakas, 1994). Phenomenologically, epoche means to put aside all presumptions about a phenomenon and focus on the data. He claimed that researchers should suspend their misconceptions about the phenomenon. Rather than introducing their preconceived ideas, they should remain open and sensitive to the data. Through this method, they can gain new understanding by allowing meaning of the experience to naturally emerge (Moustakas, 1994).

It means that as a researcher, I must apply epoche by suspending all my pre-understanding about mental illness and remain open to research participants' experiences. Through this openness, I can gain insights into the pre-reflective meanings of participants' experiences. To achieve epoche, Husserl introduced three essential elements: "*reduction, horizontalization and imaginative free variation*" (Langdridge, 2007, p. 18).

As proposed by Husserl, phenomenological reductions mean that researchers should faithfully concentrate on what is given and accept it as the participants' experience of the phenomenon. Further, Husserl (1990, 1970) stated that the whole data should be treated horizontally, that means paying equal attention without undue preference to one part over another. It also signifies that all experiences are significant, and we should not place more importance on only one subject and neglect others, but must understand that every life experience is unique (Creswell, 2014). It is only possible, when a given self-evident is recognised as important and the whole data is examined horizontally that the different elements of the experience and the features associated with it become more visible (Pascal, 2010). As stated by Moustakas (1994), it is "*when one looks with confidence, what one sees will be radically different than when one looks with doubt*" (Mousttakas, 1994, p.71).

Husserl explained that it is possible to create a portrayal of realities, which he described as features that would make the objects being observed and experienced as different from others. He went further by saying the characteristics of an experience can only become uncovered by examining the text, but not by imposing pre-existing ideas (Kaufer and Chemero, 2018). He argued that the purpose of the phenomenological approach is to identify the meaning of people's experiences by studying the structure of the experiences. To him, it is the structure (essence) of how the event happens that makes it an experience, how it is perceived in time and space. The essence of an experience is described by Van Manen as:

> "The essence of a phenomenon is a universal which can be described through a study of the structure that governs the instances or particular manifestation of the essence of that phenomenon... A universal or essence may only be intuited or grasped through a study of the particulars or instances as they are encountered in lived experiences" (Van Manen, 1990, p.10).

He referred to the method of establishing the meaning of experience from the participants' self-evident as "*imaginative free variation*" (Langdridge, 2007, p. 18). In other words, as a researcher, I should concentrate on the experiences as presented by participants to allow the true meaning of their experience to emerge inductively without imposing my own ideas.

Heidegger and other phenomenologists further developed Husserl's ideas, though in a different direction. While Husserl proposed epistemologically that the suspension of pre-existing ideas would produce pure knowledge of experience. Heidegger argued ontologically

that the complete bracketing of preconceptions is impossible because individuals have their standpoints which can be social or historical positions and these features influence people's understanding (Mills & Birks, 2014). Hence, Heidegger moved from the ideas of transcending one's subjectivity to focus on understanding of what is perceived while living in the visible world (Grbich, 2007; Reiners, 2012).

Existential phenomenology (Heidegger's ontological phenomenology)

There are many perspectives that emerged from Husserl's philosophy, because not all of his followers subscribe to his idea of abstraction and reflexive methodology (Gallagher and Zahavi, 2008; Van Manen, 2014). Notably, Heidegger argued that it is impossible to transcend our subjective position in the world in which we are practically engaged. While Heidegger disagreed with Husserl's transcendental ideas, he turned to other existentialists (such as Kierkegaard and Nietzsche). Heidegger stated that humans possess the ability to create meanings of their lived experience and achieve their potential in the world in which they actively occupy (Connelly, 2010). He believed that what is given in the primal realm is an abstraction, but the meaning of an experience is found in the world that human beings practically inhabit, both in body and in mind (Aho, 2014; McConnell-Henry et al. 2009). Whilst the person, who experienced the event was not clearly recognised in Husserl's transcendental phenomenological stance, individual position in the world became the main principle of Heidegger's (1927/1967) phenomenological standpoint. Heidegger used the term "*being-in-the-world*" (*in-der-Welt-sein*) to state that it is impossible to abstract ourselves from the world in which person's live (Alvesson and Skoldberg, 2000, p. 80). Instead, he believed individuals' realities are invariably influenced by the things taking place in their environment (Polit, 1999; Reiners, 2012).

Heidegger focused on experience as it is existentially present, from description to interpret and understand the experience (Finlay 2008; Grbich, 2007). He had the opinion that human beings are capable of interpreting and giving meaning to any situations that they experience and have knowledge of how it affects the context in which people operate (Gray, 2016; Wojnar and Swanson 2007). Therefore, interpretive phenomenological research is conducted to have experience of people who actually experience a phenomenon of interest which makes the research findings rich and detailed (Healy, 2011). For example, women suffering from mental illness will explain their illness in the way they understand it and how it affects them as women or as mothers.

Again, Heidegger challenged Husserl's belief of suspending one's pre-existing ideas to have a new and unbiased understanding of a phenomenon. Heidegger stated that it is practically

impossible to bracket one's foreknowledge about an event. He argued further that people always speak from an ideological position (McConnell-Henry et al., 2009). He believed that a comprehensive understanding of a phenomenon can be achieved when it is examined in relation to individuals' historical and cultural positions (Laverty, 2003; Reiners, 2012).

This notion was emphasised by Spector who stated:

> "We learn from our cultural and ethnic backgrounds how to be healthy, how to recognise illness, and how to be ill. Furthermore, the meanings attached to the notions of health and illness are related to the basic, culture-bound values by which we define a given experience and perception" (Spector, 1991, p. 49).

Culture provides a basis for the expression of beliefs about shared identity, it provides unique traditions and expressions (Kevin et al., 2019). Individuals growing up in a culture learn acceptable ways to behave and function in their culture. Therefore, meanings and response to events will be influenced by the environment in which people live.

In *Being and Time*, Heidegger (1927/1967) discussed the fundamental existential features that are peculiar to all human beings. For self-understanding of situatedness in the world, Heidegger used the term '*Dasein*' to represent man (Langdridge, 2007, p. 15). Being (man) that is 'here', is not in the primal realm as proposed by Husserl, but in the one that is immersed in the 'world' where Dasein interacts with other people and contributes to his physical environment (Van Manen, 2014, p. 111). Dasein existential features as presented by Heidegger are: "*temporality, facticity, mood, being-towards-death, care, authenticity and being-with*" (Langdridge, 2007, p. 23). In the present study, Dasein represents the participants' lived experiences. It means I must be open to their accounts of reality and understand the experience from the participants' perspectives.

According to Heidegger, Dasein existence is of little time (temporal), the existence that includes the past, present and the future. Though Dasein's existence is in 'now', as he is aware of his presence, he also has the knowledge of his past. He links the past and the present together to foretell what the future will hold (Polt, 1999). It is stated by Reker and Wong (2012) that: being-in-the-world is "*fully experiencing the meaning of the movement in the here and now and having an acute awareness of what is possible in the future*" (Reker and Wong, 2012, p. 387). For example, a woman with mental illness can examine her life before her diagnosis, so look at her present situation (the mental illness and lost opportunities). Considering her present ill-health condition and available resources (support and good health care) she can predict whether her life aspirations before mental illness can be achievable in the future.

Heidegger proposes that Dasein lives in the world that he did not create and which he cannot control, because he was "*thrown into existence at birth*", and neither does he have control over his past because his existence has been predetermined (Langdridge, 2007, p. 23). Heidegger stated further that Dasein cannot be freed from his past, his choices are influenced by his pre-determined existence (Crowell, 2004; Harper & Thompson, 2012). For instance, at birth, human beings have no control over their ethnic group, gender, or family to which they belong. Yet, the past (historical background) influences life choices. This was referred to as facticity in Heidegger's ontological philosophy (Kaufer & Chemero, 2018).

It is inescapable that Dasein's existence will come to an end. Heidegger explained this feature by using the phrase "*being-towards-death*" (Langdridge, 2007, p. 18). This is the reality that Dasein will need to accept (authenticity) because his existence in the world is temporal and inauthentic (Polit & Beck, 2010). While in the world, Dasein experiences different challenges that may cause anxiety. It could be anxiety about his limited existence, ill health or as a result of his encounter with other beings in the world which he inhabits – "*being-in-the-world-with-others*" (Langdridge, 2007, p. 23). Amid life's adversities, there are some points that Dasein's shifts focuses from the things that create fear (angst) to care for things that bring him happiness (Polt, 1999; Schear, 2013). Relating it to the present study, suffering from mental illness is part of the challenge that the present study's participants experienced because of their existence. Their mental health problems can create unpleasant moments in their interactions with other people in community. As Dasein has relaxed moments from anxiety, many women with mental illness engage in other things that give them comfort, such as having children, as motherhood gave them happiness and a sense of responsibility (Bartsch et al., 2016; Connerty et al., 2016; Hine et al., 2019). Heidegger's existential phenomenological perspective was further developed by other phenomenologists, such as Merleau-Ponty, who provided a distinctive way of examining and understanding lived experiences.

Merleau-Ponty (1962) – Phenomenology of perception

In his Phenomenology of perception, Merleau-Ponty (1962) shared both Husserl and Heidegger's idea of understanding lived experience. As a phenomenologist, he echoed the views of Husserl that scientific methods cannot give comprehensive understanding and meaning of people's experience compared to what can be achieved when a qualitative approach is used (Merleau-Ponty & Landes, 2013). Rather than subscribing to the transcendental idea proposed by Husserl, Merleau-Ponty believed in the embodied nature of human existence that involves practical activities and relations (Anderson, 2003; Langer, 1989). His phenomenology of perception focused on subjectivity and embodiment, explaining that individuals experience a phenomenon according to their embodied position in the world. This idea was developed from Heidegger's view of being-in-the-world, stating that people exist

in the world in body-subject where the body serves as a means of communicating with the world (Marshall, 2008). He explained further the primacy of our own individual situatedness in the world (Morris, 2012; Romdenh-Romluc, 2010). That is, the experience of mental illness is personal to the current study participants who are living with the illness. While it is possible to show empathy to the women who experienced the illness, it is impossible to share their experience because it is personal to their body-subject.

Locating the study within the existential phenomenological perspective

Human beings exist in the world in which they find themselves rather than in the abstract entity or realm stated by Husserl. Existential phenomenology is particularly suitable for exploring human experience as it is lived in the real world. It will produce knowledge about the subjective experience of research participants (Harper and Thompson, 2012). I locate the present study within Heidegger's existential-phenomenological perspective because the research participants physically live in the world, not the primal realm as explained in descriptive phenomenology (Polt, 1999; Quay, 2016). Husserl's phenomenological idea is based on reflecting what is given through intuition in consciousness, but from Heidegger's perspective, when a person is actively passing through a situation it cannot be reflected because the situation is taking place 'now' and the circumstances are present 'here', Husserl's phenomenological idea is about recollecting past experience (Van Manen, 2014), Heidegger's lived experience is centred on the individual's present life situation (McConnell-Henry et al., 2009). Additionally, the focus of Husserl's methodology is only on the 'the things themselves' and the person who experienced the phenomenon was not recognised. By assuming the existentialist position, I acknowledge the subjective position of my research participants and reject the transcendental claim of Husserl. I argue that it is impossible to describe an experience without reference to the experiencing person. The research participants whose experience of mental illness I explored, were my starting point. Without the research participants, new knowledge on the subject being examined would not be achievable. Furthermore, the lifeworld (*Lebenswelt*) we live every day with other '*selves*' (Thiselton, 2009, p. 32) was not recognised in transcendental phenomenology. In existential phenomenology, relatedness is considered as a fundamental feature of human beings. Using Heidegger's term, "*being-in-the-world-with-others*" (Landridge, 2007, p. 31), it means women with mental illness do not live alone but in a social world with other persons around them. By the virtue of their interaction, the actions or behaviours of others will have an effect on the participants' life.

Hermeneutics

Hermeneutics (*hermeneuin*) is a word in Greek language that means to interpret or understand (Connolly & Keutner, 1988; Crotty, 1998; Palmer, 1969). It is located within the interpretive existential phenomenology. It is an approach for discovering the hidden meanings of people's experiences in relation to their social situations (Dowling, 2007; Streubert and Carpenter 2011; Thiselton, 2009).

It was first used in the 17th century in ancient Greece by Hermes to translate the words of the gods to people in a way that human beings could understand (Caputo, 1987; Moules, 2002). It was also used for the interpretation of Torah (Bible) by Jewish religion teachers also known as Rabbi (Apel, 1980; Dohrmann and Stern, 2008; Punt, 1996). Hermeneutics was later developed as a theory to understand and interpret texts by Schleiermacher (1768-1834). Understanding of texts as stated by Schleiermacher involved two aspects, grammatical and psychological interpretations (Guignon, 2002; Huang, 1996). He explained that the understanding of text could be understood by the language (grammar) used by the author or speaker. Different from grammatical interpretations, Schleiermacher explained the psychological interpretation as a mental reconstruction of experience. He went further that psychological interpretation involved placing oneself imaginatively into another person's position in order to understand the person's experiential world (Prasad, 2002). Dilthey (1833-1911) continued with Schleiermacher's work to develop hermeneutics to epistemology as a way of providing understanding to human experiences.

Husserl extended his philosophy to how language is used by people to describe their feelings about an experience. Thus, he stated that language is a tool that is used by people to describe their feelings and engage with others. This aspect of Husserl's philosophy was considered by Heidegger towards the later part of his philosophy (Daidsen, 2013). Heidegger's philosophy on the understanding of texts was further developed by Gadamer and later by Smith (Moran, 2000).

Gadamer's hermeneutics phenomenology

Gadamer was one of the great philosophers of his time whose work on interpreting human experiences was influenced by the ideas of great thinkers such as Schleiermacher, Husserl and Heidegger (Henriksson et al., 2012; Van Manen, 2014). As initiated by Husserl, Gadamer shared the opinion that scientific methods cannot reveal the meaning of people's experience. However, he rejected the transcendental perspective of Husserl's philosophy and aligned with Heidegger's idea of experience as it actively lived in the social world (Healy, 2011; Van Manen,

2014). Gadamer believed that the understanding of human experience is more than describing the essence of what is consciously known, as claimed by Husserl, but also to search for meanings that are embedded in everyday life (Agrey, 2014). While Schleiermacher applied hermeneutic only to the understanding of texts. Gadamer extended the textual hermeneutics to human experience also (Agrey, 2014). He developed modern hermeneutics following Heidegger's ideas of understanding the human experience in relation to their historical and cultural context (Healy, 2011; Jensen, 2008). Hermeneutic phenomenology is described as an approach and a philosophy (Dowling, 2007; Van Manen, 1990).

In *Truth and Method*, Gadamer (1900-2002) highlighted the importance of language, dialogue, prejudice and tradition in understanding human experiences (Laverty, 2003). Gadamer emphasised the importance of language (both verbal and non-verbal) which is the means by which human beings manage their social lives and create their symbolical existence (Alvesson and Skoldberg, 2009). It is used to express feelings, give meaning, and provide an understanding of a phenomenon (Gadamer & Linge, 2008). Thus, he postulates that "*Being that could be understood is language*" (Boroditsky, 2011, para 2). According to Gadamer, the understanding of experience contains the three aspects of time: the past, present, and future (Healy, 2011). He indicated that truth is not relative to a particular period or culture, but different meanings of reality are revealed during different time or cultures (Flood 2010; Neubauer et al., 2019). He explained that it is the language that provides the understanding of meanings and interpretations of experience in participants' realities of time and culture stated by Alvesson and Skoldberg (2009).

Gadamer agreed that one must remain open to a text, the meaning of the text in the person's social-historical existence is very important (Healy, 2011). Heidegger had pointed out that human beings exist in the world in which one finds oneself, that is being thrown into the world. Gadamer used the concept *facticity*, an element of human existence, coined by Heidegger to explain how understanding could be achieved through culture and historical position (Landgridge, 2007). Gadamer was of the same opinion as Heidegger, Gadamer stated that it is impossible to forget one's preunderstanding as claimed by Husserl because the knowledge is deeply embedded in historical consciousness (Van Manen, 2014). Tradition is the historical authority that pervades and influences our thinking and behaviour (Van Manen, 2014). He went further to state that a person who experienced an event has previously understood (universal knowledge) the phenomenon of it from historical, cultural, and social background (Lopez & Willis, 2004; Wright, 2000). Likewise, researchers are embedded in historical, social, and environmental contexts that shape the questions they ask, as well as the interactions between themselves and those engaged in their research (Willis, 2007). Gadamer advised

that researchers should conduct phenomenological studies to interpret the meanings of subjects under study in relation to the social environments, in which the study is conducted. Though Gadamer stated that pre-understanding guides the understanding of an event, but not to prevent one from understanding the meaning and significance of the phenomenon (Van Manen, 2014). Rather, he advocates for 'unbiased prejudice' (vorurteile) by saying: "*the prejudices, of the individual, far more than his judgements, constitute the historical reality of his being*" (Gadamer, 1962, in Thiselton, 2009, p. 218). As a researcher, my pre-understanding should not be an obstacle from understanding participants' experiences, but the use of cultural resources is to deepen my understanding of the quality, texture and meaning of living with mental illness for those who are undergoing that experience. Gadamer was of the opinion that the awareness of one's history, culture and understanding of the text constitutes the "*fusion of horizon*" (Crotty, 2003, p.101). Thus, the 'fusion of horizons' can be explained as "*the totality of all that can be realised or thought about by a person at a given time in history and in a particular culture*" (Clark, 2008, p. 58). That is, history and culture together with consciousness influence human understanding, the idea that the past and the present are constantly intermingled to shape an individual's understanding (Austgard, 2012; Gadamer & Linge, 2008).

In hermeneutics, generating new knowledge does not take a mono-logic stance as in the positivist approach, but through dialogue among people with mutual agreements (Thiselton, 2009). The researcher was involved in a conversation with participants in order to step into the participants' meaning fields to understand an experience from their own point of view (Fleming, Gaidys & Robb, 2003; Trevithick, 2005). The conversation starts from the researcher's pre-understanding and her situated meaning, is transformed during a dialogue with an experiencing person as explained by Alvesson and Skoldberg (2009). Researchers ask questions from their preunderstanding while participants respond from their positional knowledge as experienced individuals. As the research participants expressed their views, the researchers also broaden their understanding of the phenomenon as they question and re-question their existing knowledge (Henriksson et al., 2012; Neubauer, Witkop & Varpio, 2019). Participants' accounts of their realities may challenge and transform the researcher's preconceived idea to increase the understanding of the phenomenon that the researcher may possess (Henriksson et al., 2012). It suggests that meaning-making, within the hermeneutic method, requires the researcher and participants' shared perspectives about the subject which is being investigated. The so-called fusion of horizons occurs from the researcher's pre-understanding and the participant's experience of the phenomenon in question (Langdridge, 2007).

In relation to the text, the researcher starts by reading and questioning the text, listening to it in a dialogue form (Alvesson and Skoldberg, 2009). This process is performed by reading the whole text repeatedly, understanding of the whole text will provide meaning to small parts. These meanings of the small parts can be understood by referring to the whole text. In this way, there is no true starting point where understanding can be developed. Understanding the whole subject involves the understanding of small parts and the whole only from small parts. This part-whole relationship is known as a hermeneutic circle (Alvesson and Skoldberg, 2009; Streubert and Carpenter 2011). As explained: "*to understand any given part, you look to the whole; to understand the whole, you look to the part*" (Smith, 2009, p. 28). Though this notion was challenged by Palmer, who stated, "If we must grasp the whole before we can understand the parts, then we shall never understand anything" (Palmer, 1969, p. 87). He believed that the process of understanding goes beyond logic and analysis in some essential respect, "intuitive and divinatory" (Palmer, 1969, p. 87). However, the dialectic between the small and the whole is crucial because useful information for understanding the meaning of the experience can be obtained through the process. The meaning of the experience is revealed through the language used by participants and the language that originates from participants' culture (Prasad, 2002). Therefore, a deeper understanding of the text cannot be achieved without reference to its cultural context (Fry 2009; Thiselton, 2009). As the researcher actively engaged with the back-and-forth reading of the text, the meanings of the experience will emerge to remind one's previous assumptions. Likewise, a different perception may emerge to produce a new understanding of the phenomenon (Flood 2010; Gadamer & Linge, 2008).

I adopted Gadamer's hermeneutic phenomenological approach because it allows familiarity with the historical aspects of the phenomenon to adequately understand the text. Methodologically, it enables the interpretation of participants' experiences in relation to their cultural background. Additionally, hermeneutics allow the researcher to broaden their understanding by examining their own prejudice. Likewise, a greater understanding of participants' experiences is provided when it is discussed in relation to their existence in the world. Prior to being a researcher, I have understood mental illness from my social background which is my own horizon. Horizon is something that is flexible, something that can change form one time to another. Engaging in dialogue with participants means that I fused my horizon with that of my participants to enrich my knowledge of living with mental illness by performing the hermeneutic circles. Firstly, my historical understanding of living with mental illness begins to change from the knowledge gained from relevant literature. Conversation with my study participants will transform my inherited preconceptions, and my horizon will change from assumptions to understanding. Reading the text and constant alternation between the part and the whole will increase my understanding as I examine the participants' text by paying

attention to their socio-cultural contexts. Participants' behaviours and the concealed meanings of their experiences will become more visible by interpreting the participants' experiences in relation to their cultural context. Using Gadamer's philosophical ideas will help me to understand how socio-cultural factors can increase the burden of mental illness.

Interpretative phenomenological analysis (IPA)

Interpretative phenomenological analysis (IPA) is a methodology that can be used to understand people's account of a phenomenon and analyse the qualitative texts. The approach was first developed to be used in psychology, as it was argued that psychology is about interpreting and making meaning of the scientific and experiential world. However, the use of IPA has extended to other disciplines (Smith et al., 2009). As proposed by Smith (1996), IPA is about understanding an experiential phenomenon from the first-person perspective in a particular context (Larkin et al., 2008). IPA is existential in focus; it echoes Heidegger's ideas that human beings are actively present in the world as opposed to Husserl's transcendental phenomenological position. Though human existence is temporal, they are in the world with relationships with others. Rather than a descriptive idea proposed by Husserl, IPA shared the interpretive perspective of Heidegger. The idea is that interpretation provides more insight into participants' experience by paying attention to the historical context in which a phenomenon is experienced. It will reveal meaning which may remain uncovered by description (Smith et al., 2009).

The hermeneutics work of Gadamer provided insightful guidelines of understanding text used in IPA (Schear, 2013; Smith et al., 2009). That is, meaning of a text can be made known through the reading of the whole to understand the part, this way the meaning of the whole text will be revealed. Additionally, IPA is concerned with dialogue and language used by participants through which something hidden about experiential phenomena can become known. This links IPA to a hermeneutic stance (Smith et al., 2009). What differentiates IPA from Gadamer's hermeneutics, is the idiographic approach which is peculiar to IPA. IPA is concerned about presenting the experience of a phenomenon case-by-case, that is, analysing an individual text to identify themes, and pointing out the lived experience of each participant. After the examination of each case, the themes derived from each single case are brought together to identify both common and differing themes within the sample. For this reason, IPA is referred to as double hermeneutic (Reid et al., 2005; Smith et al., 2009). IPA studies usually include a small sample size because of the intensity of writing up individual accounts of experiential phenomenon (Shaw, 2010).

IPA was not chosen for the present study because of the small sample size (seven to ten participants) that always involved in IPA studies (Smith et al., 2009). Secondly, the Idiographic approach common to IPA studies made it difficult to use IPA in the present study. The claim for single case analysis in IPA studies is that experience of a phenomenon is uniquely embodied, situated and their meanings are perceived differently by individuals. However, the primacy and uniqueness of an individual's experience are recognised in the present study by conducting one-to-one interviews to collect data for the current study.

Descriptive versus interpretive phenomenology

In a descriptive phenomenological perspective, researchers have to generate knowledge by bracketing presuppositions to achieve a state of transcendental subjectivity (Finlay 2008, Giorgi 2011; Streubert and Carpenter 2011). An in-depth literature review prior to data collection is not encouraged in descriptive phenomenology. (Dahlberg 2006; Wertz 2005). In interpretive phenomenological research, the focus shifts from simply describing to achieving a deeper understanding of what the phenomenon means to those who experience it (Racher 2003, Flood 2010). As stated, "*experience is always more immediate, more enigmatic, more complex, more nuanced, and more ambiguous than any description can do justice to*" (Van Manen, 2014, p. 19). Heidegger argued that it is impossible to suspend one's own pre-understanding because prior knowledge guides the understanding of a given experience (Fitzroy 2012). In contrast to the assumption that pre-understanding distorts research findings (Paley 2005), foreknowledge of a phenomenon is considered to be of great support in gaining a greater understanding of the topic under investigation (Flood 2010).

To Husserl, the ultimate source of understanding is what appears in human consciousness. Thus, he stated: "*the term lived experience signifies givenness of internal consciousness, inward preciseness*" (Husserl, 1964, in Van Manen, 2014, p. 95). However, to existential hermeneutics, what Husserl proposed was an abstraction, they argued that human beings exist physically in the world they inhabit. Existentialists advocate the study of individuals in concrete situations of life. Furthermore, existentialists believed that human beings do not exist alone but in the world with other beings, that is, "*being-in-the-world-with-others*" (Landridge, 2007, p. 31). Therefore, the interaction of Dasein with other beings will have an effect on his existence, what really matters is to study our place in the world. For example, women with mental illness live with other people in the community. Their interaction with friends and relatives will influence their lives, likewise, their quality of life is affected by policies made by their states. Thus, interpretive phenomenologists consider the social-cultural contexts of those who experience the phenomenon, including how those experiences are affected by other beings (Creswell 2014; Streubert and Carpenter 2011).

By purely describing what is given, the researcher's role in descriptive phenomenology is limited in raising awareness of what something is, that is, describing an experience from the first-hand perspective (Matua & Van Der Wal, 2015; Wertz et al., 2011). Conversely, the aim of conducting an interpretive phenomenological study is to discover the taken-for granted meaning of the experiences that are hidden to the world. Likewise, the impacts of the phenomenon on individuals through empathy are also disclosed (Fitzroy 2012; Humble and Cross, 2010).

Despite the differences in philosophies, all the phenomenologists share the same epistemological and ontological positions. While Husserl was concerned about the description of past experiences, Heidegger was interested in experience that is lived through and the features that are inherent to human beings. Heidegger was more concerned about human existence in their social and cultural position. In a new dimension (with the introduction of Dasein) he discussed the fundamental features of human existence that either create happiness or unpleasant feelings. In the midst of different circumstances that surrounded Dasein, he will still have a moment to care for pleasures, interact with others or time when he experiences angst. Similarly, even though women with mental illness may feel more burden with the challenges of their ill health, there are times they would put their illness behind them and take some opportunities (job, marriage and having children). Also, by the virtue of their interaction, actions by others or their own personal deficiencies may remind them of their health situation. Merleau-Ponty expounded the work of Heidegger to explain the subjectivity and embodied position of people in the world. Gadamer's hermeneutic philosophy was influenced by both Husserl and Heidegger's phenomenological perspectives.

Data analysis methods

As it is necessary to design a framework for a research study, it is important to have an analytical method that is appropriate for the study. Coding is a way of identifying words of phrases that illuminate the meaning of the research topic (Creswell, 2014). In qualitative data analysis, different methods of coding exist; for example, the Template Analysis method that uses the deductive and inductive methods to generate themes that give meaning to the phenomenon under study (King, 2004; King & Brooks, 2017). The method is flexible, and suitable to analyse large data. It is also very useful in analysing study within qualitative approaches. In template analysis coding themes are usually arranged in hierarchy (Brooks et al., 2015). This analytical strategy was not used because within a phenomenological lens, all areas of data are to be treated equally without placing more importance on one area over another (Creswell, 2014; van Manen, 2014).

Thematic analysis (TA) is another technique of analysing qualitative studies. It was developed to identify, analyse and interpret words and phrases that give understanding of a phenomenon under study (Braun & Clarke, 2006). There are different versions of TA, the TA outlined by Boyatzis (1998) is situated within a post-positivist perspective (Guest et al., 2012; Joffe, 2011). This version is said to be more used by researchers conducting investigations in the psychology discipline (Akhtar & Boniwell, 2010; Selvam & Collicutt, 2013). The Boyatzis (1998) version of TA was believed not to be appropriate to all qualitative studies because perfect validity cannot be achieved in qualitative research compared to quantitative design (Friedman, 2008), and understanding of human experiences cannot be quantified (Drost, 2011; Polit & Beck, 2010; Kirk and Miller, 1986). Another version of TA was proposed in 2006 by Braun & Clarke. Braun & Clarke (2006) TA approach is flexible and compatible to all theoretical frameworks related to qualitative approaches (Braun et al., 2014; Clarke, & Rance, 2014). The TA developed by Braun & Clark (2013) was used in this thesis because of its flexibility. The flexibility it offers is not limited to the theoretical framework, but includes flexibility in research questions, the sampling method and sample size (Braun & Clarke, 2014). It can be used to analyse small or large interviews, and can reveal both manifestation and latent meaning of an experience.

The compatibility of the hermeneutics philosophy and thematic analysis method

As recommended, the method of analysis must be appropriate and able to support the chosen theoretical framework and the research question (Bryman, 2008; Holloway and Todres, 2003). For this purpose, thematic analysis (TA) was chosen as a method of analysing the interview data because of its appropriateness for the analysis and its compatibility with the hermeneutics methodology. I believe that the two approaches are strong and compatible to provide meanings of lived experiences.

First, both hermeneutics and TA are located within a qualitative approach. The hermeneutics philosophy is an approach that focuses on interpretation of a phenomenon with attention to the background environment of the phenomenon under investigation to unveil the hidden meaning of the experiences (Gadamer & Linge, 2008; Thiselton, 2009). Similarly, thematic analysis is not just about description, but it includes "*the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work*" (Van Manen 1997, p. 78). As suggested, the flexibility of TA allows it to be a useful tool to provide a rich and detailed account of a social phenomenon (Braun & Clarke, 2006).

In the Heidegger philosophy, language is crucial because it is "*the house of Being … in which the manifestness [Offenbarkeit] and the power of revelation [Kundschaft] of the world first of all burst forth and are*" (Heidegger, 1995, p.109). It suggests that language is a medium of communication and means of revealing the meaning of spoken words and recovering the potentiality in the world. This was echoed by other phenomenologists such as Gadamer who emphasised that the language used by participants is important as it reveals the meanings of their lived experience (Gadamer & Linge, 2008; Ho et al., 2017). Likewise, TA seeks to find words and phrases that illuminates the lived experiences in a text (Braun & Clarke, 2006, 2013).

Openness to data when searching for the meaning of experiences is encouraged in the hermeneutics tradition. It is argued that by having an open mind to the data, the invisible aspects of the experience can be made manifest (Dahlberg et al., 2008; McCaffrey et al., 2012). In a similar way, a researcher needs to be attentive and sensitive to the data and must be able to identify patterns that illuminates lived experiences, when using thematic analysis (Braun & Clarke, 2006). The circular movement of back and forth, and the reading of whole and parts of text is peculiar to the hermeneutic approach (Laverty, 2003). This idea needs to be observed to avoid making meanings of an experience rapidly without reflecting and further examining the texts. Also, there is a need for researchers to break the text into small units to familiarise themselves with the data. It will enable easy identification of words that highlight experiences within interview data or across an interview dataset (Braun & Clarke, 2006). Both hermeneutics and thematic analysis allow meanings of experiences to emerge naturally from the data.

Summary

This chapter explained the different epistemological and ontological positions that are used to pursue knowledge. I went further to discuss the theoretical framework that formed the epistemological basis of the study which is a constructivist view. An explanation about the foundation of phenomenology was presented and the reasons for adopting it as the most appropriate methodology for the present study were stated. Different approaches within interpretive perspectives such as hermeneutics and interpretive phenomenological analysis (IPA) were presented. Then I located the study within an interpretivist perspective and the purpose of choosing Gadamer's (1900-2002) hermeneutics phenomenology as the methodology for conducting the present study was demonstrated. The chosen method for analysing the data generated for the study was provided and the compatibility of thematic

analysis with the hermeneutics methodology was explained. The next chapter will look at the methods developed to answer the research question and to achieve the study aims and objectives.

<u>**Chapter Five - Research Methods**</u>

This chapter describes methods available to investigate a research problem and the rationale for the application of specific procedures or techniques used to achieve the study aims and objectives. Different methods of collecting data were discussed and also the rationale for choosing semi-structured interviews. It states the study settings, sample, sampling, and recruitment of participants. The chapter explained the process of seeking approval for the study, it provides the insight into the role of gatekeepers and how access to potential participants was negotiated with gatekeepers. Ethical principles that guided the study are explained, this is followed by the data analytical process. Steps taken to demonstrate the trustworthiness of the study were discussed. Personal experience of engaging research participants in dialogue was highlighted before providing the chapter summary.

<u>**Data collection methods**</u>

This study is situated within interpretive (constructivism) epistemology and the qualitative approach of conducting research. Interpretivists assert that human beings possess the ability to think, express themselves and make meanings of their experiences (Gray, 2016; Porta & Keating, 2008). Further, the qualitative method provides deeper understanding of people's thoughts and feelings that may affect their behaviour because of methods of generating data used in these studies (Flick, 2019; Scott & Garner, 2013). Therefore, it is important to choose a data collection method that will enable participants to talk about their personal experiences in a way that will provide more understanding.

Different methods of exploring participants' subjective experiences of living with mental illness such as focus groups and individual interviews exist in qualitative research design and the two methods can be combined (Bryman, 2016; Flick, 2014; Holloway, 2008). The two research methods (focus groups and individual interviews) can be carried out face-to-face and through online technologies (Hammond, 2018).

Online research methods

Researchers can engage with the participants online at the same time (synchronous) and receive answers instantly by using technologies such as chat rooms, telephone, skype or Zooms (Janghorban et al., 2014; Stewart & Williams, 2005; Stieger & Gortiz, 2006). Participants may not stay online with researcher at the same time (asynchronous) but respond to the research questions at a convenient time (through email). This type of online research method saves the time spent on interview transcription (Bampton et al., 2013; Golding, 2011;

Redlich-Amirav & Higginbottom, 2014). It offers researchers the opportunity to read and reflect on participants' responses and ask for more clarification as compared to when interviews are transcribed after interviews are completed. An online research strategy saves time and money of travelling to collect data (Hammond, 2018; Mann & Stewart, 2000; Wood & Griffiths, 2007). Researchers' safety and wellbeing are protected as they can collect data within the comfort of their homes or offices (Deakin and Wakefield, 2013). People may be more likely to take part on sensitive issues if online methods are used as compared to traditional methods because of anonymity (Bampton et al., 2013).

With many benefits that online research methods offer, they also have disadvantages. There may be technical problems that interrupt the flow of the interview (Deakin and Wakefield, 2013; Nicholas, Lach & King, 2010). Telephones of some of the prospective participants may be engaged or not answered. Some participants may engage in other activities that may affect their level of concentration and disrupt the flow of the conversation (Novick, 2008; Read, 2018). It is easy to misinterpret a participant's response. For instance, the interviewer may feel the silence of participants following a question as a sign that they are not willing to respond to the question; contrarily, participants may be thinking of ways to response to the question (Illingworth, 2006). Participants who feel threatened by research questions or believe that they are being judged can terminate the interview without notice (DiMarco, 2003; Duffy, 2002).

In addition to the aforementioned disadvantages of online research methods, the electricity supply in Nigeria is not reliable. This may give participants difficulty in connecting to online facilities or engaging in long conversation if their phone is not charged (Adebayo, 2015; Choji, 2014; Olowosejeje et al., 2019). Not all potential participants are computer literate which means many people who can provide the good information on the topic under investigation may not be included. Paying a subscription fee before connecting online or buying credit on phone to maintain the line will make participants incur financial expenses which may not encourage them to contribute to the study. Therefore, online methods of conducting the study were rejected and consideration was given to face-to-face focus groups and individual interview methods.

Focus groups method

Focus group is a method of collecting information from many people at one time (Stewart & Shamdasani, 2015; Wildemuth, 2009). This method of generating information demonstrates a notion that meaning, and interpretation of social event is a collective action (Austin & Sutton, 2014; Bloor et al., 2001). It is appropriate for collecting new ideas about a social phenomenon (Chadwick et al., 2008; Hennink et al., 2020). The method saves time and money compared

to individual interviews (Flynn, Albrecht & Scott, 2018; Krueger & Casey, 2014). Information generated from focus groups is rich and detailed because participants can motivate each other to bring forth new ideas and further develop it. They can question each other's opinions to validate what has been stated or to produce new ideas about the phenomenon which is not applicable in one-to-one interviews (Kamberelis & Dimitriadis, 2013; Tolley, 2016). Though many different ideas are generated in focus groups, these ideas may not be well developed compared to individual interviews because participants in focus groups take turns in voicing their opinions (Hennink, 2014; Williamson, 2018). Another problem with focus groups is that even if they are carefully controlled, a few individuals may still dominate the discussion, their views overriding other participants (Barrett & Twycross, 2018; Tausch & Menold, 2016).

The presence of other people can be inhibiting for participants to talk on sensitive issues (Acocella, 2012). It is quite challenging to bring together several participants from different areas to the same location to form one focus group. Therefore, it may be difficult to get enough sample to participate in the study (Greenbaum, 2000; Krueger & Casey, 2014). It is difficult to clearly identify the views expressed by individuals in focus groups, as their own definitive personal opinions about a phenomenon may be different because they may be speaking in a specific context, within a specific culture (Smithson, 2000). Conducting focus groups with vulnerable people (e.g., people with mental illness) is challenging because of their physical and emotional safety; information shared in the group may cause emotional distress to many of the participants (Williamson & Burns, 2014). Focus group discussions lack confidentiality and anonymity because the researcher cannot control information that members may share outside the group (Flick, 2014; Nyumba et al., 2018). Concerns about the safety of participants and lack of confidentiality in focus groups make it unsuitable for the present study.

Interview methods

Interviewing methods enable reciprocity between researcher and participant (Galletta 2013; Polit & Beck 2010). They enable participants to discuss their experiences and help a researcher to develop an understanding of the language used by participants to express their feelings (McGrath et al., 2019). Different types of interviewing methods are available, such as structured, unstructured and semi-structured (Seidman, 2013). Unstructured interviews mean that there is no standard interview schedule to guide the flow of the interview. It may lead to lack of correlation or pattern in the participants' response (Patton, 2015). In this type of interview, the researcher may introduce the topic under investigation and ask open-ended questions for discussion (Rubin & Rubin, 2012). They are useful to generate information where there is little knowledge about a phenomenon (Fontana & Prokos, 2007). The unstructured

interview was not considered because the goal of the present study is well defined, and the interview schedule was designed for the study.

Contrarily, the structured interview has non-flexible research questions to generate data from participants, which means that the interviewer is limited to the interview guide and cannot pursue any interesting issues that may arise during the conversation (Hennink et al., 2015). It is used to complement other methods of data collection, such as observation to provide more understanding about a phenomenon (Gray, 2016). The consequence of strictly guided interview questions is that interviewers are unable to collect rich and useful information on the subject of interest (Merriam & Tisdell, 2016). It was believed that the structured interview method was not appropriate to answer the research question. Thus, attention was shifted to the semi-structured interview.

Semi-structured interview

The semi-structured interview is flexible in design, the flexibility of this interviewing method made it possible for participants to freely express and articulate their views (Liamputtong, 2013). It allows diverse perceptions to be expressed by participants when responding to researcher's questions (Hennink et al., 2020; Longhurst, 2009). Another advantage of a semi-structured interview is that it enables the interviewer to use follow-up questions and allows conversation to be developed in ways that could not have been expected when the interview schedule was being made (Kallio et al., 2016; Liamputtong, 2013). It is not a method where responses to research questions are predetermined, rather, the semi-structured interview method only guides the interview with open-ended questions that enable participants to share information they wish to provide in relation to their experiences. For the purpose of having in-depth understanding of participants' experiences of living with mental illness, a semi-structured interview method was chosen for the study. This is essential because of the belief that the approach will enable participants to speak, elaborate on their answers while as a researcher I can ask questions and seek clarification of their responses:

> In order to understand other persons' constructions of reality, we would do well to ask them … and to ask them in such a way that they can tell us in their terms (rather than those imposed rigidly and a prior by ourselves) and in a depth which addresses the rich context that is the substance of their meanings (Jones, 1985, p. 46).

In semi-structured interviews, an interview schedule is developed to guide the discussion (Low, 2013). Likewise, a flexible interview schedule was designed to guide the study and to ensure consistency in questions asked the participants. The method aligned with phenomenological perspectives that people can make meaning of their experiences (Laverty,

2003; Van Manen, 2014). Semi-structured interviews can be conducted online or through face-to-face methods, but the online interview was not chosen for this study because of its disadvantages as highlighted in the section that discuses online research methods on pages 77-78. Therefore, the face-to-face and individual interview was chosen as the most appropriate method for this study. Though it has been argued that interviewing is time-consuming (Gray, 2016) and comes with a financial concern of interrogating one participant at a time (Creswell, 2007; Seidman, 2013). However, it allows the voices of participants to be heard separately (Holloway and Galvin, 2017; Sagoe 2012). The confidentiality offered by individual interviews allow participants to share sensitive information about their experience that will enrich the data and provide a deeper understanding of their experiences (Irvine et al., 2013).

The settings

This study was carried out in the two mental health specialist hospitals situated in the southwest of Nigeria. The first hospital is in Lagos, it opened four days a week between the hours of 8am to 4pm. It provided care for men, women and adolescents experiencing mental illness as in-patients and out-patients. The hospital operated an open-door walk-in policy, where patients could receive treatments without referrals or scheduled appointments. The hospital extended its services to people from other states in the country and neighbouring countries (Adeosun et al., 2013).

Another set of interviews were conducted in the second mental hospital in the southwest region of the country. It was built in an urban area in the state and seated on 732 acres of land, providing care for people with mental illness within and outside the state (Somoye et al., 2014). It attended to people four days in a week and ran its services from 8am to 4pm daily (Olatunde & Odusanya, 2015). The hospital had 24-hour emergency services, and in-patient and out-patient clinic for adolescents, men and women with mental illness and substance abuse problems (Olatunde & Odusanya, 2015).

Gatekeeping

In addition to formal approval to conduct research, access is mediated by gatekeepers who can facilitate or refuse access to participants (Bryman, 2012). Singh and Wassenaar (2016, p. 1) described a gatekeeper as "*someone who controls access to an institution or an organisation, such as a school principal, managing director or administrator*". According to Wilcox and Cameron (2006), there are different levels of gatekeepers in an organisation, identifying each gatekeeper of an organisation and how to work with them can be difficult, they

are important because information flows through these key individuals (Berg, 2004; Tushamn & Katz, 1980). In some organisations, the gatekeepers are present at the top of the organisation and in others, there could be specific departments or chosen positions for them (Mashall & Rossman, 2006; Wells, 2009). Regardless of their designated positions, their cooperation is important because of their specific influences in organisation (McFadyen & Ranking, 2016; Wanat, 2008).

When a study gets organisational approval, access to sites and potential participants can be delayed, limited, and obstructed by gatekeepers (McFadyen & Ranking, 2016). Factors that may influence gatekeepers' action to grant or obstruct researchers' access to a research setting or potential participants were explained as the level of gatekeepers' understanding of the research, that is, if they have limited information about the research. The researcher may fail to provide gatekeepers with sufficient information about the research project and the benefits to the organisation (Gray, 2013; Holloway & Wheeler, 2009). Likewise, a gatekeeper may obstruct access if there is no information concerning a research project between staff in the organisation. For example, some staff members may not aware of the impending study because of communication problems between employees in an organisation (McFadyen & Ranking, 2016). They can intentionally reduce or obstruct access to data if they believe that the research outcome will have negative impacts on the image of their organisation and it may affect their job (Gray, 2013; Wanat, 2008). They can also intentionally restrict access to protect potential participants, especially if the research involves vulnerable individuals in order to protect them from exploitation (Bryman, 2008; Coyne, 2010). The gatekeeper's role is described as "*a position of power, control and responsibility*" (McFadyen & Rankin, 2016, p. 86) while they can influence other staff to cooperate with the researcher, some gatekeepers may take this role to the extreme to withdraw their cooperation.

However, positive ways of negotiating access with gatekeepers and gaining their cooperation, includes involving gatekeepers in the research early and providing them with enough information about the project. This can earn their permission and increase the level of their cooperation (Holloway & Wheeler, 2009; McFadyen & Ranking, 2016). Researchers can contact gatekeepers (doing follow-up) to facilitate access to potential participants. Though it was argued that follow up did not always guarantee permission and support from gatekeepers (McFadyen & Ranking, 20016).

<u>Negotiating access</u>

After the study approval from the hospitals' Research Ethics Committees, getting access to the participants was the next step. From the existing literature, I understood that the cooperation of the gatekeepers can enable researchers to achieve success in their research projects by granting permission to contact potential participants or frustrate their efforts by refusing access because of their position in organisation (McAreavey & Das, 2013; Singh & Wassenaar, 2016). For both hospitals, there were two gatekeepers: The Head of the Nursing department and the Ward Manager. Access to the gatekeepers in the first hospital was facilitated by my insider who provided their contact details. An insider is described as a person researching his own group (Jackson, 2018). Another definition of insider was provided by Merton (1972) who explained an insider as a person who has information of his or her community and its people, this explanation of an insider was adopted in the present study. The insider was the hospital's research ethics committee's secretary who provided the contact details of the hospital outpatient clinic administrator. The administrator was the head of the nursing department and the first gatekeeper with whom I discussed the study, a copy of the information pack and the hospital approval were sent to him. He directed me to the outpatient ward manager, stated his awareness of the study and asked her (the ward manager) to provide support in accessing the potential participants.

Though the head of the nursing department had given permission, from what I read in literature, I understood that cooperation from the ward manager and nurses was also important because of their position as another set of gatekeepers and the informal relations they have with the participants. I contacted the ward manager and provided her with information about the research. The ward manager had foreknowledge of my project from the administrator prior to our discussion. It saved time and made my negotiation with her easy and productive. Discussion with the ward manager was more than negotiating my access to participants, it included assisting in identifying women that were willing to take part in the study. My challenge at that time was that I was unable to visit the hospitals and recruit participants immediately after the ethics approval was granted. My experience with the gatekeepers was positive as they assisted to identify potential participants. An eligibility criteria list (see appendix 12) was forwarded to the ward managers to find potential participants. An information pack about the study was sent to two gatekeepers to give information on the study and give permission for the interview with the identified women. The information pack contained an invitation letter (appendix 13), information sheet (appendix 14) and my contact details (appendix 15) if there was a need for further information to enable them to decide about taking part in the study. Inside the pack, there was consent form (appendix 16) and reply slip (appendix 17) to arrange

contact with people that were interested in participating in the research. A flier (appendix 18) made for the study was included in the pack, the purpose of which, was to provide awareness of the study among the women attending the outpatient clinics. Others who were interested, aside from the women identified by the ward manager may had the opportunity to participate by seeing the flier. The same request was put to the ward manager of the second hospital, who gave their support.

Access to participants: Phase two

During the preliminary analysis of data for phase one of the study, I began preparation to conduct another set of interviews on mothers with mental illness in the same two mental health hospitals. This was a result of the themes that emerged in the analysis of phase one data that were peculiar to only women that were married with children and had mental illness. I believed that arranging for another sets of interviews that focused on mothers with mental illness would provide an opportunity to have an in-depth knowledge of their experiences and make a contribution to existing knowledge. The hospitals where the first interviews took place were contacted for permission and it was granted.

My relationships with the gatekeepers during the data collection for phase one facilitated early contact with participants when conducting phase two of the study. Similar to the recruitment method used in phase one of the study, the hospitals' staff were requested to assist in identifying potential participants. This was done firstly to save time, and secondly, they would know people who have a good level of recovery. Revised copies of eligibility criteria, an information pack, the informed consent and reply slip were sent to the hospitals' manager before visiting the hospitals. While visiting the two hospitals again, I felt like returning home because of the connection I had developed with the two hospital officials, especially the ward managers and the nurses.

I was discouraged by the initial low responses from people showing interest in participating in the study. One of the gatekeepers encouraged and reassured me about the value of my research project.

Extract from my research diary:

> "I was in the clinic today, not able to get the attention of the mothers, preoccupied with their treatments and much in a hurry to leave the clinic, no reply slip in the research box. Ward manager said she will write it on information board, tell the women about the study to let them know that their mental health problems is recognised as a real issue for mothers and there is a woman like them who wanted to know their challenges and let the public know about it. […] she [ward manager] strengthened me by her words and the feeling that what I am doing is valuable"

I was motivated to get up early the following morning, to visit the clinic for recruitment, because of the encouragement received from the ward manager. Getting to the hospital early before the women's consultation time gave me an opportunity to talk about my project. Through this method, I was able to recruit more people into the study and conducted enough interviews.

Sampling

Sampling is the process of selecting a few people from the study population to represent the whole population (Bryman, 2015; Carlsen & Glenton, 2011). Researchers using a qualitative approach typically use sampling techniques that will enable them to have a deeper understanding of the phenomenon under investigation. There are different methods of sampling, such as snowballing, theoretical and purposive sampling that exist in qualitative research.

The snowballing technique is used when investigating people that are relatively rare or difficult to reach especially when the target study population cannot be accessed through a poster or by announcement. Researchers initially identify a few potential participants and rely on initial participants to introduce other people with a similar situation. More people may like to take part in the research because of the recommendations of the initial participants. Through this method, the sample size increases as the study continues. It is also called the chain method because of the way participants are recruited to the study (Bryman, 2015; Holloway, 2016). This method of sampling was not considered appropriate for the present study because participants can be recruited from mental hospitals where they receive treatments.

Theoretical sampling is related to grounded theory methodology where sampling, data collection and analysis are carried out simultaneously (Conlon et al., 2020; Trotter, 2012). The selection of participants is not defined at the initial stage of the study, rather, participants are recruited into the study when a new idea emerges during data analysis. Inviting new participants to take part in the study stops only when data saturation is achieved, and new ideas are not generated. Unlike other types of non-probability sampling, it aims at generating and developing theory rather than representing a study population (Bryant & Charmaz, 2019; Urquhart, 2013). This study is situated within a hermeneutic phenomenological approach; thus, the theoretical sampling method is not appropriate for the study because the sample size has been defined when designing the study.

Purposive sampling is also known as selective or judgement sampling because groups of people are intentionally selected to participate in a study because of their knowledge about

the phenomenon being investigated (Holloway, 2017; Palinkas et al., 2015). Additionally, the identified individuals must be willing and available to share their knowledge of the phenomenon (Hesse-Biber & Johnson, 2015). It was suggested that purposive sampling would result in selection bias (Hamilton & Bowers, 2006). This was argued by Munhall who stated that qualitative study is about having deep understanding of a phenomenon and to have that understanding:

> We deliberately select participants who may be considered experts in the same phenomenon that we are exploring...When we purposefully select according to the best example, the characteristics of whatever we are studying are easier to identify (Munhall, 2007, p.530).

This point was stressed further by Dowling (2007) who stated the purpose of conducting a phenomenological study is to have an understanding of experience, therefore, sampling bias may be of little or no importance. This study is not aimed to generalised findings on the women's experiences of mental illness but to add to the existing literature, therefore, involving a group of women who can provide rich information about the topic of interest is essential. For this purpose, the sampling method used in the present study was purposive.

Participant recruitment

The number of participants interviewed for phase one of the study was twenty, ten interviews from each clinic. Interviews with participants were conducted between August and October 2017. Participants were recruited into the study from two mental health hospitals in the southwest of Nigeria. Staff (ward manager) of the two hospitals assisted in the identification of potential participants by using the eligibility criteria for participating in the research. Criteria for identifying potential participants to take part in the study are stated below. Hospital staff were involved in the recruitment of the study participants because they had the clinical information of the researched people and know the people who are capable of answering the research questions so that the aim and objectives of the study can be achieved.

Inclusion criteria

All the women experiencing mental illness could not be included in the study because of limited time and economic reasons. The study needed a few people with the knowledge of the phenomenon because of their situational position and willingness to share their experiences. Based on the recommendations of Newington & Metcalfe (2014), guidelines for the selection of the experienced individuals (see eligibility criteria phase one, appendix 12) that would take part in the study was provided to reduce sampling bias. It included the following:

- Women above the age of 18 years with a diagnosis of schizophrenia

- Have been receiving treatment for a period of at least 12 months
- Attending hospital outpatient clinics
- Able to speak English.
- Capacity to provide informed consent.
- Willingness to participate in the study.

The reason for choosing only women who could express themselves in English was because of the translation problem. Translating words in the Yoruba language to English may not have conveyed the exact meaning in Yoruba. Secondly, within the Yoruba language, there are different dialects (Arokoyo & Lagunju, 2019; Fabunmi, 2010; Omoniyi, 2011), therefore, it was essential to select women that were English literate.

When embarking upon the present study, the plan was to explore the experiences of women, including mothers suffering from schizophrenia (a mental illness), as stated on the inclusion criteria lists designed for the two phases of the study. It was developed based on the knowledge gained from previous studies (Adeosun et al., 2014; Afe et al., 2017; Ibrahim et al., 2016; Makanjuola et al., 2016; Olagunju et al., 2016), conducted on people suffering from mental illness in the southwest of Nigeria. It was my belief that people from the southwest of Nigeria, suffered from only schizophrenia because the previous studies investigated the experiences of people affected with this type of mental illness including their caregivers. This belief was challenged during the recruitment process for phase one, that not all the women were receiving treatments for schizophrenia. After realising this, the study sample comprised of women with different types of mental illness, as explained further on pages 92-93, under phase one semi-structured interviews section, and page 106, gaining ethical approval for phase two section.

Exclusion criteria

Some women were not selected into the study even though they experienced mental illness like people identified to participate in the study because:

- Of the severity of the symptoms of their illness
- Of their safety and the researcher's safety
- Their possible inability to provide informed consent
- They were unable to express themselves in English.

Women in the exclusion criteria may not have been able to answer the research questions because of the points mentioned above. Additionally, including them in the study may have caused ethical problems if they sustained injury because of their involvement in the research. For the selection of participants for phase two of the study, inclusion criteria for phase one of the study was revised. Instead of women above the age of 18 years, mothers were selected

if they were above the age of 18 with mental illness while the exclusion criteria remained unchanged. Eligibility criteria for the phase two is presented in appendix 23.

Participant demographics: Phase One

The sample in the study were women with diverse mental health illnesses, such as anxiety disorder, depression, bipolar disorder and schizophrenia. Participants were between the ages of 21 and 55 years old, receiving treatment at the hospital where they were recruited and interviewed. The participants' average age was 33.25 years. Out of the 20 participants, eight were single, seven reported married and four separated, while one was a widow. Almost all of the participants (18 out of 20) were from a Yoruba speaking ethnic background, only two of the participants were from the Ibo ethnic group but were married to Yoruba men. The number of participants who stated they were unemployed were 13, six were employed and one was a student. Additional information about participants, such as the duration of their illness and their living area at the time of conducting this study, is presented in Table 6.1 (See page 113).

Participant demographics: Phase Two

A total number of 26 participants, who were mothers, were interviewed in the second phase of this study. They were between the ages of 28 and 64 years, averaging 43.31 years. The participants' diagnosis of mental illness varied and likewise the years lived with the illness. The marital status of the sample varied, 12 reported being married, 12 participants indicated that they were divorced or separated from their partners, and two were widows. The majority of the participants (14) were unemployed, 11 were employed and one had retired from civil service. In total, the mothers had 69 children, and the majority of the children were female (40 out of 69) and their ages ranged from three months to over 18 years. The number of children between three months to one year was 19, and 10 were between the ages of one to three. There were 13 children ranging in age from four to nine years, 11 were between 10 to 17 years while 16 children were 18 years and above. Additional information about the participants' demographic is presented in chapter seven, page 138 and 139.

Designing the interview schedule: Phase one

An interview guide is a main tool in supporting the interviewer's capability to pose the questions, which are relevant to the topic of interest (Brinkmann & Kvale, 2014). It serves as a means of administering the same set of questions in a consistent way to all the participants (Castillo-Montoya, 2016; Holloway & Wheeler 2010; Frey & Oishi,1995). An open-ended research question schedule was designed to make comprehensive and detailed accounts of

participants' experiences in the present study. Open-ended questions align with a semi-structured interviewing method, it is flexible, and allows participants to express their experiences in their own words that will enrich their shared information (Bryman, 2016; Kvale & Brinkman, 2009). Furthermore, an interview schedule provides guidance on what to discuss (Gill et al., 2008; Krauss et al., 2009), allows the researcher to seek more explanations or clarify answers provided by participants by using prompts and follow-up questions (Gaiser & Schreiner, 2009; Mishler, 1996).

Mental illness is a sensitive issue that is not always discussed in the participants' culture (Olugbile et al., 2009). Additionally, it is an illness that is associated with stigma and labelling (Abdulmalik et al., 2019; Atilola and Olayiwola 2011). It is likely that participants may have gone through different stages of unpleasant experiences because of their illness. Sharing their experiences may make them become emotional and stressed. To avoid causing psychological problems to the participant, the research question was designed in a way that would prevent or limit emotional distress so that they could have lighter moments during the interview. The questions were designed with sensitivity, to prevent evoking any unpleasant memories of their experiences that may have put myself and participants in physical danger. The interview guide was reviewed by my supervision team for clarity, and to ensure it was robust enough to achieve the study aims and objectives and importantly, for ethical issues.

The first interview questions focused on participants' experience of living with mental illness and how it impacted their lives, their perceptions about mental health services provision, and their needs. It started with simple questions to develop rapport, to make them comfortable, so that they could provide more information from their experiences. Also, it ended with simple questions to leave participants in a happy mood, ensuring that they did not have any unnecessary emotional distress for participating in the research.

The interview schedule had an introductory question with a focus on participants' demographic, followed by their experiences of living with mental illness and questions that were for probing and specifying participants' expressions. The research questions were based on my theoretical knowledge of the chosen topic. Using open-ended questions indicated that participants could respond to the question in their own way and that their responses may challenge my foreknowledge to produce new understanding. Participants were given a chance to ask questions because it was two-way communication. Likewise, they could also provide further explanations and suggest methods on how their needs could be addressed. This method aligns with the hermeneutic philosophy where both researcher and participant engage in dialogue, and jointly produce new knowledge of a social phenomenon from their mutual

conversation (Laverty, 2003; Van Manen, 2014). The interview guide for phase one of the study is presented in appendix 4.

<u>**Designing the interview schedule: Phase Two**</u>

Another open-ended interview guide was developed to collect data for phase two of the study as demonstrated in appendix 22. Revisions were made to the phase one interview guide to focus on the exploration of the lived experiences of mothers having mental illness. The same principles of designing questions for phase one were followed in developing interview guides for phase two. Participants' wellbeing was taken into consideration; thus, the research questions were framed in a way that would not cause physical and emotional problem to participants. It was designed to meet the aim and objectives of the study, and to generate deep understanding of their experiences. It centred on their experiences of living with mental illness as mothers. The impacts their illness has had on their families were examined. Open-ended question meant participants could go beyond what was asked to establish their evidence, and they could also ask questions. As the participants divulged information about their experiences, they also had the opportunity to ask questions relating to the study.

<u>**Piloting**</u>

A broader definition of pilot studies was provided by Moore and colleagues by defining it "*as preparatory studies designed to test the performance characteristics and capabilities of study designs, measures, procedures, recruitment criteria, and operational strategies that are under consideration for use in a subsequent, often larger, study*" (Moore et al., 2011, p. 332). This definition revealed that piloting a study has many benefits. It can be used to test the appropriateness of the designed research questions and whether it can help to achieve the study goal (Kvale, 2007; Polit & Beck, 2017). The researcher can determine if the chosen methodology and methods of collecting data are suitable for the proposed study (Arain et al., 2010; Hassan et al., 2006). A researcher can be informed about challenges involved in collecting data and prepared how to address problems when a pilot study is conducted (Lancaster et al., 2004; Malmqvist et al., 2019). The knowledge gained through piloting when applied to the research process can improve the quality of the outcome of the larger study (Denzin & Lincoln, 2013; Malmqvist et al., 2019). Interviewers can recognise their weakness and find ways of improving through the process of piloting a study (Castillo-Montoya, 2016).

As recommended by Hennink et al. (2011), participants involved in a pilot study should be members of the main study population, experiencing the same phenomenon. The first phase of the present study was piloted with a community member with depression to test the

research questions and my interviewing skills. Based on the recommendation of Hennink et al. (2011), the pilot study was supposed to be tested among women with mental illness in the southwest of Nigeria, but I was unable to have contact with any of the target study participants at the time. Knowledge gained from the pilot study was put into practice when carrying out the main study. It took place in July 2017 and the interview lasted for 20 minutes after she signed informed consent. Initially I felt uncomfortable either due to interviewing someone very close in the community, or I had not gained enough confidence. During the analysis of data from the pilot study, I could identify some weaknesses on my part, especially when I needed to ask for more explanation which I failed to do. However, building rapport with the patient and paying attention to her words, made my participant share her experiences. The findings of the pilot study demonstrated that the research questions could be very helpful in achieving the aim of the study.

Phase two of the study was piloted in June 2018 before conducting the larger interview session. It took place in a mental hospital in Nigeria with two members of the study participants. Experienced gained from the first pilot study and phase one of the study had improved my interviewing skills and the quality of the second pilot study. The hospital environment was no longer a new place and I had knowledge of some of the activities in the outpatient clinic. Previous engagement with the researched population and staff increased the confidence and the positive energy I brought to the study. Participants were reminded of the purpose of the study again and were asked for questions about the study they may like to have. Participants gave their written consent, and we commenced the interview for 25 to 30 minutes. The use of prompts and asking questions by using participants' words was no longer a difficult task. Sometimes participants' response to a question may have covered other areas of their experience, but because of my improved interviewing skills, I now knew how to use follow up questions and prompts to bring them back to areas that I needed more explanation.

Semi-structured interviews: Phase One

I started the preparation for data collection on the 13 August 2017 when I travelled to Nigeria. Gatekeepers of the two mental health hospitals were contacted before leaving the UK. One of the hospitals was visited the next day (14 August 2017), the journey from where I stayed to the hospital was three hours. Visiting the hospital was an opportunity for me to meet the hospital staff (the insider and the gatekeepers) I had been communicating with on the phone. Also, to familiarise myself with the hospital environment. During my negotiation with the gatekeepers, it was agreed that a box would be placed in the ward where identified potential participants could drop their reply slip if they were interested in being contacted to take part in the study. I opened the box with fourteen reply slip, I was happy and excited to start making

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arrangement for interviews. Looking at the slip; I noticed that not all the fourteen women included their contact details. Of the fourteen women that showed interest, I was able to contact only eight that included their telephone numbers. Another challenge was that five of the eight women lived outside the state where they received treatments. The five women were willing to be interviewed, but according to them, they could not visit the hospital unless they had a clinic appointment. Interview dates were arranged with the remaining three women. Arrangements were made with the ward manager for a private, quiet and well-ventilated room with easy access to conduct the interviews. The three participants were interviewed, the first interview took place on 18th August 2017.

I planned to have 10 interviews in each hospital and so far, only three interviews had been conducted, so I had to start recruiting more women into the study. The ward manager offered to look at the women's record again to find people that may be eligible but had not been contacted and also to announce the research to patients when they were in the waiting room. I appreciated her efforts and stated while she was doing that, I asked if I could come to the hospital in the morning to speak to patients about the research. She gladly accepted my request, with her cooperation on the morning of the clinic days, I spent 10 minutes in the hospital waiting room to speak with a group of the women about the research and the benefit of taking part in the study. The outpatient clinic opened 8am to 4pm four days a week. During the recruitment period, I needed to get to the clinic early which meant I had to leave the house at 5:30 am and get to the hospital around 7:40 am. Getting to the clinic early gave me the opportunity to spend the 10 minutes that I was given to inform potential participants about my research. Through this process I was able to get more people to participate in the study. Of the seven women that were newly recruited into the study, three were interviewed after consultation with the doctor because of living a long distance from the hospital. I then had the opportunity to interview one of the five women, who first showed interest. In the 30 days I spent in the hospital; she was among the three participants who were interviewed after receiving medical treatment. The remaining four women were interviewed on different days from their clinic appointment, according to the day and time arranged. As planned, I completed 10 interviews in the first mental hospital.

However, during the interview I observed that participants were diagnosed with different types of mental illnesses (such as anxiety disorder and depression) not just one type of mental illness. My initial focus on experiences of women with schizophrenia was influenced by previous studies in the southwest (Adeosun et al., 2014; Adewuya et al., 2006; Lasebikan et al., 2013; Mosanya et al., 2014). Also, studies from other parts of the country (Enaohwo et al., 2014; Ibrahim et al., 2016; Igberase et al., 2012) were on schizophrenia. At the time of seeking approval for the study my focus was to explore the lived experiences of women suffering from

schizophrenia based on information from the previous studies. It was my belief that schizophrenia was the only type of mental illness that women (including men) from this part of the country or Nigeria as a whole were afflicted with. Then, I became suspicious that it could be because living with schizophrenia was used as inclusion criteria was the reason few women (14) volunteered to take part in the study. On the other hand, it could be that the ward managers were unable to identify enough women that meet the inclusion criteria. For instance, women who were not diagnosed with schizophrenia may not have liked to be involved in a study that was addressing people suffering from it. This problem was noted and addressed when I was discussing the research with the women attending the outpatient clinic.

The remaining 10 interviews were conducted in the second hospital in Lagos. It started in September 2017, but I had regular contact with the gatekeepers, even when I was interviewing participants in the first hospital. Also, I visited the hospital in August 2017 when I arrived in Nigeria. From my experience in the first hospital regarding participants' recruitment, I believed I could experience the same situation in the second hospital. Thus, I was prepared to use the same method to get more women interested in the study. Interviewing women in the second hospital was much easier than in the first hospital. Although only six women showed interest by sending their reply slip, it could have been, because the gatekeepers in the second hospital did not put more time and effort like the first hospital manager, or the problem was my eligibility criteria. I was not troubled about the small numbers of women that wanted to participate because I had handled similar situation before. I arranged with the ward manager to permit me to speak to the women about the study so that more potential participants would probably be interested. Similar to what happened in the first hospital, the ward manager agreed that I could recruit participants myself through this process. The location of this hospital was less than an hour journey to where I stayed during the data collection period. It was much easier for me to get to the hospital well ahead of the participant's consultation time to inform them of the study. Many potential participants that showed interest were given an information pack for more information about the research project. Through this method, another six participants were added to the study.

First, I contacted six people who initially showed interest in participating. Of the six women, one did not answer her phones, and one answered but did not want to be interviewed again because her family did not support her to do it. Arrangements were made with the remaining four women; they were interviewed in a hospital building. A request was made for a private, quiet, and well-ventilated room that could be easily accessed by participants; all the interviews were conducted in this room.

An open-ended interview schedule designed for the study (see appendix 4) was used to interview all of the 20 participants to ensure consistency. Before the women were interviewed, I reminded them of their voluntary participation in the study. I explained to them that they could withdraw from the study, if they did not want to continue the interview. Furthermore, they were assured that their identity and information shared would be protected. The participants and I signed two copies of informed consent prepared for the study, a copy was given to each participant while I retained the second copy. Before the interview commenced, the participant's permission to have their voices recorded was sought and granted so I did not miss any information they shared with me. At the start of the interview, I asked participants to tell me about themselves so that I could try to build rapport and develop an understanding of their background and their experiences of living with mental illness. This was followed by asking them detailed information about living with mental illness. Attention was given to participants as they were talking about their experiences so that I had a deeper understanding of what they were sharing with me. The semi-structured interviews and open-ended questions enabled participants to talk and ask questions. Whenever I needed more explanation on what had been said, I used questions such as 'Can you tell me more about this? As recommended by Mishler (1996) and Patton (2015), when a researcher uses words spoken by participant to present their views, it shows that the researcher pays more attention and shows interest in what the participants were saying and may encourage them to divulge more information. Therefore, when it was necessary for me to ask for clarification or I wanted them to provide more explanation, I used exact words or phrases used by participants.

While I achieved the number of interviews I planned to conduct, I did not meet the one-hour interviewing time set for each participant. The interview period was forty to forty-five minutes, and the short duration might have been a weakness from me as a novice researcher, that I had not mastered the interviewing skills, or that the participants were unwilling to speak further. At the end of the interviews, participants were thanked for giving me their time and being part of the study. Before ending the interview, participants were asked if they had any questions to ask or any other information they would like to add. This made some participants disclose new and unanticipated information about their experiences. After the end of each interview, the participant was reminded that her anonymity and confidentiality were protected. Any of the participants who may have had emotional distress because of their involvement in the study were encouraged to speak to their service providers or voluntary organisations. For example, the Mental Health Foundation have offices in the two cities where the interviews were conducted. Participants who wanted to ask questions about the study could still do so, even when the interview had finished by using the contacts on their information pack.

Semi-structured interviews: Phase Two

Methods of data collection such as semi-structured interviews and open-ended questions used in phase one were used to generate data for phase two of the study. Interviews for phase two were conducted from 3rd of June to 2nd of August 2018, using the two hospitals in phase one of the study. Working with the gatekeepers was very easy and productive because of the relationship I had with them during the first data collection exercise. Revised documents for phase one of the study (Appendix 22 to 26) were sent to the two ward managers of the hospitals for identification of potential participants. My experience from phase one of the study about recruiting participants made me understand that not all the people contacted or showed interest would be available for the interview. Therefore, I requested that the ward managers should allow me to be in the waiting room in the morning to announce the study to the women. They agreed to it because I had used the method before and it did not affect the ward activities.

Interviews were conducted in a private and quiet room to ensure that information shared by participants was kept secret from everyone in the hospital and their identity protected. In the first hospital, seven interviews took place after participants' treatments, four of the mothers lived in a place far from the hospital. The remaining three preferred to grant the interviews after the doctor's review because of childcare problems if they were to come on a different day. Though I wanted to interview 20 mothers, 10 from each hospital similar to what I did during phase one, the number of mothers that turned up for the interview (especially those that waited to be interviewed after treatment) were more than planned. I felt it would look unprofessional and discouraging to cancel the arranged interviews with the other women. Thus, 13 mothers with experiences of mental illness were interviewed in each hospital.

Before starting the interview, participants were reminded of the purpose of inviting them to the interview, of the benefit and what was involved. Though information about the research was stated in the information pack given to them, an information sheet and consent form were read and explained to them again. This was done to ensure that they had taken an informed decision and were willingly taking part in the study. Participants were given two copies of the form to sign; a copy was given to participants, and I retained the second copy. Permission to record their voices was sought and granted by participants before the start of the interview. The interview schedules used for the interviews had four sections (see appendix 21). The first section centred on participants providing information about themselves and was used to build rapport. Other questions were focused on their experiences of motherhood and having mental illness, impact of the illness on their family, and the mental health services they received. Follow-up questions and prompts to encourage participants to speak more about their lived experiences were used based on their responses. While participants were asked questions,

they were also encouraged to ask questions because it was a two-way discussion, a mutual dialogue to produce new knowledge.

When the interview finished, participants were thanked for having the courage to participate, their time and for sharing their experiences with me. Once more, participants were assured that their identity and information would remain confidential and would not be used outside what was written in the consent form. Participants were advised to talk to their health professionals if they experienced any psychological problem or accessed support at the Mental Health Foundation near the hospital. Participants who wanted to ask questions about the study were encouraged to do so using the contact details provided.

Data analysis

Analysis of qualitative data can be facilitated by using computer-assisted software such as ATLAS.ti, MAXQDA and NVIVO (Gibbs, 2018). The software can be used to code, analyse and interpret text, and to create report (Maher et al., 2018). These computer applications can be used to perform other functions, such as organising and managing data, to extracting audio and visual files. Using the applications saves time and enables researchers to form clusters, networks or categories of data (Seror, 2005).

However, the qualitative data analysis software has limitations. The software can be used to organise and code data, but the analysis is performed by the researcher not computer software (Evers et al., 2011; Mangabeira et al., 2004). It was claimed that computer-assisted software saves time (Richard, 2016), but this purpose is defeated, considering the time spent learning how to use the software (Zamawe, 2015). Researchers are required to familiarise themselves with their data and making use of computer software demands time equally as when manual techniques are used (Bulloch & Rivers, 2010). It was stated that computer software helps to improve accuracy in qualitative research (Bezeley, 2007), however, I argued that computer programs may only provide partial retrieval of information based on personal experience. For example, my findings show that distance is one of the reasons participants were not accessing mental health facilities regularly. While some participants used the word 'distance', different words such as 'the hospital is very far', 'I don't live in this state so is difficult to come regularly for treatment', 'it would have been different if the hospital is near where I live'. All these words mean distance; participants responded differently to the same question even though their answers had the same meaning. I would have missed this information if I had used NVIVO to search for distance alone. It was argued that assigning code to data that is peculiar to computer software programs is not essential in hermeneutical phenomenological study because of the richness and interpretive research processes of the study (Fielding,

2000; Goble et al., 2012). Therefore, I considered the process of using a pen and paper method of performing analysis that would promote deep and insightful interactions with the data.

Using the traditional method of line-by-line paper text analysis helped to remain close to the data. It helps to identify themes and phrases that provide insight into the participant's experience. It is easy to view the whole theme and the inter-relationships at a glance on a table if the traditional form of analysis is used than viewing it on screen. A manual method of data analysis was conducted by using thematic analysis.

Thematic analysis

Thematic analysis (TA) is a method of analysing qualitative data to bring out themes and subthemes that represent the meaning of a phenomenon (Braun & Clarke, 2006). The use of thematic analysis to analyse participants' transcripts was justified in the methodology chapter page 74. The application of the method to analyse qualitative data is demonstrated in this section. The thematic analysis proposed by Braun & Clark (2006) had six phases of analysing data, it was extended to seven steps in 2013. The seven analytic steps are: "*transcription, reading and familiarisation, coding-complete across entire data set, searching for themes, reviewing themes, defining and naming themes and writing- finalising analysis*" (Braun & Clarke, 2013, pp. 202-203).

The first step was to have the audio interview transcribed to textual data where it could be read and ready for coding. In the present study, all the audio-recorded interviews were transcribed verbatim. The anonymised transcripts were printed into hard copy for reading and ready for analysis. This was followed by reading and familiarising myself with the data which is the second stage of the analysis method. The participants' text was analysed individually, and during this analysis, hermeneutic principles were applied. The data was read multiple times to have a good understanding of the text. What followed, was to start coding the text by looking for words or phrases that gave meaning to participants' experiences. Data was divided into small units for it to be easily managed. Again, the text was read to understand the content of each unit and the whole text. Coding was performed by reading the text line-by-line and words or phrases that provided insight into participants' experiences were highlighted. Appendix 28 is presented as an illustration of coding and how themes were derived inductively from participants' scripts. Notes were written to highlight the information on each segment of the text. The identified codes were arranged into themes, which was an initial stage where many and different codes were identified to form five themes and subthemes. As recommended by Braun & Clarke (2006), visual presentations of the themes can be made by

using tables or mind-maps. The idea of having identified themes in visual form is to understand how the themes and their subthemes are related and fit together. The initial themes and subthemes generated from phase one of the study is presented in figure 5.1 below.
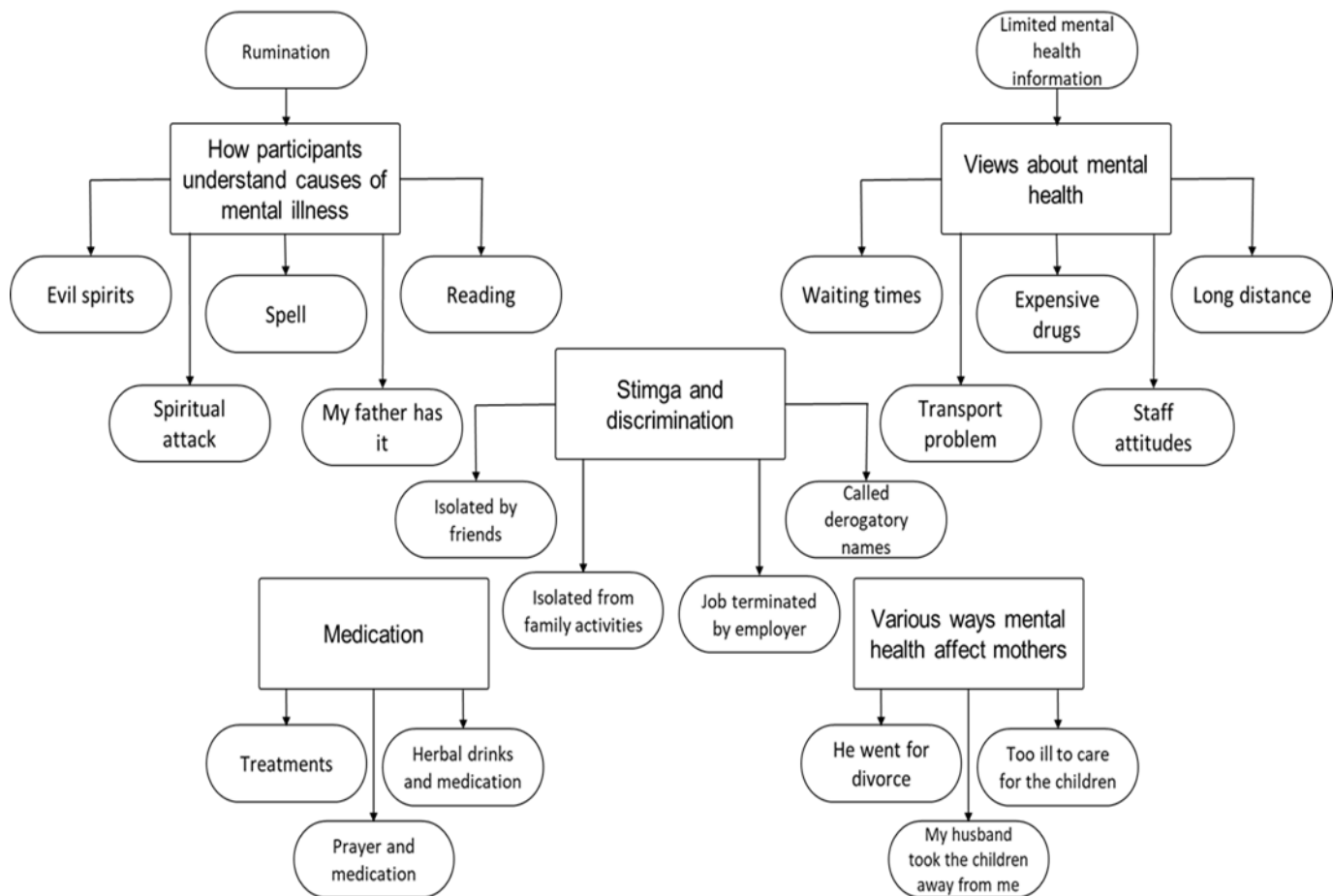
Figure 5.1: Phase 1-Initial generated themes

The initial themes and subthemes generated were reviewed to have themes that answer the research questions. Braun & Clarke (2006, p. 82) explained that "*there will be a number of instances of the theme across the data set, but more instances do not necessarily mean the theme itself is more crucial.*" Thus, the themes to remove or retain for discussion depend on the researcher's judgement. The initial theme in figure 5.1 was reviewed to have themes that are cohered together meaningfully and best represent participants' lived experiences of living with mental illness. By reviewing the themes for relevancy, some of the codes initially generated were removed. The retained codes were rearranged to form new themes and renamed to reflect language used by participants' and their experiences. The theme changed from five to three themes; the final three themes and subthemes are demonstrated in figure 5.2.
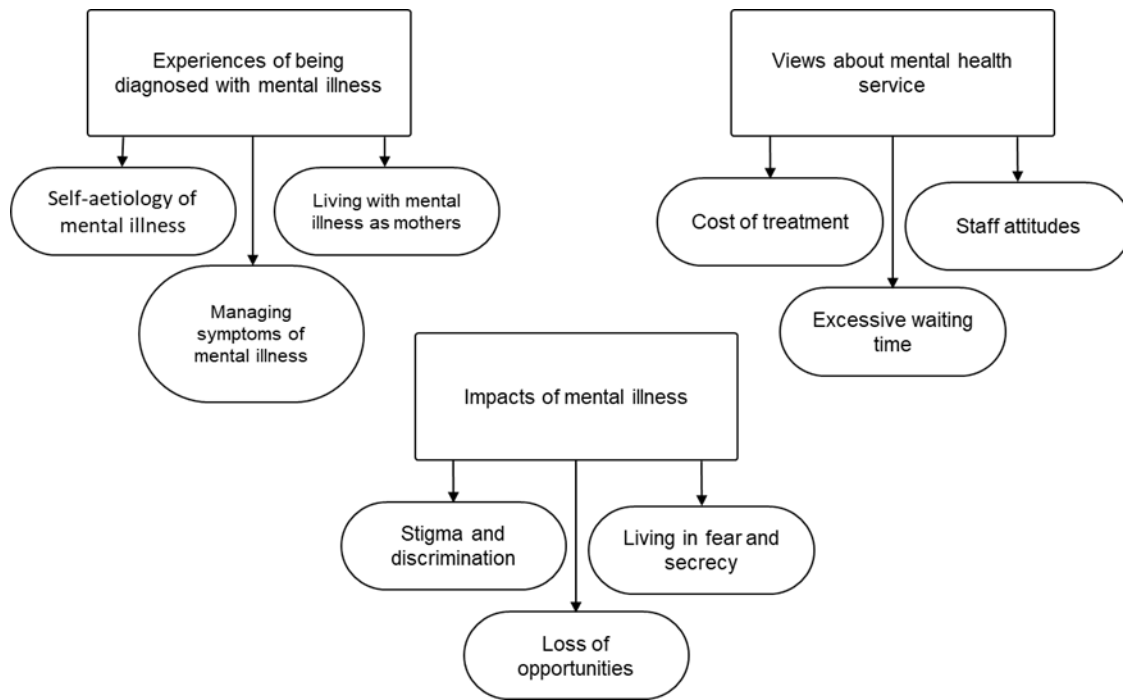
Figure 5.2: Phase 1 - Final theme generated from coding

Analysis of data from phase two of the study was performed by using the same procedure to analyse the phase one dataset. The preliminary themes generated for the phase two study were seven themes and subthemes (see figure 5.3).
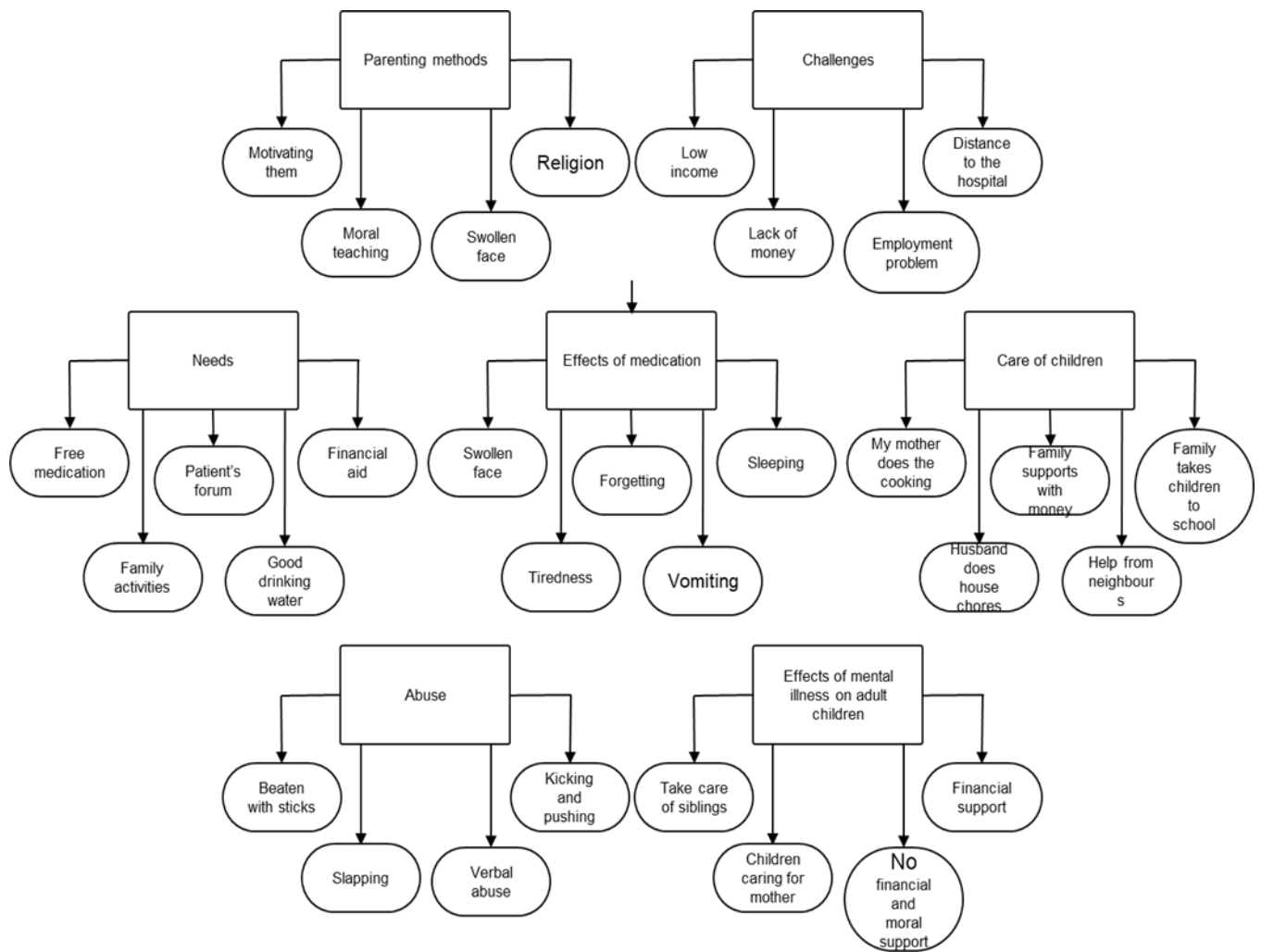
Figure 5.3: Phase 2 – Initial themes generated from mothers' experience

Reviewing of the initial code and themes for the phase two data was carried out to select those that best highlighted participants' experiences. The seven themes generated initially were reduced to four after examining them carefully. These four themes were renamed and diagrammatically presented in figure 5.4 below.
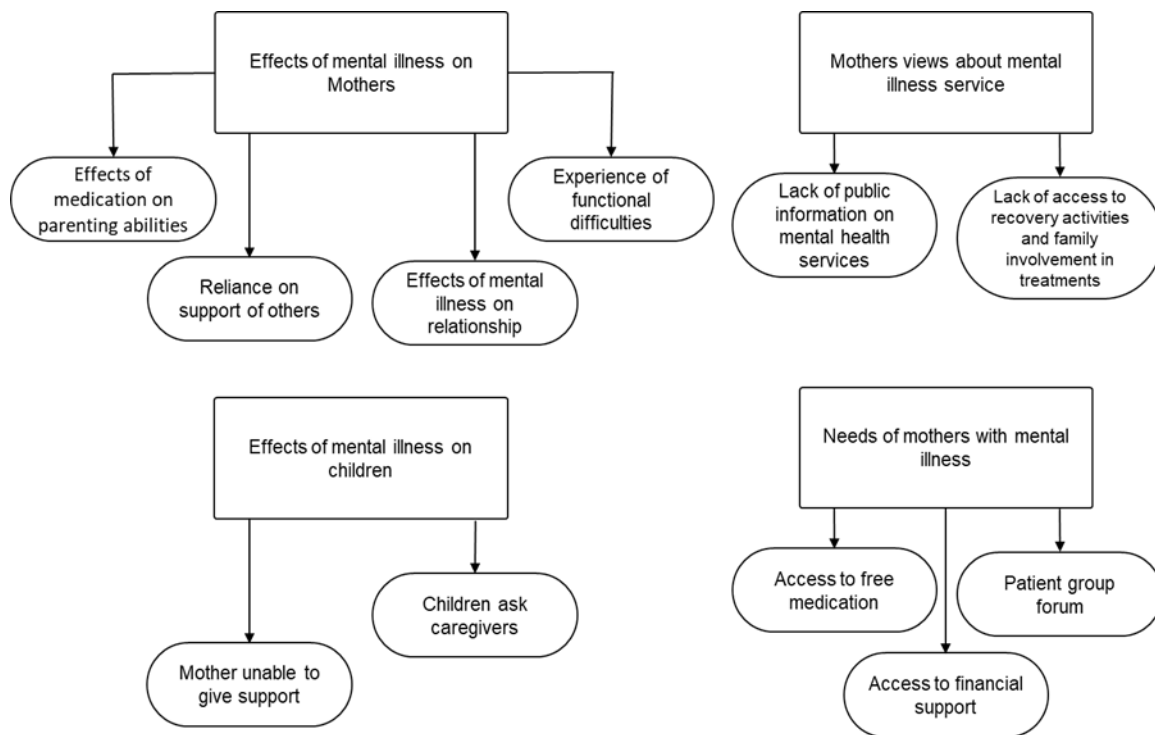
Figure 5.4: Phase 2 - Final themes illustrating mothers' experiences

The final stage of Braun and Clarke (2013) method of data analysis was to write the findings of the analysis. Themes derived from participants were used to present participants experiences and were supported by quotes from participants' data. Findings from the analysis were compared with the existing literature to check whether they supported or challenged the existing knowledge and information about the experiences of women living with mental illness. Findings from participants' interviews for phase one and two are presented in chapter six and seven respectively.

Research ethics

Research ethics can be defined as the moral principles that govern how researchers should conduct their research projects (Resnik, 2020). The ethical principles of conducting human research are constantly developing; they were first published in 1990 to inform research ethics, policies, and practices with intention to protect participants (Penney, 2020; Punch, 2014). The ethical principles that guided this study are stated in the 2018 British Psychological Society (BPS). The BPS ethical principles covered five areas such as: "*consent; confidentiality and anonymity, justice, non-maleficence and beneficence*" (BPS, 2018, p. 6).

Informed consent

As described, informed consent is "*a fundamental principle in social research ethics*" (Bryman, 2008, p. 694). In accordance with BPS (2018), researchers should ensure that every person from whom data is collected for research purposes should freely provide informed consent. A consent form should include details of the study and an explicit statement confirming that information about the research has been given to the participant and has been understood (Pandiya, 2010). Information concerning the purpose of the study being undertaken, is important to enable participants to make an informed decision about their involvement (Crow *et al.*, 2006). It helps them to think and talk about their experiences (Wilson, 2015).

Prior to taking part in the study, participants were provided sufficient information and given enough time to decide about their involvement. Information about the title, purpose and methods of conducting the research was stated in the invitation letter, information sheet to participants and the consent form. Information including the protection of participants' confidentiality and anonymity, and how their data would be used was provided. Detailed information about the study was stated in the information pack given to participants and presented in appendix 13, 14 and 16 for participants in phase one and appendix 24-26 to make a decision for participating in phase two of the study. It was recognised that consent is not a once-and-for-all prior event, but as an ongoing process (Gupta, 2013; Kadam, 2017). Thus, before the start of the interviews, participants were reminded about the purpose and nature of the study including what was required of them. The obligation in the study was to share their experiences voluntarily and with their permission, have their voices recorded. Content of the consent form was explained again so they understood how the information they provided would be used. It was only when participants agreed to continue with the interview that they were given a consent form to sign as evidence. A copy of the jointly signed consent form was given to consenting participants while I retained the second copy.

Confidentiality and anonymity

Confidentiality means keeping information secret from an unlawful person (Surmiak, 2018) while anonymity is about protecting the identity of someone by not disclosing information that can enable people to identify the person (Saunders et al., 2015). Information regarding participants' confidentiality and anonymity were stated in all documents given to participants. Before and after interview, participants were reassured of their data and identity protection during and after the study. Additionally, all the interviews took place in a quiet and private room at the entrance of the hospital outpatient department. Other women in the waiting room or staff in the nursing room would not have the knowledge of the person being interviewed because of the location. Again, interviews were conducted behind a closed door with only myself and

the participant in attendance. Also, the interviewing room was not close to the patients' waiting room, so no one else was listening to the information shared by participants.

The recording instrument was stored in a protected case that could not be opened by another person. Interviews were transferred from the device used for recording into a password-protected laptop to prevent unauthorised access to the data. Furthermore, copies of the consent form were locked in a secure place to prevent unauthorised access.

Pseudonyms were used in the study to protect the participant's identity as stated by Damianakis & Woodford (2012). Participants were asked to choose names that they would like to be addressed by them in the study. However, they were asked not to use any names related to them or their family members so that they would not be recognised in the course of dissemination of the study's findings. This method was adopted following the suggestion of Allen & Wiles (2016) that states allowing participants to choose names for themselves gives them a sense of control over their involvement in the study. Damianakis & Woodford (2012) further stated that it makes participants feel respected, increase their confidence and increases the likelihood of them divulging more information during interview.

Principle of justice

According to Vanclay et al. (2013), the principle of justice implies that research participants are not exploited, have access to equal information and are treated fairly. Measures taken to ensure that the principle of justice was followed in the study include: the eligibility criteria was designed to recruit participants into the study, this was to ensure that all people that were interested and eligible to participate in the study were involved. Fliers were made available at the hospitals' outpatient departments where the potential participants were receiving treatment. People who may not have been identified mistakenly by ward managers but were willing to be involved in the study could show their interest. Moreover, sufficient information about the study was provided written and verbally. Information packs containing the same materials for decision-making were provided to all people interested in contributing to the study by sharing their experiences. The same interview guide was used during the interview to ensure participants were asked the same questions, only follow-up questions were different because of the different ways in which participants responded to the same question.

Non-maleficence

Research ethics state that taking part in research should not cause any risk to participants or if there is any risk it should be minimal (Vanclay et al., 2013). Risk to research participants may be physical or psychological (Labott et al., 2013). To prevent participants sustaining physical risk, the interviews were conducted in well-ventilated rooms with easy access. The interview guide was designed in a way that participants were left in a good mood, with my

contact details for any further questions related to the study. The rooms were clean and free of objects that could cause a fall or cause a person to sustain injury. Participants did not show signs of any psychological problem during interview, but in the likelihood that any of the participants experienced emotional distress after participation, they were encouraged to speak to their service providers. Additionally, they were provided the contact details of the Mental Health Foundation office in the city and advised to seek their help. They were reassured about their anonymity and confidentiality in granting the interviews. A debriefing note (appendix 27) was given to each participant at the end of the interviews.

Beneficence

As explained by Beauchamp & Childress (2009), beneficence means that the research outcome should have benefits to people. Participants are the first people to get benefit by participating in the research by recounting their experiences and making their voices heard. It may be a source of empowerment to many of the women for speaking out what was in their inner mind. If the findings of the study informed the mental health services in Nigeria, the benefit would extend to other people living with mental illness in the southwest and probably the whole of Nigeria.

Gaining ethical approval: Phase One

The feature of qualitative research is to gain understanding of a phenomenon in which researchers actively engage with participants to obtain information (Hammarberg et al., 2016; Maher & Dertadian, 2018). The understanding of people's experiences may enable researchers to have knowledge of the private and public lives of individuals that may cause ethical dilemmas (Rolfe et al., 2018; Surmiak, 2018). To minimise ethical problems that may arise, before going to field work, researchers are required to state the purpose of the research project, individuals involved, how they will be accessed and the implications of the study for the people involved in the research (Surmiak, 2018). The process of obtaining ethical approval for the present study from the University of Huddersfield and the two institutions where the study was conducted are discussed below.

University ethics process

The current study obtained ethically approved from the School of Human and Health Sciences at the University of Huddersfield. Documents for the data collection were prepared and submitted to my supervision team. The documents included the phase one research question (appendix 4), invitation letter (appendix 13), information sheet (appendix 14) and consent form for participants (appendix 16). The submitted documents included the process taken to ensure

my safety while conducting the interviews. As a lone worker, a risk assessment form by the University of Huddersfield (appendix 5) was filled and instructions stated in the form were followed to reduce risks (self-risk) when interviewing participants. These documents were submitted to the School Research Panel (SREP) for ethical approval. The documents were reviewed, and ethical approval (appendix 6) dated 29 March 2017 was granted by SREP to allow data to be collected for the study.

Study sites ethics processes

After the SREP ethical approval, the two mental hospitals in Nigeria, where the interviews were to be conducted, were contacted by email to request permission to carry out the study in their outpatient departments. Due to a lack of response to my emails, a family member was asked to assist me to follow-up my application. Eventually, a new application was sent through my family member to the two hospitals. The research study proposal included letters to the two hospitals (appendix 7a and 7b) and documents that were submitted for SREP approval. A message from the study sites on how to register my interest to conduct research in Nigeria was received, a copy of the completed Nigeria Research Ethics Form is presented in appendix 8. A certificate from Bioethics Research Centre (appendix 9) was issued after completing the assessment for the Nigerian National Code for Health Research Ethics. This certificate was presented to the two hospitals in Nigeria to obtain ethical approval dated June and July 2017 respectively (appendix 10 and 11).

Gaining ethical approval: Phase Two

This is a two-phase study, meaning that another set of interviews were required to achieve the study's aims and objectives. The second phase of the study involved different groups of women; therefore, revisions were made to previous research documents while the research activity for the phase two of the study was guided by research ethic principles outlined by the British Psychological Association (2018) which aligned with the University of Huddersfield research ethics as stated on pages 101-104.

I expressed the need to collect another set of interviews with my supervision team. The new interviews would be conducted on women who were mothers and at the same time having mental illness. Revisions were made to the documents submitted to the SREP to gain the first approval, that is consent form, participants' information sheet and a new interview guide designed for the data collection (see appendix 20 to 26). School approval to conduct interviews for the second phase of the study was received.

The two hospitals were informed of my intention to hold interviews with mothers experiencing mental illness. My encounters with the women during the first interviews made me understand that not all the participants were diagnosed with schizophrenia. I made this change on my letter to the hospitals' research ethic committees. The study title read "An exploratory study of the lived experiences of mothers with mental illness in southwest of Nigeria". However, the study sites wanted me to continue on the first study title on which ethical approval was issued. I was advised that an attempt to change the study title would cancel my study approval and phase two of the study would be treated as a different study with a new ethical approval process. This would take a long time, therefore, I decided to conduct interviews for phase two using the initial word 'schizophrenia'. Approval from the two hospitals were still valid at the time of conducting the phase two study. Approval from the second study site lasted for two years while that of the first hospital was valid for only one year. A letter from the first study site documenting the validity and the process of applying for another ethical approval should the study extend beyond the approved time is presented in appendix 21.

Demonstrating trustworthiness

Trustworthiness is a way of establishing the quality or the level of confidence that the reader has in a study (Schmidt, 2015). It is about demonstrating the integrity of knowledge that a study claims to possess (Carminati, 2018). The methods of demonstrating trustworthiness of quantitative studies are not applicable to qualitative studies because the focus of the two approaches is different. Qualitative research is concerned about understanding experiences in the social world, while quantitative is related to natural science to quantify objects (Noble & Smith, 2015). Therefore, methods of establishing trustworthiness (rigour) in quantitative studies such as reliability, replication and validity cannot be used in qualitative research. Thus, trustworthiness is considered more appropriate for evaluating qualitative studies because of using different methodologies in qualitative research to investigate the same phenomenon (Leung, 2015). Methods of evaluating qualitative studies proposed are "*credibility, dependability, confirmability, and transferability*" (Lincoln & Guba, 1985, as cited in Nowell et al., 2017, p. 4). These are the four assessment criteria used in the current study to demonstrate the trustworthiness of the results.

Credibility

Credibility is the term used in a qualitative study to replace internal validity in quantitative research. According to Lincoln & Guba (1985), it means that researchers present a true reflection of participants' experiences. It involves using suitable methodology and methods, and deep personal involvement of the researcher and the participants (Morse, 2015). There

was protracted engagement with each setting (a period of 4-5 weeks) during the data collection process. It enhanced my familiarity with the study settings and gave me the opportunity to find local issues and salient features of each site and acquainted me with the study's participants. Credibility was further enhanced by engaging in a dialogue with participants for a minimum of 45 minutes, exploring their lived experiences, as stated in the study aim and objectives. The interview schedule was piloted to increase the study quality. The semi-structured interview procedure used for data collection allowed me to focus during the interviews. The semi-structured interview guide allows the use of prompts for expansion of answers and gives opportunity for requesting more information and detailed answers if required.

Activities such as audio recording, verbatim transcription and using participants quotes ensured that the voices of participants were presented in the thesis. Credibility means that the researcher's findings reflect participants' social reality (Nowell et al., 2017). This view is supported by Munhall (2007) who believed that trustworthiness is achieved in qualitative research when "*the research findings [...] enable understanding, give us possible interpretations, offer us possible meaning, and guide us [...] personally and professionally*" (Munhall, 2007, p. 562). This is a hermeneutic phenomenological study; participants' lived experiences were interpreted in relation to their culture in order to present a greater understanding of their experiences. The use of the thematic analysis method was helpful in identifying themes and subthemes that are the most meaningful parts of participants' experiences. To increase the credibility of findings, emerging themes and sub-themes were reviewed by my supervision team to check that data is interpreted well to portray the reality of the participants' social world. Instead of reporting everything that participants stated, presenting the most meaning accounts of their shared experiences added to the creditability of the study findings.

Dependability

Dependability is described as "*the stability of findings over time*" (Bitsch, 2005, p. 86). It means that methodology and methods used to conduct a study should be appropriate and documented, so the findings are consistent if the study is repeated in the same or similar environment with the sample and methods of inquiry (Shenton 2004). This has been questioned because of the different methods used in the qualitative studies, as different methods exist in the qualitative approach (Silverman, 2010). Although, this does not mean that researchers should not document their research procedures to demonstrate the quality of

the study's findings (Thomas & Magilvy, 2011; Seale, 2002). The argument is that repeatability is not the focus of qualitative study but to provide a deeper understanding of the social phenomenon being investigated (Silverman, 2010).

To demonstrate dependability, I explained my understanding of the different world view that exists on the constructing of meaning (chapter four, pages 56-57) and located the present study in an interpretivism perspective (chapter four, pages 57-58). The interpretivism perspective of the world view influenced the chosen methodology (hermeneutic phenomenology) for the study which was discussed in chapter four. To achieve dependability, the foundation of phenomenology (see chapter four, page 60) and how the hermeneutics tradition started and how it applied to research was discussed (chapter four, page 67). This explanation was to demonstrate that the approach used in the present study is appropriate, accessible and can be examined. The suitability of hermeneutic phenomenology to produce a deeper understanding of human experience was demonstrated by Van Manen who stated:

> Hermeneutics and phenomenology are human science approaches rooted in philosophy...therefore, it is important for the human science researcher...to know something of the philosophic traditions...enough to be able to articulate the epistemological or theoretical implications of doing phenomenology and hermeneutics (Van Manen, 1990, pp.7-8).

Subsequently, explanations on the overall design and methods of achieving the study aims and objectives were stated in chapter five. The chapter discussed procedures of collecting data, how the data generated were analysed and how the findings unveiled the meaning of participants' experiences. Quotes from participants' transcripts were incorporated into the discussion of findings to present the meaning of living with mental illness as reported by participants.

Confirmability

Confirmability is comparable with objectivity in a quantitative study (Lincoln & Guba, 1985). Confirmability of the data means that themes and interpretations of the findings are not the researcher's opinions but are clearly derived from the data. The purpose is to reduce researchers' bias by setting aside their predispositions (Korstjens & Moser, 2018; Smith & Noble, 2014). Gadamer (1900-2002) upheld the view that one cannot completely suspend his or her pre-understanding about a phenomenon. He stated that where possible, researchers should acknowledge their presuppositions and differentiate it from the interpretation of participants' experiences. My pre-conceived beliefs and opinions about women and mothers with mental illness were set aside to concentrate on the data as it was given by participants. Each transcript was being coded more than once. Data analyses were performed using thematic analysis, as proposed by Braun & Clarke (2013, 2006). The seven steps introduced

by Braun & Clarke (2013) to guide the analysis of data contributed to the credibility of the present study. Each transcript was read several times and line-by-line manual coding of text was performed as suggested by Braun & Clarke (2013). Words or phrases that revealed a participant's experience were highlighted with coloured makers (appendix 28). This method increased my interaction with the data. Identified words and phrases were written on sticky notes and placed on a table to reflect on it and used to develop themes and subthemes. These themes and subthemes were reviewed to determine their relationships. In addition, quotes from the participants' text were used to further support the data analysis of the findings.

Transferability

Qualitative research is specific to a particular setting, it is important for researchers to provide sufficient information about the study context to determine whether it is transferable to other settings with similar experiences (Moon et al., 2016; Tobin & Begley, 2004). Participants were selected through a purposive sampling technique which was helpful in obtaining rich information about participants' experiences. Detailed information of the participants' demographics are presented in chapter six and seven respectively, and the interviewing process and data analytical procedure were stated. Transferability of this study's results to other settings depends on whether the participants of this study share similar beliefs and experiences as people in another setting or not. However, the study's results demonstrated human experiences and beliefs, the meaning of people's perceptions of reality, accessibility and availability to timely treatments, and the care of women experiencing mental illness by family members.

Reflexivity

> "I want to appreciate you for what you are doing because it shows we want to move; it shows you have passion. If not, what is the essence of what you are doing? It makes me feel happy that better days are coming because this effort will not be in vain because somebody will look at it and want to do something" – Adesewa (a participant).

Reflexivity is defined as an active process used by researchers to develop insight into their work and to guide future actions. It is about researchers taking a critical review of their involvement in the research and its impact on the processes and findings of the study (Newton et al., 2012). Horsburgh (2003) defined reflexivity as the "*active acknowledgement by the researcher that his or her own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation*" (Horsburgh, 2003, p. 309). At the same time, it can be understood in terms of epistemological positions embraced or by exploring personal experience when conducting the research (Dowing, 2006; Gough, 2016).

Epistemological reflexivity is where the researcher confirms the methodological cohesion by selecting an appropriate theoretical framework for the study, it is done by using a suitable sampling method, and confirming the relational ethics (Bradbury-Jones, 2007; van der Riet, 2012). This is explained by Calas & Smircich (1992) who stated: "'*reflexivity that constantly assesses the relationship between knowledge and the ways of doing knowledge*" (cited in Alvesson and Skoldberg, 2000, p. 61). Finlay & Gough (2003) stated reflexivity extends beyond the methodological aspect of research. It recognises the researcher's field experience while engaging with participants. Contrary to the methodological aspect of research, personal reflexivity is listening to one's own feelings, the unconscious responses, and paying attention to the emotions of the research participants (Berger, 2015; Hamzeh & Oliver, 2010). It is part of the features that differentiate qualitative research from quantitative study (Taylor & White, 2000). While researchers' subjectivity is suppressed in quantitative research, it is known to provide insights in the context, relationships and power dynamics that exist in research settings in qualitative study (Finlay & Gough, 2003). In this study, I discuss my fieldwork experience while studying the experiential world of women living with mental illness.

I experienced difficulty in recruiting enough participants to the study at the beginning of phase one. The method used to overcome this challenge was applied during the phase two data collection. I will not interpret the women's willingness to participate in the study and share their experiences of living with mental illness, as a result of shared gender. Rather, I explained that participants were prepared to make their voices heard and wanted their disadvantaged position in society to change as shown in the above quote from one of the participants.

Researcher and participant relationship was debated as an issue of power and status, a situation where the researcher is in a privileged position because of being the person conducting the research (Finlay & Gough, 2003; Råheim et al., 2016). As a researcher I developed and asked participants the research questions, but participants views were respected. I positioned myself as an inexperienced person, someone who was learning from the experts (participants) to make the interview an empowering experience. Every culture has its own language and connotations as stated by Berger (2015). Having a clear understanding of participants' culture and the language used to express their feelings, helped me to understand their views; interpreting their experiences may not have possible if I had been in an unfamiliar environment.

I have learned to listen to the voice of others, as the etiquette of the interview process requires this. As we engaged in conversation, I learnt about their challenges of living with mental illness as women and mothers in a society where mental illness is regarded as taboo. As Mauther and Doucet (2003, p. 419) stated, "*Situating ourselves socially and emotionally in relation to respondents is an important element of reflexivity*". Thus, while understanding the participants' experiences and how they managed their health problems, I became conscious of my own existence as a woman and a mother. Interviewing the participants expanded my horizon of what it means for women and mothers to be diagnosed with mental illness. My assumptions about people having a mental illness changed as the participants were talking about their experiences, things that I had once taken for granted became more important.

Summary

This chapter discussed the methods employed to collect data for the study. It explained how ethical approval (internal and external) was obtained and how interview guides were designed. The role played by gatekeepers in identifying and accessing participants was stated, including the data analytical process. Ethical principles that guided the study in terms of relationships with participants were discussed. Explanations on the trustworthiness of the study's findings were provided and I reflected on my experience as a researcher. The next chapter discusses findings of phase one of the study.

Chapter Six – Findings: Phase One

The findings of phase one of this study are stated in this chapter. It is centred on the analysis of 20 interviews with women receiving treatments for mental illness in southwest Nigeria. The lived experiences of these women were explored through a semi-structured interviewing method and texts were analysed using a thematic approach as developed by Braun and Clarke (2013). Gadamer's hermeneutic method of understanding text was employed during the analysis. Gadamer (1900-2002) emphasised the importance of history and the effect of tradition on the interpretative process. Therefore, the presentation of the findings will be influenced by participants' social and cultural contexts to provide insight into their experiences.

There are three main themes derived from the analysis of the text, and each of the themes has subthemes. The first theme is titled, the experience of being diagnosed with mental illness, it has three subthemes such as self-aetiology of mental illness, living with mental illness as mothers, and managing the symptoms of mental illness. The second theme is called impacts of mental illness and has three subthemes. It discusses the living condition of participants after their diagnosis. Experiences of stigma and discrimination, living in fear and secrecy, and loss of opportunities are the three subthemes from the second theme. The third theme is on the participants' perception of mental health services, it is called views about service provision. The three subthemes discussed under this theme include the cost of treatments, staff attitude, and excessive waiting time. Excerpts from participants' text were included to support the findings. Findings from the data analysis are based on twenty semi-structured interviews, which will be presented in relation to studies reviewed in chapter three of the present study. The demographic features of the participants are stated below.

Participant characteristics

The participants were aged between 21 to 55 years old, and the years spent while living with mental illness ranged from two to 15 years. Out of the 20 women interviewed, eight reported that they were not married, seven were living with their partner, four had separated and one was a widow. Half (10 of 20) of the participants reported living outside the state where they received treatments. Of the remaining 10 participants, six were attending mental health care from rural areas and four were in the same town where the hospitals were located. Regarding employment status, six participants were working, the majority (13 of 20) said they were unemployed, and one participant described herself as a student. Their characteristics are summarised in Table 6.1. For ethical issues, pseudonyms are used instead of real names to protect participants' identities.

Table 6.1: Characteristics of the study sample

Name	Age	Years living with the illness	Marital status	Women that are mothers	Employment status	Residential location			Travel distance to hospital
						City	Rural	Outside the state	
Adama	29	2	Married	×	Unemployed	×			9.2km
Isioma	25	8	Single		Student			×	303.6km
Bidemi	49	5	Married	×	Self-employed			×	118.3km
Kunbi	26	8	Single		Employed	×			16.5km
Tinuola	23	9	Single		Unemployed			×	166.9km
Feyisara	22	4	Single		Unemployed	×			7.1km
Ebunoluwa	55	12	Married	×	Unemployed		×		69.1km
Riyike	32	10	Single		Unemployed			×	219.3km
Omoyeni	21	5	Single		Unemployed			×	154.7km
Sefinatu	40	2	Widow	×	Self-employed		×		92.km
Jayeola	34	3	Married	×	Unemployed		×		92.4km
Labake	52	15	Separated	×	Unemployed			×	131.9km
Ojuola	24	2	Separated	×	Unemployed		×		69.1km
Rabiatu	42	2	Separated	×	Self-employed		×		60.1km
Derayo	40	7	Married	×	Self-employed		×		63.7km
Asake	24	2	Single		Unemployed			×	241.8km
Enitan	31	8	Married	×	Unemployed			×	131.3km
Adetutu	34	11	separated	×	Unemployed			×	292.2km
Adunni	36	7	Married	×	Unemployed			×	236.8km
Iyabo	29	3	Single		Employed	×			31.7km

Experience of being diagnosed with mental illness

The theme consists of three subthemes such as self-aetiology of mental illness, living with mental illness as mothers, and managing the symptoms of mental illness. It provides different views held by participants regarding the reasons for their mental illness. Also, the experiences of mothers among the participants are stated in the second subtheme. The last subtheme discusses how participants' beliefs and knowledge about mental illness influenced their help-seeking behaviour. The theme and three subthemes are represented in figure 6.1 below.
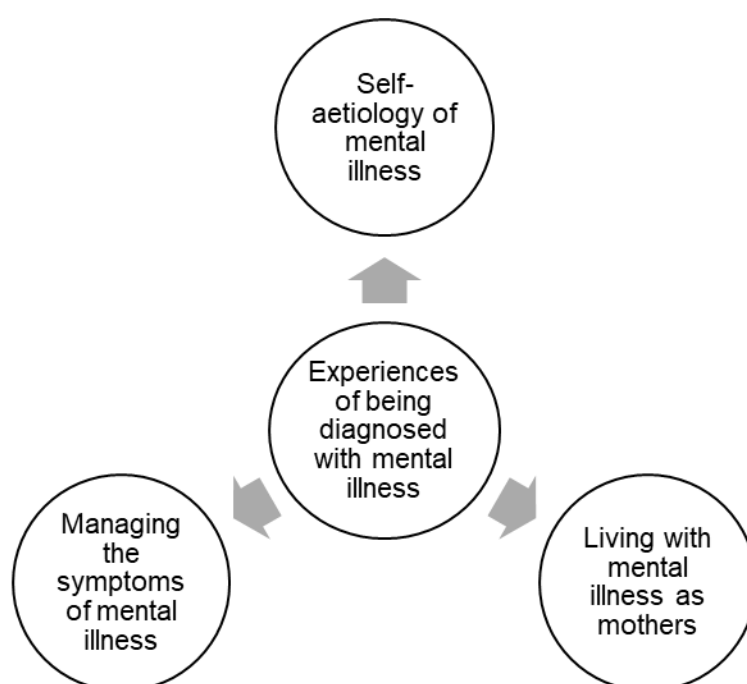
Figure 6.1: Experiences of receiving the diagnoses of mental illness

Self-aetiology of mental illness

Multiple explanations were held by participants regarding the causes of their mental illness. The beliefs and knowledge of mental illness among the participants ranged from spiritual, to biological and social problems. More than half (11 of 20) of the participants believed that their mental illness was from spiritual forces such as bewitchment, being maliciously attacked by wicked people with evil powers, or being possessed by evil spirits. This subtheme was supported by excerpts from four participants' texts:

> *"There was a sacrifice in front of my shop. I went there and threw the sacrifice away. Nothing happen until two or three months after I started*

feeling sick. … I was attacked by other market women that are jealous of my fortune" (Rabiatu).

Tinuola reported:

"I believed my illness is not natural, I'll tell you the truth, I still see them [spirits]. They talk loud to my ears, I can't sleep, they follow me everywhere. Won ma damilamu pupo [the spirits trouble me too much] I hurt people around me when I run from them."

Sefinatu stated:

"I have been having dreams upon dreams, and the illness started. My illness is from my enemies because they don't want me to be successful that was why they attacked me"

Enitan said:

"Is spiritual attack, I saw black birds coming to our house at nights, at times cat and these are evil things, a warning that bad things like death, sickness will happen, very bad evil things […] The devil is fighting for my soul."

Participants were of the beliefs that their mental illness was caused by supernatural forces such as being possessed by evil spirits and believed they suffered spiritual attacks from enemies. The interpretation of mental illness to supernatural forces by participants could be explained as cultural influence. The Yoruba interpreted life experiences from a spiritual worldview, they had the belief that the world is made up of physical and spiritual realm and events taking place in the physical world have been determined in the spiritual dominion (Ayodele, 2016; Awolalu,1981). They believe that ill health such as mental illness can be caused by malevolence of enemies (Jegede, 2005). Also, it can be caused by being controlled by aggressive spirits as a punishment especially if the person has committed an offence (Olugbile et al., 2009). From the quote, a participant (Enitan) reported seeing blackbirds and cats before the manifestation of the symptoms of her mental illness. There is a belief that people with immanent power can cast spells or bewitch another person to have a mental illness. Certain animals such as owls, cats, spiders, werewolves, or effigies are believed to be instruments used by wicked people to perform destructive acts such as mental illness (Adekunle, 2018). Further, the Yoruba have a belief that the spirit (*emi* or *eleda*) of a person can be affected to cause sickness or death through a dream or in the night, as it is always stated '*oru laseka'*, that is, evils are done in the night (Olugbile et al., 2009). With the worldview that good or ill-health are spiritual issues among the Yoruba, it is cultural for individuals suffering from mental illness to attribute it to spiritual attack, meaning '*asasi'* or '*afise*' (Egunjobi, 2020; Jedege, 2005), just as reported by 11 participants in the present study. This finding revealed how cultural belief affects people's thoughts and feelings about health and illness.

Multiple causes of mental illness were given by participants in the present study, likewise, different views about the cause of mental illness were reported by participants in Araten-Bergman et al (2016). The supernatural causes of mental illness held by 11 participants in the present study were similar to the findings of Araten-Bergman et at. (2016). At the same time, there are differences between the current study and the other study. Participants in the present study were only women while Araten-Bergman et al (2016) samples were men and women. Again, samples in Araten-Bergman et al (2016) were older in age, they were between 60 to 69 years compared to participants in the present study with age ranged between 21 to 55 years. While Araten-Bergman et al. (2016) consisted of 18 participants with schizophrenia, the present study recruited women with different diagnoses of mental illness. Araten-Bergman et al. (2016) reported their mental illness as fate and correction from God for their sins, whereas participants in the current study linked their mental illness as wickedness from evil people. The findings of the current study are also compared with Makanjuola et al. (2016). The majority (70%) of participants in that study reported spiritual causes of mental illness as they believed that they were bewitched or spiritually attacked by enemies. The differences between the current study and Makanjuola et al. (2016) are: the present study only sampled women and recruited participants from mental health hospitals. The latter study was conducted in three different countries, consisting of men and women from traditional healing centres.

Different explanations about the causation of mental illness were reported by nine other participants who did not view that their illness was caused by spiritual problems. Their explanation can be understood in terms of biological, environmental, psychological, and social problems. These extracts illustrate participants' causal attribution of their mental illness:

Riyike reported:

> *"I starts experiencing my illness when I was in secondary school. You see my father erupted with the same illness, schizophrenia, my own was originally schizophrenia which I actually know the symptoms properly. I carry all his good and bad genes" (Riyike).*

Another participant revealed:

> *"I don't know that stress, thinking, sadness, can lead to sickness, this problem has been there for 12 years, when my son went to prison. […] Is my first son now, he supposed to care for me and care for his younger ones, he supposed to be the family breadwinner. […] when you are carrying a load that is too much for you to carry, you cannot be the same person again" (Ebunoluwa).*

Adama stated:

> *"I had accident that I stay long in hospital. I start feeling unwell. I didn't notice it at first is after washing I will be panting seriously; it will take time before I get myself back. It keeps on increasing and increasing, I just believe something wrong with me internally"*

Another participant said:

> *"My mother in-law was on my neck, is like I don't want to give her grandchildren, my husband told me the way I worry can affect me but men being what they are, maybe he has children outside, I ignore him so I worry too much, about on unnecessary things, at the end of it I am affected"* (Bidemi).

A participant (Riyike) reported the cause of her mental illness as hereditary from her father. Having the same health problem as her father may be the reason for not linking her illness to spiritual problems or it may be that education has increased her knowledge about causes of mental illness. Issues such as imprisonment and childlessness are big social problems in the Yoruba tradition. In the Yoruba context, individuals with an imprisonment record do have difficulties in getting a job (Yekini and Salisu, 2013) and participating in community activities (Shojabi-Ibikunle, 2014). They are labelled '*elewon*' (ex-convict), and the shame and stigma associated with being an ex-convict or serving a jail term extends to the families of individuals who have had a prison experience (Ajala & Oguntuase, 2011; Osayi, 2013).

Similarly, motherhood is regarded as one of the most valuable aspects of a woman's life as it is usually said '*Woman's glory is crowned in childbirth*' (Kimathi, 1994, p. 82). In Yoruba culture, women are usually blamed for childlessness (Baloyi, 2017; Fehintola et al., 2017; Okonofua et al., 1997), a woman can be divorced by her husband or pressured by family members to end the marriage if the wife bears no children (Oduyoye, 1995; Siwila, 2015). This is emphasised by Mbiti (1991, p. 41) saying, "*If there is not yet a child in the marriage there is no guarantee that the marriage will endure*". Imprisonment and childlessness attract stigma in the Yoruba culture, women experiencing such problems may become ill because of stress and social implications.

Attributing the cause of mental illness to social factors has been discovered in previous studies (Nohr et al., 2019; Ntshingila et al., 2019); however, the nature of the problem is different. For example, participants in Nohr et al. (2019) attributed their mental illness to excessive alcohol consumption influenced by Cuban drinking patterns and the pressure of meeting family demands. The social problems identified in Ntshingila et al. (2019) was as a result of negative childhood experiences, such as loneliness, sexual abuse, and living in an environment characterised as having a high rate of violent crime. Multiple explanations of causes of mental

illness discovered in the present study suggest that health and illness are determined by different factors and not limited to biological factors alone.

Living with mental illness as mothers

Participants were recruited based on those living with mental illness and their willingness to share their experiences. There were 12 mothers among the 20 women that participated in phase one. The experiences of the 12 mothers include the difficulties of not being able to carry out their social role as mothers and wives, or they had had their children taken away from them because of their mental illness. Quotes from three participants' scripts were used to support the findings:

Labake responded:

> *"Is over five years I left his [husband] house. He said, 'you can't live with me with this madness, you can't care for me, you can't bear children again'. He didn't visit me in hospital […] doesn't want to see me again, I live with my mother"*

Another participant said:

> "*I couldn't bath for my children even me I was not able to wash, not doing many things. So many times, I said why am I like this. I think in my mind that what I was doing before this sickness [mental illness] I can't to do it any longer*" (Adunni).

Adetutu reported that:

> *"I have not seen them [*her children*] for long time. He [husband] took them, [...] I was crying, so, I just came back to my senses that I don't need people to ask what I need because they cannot even give me what I need, I need to see my children.*"

The above quote from participants' interviews revealed how mental illness affected motherly roles and relationships. For Labake, it was an experience of a broken relationship. She spoke of how she separated from her husband because of her mental illness. Her husband believed she could not be a good wife or mother again because of her mental illness and separated from her. Experiences of these mothers could have been caused by the severity of their mental illness or explained from participants' community understanding and response to mental illness. Rather than the symptoms of mental illness, the shame and ridicule of having a wife with mental illness in the Yoruba tradition may have influenced the separation. Culturally, Yoruba people believed that mental illness is incurable, and the illness affects the person's offspring. Also, it is believed that people suffering from mental illness have functioning impairments (Jegede, 2002; Olabode, 2009). Thus, the husband may believe that her children may have mental illness like her which the husband may be trying to avoid. The patriarchal system that dominates the participants' community gives a man the right to divorce or separate

from his wife on account of illness (such as mental health problems), infertility, or to run a polygamous home (Aluko, 2015; Akintan, 2013). Adetutu stated her children were taken from her by her husband and was not given the opportunity to have contact with them. It could be argued that Adetutu was denied access to her children by her husband because of the stigma of having a wife with mental illness. It may also have been to protect the children as it is believed that persons with mental illness are violent and can cause harm. Participants who were unable to care for dependent children because of symptoms of mental illness were identified in the present study and this was similar to the findings of Bartsch et al. (2016). Participants in the present study and Bartsch et al. (2016) had hospital admission which further affected their motherly role. Participants (five of the 12 mothers) in the present study had their children taken away from them by their spouses. Similar to mothers in phase one of this study, mothers in Blegen et al. (2016) had the same age range as the present study participants. Participants in the present study and Blegen et al. (2016) experienced challenges in caring for their children because of their mental illness. However, having children withdrawn from their mother's care and separation experienced by a few participants in the present study was not discovered in Blegen et al. (2016). Mothers in Blegen et al. (2016) had opportunities for therapy and were encouraged to discuss their struggles about caring for their children, though they were afraid to do so because of the fear of losing their children's custody to government child safety agencies. The situation was different to mothers in the present study, support about childcare was only from participants' families. Participants in Blegen et al. (2016) had experiences of having their children removed from them by the Child Welfare Agency.

Since the majority of the participants (12 of 20) constituted women with children, it was decided that the experiences of this group of women needed more investigation which led to another data collection exercise. It was believed that interviewing more mothers about their lived experiences would provide a deeper understanding of mothers who are living with mental illness. Their situated experiences can be fully explored with another set of interviews and interview guide prepared for that purpose. This aim was achieved in phase two of this study and presented in the next chapter.

Managing the symptoms of mental illness

The individual's perception regarding causes of mental illness may influence help-seeking behaviour. In the present study, the majority (16 of 20) participants reported receiving treatments through other means apart from medical care. The following excerpts are used to support the findings:

Labake stated:

> *"I have travelled to convention [prayer camp] to meet my Lord, I put in for deliverance, and reverend father prayed for me. I was in church yard for long time praying and fasting, my Lord has divine power to cure me."*

Another participant responded:

> *"Medication cannot cure it [mental illness] unless I back it with prayer […] I don't joke with prayer. I fast a lot I believe all things are possible with God. Doctor will try is only God that cure, one day he [God] will visit [cure] me" (*Ebunoluwa).

Similarly, Feyisara said:

> *"'We [herself and her family] consulted some Islamic scholars they prayed for me; I pray in mosque. Prayers from men of God help in my situation. Now I leave everything to him [God], he will take it [mental illness] away from me"*

Ojuola reported:

> *"These drugs can only maintain the person to calm down, to sleep but it cannot cure the koko (the main thing: the mental illness). […] I take agbo [herbal mixture], I take native drug, I use it to bath […] I want my brain sharp as before*"

When suffering from illness, seeking liberation from distress, becomes the fundamental issue. Though participants were accessing medical facilities for the treatments of their mental illness, they also reported seeking spiritual help to cure their illness. This was not limited to participants who reported spiritual causes of mental illness alone. They believed that medication alone could not completely cure their illness but could do in conjunction with spiritual treatments. Participants reported engaging in religious activities such as praying and fasting, attending prayer sessions for deliverance, used herbs from traditional healing clinics. The holistic care provided by traditional and faith clinics may contribute to participants seeking treatments from them. Prayer and herbs may provide relief to their suffering, but such religious practices may worsen their mental health symptoms. In the act of observing fasting, they may not be able to eat, use their medication as prescribed, or be unable to sleep well because of prayer sessions. Most herbal mixtures have no measurements and are difficult to monitor (Ekor, 2014), and the use of herbal mixture with conventional drugs may cause other health problems (Fatima and Nayeem, 2016).

Managing the effects of mental illness through religious activities was discovered in the study of Tuffour et al. (2019). Participants in Tuffour et al. (2019) were identified as a black African minority group, using religious activities in addition to medications to alleviate their mental illness distress, similar to findings in the present study. However, the samples in Tuffour et al. (2019) consisted of men and women while participants in the present study were of the same gender. Rather than seeking alternative treatments, participants in Biringer et al. (2016)

engaged in physical social activities to reduce negative thinking. In addition to that, the authors found that participants accessed different information on how to positively manage their illness. Participants in Biringer et al. (2016) were likely to have a higher level of recovery than the sample in the present study. Furthermore, Bringer et al. (2016) study was conducted in Norway, so information about mental illness may be more readily available to patients than in Nigeria and the possibility is that participants were more technologically literate than those of the present study. Differentially, Lee et al. (2020) and Yeisen et al. (2017) participants relied solely on the use of medication. These two studies were conducted in the USA and Norway respectively, the differences in seeking help among participants of these studies and that of the present study could be linked to cultural and environmental factors.

Still on managing symptoms of mental illness, participants in Saavedra et al. (2016) were said to use employment as a method of reducing the effects of their mental illness. Saavedra and colleagues also discovered the negative effects of employment on participants such as reduced energy and low earnings because of absenteeism. The majority of participants in the present were unemployed compared to participants in Saavedra et al. (2016), it may be that participants in Saavedra et al. (2016) had fewer symptoms of mental illness than the present study participants. Again, there may be more job opportunities in Spain than in Nigeria or people with mental illness are less stigmatised in Spain than in southwest Nigeria.

Impacts of mental illness

Living with mental illness affected many areas of participants' lives. The illness disrupted their social activities, affected their social identity and they suffered losses. This theme has three subthemes, they are stigma and discrimination; fear and secrecy; and loss of opportunities. The theme and its subthemes are presented in figure 6.2.
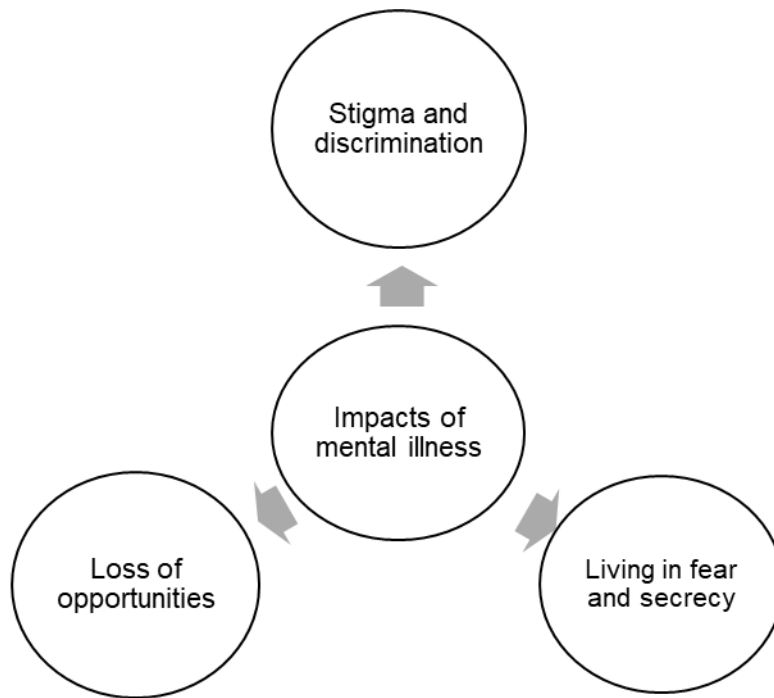
Figure 6.2: Summarise the impact of mental illness on participants

Stigma and discrimination

Participants who reported they experienced discrimination are being stigmatised because of their mental illness were more than half (13 out of 20) of the women who were interviewed. These extracts illustrate participants' views of the ways in which social stigma towards mental illness affected them within the family, among friends, and in the community:

Derayo reported:

> "They (neighbours) will abuse me, mad woman, crazy woman, they are calling you at Yaba (mental hospital). They say bad words that make me sorrowful. They cause trouble just to abuse me"

Another participant stated:

> "Since my illness started my friends are cold to me. Before they would visit, we talk, we do things together. We are not close again, I don't go to party with them, and they don't come to my place again, we are in a different world now" (Jayeola).

Tinuola revealed:

> "Everybody in our village know that am not well. I said things I don't know myself, some people called me witch. They chase me and beat me for destroying their things. […] My mother had restaurant where she sells food. Some of her customers left, they said am a witch"

Similarly, Riyike reported:

"When am with them [siblings], they behave warily, one by one they disappear […] they don't involve me when doing things in family, and if am not happy with their idea, they say, erm, is your illness. I feel like outside person"

Different experiences of stigma and discrimination were reported by participants because of their mental illness. Their experiences of stigma and discrimination were from friends, families, and their community. The forms of discrimination experienced included physical abuse, social rejection, apathy, provocation and being discredited by family members. It created hurt feelings for participants because their conditions were not given consideration by people who were expected to show empathy and protect them. Though the actions of friends and families are not justified, families and friends' behaviour towards participants may be influenced by cultural beliefs about the causation of mental illness. This is reinforced by poor mental health literacy among the public (Aluh et al., 2018; Atilola, 2016). Symptoms of mental illness may be misinterpreted as dangerousness and the intention of the participants to attack people around them. Stigma and discrimination may cause participants to have withdrawn themselves from social activities and they may lack support from families and community members.

Similar findings have been discovered in other studies (Burke et al., 2016; Huggett et al., 2018; Ibrahim et al., 2016). In the study of Burke et al. (2016), experiences of mental illness stigma among the 12 participants included humiliation, being ignored, and excluded from taking part in social activities. As reported, the impacts of these discriminatory acts led to social withdrawal and interaction problems. In addition to stigma and discriminatory attitudes from family and friends, Huggett et al. (2018) participants reported experiencing stigma from their services providers. Explaining their experiences from family, friends, neighbours to health professionals, they described it as a "hierarchy of stigma". While the participants themselves were treated differently by family and friends, their families were also stigmatised because of their mental illness. This finding was consistent with Ibrahim et al. (2016) where 65% of the sample reported physical abuse, neglect, and poor social support. Further, a higher level of stigma made 22.5% of participants report suicide intention. The study of Burke et al. (2016) and Huggett et al. (2018) were conducted in the UK whilst Ibrahim et. al (2016) was carried out in Nigeria, but stigmatisation and discriminatory experiences were peculiar to the studies' participants. Though the level of stigma may differ because of the types of diagnosis, severity of symptoms, and the duration of the illness. These findings signify that regardless of age, race, or ethnic background, people living with mental illness do experience stigma and it is detrimental to their health and wellbeing.

Instead of discrimination or hostility, others (seven participants) reported receiving support from colleagues, friends, and church members. According to them, the support of these people had improved their health condition:

A participant reported:

> "From office they noticed that I was not me, is my colleagues that noticed I was just aggressive […] I was just unnecessarily aggressive, the way I was responding on phone, sending mails, the way I was just behaving to people, they noticed is not the usual way they just get across to my family" (Iyabo).

Another participant revealed:

> "It was difficult for me to raise money for my medication and come regularly. […] I have people assisting me. I don't want to mention names, but one gave me about sixty thousand naira (£120) which I use to buy injection, tablets. I have people that bring me here regularly with their car, so my health is improving" (Adetutu).

Ewatomi stated:

> "Sometimes when I feel like talking to someone, I have an elderly woman since I don't have parents, I asked her any anything, when I asked her questions, she will answer me, she will counsel me. sometimes she will tell me, is not good for you to stay alone come and stay with me."

Another participant said:

> "I have a true friend that knows about it, then the elders know, that is in the church, […] they have to find out what the problem was and then I don't have to hide for them. They have to pray with us [herself and husband], so we explain to them. They visit regularly to ask about my welfare" (Jayeola).

This finding demonstrated that the experience of illness is different for individuals. Though all the participants were from the same setting with the same illness, their experiences of the same phenomenon differed. Social support for people with mental illness can motivate and encourage them to have regular treatments and be involved in activities that will promote their recovery. The benefits of social support enjoyed by participants may include emotional and psychological help compared to participants that concealed their mental illness.

The finding of the present study is different from Huggett et al. (2018) where participants were said to have a hierarchy of stigma because of their mental illness. Further, the present study's finding is contrary to what was discovered by Ibrahim et al. (2016) where 65% of the study participants were stigmatised by people who had knowledge of their mental illness. Ibrahim et al. (2016) study was conducted in the northern part of Nigeria while the present study was carried out in western region of the country. The differences in the findings of Ibrahim et al.

(20116) and the present study strengthened the claim that experience of health and illness differs in person and culture.

Living in fear and secrecy

This second subtheme explained the situation of participants upon their diagnosis. Non-disclosure of mental illness was reported by more than half (11 of 20) of the women who participated in the research project. The following quotes provided insight into their mental illness experiences:

Kunbi reported:

> *"Nobody knows about it [mental illness] at my place of work […] I cannot disclose my illness to anyone because of nasty behaviours from people and because of what I experienced […] my school friends were cold to me. If I disclose it at work, I may lose my job"*

Another participant revealed:

> *"I can't not say it; I hide it [mental illness] from people and my colleagues because if they know that I have this type of sickness they may not behave well to me again. People don't count anybody with mental illness as a normal person"* (Sefinatu)

Asake expressed her view by saying:

> *"Is better they don't know your secret. People gossip too much; before you know it, your story will be everywhere, I don't know if I will be able to handle how people will behave to me. I stay at home if am not well, I say to my customers that I travelled"*

Similarly, Adunni reported:

> *"There is no way you can talk to somebody that you are coming from a psychiatric hospital, is a taboo. They will tell you; you are crazy, you are this and you are that. So, I keep it secret, I don't tell anybody"*

Reasons for concealing mental illness by participants included the fear of being dismissed from work. From the excerpts, work (either employed or self-employed) has contributed to participants' interaction with other people in their community. It is a source of income for them while promoting their wellbeing. The study of Biringer et al. (2016) highlighted the positive effect of employment on people with mental illness by facilitating their recovery. From participants' perspectives, disclosing their mental illness may stop them from working and lead to financial problems. Participants had a realistic view of what they would experience if their mental illness was made known to the public, such as not being treated as a 'normal' person, abuse, and isolation. They believed hiding their mental illness would save them from the

stigmatisation associated with mental illness and emotional distress that may arise from the behaviour. On the other hand, concealing mental illness has disadvantages as it would also reduce their social interaction to prevent others from having knowledge of their illness. The consequences of their limited social interaction may deprive them of job satisfaction at the workplace and a reduced their sense of belonging in the community. Further, they may not be able to receive needed support if their mental illness is not known to others, making life more difficult.

Rather than concealing mental illness as discovered in the present study, participants in the study of Mora-Rios et al. (2016) made their mental illness known to others. They experienced stigma and discriminatory practices that prevented participants in the present study from hiding their mental illness. However, they developed methods of coping with people's attitudes towards them, such as tolerance, and challenging behaviours that were not favourable to them. The sample and clinical presentations of participants in this study is different from Mora-Rios et al. (2016). First, all the 23 participants in the study of Mora-Rios et al. (2016) were diagnosed with schizophrenia while participants in the present study had different diagnoses. The nature of illness of participants in Mora-Rios et al. (2016)'s study may have made it difficult to conceal their mental illness. Secondly, participants in the present study were women who may have found it stressful to deal with public stigmatisation. On the contrary, Mora-Rios et al. (2016) sample consisted of men and women who were said to use methods of social withdrawal and challenged discriminatory attitudes to limit unpleasant responses. However, the lack of elaborate explanation from the authors did not specify the gender that used these methods.

The remaining nine participants said their illness was known by others for different reasons. The following quotes are from five of the participants who had those experiences:

A participant reported that:

> *"I have a true friend that knows about it, then the elders know, that is in the church, […] they have to find out what the problem was and then I don't have to hide for them. They have to pray with us [herself and husband], so we explain to them. They visit regularly to ask about my welfare" (Jayeola).*

Bidemi said:

> *"What I tell people is am a depressed patient […] so whatever you think it doesn't concern me and if you want me to talk more about it, I will tell the person everybody has their own illness. There are people with diabetes, cancer, people with depression will go to any hospital that can cure it."*

Isioma stated:

> *"They will say things at my front; they will say it at my back. I don't care, health is wealth if I don't take my drugs anything can happen. I don't mind, anybody can say what they like […] because somebody laughing at me will not prevent me to take my drugs. […] I know at least one day I will be okay"*

Derayo revealed:

> *"I don't hide it like others, I do tell people I am a psychiatric patient, but I have overcome it am only going to hospital for maintenance […] to some extent you will know that something is wrong somewhere if in case of anything you will have to understand me better, they will know how to interact with me"*

Ewatomi said:

> *"At least I feel much better now, whether people know me with it or not, I want to get well and take care of my children […] since I still have chance of coming here and am using my drugs, it can't be for ever, it will go, I will get better"*

Some participants disclosed their mental illness for spiritual support, or to have social interaction with other people, while some were just not too concerned about stigma but about their recovery. Disclosing their mental illness may have given them courage to continue receiving treatments and support. Their different outlook on their mental illness influenced their health behaviour compared to other participants that concealed their mental illness. This group of participants may have experienced higher self-esteem, more social network and reduced internalised stigma.

Contrary to this finding, the study of Thoits (2016) in the USA discovered that 77% of the participants used a deflecting strategy to rebuff their mental illness instead of disclosing the true state of their mental health. While Thoits (2016) participants' responses can be argued as being a strategy to reduce stigma for not disclosing the true state of their mental health, it could also be that many of the participants that rebuffed having mental illness had not been assessed for mental illness. However, public knowledge about mental illness is expected to increase and public attitudes towards people living with mental illness should encourage more disclosure of the illness compared to Nigeria.

Loss of opportunities

Living with mental illness can affect daily life functioning and reduce life expectations. Out of the 20 participants, 11 reported difficulties of achieving desired goals in different areas of their lives as revealed through the following extracts from three participants:

Omoyeni explained:

> *"I was in my 200 level in uni (second year in university) the time my sickness started. What happens is that I can't read, everything about accounting is mathematics, I can't sit down to read, I was not concentrating. I failed my exams because my sickness was not allowing me to concentrate, I pulled out"*

Another participant said:

> *"There was somebody I really crave to marry, I really loved him but unfortunately, this illness affected the relationship. […] you know, I think he was afraid of taking someone that is mental as wife"* (Feyisara).

Adetutu responded:

> *"All about fashion designer's work it to think, since my sickness my sense is not like before. I started forgetting things, I can't set plates on sewing machine, I am not well to do the job again. […] Now I can't make money, people are feeding me"*

Depending on the age of onset and the type of mental illness, the illness affects people's functional and working capacity in various ways. Participants reported the different ways in which their life has been affected because of having a mental illness. It included not able to marry and raise a family for themselves like other women without mental illness. There are other women who experienced setbacks regarding their educational status and career path. In addition to stigma and discrimination associated with mental illness, symptoms of mental illness can make studying or working become impossible. Lack of energy and poor concentration related to mental illness can result in poor attendance and make the prospect of pursuing a career difficult. Returning to study or getting a job may be a challenge to these participants (11 of 20) who reported a loss of opportunities. Although this was not the main focus, the experience of loss was more prominent in participants with severe symptoms compared to those with fewer symptoms of mental illness.

The quantitative study of Buchman-Wildbaum et al. (2020) discovered similar findings. The losses reported in Buchman-Wildbaum and colleagues were unemployment, unable to achieve high school education, and disruption of normal daily routine. In addition to losses reported by the Buchman-Wildbaum et al. (2020) participants, the sample in the present study reported difficulty in getting married while all the participants attained high school education. The sample size of Buchman-Wildbaum et al. (2020) was bigger (200 participants) and consisted of both men and women while the present study was conducted with only 20 women. The finding is also consistent with Tanaka et al. (2018) where participants reported unemployment and reduced social contact.

Views on mental healthcare services

Participants' perceptions regarding the mental health services were arranged into three subthemes: cost of treatments, staff attitudes, and excessive waiting time. Their views were centred on the challenges experienced before they could receive treatments. The participants' views are summarised in figure 6.3.
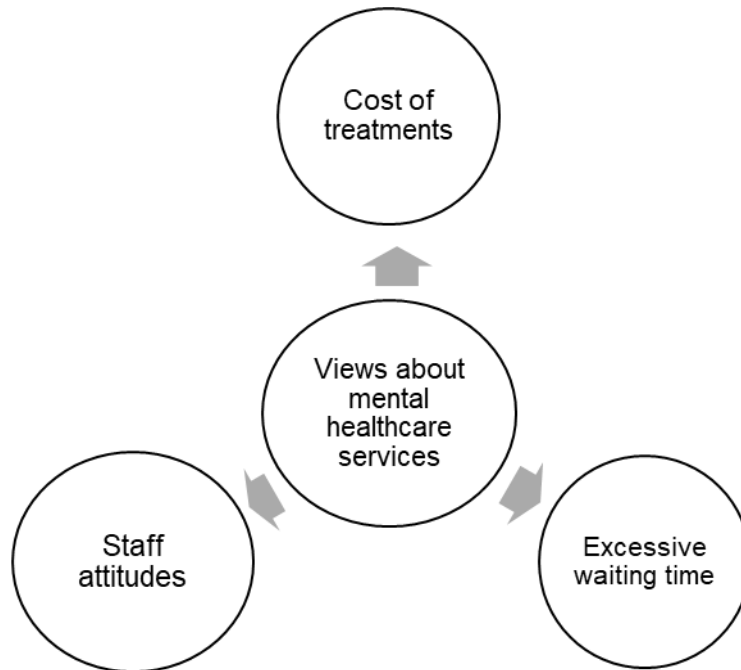
Figure 6.3: Perceptions about mental healthcare services provision

Cost of treatments

Nearly all the participants (15 of 20) reported the cost of services as one of the barriers to mental health services utilisation. This cost, as stated by participants, included the price of medication and transport to where hospitals are located. Participants' experiences regarding the high prices of medication are presented below using excerpts from participants' transcripts:

Derayo reported:

> *"The medicines are too cost; I am not working. So, I don't take the drugs all the time, I use formula one-zero-one. One in the morning, I won't take anything in the afternoon, in the night I take one again."*

Similar report made by Tinuola:

> *"My drug is expensive, Seroxat [antidepressant] is N10000 [£22.47]. I can't buy in bulk, I use to buy in sachet, just small portion. Sometimes I beg for money to buy them. Is tough for me to buy my drugs."*

Another participant revealed:

> *"Medication is always available but is expensive. Well, for poor people like me, is too cost. I use two tablets which is N7000 [£15.73]. Sometimes is more than that, the price is not fixed"* (Asake).

Ojuola stated:

> *"They said ern, if you want to go home with all drugs on your paper you must drop N17650 [£39.66]. That is too much, I don't have that kind [of] money […] I only buy the one that will soon finish, the counting one."*

As stated by participants, the high cost of medication was regarded as a big problem in accessing and maintaining treatments for their mental illness. Some of the participants reported missing their daily dose or buying as small amount as they could afford. Further, it was stated that the price of the medications was not stable, that is, sometimes participants may have paid more than their budget on getting to the medication dispensing place. Lack of income or low income by some of the participants (14 of 20) contributed to the difficulties experienced in purchasing their medication. The inability to use their medication regularly as prescribed may have worsened their mental illness symptoms and increase their suffering.

Participants in the present study and the Iseselo & Ambikile (2017) sample in Tanzania acknowledge the efficacy of the medication but stated lack of access to regular use of their medication as prescribed. In Tanzania, treatments of mental illness were free as discovered by Iseselo and colleagues, whereas, individuals paid for mental healthcare services in Nigeria. Participants in Iseselo & Ambikile (2017) reported the reasons for not using their medication as directed by their doctors was because of irregular supply of medication in government hospitals and the expensive prices at private pharmacies. Contrarily, medications are available in Nigeria government hospitals as stated by participants but at high prices. In Iseselo & Ambikile (2017), participants wanted to support the government to increase the number of medication supplies by contributing money. On the other hand, participants in the present study expressed the desire for the price of medication to be reduced or free treatments.

The cost of treatments, as stated by participants, included difficulties in accessing the mental health facilities because of the locations which had increased their spending. Excerpts providing insight into participants experiences of inconvenient access to mental health hospitals are presented:

> "I came yesterday and spent the night here (clinic), so I can see doctor today. It is hard for me to come for appointments because of distance. […] I don't like missing my appointments, but distance and transport money is my problem (Tinuola)"

Another participant said:

> "I am not here always. Where am living is very far that is why when I come to fellowship in church […] The fellowship is every Wednesday morning. I will stay overnight in church and come to clinic on Thursday morning" (Asake).

Adunni reported:

> "The distance is too much I can't come to clinic, see my card the last time I was here, three months ago, […] chemists are not selling these drugs we are buying here, is difficult to buy my drugs once it finished, the distance is affecting me"

Riyike stated:

> "It is hard for me to come as the doctor said because of distance […] Since I know this is the drug I am taking, let me continue to be using it, then why am I coming to hospital?"

Another participant said:

> "I don't come regularly, distance from my station to here is far, why I come today is to tell doctor […] to allow me get my injections from doctors at general hospital where I serve, I can't continue coming, is far and road is not good" (Isioma).

The location of mental health hospitals out of locally accessible areas was reported by participants as an additional challenge to the high cost of medications. The majority of the participants lived in rural areas or outside the states where they were receiving treatments (see table 6.1). While some participants reported moving from their houses to somewhere near mental health centres, others reported staying in the clinic overnight to have treatments. The money spent on food and transportation may have contributed to participants' inability to buy enough medication and lack of faithfulness to their treatment regimen. Further, the stress of spending long hours on the road may have discouraged people from maintaining treatments. It implied that many people in need of mental healthcare may not be able to access it. Thus, the mental health system should be reformed to make provision for facilities that are within people's environment.

The geographical location of mental health hospitals was identified as part of the barrier to using the facilities in Hailemariam et al. (2017). Walking to the clinic was reported as the only option in this study and it usually took a few hours to get to the hospital. Caregivers stated the difficulties of bringing sick relatives with little strength by foot to the hospital. Participants in the present study and Hailemariam et al. (2017) were of the same age range but the sample in Hailemariam et al. (2017) included both men and women while only women were interviewed in the present study. The present research project was conducted with women that were accessing mental health services while Hailemariam et al. (2017) included those who were receiving treatment at the time of conducting the study, those who have stopped treatments, and people who had never used hospital treatments. Families and service providers of people with mental illness were interviewed in Hailemariam et al. (2019) while the present study is limited to the investigation of service users only.

Staff attitudes

Participants (11 of 20) reported staff attitudes in medical settings were found to be negative. They explained that staff exhibited negative behaviour such as verbal abuse and ignored participants during interactions. Some of the participants' statements regarding staff negative attitudes are stated below:

Ojuola stated:

> *"Staff is the problem here. If you talk to them politely, they will still be rude to you. […] They can remove your file and put it at back you will be the last person to see doctor. Even when I got to the doctor's office, she was still excused out, conversing with colleagues. They treat us this way because of our sickness."*

Iyabo reported:

> *"They [nurses] talk down on people because they [patients] are here for one reason or the other […] they look at you as a pauper. You will be ashamed when they shout at you in front of others. They don't have regard for anybody."*

Another participant stated:

> *"Most times conversation is too much between them, I said this is a mess when people are in pain. It was when they saw that my voice was loud that was when they started doing something, reshuffled the whole thing. They pretend not to hear when you talk to them, they don't like to stand up when is getting to closing time, […] She[staff] said am not collecting paper again, come tomorrow"* (Feyisara).

It appeared that staff was enforcing over participants because of their knowledge of participants' care and treatments. Different negative attitudes such as refusing to allow them

to see a doctor when it was their turn, shouting at them in the presence of others to ridicule them, and not attending to their needs. The negative behaviours of the staff could be explained as punishment to the participant for challenging their actions. On the other hand, it may be that staff were overstretched in meeting the demands of many patients attending the hospitals. Participants may become fearful and unable to disclose important information about their treatments to staff. It is possible that patients may not have their needs addressed by staff.

Kisa et al. (2016) found in their multi-site study that participants reported unfavourable feelings about their service providers because of discrimination and were spoken to harshly, threatened not to be treated, or not attended to when they came late for appointments. Both Kisa et al. (2016) and the present study were conducted in developing countries and shared the commonality of limited trained mental health workers. In addition to other challenges that participants experienced, the unfriendly behaviour of staff may discourage patients from accessing the services. The negative staff attitudes reported by participants in the present study can be compared with Burke et al. (2016) findings where participants reported been treated differently from others without mental illness. However, Burke and colleagues did not provide more information on the treatment received by their participants that was reported as unsatisfactory.

Excessive waiting time

Of the 20 participants, 12 expressed their frustration over spending long hours in hospitals before they were attended to. It was particularly more of concern for people accessing the health facilities from long distance. This finding is supported with the following quotes from four participants:

> *"I usually come here when I am off-duty because I know I will spend the whole day here. You will wait for your card […] then you will go back to reception waiting for doctor to call you. That can take hours before it gets to your turn. The same thing happens at pharmacy"* (Kunbi).

Similarly, Adama reported:

> *"The time we spend here is too much. We queue to see doctor and queue to buy medicine. You cannot come here [clinic] and go quick. People are too many, that is why we can't finish on time"*

Expressed by Bidemi:

> *"People will prefer to go for their businesses than to come and spend a whole day here to see doctor. If you don't see doctor, how will you know medicine to buy? It takes people that really loves you to stay here with you for a whole day"*

Another participant reported:

> *"There was crowd, the queue is not moving. Nurses call us in, batch by batch, […] four or five hours somebody can still be in this place. Many people are from far place, they [staff] should manage time"* (Ojuola).

Participants reported the long length of time spent between the time of registration when they arrived at the clinic, to the time of seeing a doctor and buying medication. According to participants, coming to the hospital meant spending a whole day in the clinic because they would not be able to do any other activities. Participants accessing the mental health clinic from a long distance may have been more affected compared to participants living close to the hospital environment. It may affect participants keeping regular appointments especially those that need someone to accompany them to hospital. Relatives may prefer to go to where they will get an income rather than spending long hours in hospital if there is no empathy.

The excessive waiting time discovered in the present study was different from the one found in Memon et al. (2016). Memon et al. 's (2016) participants' experience of long waiting periods was for initial assessing their mental illness and the likely treatments. Factors such as communication problems, ignorance of hospital services, and participants' choice of health professionals because of cultural issues were responsible in Memon and colleagues' participants. Individuals attending clinics in the UK have a specific time for their consultation time and little waiting time (NHS, 2016) compared to Nigeria there is no specific time for appointments (Ogaji & Mezie-Okoye, 2017).

The cause of excessive waiting time as identified by participants is over-crowding. This can be explained in terms of few mental health hospitals serving many patients. New mental health hospitals are not built to meet the demand of the increasing number of people with mental ill-health (Jack-Ide, Uys & Middleton, 2013). Again, the shortage of mental health professionals in Nigeria also contributed to long hours spent waiting by participants before receiving treatments. For example, there are less than 300 psychiatrists in Nigeria for more than 200 million people (CIA, 2018; The World Factbook, 2021**).** Overcrowding also affects the limited hospital staff who may over labour themselves to attend to all patients in the clinic. The stressful working conditions may affect the health providers and further reduce the number of workers attending to patients, reducing the quality of treatments they receive.

While participants were expressing their dissatisfaction about spending a long time in the clinic, they reported preferential treatment from health workers to other patients. The statements were confirmed during interviews by six other participants who said they did not wait in the queue to receive treatments. Below are excerpts from three participants:

"My auntie is working here so the understanding is there I was brought here straight away. I don't need to queue because my auntie is working here, getting treatment was straight away and it was easy. […] I don't get here very early, people that come in the morning let them come and go before I come" (Jayeola).

A participant said:

"My family is well to do. You know the way our system is. Any time my sister book appointment they answer her quickly because they [staff] see a family that is well to do. They answer us quickly because of what they see" (Rabiatu).

Similarly, Enitan reported:

"I only know one woman there […] I have her number, she do call and I do call her too… So that has been the general belief of everybody because you have to start from somewhere you can't just come in from the gate now […] before you can even come here you must know somebody that can direct you" (Enitan).

Patients were attended to on a 'first-come-first-serve' basis, but preferential treatments were given to the very ill, older people, and pregnant women without joining long queues. During the interview, participants stated that health workers helped their relatives to receive quick treatment under the pretence that they were helping patients that may not have been able to stay in the queue for a long time because of other health conditions. However, health professionals use this method to give immediately treatments to their friends, family, other workers in the hospitals and patients from rich families who arrived late. The inability to involve health professionals in the present study prevented their views regarding participants' claims to be heard. However, differential treatment (except for serious health conditions) is contrary to nursing professional conduct. Instead of the poor practice, nurses are to be dedicated health workers, providing quality of care, comfort, and compassion to patients receiving treatments in their care (Nursing and Midwifery Council, 2015). The behaviour of the health workers suggests oppression of patients, increasing the deprivation caused by the government for inadequate provision for people with mental health problems. This finding was not reported in any of the reviewed literature.

Summary

The experiences of women living with mental illness in southwest Nigeria was stated in this chapter. It explained the different beliefs of participants about their mental illness and how mental illness has affected their aspirations; public behaviour towards participants because of their diagnosis; and participants' reactions following their experiences. The chapter presented participants' perceptions of mental health services provision and their challenges in accessing

the services. The lived experiences of mothers will be discussed in the next chapter for a greater understanding.

Chapter Seven – Findings: Phase Two

In this chapter, attention was paid to mothers with mental illness to understand how they manage motherhood, their ill-health, and the provisions available to them. Phase one of this study focused on the lived experiences of women with mental illness in southwest Nigeria. Among the samples studied in phase one, were mothers with different experiences from other women who never married or had children. Thus, the second set of interviews was conducted with the aim of understanding the subjective experiences of this group of mothers. Phase two of the study was also undertaken in the same two hospitals where the first sets of interviews were conducted.

The analysis of phase two is based on semi-structured interviews conducted with 26 mothers experiencing mental illness, which produced four main themes. The four themes that emerged from the empirical data were: effects of mental illness on mothers; effects of mental illness on children; mothers' views about mental health services; and unmet needs of mothers with mental illness. Each of the themes has subthemes that illuminate participants' experiences, for example, the first theme is called effects of mental illness on mothers. The four subthemes that emerged from this first theme are: effects of mental illness on mothers' parenting abilities, reliance on the support of others, effects of mental illness on relationships, and financial problems. The second theme is titled effects of mental illness on children, and it has two subthemes: mothers' inability to give support; and children as caregivers. The third theme explained the views of mothers concerning the mental healthcare delivery. It has two subthemes; they are lack of public information on mental illness and lack of access to recovery focused activities. Lastly, the fourth theme is focused on the needs of mothers regarding mental healthcare services provision. It has three subthemes: access to financial support; access to free medication, and patients support group. These findings were presented with excerpts from participants' transcripts for deeper understanding.

Participant Characteristics

The study group for phase two of this study were 26 mothers who experienced mental health problems with ages ranging from 28 to 64 years and an average age of 43.31 years. More than half (14 of 26) of the participants were unemployed, 11 were working and one had retired. There were 12 participants who lived separately from their spouse, followed by 12 who were married while two were widows. Their mental illnesses varied in severity and duration, they were diagnosed with depression (9), included bipolar disorder (6) and schizophrenia (11). All the mothers were receiving treatment at the time of the interviews. They had a total number of 69 children ranging in age from three months to over 18 years. Participants' demographic information is presented in table 7.1 and information about their children in table 7.2.

Table 7.1: Participants' demographic information

Name	Age	Diagnosis	Duration of illness (years)	Marital status	Employment status	Children
Wemimo	28	Depression	7	Separated	Employed	2
Busayo	32	Bipolar disorder	4	Separated	Unemployed	1
Gbemisola	57	schizophrenia	14	Widow	Unemployed	3
Mojisola	32	Schizophrenia	6	Married	Employed	2
Funmilayo	34	Schizophrenia	2	Married	Employed	2
Tomiwa	34	Depression	10	Separated	Unemployed	2
Ireti	28	Bipolar disorder	6	Married	Unemployed	3
Bejide	50	Schizophrenia	4	Married	Unemployed	3
Yewande	64	Depression	28	Separated	Retired	5
Adebimpe	59	Bipolar disorder	20	Separated	Unemployed	4
Adesewa	31	Schizophrenia	4	Separated	Employed	3
Ewatomi	29	Schizophrenia	3	Separated	Unemployed	2
Pelumi	62	Bipolar disorder	18	Married	Unemployed	4
Damola	61	Schizophrenia	14	Widow	Unemployed	3
Ibironke	47	Bipolar disorder	8	Married	Employed	3
Faderera	56	Depression	7	Separated	Employed	4
Jumoke	54	Schizophrenia	12	married	Employed	3
Abisoye	35	Bipolar disorder	2	separated	Unemployed	1
Abebi	50	Depression	5	married	Employed	3
Foluke	33	Schizophrenia	15	Separated	Unemployed	1
Semilore	55	Depression	10	married	Employed	3
Abimbola	36	Schizophrenia	11	separated	Unemployed	3
Yemisi	39	Depression	2	married	Employed	2
Temitope	53	Schizophrenia	22	separated	Unemployed	1
Olanike	29	Bipolar disorder	5	Married	Unemployed	3
Folashade	38	Depression	2	Married	Employed	3

Table 7.2: Demographic data of participants' children

Number of boys	Number of girls	Children age range				
		3-12 months	1-3 years	4-9 years	10-17 years	18+
29	40	19	10	13	11	16

Effects of mental illness on mothers

This is the first theme generated from the data analysis, providing an understanding of the participants' experiences of motherhood and living with mental illness. The first main theme called the effects of mental illness on mothers has four subthemes which are illustrated in figure 7.1.
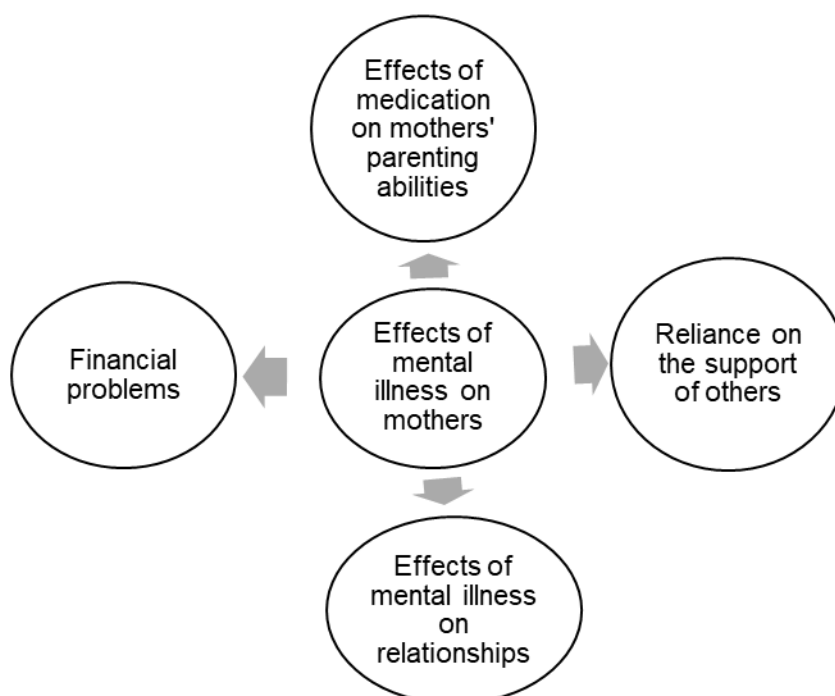
Figure 7.1: Shows the relationship between the theme and its subthemes

Effects of medication on mothers' parenting abilities

Out of the 26 mothers interviewed, 13 reported different challenges in caring for their children because of the side effects of medication. Quotes from four of the participants were stated to provide insight into their experiences:

> *"I'm always tired in the morning because of the drugs that I was using. I don't have much strength to attend to them [children] as a mother. if I take that legatine [medication] the whole room will be turning upside down as if the whole building is rolling, it really weighed me down" (Wemimo).*

Busayo said that:

> *"Most of the time I sleep because of the drugs they [nurses] administered to me. I use paroxetine and other tablets, my eyes will be rolling, the black will go away. I was unable to manage myself or cope with my child. I could not stand properly on my legs" (Busayo).*

Similarly, Gbemisola said:

> *"There are sometimes that I always want to commit suicide when the spirit comes pressuring me to it. […] After I started taking the drugs I always withdraw, I don't discuss with the children, I don't do anything with the children […] I was always feeling tired, always sleeping."*

Mojisola reported that:

> *"When I first gave birth to this child I was on drugs, so I couldn't breastfeed or take care of him because the drug was too powerful. If I want to talk is saliva, my clothes soak with saliva. I always use cloth to hold my mouth, I was too ill"*

Half (13 of 26) of the participants spoke of the adverse effects of medication used in treating their mental illness and how it affected them in their motherly role to their children. The side effects of medication experienced by participants included tiredness, lack of energy, drooling, sleeping, feeling dizzy, and also isolating themselves with no interaction with their children. The effects of medication made it difficult for them to recognise their children's needs. While some of the mothers may have been aware of their children's needs, they had difficulties meeting the needs because of medication effects. The implication of the side effects of medication and the inability to respond to children's needs is that some of the children's needs may be neglected.

This is consistent with the finding of Lee et al. (2020) who found that medication side effects hindered participants' social functioning. The side effects of medication reported by mothers in the present study were similar to what Yeisen et al. (2017) discovered. Findings of Bartsch et al. (2016) revealed the challenges the 12 mothers diagnosed with bipolar disorder experienced in caring for their children, similar to the stress experienced by mothers in the present study, the Bartsch et al. (2016) participants reported being unable to respond to their children's needs such as cooking for them. However, the total number of children in Bartsch et al. (2016) was lower (12) than the number of young children (42 out of 69) in the present study. While only four infants lived with their mother in Bartsch et al. (2016), there were 19 infants below the age of 12 months in the present study living with their mother. Mothers in the present study may experience more challenges because of the higher number of infants they need to care for compared to participants in Bartsch et al. (2016).

Reliance on the support of others

Mothers (13 of 26) who experienced difficulties in meeting the needs of their children sought help from other people around them to assist in performing their motherly roles which they were unable to meet because of the side effects of medication used:

Funmilayo reported:

> *"I wasn't too much in control of myself. People were doing so many things for me at that time. Is good to have a good support system […] my husband and my parents were attending to my children. staying awake in the night, feeding, changing nappies, I couldn't have done that without their support."*

Similarly, Tomiwa said:

> *"Sometimes, because my boy is very stubborn, that my baby I have one neighbour that will help me to look at him when his father is not at home. If am admitted in hospital my husband will take him to his mother"*

Another participant stated:

> *"I don't have money for a housemaid, is my sister helping me. she fetch water, cook and feed my baby. I don't have strength to cook, if I put hand inside water I will be panting as if I want to faint. She [her sister] is the one helping me, stay with them when I go to clinic" (Ireti).*

Whilst Bejide stated:

> *"Those periods that I was seriously ill, he [husband] has to take on the mantle. He took over the kitchen, he was the one doing everything, from one thing to another. He was the one going to market, doing cooking, and doing personal things for me and the children."*

Participants reported different support received such as cooking, watching, feeding, and taking care of infant children when attending hospital for treatments. The support reported by participants was from family and friends, and helpful in meeting the needs of their children. The positive support received by mothers in this study extended from family members to neighbours to ensure that needs of the children were met. The support relieved the mothers of any anxiety they may likely have experienced for not meeting their children's demands and it may have facilitated their recovery. While the finding demonstrated that family members and neighbours are important in ensuring the wellbeing of mothers with mental illness and their children, it also highlights how they shared the burden of mothers, who experienced mental illness. It meant the family members spending time with them and putting aside their own activities to assist the mothers.

This finding is consistent with the work of Awram et al. (2017) in Australia that mothers with mental illness do use support when they lack the strength to carry out their motherly role. While support was given to participants in the present study by family, friends, and neighbours, the Awaram et al. (2017) participants received support from formal and informal sources. This finding is different from previous studies that experienced challenges in caring for their children but were unable to seek needed support because of fear of being labelled as dangerous mothers (Blegen et al., 2016; Halsa, 2018). The 10 mothers in the study of Blegen et al. (2016) had children of the same age range as the participants in the present study and experienced challenges in meeting the needs of their mental illness. Participants in Blegen et al. (2016) reported being unable to ask for help and relied on techniques learned from health professionals. Similarly, 16 mothers in Halsa (2018) refused to ask for help in caring for their children so that no one could perceive them as incompetent mothers and prevents the risk of losing custody of their children. Hence, they decided to parent alone even with the difficulties of meeting their children's needs. The recovery level of mothers in the two previous studies (Blegen et al., 2016; Halsa, 2018) may be higher than that of mothers in the present study. Participants in the present study lived with extended families which is different from the living arrangements of mothers in the two previous studies. The traditions of living with extended family members and the presence of friends in the lives of the present study's participants may have contributed to the positive informal support they received.

Using other people's support when mothers felt they were unable to meet the needs of their children was also identified in the study of Van der Ende et al. (2016). They extended their parenting support to receive assistance from health professionals which was not discovered in the present study. While mothers in Van der Ende et al. (2016) reported diverting their aggression to their children, this was not identified in the present study.

Effects of mental illness on relationships

Of the 26 mothers interviewed, two were widows, from the remaining 24 participants, 12 reported being separated from their husbands because of their mental illness. Experiences of their broken relationships are provided in the following quotes:

Yewande said:

> *"The situation became critical, he [husband] could not endure it again, [..] he said, 'you can't cook, you can't care for me, I didn't request for this [mental illness]', erm, he cannot endure my sickness, he sent me out and married another wife."*

Adebimpe reported:

> *"I had crisis, he could not manage it, he left me […] he took my wedding ring to marry another woman. He said he cannot continue spending on sickness that is not going. He does not want to go ahead with the marriage, he eventually went out."*

Similarly, Adesewa stated:

> *"My husband's relatives were like haaa […] I was the one that was not making him to progress. I am a witch; my sickness is evidence that I was the one behind his misfortunes. I was seriously sick, so he had to send me to my parents' house"*

Foluke revealed:

> "*When the relationship is getting to something serious, to get married and have a home. They [husband's relatives] start noticing something is not right, he [husband] can't hide it from them, his father said he has not found wife, he cannot pay my dowry. Nobody needs to tell me that he left me because of my illness.*"

Participants linked their broken relationships to their mental illness, this can be explained in terms of peoples' belief about mental illness, economic and social factors. A participant reported being called a 'witch' because of her mental illness and what followed was a marital problem. The cultural belief of people in the participants' setting was that mental illness is caused by spiritual forces. Culturally, it is believed that witches have the power to cause misfortunes, sickness, stop people's progress, or even death (Gbule, 2015; Oloruntele, 2009). Symptoms of mental illness such as delusion and hallucinations are believed as confession or indiscreet talk from a witch when exposed by gods or deities for their evil deeds (Gbule, 2015). As it is believed that men (wizards) and women (witches) who were possessed with evil power may suffer from mental illness because of their wickedness (Egunjobi, 2020; Jegede, 2005).

The patriarchal culture of the Yoruba speaking people of Nigeria identified women's social role in household activities such as cooking. Experiencing severe symptoms of mental illness may prevent participants from performing their expected social duties. Again, marriage in Yoruba culture is not just about a man and a woman coming together to form a family, but the union of the two families (Olatunbosun, 2011, Olugbile et al., 2009; Oyewale, 2016). It is a process where each family is required to investigate the person their children want to marry and the spouse's family. They wanted to know whether the marriage would be fruitful, peaceful, and blessed with a long life. Issues such as illness (mental illness or leprosy) and imprisonment could hinder the marriage or lead to divorce if the marriage has taken place (Baloyi, 2017; Olatunbosun, 2011).

Among the reasons for separation stated by participants was the cost of treating the mental illness. It may be frustrating since it is the patient and their relatives that pay for treatments especially when the cost of treatments has been described as expensive. The patients or relatives paying for treatment may be unable to afford the cost if the illness requires long term treatments. Aside from the mental illness, it can be stated that cultural, social, and economic factors played significant roles in the challenges experienced by participants.

Experience of marital problems due to mental illness was identified among the female participants in the study of Islam et al. (2018) in Bangladesh. Though the 19 participants said they had married their husbands at an early age, the presence of mental illness in the life of the women was said to lead to separation from their husbands (Islam et al., 2018). It was reported that the participants went through domestic abuse from their husbands or husband's relatives before their separation. In a similar way, participants in the present study reported being separated from their husbands because of their health condition. The financial strains caused by prolonged treatments of mental illness and the inability of the women to take care of their husbands during the illness, caused frustration and separation. The similarities in the findings of the present study and Islam et al. (2018) provided an understanding of parts of the problems experiencing by women living with mental illness.

It is worth having knowledge of 12 other mothers who did not report separation from their spouses but experienced different problems. Out of these 12 mothers, seven discussed their husbands' abusive behaviour. For example,

Abimbola stated:

> *"He will give me slap, he started maltreating me one he did last, he pushed me inside water, water that I want to use to bathe my baby. […] My sister took me to women affair to tell them what I have been facing in my husband's house. So, they called him, and he started saying I am a psychiatric patient, he started bringing out my prescriptions. Truly as they see that I am taking medication they said we should go home."*

Another participant said:

> *"He will take my money without telling me. If I asked him, he would say he borrowed it or take it by force. My house that my parents gave me […] I discover that he [husband] has sold the place because the CoO [Certificate of occupancy] is with him. […] I will never sell my father's house, my inheritance"* (Adebimpe).

Ireti reported:

> *"My husband used to beat me, serious beating, beat me as if he was fighting with his mate. Last week he hit me again and I fainted, I don't know what happened. When I came to my senses, I saw that I have bruises. if I should leave this home, what will happen to my children, that was my thinking that increases my illness."*

Ibironke recounted:

> *"Nagging and nagging all the time about everything that happens to me, you are too fat, you are lazy, you sleep too much. Whenever I said daddy am fed up with this man (her husband), he (father) said: sofe di dalemosu ni? You will not put bad legacy on those kids because if you leave their father now, they too will marry, and they will be ready to leave their husband if anything happens, endure it"*

Different types of abuse were reported by participants, such as physical, financial, and psychological. Participants reported physical abuse by their spouse, and psychological abuse may go along with this. Physical or verbal abuse may further increase the participants' mental illness symptoms. Physical and psychological abuse were used by the participants' spouse as signs of being tired of the relationships. A mother reported financial exploitation and the selling of her house by her spouse. Financial abuse may lead to poverty which may further increase a participant's mental illness and impact general wellbeing. This kind of abuse can be explained as a way of controlling the participants and makes them economically dependent on their spouse. It can make it difficult for such participants to leave the relationship. Financial, physical, and psychological abuse can create a hostile environment for the mothers and increases their mental illness symptoms.

When the participants were asked for the reasons they continue in the abusive relationships, their responses included the fear of their children being maltreated and lack of support from their family. In addition to the lack of support from the mother's relatives to leave the relationship, the mother may not have money to take care of herself and her children. Tradition allows husbands to prevent their children from going with their mother in a situation where the mother refused to stay with her partner. Likewise, a husband can refuse both the woman and 'her children' to live in his house, people respond differently when it relates to mental illness (Olatunbosun, 2009). In some situations, the mother may prefer to continue with the relationship if she believes her children will suffer in her absence. Another participant who made an effort to leave her marriage was discouraged by her father for social reasons. It is believed that once a Yoruba woman is married, her husband's place becomes her permanent home. It is regarded as shameful for a woman to divorce and return to her parents' house, and the stigma also extends to the children of such a woman. Therefore, to save herself and her family from ridicule and embarrassment, the woman has to endure (Akanle et al., 2018).

A different experience was reported by a participant who was physically abused by her husband and sustained injury. She contacted government officials for protection against physical abuse from her husband. The participant's demand for protection and justice was unsuccessful because her husband was able to provide evidence that she was a woman with mental illness. The government officials may have considered the participant as someone without sound judgment. The response of the government officials opens the avenue to examine the rights and provisions available for people with mental illness in Nigeria in terms of mental health policy and its implementation. This is given full consideration in chapter seven of this thesis.

Experiences of marital problems and domestic abuse shared by participants in the present study is similar to the findings of Vranda et al. (2018). It was discovered that 62% of women in Vranda et al. (2018) experienced different forms of abuse such as physical and sexual violence from their husbands. Mothers in the present also experienced different types of abuse such as physical, financial, and psychological from their partners. Participants in the present study were not afraid to disclose information about the pain and trauma of their domestic experiences. Secondly, mothers in the present study chose to continue with their marriage because of their children, financial and cultural reasons. Differentially, participants in Vranda et al. (2018) were afraid to disclose their domestic abuse because of a lack of privacy from health professionals who may disclose their shared information and result in further punishment from their husbands. The fear of being stigmatised for having a mental illness, lack of protection from health officials, and being used to physical assaults from their partners were among the reasons reported by Vranda et al. (2018) for the chaotic relationships.

Financial problems

The majority (17 out of 26) of the participants disclosed having financial problems. This large numbers of participants suggests financial difficulties are not limited to the unemployed participants alone, but also extend to those who are working. Excerpts from four of the mothers are stated below:

Ewatomi reported:

> *'It affected me, all the resources I have before the illness, my shop, all my money, the whole thing finished, I don't have anything again. The little gifts I receive from family is covering up something, that is how am able to cope with my medication"*

Pelumi stated:

> "I find myself on zero level again. As am talking to you I don't have anything, I depend on my family to eat or to do anything. Sometimes I have to pay additional money in hospital like five hundred naira [£2] for card, is difficult to buy my drugs because I don't have cash"

Similarly, another revealed:

> 'All my money went on this sickness, I suffered, no work. It was hard without money, no help. When I could not get help, I sold all my gold, beautiful earrings and necklace to buy drugs, to eat, what to wear and other things to be taken care of. Is [mental illness] eating me up slowly" (Damola).

Semilore disclosed:

> "My salary is seventy-five thousand naira [£144.23] is not enough. If they [health professionals] write medication now, I will have to keep the prescription until I have money. How are we [herself and children] going to cope? […] Not only feeding but everything that comes up, thinking what we are going to eat […] I don't know what to do, who to turn to"

Financial insecurity was reported by the majority of the mothers, both participants that were working and those who were unemployed were affected. They became vulnerable to financial problems because of the mental illness that prevented them from working and having an income. Some participants claimed they were working before their mental illness but stopped working because of the severity of the symptoms of their illness. While they were unable to work because of illness and became poor, living in poverty increased their mental illness symptoms because of the inability to maintain treatments. Among the participants, those that were employed reported receiving low income and experienced difficulties in meeting their basic needs and maintaining treatments. Having children to care for increased their expenses and the likelihood of living in poverty. The majority of the mothers stated they relied on their relatives financially to meet their needs; the situation may become worse if the relatives supporting them also experienced a financial crisis.

As identified in the present study, experience of financial problems was discovered among 21 individuals with mental illness in the study of Saavedra et al. (2016). Participants in this study also linked their financial insecurity to lack of employment. Although Andalusia in Spain was stated to have the highest unemployment rates (33%) in Europe, participants stated their mental illness made it difficult for them to secure a job. Consistent with the findings of the present study, some of the participants were working before their diagnosis, were reported to have left their jobs because of the disability caused by the long duration of their mental illness. Though unemployment and financial insecurity may be common to participants in the present study and Saavedra et al. (2016)'s sample, financial assistance and free treatment were provided to participants in Saavedra et al., 2016) contrary to practice in Nigeria.

Living with mental illness, unemployment, and caring for children can increase the financial hardship of mothers with mental illness. Consistent with the findings of Rampou et al. (2015), 10 mothers with mental health problems stated lack of money to meet basic needs as discovered in the present study. Mothers in the present study relied on family and friends for their expenses while those in Rampou et al. (2015) received disability allowance from the State Welfare Services. Therefore, the economic hardship experienced by mothers in the present study may be higher than other mothers in the two previous studies (Rampou et al., 2015; Saavedra et al., 2016) because of lack of financial support for mothers with mental illness in Nigeria

Effects of mental illness on children

The effects of mental illness on adult children were the second theme that emerged from the information shared by participants about their experiences. Mothers' inability to give support and children as caregivers are the two subthemes that emerged from this second main theme. The theme and its subthemes are represented in figure 7.2.

Figure 7.2: Illustrates the effects of mothers' mental illness on adult children

Mothers' inability to give support

Out of the 26 mothers, 14 stated the impacts of their mental illness on their children especially their adult children. They reported that mental illness did not only affect their own lives but had lingering effects on their children as well:

Gbemisola reported:

> *"They [children] did not enjoy me, not even as a mother the thing [her mental illness] really affects them. At least to counsel them, teach them morals […], because of my crisis I could not help them, I can tell you they are not themselves. They don't hear from anybody, just gets aggressive, fighting themselves, passers-by will be looking, it is a challenge, a big challenge"*

Faderera stated:

> *"It affects my first daughter more than others, at least she would have been maybe a graduate now had it been the money not spent on my sickness she would have been somewhere better, maybe a manager of a company today. She was sent out of school because I cannot pay for her"*

Pelumi revealed:

> *"The motherly advice which I didn't give her led her to that mistake. I was in and out, hospital to church, I didn't know people that are present in her life. So, she was not that enlightened, she was young. It is no motherly care then that landed her to fall for a wrong man."*

Damola disclosed:

> *"My neighbour will come and tell me please put yourself together because these children are growing, this is the time they need me, that I should please put myself together, but I cannot just do it by myself, the sickness weighs me down. […]. My son was in Polytechnic then, I thought he was in school until he was paraded for robbery"*

Mothers stated the various ways in which their mental illness has affected their children. They were not physically available because of hospital admissions or physically present but not sensitive to children's needs. Their inability to protect and support their children morally and financially has had deleterious effects, such as inadequate education, violence, and early marriage. Someone with lower educational attainment may experience difficulties in getting a high-income job and is more likely to engage in menial jobs with little earnings. This will further put the child in a disadvantageous position compared to other children with good educational opportunities. The material deprivation experienced by the children will also affect the mothers because the children may lack resources to support their mothers later in life. It may turn into a vicious cycle of poverty; first, it was the mother's mental illness that exposed the children to social and economic deprivation. In turn, the economic insecurity will affect both the mother and their children.

The participants' mental illness must have caused loneliness for their children. Loneliness, lack of attention, safety, advice, and discipline may have contributed to experiences of early marriage and involvement in criminal activities reported on their children by participants. Mothers are believed to be people who spend the most time with their children, hence, their physical and emotional absence produced lingering effects in the life of their children. The mothers were unhappy for being unavailable to provide support for their children at an appropriate time.

Mothers in the present study and the 15 parents interviewed in the study of Strand et al. (2020) were of the same age range, experienced mental illness, and had frequent hospital admissions. Findings from the previous study (Strand et al., 2020) and the present study showed that the severity of the mothers' illness affected their children's behaviour as they lack energy or the ability to care for their children. Behavioural problems such as suicidal thoughts, controlling and demanding attitudes were exhibited by Strand et al. (2020) participants children. Contrarily, engaging in criminal activity, social disturbances, and educational problems were the effects of the present study participants' mental illness on their children. Mothers in Strand et al. (2020) who realised that they could not control their children's behaviours because of their mental illness sought the help of family, friends, and health professionals to assist them in their parenting. It was discovered that some of the mothers gave their children to foster parents for monitoring to prevent their children's bad behaviour from getting to the extreme. Formal and informal support was not requested to protect the older children of mothers in the present study during participants' acute illness or hospitalisation.

Children as caregivers

Participants (12 of 26) reported their adult children taking care of them when they were critically ill. As reported by participants, the children felt an obligation to care for their mothers even though it was stressful. The children's caregiving activities to their mothers are stated below:

Bejide stated:

> *"At a point when the something was hot; they had to put eyes on me, twenty-four hours. I tried to escape from house, after that, they made sure they kept eyes on me, locked the door and kept the key. Sometimes I will make calls to people and with what I was saying to people, they call them back and say what is wrong with your mum, so they have to control so many things."*

Adebimpe revealed:

> *"My son normally gives me money to come to hospital when it is my day to come. If he has not collected salary, I will not come because of my prescription. He doesn't like coming because of his work […] but anytime he gives me money then she will arrange things in my bag, my daughter has been the one bringing me."*

Jumoke reported:

> *"Taking drugs was not easy as my children said. When they want to dish food for me, they will look for a way of grounding the tablets and hide it in the food without my knowledge. I like taking coke and malt, so they will grind*

the tablets and put it in the malt. So that was how the drugs started getting to my system"

Folashade recounted:

> *"They (children) understand that sometimes I may not feel like doing anything. When I don't get strength things like washing clothes, cleaning house, and assisting me with their brother they do that. When my daughter didn't go to school for two weeks her teacher came to ask about her, I said she is helping me. He [teacher] said ha! is dangerous, a twelve-year-old girl doing what you supposed to be doing. I said is because there is nobody to help me, nobody to call"*

The mothers' reported their adult children taking care of them when they were too ill. The children provided financial and practical support for their mothers. A participant stated how her children used to protect her from wandering out of the house. She went further that her children prevented her from activity that could expose her illness to neighbours. Similarly, one of the mothers spoke about how her children shared the work among themselves. Her son was providing financial support while her daughter took the responsibility of bringing her to the clinic for treatments. As disclosed by another participant, the severity of the symptoms of her mental illness prevented her from taking her medication. However, her children found ways of making her use the medications for her to get well. Also, a mother explained that her children were the ones helping her to do household chores and importantly taking care of their siblings due to a lack of strength.

The children were a great source of support for their mothers, but the mothers' mental illness and the reversed roles taken by the children were a challenge and burden for them. The children devoted their resources (energy, time, and money) to care for their mothers and siblings, these overwhelming responsibilities may slow the progress of the children. Lots of money spent on a mother's illness could have been invested in a business. There is a possibility that the children were deprived of social activities or reduction in the time they needed to spend studying. Likewise, some of the children may develop emotional and psychological problems because of the exposure and burden of their mothers' mental illness. Caring for ill mothers may be taken as a moral obligation on the part of the children, but it also meant that some of their own needs and comfort were forsaken while they were performing these responsibilities.

<u>Mothers' views about mental health services</u>

Participants' views about mental health services include a lack of public information about mental illness and lack of access to recovery focused activities. They believed that lack of public information regarding mental illness caused problems for many people experiencing

this condition. The two subthemes together with its main theme are illustrated in figure 7.3 below.

Figure 7. 2: Presents mothers' perception about mental health services

Lack of public information on mental illness

Not having access to health information related to mental illness was stated by participants during interviews. Of the 26 mothers, 15 believed that there was little or no information about mental illness or how to get help if someone was affected by mental illness:

> *"Many women do not know they have a disorder, no information. Like if I wasn't referred here, I wouldn't know am having a problem because I was asking the doctor, I told him when I walk my heart precipitates, is it not a normal thing? No one can see that as a medical problem and since that happening to me definitely it will happen to millions of people out there" (Jumoke).*

Damilola stated:

> *"Nobody talks about mental illness and mental hospital. Even you see people of my age they don't know what is happening around them. Those women on streets if they know they have this illness, if there is information that when you are feeling this and this come and check yourself, they will come for treatment"*

Another participant said:

> *"I have never seen it on TV or radio that people will tell you that okay, depression that people should know about it, that is something you can get treated for because people see it as natural thing. Ko seni tio ki banuje, ko seni tio kin ronu, (there is no one that does not think, no one that does not feel sad), is normal. Whereas it is getting too much and when it is getting too much it becomes a problem" (Adesewa).*

The above excerpts from participants revealed that many people with mental illness may not have their illness diagnosed and treated at an early stage because of a lack of knowledge that they have the illness or information on how to access treatment. The implications of delaying treatment include an increase in symptoms of mental illness, spending more money to receive

treatment, and may lead to other physical illnesses. It may be a contributing factor for the increase in the treatment gap and seeking alternative treatment. Lack of information about mental illness and accessing treatment was discovered in Kisa et al. (2016). Kisa et al. (2016) study was conducted in developing countries, mental illness may be interpreted as low priority in Nigeria and likewise in the countries where the Kisa et (2016) study was conducted.

Lack of access to recovery focused activities

Most of the participants (18 of 26) described their treatments as mainly pharmacological approach only. However, the mothers believed that treatments should not be limited to medication alone, but should include other activities that would facilitate their recovery and involve their families:

Faderera stated:

> *"If the thing [illness] is still serious, if the person cannot answer their questions, they will interview the person that brought the patient. There is no other activity than to see a doctor and go home unless you want to buy drugs. […] Is good to have special activities for mothers"*

Similarly, Gbemisola reported*:*

> *"No one ask about your children. You see a doctor, collect your prescription and buy your drugs. That is just it, but they will ask you questions, do you have any complaints about your drugs? I want my children to know about it, when I cannot do things for them, they know is my illness"*

Adesewa said:

> *"I will be happy to be involved or allow my children to be involved in any other programmes. There is nothing like activities for the family of women that have this illness. The only time doctors ask about your family is when they are doing assessment. We need such programmes where family will involve"*

Jumoke said:

> *"They [service providers] will tell you to continue with your drugs, go and come so/so time, and you go, that is all. They don't listen to you again for any other things outside the medication. The treatment should be more than that but that is the only service"*

Participants wanted their health services providers to recognise them as mothers not just as patients. They believed that being recognised as mothers by health workers gave them a sense of responsibility and honour than seeing them just as patients. Furthermore, the mothers stated that the health professionals should involve their family members in their treatments. Involving family members during assessment and treatments may provide more

understanding of participants' mental illness to health professionals because they possess the knowledge of the participants' background. Family members who have been caring for participants would have more knowledge about their preferences that may help service providers in their treatments plan.

At the same time, family members would also benefit by being involved in the treatments of their relatives. Health professionals could provide information about the type of behaviours that may look different to family members but are part of the illness. Family members can develop new methods of caring for their relatives because of the information they receive through their involvement in the treatment to promote ongoing treatments. Also, the knowledge gained by being involved in their ill family member's treatments may influence their beliefs about mental illness and give the family member suffering from the illness more support.

Again, the mothers were of the opinions that treatments should go beyond prescribing medications to activities that would promote their wellbeing. This is explainable as the participants did not have the same diagnosis. Rather than applying universal treatments, individual or group therapy should be given to participants with fewer symptoms than keeping all of them on medication only. However, the reason for the use of medication maybe because of the severity of the symptoms of their mental illness. Including different activities with medication may improve the quality of life of participants but may only benefit participants that have had improvement in the symptoms of their illness. While it is important to provide different activities to participants to improve their quality of life, they may not be able to pay for interventions that would benefit them because they pay for their treatments.

This finding differs from what was discovered in the qualitative study of Connerty et al. (2016). Parenting skills training and suitable family interventions in the community was available to eight mothers with mental illness in Connerty and colleagues' study. Mothers in the present study did not have access to any recovery-focused activities and stated the need for programmes that would enhance their recovery. However, mothers in Connerty et al. (2016) were unable to access parenting support programmes provided for parents. Among the reasons stated for not utilising parenting support programmes in Connerty et al. (2016) study was the inability to make decisions on what programme to attend and the problem of attending programmes with young children.

Unmet needs of mothers with mental illness.

After sharing their views about mental health services delivery, mothers were asked if they had unmet needs. They gave various explanations which they believed would improve service delivery and help them to maintain treatments and promote their health and wellbeing. The

three subthemes that emerged from this theme were; access to financial support; access to free medication; and patients support group. The theme and its three subthemes are illustrated in figure 7.4.
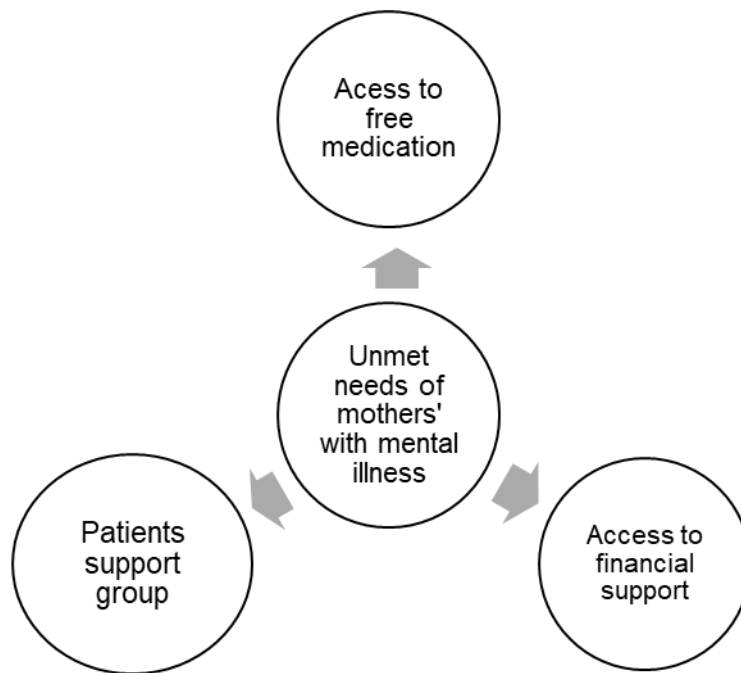
Figure 7. 3: Shows the assistance needed by mothers to access services

Access to free medication

Almost all the participants (22 of 26) reported they bought medication at high prices. They reported lack of money to buy medication at the appropriate times was a hindrance to maximise the benefits of mental health care services. For a deeper understanding of their experiences, excerpts from four of these mothers are presented in this study:

Folashade disclosed:

> *"I have not taken my drugs for two months. If I have my way to free medication, it won't be like that, I can't beg for money to buy drugs as other people do. They [staff] should always give free drugs"*

Another participant said:

> *"With this illness [mental illness] you continue taking drugs just as you need to take food. […] They are too expensive, only when the drugs are free that someone can be free from it, then you are sure of taking drugs very well"* (Abisoye).

Jumoke shared her views:

> *"There should be free drugs for everyone having this illness to get better. Without free drugs the whole thing will still go down to zero. You [researcher] can help to tell people in charge to help us with free drugs"*

Another participant reported:

> *"If the government is genuinely concerned about helping people to get better, they should give free medicine. These drugs are expensive, […] is difficult to buy them without help. For people that are not working, it should be free"* (Abebi).

The importance of medication in treating the symptoms of mental illness was recognised by participants as it was shown in their effort to access and use their medication as prescribed. However, high price and lack of money to buy medication hindered the mothers from receiving or maintaining treatments. Not being able to use medication as advised by their services providers may worsen the symptoms of their mental illness, cause physical health problems, or untimely death. The number of years participants have been living with the illness was between two to 28 years, indicating that they have spent money on treating the illness and the possibility that they were exhausted financially. Thus, providing free access to medication for mothers with mental illness would alleviate this problem and reduce their challenges.

This finding is similar to the findings of a previous study where participants disclosed not being able to access medication at the appropriate time which prevented them from complying with their medication regimen (Iseselo and Ambikile, 2017). However, the reasons stated by mothers in the present study was the high cost of purchasing medication and lack of money because of the system that is in operation in Nigeria where patients pay for their treatments. Participants in Iseselo and Ambikile, (2017) had access to free medication in government hospitals but needed to buy at high prices in private pharmacies when government hospitals ran out of stock. The decision to increase medication supply in government hospitals by contributing little money for treatments made by the Iseselo and Ambikile (2017) study sample was not expressed by mothers in the present study.

Access to financial support

Mothers (18 out of 26) expressed their need for financial help to alleviate their material deprivation and to continue with their treatments. Their need for financial support are presented using extracts from their text to provide an understanding of their economic situations:

> *"Government should support mothers financially. Economy is bad, I like the government to help with money to feed and feed our children. […] I need money to come to hospital and buy medicine, that one is very important"* (Foluke).

A similar opinion was shared by Abimbola, who said:

> *"I don't have money; I wait until my siblings get money to come to the hospital. If the government is giving us (mothers) money, like giving money monthly, token money to look after ourselves and our children, it will help, I will not miss my appointments"*

Ibironke stated that:

> *"Government should help in terms of supporting with money, at least small allowance for feeding and maintenance, helping women in this situation so that they can belong in the society without turning to beggars before they eat"*

Semilore reported:

> *"The doctors are trying their best, once they give you a prescription you won't expect them to bring out their money, they will just do what they are here for because they are being paid. It is now left for patients to go and sort themselves out. […] The thing is that there is no money for medical care, that is why I am saying government should support us with money"*

The study sample experienced many stressors such as unemployment and poverty in addition to their mental illness. The number of mothers that were not working (14 of 26) were more than those who were employed. Those who were working reported receiving an income that was insufficient to meet their needs. Mothers that were divorced and unemployed were more likely to experience financial problems than those that were married because their financial support would be reduced. Participants described a lack of money to buy medications and meet both their basic needs and those of their children. Participants with adult children relied on their children or families to support them. Financial hardship in mothers who were experiencing mental illness may lead to sleeplessness, more unmet needs, increasing mental health problems, or other physical illness. Thus, the need for financial assistance to meet basic needs is expressed by these mothers.

Existing literature with findings on participants' expressing financial support from formal sources is limited. Studies conducted in western societies may discover financial hardship among participants (Memon et al., 2016; Saavedra et al., 2016; Van der Ende et al., 2016), while the participants received some financial support, it was insufficient to meet their medical needs. Previous research conducted in the developing world discovered financial insecurity among the people that participated in research projects (Hailemariam et al. 2017; Iseselo & Ambikile, 2017; Kisa et al. 2016). The need for monetary support from the government rather than their family members has not been widely reported, except in the study of Rampou et al. (2016) in South African, where mothers with mental illness received disability grants from government.

Patients support group

Some of the participants (15 of 26) expressed the need to organise support groups for people with mental illness. They explained the benefits of having a commonplace, somewhere they could relate to each other as highlighted in the following quotes:

Faderera explained*:*

> *"It will be of good benefit to have something like a patients' forum to share experience and interact together. We need to interact socially and learn from others, and you can get vital information from other people"*

Another participant stated:

> *"Is good when you talk to someone that actually has that pain as well. It is good to have other people in the same situation who can understand you better. […] is good to associate with people who have gone through the same stuff"* (Yemisi).

Busayo reported:

> *"We need to interact with ourselves and share our problems, we can be of benefit to one another. We need to come together to address things we don't like; we need to make things happen"*

Similarly, Temitope reported:

> *"When we come together as a group, we can socialise with one another, we can come together and talk, lecture ourselves. We need to come together and communicate, when we communicate together, we can tell them (*staff*) what government can do for us"* (Temitope).

It was surprising to have the mothers showing the desire to have a group forum where they could meet and socialise. The beliefs about the causation of mental illness in their community increase the stigma associated with the illness. However, having a forum where they could

socialise and share experiences, may reduce participants' distress. The support group would consist of people with different levels of recovery, as stated by participants, it would provide an opportunity to learn from each other. As presented on pages 152-153 (the subtheme named: lack of public information on mental illness), more than half of the mothers (15 out of 26) reported lack of public information on mental illness. Organising patients support groups could be an opportunity to educate the public about mental health and mental illness, and address the stigma and prejudice relating to mental health problems. It may enable participants to have access to relevant and up-to date information about mental illness and other activities that may benefit them.

Also, it may be an opportunity for mental health service providers to consult people with mental illness about service provision. It may increase the knowledge of the health professionals about having a mental illness because it will be an opportunity for participants to share some areas of their experiences that are not known to the service providers. Information received by service providers through that forum could be used to design health services that would benefit the wider population. In turn, involvement in the evaluation of mental health services may increase participants' self-confidence, provide employment opportunities, and improve their living conditions.

The reason for mothers in the present study to express the need to have patients' support group was to socialise with other people with mental illness and learn from each other. However, 17 mothers in the qualitative study of Hine et al. (2019) accessed different activities, such as sporting clubs, using online parenting forums and book clubs for social interactions and encouragement in their parenting role. Mothers in Hine et al. (2019) were exposed to different social activities and derived satisfaction from the activity of their interest. Mothers in the present study were only expressing their needs. Social groups for people with mental illness might be organised or unavailable for participants. It shows that the environment in which individuals live influences their health and wellbeing.

Summary

Lived experiences of mothers living with mental illness in southwest Nigeria were discussed in this chapter. The chapter presented different challenges experienced by this group of women on how mental illness has affected them as wives, mothers and the impacts on their economic status. Following that, how mothers with mental illness can be supported to receive and maintain suitable mental healthcare services was stated. The interpretation of participants' lived experiences with consideration to their social context will be presented in the following chapter.

Chapter Eight – Discussion

This chapter will discuss the findings of the study from the interviews. The study achieved its aim to investigate the lived experiences of women and mothers living with mental illness in the southwest of Nigeria through qualitative research methods. The first set of interviews were collected on the lived experiences of 20 women with mental illness. Some of the emerged themes were related to the dual burden of having a mental illness and being a mother. Another set of interviews was conducted for a deeper understanding of the lived experiences of mothers with mental illness. Interviews for the second phase of the study, which was informed by the analysis of the phase one interviews, was carried out with 26 mothers who willingly shared their experiences. The themes that highlight participants' experiences are discussed under four headings: experiences of being diagnosed with mental illness; effects of mental illness on participants; the challenges of being a mother with mental illness; and mental healthcare services and needs of participants. Each of the themes has subthemes which are discussed in this chapter.

In discussing the participants' experiences, I return to Gadamer's hermeneutical philosophy that states a deeper understanding of a phenomenon is achieved through language, culture, and history (1900-2002). The purpose was to provide an explanation of the actions and behaviours of the participants which may seem strange to people outside the participants' society. Furthermore, the discussion will be presented in relation to existing literature and theories related to the themes.

Experiences of being diagnosed with mental illness

This theme has two subthemes: self-aetiology of mental illness, and managing the symptoms of mental illness. While the first theme was on how participants perceive the causes of their mental illness, the second subtheme focuses on how they seek help for treating their illness.

Self-aetiology of mental illness

Culture plays a significant role in how people understand, interpret, and communicate happiness and sufferings (Langdon & Wiik, 2010; Ravindran & Myers, 2012; Rubin, 2014). The Yoruba are not exceptional; they believe that God is a supreme being whom they also call Olodumare (Atanda, 2007; Fadamiro & Adedeji, 2016; Owomoyela, 1981). It is their belief that there exist other divinities (Orisha) that serve as intermediaries between Olodumare and human beings through worship, and receiving a blessing from Olodumare (Ayodele, 2016; Awolalu and Dopamu, 2005; Oduyoye, 1972). Likewise, the deities can put punishment on

people for non-obedience to the supreme being (Arinze, 1970; Ayodele, 2016; James, 2018). Thus, it was stated: "*between God and human beings, there are other beings that populate the universe. These are the spirits […] some of them may be used to do certain things*" (Mbiti, 1975, p. 65).

Illnesses, such as mental health problems, can be interpreted as a punishment from these deities with God's knowledge. They have the belief that God has knowledge of everything that happens to human beings. Also, there is a belief that some people possessed the power to perform some mischievous acts or to help others (Akintunde, 2004; Oyelaran, 2020). This sociocultural belief is not limited to the Yoruba (southwest) but has extended to the southeast, to the Ibo. The Ibo people also believed in the existence of Chukwu (God), the one with supreme power whom people worship through other deities such as Ala, and punishments from Amadioha (Iheanacho et al., 2015; Kanu, 2018). Hence, the supernatural causation of mental illness is also shared by Ibo women who were among the participants in the current study.

The belief that mental illness was caused by supernatural forces was held by more than half (11 out of 20) of the participants in phase one of this study. This can be linked to cultural influences. Culturally, the Yoruba-speaking people believed that they could be blessed or afflicted with illness by the deities as punishment for committed sins. Likewise, some people with mystical powers may cast a spell (*asasi*) or bewitch someone (Adekunle, 2018; Egunjobi, 2020; Jegede, 2005) through dreams or physically, as stated by the participants. This finding is similar to what was discovered by Araten-Bergman et al (2016) in Israel where participants reported causes of mental illness as bewitchment, fate, and correction. The difference between this study and the present study are: the present study consisted of only women participants with different diagnoses while Araten-Bergman et al.'s (2016) sample were men and women with the same type of mental health problems. Participants in the latter study stated their mental illness was a punishment from God for sinful acts or fate while participants in the present study believed their illness was caused by wicked people. Likewise, the majority (70%) of the Makanjuola et al. (2016) participants reported spiritual causes of mental illness similar to what was discovered in the present study.

However, participants in the present study were recruited from mental health clinics while Makanjuola et al.'s (2016) sample was drawn from a traditional healing centre. Seeking treatments from traditional healers can be argued as evidence to reinforce Makanjuola et al. (2016) participants' beliefs about supernatural causes of mental illness. Although, participants in the present study were not recruited from traditional healing clinics, they also looked for alternative treatments which suggest the pluralistic ways of treating illness in the present study

participants' culture. The causes of mental illness reported by the present study participants were not limited to spiritual problems alone but included social problems, also discovered by Nohr et al. (2019) and Ntshingila et al. (2019). The Nohr et al. (2019) study in Cuba discovered social problems such as family pressure and excessive alcohol intake as a way of reducing family and economic problems. Environmental and social problems such as sexual abuse and living in areas with high crime rates were discovered by Ntshingila et al. (2019) in South Africa. The findings of Nohr et al. (2019) and Ntshingila et al. (2019) were different from the social and environmental causes of mental illness found in the present study. Problems such as childlessness and injury from accidents were found as the social causes of participants' mental illness. The findings of the present study show that people give meaning to mental illness from social and cultural contexts. The cultural interpretation and social problems reported by participants revealed that causes of mental illness go beyond the borders of the biomedical model.

Managing the symptoms of mental illness

Health seeking behaviour, such as accessing mental healthcare services was discovered among the participants. The efficacy of the medication to reduce the symptoms of their mental illness made them continue to access mental health facilities, despite the reported high cost of medication and side effects. The use of medication for treating mental illness discovered in the present study has been identified in existing literature (Lee et al., 2020; Yeisen et al., 2017) conducted in the USA. The total reliance on medical treatments was identified in Lee et al. (2020) and Yeisen et al. (2017). These findings can be explained as participants' understanding of mental illness and the method of managing mental illness in the society where the studies were conducted. It could also be the result of including only participants from white ethnic backgrounds in the study. However, the methods of treating symptoms of mental illness by participants in the present study included the use of herbs and vising spiritual leaders.

Participants understood that it may take a longer time before they could be healed but taking medicine indefinitely is contrary to their understanding of healing. In the present study. The majority (16 of 20) of the women who participated in phase one of the present study, reported using alternative treatments in combination with medical treatments. The recurring nature of mental illness whenever they stopped medication was a concern: *"What is there is that the drugs, that someone cannot do without taking them is the problem. doctors will say continue until you are well"* (Ojuola, a participant). Again, participants need medication that can give permanent healing from mental illness which they cannot find in conventional medicines:

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"*These drugs can maintain the person to calm down, to sleep but it cannot cure the koko*" (a participant).

Engaging in other forms of treatments revealed the inherent pluralism of healing practices that exist in participants' culture (Asuzu et al., 2019; Mokgobi, 2014). Two forms of alternative treatments were identified in the present study, those who sought traditional treatments and participants that visited faith clinics. In the Yoruba context, traditional healers are believed to be messengers to specific deities as there are four hundred and one deities (Okanlenirinwo orisha) and each for a specific assignment (Ayodele, 2016). They possess the power to heal diverse illnesses by using selected plants, roots, and stems (Amusa, & Ogidan, 2017; Awodele et al., 2013; Lifongo, et al., 2014). Their methods of healing include possession, prophecy, and communication with the divinities through incantations as well as the use of ritual melodies and dances for therapeutic and healing purposes (Agara et al., 2008; Lasebikan et al., 2012; Kajawu et al., 2016).

The use of herbal treatment for healing practiced by participants is a common practice among the Yoruba people (Awodele et al., 2013; Gureje et al., 2015). The Yoruba view of health is not just about the proper working of body organs and the absence of pain, but rather about mental, physical, spiritual, and emotive stability of oneself. Even if it is a somatic illness, the Yoruba pay attention to psychological, societal, and emotional parts of the illness (Abimbola, 2005; Ayodele, 2016; Omonzejele, 2008). This concept of complete cure is embedded in the Yoruba's ideas of healing, it is this holistic approach valued by participants that are practiced by traditional healers. Further, traditional healers (Babalawo or Onisegun) share a common belief about the spiritual causes of mental illness (Falayi, 2014; Gureje et al., 2005; Oyebola, 1980) with participants in the current study. However, this form of treatment has implications for the well-being of the participants. The use of herbal mixture can increase their mental health conditions because of the inconsistent ways in which the herbs are prepared. Also, there is a danger of toxicity because the methods of preparing the medicines are not standardised, but the preparation and uses are based on the herbalist's intuitions. Furthermore, it is difficult to monitor the traditional healers because their practices are rooted in mysticism and remain unseen (Akpan & Ekrikpo, 2015; Ekor, 2014). There is the possibility that participants may be exposed to the risk of contamination because of hygiene problems (Singh & Prakash, 2011). This form of help-seeking behaviour was in Makanjuola et al. (2016) where participants attributed their mental illness to spiritual problems. These participants were recruited from traditional healing centres which can be called evidence of their beliefs about mental illness causation. Contrarily, participants in the present study were sampled from outpatient clinics in mental health hospitals.

While some participants consulted traditional healers in conjunction with medical treatments, other participants engaged in religious activities, that is, a little medicine and a little prayer. The Stress-Process Model Coping states that people with chronic illnesses such as mental illness use active or avoidant coping methods (Prado et al., 2004). An active coping method is described as a problem-focused method, it involves taking actions to reduce the effects of the problem through emotional support, engaging with others, and use of therapy (Prado et al., 2004; Lazarus & Folkman, 1884). Religious activity is classified as one of the active coping resources because it covers all the activities involved in an active coping strategy (Prado et al., 2004; Siegel & Schrimshaw, 2002). Religious practice increases social support and reduces psychological distress because of the opportunity to interact with people (Herrera et al., 2009; Katerndahl & Parchman, 2002). It is different from avoidant coping method which is about self-blame and denial (Alix et al., 2020; Steglitz et al., 2012; Ullman et al., 2014). In this study, participants used religious activity as a coping mechanism and a form of treatment for mental illness.

In the Yoruba context, churches are places of worship for miraculous healing and spiritual commitments. The priests or prophets (Aladura or Alasotele) advocate continuous prayer, fasting, and the use of anointing oil for their followers. The faith leaders sometimes give revelation to their followers concerning their problems through visions and prophecies as therapeutic practices (Arulogun & Adefioye, 2010; Augkwa 2012; Olugbile et al., 2009). Likewise, spiritual healings are performed by Islamic healers using Tira and Hantu for miraculous healing of their members (Oyebola, 1980; Sanni, 2002). Participants that are engaged in religious activities stated that they were involved in prayers and observe fasting and vigil to facilitate their spiritual healing. However, engaging in religious activities such as deliverance that involves fasting may worsen participants' mental health conditions.

The spiritual healing activities will prevent them from eating properly, sleeping well, and using their medication regularly. Not only were they not completely cured according to their expectation, but they were exploited by their spiritual leaders who took advantage of their mental illness as demonstrated in a quote from one of the participants: "*Churches ate my money […] because I have a challenge one person will say bring this, bring that in the name of God to the extent that I don't have anything again and the problem is still there*" (Adetutu, a participant). Using religious activities as coping resources and treatments for mental illness discovered in the present study was also identified by Tuffour et al. (2019) in England. This qualitative study was conducted in western society, but participants were men and women of Black African ethnic origin. It can be argued that participants in Tuffour et al. (2019) and the present study were influenced by their cultural background. However, participants in the

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present study were deeply involved in religious activities such as seeking deliverance, prophesy, keeping vigil, using holy water and anointed oils which were not reported in Tuffour et al. (2019). This finding is different from what was discovered in the study of Saavedra et al. (2016) in Spain. In addition to the use of medication, participants in this Spanish study engaged in different active coping strategies such as employment to increase their social interaction and financial status. It can be stated that these participants were people with a high level of recovery, compared to participants in the present study.

Effects of mental illness on participants

The second theme looked at various ways of living with mental illness had affected the lives of participants. In this section, the discussion will be on how the stigma of mental illness led to a loss of opportunities, marital problems, unemployment and financial problems because of loss of income, they experienced financial problems and drifted into poverty.

Stigma and discrimination

Mental illness stigma persists despite efforts to eradicate it because it reduces the self-esteem and quality of life of many people who experience it (Abbey et al., 2012; Corrigan et al., 2014; Hatzenbuehler & Link, 2014). Of the 20 participants who took part in the first set of interviews, 13 reported being stigmatised by families, friends, neighbours, and employers. The discriminatory and stigmatisation of participants included verbal abuse and being isolated by friends and community members. The labelling theory states negative cultural stereotypes as a way of rejecting individuals diagnosed and receiving treatments for mental ill-health (Corrigan and Watson 2002; Ritsher and Phelan, 2004). Reasons for the social stigma and discriminatory behaviour towards participants can be explained from cultural beliefs about mental illness causation. To an average Yoruba person, individuals with mental health problems are harmful and aggressive. Therefore, different hurtful words such as 'Alagana', 'asinwin', 'olode-ori', 'were' (meaning someone who is unpredictable and can maliciously injure others) are used to qualify people suffering from mental illness (Jegede, 2005, 2010; Odebode, 2004). Yoruba people believe that no one suffers from mental health unless a person is 'mad' and a person is assumed to suffer from 'madness' only when such a person becomes aggressive (Adeosun et al., 2013; Adewuya & Makanjuola, 2008; Odebode, 2004). Therefore, people are always vigilant to avoid being hurt (Afe & Ogunsemi, 2016; Aina, et al., 2015). Arguably, this could be the reason participants experienced social distancing, hostility, and a lack of empathy in the community. On the other hand, participants may experience severe symptoms of mental illness which may have caused the social distancing or isolation they experienced from the public.

The experience of being treated differently as a result of having a mental illness discovered in the present study was found in the study of Burke et al. (2016) in England. Participants in Burke et al. (2016) went further and stated that health professionals stigmatised and treated differently from others without mental illness. It could be that participants in Burke et al. (2016) utilised the same health facilities as people without mental illness while participants in the present were drawn from standalone mental health hospitals. The findings were also similar to the work of Huggett et al. (2018) in England, but their experiences of stigmatisation were extended to their families, while the experience of stigma, was not extended to the relatives of participants in the current study.

Participants responded to public stigma differently, 11 of the 20 participants decided to hide their mental illness. The reason for doing this was to avoid psychological distress that may arise from people's actions towards them. Concealing mental illness to avoid psychological distress, stigma, and discriminatory behaviour even when it has not occurred can be termed as self or anticipated stigma (Ritsher & Phelan, 2004; Quinn & Earnshaw, 2013). They engaged in avoidance coping strategies such as social isolation, little or no interaction with people at the workplace or in the community. The level of recovery and the type of mental illness experienced by participants may have made it possible for them to successfully conceal their illness.

While it is possible to experience discrimination if their mental illness was disclosed, at the same time, non-disclosure of their illness may have hindered them from getting social support if they needed it. Reduced social interaction and loneliness to cover up their mental illness may have caused an emotional problem they wanted to prevent. The use of avoiding coping methods identified in the present study is different from the findings of Mora-Rios et al. (2016) in Mexico. Mora-Rios et. al. (2016) participants did not conceal their mental illness and rather than hiding their illness or feeling resigned to stigmatisation from the public, they chose to challenge discriminatory practices and educate others about mental illness.

There were few participants who acted differently from other participants. They seemed unconcerned about the stigma from friends, family, or community members. They did not hide their mental illness and were not ashamed of living with the illness or negative reaction from the public. Even though they had the knowledge of people's negative attitudes towards them, they did not agree with the stereotypes that others had about them. The indifferent attitudes of this group of participants could be because they were used to people's discriminatory behaviour, and so were no longer affected emotionally. Participants who exhibited this behaviour may receive social support and interventions that will promote their recovery

compared to other participants that used avoidant coping methods. This finding is different to what was discovered by Thoits (2016) in the USA. The majority of the participants (77%) in this quantitative study rejected having mental illness even when 94% were discovered to have impairments from suffering from this condition.

The Yoruba have a strong tradition when it comes to marriage (*Igbeyawo*), both physical and spiritual inquiry is conducted by the families of the man and woman. First, the parents carry out an investigation to know whether there are any negative occurrences in the family. The second investigation is to consult seers to know if there is any evil in the family and to understand if the union will be productive, that is, bringing wealth, peace, and fertility (Akintan, 2013; Balogun, 2012; Oyekanmi, 2015). History of illnesses such as mental illness in a family can destroy the marriage proposal because nobody wants to marry from '*Iran asiwin*' (a family where mental illness is their usual illness), with the belief that such a woman will also have children that will inherit their mother's illness (Jegede, 2005; Omobola, 2013). Sometimes, the shame of having health problems such as mental illness made some people commit suicide, they preferred to die than to be exposed to the shame and humiliation (*iku yajesin*) associated with the illness (Atilola & Ayinde, 2015; Oladeji & Gureje, 2011).

Loss of opportunities, such as not being able to continue education, and raise their own family reported by participants, can be attributed to the effects of stigma rather than the symptoms of mental illness. Social distancing, little or no interpersonal relationships, and hostility that persons with mental illness experience in the community (Gureje et al., 2005; Oyewole, 2016) could be an additional problem for participants to reach their goals. Consistent with this finding, are the studies of Ibrahim et al. (2016) in Nigeria and Tesfaw et al. (2020) in Ethiopia. Stigma contributed to Ibrahim et al. (2016) participants' loss of opportunities, while severe symptoms of mental illness and lack of family support were identified as barriers in Tanaka et al. (2018).

Marital problems

Participants (12 of 26) who were married had marital problems, such as separation because of their illness. First, these marital problems might come from the belief that the illness cannot be fully cured, as they are popularly called '*alawoku*' (Jegede, 2005; Olabode, 2009). In addition to humiliation from community members, the husband may have the notion that his woman will not be able to perform her social role effectively as his wife. When they get older, parents often live with their children because of the absence of a social security system in Nigeria (Anifalaje, 2017; Emeh, 2014). The violence and separation between husband and wife are often caused by the involvement of the in-laws who may hold strict cultural beliefs about causation of mental illness, the patriarchal system, and various superstitions:

> "*My in-laws packed all the troubles in her house along with her, his spending all his money on you, you eat too much, how long is he going to continue with this [pay for her treatments] she will start raining curses*" (Ibironke, a participant).

Another quote showing the influence of family members in a participant's broken relationship was from Adesewa:

> "*My husband's relatives were like haaa […] am a witch; my sickness is evidence that I was the one behind his misfortunes. So, he had to send me to my parents' house*".

Furthermore, the financial stress of treating mental illness may be too much for the husband who may prefer to end the relationship than to continue 'wasting' money on 'incurable' illness. This is substantiated from Adebimpe's response:

> "*I had crisis, he could not manage it, […] He said he cannot continue spending on sickness that is not going. He does not want to go ahead with the marriage, he eventually went out.*"

While some participants received financial support from their husband at the early stage of their illness, it was a different story for other participants who stated that their partners took advantage of their mental illness to abuse them financially:

> "*He will take my money without telling me. If I asked him, he would say he borrowed it or take it by force. My house that my parents gave me […] I discover that he [husband] has sold the place (Adebimpe).*

In the Yoruba context, a woman who left her matrimonial home based on adultery, murder, stealing and mental illness to live in her father's house is '*Dalemosu*', and the shame of becoming dalemosu extends to her family members. Secondly, there is a belief that a woman needs to endure any marital challenge because of her children except the partner refused to mend the broken relationship (Aluko, 2015; Akintan, 2013, Makinde, 2004). This was an account of participants (12 of 26) who preferred to endure the marital problem (verbal and physical abuse) than to leave their spouse: *"You know they [her children] are still growing, they will need their mother, so I continue with the marriage, I stay to take care of my children*" (Ibironke, a participant).

Different reasons were identified in the present study that led to participants' marital problems. They included the interference of family members, and lack of money to continue with the treatment of participants' mental illness. The experience of marital problems identified in the present study was found in other studies (Afe et al., 2017; Islam et al., 2018; Vranda et al., 2019). Afe et al. (2017). It was discovered that the financial burden of mental illness

contributed to marital problems which resulted in physical and sexual abuse because of the frustration of their reoccurring mental illness and continuous spending to maintain their treatments. However, the financial problem led to separation from their spouses among participants in the present study. Another difference was the sexual abuse identified by Afe et al. (2017) which was not found in the present study. It may be that participants in the present study viewed sexual coercion as part of their obligations to their spouse and not as abuse. The financial abuse identified in the present study did not occur in Afe et al. (2017).

Women in the Vranda et al. (2019) study in India were afraid of disclosing their domestic abuse because of a lack of support and protection from family members and health professionals. The similarity between the findings of Vranda et al. (2019) and the present study was that participants did not want to end the relationships because of social stigma. Vranda et al. (2019) were ashamed of other people having the knowledge that they were abused by their partners. Likewise, participants in the present study preferred to endure the relationship to avoid stigma (not to be labelled as dalemosu) and to care for their children. Different from the experiences of the Vranda et al. (2019) participants, separated mothers in the present study were supported to reunite with their families. Although separation or divorce is not encouraged in Yoruba culture in a situation where life is at risk, there is always support from other family members. It can be argued that culture is one of the factors that put participants in a more disadvantaged and oppressed position.

Unemployment

The consequences of living with mental illness for participants included unemployment. Studies have established a high level of unemployment among people with mental illness because of symptoms of the illness (Ljungqvist et al., 2016; Lund et al., 2013; Patel et al., 2010) and stigma (Brouwers, 2020; Trani et al., 2015). Mental illness is known as '*arun opolo*' (brain disease) in the Yoruba language, it is believed that individuals with mental illness lack the cognitive ability to contribute to the development of their society (Gureje et al., 2005; Oyewunmi et al., 2015). Participants did not exist in a vacuum but lived in the same environment with employers and possibly had the same culture and beliefs. Employers who have misconceptions about mental illness may find it difficult to give work to people with mental illness or allow them to retain their jobs. In addition to the notion that they may not be efficient at work, it may be that participants were denied job opportunities for safety reasons, not to cause harm to themselves and other workers.

Findings related to high unemployment rates among participants identified in the present study are different from what was discovered in existing literature (Biringer et al., 2016; Saavedra et al., 2016). Biringer et al. (2016) found engaging in work activities as an opportunity for participants to interact with others and reduce their mental illness symptoms. Despite the low educational status of participants in a qualitative study conducted in Spain, the majority (18 of 21) of them were employed (Saavedra et al. (2016). The differences between high unemployment rates in the present study and high rates of employment in other studies (Biringer et al., 2016; Saavedra et al., 2016) can be explained in three ways. Firstly, it may be that participants in other studies showed a high level of recovery and exhibited fewer symptoms of mental illness than participants in the present study. It can also be argued that mental illness-related stigma is more pronounced in the southwest of Nigeria compared to how society behaves toward individuals with mental illness in Spain and Norway where the two studies were conducted. Generally, there may be a shortage of employment opportunities in Nigeria which may have nothing to do with participants' mental health conditions.

Financial problems

Unemployment causes loss of income that may lead to financial constraints. Financial problems may mean people with mental illness drift into poverty because it would be difficult to meet expenditures for treating the illness and meeting other needs (Aneshensel, 2009). Although a detailed discussion of the meaning of poverty is beyond the scope of this study, it is worth mentioning that mental illness and poverty are interlinked (Patel et al., 2010). Mental illness prevents people from working which may lead to financial problems, reducing access to resources that can improve wellbeing. On the other hand, delaying access or not being able to access healthcare worsens mental health conditions. This is the experience of 27 of 46 participants in the present study who lost their source of income because of their mental illness. Lack of sources of income made it difficult for them to meet their expenses, particularly for high costs of treatments that are paid out of pocket. In this sense family support is crucial, participants relied on family and friends to be able to access care and meet other needs. The situation becomes worse if the family member also experiences a financial problem. The time spent caring for their sick relatives may reduce their productivity and their earnings or they may be made redundant at work. Participants with younger children are more likely to be affected by financial problems compared to other participants without children or mothers whose children are older and working.

The mothers also faced the additional burden of providing the basic needs of their dependent children. Participants who did not have a family to provide financial support on an ongoing

basis may miss their clinical appointments or medication. The adverse effects of irregular use of antipsychotic medications include an increase in the symptoms of mental illness. Experiences of participants in the present study concerning financial problems were also similar to the Rampou et al. (2015) participants in South Africa. In both studies they had younger children's needs to meet, in addition to their own. However, practical support such as childcare was received by the present study participants from friends, family, and neighbours but was unavailable to the Rampou et al. (2015) participants. While Rampou et al. (2015) received disability grants from the South African governments for their daily living, participants in the present study were supported financially by their family members.

The challenge of being a mother with mental illness

This section presents the experiences of mothers with mental illness, whose participation contributed to the new knowledge achieved by conducting this study. Findings show that the mothers' mental illness had an impact on their families especially their children. The negative effects of mothers' mental illness on children will be discussed under three subthemes: mental illness and effects on motherly role; mental illness and children's role; and mental illness and effects on children.

Mental illness and effects on motherly role

Womanhood is complete when a woman becomes a mother and it is the highest position of honour accorded to a woman in Yoruba culture (Makinde, 2004; Omobowale et al., 2019). While being a mother attracts respect and fosters a sense of connection to others, it also comes with the challenges of raising children and supporting them to a level they can achieve their goals. The motherly role is more challenging for participants with the burden of managing their mental illness and the struggle to raise their children at the same time. Of the 26 mothers, 13 felt that their medication affected them to an extent that they were unable to respond to their children's needs. This finding is consistent with other studies (Bartsch et al., 2016; Connerty et al., 2016; Klausen et al., 2016). Participants in the present and existing studies experienced difficulties in caring for their children because of severe symptoms of their illness. Participants in Connerty et al. (2016) and Klausen et al. (2016) reported not being physically available to perform daily routines of caring for their children. However, participants in the present study were physically present but not available emotionally to understand and respond to their children's needs because of medication side effects.

To overcome this challenge, 13 of 26 participants reported been helped by family members and others (friends and neighbours) to carry out their motherly role which the symptoms of

their illness had made them incompetent to perform. The informal support received was reported by participants as helpful, and emphasis was laid on support received during the acute phase of the illness by 13 of the 26 mothers. In contrast to western nations where husbands could perform household chores without concerns, gender roles are clearly distinguished in Yoruba community (Oyekanmi, 2015; Odimegwu and Okemgbo, 2008). The roles of men in the family include making decisions, providing financial support and security from external invaders for his family. On the other hand, women are expected to carry out the responsibilities of cooking and protecting the interests of her family (Aina et al., 2015; Olawoye et al., 2004; Mudiare, 2013). Seeing husbands coming out to assist in doing household work in a society where there was a predominance of traditional masculine beliefs was counted as priceless support. Social support is explained as emotional, financial, and physical help received from individuals in distress from family, friends, and in the community (Ozbay et al., 2007). People who have access to social support are said to have an increased level of recovery (Ioannou et al., 2019). This finding emphasised the importance of social support in times of need.

Lack of energy and motivation to carry out their motherly duties made participants use the support of others. Few studies have discovered that mothers with mental illness had been supported in their parenting responsibilities (Bartsch et al., 2016; Blegen et al., 2016). In addition to practical support from families, participants from these studies received parenting skills guidance from healthcare professionals. Participants in Awram et al. (2017) and Hine et al. (2019) did not stop on formal and informal support alone but went further to develop their own parenting skills to help them perform well in their motherly role and improve their own health. However, participants in the present study relied only on practical support, parenting skills, and advice from family and friends. Formal support was not accessed because the provision was either unavailable, or they were unaware of it. Halsa (2019) findings were different from the present study's findings. The fear of criticism and child removal by the state agency for mistakes were reported as the reasons for the participants not using support but practised intensive methods of parenting. It is likely that the Halsa (2019) participants experienced low symptoms of mental illness, but lack of support for mothers with mental illness may erode their self-confidence in their parental ability and discourages openness.

Mental illness and children's role

Another emerged theme was the role played by the children of participants in supporting their ill mothers. Their role included the safety of the mother, ensuring the medication was used regularly: *Taking drugs was not easy as my children said. When they want to dish food for me,*

they will look for a way of grounding the tablets and hide it in the food without my knowledge" *(Jumoke, a participant)*. Younger children were not left behind as they also care for their younger siblings even though they were only children themselves which may persist into adult life: *"When I don't get strength things like washing clothes, cleaning house and assisting me with their brother they do that"*. While it can be stated that the children were helpful, the mothers' illness also affected the children's wellbeing. The reverse role played by the children was time-consuming, it prevented them from living an autonomous life and created negative effects on their private and social life.

The care includes financial provision for their mothers to stay engaged with treatments. This is supported by quotes from a participant: *"My son normally gives me money to come to hospital when it is my day to come. If he has not collected salary, I will not come because of my prescription" (Adebimpe).* The health condition of participants also affected their children financially as they paid for their mothers' treatments. It meant they had to deny themselves certain opportunities to ensure that their mothers received treatments. The burden of caring for an ill mother may make the children exhausted and frustrated. Continuous expense on mothers' treatments may reduce children's savings and along with the challenges of meeting other needs, there remained the possibility of drifting into poverty.

Mental illness and effects on children

The negative effects of mothers' mental illness on children sometimes lingered to adulthood. In the present study, 14 of 26 mothers stated their mental illness had hindered them in providing support, which had caused problems for the children. For example, a participant recounted how her son was imprisoned for a crime that could have been prevented if she had not had mental illness: *"My neighbour will come and tell me please put yourself together because these children are growing, this is the time they need you […] the sickness weigh me down. […] I thought he was in school until he was paraded for robbery" (*Damola, a participant*).* The social consequences of becoming an *elewon* (a convict) may remain for a lifetime. Likewise, some of the participants' children who were unable to have a higher education because of their mother's treatments, may find it difficult to secure a well-paid job and live comfortably like their counterparts without a parent with mental illness and with access to good education. Aside from income and material deprivation, Sen (1999) stated that the inability to live a life that others would value is poverty. Therefore, the cycle of poverty continues as the mother's mental illness led to her poor financial state, which affected her family's economic situation. Severe mental illness as causes of lack of child discipline and control of bad behaviour discovered in the present study, was similar to the findings of Strand

et al. (2020) and van der Ende et al. (2016). Parents in these studies reported a lack of confidence and loss of child custody, which contributed to their parental challenges. Instead, mothers in the present study reported children's bad behaviour to their recurrent mental illness that made them emotionally unavailable to support their children at different stages of their development.

Mental healthcare services and needs of participants

As stated in chapter one page 23, the Nigerian mental health care system is provided through three levels (primary, secondary and tertiary) and each level has its clear roles. However, from the findings of the present study, the delivery of mental health care services was not provided as stated by the Nigeria Federal Ministry of Health. Likewise, the services are not delivered as specified in the Nigerian mental health policy (NMHP) of 1991 (see appendix 29).

Findings related to participants' experiences of accessing mental health services will be discussed with references to Nigeria's mental health policy. I will also look at the African Charter on Human and People's Rights (ACHPR) to explain the services delivery and apply the UN Committee convention on Economic, Social and Cultural Rights (CESCR). It could be asked, of what purpose are the two treaties to the present study. Nigeria is a ratified member of the ACHPR, and Nigeria's mental health policy was based on principles of equity and justice advocated by the charters, and in line with WHO standards. The CESCR emphasised the right of individuals to enjoy physical and mental health to the highest attainable level (Ssenyonjo, 2017). Additionally, the four CESCR frameworks are relevant to the findings of the present study as it provides more understanding of participants' experiences of accessing care. The CESCR interrelated frameworks to the utilisation of health care are "*Availability, Accessibility, Acceptability, and Quality (AAAQ)*" (CESCR, 2000, pp. 4-5).

Availability

From the four dimensions of access to health stated by the UN committee, availability can be described as the presence of health services. In the present study, availability will be explained in two ways: the physical aspects of health activities and the services rendered by mental health hospitals. Physical availability of services includes hospitals, medical staff, medication, and other amenities such as clean water and sanitation facilities. The second area of availability consists of health promotion and preventive activities. As reported by the participants, mental hospitals were not available within their vicinity. While mental health hospitals exist in Nigeria, the plan was not followed as documented in the national mental health policy and guidelines of the WHO. Individuals with mental illness cannot access

treatments from primary healthcare because of the non-availability of the services at local levels (Addullahi et al., 2016; Omoluabi, 2014). The eight mental health hospitals in the country are standalone public hospitals and are located in urban areas (Jack-Ide & Uys, 2013). The standalone hospitals are specialist hospitals that should be providing services at the tertiary level. Of the eight specialist hospitals, two were in the southwest where this study was conducted. The southwest region consists of six states which indicates that people from the remaining four states will access care from any of the two states where mental health hospitals are located. However, this was contrary to what was stated in the policy:

Section 4.1.2 of the NMHP:

> *"Individuals with mental, neurological and psychosocial disorders shall have the-same rights to treatment and support as those with physical illness and shall be treated in health facilities as close as possible to their own community person shall suffer no discrimination on account of mental illness"*

The majority of participants (75%) reported living outside the states where the hospitals were located. Their travelled distance ranged from 60 km to over 300km. Accessibility problems in term of distance to mental health facilities, was a barrier to participants in rural and other states to receiving regular treatment: "*I came yesterday and spent the night here (clinic), so I can see doctor today. It is hard for me to come for appointments because of distance. […] I don't like missing my appointments, but distance and transport money is my problem*" (Pelumi). Availability of any services means it can be accessed when it is needed, the distance covered by participants to access services at the tertiary level which should have been provided by their local or state governments, indicates the poor level of mental health services. Even though the service is available it is not in sufficient quantity.

In western nations, the UK for example, mental health services are provided by different sectors and settings. It ranges from home and, community, to institutions (Das et al., 2016; NHS, 2019). The services are provided by different sectors, including public, private, and specialty care. Individuals with physical illnesses have easy access to treatments compared to people with mental health conditions in Nigeria (Anyebe et al., 2019; Westbrook, 2011). Though it was stated in the policy that mental health services would be available at primary care, it was not implemented.

Section 4.1.4 of the NMHP:

> *"To achieve a comprehensive coverage of the population, delivery of mental health care shall be firmly established in the primary health care setting and any other setting that may from time to time be considered appropriate. The*

services shall be promoted by all health care personnel with active participation of members of the community".

Convenience of mental health services at the primary level would have been helpful for people with problems of keeping a medication routine, would provide follow-up, and identify those at risk of relapse into illness. Comparing the physical availability of mental illness hospitals to clinics dealing with physical illness, it can be argued that persons with mental illness have been marginalised. This finding is similar to the findings of Hailemariam et al. (2017) in Ethiopia. The inconvenient geographical location of mental health hospitals in Ethiopia was identified as part of the reasons many people stopped using the services. Travelling long distances before accessing care was not found in the study of Memon et al. (2016) conducted in England. Lack of adequate planning may have contributed to where mental health hospitals are located in Nigeria.

In terms of medical staff, or human resources, Nigeria's mental health system is characterised by limited professionals (especially doctors), which contributed to participants' challenges. In 2011, per 100,000 population, the ratio of psychiatrists was 0.06, 0.19 for nurses, and for psychologists was 0.02 (Abdulmalik, 2019; WHO, 2011, 2006). Psychiatrists are the only medical staff with the right to carry out clinical assessments and prescribe medication to patients. Thus, the shortage of psychiatrists in hospitals is a barrier to accessing health care. The participants (12 of 20) reported excessive waiting time in hospitals before receiving treatments. The cause of spending a long time in the clinic was explained as over-crowding. The excessive waiting time reported by participants can be interpreted as a shortage of doctors and the non-availability of mental health services at primary and secondary levels. Thus, the functions of the remaining two tiers of governments to provide services, have been shifted to the tertiary level as the only arms of government providing services to the large number of people seeking treatments without a rise in the number of doctors. The shortage of health workers has health implications for both staff and patients. The implication of the limited number of medical staff in hospitals is that many people may not be able to access treatments in a timely way or at all. The few available numbers of psychiatrists will be overwhelmed with the problem of meeting the increasing demands of persons with mental illness. The shortage of health professionals in mental health hospitals was identified in the study of Hailemariam et al. (2017) and Kisa et al. (2016). These two studies were both conducted in African countries.

The shortage of healthcare workers may have contributed to experiences of spending long hours in the clinics before receiving treatments. *"'I usually come here when I am off duty because I know I will spend the whole day here. You will wait for your card […] then you will go back to reception waiting for doctor to call you. That can take hours before it gets to your*

turn. The same thing happens at pharmacy" (Kunbi). Spending nearly a day in the clinic as reported by participants is excessive compared to an average of 41 minutes waiting time in the clinic by patients in Malaysia (Ahmad et al., 2017), for example. Mental healthcare service in Nigeria is different from the practice in developed countries such as the UK, where patients accessing treatments were given a date and time (National Health Service, 2016). People accessing care in mental health hospitals in Nigeria are not giving a specific time for treatment. Both patients who have been in the clinic very early and those who arrived after them may leave the clinic at the same time depending on the type of treatment and the consultant. Waiting for a long time in the clinic by patients who are exhausted because of long-distance treatments is discouraging. Similar to this finding, waiting for a long time before treatments were discovered in the study of Memon et al. (2016). However, the waiting time in Memon et al. (2016) study was before the participants' initial clinical assessment. Memon and colleagues identified the reasons for a long waiting time, as cultural and communication barriers, and financial problems of accessing services that are not freely provided. In contrast, excessive waiting times discovered in the present study meant the time spent by participants within the hospital premises before treatments.

It may be argued that the second aspect of availability which are health promotion and prevention programmes have not been provided in Nigerian mental health services based on the findings of the present study. Of the 26 mothers that participated in the present study, 18 stated that treatment is limited to medication only. Apart from the side effects of medication, the 'one-size-fits-all' method of treatment cannot effectively meet the needs of people with different diagnoses of mental illness. Literature has demonstrated that mental illness such as anxiety and depression can be managed well through psychological treatments (Bloom, 2010; Moncrieff & Kirsch, 2015).

Psychotherapy and physical exercise have been identified to reduce mental illness without side effects like medication treatments (Jakobsen et al., 2020; Kirsch, 2019; Strauss et al., 2014). Using medication only to treat all persons identified in the present study undermined the person-centred treatment approach, meaning that treatments are not provided according to participants' specific needs. Lack of other treatment options shows low levels of empowerment of participants (and other people using the services). Furthermore, participants stated they did not have enough time with doctors to gain more information about their treatments and discuss their concerns. "*They will tell you to continue with your drugs […] They don't listen to you again for any other things outside the medication*" (Jumoke, a participant). Time is an important element in patient-doctor relationships, creating time would have given the participants an opportunity to discuss their needs and how to support them. However, the

lack of enough time with doctors stated by participants may be an attempt to save time to attend to other patients. Additionally, the limited number of available staff may be under pressure to provide services for patients who could have used primary or secondary services instead of tertiary healthcare services. The implication of the heavy workload is that staff may be over-stretched and become ill. Their illness may result in absenteeism which may further limit the number of staff in hospitals thereby increasing patients suffering.

Accessibility

Accessibility of mental healthcare services is another important area that must be considered. In relation to participants' experiences of healthcare services, this can be discussed in four ways, physical, economic, information and non-stigmatisation. In the present study, physical accessibility can be explained as participants' ability to reach the hospital environment for treatments (CESCR, 2000). The implications of not being able to access care within participants' local areas have been discussed extensively in the 'availability' section. In addition to distance and travel time to mental hospitals, participants also incurred additional expenses such as money spent on transport to attend clinic appointments. Other expenses incurred for accessing treatments included food and lodging expenses (especially for participants from rural areas). In some cases, these expenses were multiplied if participants were accompanied by family members during a crisis. In addition to physical accessibility, participants were therefore also confronted with economic problems.

Economic accessibility, which is also known as affordability, refers to people's capability to pay for facilities without any financial hardship (Hasan et al., 2017). Although medication is available in hospitals, ensuring the affordability of medicines is important for continuing access to care. Lack of economic accessibility was raised by participants in the form of the high price of the medication. The majority (17 of 26) of women who participated in phase two of the study, stated they were unable to afford the cost of medication due to financial problems. The danger of expensive and unaffordable medicines can lead to catastrophic spending, a situation where a large proportion of household income is spent on treatments. Some participants reported that the high cost of services and financial problems have pushed them into deeper poverty by selling their assets (distress financing), in order to receive treatments: "*When I could not get help, I sold all my gold, beautiful earrings and necklace to buy drugs, to eat" (a participant).* Participants who did not have enough money to buy the needed quantity stated they reduced their medication dose or did not follow the specified time to take the medicine. This practice may worsen the symptoms of their mental illness. The stress of the high cost of medicine and the financial problem of purchasing medication was a result of the use of user

fees to finance public health services. Participants and their family members bear the problem of low budget allocation by the government, leading to reduced utilisation of the services. The experiences of the participants drew my attention again to the words of Draper (1991) that stated: "*health is more than a biological state but is rather a reflection of the wider human condition in all its social, economic and cultural aspects*" (Draper, 1991, p. 1).

High cost of medication as a barrier to treatments among people with mental illness was found by Iseselo & Ambikile (2017) in Tanzania. The differences between this study and the present study are: the Tanzanian participants received free treatments from public hospitals for their mental illness as usual practice in Tanzania. Participants in the present study paid out of pocket for their treatments because of a lack of provision for mental health treatments in Nigeria. Medications are not usually available in public hospitals in Tanzania, as a result, they were forced to buy at high prices at private pharmacies. Contrarily, medications are always available in Nigeria mental hospitals but are expensive for participants to afford.

Information is the third point to discuss under the accessibility framework and is essential in accessing care. At national level, there is a lack of access to information about mental health and mental illness in Nigeria (Aluh et al., 2019; Aina, 2004; Oduguwa et al., 2017). The subject of mental illness is often avoided culturally; many people are not habitually motivated to discuss it openly (Bakare, 2014; Labinjo, Serrant, Ashmore & Turner, 2020). Technology has been helpful in providing different ways in which information can be accessed, such as through the internet and smartphone applications (Abdel-Aziz & Abdel-Salam, 2016). However, people with mental illness were badly portrayed in the media in Nigeria (Adekomaiya, 2019; Atilola and Olayiwola, 2012). Lack of adequate health information about the causes of mental illness may have contributed to stigma and discrimination against participants by people around them. Some of the participants reported poor knowledge about mental illness and its medical treatments until they were affected by the illness:

> "*Many women do not know they have a disorder, no information. Like if I wasn't referred here, I wouldn't know am having a problem because I was asking the doctor, I told him when I walk my heart precipitates, is it not a normal thing? No one can see that as a medical problem and since that happening to me definitely it will happen to millions of people out there*" (Jumoke).

> "*Nobody talks about mental illness and mental hospital. Even you see people of my age they don't know what is happening around them. Those women on streets if they know they have this illness, if there is information that when you are feeling this and this come and check yourself, they will come for treatment*" (Damola).

Lack of mental health education may have contributed to beliefs in the supernatural cause of mental illness and the spiritual healing methods sought by participants in the present study. If participants were able to access information on mental health issues, they may be able to search for different ways of managing the illness and the method that meets their needs. Inadequate information about mental illness is not only limited to individuals in the society, there is no adequate information regarding the statistics of people with mental illness at national level. This has hindered financial support for mental health from both national and international bodies (Abdulmalik et al., 2019; Agboola et al., 2018). Individuals with mental illness in the country are the people who bear the burden. Also, a lack of financial support for mental health from external bodies may contribute to the high cost of medicine, and an inability to finance different interventions that can empower people with mental illness. A lack of routine information about mental illness will not enable policymakers to make evidence-based decisions and plan on how to improve mental health services delivery. This is different from the findings of Biringer et al. (2017) in Norway where people are able to access information from various sources and develop positive ways of managing their mental illness.

The fourth aspect of accessibility is the non-stigmatisation of people with mental illness. Stigma occurs on three levels: self, social and structural (Corrigan et al., 2005; Hatzenbuehler and Link, 2014). Self-stigma is explained as an individual's feeling of shame of having a mental illness. It can lead to isolation and lack of confidence in people with mental illness. Social stigma is referred to as discrimination by an individual or members of a society (Corrigan and Watson, 2002; Corrigan et al., 2014; Livingston & Boyd, 2010). While social stigma is caused by history and cultural influences, in turn, it provides fertile ground for the production of self and structural stigma (Holley et al., 2012; Link & Phelan, 2001). Participants' experiences related to self and social stigma have been discussed earlier in this chapter when analysing the effects of mental illness on participants. I stated participants' different reactions to self and social stigma such as discrimination, concealment of mental illness, limited social interaction, and emotional distress caused by people's actions. This section will look at structural stigma and its impacts on participants.

Structural (or institutional) stigma is about how amenities are organised in society in a way that put people in an increased vulnerability (Link & Phelan, 2001; Livingston, 2013). Previous to Link and Phelan (2001) analysis of structural stigma, Galtung (1993) had made it known that mental illness-related stigma is not limited to self and public negative attitudes but extends to institutions that provide healthcare services. He described how a group of people in a society experience unequal life chances compared to other people because of the unequal allocation of resources in the system, as structural violence. Structural violence is when:

"an *avoidable impairment of fundamental human needs or, to put it in more general terms, the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible*" (Galtung, 1993, p. 106). In his view, structural violence does not cause direct harm but indirectly puts the affected persons in a disadvantaged position. It was further defined as "*static, insidious, silent, taken-for-granted, and hidden*" (Taylor, 2013, p. 258). Structural violence is stated to be deeply embedded in history, including individual and institutional actions to create inequitable social policies and practices that put people in a disadvantaged position in society (Farmer, 2013). Structural stigma is not related to psychological distress caused by social stigma but concerns human rights to health and social justice (Parker, 2012). Galtung (1993) and Link & Phelan (2001) idea of structural stigma can be applied to the mental health system and services in Nigeria.

Mental health is excluded in the country's National Health Policy, educational or criminal justice policy (Abdulah & Brown, 2011; Abdulmalik et al., 2016; Igberase & Okogbenin, 2017). Though a bill was adopted to revise the 1991 national mental health policy by the government in 2013, it has not been passed as law and has not been implemented (FMOH, 2013). Even though the mental health policy is based on the principles of social justice and equity, people with mental illness are in a more disadvantaged position compared to individuals with other non-communicable diseases. The low priority accorded to mental health care by policymakers can be termed as stigmatising and discriminatory against individuals with mental illness. Therefore, the high unmet needs of participants may have been the result of policymakers' low priority for mental healthcare.

The lingering problem affecting the mental health system in Nigeria is inadequate financing (Mbamalu, 2019). For example, 3.3% of the annual budget was allocated to the mental healthcare system in 2012 (Project MedCOI, 2017), 3.95% in 2018 (Hafez, 2018), an allocation lower than the WHO recommendation of 5% (WHO, 2006). Though the poor funding also affected other healthcare sectors as 6% was allocated in 2012 (Project MedCOI, 2017) and 4.3% in 2020 (Ugochukwu et al., 2020) instead of the 15% agreed by African Unions on health budgets (Project MedCOI, 2017). Funding is an essential aspect of mental illness as emphasised by WHO:

> "*Mental health financing is a powerful tool with which policy-makers can develop and shape quality mental health systems. Without adequate financing, mental health policies and plans remain in the realm of rhetoric and good intentions*" (WHO, 2003, p. viii).

The insufficient funding of the mental health system has prevented optimal healthcare delivery to people using the services (Lasebikan et al., 2019; Hafez, 2018; Ugochukwu et al., 2020;

Uneke et al., 2012). Insufficient funding may have contributed to the absence of routine data collection and evidence-based planning decisions for mental health services. In terms of financial coverage, the provision of cash transfer incentives made available for reproductive health programmes does not exist for people with mental illness (Abdulmalik et al., 2016; Agboola et al., 2018; Oloniniyi et al., 2019). Rather individuals with mental illness pay out of pocket for their treatments. This affects equitable access to quality and affordable mental healthcare delivery (Omoluabi, 2014). Out-of-pocket payment without a source of income has increased participants' financial problems and stress levels. The commitment, strategic operational support, and accountability to infectious and other non-communicable diseases show that the Nigerian government has the capacity to respond to the basic health needs of people with mental illness (Abdulmalik et al., 2016). The failure of the government to give the same support to the mental health system can be argued as structural stigma or violence against individuals with mental health problems in Nigeria.

According to the WHO (2010), a strong health system requires a robust finance structure to provide a sufficiently trained and well-remunerated workforce, and well-maintained facilities for the population to access timely health service delivery. Lack of sufficient funding hinders the opportunity to train and employ more health care professionals (Abdulmalik et al., 2016; Abimbola et al., 2016; Adeloye et al., 2017). The available health professionals were not well paid and worked under poor conditions which have resulted in industrial actions (Odigwe, 2013; Oleribe et al., 2016; Omoluabi, 2014). It could be argued that policymakers' low interest in mental health has weakened the country's mental health services delivery. The majority of participants (18 of 26) in phase two of the study reported a lack of access to other interventions except for medication treatments. Inadequate funding and the shortage of health professionals may have limited participants' treatments to medication only. However, different methods of providing treatment are essential since participants have different diagnoses. Mental health services also lack community services. The problems in mental healthcare delivery cannot be addressed as lack of capacity to meet the needs of the Nigerian population with mental illness but can be argued to mean a lack of priority for mental health services.

Acceptability

Acceptability of healthcare services means that public policies and the delivery of services are sensitive to people's needs (Macioce, 2019). It is not enough to have mental health services in place, but it must be acceptable. In this study, a number of factors were identified that may lead to poor acceptability of mental health services to participants. The experiences of not being able to access services locally and at a convenient time may reduce the acceptability of

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the services. Receiving treatments over a long-distance, consumes a lot of time. It affects productivity time for caregivers and participants that were employed, and creates additional expenses for participants.

 The findings of this study include expensive and unaffordable costs of treatment which can be linked to a lack of financing strategy. In addition to the unaffordable costs of treatments, participants' experiences of not being treated with respect by service providers limited their acceptability of the services. Inequalities in funding mental health systems reduced programmes and interventions for people using the services, leading to a lack of a person-centred approach to the one-size-fits-all method of care. There is a shortage of health professionals of different disciplines to meet the diverse needs of the population. The limited psychiatrists available in mental health hospitals contributed to overcrowding and excessive waiting time for treatments reported by participants. The challenges experienced by participants in utilising the health care facilities may affect how the service provided by the clinic is accepted by the population.

Quality

Quality of care is the last and most important part of the framework to be discussed. It is defined as "*the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*" (WHO, 2018, p. 30). It implies that the quality of health services can be measured, quality of care includes curative and preventive care (Busse et al., 2019). To be of high quality, it was suggested that health services should be safe, people-centred, financially protected, integrated, timely, equitable, effective, and efficient (Unger et al., 2003; WHO, 2018). Comparing the findings of this study against this definition, it can be stated that mental healthcare service delivery in Nigeria is low in quality. The contributing factors for the low quality of mental health care in Nigeria include lack of effective leadership and health system governance in the mental health system (Abdulmalik et al., 2016; FMOH 2004; Uneke et al., 2012). Health care governance is concerned with policy formulation, implementation, and the general functioning of the healthcare system at all levels (Minas, 2012; Walt et al., 2008). The absence of mental health officials in the ministry of health at national level has been documented (Anyebe et al., 2019; Jack-Ide, Uys and Middleton, 2012). The consequence of this includes a lack of effective implementation of mental health policies and legislations including lack of a uniform standard of care across the mental health hospitals in Nigeria (Ngui et al., 2010; Ugochukwu, 2020; WHO-AIMS, 2006).

Integrating mental health into primary healthcare would have reduced participants' expenses to accessing care and increased their engagement with the services. Likewise, the few health professionals providing the services would not be overwhelmed with the burden of providing care for the large population. This is supported by the WHO statement that states: "*If countries spent more at the primary care level, they would be able to reach more people, and start to address problems early enough to reduce the need for expensive hospital care*" (WHO 2011, p. 4).

After stating their challenges, participants expressed various ways in which they could be supported to continue accessing care and improving the quality of services provided. First, is the provision of free medication which they believed would not only help them but extend to other people in a similar situation. Surprisingly, participants raised the desire to have a patients' support group that was coordinated by health providers. It was their opinion that the group would provide an opportunity for people using the services to discuss their experiences to learn from others in the same condition. Furthermore, it could be a way of transforming mental healthcare services in Nigeria by engaging with service providers to discuss their needs. Participants' involvement in the planning of health services may increase their self-esteem and opportunity to reach out to individuals who may not have used the services. It was surprising to find participants expressing the need to come together as a group even with the stigma associated with mental illness.

Returning to a phenomenological perspective, the findings of this study further justified the existential work of Heidegger (1927/1962). that human beings co-exist with other beings. The presence of others either contributes positively or impacts negatively on one's life. The findings of the present study show that participants at different times from different people and in different situations, received different behaviour and actions from people. Some of which may have made them feel valued and supported. On the other hand, other peoples' actions may have sometimes caused anguish and despair to participants. The use of Gadamer's hermeneutic methodology did not only broaden the understanding of participants' experiences by relating it to their social and cultural background, but also revealed that mental illness is not the only issue to which participants contend, and that their culture has put them in an oppressive position. Whether the structural stigma experienced by participants was the consequences of cultural influence or an unintentional act, findings revealed that participants were in a more disadvantaged position because of the institutional policies.

However, a conceptual model (figure 8.1) has been developed, based on the identified factors that are preventing participants from having regular access to medical care. The identified

barriers will be discussed in the concluding chapter before suggestions on how to improve mental health services.

Figure 8.1. A conceptual model
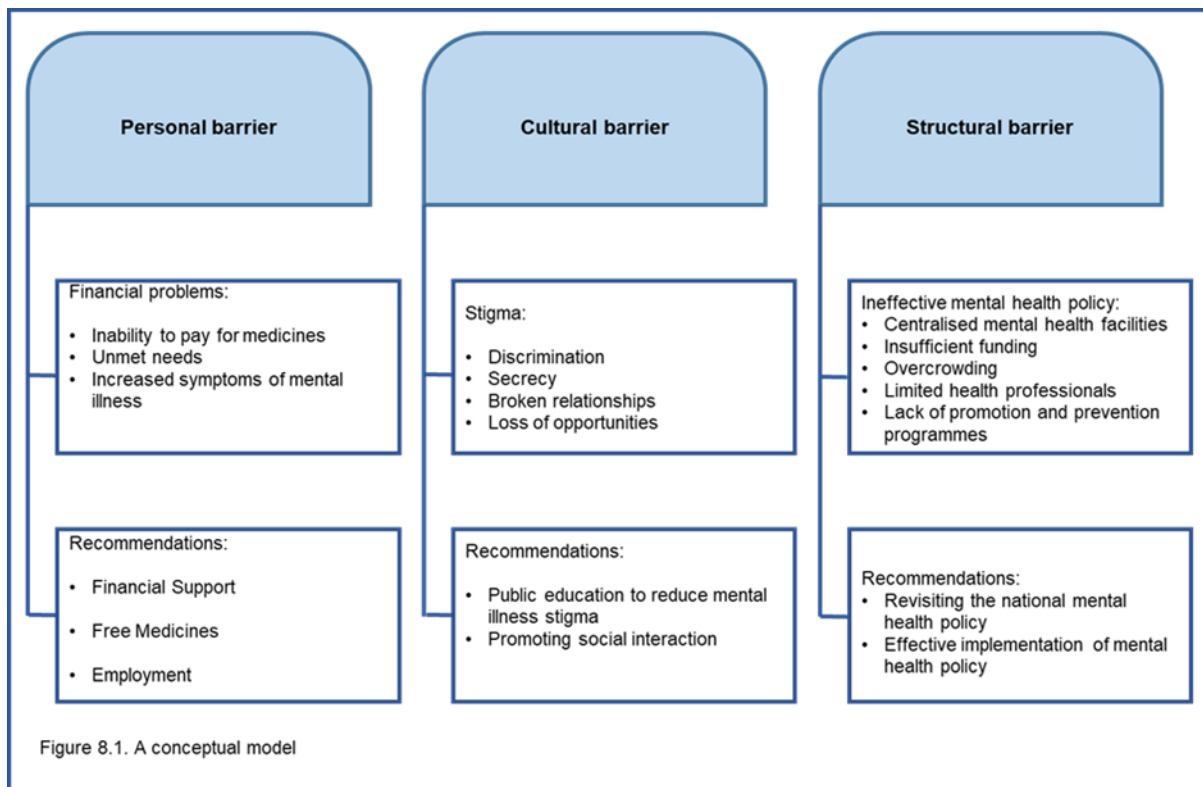
Figure 8. 1: A Conceptual model for identified barriers to accessing care

Summary

This chapter provided discussion about the participants' experiences of mental illness, which was discussed in relation to their social and cultural situatedness for a deep understanding. The discussion includes the effects of mental illness on participants with extension to their families, especially the children. How the inadequate mental health service delivery further affected participants by preventing them from having access to timely and cost-effective treatments were stated. Based on the identified barriers, a conceptual model was developed to highlight causes of the problems and possible solutions to improve the services. I will bring the discussion of the participants' experiences to an end in the next chapter, recommendations and areas for future research will be stated.

Chapter Nine – Concluding Thoughts

The current study examines the lived experiences of women with mental illness in southwest Nigeria. Data was collected for the study in two phases; the first phase of the study was designed to explore the everyday experiences of women living with mental illness in the southwest of Nigeria. Semi-structured interviews were conducted with 20 women who volunteered to share their experiences. Findings from the first interviews informed and led to phase two of this study. Like other women, many women with mental illness have children and are involved in nurturing their children. Understanding the lived experiences of this group of mothers is important. Thus, phase two of this study examined the experiences of women diagnosed with mental illness and being a mother at the same time. For this purpose, 26 mothers with mental illness were recruited into the study from two mental health clinics in the same part of Nigeria. Findings from the two sets of interviews were presented in chapters five and six of the present study.

This chapter will cover different sections such as how the study achieved its aim and objectives, and the contribution of the study to knowledge. The major identified barriers that greatly impacted the lives of participants will be discussed. Then, suggestions on how to address the identified problems to improve the access to health care will be presented. The chapter will highlight the limitations and strengths of this study, how findings of this study will be disseminated, and areas that may need further research are provided. Final thoughts on the study are then given.

Achieving the study's aim and objectives

The review of existing literature immensely contributes to the study, achieving its aim and objectives. First, it helps to identify where there is a paucity of knowledge regarding the experiences of women with mental illness in the southwest of Nigeria. To fill the knowledge gap, the investigation was carried out to have the knowledge of the day-to-day functions and routines of women and mothers with mental illness in the southwest of Nigeria. Also, reviewing previous literature helped to choose the most suitable methodological approach for the present study and created the opportunity to locate the present study within the wider literature.

Research methodology is used to justify that the approach used to conduct a study will answer the research questions. This study was situated within the interpretivist perspective and approached from the relativist's point of view. Hermeneutic phenomenology was chosen from

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various approaches within interpretivism epistemology because of the benefits it offers. The concepts of Gadamer's hermeneutic methodology include dialogue, language, history, and culture of the researched while time is also a significant factor. A new understanding of living with mental illness was produced because of the willingness of participants to share their experiences and the interest to pursue new knowledge as a researcher. Language, the powerful tool that was used to engage in the mutual conversation, also unveiled the deep meaning of participants' experiences. Understanding these experiences, keeping in view the cultural background, increased the understanding of their social and health situation. Time is significant when talking about culture and experience, culture can change from time to time, likewise, what is important to participants at the time of the interviews may not be relevant in the future.

Sampling was purposive on the basis that identified people would provide information relevant to the subject because of their experiences. Data were collected from participants through a semi-structured interview technique. It allowed interaction with participants, and allowed participants to talk freely, and elaborate on their responses while they could also ask questions. It would have become difficult to achieve if a questionnaire was used. From a hermeneutic perspective, pre-understanding must be put aside to concentrate on participants' data to allow new understanding to emerge naturally. Similarly, the thematic analysis method required that text must be read several times for understanding and to search for words that present participants' experiences. The process was followed to analyse participants' texts and to identify themes in the study. The chosen methods to conduct the research helped to achieve the study's aims and objectives. The chosen approach (Hermeneutics) to conduct the study helped to unveil the social and cultural interpretation of mental illness and the impacts it had on participants. Then, the UN CESCR's General Comment No. 14 AAAQ framework was used to discuss the findings related to mental health service provision in the country. This was done to reveal the state of the mental health system in Nigeria and participants' challenges (including other people in the population) in accessing care.

Contribution to Knowledge

The Current study provides insight to the health and social care of the women and mothers who participated in this research project. The current study provides insight into different aspects of motherhood that can be affected by the illness. This was made known through the use of a hermeneutic approach, the commitment of the participants, and the cooperation of their gatekeepers.

Using a hermeneutic approach to conduct the present study differentiates it from previous studies carried out in this part of the country. Prior to undertaking this study, the method of conducting research widely adopted in the southwest of Nigeria was quantitative approach (survey questions). This method limits participants to respond positively or negatively to predetermined answers without the opportunity to express their views in their terms. The chosen method of data collection enabled the researcher to develop rapport with participants, as it allowed dialogue to take place between the researcher and the participants. After the interviews, there was prolonged engagement with the generated data to present a deep analysis of participants' experiences. Hermeneutic phenomenology enables the study of a phenomenon in relation to the participants' social situatedness which has produced a new understanding of the topic and the originality of the present study.

The contribution of the gatekeepers cannot be ignored. The participants were vulnerable and hard to reach people who were enrolled in this study with the cooperation of their gatekeepers. Access to the study population involved different steps, including getting information from the hospitals' insiders to reach gatekeepers, such as outpatient clinic administrators and ward managers. The negotiation that took place, between the researcher and the second level of the hospitals' gatekeepers (ward managers), was more than about negotiating access to the study population, they also assisted in identifying eligible women to participate. Further, when it was evident that I had not recruited enough women to the study, the new method of recruiting participants that I designed was also supported by the gatekeepers. This shows the rapport and relationship that developed between the researcher and the gatekeepers. The steps taken to get the gatekeepers involved in the research were stated in chapter five (pages 83-85).

The aims of this study could not have been achieved without the willingness and the commitment of the women who participated in the research project. Challenges (stigma, financial problems, and discouragement from family) did not stop their determination to make their voices heard through their involvement in the research. Their contribution helped to gain an insight into their health and social care experiences, including how the existing mental health services impact on their wellbeing. Emphasis will be made on two areas of the findings to illustrate how the current study originally contributes to knowledge and understanding of the experiences of women living with mental illness in the southwest of Nigeria. The first area was on participants' experiences of mental healthcare provision. The second area was concerned with the psychosocial experiences of the women.

A new insight into the healthcare experiences of the participants

Experiences of mothers with mental illness have attracted little or no attention from scholars in the southwest of Nigeria. Exploring the lived experiences of this population has contributed

to knowledge. The mental health hospitals under study fall short of providing appropriate services that mothers with mental illness and their families need, which as expressed by participants, was a challenge. Examples include the lack of parental skills training from service providers to support the mothers in raising their children, and financial support from the government to meet their needs. Furthermore, the findings revealed that participants and their families were unable to participate in decision-making with the service providers when deciding the course of their treatments. This was because of the lack of a conducive atmosphere, where mothers felt they could express their individual concerns and expectations.

All the participants were receiving medication for their illness. This universal treatment did not encourage service providers to consider the individual differences (treatment preferences, financial needs, protection against domestic violence, social rehabilitation, and work experience) that may be contributing to and surrounding their situation. This study adds that a universal treatment for all people with mental illness is not appropriate, and a person-centred approach, which is unavailable in Nigerian mental health services, needs to be addressed.

Previous studies by Buchman-Wildbaum et al. (2020), Burke et al. (2016), and Ibrahim et al. (2016) have demonstrated that people living with mental illness are stigmatised; the present study arrived at the same findings. In addition to social stigma, the present study identified the threat posed by structural stigma to participants, which may be applicable to others with mental illness in the country. According to Galtung (1993), Link and Phelan (2001) and Farmer (2013) who analysed the nature of structural stigma, it is an indirect act without any intention of causing harm to people. This is noted in the form of the mental health policy in place in Nigeria that does not make adequate provision for people with mental illness. People with mental illness, in particular, bear the burden of hardship caused by ineffective policy, as they are marginalised and placed in a more vulnerable position. Thus, it is suggested that a new mental health policy with adequate provision for service users is needed.

A new insight to psychosocial experiences of the participants

The present study also revealed the hidden pains that participants had endured alongside the long-suffering of the illness as a result of cultural silence. Mental illness is not openly discussed in Yoruba culture and people suffering from the illness are often silenced and marginalised, which means that participants were put in an even more disadvantaged position. Therefore, I believe that conducting this research has enabled participants to speak out about their oppression and the deprivation they have experienced. Their contributions, it is hoped, will help to challenge Yoruba cultural beliefs that people suffering from mental illness cannot live

meaningful and productive lives; also, that mental illness is an illness that can be managed like any other illness.

Furthermore, the findings of this study revealed the complexity of Yoruba culture. On one hand, there is the experience of stigma because of the cultural beliefs about the causes of mental illness. on the other hand, there is a collectivist spirit, where relatives and neighbours provide support to family members and friends suffering from the illness. Further, the findings show that participants were accessing more than one type of treatment simultaneously, which suggests the pluralistic ways of treating illness in the present study participants' culture.

What was known about the perceptions of women with mental illness in southwest Nigeria was that they were dangerous, unkept and the illness is incurable (Ikwuka et al., 2014; Jegede, 2005). Rather, the findings of this study show that women with mental illness have been rendered powerless, made poor, and oppressed because of the patriarchal structure of Yoruba culture. From the findings, it could be stated that the distress and loss suffered by participants (jobs and relationships) were more to do with cultural issues than the actual illness. Participants' culture placed value on gender roles and reduced women to certain occupations which may have limited them financially. It was discovered that participants' poor financial status further worsened their health conditions and increased their vulnerability. This clearly shows that most of the women need financial support from the government. A conceptual model has been developed based on the findings of the current study. The framework will contribute to improving the health and social conditions of women with mental illness in the southwest of Nigeria.

Finally, this study has the potential to contribute evidence that might be of interest to policymakers in the southwest of Nigeria. The study further adds that collaboration, patient and service provider relationships, social capital and access to mental health information, are essential in promoting the resilience and psychological wellbeing of people with mental illness.

Limitations and strengths of the study

This study has a number of limitations. First, participants were mainly women who could share their experiences in the English language. Other women excluded from participation because of being non-literate in English could have used their experiences to deepen the understanding of the topic. Participants were recruited from mental health hospitals; their experiences may be different to women who have had no contact with mental health facilities. Therefore, the findings are in the context of this study and cannot be generalised for the whole population of people suffering from mental illness in southwest Nigeria.

The present study examined the experiences of women and mothers suffering from mental illness. It may have been helpful to gather the perspectives of family members (partners, children, and other caregivers) and health professionals that were not involved may produce additional information that will further illuminate the understanding of the experiences.

Using qualitative approaches added quality to this study. The chosen methodology allowed participants to talk about their experiences without been restricted to pre-set answers, thereby producing new knowledge and a greater understanding. Another strength of this study is that it involved different groups of women with mental illness, it identified problems peculiar to each group and discussed their experiences. Presenting the findings in relation to participants' traditions increased the understanding of living with mental illness in southwestern Nigeria.

Highlighting barriers to accessing healthcare services

This section presents the overarching themes that highlight the vulnerability of the participants. The conceptual model shown in figure 8.1 summarises the identified barriers and suggestions on improving access to care for individuals with mental illness in the southwest of Nigeria and plausibly the whole country. It is grouped and discussed under three subheadings: personal, cultural, and structural barriers. The purpose of classifying the identified problems affecting participants was to understand the causes of these problems and how to address them.

Personal barriers

Financial problems were identified as a potential barrier for participants, which were preventing them from accessing mental health treatments regularly. The majority (27 of 46) of the participants were unemployed, which may have brought financial problems. Furthermore, the duration of the illness at the time of the interview was between two to 28 years, meaning they had already spent a considerable amount of money on treatments. A mother's mental illness and financial problems had effects on her children. An example is when a child's education is stopped for the mother to receive treatment or when adult children spend substantial parts of their income on mother's treatments. Selling off assets to pay for treatments and to meet other needs, was also reported by participants. Paying out of pocket for treatment and other expenditures, such as transport costs to clinics, money to buy food, and lodging may have increased the poor financial conditions reported by participants. It suggested there would be periods when they could not access care because of a lack of money. The financial problems may result in not being able to meet some of their social needs or to receive timely treatment, and this further increases the symptoms of mental illness.

Cultural barriers

Misconceptions about mental illness contributed to stigma and discrimination reported by participants. In order to avoid being stereotyped, concealment of mental illness was reported by participants. Some participants (13 of 20) reduced their interaction with people to prevent emotional problems that may arise from the behaviour of others towards them. Stigma may have contributed to the loss of income reported by participants. Employers who may have misconceptions about mental illness may be unlikely to employ someone with the illness. Apart from symptoms of mental illness, the experience of discrimination and social exclusion may cause participants to withdraw from school resulting in low educational attainment. A large number (23 of 46) of women recruited into this study were separated or never married, because of mental illness stigma reinforced by cultural beliefs. The effects of failed marriage because of a mother's mental illness on children, include behavioural problems. This problem may have been prevented if the mothers had been living happily with their spouses without social and cultural problems separating them. Where the mother is not physically or emotionally available to support children, fathers may support in training their children.

Structural barriers

The treatments of people with mental illness in Nigeria are controlled by the country's mental health policy. Not only is the policy old, but it has not been well implemented and has not met the needs of the population using the services. Findings showed a lack of equity in the distribution of mental health resources; the rights to health of persons with mental illness are far from fulfilled, even at the primary level. Ineffective implementation of mental health policy affected participants in numerous ways, including the high costs of treatments, overcrowding, and participants spending a long time in the clinic before treatments. The adverse effects of structural barriers include negative staff attitudes towards participants, which can be argued as a result of the overwhelming burden of caring for a large number of patients with few health professionals. The lack of a person-centred treatment approach was reported, which was part of the challenges participants encountered in accessing care because of a lack of evidence-based planning linked to ineffective mental health policy.

<u>**Recommendations**</u>

The findings show various challenges that participants experience as a result of living with mental illness. They ranged from personal to societal and institutional problems. This section will look at how the identified problems can be addressed to improve the participant's quality of life. If the recommendations are followed, the benefits will also extend to other people

receiving treatments for mental illness in the southwest of Nigeria and plausibly in Nigeria as a whole.

Recommendations for mental health care policy

In this section, I discuss the problems caused by low priority for mental illness and lack of effective implementation of mental health policy in Nigeria. I recommended the reform of the existing mental health policy with the purpose of improving access to services that are affordable and convenient and allocating sufficient funding to the mental healthcare system. The discussion will include the advantages of collaborating with private and non-governmental organisations to improve the service delivery.

Improving access to services

The country's stipulated method of providing mental health services included primary, secondary and tertiary care. The findings of this study show that only the tertiary arm of government was functioning. The lack of mental health clinics in rural areas indicate that not all people experiencing mental illness would receive medical treatments for their illness. It is suggested that mental health services should be incorporated into primary health care for easy access to treatments. Initial assessment and treatments, referral, and prevention activities can be carried out at the primary level to reduce overcrowding of people using the services at the tertiary level. Additional expenses for travelling long distances to receive treatment would be eliminated if services are delivered at the primary health care level. Health professionals at the primary care level can easily do a follow-up on patients to ensure they attend their appointments. Furthermore, staff can provide support to patients who may have problems in keeping a routine with their medication especially patients with limited social support. Patients who do not have the financial capability to purchase their prescriptions all at once should have the opportunity to buy in small quantities if there are mental health clinics that can be locally accessed.

Health workers together with services users can more easily design and implement health promotion activities for a small number of patients attending primary care than meeting the needs of a large number of people receiving treatments at the tertiary level. The use of text messages to remind patients of their appointments, as practiced in developed countries such as the UK, could be introduced to the system to increase access to care. This will be easy for staff to manage when a small group of people is involved, rather than dealing with a large population. Furthermore, the problem of overcrowding and excessive waiting time reported by participants may not exist if services are provided at primary and state levels. Health providers

will have a small number of patients to attend to, as compared to when the whole population converges at the tertiary level. The benefit of it includes the ability of patients to build good relationships with service providers and engage staff about their treatments. The burden of treating large numbers of participants with limited staff will be reduced, promoting the wellbeing of the health professionals.

Allocating sufficient funds

Providing a quality mental health service needs proper funding and political parties must ensure that accessible and acceptable mental health services are provided. While revising the mental health policy, the policymakers should increase the budget for mental health care services. Insufficient funds allocated to mental health care might have caused the numerous problems confronting the services, such as the higher concentration of mental health hospitals in urban areas. Adequate funding may provide an opportunity to carry out services such as regular statistics of the number of people with mental illness. Evidence-based decision-making would bring proper planning and interventions that can be monitored for effective implementation for the population in need of the services. If mental health care receives sufficient funding, more professionals may be trained to reduce the problem that is currently affecting the system. The trained staff may have the opportunity to take part in continuous professional development training and receive good remuneration that will motivate them to perform efficiently. There is a possibility that more people will be interested to be trained as mental health professionals. Availability of other health workers such as social workers and psychologists may provide services for social and emotional needs in addition to medication treatments.

Paying out of pocket for treatment suggests that only people who can afford to pay receive treatment. This indicates that many people who cannot afford the cost of treatments will not be assessed, diagnosed, and treated. The financial coverage enjoyed by people with a physical illness should be extended to persons with mental illness. The high cost of medication could be reduced for easy accessibility. If adequate funding is allocated to the mental health system, routine statistics to understand the magnitude of the problems of mental illness would be possible. The government could collaborate with different organisations to deliver quality mental health services. Not all persons with mental illness will need pharmacological treatments, psychological interventions such as Cognitive Behavioural Therapy (CBT) may be a suitable approach for many people to manage their illness. It is likely that the use of medication to treat all participants as reported, may be the result of insufficient funds to implement different options of treatment.

Collaborating with other organisations to provide care

Revisiting the mental health policy is just one of numerous ways in which the government can ensure the rights to mental health care of people who may need the service. The government can create partnerships with different organisations to ensure the needs of people with mental illness are met. They can collaborate with the private sectors to provide vocational training or job opportunities to make positive impacts in the lives of people with mental illness. Other private organisations may like to contribute monetarily to the mental healthcare system. Such funds can be used for maintaining regular medication supply, free medication, or acquiring new and modern hospital equipment for the wellbeing of individuals using mental health care. Similar to the care for physical illness, the government should encourage individuals to have private hospitals to provide care for people with mental illness. However, efforts must be made to regulate their activities, so that people receiving treatments from private clinics are not subject to exploitation and maltreatment, and ensure their services are of a good standard.

Working with non-government organisations (NGOs)

The work of non-government organisations in ensuring that people with mental illness have access to care cannot be underestimated. They can provide different services such as counselling and rehabilitation. They can also increase mental health awareness and reach out to people with mental illness, especially in rural areas where there are no medical facilities. It will enable them to be more sensitive to people's needs because of their closeness. Social problems in the community that can affect patients to respond to treatments can be identified and addressed. Another benefit that the involvement of NGOs can bring to mental health care is that they can assert their efforts to lobby for policy reform that will support sustainable healthcare. In addition, they can foster equitable partnerships with private organisations for the training and employment of persons with mental illness. Likewise, NGOs can advocate for people with mental illness and their families. Due to their humanitarian services, NGOs can receive funds from international bodies to organise health prevention and promotion programmes for the benefit of people with mental illness.

<u>**Recommendations for mental health care practice**</u>

Health professionals have much to offer in making the mental health service users' experience a pleasant one. Negative behaviour was reported by participants in phase one of this study which can discourage persons with mental illness from utilising the services. Rather, staff should attend to patients with respect, showing empathy and giving prompt attention to their

needs. While patients are waiting for treatments, that opportunity can be used to educate them and their families on how to manage mental illness.

Provisions for mothers with mental illness

Lack of provision for mothers with mental illness was reported by mothers who participated in this study. I suggest that there should be guidelines on assessing and supporting mothers with mental illness. Health professionals could have sessions with mothers and children together or separately to understand their needs and to provide appropriate support. Through this method, information about the nature of mothers' illness and how to give support could be made available to their children. Mothers with mental illness may need to develop new skills because of their illness, it would be helpful if health workers could provide parenting support. Parenting skills needed may change as the children grow up so mothers should be encouraged to seek support when necessary. In addition, emotional support should be given to children (and families) of women with mental illness because of the practical care they provide for their ill mother.

Involving family members in treatment

Participants stated that their family members were not involved in their treatments. As much as possible, health professionals should involve family members in the treatment of people with mental illness. The family spends more time with their ill relative and understands them more than the health workers. Family members may provide useful information concerning the patient and this will play a key role in improving the overall effectiveness of treatments. On the other hand, family members can have access to information that will increase their practical support in a way that will not affect their own health. A person-centred approach or recovery-focused activities that are sensitive to patient's social and emotional needs should be adopted by health professionals. Also, programmes that would improve the health conditions of persons experiencing mental illness are necessary to empower them.

Collaborating with religion and traditional healers to provide care

Religion is an important aspect of Yoruba culture, which impacts hugely on how social and health issues are interpreted and treated (Arulogun & Adefioye, 2010; Awodele et al., 2013; Oyebola, 1980). More than half of the study participants looked for treatment from religious and traditional healers before medical care or simultaneously. My findings show that mental health care is not accessible to all people with mental illness because of limited mental hospitals and trained staff. I propose that health professionals should collaborate with religious

and traditional healers to provide holistic care. It would be an opportunity to guide the activities of these alternative care providers against practices that will worsen the health outcomes of people with mental illness.

Reducing financial problems

The steps recommending alleviating participants' financial distress, include the provision of free medication. This would reduce their financial expenses and help them to meet other needs. Efforts should be made to reduce the financial burden of paying out of pocket for treatments by mental health service users. Extending the coverage of the National Health Insurance Scheme (NHIS) enjoyed by people with other chronic illnesses such as cancer, HIV/AIDs, and tuberculosis to people with mental illness is suggested as a positive solution. It promotes equity, the enjoyment of the right to health and would reduce the financial burden of their illness on families, who are supporting them to have continuous access to treatments. Financial support can reduce parent's stress and recover a mother's ability to provide a safe environment to nurture their children. Financial distress in women with mental illness can be eliminated by encouraging them to start income-generating projects through using vocational skills. People with a high level of recovery should be supported to get work. It would serve as a way of integrating back into society and a source of earning income.

Reducing stigma

Mental illness is not always discussed in Yoruba society (Adewuya et al., 2011; Gureje et al., 2005; Oshodi et al., 2014), but the burden of the illness is increasing which makes it necessary to start raising awareness. Structured psychoeducation can be made available to families of individuals with mental illness through different methods, such as producing fliers in different languages that can be easily accessed. Digital audio or visual recordings for information on identifying symptoms, signs or relapse, and self-management plan for mental illness could be used. This would enable family members to increase support for their relatives experiencing mental ill-health.

If the peer social group expressed by participants is organise by health providers, it could improve the wellbeing of people living with mental ill-health. Individuals who have recovered from the illness and are willing to be recognised could be introduced to participants to share their experiences. It may help others, who are receiving treatments, to increase their confidence and improve their self-esteem, reducing any effects that the stigma might have had on them. Through dialogue with services providers, people with mental illness can use the peer group to be involved in the planning, implementation, and delivery of mental health

care to meet their specific needs. Peer support can better improve the recovery outcomes for people with mental illness compared with service providers because the power and control issues that exist between service providers and their patients may not present in peer support. Opportunities such as vocational and rehabilitation programmes may be available to individuals with mental illness if a peer social group is formed.

Education can change how some social issues are perceived in a culture; therefore, mental health education is recommended as a way of reducing the mental illness stigma that is pervasive in the participants' community. It may be helpful to invite famous people such as athletes, artists, or national heroes to work together with health professionals to talk about mental illness. The support of these people may increase social motivation and be effective in changing public attitudes about mental illness. Recovered individuals with mental illness who are successful could educate the public on mental illness. The stories of these people could modify public attitudes when it comes to employing individuals receiving treatments or with a history of mental illness. Educating the public on mental illness may reduce social stigma, increase social support, and enhance seeking timely treatments by persons experiencing mental illness symptoms.

Raising awareness on the non-stigmatisation of people with mental illness involves the joint efforts of individuals, and communities including the media. Media can be used to correct wrong beliefs about mental illness and the people suffering from it. Through media, a large number of people could be reached to reduce mental illness stigma by showing the artistic work of people with mental illness. This measure could be useful in changing the attitudes of individuals who may not want to invest in people with mental illness. Different programmes related to mental illness could take place on television to increase mental health and mental illness awareness. Additionally, fliers, books, and educational materials could be made available in public libraries for adequate information on mental health. Religious leaders have an important role to play in reducing mental illness stigmatisation through their preaching.

Recommendations for future research

This is an area where little or no research has been carried out; it is my hope to extend the research project to different interventions that may be of great benefit and be cost-effective for women and mothers with mental illness. Future research will include the perspectives of family members (such as children, parents, and spouses), to have an additional and a deeper understanding of the phenomenon. Perceptions of health professionals about service users and mental health provisions are also important and may be considered in further research, as they may add potentially valuable dimensions to the subject. Future research may focus

on understanding the views of young people's experiences of mental illness, because most of the women in the study experienced their illness from adolescence.

Dissemination of the findings

Findings of the present study have been presented at a conference organised by the University of Huddersfield. Also, it will be presented in other conferences, seminars and used for teaching purposes. After the study has been examined, it will be in the University of Huddersfield repository and there will be publications from the findings. It is anticipated that the findings will be submitted to the two mental health hospitals where the interviews were conducted to inform them of the views and concerns of the service users. There is a possibility of presenting it to policymakers where it may inform mental health policy and regulations in Nigeria.

Final thoughts

Researching this topic has increased my personal development and understanding of women and mothers' experiences of living with mental illness. The deeper understanding achieved was made possible because of the hermeneutic phenomenological approach used in the study. My findings revealed that the suffering of people with mental illness in the southwest of Nigeria was made worse because of tradition, culture, and political factors. Consequently, participants experienced marginalisation, felt powerless, and were in a more vulnerable position than the mental illness itself. This study has advanced knowledge of existing literature which has examined the experiences of women with mental illness. It has added new knowledge on the influence of social and cultural factors on women's mental health. The majority of the identified problems are caused by the lack of an effective mental health policy. Therefore, a new policy with comprehensive approaches to improve the wellbeing of individuals with mental illness in Nigeria is recommended.

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Appendix 1: CASP guidelines for critiquing a qualitative research study (A=low, B=moderate, C= high)

Studies	Elements influencing the robustness of the research										Total	Category
	Clear aims	Method	Design	Sampling strategy	Data collected	Reflexivity	Ethical issues	Rigour	Clear findings	Research value		
Araten-Bergman et al. (2016).	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	9	A
Awram et al. (2017)	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	9	A
Bartsch et al. (2016)	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	9	A
Biringer et al. (2016)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	9	A
Blegen et al. (2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	9	A
Burke et al. (2016)	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	8	B
Connerty et al. (2016)	✓	✓	✓	✓	✓	✓	✓	✗	✓	✓	8	B
Hailemariam et al. (2017)	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	8	A
Halsa (2018)	✓	✓	✓	✓	✓	✗	✓	✓	✓	✓	9	A
Hine et al. (2018)	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	8	B
Huggett et al. (2018)	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	8	B
Islam et al. (2018)	✓	✓	✓	✓	✓	✗	✓	✗	✓	✓	8	B

Iseselo & Ambikile (2017)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	9	A
Kisa et al. (2016)	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	9	A
Klausen et al. (2016)	×	×	×	×	×	✓	✓	×	✓	✓	9	A
Lee et al. (2020)	×	×	×	×	×	✓	✓	×	✓	✓	9	A
Memon et al. (2016)	×	×	×	×	×	×	✓	✓	✓	✓	9	A
Mora-Rios et al. (2016)	×	×	×	×	×	×	✓	×	✓	✓	8	B
Nohr et al. (2019)	×	×	×	×	×	✓	✓	×	✓	✓	8	B
Ntshingila et al. (2016)	×	×	×	×	×	✓	✓	✓	✓	✓	9	A
Rampou et al. (2015)	×	×	×	×	×	×	✓	✓	✓	✓	9	A
Saavedra et al. (2016)	×	×	×	×	×	✓	✓	✓	✓	✓	9	A
Tanaka et al. (2018)	×	×	×	×	×	×	✓	✓	✓	✓	8	B
Tuffour et al. (2019)	×	×	×	×	×	×	✓	✓	✓	✓	8	B
Van der Ende et al. (2016)	×	×	×	×	×	×	✓	✓	✓	✓	8	B
Vranda et al. (2018)	×	×	×	×	×	✓	✓	×	✓	✓	8	B
Yeisen et al. (2017)	×	×	×	×	×	✓	✓	✓	✓	✓	9	A

Appendix 2: CASP guidelines for critiquing a quantitative research study (A=low, B=moderate, C= high)

Studies	Elements influencing the believability of the research			Elements influencing the robustness of the research									Score	Category
	1	2	3	4	5	6	7	8	9	10	11	12	Score	Category
Afe et al. (2017	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	12	A
Buchman-Wildbaum et al. (2017)	✓	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	✓	*11*	*A*
Ibrahim et al. (2016)	✓	✓	✓	✓	✓	✓	×	×	✓	✓	✓	✓	*10*	*A*
Makanjuola et al. (2016)	✓	✓	✓	✓	✓	✓	×	×	✓	✓	✓	✓	*10*	*A*
Strand et al. (2020)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓	×	×	*9*	*B*
Tesaw et al. (2020	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	✓	*10*	*A*
Thoits, (2016)	✓	✓	✓	✓	✓	✓	✓	✓	✓	×	×	×	*10*	*A*

1— Clear research title, 2— Clear statement of research aims/objectives, 3—Abstract, 4—Research purpose, 5—Logical consistency, 6—Literature reviews, 7—Theoretical framework, 8—Sample, 9—Ethical consideration, 10—Operational definition, 11—Methodology, 12—data analysis and clear statement of findings.

Appendix 3: Extraction table of reviewed studies

Name of author(s) and date	Sample	Location	Findings
Afe, T.O., Emedoh, T. C., Ogunsemi, O. O. & Adegohun, A. A. (2017).	The aim of the study was to understand the motives behind violence and abuse from intimate partners towards women with mental illness, 79 women living with mental illness participated in the cross-sectional survey.	Nigeria	The study found that the severity of the women's mental illness, and the lack of income are the causes of the abuse. Other factors included low-income status or unemployment of the partner and the age of the women and their partners. For example, rate of verbal, physical and sexual abuse was higher among couple under 40 years of age while high rate of verbal abuse was discovered among older partners that are over 40 years.
Araten-Bergman, T., Avieli, H., Mushkin, P & Band-Winterstein, T. (2016).	18 people living with severe mental illness were recruited into the study to take part in an in-depth semi-structured interview. Participants aged 60 to 69 years.	Israel	The study found that the ageing people with schizophrenia have causal attributions which are external and culturally inclined. This also informs their outlook on their situation.
Awram, R., Hancock, N. & Honey, A. (2017).	10 Australian women who self-identify as mothers balancing mental health recovery participated in an in-depth interview to explore the strategies used by mothers to balance the responsibilities of mothering and mental health recovery.	Australia	The study found that the mothers used 4 interconnected strategies to balance the responsibilities of mothering and mental health recovery, and they are: prioritising in the present; looking after myself; buffering children; and using support. Awareness was also an important concept that the mothers found helpful as it helps them successfully identify and use their strategies. Mental health services are encouraged to help mothers develop this awareness.
Bartsch, D. R., Roberts, R. M., Davies, M., & Proeve, M. (2016).	11 mothers and 1 father which either with borderline personality disorder diagnosis participated in this study's focus group to explore their experiences of parenthood and mental healthcare service provision.	Australia	The study reported that parenting can be both a rewarding and challenging experience for parents with mental illness. Other themes identified stigma and fear of loss of custody
Biringer, E., Davidson, L., Sundfor, B., Lier, H. O., & Borg, M. (2016).	The longitudinal study included 8 service users in an in-depth interview to understand their expectations around their treatment, goals and recovery at the beginning of their treatment. The study aimed to explore participants' experiences 2 years after receiving treatment and support from health care professionals.	Norway	The study highlights that to effectively facilitate recovery, the personal goals and aspirations of the service users need to be considered and incorporated in their recovery plans. Counselling around their family and everyday lives proves to be very important to reaching and maintaining recovery.

Blegen, N. E., Eriksson, K., & Bondas, T. (2016).	This study explored the experiences of 10 mothers as they suffer from mental illness and receive care from health care professionals	Norway	The study highlights the multi-faceted considerations to be taken when providing care for parents suffering with mental illness. The study shows that patients do not ordinarily share their feelings on being a mother in care. In addition to this, is the struggle between their personal needs and wearing a 'mask of silence', and fear of condemnation.
Buchman-Wildbaum, T., Richman, M. J., Váradi, E., Schmelowszky, Á., Griffiths, M. D., Demetrovics, Z., & Urbán, R. (2020).	200 people experiencing mental ill-health completed self-report questionnaires to determine the structure of the Hungarian version of the personal loss from mental illness (PLMI)	Hungary	Study found that participants suffered higher as patients with mental illness diagnoses. It is important for healthcare providers to further understand coping and recovery in people with mental illnesses.
Burke, E., Wood, L., Zabel, E., Clark, A & Morrison, A. P. (2016).	In order to gain a better understanding of living with mental illness, 12 service users of mental health facilities participated in an in-depth semi structured interview.	UK	This study shows that stigma towards mental illness is a huge concern to service users with receiving treatments for mental ill-health.
Connerty, T. J., Roberts, R & Williams, A. S. (2016).	To understand the lived experiences of mothers with mental illness who also have infants, 8 women who had been discharged from a mother-baby unit partook in a semi-structured interview.	Australia	The study provides insight into the experience of women with mental illness in the community and their decision-making process. Findings show that participants experienced difficulties in taking decision and sometimes required the help of others.
Hailemariam, M., Fekadu, A., Prince, M., & Hanlon, C. (2017).	This study carried out in-depth interviews with 50 participants. It included different groups of people such as service users, health providers, caregivers and people that have stopped using mental health services.	Ethiopia	The study found financial problem as one of the major barriers to mental health care. The authors stated the need for economic interventions that give service users options to affordable and effective treatment.

Halsa, A. (2018).	14 women partook in the semi-structured interviews to explore being a mother with mental illness.	Norway	The study showed that the mothers understood their parental struggles as personal problems which resulted in self-blaming, loneliness and even a reluctance to express the need for help.
Hine, R. H., Maybery, D., & Goodyear, M. J. (2019).	To explore the experiences of rural mothers recovering from mental illness, 17 mothers with mental illness, partook in in-depth interviews	Australia	The study found that although the mothers had strong desires for connection, previous experiences of rejection and trauma places barriers to their development of trust
Huggett, C., Birtel, M. D., Awenat, Y. F., Fleming, P., Wilkes, S., Williams, S. & Haddock, G. (2018).	In exploring the experiences of stigma in people with mental illness, 13 people with mental illness were enrolled to take part in an in-depth interview.	UK	The study highlighted the participants' perspectives of their society and how it shaped their interpretation of the stigma they received. They expressed their views of 'hierarchy of labels' and how they believe it to have strong impacts on various levels in the society not only towards people with mental illness and their mental health, but also their immediate network such as families and friends.
Ibrahim, A. W., Mukhtar, Y. M., Sadique, P. K., Tahir, B. M., Olabisi, A. M., Bukar, R, I. Abba, W. M. and Abayomi, O.B. (2016).	To investigate the internalised stigma of mental illness, 235 participants with mood disorder diagnosis participated in a mental health facility-based cross-sectional study.	Nigeria	The study found that approximately 1 in 3 people with severe mental illness experienced high to moderate self-stigma. It is essential that guidance and support such as self-esteem, adherence to medication and mental health education is provided to people with mental illness especially females, as it discovered they experienced high level of internalised stigma than men.
Iseselo, M. K., & Ambikile, J. S. (2017).	This study aimed to explore the experiences and views of people with mental illness, caregivers and mental health care providers around psychotropic medication. Four patients and seven mental health care providers participated in an in-depth interview. A further 18 caregivers participated in focus groups.	Tanzania	This study highlighted significant issues around the affordability and availability of medications for treating mental illness. The cause of the irregular supply of medicines was linked to insufficient funds from government.
Islam, M. M., Jahan, N., & Hossain, M. D. (2018).	10 women were interviewed to fully explore violence against women with mental illness in Bangladesh.	Bangladesh	The study highlights the constraining lives of the participants. The women experienced abuse from their partners for many reasons such as lack of social support.
Kisa, R., Baingana, F., Kajungu, R., Mangen, P. O., Angdembe, M.,	This study engaged 77 participants (policy makers, service users, caretakers, and	Liberia, Nepal and Uganda	This study highlights the experiences of poor access to mental health care services people with mental health illness in these post-conflict countries. Factors contributing to this include lack

Gwaikolo, W., & Cooper, J. (2016).	health care workers) across in-depth interviews and focus groups.		of policies, educational programmes, provision and affordability of medication, negative attitudes and stigma from health care professionals.
Klausen, R.K., Karlsson, M., Haugsgjerd, S. & Lorem, G, F. (2016).	In exploring the personal stories and experiences of being admitted to mental health care facilities, 10 mothers engaged in this study, used a narrative approach to share their experiences and thematic analysis was used by authors to analyse participants' data.	Norway	The results show that the mothers interpreted their distress to the natural life events and strains, and their admissions as interruptions. This shows a need for a more holistic approach which provides both personal and social support in areas of parenting and mental distress.
Lee, M. Y., Eads, R., Yates, N., Liu, C., & Wang, X. (2020).	18 participants with a diagnosis of mental illness participated in in-depth interviews to explore the experiences of mental health recovery without the current use of medication.	USA	The study reinforced that no one size fits all and treatment should be personalised and should not be medication only.
Makanjuola, V., Esan, Y., Oladeji, B., Kola, L., Appiah-Poku, J., Harris, B., . . . Gureje, O. (2016).	The authors used a mixed method approach (interviews and questionnaires to gain understanding of how 85 people with mental illness perceived the cause of their illness.	Nigeria, Ghana, Kenya	The study found that those with high levels of internalised stigma had a higher propensity to attribute supernatural forces to their mental illness compared to those with lower levels of internalised stigma.
Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T. & de Visser, R. (2016).	In investigating the perceived barriers to access to mental health care provisions by people from Black and minority ethnicities, 26 adults from Black and minority ethnicities (13 men and 13 women) participated in focus groups.	England	The study found that there was a lot of room and need for mental health education and awareness in black and minority ethnic communities.\nTailored engagement around mental health services that considers the cultural settings of people from Black and minority ethnicities, would help to combat stigma and inform a better understanding of their needs whilst improving access.
Mora-Rios, J., Ortega-Ortega, M., & Natera, G. (2016).	23 participants (12 women and 11 men) went through in-depth interviews to explore the sociocultural aspects of their mental illness and means of coping.	Mexico	The study showed that the participants attributed their illness to religious or mystical elements which in turn influenced how they sought to deal with it and what it meant to them. Different methods were used by participants to restrict the negative behaviour from others such as educating public about mental illness.
Nohr, L., Steinhäuser, T., Ruiz, A. L., Ferrer, J. E. S., & Lersner, U. v. (2019).	14 psychiatric patients were interviewed to understand causal attributions in Cuba.	Cuba	The study found 6 patterns of causal attributions: personal shortcomings, family influence, the cultural, economic, and political environment in Cuba, excessive demands, physical causes and symptom-related explanations.

Ntshingila, N., Poggenpoel, M., Myburgh, C. P. H., & Temane, A. (2016).	Eight women living with borderline personality disorder went through in-depth phenomenological interviews to gain an insight to their experiences.	South Africa	The study found that the participants had expressed negative experiences of violations, physical and emotional insecurity, unhealthy dynamics in the family, learning difficulties in their childhood. They also expressed a continuous failing relationship, feelings of emptiness, emotional distress.
Rampou, A. M., Havenga, Y & Madumo, M. (2015).	10 mothers with severe mental illness living in their homes participated in in-depth interviews to explore their experiences of motherhood.	South Africa	The study found that the mothers experienced several challenges. There is a need for a more family-focussed approach to mental health care, around treatment and rehabilitation.
Saavedra, J., Lopez, M., Gonzales, S. & Cubero, R. (2016).	21 participants who were clinically diagnosed with several mental illness participated in semi-structured interviews to explore the meanings that participants attribute to their work experiences and its impact on their recovery.	Spain	Participants highlighted work as hinderances to their recovery. For example, narratives of conflicts, stress, job insecurity and unfulfillment were common. This shows that although employment can seem beneficial for recovery, the benefits should be assessed based on individual experiences, aspirations and backgrounds.
Strand, J., Boström, P., Grip, K., (2020	15 parents in outpatient clinics for mental illness engaged in in-depth semi-structured interviews to explore their experiences of parenting.	Sweden	The study shows that participant's mental illness affected their parenting to large extent. The parents reported difficulties such as motivation, fatigue, auditory hallucinations which interfere in their ability to perform parental roles such as protecting, monitoring, maintaining routines and reciprocating to their children.
Tanaka, C., Tuliao, M.T.R. &Tanaka, E. (2018).	39 participants with mental health problems (PMHP) participated in interviews with their carers, and community health volunteers who know them well to explore the discrimination experienced by people with mental health problems in low- and middle-income countries.	Philippines	The study shows that participants still experience stigma despite the stigma-reduction strategies. The lack of readily available mental health care in the community contributes to lack of awareness which further fuels stigma. Effects of the stigma experiences by people with mental health problems leads to reduced networks and opportunities for economic advancement.
Tesfaw, G., Kibru, B., & Ayano, G. (2020).	423 participants living with mental illness were recruited randomly to explore their experiences of internalised stigma.	Ethiopia	The study found that people with severe symptoms of mental illness had higher levels of perceived stigma. It was particularly higher for females who at the onset of their illness, had multiple admissions to the hospital and have had the mental illness for over a year.
Thoits, P. A. (2016).	9,282 participants were walked through a survey in structured interviews to assess mental illness identity deflection.	USA	The study found that participants who had been in treatment for serious impairment and also deflected experiencing mental illness. It may be that those participants rejected having mental

			illness to protect themselves from labelling and mental illness stigma
Tuffour, I., Simpson, A., & Reynolds, L. (2019).	12 Black African service users recovering from mental illness, participated in semi-structured interviews which aimed to explore the experiences of Black Africans as service users in mental illness recovery and to understand how they conceptualise recovery.	England	The study found that for the participant, recovery was conceptualised as a pragmatic and subjective concept spread through a range of clinical, spiritual and functional dimensions, individual differences cultural and social backgrounds.
Van der Ende, P. C., Van Busschbach, J. T., Nicholson, J., Korevaar, E. L., & Van Weeghel, J. (2016).	Experiences of 19 mothers and 8 fathers with a mental illness were explored through in-depth interviews to understand the difficulties parents with mental illness face and gain insights into their parental strategies.	USA	Research found that these parents experience both negative and positive feelings around parenting. Participants expressed feeling inadequate and their children being a burden, but they are also the joy of being a mother and valued how their children provide avenues of enrichment, structure, and distraction from problems. The strength and opportunities to develop meaningful relations. The study also found that peer groups can prove to be very valuable mentally and emotionally.
Vranda, M. N., Kumar, C. N., Muralidhar, D., Janardhana, N., & Sivakumar, P. T. (2018).	100 women at a tertiary mental health care facility were engaged to understand their help-seeking behaviours and reasons around disclosure and non-disclosure of intimate partner violence (IPV). Their feelings before and after reporting, support received from mental health professionals after disclosure.	India	The study found that majority of the women hid their abuse due to fear from their partners. In addition, the was a lack of trust in mental health care professionals and there was no confidentiality or privacy as it is common practice for mental health professionals to have it discussed in the presence of said violent partners.
Yeisen, R., Bjornestad, J., Joa, I., Johannessen, J. O., & Opjordsmoen, S. (2017).	To identify factors which may affect adherence to medication in the initial 24-month timeframe after the commencement of the treatment for mental illness, twenty participants (7 male, 13 female) who had used antipsychotics (engaged in semi-structured interviews and had 2-year follow-up.	Norway	The authors discovered total reliance on medication for treatment and as coping method from negative effects of their illness. The study also highlights the importance of health care staff and the role they play in supporting their service users to maintain good adherence

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Interview schedule

This interview schedule served as a guide for each interview in order to ensure consistency of questioning.

Introduction

First of all, I would like to thank you for agreeing to participate in this research study and for allowing me to interview you.

My name is Abiodun Abegunde and I am a research student from the University of Huddersfield. The title of the research study is: "An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria"

The purpose of this study is to inform a better mental health service for women with the issue of mental illnesses such as schizophrenia in Nigeria. I will ask you some general questions about you before moving on to find out in more detail about your experiences of living with schizophrenia.

I will be audio-recording the discussion because I don't want to miss any of your valuable comments. Your participation in this interview is entirely voluntary, you do not have to go ahead with the interview if you have changed your mind. If you still wish to participate can I remind you that you are free to withdraw from the interview at any time. Your decision to take part or to withdraw from this interview will not affect the treatment you are receiving at this hospital because I am totally independent of the hospital where you are receiving care.

I am conscious of the fact that by reconstructing your experiences, you may find it very emotional and distressing. If at any time you feel unable to answer a question or you do not wish to provide any additional comments, please let me know your concerns. You are free to stop the interview at any time if you choose not to continue and you are free to ask me questions before and after the interview.

Is there anything you would like to say or ask before I start the interview?

Interview questions

First of all, I would like to find out a little bit about you

1.Can you tell me about yourself?

Prompt: Are you married? Have you got any children? What are you doing as a job?

Now I would like to move on to find out about your experiences of schizophrenia

2. When were you first diagnosed with schizophrenia?

Prompt: How did this make you feel?

3. Can you take me through what happened before you chose to seek medical help?

4. How do you feel about your illness. Has this changed from when you were first diagnosed?

5. Did you tell family / friends / employer about your diagnosis?

Prompt: How did your family / friends respond when they heard about your illness?

6. Has your illness affected any family members?

7. Please explain in as much detail as you can your experience of living with schizophrenia?

8. Has your health interfered with your normal social activities with family, friends, neighbours or job?

Prompt: can you explain further?

9. What has helped you the most since being diagnosed with schizophrenia?

10. Do you have any concerns / worries about living with schizophrenia?

I would like to find out about your views on mental health service provision, thinking back to when you were diagnosed,

11. How did you hear about mental health services?

12. Do you think that most women with schizophrenia have the knowledge of mental health services?

If no – what do you think might be the reason?
What do you think can be done to make the services accessible to other women?

13. Do you experience any challenges accessing treatment / hospital?

14. Can you tell me about your experiences of accessing mental health services?

15. Were you given information in an understandable way regarding your illness?

16. Have you had to stop any of your medication for any reason?

I would like to find out about your health and social care needs and to know if these needs are being met.

17. Did you have any health and social care needs when you were diagnosed with schizophrenia?

Prompt: Can you say a bit more about this? Were your needs met?

18. What resources are available for women with this schizophrenia to support them with their needs?

Prompt: are they helpful?

19. Are there any unmet needs or challenges that you can identify?

20. How might these unmet needs/challenges be addressed?

Prompt: Do you have any suggestions?

We are now coming to the end of the interview so I would just like to ask you
Is there anything else you would like to add based on your experience so far that you think is relevant and that I have not asked you about?

Before I conclude the interview are there any questions you would like to ask me?

Conclusion: Thank you for your participation and commitment to this study. This study would not have been possible without you. I appreciate your help and candidness in answering what are sometimes uncomfortable questions. Again, because of your contribution, other women in your situation may be able to access mental health care services.

If you need further information about the study, please do not hesitate to contact me – Abiodun Abegunde. Email address: Abiodun.Abegunde@hud.ac.uk

You can also contact the research supervisor – Dr B. Golding on +44(0)1484473845 or through email: B.Golding@hud.ac.uk

 Thank you again for participating in this important research study.

Appendix 5: Risk assessment form

THE UNIVERSITY OF HUDDERSFIELD: RISK ANALYSIS & MANAGEMENT (RAM)

Hazard(s) identified	Details Risk(s)	People at Risk	Risk management measures	Other comments
ACTIVITY: Interview			**Name**: Abiodun Emily Abegunde	
LOCATION: Hospital			**Date**: March 2017	**Review Date:**
Conducting interviews in hospital environment as a lone researcher.	Personal safety.	Researcher.	To give the nominated persons the place, time and duration of the interview and, when to be expected. And when I am out of the country doing data collection, I will be maintaining regular contact will my supervisor, informing her of my activities. To inform the nominated persons of the researcher's location at intervals.	Specific arrangement about safe travel to the place of the interview and the location will be identified with nominated persons prior to the interview date. The phone numbers of those people the researcher needs to contact will be stored in mobile phone memory. They will also be carried as hard copies.
Loss or theft of data.	Security of data	Interviewees.	Dictaphones with audio recordings will be transported in a lockable case. Electronic data will be stored only on password protected computer and storage devices.	Electronic data storage devises to be transported in a lockable case in the boot of a car.
Psychological wellbeing	Emotional distress	Researcher.	If I experience psychological distress by listening to the participants' stories, I will make use of the University wellbeing service.	

Appendix 6: SREP approval

5 May 2017

TO WHOM IT MAY CONCERN

School Research Ethics Panel (SREP) Submission

Applicant Name:	**Abiodun Abegunde (PhD Candidate)** **School of Human and Health Sciences** **University of Huddersfield**
Research Project:	**"An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria"**
Reference:	**SREP/2017/021**

I confirm that the above titled research project received ethical approval from the School of Human and Health Sciences Research Ethics Panel (SREP), University of Huddersfield on 29 March 2017.

I also confirm that indemnity for this project is covered by the insurance policy held by the University of Huddersfield, as it falls within the normal range of research activity.
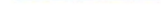
W. P. Gillibrand

Dr Warren Gillibrand
Deputy Chair, School Research Ethics Panel (SREP)
School of Human and Health Sciences
Direct Tel: +44 (0)1484 473689
Email: W.P.Gillibrand@hud.ac.uk

Appendix 7A: Phase 1 – Letter to the first hospital for ethical approval

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The Chairman,
NPHA Research Ethics Committee,
DRT's Office,
Postgraduate Building,
Neuropsychiatric Hospital,
Aro, Abeokuta.
Ogun-State, Nigeria.

Date: 28th October 2016

PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR INSTITUTION.

Dear Sir/Madam,

I am a Postgraduate Researcher undertaking a PhD at the University of Huddersfield within the School of Human and Health Sciences. My Research Study is titled: *"An exploratory study of the lived experiences of women with schizophrenia in the south-west of Nigeria"*

The aim of this study is to investigate the lived experiences of women living with schizophrenia in the South-west of Nigeria. It is envisaged that this study will add to the currently available literature. By exploring the experience of these women, research findings may help to develop specific strategies to reach out to other women that are affected with the illness but who are unable to access the mental health services.

Qualitative method will be used as a method of enquiry, using semi-structured interviews to investigate the lived experiences of 10 women with the diagnosis of schizophrenia attending the hospital outpatient clinic.

Participants' confidentiality will be maintained during and after the study. Data collected from participants will be transcribed by the researcher and it will be treated with the strictest of confidence. They will also be informed that no identifying data including their name, address and locations will be shared with a third party. All data collected from participants during the research will be kept confidential and secure for the period of ten years in anticipation that the research may, at some point, be published in a journal or report. I will adhere to the confidentiality and data protection regulations set out by the University of Huddersfield. Interview audio-recording equipment, transcriptions and consent forms will be securely store in different locked locations where only the researcher can access it and all computerised data will be password protected to prevent unauthorised access.

I can assure you that the participants' anonymity will be ensured. The names and contact details of the individuals who have agreed to take part in this study will be stored securely as

stated above. If it necessary to use the participants' words in the presentation of the findings, the use of pseudonyms or numbers will be employed to protect participants' identity. Audio recording equipment will be transported in a lockable case and electronic data will be encrypted or password protected to prevent unauthorised access. The reference to the respect for anonymity is incorporated into all documentation that will be sent to prospective participants (see attached documentation – invitation letter, information sheet and consent form). The researcher will adhere to the Data Protection Policy issued by the University of Huddersfield and also the guidance notes issued by the University of Huddersfield for researchers.

I can assure you that I will make every effort to ensure the study does not disrupt the working environment in any way and I will abide with the institution research ethics.

This research study is supervised by Dr B. Golding. If you require further information about the research, please do not hesitate to contact either myself or my research supervisor. Her contact detail are:

Email: B.Golding@hud.ac.uk
Telephone: +44(0)1484473845

I look forward to a response from you at your earliest convenience.

Yours sincerely,

Abiodun E. Abegunde
Postgraduate Researcher
Email: Abiodun.Abegunde@hud.ac.uk

University of
HUDDERSFIELD

The Chairman
Health Research and Ethics Committee
Federal Neuro-Psychiatric Hospital,
8 Harvey Road
Sabo-Yaba,
Lagos
Nigeria.

Date:

PERMISSION TO CONDUCT A RESEARCH STUDY IN YOUR INSTITUTION

Dear Sir/Madam,

I am a Postgraduate Researcher undertaking a PhD at the University of Huddersfield within the School of Human and Health Sciences. My Research Study is titled: *"An exploratory study of the lived experiences of women with schizophrenia in the south-west of Nigeria"*

The aim of this study is to investigate the lived experiences of women living with schizophrenia in the South-west of Nigeria. It is envisaged that this study will add to the currently available literature. By exploring the experience of these women, research findings may help to develop specific strategies to reach out to other women that are affected with the illness but who are unable to access the mental health services.

Qualitative method will be used as a method of enquiry, using semi-structured interviews to investigate the lived experiences of 10 women with the diagnosis of schizophrenia attending the hospital outpatient clinic.

Participants' confidentiality will be maintained during and after the study. Data collected from participants will be transcribed by the researcher and it will be treated with the strictest of confidence. They will also be informed that no identifying data including their name, address and locations will be shared with a third party. All data collected from participants during the research will be kept confidential and secure for the period of ten years in anticipation that the research may, at some point, be published in a journal or report. I will adhere to the confidentiality and data protection regulations set out by the University of Huddersfield. Interview audio-recording equipment, transcriptions and consent forms will be securely store in different locked locations where only the researcher can access it and all computerised data will be password protected to prevent unauthorised access.

I can assure you that the participants' anonymity will be ensured. The names and contact details of the individuals who have agreed to take part in this study will be stored securely as stated above. If it necessary to use the participants' words in the presentation of the findings, the use of pseudonyms or numbers will be employed to protect participants' identity. Audio recording equipment will be transported in a lockable case and electronic data will be encrypted or password protected to prevent unauthorised access. The reference to the respect for anonymity is incorporated into all documentation that will be sent to prospective participants (see attached documentation – invitation letter, information sheet and consent form). The

researcher will adhere to the Data Protection Policy issued by the University of Huddersfield and also the guidance notes issued by the University of Huddersfield for researchers.

I can assure you that I will make every effort to ensure the study does not disrupt the working environment in any way and I will abide with the institution research ethics.

This research study is supervised by Dr B. Golding. If you require further information about the research, please do not hesitate to contact either myself or my research supervisor. Her contact detail are:

Email: B.Golding@hud.ac.uk
Telephone: +44(0)1484473845

I look forward to a response from you at your earliest convenience.

Yours sincerely,

Abiodun E. Abegunde
Postgraduate Researcher
Email: Abiodun.Abegunde@hud.ac.uk

Appendix 8: Nigeria Research Ethics Form

NPHA ETHICS COMMITTEE

APPLICATION FOR ETHICAL APPROVAL

Title of Research Project: An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria

Principal Investigator's Name: Abiodun Emily Abegunde

Department: Human and Health Sciences

Faculty/Institution: University of Huddersfield

Phone No: +447508933945

Email: Abiodun.Abegunde@hud.ac.uk……

Area of Research (e.g., Malaria, HIV/AIDS, Hypertension, Drug Abuse, Child & Adolescent Psychiatry, etc.). <u>Social research</u>

Research includes the following elements *(tick as appropriate):*

1.   Nature of Study

✔ Interviews only	☐ Clinical Studies	☐ Community Work
☐ Laboratory analysis	☐ Clinical Trial	☐ Pharmacokinetic Study
☐ Intervention	☐ Use of existing data	☐ Others

Please specify below

_____

2.   Type of Project

| ☐ | International Projects | ☐ | Other academic Projects | ☑ | PG: FWACP, FNMC, MSc, MPH, **PhD**. |

| ☐ | Others above MSc | ☐ | Others below MSc | ☐ | Undergraduate |

3. **Mode of Funding**

| ☑ Self-Funded | ☐ Nationally/Institutionally Funded | ☐ Internationally Funded |

Sponsor (Specify)

_____

Study Requirements

Biological Sampling required? | Yes | | **No** |

If yes, which samples? | Blood | | Urine | | Saliva | | Tissue Biopsy |

Others (Please Specify) _____

4. **Disposition of samples**

Are samples going to be shipped out of Nigeria?

Yes | | No | |

5. **Duration of Study** | 6 months |

Corresponding Investigator's Name: Abiodun Emily Abegunde

Supervisor's Name (where applicable): Dr. B. Golding

Contact Address: University of Huddersfield, School of Human and Health Sciences

Phone: +44(0)7508933945.

Fax: …………………………… **E-mail**: Abiodun.Abegunde@hud.ac.uk

Signature   **Date**:

DECLARATION IN SUPPORT OF APPLICATION FOR ETHICAL APPROVAL

I certify that the information provided in the study protocol is true to the best of my knowledge. I agree to undertake the research according to the ethical principles described in National Code for Health Research Ethics, relevant Federal and local laws, ICH-GCP6 guidelines (where applicable), government and institutional guidelines and regulations. I understand that the Ethics Committee will provide Ethical Approval for this protocol for a specified time period not exceeding 1 year and that continuation of the research beyond this period will require renewal of the approval. I understand that the Ethics Committee may, without prior notice, observe of cause to be observed, the research for which approval has been given in order to ensure compliance with approved protocol, suspend or terminate the conduct of this research if necessary.

Name of Investigator: Abiodun Emily Abegunde

Signature: **Date:**

Appendix 9: Bioethics Research Certificate

Center for
Bioethics & Research

Thursday, December 22, 2016

NHREC/TR/02/06/2007a

Certificate

In recognition of successful completion of the revision of the Nigerian National Code for Health Research Ethics of Center for Bioethics and Research, Nigeria and the University of Miami, Florida online course

This certifies that

Abiodun Abegunde

♦ reviewed regulatory and informational documents on human-subject protection

♦ passed a quiz on the responsible conduct of human studies

♦ signed a statement of commitment to the protection of the rights and welfare of human subjects participating in research.

Dr. Clement A. Adebamowo
BM ChB (Hons), FWACS FACS ScD
Director, Center for Bioethics and Research

Cc: Program Administrator

102, Basorun Road, Ashi, Ibadan.
P.O. Box 29822, Secretariat Post Office, Ibadan, Oyo State, Nigeria.
+234 708 097 0008 | admin@bioethicscenter.net | http://www.bioethicscenter.net

Appendix 10: Ethical approval from the First hospital

NEUROPSYCHIATRIC HOSPITAL, ARO.
RESEARCH ETHICS COMMITTEE
P.M.B. 2002, ABEOKUTA, OGUN STATE, NIGERIA.

Ref No. __NPHA/276/VOL.III/1051__   Date: _____ 12th July, 2017

NPHAHREC Registration Number: NHREC/24/07/2013

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

RE: An exploratory study of the lived experiences of women with schizophrenia in the South West of Nigeria.

NPHA Ethics Committee assigned number: **PR015/17**

Name of Principal Investigator: **Abiodun E. Abegunde**

Address of Principal Investigator: **Human & Health Sciences Department, University of Huddersfield, United Kingdom.**

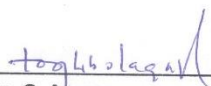Date of receipt of valid application: **25th May, 2017**

Date of meeting when final determination on ethical approval was made **12th July, 2017.**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and given full approval by the NPHA Ethics Committee.

This approval dates from **12th July, 2017** to **11th July, 2018**. If there is delay in starting the research, please inform the NPHA Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the NPHA HREC assigned number and duration of NPHA HREC approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the NPHA HREC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code of Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the NPHA REC. No changes are permitted in the research without prior approval by the NPHA HREC except in circumstances outlined in the Code. The NPHA HREC reserves the right to conduct compliance visit to your research site without previous notification.

You are to submit a copy of your report to the committee for vetting before any peer review or examination defense upon completion of your research.

Toghbolagav

Dr. G. Amoo
Chairman, NPHA Ethics Committee

E-mail: hrec@neuroaro.com   Phone No: +234 - 8133970504

Appendix 11: Ethical approval from the second hospital

FEDERAL NEURO-PSYCHIATRIC HOSPITAL, YABA - LAGOS

Chairman, Management Board	Dr. R. A. Adebayo M.B.Ch.B, M.Sc., PGD Hosp. Mgt., FWACP Acting Medical Director	Adeyinka Antwi BA (Hons), MBA, PGD (Hosp. Mgt.), ANIM, FIHSAN, FPMN Head of Administration

Ref: FNPHY/ERC/17/184   16th June, 2017.

Abiodun Emily Abegunde,
University of Huddersfield,
School of Human and Health Sciences
Queensgate, Huddersfield,
HD1 3DH
United Kingdom.

Dear Abegunde,

RE: AN EXPLORATORY STUDY OF THE LIVED EXPERIENCES OF
WOMEN WITH SCHIZOPHRENIA IN THE SOUTH-WEST OF NIGERIA

I am directed to refer to your letter dated 28th October 2016 on the above subject
matter and to convey approval for you to conduct your research as you requested.

A copy of your final project should be sent to the hospital library for record
purpose.

Thank you.

Mr. I. G. Amoo
Secretary: Ethical Review Committee
FOR: ACTING MEDICAL DIRECTOR

8, Harvey Road,
P.M.B. 2008
Yaba, Lagos, Nigeria
Tel: 01 - 4545063
E-mail
neuropsychiatrichospitalyaba@yahoo.com
enquiries@neuropsychiatrichospitalyaba.gov.ng
Website:
www.neuropsychiatrichospitalyaba.gov.ng

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Participant Eligibility Criteria List

Research study title: "*An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria*"

In order to reduce sampling bias and also to be clear that people who could be made worse by participating in the study are not subjected to the risk. These criteria will serve as guide to recruit the study participants.

The eligibility criteria for participating in the project are:

- A female from 18 years and above

- Having a primary diagnosis of schizophrenia

- Have being receiving treatment for a period of at least 12 months

- Attending hospital outpatient clinics

- Able to speak English language.

- Capacity to provide informed consent.

- Willingness to participate in the study

Appendix 13: Phase 1 - Invitation letter to participant

University of
HUDDERSFIELD

20 February 2017.

<u>Invitation to participate in a research project</u>.

Dear Madam,

I am a Postgraduate Researcher undertaking a PhD at the University of Huddersfield within the School of Human and Health Sciences. My Research Study is titled: "An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria".

You are invited to take part in the study, which aims to gain knowledge of the experiences of women living with schizophrenia and the existing service provision for women with the illness. It is anticipated that the information generated may aid health services in refining and expanding service provision and support for women with a diagnosis of schizophrenia in the south-west of Nigeria.

At the interview, you will be asked to discuss your personal experiences of living with a diagnosis of schizophrenia and what it means to you. Your views of the existing service provision will also be explored.

If you agree to participate, the one-to-one interview will take approximately 1 hour and it is very informal. The interview will take place in private in a quiet room in the hospital and it will be audio-recorded in order not to miss any of your valuable comments.

Your anonymity will be ensured in all documentations. Information collected from you during the interview will be securely store to prevent unauthorised access and your confidentiality will be maintained. Electronic data will be encrypted, or password protected to prevent unauthorised access. The information you share with me may be included in my thesis. It may also be published in academic journals, conferences, posters or as a teaching resource. If it is necessary to use your words in the presentation of the findings the researcher will use pseudonym or number to protect your identity. Any identifying material such as names and addresses will be removed in order to maximise your anonymity.

Although I consider your potential contribution to be very valuable to this research, please be informed that participation is voluntary. You are under no obligation to take part and deciding not to participate would, in no way, affect the care you receive. You are free to withdraw from the study at any time without giving a reason. If you agree to take part in this study, please sign the attached participant reply form.

If you would like more information about the research, please contact me - <u>Abiodun.Abegunde@hud.ac.uk</u>

This research study is supervised by Dr. B. Golding. If you wish to contact her for further information his email address is: B.Golding@hud.ac.uk. Telephone number: +44(0)1484473845

Looking forward to your involvement.

Yours sincerely,

Abiodun E. Abegunde
Postgraduate Researcher.

Appendix 14: Phase 1 – Information sheet

University of
HUDDERSFIELD

PARTICIPANT INFORMATION SHEET

Title of the research: An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria.

You are being invited to take part in this study. Before you decide to take part it is important that you understand the aim of the research and what it will involve. Please take time to read the following information carefully and discuss it with me should you wish to. Do not hesitate to ask if there is anything that is unclear or if you would like more information.

What is the study about?

The aim of this study is to explore the lived experiences of women with a diagnosis of schizophrenia. By exploring the experience of these women, research findings may help to develop specific strategies to reach out to other women that are affected with schizophrenia but are unable to access the mental health services.

Why I have been approached?

You have been asked to participate in this study because you are a service user.

Do I have to take part?

Taking part in the research study is voluntary. It is your decision whether or not you take part. If you decide to take part, you will be asked to grant an interview and you are free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part will not be of any harm to you.

What will I need to do?

If you agree to take part in the research interview you will sign the attached agreement form to show your interest in taking part in the study, after receiving your agreement form the researcher will send you another letter to ask for your convenient date and time to do the interview. The one-to-one interview will take I hour and is very informal. The interview will take place in private, in a quiet room, in the hospital and with your permission, the interview it will be audio-recorded in order not to miss any of your valuable comments.

You will be asked to sign a consent form before the commencement of the interview to indicate your voluntary action to take part in the study.

Will my identity be disclosed?

All information disclosed within the interview will be kept confidential. Your identity will not be disclosed to anyone. Identifying information such as name, address and location will be removed to protect your identity. Instead of using your name, pseudonym or number that has no connection with your name will be used.

What will happen to the information?

Data collected from all the interviews will be used to complete my thesis and the data may also be used to support any journal articles or conference papers that are written as a direct result of this research study. The data may also be used for teaching in the future. All information collected from you during this research will be kept secure for the period of 10 years in anticipation that the research may, at some point be published in a journal or report. Your anonymity will not be disclosed in the presentation of the findings of the researcher, your permission for this is included in the consent form. Identifying information will be locked in a separate location where only the researcher can access it. Electronic data will be encrypted, or password protected to prevent unauthorised access. Documents will be securely store in different locked location. Security codes will be assigned to computerised records to prevent unauthorised access.

Who can I contact for further information?

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. My contact detail is:

Abiodun E. Abegunde - Abiodun.Abegunde@hud.ac.uk

If you require further information about the research, please do not hesitate to contact me the research supervisor, Dr B. Golding. Her contact detail are:

Email: B.Golding@hud.ac.uk
Telephone: +44(0)1484473845

Appendix 15: Contact details

University of
HUDDERSFIELD

Contact Information Slip

This study is being conducted by a Postgraduate Researcher undertaking a PhD at the University of Huddersfield, UK.

For more information about this research study before, during and after the study, you can contact:

Abiodun Abegunde

Postgraduate Researcher

Email: Abiodun.Abegunde@hud.ac.uk

OR

Dr. Berenice Golding

The Research Supervisor

Email: B.Golding@hud.ac.uk

Telephone: +44(0)1484473845

University of
HUDDERSFIELD

CONSENT FORM

Title of Research Project: An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria.

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details, please contact your researcher.

I have been fully informed of the nature and aims of this research as outlined in the Information Sheet version 2017, dated 20 February 2017.

I understand that I have the right to withdraw from the research at any time without giving any reason.

I give permission for my words to be quoted (by use of pseudonym).

I understand that the information collected will be kept in secure conditions for a period of 10 years at the University of Huddersfield.

I understand that no person other than the researcher will have access to information I shared within the interview.

I understand that some extract from data may be presented in the thesis, published in a journal or report and may be used for teaching in the future.

I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report.

I understand that if I share any information that might indicate that I am at risk that the researcher will inform a member of hospital staff.

I consent to taking part in the study.

If you are satisfied that you understand the information and are happy to take part in this project, please print and sign below.

Signature of Participant:	Signature of Researcher:
_____	_____
Print: _____	Print: _____
Date: _____	Date: _____

(One copy to be retained by Participant / one copy to be retained by Researcher)

Appendix17: Reply form

University of
HUDDERSFIELD

PARTICIPANT REPLY FORM

Research study titled: An exploratory study of the lived experiences of women with schizophrenia in the southwest of Nigeria.

> I have read and I understand the Invitation letter and Participant Information Sheet. I wish to take part in the study, but I would like to find out more about the research.
> I, _____ consent to be contacted by Abiodun Abegunde from the University of Huddersfield in relation to the above-named study. Abiodun can contact me on:
>
> Name: _____
>
> Telephone No: _____
>
> Email address: _____
>
> Other: _____

Please use the attached envelope to return the signed agreement form through the study box provided in the hospital outpatient reception. You will receive another letter from the researcher to provide the date and time that is convenient for you to do the interview.

Appendix 18: Flier to recruit participants

You are invited to take part in a research taking place to understand the experience of women receiving mental care for a diagnosis of schizophrenia.

Your participation may help to develop specific strategies to improve services and reach out to other women in a similar situation.
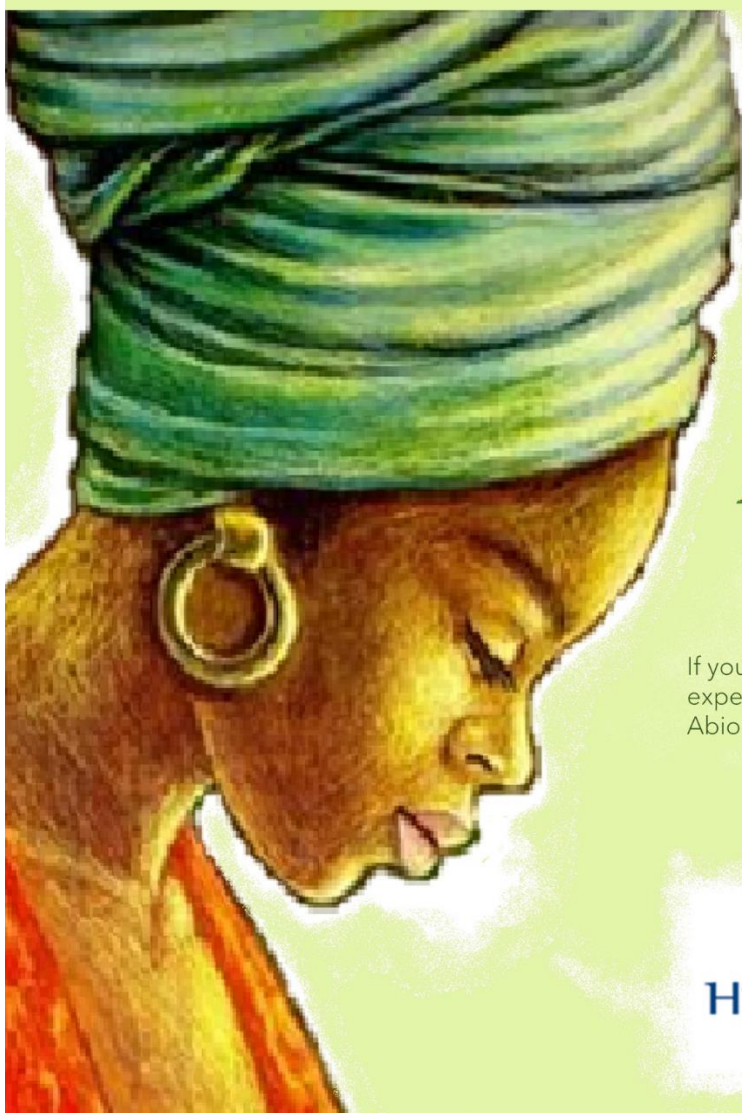
Your identity will be protected and all the information you share with me will remain confidential

If you are willing to share your experience, please contact me at: Abiodun.Abegunde@hud.ac.uk

University of HUDDERSFIELD

Appendix 19: Phase 2 – Letter to the first hospital

University of
HUDDERSFIELD

The Chairman,
NPHA Research Ethics Committee,
DRT's Office,
Postgraduate Building,
Neuropsychiatric Hospital,
Aro, Abeokuta.
Ogun-State, Nigeria.

Date: 03 April 2018.

The study titled: An exploratory study of the lived experiences of women with schizophrenia in the southwest of Nigeria.

Dear Sir/Madam,

I am a Postgraduate Researcher undertaking a PhD at the University of Huddersfield within the School of Human and Health Sciences, UK. My Research is titled: "An exploratory study of the lived experiences of women with schizophrenia in the southwest of Nigeria". This study has received Ethical approval from the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel. Study approval number: SREP/2017/021 dated 29 March 2017 (page 32 of the study proposal).

The study also gained ethical approval from your institution (ethical approval number FNPHY/ERC/17/184 dated 16th June 2017, page 33 of the study proposal). With this opportunity, I carried out the first part of the research in your hospital outpatient department between August to September 2017. The study examined the lived experiences of women with a diagnosis of schizophrenia in which ten outpatient women were interviewed (Please see page 1 of 2017 of the study proposal). This second study will serve as a continuation and the concluding part of study on the lived experiences of women with schizophrenia in the south-west of Nigeria. This second study will focus on the lived experiences of mothers with a diagnosis of schizophrenia. It is anticipated that the information generated in this research will help inform mental health care service provision and support for mothers with mental illness.

Qualitative method will be used as a method of enquiry, using semi-structured interviews (page 5 of 2017 of the study proposal). Ten mothers with a diagnosis of schizophrenia attending the hospital outpatient clinic will be examined. As stated in pages 6 to 7 of the study proposal submitted in 2017, participants' confidentiality will be maintained during and after the study. The researcher will transcribe data collected from participants and it will be treated with the strictest of confidence. Participants will also be informed that no identifying data including their name, address and locations will be shared with a third party. All data collected from participants during the research will be kept confidential and secure for the period of ten years in anticipation that the research may, at some point, be published in a journal or report. Interview audio-recording equipment, transcriptions and consent forms will be securely store

in different locked locations where only the researcher can access it and all computerised data will be password protected to prevent unauthorised access.

I can assure you that the participants' anonymity will be ensured. The names and contact details of the individuals who have agreed to take part in this study will be stored securely as stated above. If it necessary to use the participants' words in the presentation of the findings, the use of pseudonyms will be employed to protect participants' identity. Audio recording equipment will be transported in a lockable case and electronic data will be encrypted or password protected to prevent unauthorised access. I will adhere to the Data Protection Policy issued by the University of Huddersfield and the guidance notes issued by the University of Huddersfield for researchers.

I will make every effort to ensure the study does not disrupt the working environment in any way and I will abide with the institution research ethics.

I look forward to a response from you at your earliest convenience.

Yours sincerely,

Abiodun E. Abegunde
Postgraduate Researcher
Telephone number: +44(0)7440412344
Email: Abiodun.Abegunde@hud.ac.uk

This research study is supervised by Dr Berenice Golding. If you require further information about the research, please do not hesitate to contact either myself or my research supervisor. Her contact details are:

Email: B.Golding@hud.ac.uk
Telephone: +44(0)1484473845

Appendix 20: Phase 2 – Letter to the second hospital

University of
HUDDERSFIELD

The Chairman
Health Research and Ethics Committee
Federal Neuro-Psychiatric Hospital,
8 Harvey Road
Sabo-Yaba,
Lagos.
Nigeria.

Date: 03 April 2018.

The study titled: An exploratory study of the lived experiences of women with schizophrenia in the southwest of Nigeria.

Dear Sir/Madam,

I am a Postgraduate Researcher undertaking a PhD at the University of Huddersfield within the School of Human and Health Sciences, UK. My Research is titled: "An exploratory study of the lived experiences of women with schizophrenia in the southwest of Nigeria". This study has received Ethical approval from the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel. Study approval number: SREP/2017/021 dated 29 March 2017 (page 32 of the study proposal).

The study also gained ethical approval from your institution (ethical approval number FNPHY/ERC/17/184 dated 16th June 2017, page 33 of the study proposal). With this opportunity, I carried out the first part of the research in your hospital outpatient department between August to September 2017. The study examined the lived experiences of women with a diagnosis of schizophrenia in which ten outpatient women were interviewed (Please see page 1 of 2017 of the study proposal). This second study will serve as a continuation and the concluding part of study on the lived experiences of women with schizophrenia in the south-west of Nigeria. This second study will focus on the lived experiences of mothers with a diagnosis of schizophrenia. It is anticipated that the information generated in this research will help inform mental health care service provision and support for mothers with mental illness.

Qualitative method will be used as a method of enquiry, using semi-structured interviews (page 5 of 2017 of the study proposal). Ten mothers with a diagnosis of schizophrenia attending the hospital outpatient clinic will be examined. As stated in pages 6 to 7 of the study proposal submitted in 2017, participants' confidentiality will be maintained during and after the study. The researcher will transcribe data collected from participants and it will be treated with the strictest of confidence. Participants will also be informed that no identifying data including their name, address and locations will be shared with a third party. All data collected from participants during the research will be kept confidential and secure for the period of ten years in anticipation that the research may, at some point, be published in a journal or report. Interview audio-recording equipment, transcriptions and consent forms will be securely store in different locked locations where only the researcher can access it and all computerised data will be password protected to prevent unauthorised access.

I can assure you that the participants' anonymity will be ensured. The names and contact details of the individuals who have agreed to take part in this study will be stored securely as stated above. If it necessary to use the participants' words in the presentation of the findings, the use of pseudonyms will be employed to protect participants' identity. Audio recording equipment will be transported in a lockable case and electronic data will be encrypted or password protected to prevent unauthorised access. I will adhere to the Data Protection Policy issued by the University of Huddersfield and the guidance notes issued by the University of Huddersfield for researchers.

I will make every effort to ensure the study does not disrupt the working environment in any way and I will abide with the institution research ethics.

I look forward to a response from you at your earliest convenience.

Yours sincerely,

Abiodun E. Abegunde
Postgraduate Researcher
Telephone number: +44(0)7440412344
Email: Abiodun.Abegunde@hud.ac.uk

This research study is supervised by Dr Berenice Golding. If you require further information about the research, please do not hesitate to contact either myself or my research supervisor. Her contact details are:

Email: B.Golding@hud.ac.uk
Telephone: +44(0)1484473845

Appendix 21: Letter from second hospital

NEUROPSYCHIATRIC HOSPITAL, ARO.
RESEARCH ETHICS COMMITTEE
P.M.B. 2002, ABEOKUTA, OGUN STATE, NIGERIA.

Ref No. _____ NPHA/276/VOL.IV/1118   Date: _____ 3rd May, 2018

Abiodun E. Abegunde

Human & Health Sciences Department,
University of Huddersfield,
United Kingdom.

Dear Abiodun,

RE: AN EXPLORATORY STUDY OF THE LIVED EXPERIENCES OF WOMEN WITH SCHIZOPHRENIA IN THE SOUTH WEST OF NIGERIA.
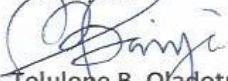
Your request on the study with the above title refers.

I have been directed to convey to you the approval of the Chairman for you to proceed with the second data collection phase of your study.

Kindly note that the *11th July, 2018* expiration date of the approval certificate for the study is sacrosanct.

You are expected to submit a request for renewal of approval when the need arises.

Thank you.

Tolulope B. Oladotun
HREC Administrative Officer
For: Chairman, NPHAREC

E-mail: hrec@neuroaro.com   Phone No: +234 - 8133970504

University of
HUDDERSFIELD

Interview Guide

Version 2 dated 03 May 2018

<u>Introduction</u>

First of all, I would like to thank you for agreeing to participate in this research study and for allowing me to interview you.

My name is Abiodun Abegunde, and I am a postgraduate research student from the University of Huddersfield. The aim of this study is to understand the lived experiences of mothers living with severe mental illness in the southwest of Nigeria. It is anticipated that this study may aid health services in refining and expanding service provision and support for mothers with a diagnosis of schizophrenia in the Southwest of Nigeria.

I will ask you some general questions about you before moving on to find out in more detail about your experiences of living with schizophrenia and motherhood. I will be audio recording the interview because I do not want to miss any of your valuable comments. Your participation in this interview is voluntary; you do not have to go ahead with the interview if you have changed your mind. If you still wish to participate, can I remind you that you are free to withdraw from the interview at any time. Your decision to take part or to withdraw from this interview will not affect the treatment you are receiving at this hospital because I am totally independent of the hospital where you are receiving care.

I am conscious of the fact that by reconstructing your experiences, you may find it very emotional and distressing. If at any time you feel unable to answer a question or you do not wish to provide any additional comments, please let me know your concerns. You are free to stop the interview at any time if you choose not to continue and you are free to ask me questions before and after the interview.

Is there anything you would like to say or ask before I start the interview?

Interview questions

First of all, I would like to find out a little bit about you

1. Can you tell me about yourself?
   Prompts: What is your name/age/background/education/occupation and marital status?

I would like to know about your experiences of being a mother

2. Can you tell me about your experience of being a mother?

3. Did you ever consider being a mother before you became one?

    Prompts: How did you envision it?

            What did your close friends/family say about this?

            Can you tell me more about this?

            How many children do you have?

4. Can you talk to me a little about being a mother with a mental illness?

5. Can you tell me about the things that you like doing with your child/children?

    Prompt: helping out around the house, help them with their school work, etc.

6. Can you take me through how you usually cope looking after your child?

Prompts: What are the strategies that you find work well with parenting your child? Examples.

What type of strategies are not helpful? Examples

 Do you receive support from your husband/family in your parenting role? Examples?

7. Can you talk to me about what understanding your child has about your mental illness?

    Prompts: How do you feel about your children knowing your illness?

     If they are not aware of it, would you ever explain it to them? If so when and how?

8. Can you take me through any challenges you may have had caring for your
 child/children?

Prompts: Are there some things you find difficult and wish you had some support within your parenting role?

What happens then?

9. Can you talk to me about any impacts you think your mental illness has had on your
   child?

    Prompt: in the family, school and in the community.

10. Does your child always live with you?

If the mother does not have primary care of the child

11. Can you tell me a bit about why you are no longer living with your child?

Prompts: Where is your child living now?

How long have/will s/he be living there?

How often do you speak with or see your child?

12. Can you tell me how living apart from your child has affected you?

Prompt: Can you tell me more about this?

I would like to find out about healthcare services available for mothers with mental illness and their families

13. Can you tell me about the healthcare services available for mothers with mental illness and their families?

14. Do you think that most mothers with schizophrenia have the knowledge of these services?

Prompts: If yes, how did they find out about them?

If no, can you tell me what ways would be useful, so they gained knowledge about them?

15. Do you experience any challenges accessing the services?

Prompt: Can you tell me more about this? Examples?

16. Can you explain to me how the healthcare services you receive meets:

Prompts: Your needs as a mother with mental illness?

The needs of your children?

The needs of your family?

Do you have any examples to share?

17. Are there needs of mothers with mental illness that are not being met?

Prompts: Can you talk more about this?

How might these unmet needs be addressed?

Closing questions

We are now coming to the end of the interview so I would just like to ask you:

18. Is there anything else you would like to add based on your experience so far that you think is relevant and that I have not asked you about?

19. Are there any questions you would like to ask me?

Conclusion: Thank you for your participation and commitment to this study. This study would not have been possible without you. I appreciate your help and candidness in answering what are sometimes uncomfortable questions.

If you need further information about the study, please do not hesitate to contact me – Abiodun Abegunde. Email address: Abiodun.Abegunde@hud.ac.uk

You can also contact my research supervisor through email: B.Golding@hud.ac.uk or Dr Berenice Golding on +44(0)1484473845.

Thank you again for participating in this research study.

Appendix 23: Phase 2 – Eligibility Criteria

University of
HUDDERSFIELD

Participant Eligibility Criteria List

Version 2, dated 03 May 2018

Research study title: "*An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria"*[1]

In order to reduce sampling bias and to be clear that people who could be made worse by participating in the study are not subjected to the risk. These criteria will serve as guide to recruit the study participants.

The eligibility criteria for participating in the project are:

- Being a mother and having a diagnosis of schizophrenia

- Have been receiving treatment for a period of at least 12 months

- Attending hospital outpatient clinics

- Able to speak English language.

- Capacity to provide informed consent.

- Willingness to participate in the study.

---

[1] This study has gained ethical approval from the NPHA Research Ethics Committee, Neuropsychiatric Hospital, Aro. Abeokuta, Ogun State, Nigeria. Study approval number: PRO15/17, dated 12 July 2017 to 11th July 2018. Ethical approval from the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel. Study approval number: SREP/2018 dated:

Appendix 24: Phase 2 – Invitation letter

University of
HUDDERSFIELD

Date: 03 May 2018.

Invitation to participate in a research project.

Dear Madam,

I am a Postgraduate Researcher undertaking a PhD at the University of Huddersfield within the School of Human and Health Sciences. My Research Study is titled: "*An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria*"[2].

You are invited to take part in the study, which aims to have understanding of the experiences of mothers living with a diagnosis of schizophrenia and the existing service provision for mothers with the illness. It is anticipated that the information generated may aid health services in refining and expanding service provision and support for mothers with a diagnosis of schizophrenia in the southwest of Nigeria.

At the interview, you will be asked to discuss your personal experiences of being a mother with a diagnosis of schizophrenia and what it means to you. Your needs in relation to motherhood and experiences in accessing health care support will be explored.

If you agree to participate, the one-to-one interview will take approximately 1 hour and it is very informal. The interview will take place in private in a quiet room in the hospital and it will be audio-recorded in order not to miss any of your valuable comments.

Your anonymity will be ensured in all documents. Information collected from you during the interview will be securely stored to prevent unauthorised access and your confidentiality will be maintained. Electronic data will be encrypted, or password protected to prevent unauthorised access.

The information you share with me may be included in my thesis. It may also be published in academic journals, conferences, posters or as a teaching resource. If it is necessary to use your words in the presentation of the findings, the researcher will use pseudonym to protect your identity. Any identifying material such as names and addresses will be removed in order to maximise your anonymity.

Although I consider your potential contribution to be very valuable to this research, please be informed that participation is voluntary. You are under no obligation to take part and deciding not to participate would, in no way, affect the care you receive. You are free to withdraw from

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[2] This study has gained ethical approval from the NPHA Research Ethics Committee, Neuropsychiatric Hospital, Aro. Abeokuta, Ogun State, Nigeria. Study approval number: PRO15/17, dated 12 July 2017 to 11th July 2018. Ethical approval from the University of Huddersfield, School of Human and Health Sciences Research Ethics Panel. Study approval number: SREP/2018 dated:

the study at any time without giving a reason. If you agree to take part in this study, please sign the attached participant reply form.

Looking forward to your involvement.

Yours sincerely,

Abiodun Abegunde
Postgraduate Researcher
Telephone number: +44(0)7440412344
E-mail: Abiodun.Abegunde@hud.ac.uk

If you would like more information about the research, please do not hesitate to contact either myself or my research supervisor. Her contact details are:

Email: B.Golding@hud.ac.uk
Telephone number: +44(0)1484473845
Dr Berenice Golding

Appendix 25: Phase 2 – Information sheet

University of
HUDDERSFIELD

PARTICIPANT INFORMATION SHEET

Version 2, dated 03 May 2018

Title of the research: An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria

You are being invited to take part in this study. Before you decide to take part, it is important that you understand the aim of the research and what it will involve. Please take time to read the following information carefully and discuss it with me should you wish to. Do not hesitate to ask if there is anything that is unclear or if you would like more information.

What is the study about?

The aim of this study is to gain an understanding of the lived experience of mothers with schizophrenia in the Southwest of Nigeria. Sharing your experience may aid health services in refining and expanding service provision and support for mothers with a diagnosis of schizophrenia in the Southwest of Nigeria.

Why I have been approached?

You have been asked to participate in this study because you are a mother and a service user.

Do I have to take part?

Taking part in the research study is voluntary. It is your decision whether or not you take part. If you decide to take part, you will be asked to take part in interview and you are free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part will not be of any harm to you.

What will I need to do?

If you agree to take part in the research interview you will sign the reply form to show your interest in taking part in the study. After receiving your reply form the researcher will contact you to ask for your convenient date and time to do the interview. The one-to-one interview will take 1 hour and is very informal. The interview will take place in private, in a quiet room, in the hospital. With your permission, the interview will be audio-recorded in order not to miss any of your valuable comments. You will be asked to sign a consent form before the start of the interview to indicate your voluntary action to take part in the study.

Will my identity be disclosed?

All information disclosed within the interview will be kept confidential. Your identity will not be disclosed to anyone. Identifying information such as name, address and location will be removed to protect your identity. Instead of using your name, pseudonym that has no connection with your name will be used.

What will happen to the information?

Data collected from interviews may be used to complete my thesis and the data may also be used to support any journal articles, conference papers or posters that are written as a direct result of this research study. It may also be used for teaching purposes. All information collected from you during this research will be kept secure for the period of 10 years in anticipation that the research may, at some point be published in a journal or report. Your anonymity will not be disclosed in the presentation of the findings of the researcher, your permission for this is included in the consent form. Identifying information will be locked in a separate location where only the researcher can access it. Electronic data will be encrypted, or password protected to prevent unauthorised access. Documents will be securely store in different locked location. Security codes will be assigned to computerised records to prevent unauthorised access.

Who can I contact for further information?

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. My contact information is:

Abiodun Abegunde
Telephone number: +44(0)7440412344
E-mail: Abiodun.Abegunde@hud.ac.uk

If you require further information about the research, please do not hesitate to contact my research supervisor:

Email: B.Golding@hud.ac.uk
Telephone number: +44(0)1484473845
Dr Berenice Golding

Appendix 26: Phase 2 – Consent Form

University of
HUDDERSFIELD

CONSENT FORM
Version 4, dated 03 May 2018

Title of Research Project**:** An exploratory study of the lived experiences of women with schizophrenia in the Southwest of Nigeria

This study has been approved by the NPHA Research Ethics Committee, DRT's Office, Postgraduate Building, Neuropsychiatric Hospital, Aro, Abeokuta. E-mail: hrec@neuroaro.com

Study approval number: PRO15/17.
Duration of approval of the study**:** 12th July 2017 to 11th July 2018.

It is important that you read, understand, and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate. If you require any further details, please contact the researcher.

I have been fully informed of the nature and aims of this research as outlined in the Information Sheet and invitation letter dated 03 May 2018.

I understand that I have the right to withdraw from the research at any time without giving any reason.

I give permission for my words to be quoted (by use of pseudonym).

I understand that the information collected will be kept in secure conditions for a period of 10 years at the University of Huddersfield.

I understand that no person other than the researcher and the study supervisors will have access to information I shared within the interview.

I understand that some extract from data may be presented in the thesis, published in a journal or report and may be used for teaching in the future.

I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report.

I understand that if I share any information that might indicate that I am at risk to myself or others that the researcher will inform a member of hospital staff.

I consent to taking part in the study.

If you are satisfied that you understand the information and are happy to take part in this project, please print and sign below.

Signature of Participant: _____	Signature of Researcher: _____
Print: _____	Print: _____
Date: _____	Date: _____

(One copy to be retained by Participant / one copy to be retained by Researcher)

If you have any question about your participation in this research, you can contact the researcher:

Abiodun Abegunde
Telephone Number: +44(0)7440412344
E-mail: Abiodun.Abegunde@hud.ac.uk

For further information, you can contact the research supervisor:

E-mail: B.Golding@hud.ac.uk
Telephone number: +44(0)1484473845
Dr Berenice Golding

Appendix 27: Debrief note

University of
HUDDERSFIELD

<u>Participant Debrief</u>

Thank you for participating in this research study by allowing me to interview you, your responses are valued. The purpose of this study is to understand what this experience means to you and by sharing your experience, you have created an opportunity to inform the quality of health care available to you and other women in your condition.

The information you shared with me will be used for research purposes only. I am reassuring you that your identity will be protected, and your information will be stored properly to prevent unauthorised access. Your name and address will not be disclosed to anyone. If it is necessary to use your words in the findings, number or pseudonyms will be used instead.

I realise that the subject matter may have been rather emotive and again I would like to thank you for sharing your experiences with me. Even though the interview has finished but if you have questions to ask, or additional information about your experience, please, feel free to contact me (Abiodun Abegunde – Abiodun.Abegunde@hud.ac.uk). If you need further explanation, you may contact the research supervisor, Dr B. Golding. B.Golding@hud.ac.uk Telephone number: +44(0)1484473845.

Once again, I appreciate your time, interest and effort to make this study a reality.

Thank you.

Appendix 28: Anonymised script demonstrating data analysis process

Adesewa (pseudonym) is 31 years old, a mother with mental illness who was interviewed in one of the two hospitals in southwest of Nigeria during the data collection for phase two of the present study.

Questions	Responses	Notes
Can you tell me about yourself?	My name is Adesewa (pseudonym), am 31 years. I live with my three kids here in xx [name of the town], I love music.	
Thank you for that powerful introduction. I love music too. You are a mother; can you share with me your experience of being a mother.	My experience of being a mother is a wonderful thing. Is a wonderful thing. Only when you have children you will know how to love someone so much. This kind of love is very deep and different from the love you have for any other person. Let me say part of what led to my problem was the fear of how do I take care of my children. My husband lost his job. I was the one catering for the family and three children. I have to pay school fees, feeding, clothing, everything, all by myself. So, it wasn't easy I just tried. I have to cater for them, they must not lack I have to prepare for them, I have to prepare for my children. I have to be there for them, I have to be strong for my children. I love being a mother. My children are my source of joy, they are my happiness. And I know all my sufferings will not be in vain. Erm, as a mother I wish I can do more for my children. Presently, I don't have a car, I wish I could be able to take them around, it will be easy for me to transport them to school. I wish I could have a car of my own, I wish I could have a house of my own so that we could have enough room, enough rooms to ourselves, enough compound where to play, where to move around. You know when you are mobile is always easy for you to go out. Let's go for shopping, let's go to cinema and watch a movie, let's go out, but when you are not mobile you just jump from one bus to another with your children is not easy.	Happy to be a mother Linked her mental illness to the burden of meeting family needs. The joy of being a mother Talking about social needs and how it affects her care for her children.
You said part of what led to your illness was the fear of how to cater for your children, can you tell me more about it and the other reasons?	My husband lost his job, so I have to step in and provide for the whole family. Then the stress of how to make ends meet and family pressure altogether leads to my illness. Erm, my diagnosis is in form of convulsion disorder. Initially when I started having crisis, it started with crisis then it resulted to partial stroke that was in 2014. I was at work, okay before then three days to that time I was just notice I was having constant headache, persistent headache, I couldn't sleep like three days. So, the third day when I got to work, I was complaining to my boss that I am not feeling fine	Narrated how her mental illness started Her diagnosis Symptoms of her mental illness

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that my head, my head is aching me that I couldn't sleep the headache doesn't allow me to sleep. She said I should just relax on the couch before they call doctor to see me just lie down there. So, by the time she came back to check on me, one of my colleagues came in to check on me so she was asking me questions I couldn't talk. That was how it just started, I couldn't talk, the next thing she just went out to call them when they came, they notice that my mouth has twisted to one side. I tried to stand up that I want to ease myself on getting down I couldn't move my leg again, I was just there, on that spot. I was having slushy speech. So, they said that this is an emergency that they have to carry me down to Gbagada general hospital. I said no, I have private hospital am using that I will rather go to my private hospital which I did. On getting to my private hospital, they noticed that my BP (blood pressure) has gone up, my BP shoot up. So, then I was on admission I was on bed rest, they (hospital staff) are monitoring my BP, giving me expensive drugs and at the same time I was doing exercise. Exercising my legs and my hand, just my left hand. So, I was there for days and some months, before I leave, I was able to walk. So, on getting back home I was still not fine, unable to sleep, and the headache again. I went back to my hospital and they said I should go to general hospital for proper management. So, I was referred to general hospital. On getting there I was seen at medical outpatient department. They asked me to do series of test, what could cause the slushy speech because my speech was not okay then. So, I did CT scan, MRI, cystoscopy test. I did series of test. All the tests I did, nothing, they couldn't trace anything, everything was normal. I kept coming to clinic, I kept coming to clinic, kept coming, but when I wake up in the morning, I feel tired as if I have worked throughout the night, to stand up in the morning is not easy. I couldn't work that much, early in the morning I feel tired, I feel like sleeping again or at times I will be so strong like carrying three bags of cement at once. I don't real understand what was going on, but I was not fine. So just one day like that I have been coming to OPD (outpatient department) God just directed one doctor to me. You know at times I understand things well, at times I don't, things became zigzag, zigzag, life become difficult. I complained that anytime I wake up I always get tired to take care of my children, get angry unnecessarily. He was the one that said he

Still on symptoms of her illness.

> Support from other staff

Suffered stroke

Receiving hospital treatment

Her illness reoccurred.

Different examinations to identify the cause of her illness.

Effects of the illness on her physical well being

Effects of her illness extended to failing in her motherly role

	thinks I will be managed better in psychiatric; he didn't call it psychiatric there. He said I would do better here, so he referred me down here. So, when he referred me down here, I was seen by one consultant and two other people whether they are trainees or full doctors. Anyway, they assessed me, asked some questions. I told them about the constant headaches, sleepless nights, seeing awful things that I cannot even explain. Sometimes I became fearful and lost interest in doing things including caring for my children. They said is my imaginations that they are not real. They deliberated, and they said what they suspected is severe mental illness. Depression that is been converted to that stroke, what am suffering from is severe depression in form of conversion disorder. They said because of other symptoms like seeing imaginary things and unnecessarily becoming fearful are symptoms of schizophrenia. They said all what I have been manifesting physical is not physical things that I am suffering from but is psychological it is transferred physically. So that is how I started coming here. And to God be the glory when I started, I was on drugs, I was taking series of drugs. What I noticed is that since I started coming here, I feel much better. I was been managed, gradually, gradually I come to clinics, my drugs have been reduced, it is just two now. I appreciate my coming to this clinic because it saves me lots of stress and I was able to go back to my normal lifestyle.	Referred from general hospital to mental health clinic. Explained her feelings to doctors. She was diagnosed of having mental illness. Participant acknowledged that her treatments medications are effective in treating her illness
How did you feel when were you first diagnosed with mental illness?	I don't like it. Even up till now I don't like it. I don't just have option than to just come here. When I see people around, you know when they see you attending this clinic, they look at you like haaa! This person is having mental problem, she is not okay. Erm, that name psychiatric, is not good. When people hear psychiatric haa! Were ni o, erna sun mo o were ni (is a mad person, do not move close to her). I don't just have option, my health first irrespective of whoever sees me. All I know is that I am not on the street. I am okay now.	Reported not happy attending mental health clinics because: 1. Lack of privacy 2. Stigma Prioritised her health above all other things
Are you suggesting hospital name should be changed from psychiatric hospital?	People attitude when they hear that name is not good. I don't know what to call the hospital, I can't think of any, but I know the name is not good. Once you mentioned psychiatric people will say she is not normal. If she is not having issues with her brain, what is she doing in psychiatric hospital.	She believed people have negative impression of 'psychiatric' word
Can you take me through how you	When I was not feeling fine, I was in my parents' house. So, I was there with my parents and my children were there with me, we were there	

usually looking after your children?	together. So, taking care of myself and my children is not difficult. My mother and younger ones are the one helping me. When I start taking my drugs, I feel weak and sleeps a lot. I don't have energy to do anything or maybe I should say I just don't have erm not happy, too weak then. Doctor said it was because I was new to it. They are the one doing the cooking and washing when I am not feeling well but now, I am the one doing it myself. I am not staying with my parents again am staying with my children alone. I was only with my parents when I was sick. I left my parents' house as soon as I was getting better but where I am living is not far from them, so my children can stay with my parents after school hours and if my mother needs to help me when I am down (sick) it is easy for her to get to me. After marriage, leaving in my parents' house with three children, no. I don't have problem with my family, but I can't just continue to live with them. I am working, and I can finance myself.	Relied on her family to care for her children (including herself) →Practical tasks performed by her family to support her. Left her parents' house to some where close after feeling better Believed living her family when married was not alright.
Do you have to move to your parents' house because you are ill, what about your husband?	My husband? That is another story. I said it before that my husband lost his job. My husband's relatives so they were like haaa, it is my leg o, it is my leg that is not good, am not making him to prosper. I am the one behind it. I am the one that is not making him to progress. I am a witch, my sickness is evidence that I am the one behind his misfortune. So, they were after me. They talk to my husband that I have to go, they said my husband should send me away, am the one that is not making him to progress in life, so, we went all through that. Psychologically I was not balanced but my family, relatives were there for me. My husband family mounted pressure on him, it was much. At times he misbehaves, at times he controls himself, but the pressure was much on him and I was seriously sick, so he has to send me to my parents' house because the pressure was much, I left him 2015.	Misconceptions about mental illness from her husband's family Husband's family involvements leading to separation
You said your husband misbehaves at times; can you talk more about this?	When you talk of beating, he has a degree in that, in fact, this my hair, I nearly, you see, when he slaps me, the next thing is to grab my hair. I never believe he can do that to me, but he was being controlled by his family. If I stay too long, I won't be alive today so is good that he has to send me away, at least my children are calling me mother. Though is difficult to get things done for them but when there is live there is hope.	Experience of physical abuse from her husband
It is a long time that you have left him,	My husband comes about two times to check us, to check the children, to check on me. He	

have you considered reuniting with your husband?	has been begging that we should move back to our house. I am the one who insisted that no, I will not come back. If I have to go back his family that said they don't want me should be the one to come not him. It his family that said they don't want me, if they really want me, they should be the one to come back for me and not him alone. It is not the matter of me and him, it has become family issue.	→ Husband made attempt to reunite with participant and their children participant refused to reconcile with her husband.
You said your husband wanted to reconcile with you and bring the children back. Why are you so much concern about his family?	They have to come in because they are the one telling me that I should go that I am the one behind his misfortune. My husband said his family didn't want me again that I should go. So, I came back to my parents and told them what my husband said that I have to go. My parents have to follow me down to my father in-law's place, that's the first son in his family, he is the one they handed me over to because his father has died. So, my parents have to go to their place, they have to go back there and said this is what we heard. The man said yes, that both their father's side and their mother's side, that they made the decision that I have to go for now that if they need me, they will come back for me. So it was a family decision that I should leave his house, so if I want to return their the family will come to our house and talk to my parents, is not something I can handle on my own. If I have problem with him again, my family will say they didn't send my there. So that is the reason I am not living with him.	Influence of families on marriage in participants culture. "the first son in his family, the man said" - it means the oldest person taking decision for the whole family. Afraid that her family might neglect her if she next problem with her husband
Can you take me through any challenges you may have had caring for your children?	My children, I don't really have much things to do with them. My sister helped to bath them; the first one can do little things like bath and dress up. My major work then was my baby she [sister] was there for me. I owed her much respect. In terms of cooking my mother was there for me. So, the thing is that my speech was only my concern then. I tried as much to pass my message across to them or I get a pen to communicate whatever I want to tell them.	Practical support received from family members. Effects of mental illness/stroke
Can you talk to me about what understanding your child has about your mental illness?	My children will say mummy you always taking drugs, why are you taking drugs every day. I will tell them you know I am hypertensive. That my BP is always up when I am not feeling fine so I need to take drugs, so that my blood pressure will not be high again, so that I will be okay. You know I am always in and out of hospital. But now that I am on drugs, I am better that is why I am taking drugs.	Concealed her mental illness from her children.
Is like you don't want your children to know about your mental illness?	Laughing. I just felt they are still small may be when they grow more, I will tell them but now they are still young they will not understand it	She believed her children were too young to understand.

	But I will tell them later when they are old enough to understand it.	
How old are your children?	The first one is erm, like, when I was admitted he was five year but how nine. His sister was two years and xx [the name of her third child] was six months.	Participant's children's age.
Did you tell friends or employer about your diagnosis?	My friends and my colleagues at work they have been supportive. They were all aware because I am always having crisis, they don't really know what is causing the crisis. Once it happened, my slur speech, when I am stressed up, my speech will be slurred, my face is there for them to know. Once I am not feeling fine it shows on me, my behaviour and not responding to people very well, is always on me for people to see. They know, they are aware that I am not well. September 2017 I was at home for like four months I didn't go to work. They were aware and they have been supportive, very supportive. I was at work when I first had the crisis and some of my colleagues took me to hospital, my private hospital. When I left my hospital, I didn't start in this hospital I was referred to general section. I was receiving treatment in that clinic for long time before I was referred here. All what I told them at work is that of previous referral, my treatment and marital problem. They are not aware of anything about my mental illness. I think my case is a complex one. Everything combined together to cause the sickness.	Recieved support for having ill heat from colleagues. → Symptoms of her illness she did not disclose her mental illness to colleagues.
You did not disclose to your colleagues that you have mental illness, what if they see you in mental health clinic?	If it happens that way, I will know what to tell them. I believe they will understand because they have been supportive. If they find out and ask me it's okay but I don't want to tell them myself. I don't want to expose myself too much to people.	
What impact do you think the illness has had on you?	The impact on me is that as a professional health worker when your patients see you coming to this kind of clinic, they tend to lose their trust. They will feel like so this person taking care of us, herself is not okay, she is even sick. For that I will not pray for any of my clients to see me here. My colleagues might see me they will understand, even my friends that are not in medical line I don't pray they should see me here because they will not understand. It is my marital life that caused the illness. When my husband lost his job, I have to be the one to cater for the family, my children and feeding. The income I am receiving is not enough to care for me and three children. He was not making things easy. He started misbehaving, he started drinking, at times he will beat me up. He started	She believed her mental illness will affect her relationship with her clients at work, including some friends

	misbehaving, maltreating me. At times he gets back to his senses and at times he doesn't.	
Can you tell me about any impacts you think your mental illness has had on your children?	I know it will affect them emotionally. They don't get to see their father as much which I know may affect them. My brother is helping me taking them to school because of distance I have to change their school to somewhere convenient. The feelings of missing their friends and dad are there but I try to make them happy, and I make them know that they have me, a mother who cares for them, and who will always love them.	Psychological effects on children.
What impacts your mental illness has had on your children in the community?	Maybe when I was with their dad when the situation was still tense. Like beating, pulling my hair, threw my bags outside, go, never come back, go. They were there, right there watching everything. So, it may affect them not grown up with their father. In the community, I mean where we are living now, I don't think anyone is aware of anything. My parents covered my nakedness, no one is aware of it. They have friends in the community, they are doing well with their friends.	Re emphasised physical abuse. Children were happy in their new environment
What impact do you think living apart from their father has affected your children?	His not there for them but I want them to succeed. I don't want them to have any setback even though they are still young, but I have people in my family they can look at as role model, so I make sure they are very close to my family, I know I cannot do it alone. I don't want my sickness to weigh them down, I don't want it to damage them, I just want the best for them that is why I am close to them.	She recognised she cannot train them alone, she used family support.
Can you explain further what you mean by saying you don't want your illness to damage your children?	Haa! Father will say sit down there and they will not say no when his out it will take them time to leave but me, erm because I play with them too much they don't listen to me in that way. He take them out too, buy things for them when he was working. So, I don't want them to feel they don't have things like other children so once I get my drugs, I make sure I get things for them to make them happy.	Child discipline. Making her children feeling comfortable like other children.
What are the strategies that you find work well with parenting your children?	The strategies I used to care for my children? As a mother I tried to be very close to them. I talk to them to educate them. I let them see me as their friend, someone they can talk to, as their companion. Not only as a mother, someone they can talk to, I let them see me as their first love, someone they can rely on. Irrespective of anything that happens they should always know that their mum cares for them. I am a disciplinarian. When it is time to discipline them, I discipline my children. And I trained them well. The aspect of taking care of the house, washing,	1. Through education, talking to them on friendly way. 2. Caring: shame joy and happiness 3. Discipline?

	cooking, and buying things for them, at least I tried my best as a mother.	
You said earlier that you a disciplinarian, can you talk more about this?	Religiously I bring them up. I don't take nonsense that is one thing they know about me. I don't over pamper them. When they do anything wrong, I let them know. I make them see reasons why they should not do it and when they do something that is good, I made them know that haaa you have done well. I encourage them to do something good and discourage them doing something bad. Even when I send them message as a mother I will always say, please help me to do this. When I assigned assignment for them to do as they are doing it, I will say well done, thank you at least to encourage them. And religiously too, I make them see the reason why they must be religious, God first in everything you do. I make sure that they don't have bad friends in the school. Whatever happens in the school or outside you must come back home and tell mummy. If anybody is maltreating you or telling you something bad, come back home and tell me, don't fight anybody.	A Bringing her children up in religious way. praise them for doing rightful things. on religion again To have good morals
Has there be any method(s) you have used, and you think is not working well?	I beat but not all the time is once in a while. I beat and I give punishment. I asked them to kneel down, raise up your hands and I scold them. At times I may beat. I don't beat per say, I beat not all the time only once in a while, before I beat that means you gone beyond your boundary. I don't normally beat but when I beat, I beat mercilessly, no mercy when I beat. That is why I don't like beating because when I beats, my beating doesn't have limitation. I beat for you to know that what you have done is not good. I will make sure I give you belt, good belt, at least you will see the mark on you that is why I don't like beating because when I beats, I go far, I don't beat again.	Beating her children which she has recognised it is not good and has stopped.
Can you tell me about mental health care services that are available to mothers in this hospital?	They will ask if there is anybody with history of mental illness in the family that is all. I came in through referral, I was given a referral letter from my hospital to this clinc. I came here I was given an appointment to come back on a specific date which I did. Each time I come I see the doctor, he will review me. If there are any challenges, if I am having any complaint, I let him know. The routine is that you come here, they refer you to get your card irrespective of healthcare worker or not you will get card and see doctor.	How she accessed mental health clinic.
What about the children of mothers with mental illness,	I have seen some children here, they have clinic for children, boys and girls with this illness. If you go inside ward you see many of them.	Participant misunderstood the questions.

is there any provision for them?		
I am not talking about children as patients but children as dependents of mothers with mental illness.	I am not aware of any. As a health professional I am not aware of any such provision. If there is, I will know, and I will be happy to be involved or allow my children to involve. There is nothing like activities for the family of women that has this illness. Although they said they are treating not only patients, but I have not seen that. The only time doctors ask about your family is when they are doing assessment. Doctors only ask about your family or when you can't answer their question, if the person is too sick.	Limitations of mental health what mental health services offers to patients and its limitations.
Apart from seeing doctor and collecting your prescriptions, what are the other services or programmes that available for mothers with mental illness?	I have not seen any and I have not heard any. I belief there should be a counsellor or psychologist at this unit that patients should see maybe every three months or six months but here what we do is just to see the doctor, get your prescription and go. I think there is need for people to do so. Psychologists will go deeper to comfort people because that is their own area. Psychologist should work together with doctor and we will not use drugs for long time.	still on types of treatments necessary from mental health services. suggestion to have psychologists and the benefits.
Do you think that most mothers with mental illness have the knowledge of mental health care services?	Some are aware of mental hospital, but they will not come because of the stigmatisation involved they would rather stay back, they don't want to involve. I don't want so/so person to see me, I don't want people to know am on drugs, what will people say, they will say I am mad, people will say I have mental problem. People will say this and that, which is why most women are not coming. Then many people don't' have money to pay for drugs, that is a big problem on its own.	Stigma Lack of money for treatments
Can you tell me what ways would be useful to make mothers gain knowledge about them?	Although they are trying now because when you go to health centres, they lay more emphasis on depression. I think majority of women are having depression, I just think that there should be more awareness. If I want to really say it, is like people are not aware. I have never seen it on TV or radio that they will tell you that okay, depression that people should know about it, that is something you can get treated for because people see it as natural thing. Ko seni tio ki banuje, ko seni tio kin ronu, (there is no one that does not think, no one that does not feel sad). Is normal, is normal whereas it is getting too much and when it is getting too much it becomes a problem. The stigmatisation that is involved, the NGO can come in and the private sectors too can come in. It is training that people need, everything has to do with training. They lecture	she believed there should be more awareness on mental illness using different platforms to educate people

| | them and let them see reason why people must know about this mental illness. Majority of the people that comes to hospital that they are having malaria or is typhoid, when you go d-e-e-p down you will know that is not malaria, it is not typhoid, it is depression that they are having but for them to come out, for them to say I am having this, it is you as a professional person that will try and assess, question, know the challenges, what is this person facing. When you treat person once, twice the person is not getting better, suspect something else. The private sector should be trained, and NGO should be involved. | Ignorance of many people concerning mental illness

suggestion to involve NGO and private organisations |
|---|---|---|
| What make you think majority of women are having depression? | Many things ma, many thinks. Look at my situation is because of pressure to provide for my family and my husband didn't appreciate me. Everywhere is hard, no money. You know men, when things are not working as they want, they pass the anger on their wife and children. I mean women, so many things to make women sick. | |
| Do you experience any challenges accessing the healthcare services? | This appointment I was given since last Monday, but I was on duty I couldn't come, I am newly posted to another place, so I don't want them to know that I am coming to this clinic. I didn't want to take any permission that I want to go to hospital so I would rather wait for my off day. Like last week Monday I was on duty, in the morning I will still go back to work. I know if I come here early before I resume in the afternoon, I would have gone back home. This morning I was feeling sleeping and I was contemplating whether I should not come again, that I am still going on night and I want to sleep, and I will have to go to hospital. The stress of getting here, the traffic on the road, is not the transportation fee that is the issue but the traffic on the road is a problem. There will not be enough time for me. Once I get home now, I will start dressing for work. I will go to work and once I leave this place, I will get keke Napep (tricycle) home and go to work, no time to rest and I am on night shift. Once I resume by 4pm this night, by 4pm tomorrow that is when I will close. When I am on duty, I don't use my drugs. I think the drugs, at times, some of the drugs are expensive while some are not. Like some of the drugs am taking initially, seroxat. Seroxat is expensive, if someone is not working for you to get it, to be able to afford it is not easy. I think I bought one sachet for N6500 before is now N7000 for someone that is not working or just selling little petty things by the roadside. It will | Hiding mental illness from workplace

One of her challenges in using the services is traffic.

(2) Expensive costs of medication

Prices are not stable. |

	be difficult. Some of the drugs are expensive while some are not. Like amitriptyline now is cheap, very cheap. One tablet for counting is six naira per tablet or in a sachet is ten naira per tablet. The pack is around one thousand naira.	Comparing the costs of different medications.
Can you tell me the reason you don't like using your drugs when you are on duty?	It doesn't have effect on me again because I am better now. I am able to cope with my challenges. I feel tired whenever I use it, feel weak and stressed if I don't. I have mastered it by force, so I have been able to plan myself which am really doing well with. If I am on nights, that night I don't take my drugs but on the following day I use my drugs. When I noticed that I am stressed up I am not getting enough rest I double dose but not every time, but I am okay with just that one tablet per night, occasionally I have two. I told my doctor my work schedule now for the next three or four days that I am off, I will use it but that one-day interval I don't use it. I am doing well with it that way.	Using her prescribed medications in a wrong way.
Can you explain to me how the healthcare services you receive meet your needs as a mother with mental illness?	About the money I don't really think about the money because I look about my health that is now improving compare to then. Now I am okay, am good, I don't fall sick any more unlike then I am always having crisis, am always falling sick, am not always happy but now nobody will see me and think anything is wrong with me. I belief my drugs are not something I should take for joke. Once I receive salary is the first thing for me to get because it keeps me going.	Though the medications are expensive but effective. medication as her first priority.
And how the healthcare services you receive meet the needs of your children?	When I was sick, I was just there physically but I was unable to care for them like a mother. Unable to cook for them, no attention, no affection. With the medication am able to respond to them, buy clothes for them, play with them, support them with their schoolwork and give them the confidence that they can rely on me.	Effects of mental illness on her mother only role, Improvement on her mental mental illness

What about the needs of your family?	At least they are happy that am back on my feet. I can relate to them very well. I don't need to inconvenient them all the time like taking me to hospital, coming to see me all the time, though my brothers are helping me financially when it comes to my children school fees.	Benefits of her improved mental health to her family Financial support from family
If I get you right, you are the one paying their school fees. What about your husband?	Whether his not yet working or still controlled by his family. He has not contributed anything since I left his house. At a time, I was broke [without money] I don't want to trouble my brothers, I ask my son to call him about money for book and lesson. He off his phone so I don't think I should trouble myself over that again, am a mother, I need to get better, I need to be	Lack of financial support from husband.

	strong. I need to respond to their needs; they are my life.	
Are there needs of mothers with mental illness that are not being met?	Actually, drugs for someone that is sick, medicine is important. Free medication because many people come to hospital, they don't have money. So, coming to hospital this month and the next month they don't come and no drugs for them to use will make them to break down. So, government should create free medication for the poor. Then this illness does not need stress. The stress affects it a lot. They should try and get more vehicles that will bring people from gate to where they will get their treatment. We need water in the hospital, there is no drinking water you have to buy everything yourself. They should try and create a forum where people will interact with other people even outside the hospital. They should know much about other.	1. Free medication

2. shuttle bus within the hospital

3. water

4. Patients knowing and interacting with each other than receiving treatments only. |
| Is there anything else you would like to add based on your experience so far that you think is relevant and that I have not asked you about? | I think where this clinic is located should not be here. It should be somewhere there is privacy because I think mental health goes a long way. The stigmatisation of mental health is very much even this place is small. There is no enough seat for us to sit, some have to stand, and the place is too open. I think there should be privacy, there should be somewhere private for us if it towards the end. Or where other people will be passing by and saying, haaa awon toti ya were ton toju nibi bayi (is people with mental illness that are receiving treatment there). So, I don't like this place, I don't have option, I just have to come. This place is too open, there should be more privacy. People can easily see anyone coming and going out of the clinic with that you can't hide it anymore. | - privacy

- stigma
- More The need for more seats in the hospital. |
| Apart from the location of the hospital what are the other things you can identify. | The location of the clinic is not good at all. Although the doctors and nurses are doing their work but what I said again is that they should have social workers, they should have the psychologists. There was a time I went to LUTH (Lagos University Teaching Hospital), there are these people that will see you when doctors finish with you. I think they are psychologists; they tell you how to cope with your needs, how to cope with your problems, what you can do physically, they lecture you, but they don't have it here.

I did not see my period [menstruation] for five months with pains in my stomach. I was sent to LUTH. They asked me if am taking any drugs I said am taking drugs for my illness. So, they check me and gave me some drugs, I started seeing my period again. Whenever I started | Again, she talked on the need to have health other health workers in the hospital and the benefits.

Adverse effects of using antipsychotic medications |

	their drugs (psychiatric drugs) the thing stops my menstruation and giving me pain in stomach. Another thing is my weight, I am not like this before taking the drugs. If psychologists are in general hospital, why not here. They don't have them here apart from seeing the doctors and you go on your way no other thing here. But there (LUTH) they give you an appointment, they talk to you even the things you don't know how to cope with they tell you how to cope with life. The do's and don'ts. What you should do at your leisure hours, things to keep you busy, things that will not make you to think. Perspectives to live is different. I think they should have it here too.	Reemphasising the needs for psychologists in mental health hospitals.
Is there anything else you would like to add based on your experience so far that you think is relevant and that I have not asked you about?	The illness has affected me in many ways, but I see it as part of life. I just look at it as a kind of level that somebody has to reach in life or let's say whatever a person will pass through in life, she just has to pass through it and come out. Then I want to say something about these drugs, at least if am okay is not everybody can afford the drugs. I can't help other people too because am struggling myself. Hospital can provide free medicine for people. If you [interviewer] go to pharmacy you will people begging for money to buy their drugs, they are not working, they don't expect any salary from anywhere except the support of their family or if government can give free drugs and small money, small money every month to eat.	Expressed her mental illness as fate. stated the need for free medication again. Explained the challenges experienced by some patients to buy medication →Needs to support mothers financially by government
Are there any questions you would like to ask me?	Is like your own questions has answered my own questions except I want to appreciate you for what you are doing because it shows we want to move; it shows you have passion. If not, what is the essence of what you are doing. It makes me feel happy that better days are coming because this effort will not be in vain because somebody will look at it and want to do something.	Participant appreciating the researcher for conducting the research.

Appendix 29: A copy of National mental health policy for Nigeria, 1991

Nigeria 1991 estimated population: 100 million.
Close to 20% of Nigeria population may be suffering from mental illness.
11. mental hospitals; 12 psychiatric units in University Teaching Hospitals, 8 psychiatric units in State General Hospitals, 5 units in Armed Forces Hospitals, 1 Community Mental Health out-post of a state hospital, 7 private hospitals.
The available manpower for the practice of modern psychiatry includes 77 Registered Psychiatrists, 3,500 Psychiatric Nurses 20 Clinical Psychologists, 20 Social Workers and 30 Occupational Therapists.

The scope and nature of mental illness in Nigeria, 1991	National mental health policy Nigeria, 1991
The existing facilities for the treatment of mental disorders have developed in rather isolated and uncoordinated fashion throughout the country although the services offered are appreciable. The service structures are generally overcentralized and overspecialized and are located in urban areas. The peripheral rural areas where more than 70% of Nigerians live do not have mental health care facilities in any form. Some previous attempts made to enhance mental health care, at least in the hospitals, have led to only modest achievements at the Federal Government controlled institutions.	4.1.1 The mental health policy shall be based on the national philosophy of, social justice and equity.
The Psychiatric Hospitals and the University Teaching Hospitals are overcrowded. The prisons and a few asylums used for forensic mental services are substandard and require comprehensive rehabilitation.	4.1.2 Individuals with mental, neurological and ' psychosocial disorders shall have the-same rights to treatment and support as those with physical illness and shall be treated in health facilities as close as possible to their own community person shall suffer no discrimination on account of mental illness.
The National Primary Health Care Programme which is the vehicle for the achievement of `Health for All by the year 2000' did not, until recently, have the necessary mental health care component. Even now that it is being incorporated into the PHC, the mental health component would require time and adequate funding to catch up with the rest of the Programme.	4.1.3 At all levels of health care, mental health services shall as far as possible be Integrated - with general health services. In this way the preventive, therapeutic, rehabilitative and social re-integration aspects of mental health care shall as much as possible be available to all Nigerians.
There is serious deficiency in relation to knowledge about mental health in the existing curricula for the training of general health workers. There is also a	4.1.4 To achieve a comprehensive coverage of the population, delivery of mental health care shall be firmly established in the primary health care

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dearth of suitable teaching material. As a result of this most health workers lack adequate psycho-social skills in the management of patients.	setting and any other setting that may from time to time be considered appropriate. The services shall be promoted by all health care personnel with active participation of members of the community.
There is lack of interest and there is presence of negative attitude to mental health among many health care personnel possibly due to ignorance or enduring socio-cultural prejudices against the mentally ill;	4.1.5 Appropriate training in mental health and psychosocial skills and positive attitude towards the mentally ill shall be provided to a11 health care personnel. This shall be facilitated by the provision of adequate teaching aids.
There is stigma stemming from certain cultural beefs attached to mental illness and epilepsy by the general population. This leads to a tendency to neglect, maltreat or ostracise those who suffer from these conditions with consequent increase in the number of vagrant psychotic persons.	4.1.6 Intersectoral collaboration shall be fostered among those involved in the overall national development for improvement of quality of life. These include Social Development, Agriculture, DFFRI, Education, Science and Technology, Housing, Environmental Protection, Communication, MAMSER and others.
There here is lack of nationally coordinated studies aimed at solving Nigeria's mental health needs;	4.1.7 Healthy attitudes and positive socio-cultural attributes in the population, particularly among the youths, shall be promoted to prevent aberrant behaviour with adverse consequences for mental health.
Obsolete mental health laws inherited from colonial days have not been reviewed;	4.1.8 To eliminate social stigma normally attached to mental health, encouragement shall be given to the promotion of positive attitudes towards the mentally ill among the general population.
Though largely observational and empirical, there is overwhelming evidence of presence of severe mental and psychological disorders neurological and other mental health problems in as of now, provisions for mental health care for special groups either do not exist or are not fully operational. Such special groups include disturbed children and adolescents, the elderly, prisoners, refugees, drug and alcohol dependent persons, vagrant psychotics, destitute and the mentally handicapped	4.1.9 Alcohol and drug abuse and their associated problems shall be reduced to the barest minimum by the use of appropriate preventive, therapeutic and rehabilitative measures.

4.1.14 Research in mental health and factors associated with mental illness shall be vigorously encouraged and funded, |
| Despite the abundance of traditional medical manpower and the extensive utilisation of their services by the general | 4.1.10 Special care shall be provided for the disadvantaged members of the community |

population, attempts to incorporate the practice into the health care System have provoked unresolved controversy and criticism;	such as children, women, mentally handicapped chronically mentally Ill, the elderly, detainees and prisoners, refugees and the vagrant psychotics
Rapid socio-economic changes including urbanisation appear to have contributed to a wide range of psycho-social problems in Nigeria.	4.1.11 Non-Governmental Organisations shall be encouraged to assist in the, promotion of mental health as well as in the preventive and rehabilitative aspects of mental health care services.
There is an increasing number of people with chronic disabilities arising from severe infections, infant malnutrition and diarrhoeal diseases, sequelae of trauma and vascular disorders especially hypertension. Social and vocational rehabilitation facilities for this group of persons are inadequate.	4.1.12 There shall be full collaboration with all international organisations whose objectives and programmes cover aspects of mental, psychosocial, neurological as well as alcohol and drug abuse problem
There are as of now in Nigeria, no concrete data regarding the loss in national productivity due to mental illness. A debilitating mental illness in one member of a family causes severe social dysfunction of the entire family, thus diminishing productivity and earning capacity.	4.1.13 There shall be periodic review of the legislation governing the care of the mentally ill in consonance with advances in the field of mental health.
Voluntary and non-governmental organisations in Nigeria are yet to play an appreciable role in the field of mental health.	4.1.11Non-Governmental Organisations shall be encouraged to assist in the, promotion of mental health as well as in the preventive and rehabilitative aspects of mental health care services.