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Gender-specific experiences of serious mental illness in rural Ethiopia: a qualitative study

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Abstract

Considerable variation in the gender-specific prevalence of serious mental illness (SMI) has been reported in low- and middle-income countries (LMICs). In the rural setting of Butajira, Ethiopia, the male-to-female prevalence ratio of schizophrenia was reported to be 5:1. This qualitative study explores gender-specific experiences of SMI and the extent to which sociocultural factors may explain the observed difference in prevalence estimates. Using purposive sampling, 39 in-depth interviews were conducted with community members from Butajira, a rural district in South Central Ethiopia. Transcripts were analysed using thematic analysis to elicit community perspectives on cultural explanatory models of SMI and experiences in this region. Gender-specific experiences were reported to differ due to visibility of symptoms, community responses, and varying levels of family support towards individuals with SMI. Overall, respondents described

how various sociocultural factors subject women with SMI to higher levels of physical and social isolation compared to men, greatly affecting community health workers' ability to identify and provide care to women with mental illness. Future case detection methods should involve family members as they interact with women with SMI early on in the development of their symptoms and play an essential role in their path to mental health care.

Keywords

Mental health; serious mental illness (SMI); gender; qualitative; Ethiopia

Introduction

Globally, mental, neurological, and substance use disorders account for 14% of the total burden of disease (WHO, 2016). Three-quarters of the global mental health burden exists in low- and middle-income countries (LMICs) where most people do not have access to necessary treatment (Mendenhall et al., 2014). The World Health Organization estimates that the treatment gap – the proportion of individuals who need but do not receive care – is as high as 76-90% in LMICs (Fricchione et al., 2012; Saxena et al., 2007). In addition to the effects of disability and economic loss (Saxena et al., 2007), individuals suffering from mental disorders face a number of adverse social consequences. Notably, the burden of mental disorders is particularly concentrated among individuals with serious mental illness (SMI), which includes disorders such as major depression, bipolar disorder, and schizophrenia (Saraceno et al., 2007). Despite the staggering statistics supporting the need for development of a global mental health strategy, transcultural psychiatrists and anthropologists alike have emphasized the importance of understanding the local context of individuals' mental health experiences (Bemme & D'souza, 2014; Kirmayer & Pedersen, 2014; Kleinman, 1980).

In the context of LMICs, family relationships provide a crucial form of social support to individuals with SMI. Family members are often involved in illness-related decisions, including whether, where, how, and when to seek care, compliance with treatment, and life decisions such as employment and marriage (Rathod et al., 2017). In comparison to other forms of social support, families of individuals with SMI in LMICs possess unique leverage in relation to the person's decisions, behaviours, and overall health (Ahmedani et al., 2013).

Although family members are a vital component of an individual's support system, the family's role in supporting those with SMI is frequently undermined by the stigma associated with mental illness (Larson & Corrigan, 2008). Examples of behavioural manifestations of the stigma experienced by individuals with SMI and their families in LMICs are well established. For instance, several studies assessing community attitudes in Nigeria found evidence of a preference for social distance from individuals with SMI (Adewuya & Makanjuola, 2008; Gureje et al., 2005; Ibukun Adeosun et al., 2014). In these studies, community members were found to lack tolerance for basic social contact with patients with mental illness due to stereotypical perceptions of patients as being dangerous and violent (Adewuya & Makanjuola, 2008; Gureje et al., 2005). Similarly, a study

conducted in Ghana found that respondents had more authoritarian, socially restrictive, and less supportive views towards individuals with SMI in comparison to Western populations (Barke et al., 2011). In Uganda, individuals with SMI were reported to be regarded as an embarrassment to the family, and potentially restrained or subjected to expulsion from the community (Byaruhanga et al., 2008). Studies conducted in other LMICs including Ethiopia and India have reported the tendency for relatives of patients with schizophrenia to conceal the diagnosis from others (Shibre et al., 2001; Thara & Srinivasan, 2000). Overall, stigmatizing attitudes towards SMI are known to create unique burdens for the individual, leading to social isolation and potential loss of support and social capital from extended family and friends (Ahmedani et al., 2013).

In Ethiopia, significant strides have been made over the past two decades to improve our understanding of community attitudes towards SMI. In a study examining a range of attitudinal statements, Ethiopian respondents were least willing to hire, work, become friends with, or allow a family member to marry an individual with schizophrenia in comparison to various other illnesses, including depression, anxiety disorder, alcoholism, intellectual disability, epilepsy, tuberculosis, leprosy, and polio-induced paralysis (Mulatu, 1999). A subsequent study in Ethiopia found individuals living in rural settings had reduced capacity to counteract the stigma of SMI in their communities (Kebede et al., 2003). Though stigma towards individuals with SMI is ubiquitous, it is postulated that the stigma experienced by females may be worse, limiting treatment-seeking and clinical detection of women with SMI. In Ethiopia, the vast majority of research examining gender differences in the prevalence and incidence of SMIs such as schizophrenia has been quantitative in nature and limited in its exploration due to the underrepresentation of females with mental illness (Alem et al., 2008; Kebede et al., 2005; Kebede et al., 2003; Shibre et al., 2001). In a large, community-based, longitudinal study conducted in Butajira, Ethiopia, Kebede et al. (2003) reported a striking 5:1 male-to-female ratio in the prevalence of schizophrenia, specifically. The authors explained the preponderance of males in Ethiopia was consistent with previous studies from Canada, Ireland, and Micronesia, which suggested gender differences in schizophrenia existed because women experienced a less severe form of the disorder (Beiser, 1992; Iacono & Beiser, 1992; Kebede et al., 2003; Scully et al., 2002). The potential for methodological bias was also deemed unlikely as cases were collected through a rigorous door-to-door search method using trained key informants and interviewers over the course of four years (Kebede et al., 2003). However, Cohen et al. (2007) suggested that further investigation was required to determine whether the stark contrast was due to gender differences in frequency, excess mortality, or stigmatization and consequent social isolation and underreporting of women with schizophrenia and other SMIs. Our study responds to this call by qualitatively exploring gender differences in the sociocultural factors associated with treatment-seeking behaviours among individuals with SMI in the rural setting of Butajira, Ethiopia. By examining community perspectives on cultural explanatory models and experiences of SMI in Butajira, we seek to gain a better understanding of possible interventions aimed at improving case detection for women with mental illness in similar settings.

Methods

Setting

In Ethiopia, there exist 53 psychiatric outpatient facilities, six inpatient facilities, and one mental health hospital (WHO, 2006). Over 80% of Ethiopians live in rural areas of the country; however, the majority of the approximately 65 psychiatrists available are concentrated in major cities. The primary psychiatric facility in Ethiopia is Amanuel Hospital, located in the capital city of Addis Ababa. The current study was conducted 135 km south of Addis Ababa, in the rural Butajira district (formerly known as the Meskan and Mareko district) located in the Gurage zone of the Southern Nations, Nationalities and Peoples' Region. Butajira is divided into 45 sub-districts, with one hospital, 12 health centres and 45 health posts, one in each sub-district. Each health post is staffed by at least two community health workers trained by the Ministry of Health through an innovative health service delivery program that aims to provide universal primary health care. There are also estimated to be 11 local pharmacies, a traditional medicine shop, and several traditional healers. Local traditional healing practices include the use of *tsebel* (holy water) or the Holy Quran to treat mental illness, among other practices. The district of Butajira has a population of approximately 260,000 inhabitants, the majority of which are conversant in Amharic, the working language of the marketplace and Ethiopia's lingua franca (Berhane & Byass, 2002). The major ethnic group in Butajira is Gurage, and the population is predominately Muslim (Berhane & Byass, 2002).

Participants

The sample obtained for this study represents a purposive sample of community members, including community health workers, police officers, teachers, religious leaders, government officials, individuals diagnosed with SMI, and caregivers of individuals with SMI. With the assistance of a local community gatekeeper, two native Ethiopian research coordinators recruited participants for the in-depth interviews. Inclusion criteria were 18 years of age or older, living in Butajira, able to speak Amharic, and able to provide informed consent. A trained Ethiopian research coordinator described the study in Amharic using lay terms and checked for understanding after each section of the consent form. Participants were informed that their participation was entirely voluntary, confidential, and there would be no repercussions if they declined to participate. In addition, participants were told that the interviews would be audio-recorded and that they would last up to 60 minutes. The research coordinator then obtained written informed consent from all study participants. Those who could not write were invited to sign the consent form with a mark of their choosing. One of the 40 subjects approached to participate in the study declined, resulting in a response rate of 97.5% (n=39).

Study procedures

Data collection—In-depth interviews were conducted in Amharic between April and July 2015 by two native Ethiopian researchers affiliated with Addis Ababa University who received prior training and supervision in qualitative data collection. The interviewers were staff members of the Butajira research base, which has been operational for over 20 years and has established excellent links with the local community. Interviewers were not directly

involved in providing patient care to ensure participants felt comfortable expressing their views. The interview guide consisted of open-ended questions and topics designed to stimulate discussion surrounding cultural explanatory models of SMI based on Kleinman's Explanatory Models of Illness (Kleinman, 1980). Specifically, participants were asked to describe their perceptions regarding gender differences in the causes, symptoms, treatment, outcomes, and social attitudes of SMI in Butajira, Ethiopia. Each participant was interviewed alone in a private space either in the participant's home, workspace or at the Butajira Rural Health Project office. Each interview lasted for 30–60 minutes and was audio-recorded. The audio recordings were transcribed verbatim in Amharic and then translated into English by a bilingual Ethiopian translator who kept all interviews anonymous by coding them numerically. Upon completion of the interview, participants were compensated 70 Ethiopian Birr (~\$3.25 USD) for their time. Ethical approval for the study was received from the Addis Ababa University College of Health Science Institutional Review Board, the Partners Human Research Committee, and the Boston University Medical Campus Institutional Review Board.

Data analysis

Transcripts were analysed using thematic analysis (Braun & Clarke, 2012) and guided by the questions in the interview guide. Development of the codebook began with the first two transcripts, which were read independently by three members of the research team to generate initial codes. The initial codebook was subsequently revised based on the coding of an additional four interviews, at which point the same stories, themes, issues, and topics emerged, known as thematic saturation. Coding discrepancies were discussed until a consensus was reached regarding each code and its respective definition. The codebook was then used for the remaining interviews, which were randomly assigned to each researcher in sets of three to five transcripts. To ensure consistency in the coding process, inter-coder reliability of at least 80% agreement was confirmed on three separate occasions by randomly selecting an interview from each set and having all three researchers code the same transcript. To account for potential differences, two teams (one based in Ethiopia and the other in the U.S.) performed independent analyses of a subset of 25% of the data using the original Amharic transcripts and their English translations. Coding schemes were then compared between research teams to ensure cross-cultural validity in the interpretation of the results. Through axial coding (Strauss & Corbin, 1990), connections between commonly emerging themes and patterns were noted and used to elicit cultural explanatory models of SMI in Butajira. Data management was facilitated through use of NVivo 11 Software (QSR International Pty Ltd, 2016).

Results

Demographic characteristics

Study participants comprised of 11 individuals diagnosed with SMI (28.2%), 12 caregivers (30.8%), six religious leaders (15.4%), four community health workers (10.3%), two police officers (5.1%), two teachers (5.1), and two government officials (5.1%). Of those diagnosed with SMI, 81.8% were female due to oversampling for the purposes of the study. Overall, a slightly larger proportion of the study sample was male (59%) with a mean age of 39.03 (SD

= 16.36 years). Most participants completed either primary school (35.1%) or secondary school or greater (43.2%). Of note, 55.6% of study participants who could not read or write were patients, while the remaining participants were caregivers or religious leaders. Those who completed primary school were mostly caregivers (50%), followed by patients (28.6%) and religious leaders (21.4%). Those who completed secondary school or greater were mostly community health workers (26.7%), followed by police officers (13.3%), teachers (13.3%), religious leaders (13.3%), government officials (13.3%), and patients (6.7%). Of the 35 participants who reported their religion, the majority was either Muslim (62.9%) or Ethiopian Orthodox Christian (25.7%). Demographic characteristics of study participants are described in Table 1.

Prominent themes that emerged from this qualitative study are presented in Figure 1. Gender-specific experiences of SMI in rural Ethiopia were reported to vary due to a large number of sociocultural factors; however, the results presented in this analysis focus on the most upstream factors, including: 1) the visibility of symptoms, 2) community responses, and 3) varying levels of family support towards individuals with SMI. These themes are illustrated using supporting quotes directly from the interviews in the following paragraphs. Due to space constraints, narrative data are illustrative rather than exhaustive.

Visibility of symptoms

When asked about the symptoms of individuals with SMI, study participants described general symptoms observed in both genders. These symptoms included idleness or loss of interest, talking to oneself, wandering, poor hygiene, disruptiveness, and in severe cases, nudity.

Most of the mentally ill people I know usually spend their days by sitting at the same place for a long time, by wandering in the streets or by begging and bothering shopkeepers. [Female community health worker, age unknown]

The symptoms could be carelessness about oneself, dirty clothes, lack of organization. These can be observed in both sexes. [Female community health worker, age 27]

Participants also identified distinct, gender-specific symptoms of SMI, which are grouped from least to most visible in Figure 2. Visibility was frequently described in terms of one's physical threat to society. Respondents explained that men with SMI were more aggressive, disruptive, and in some instances, violent, due to feelings of power and dominance.

It is because men are usually more powerful than the women. It will make them aggressive... women do not usually have the need to dominate by force in the first place. Men and women are not equal in their physical strength... women do not usually build their confidence on their physical strength. [Male patient, age unknown]

Families of men with SMI were also characterized as being unable to care for mentally ill men due to their aggression. One respondent, the son and caregiver of his mentally ill mother, described another male with SMI from his neighbourhood as follows:

He became crazy because of the suffering he was going through. Then he started chasing people at night. His family didn't take proper care of him. He always wanted to kill people. He is still very aggressive sometimes when his illness relapses. [Male caregiver, age 25]

Participants' illustrations of symptoms of women with SMI portrayed them as less threatening, and thus, less visible to the community. Common symptoms identified among women with SMI included unkempt hair, inability to care for children, wandering, and general loss of interest (Figure 2). In a few extreme cases, women with SMI were described as running away from their neighbourhoods or disappearing from their homes and their families.

The women are not usually (disruptive). They don't fight. They don't say anything. They are calmer... If women become (mentally ill), they will leave their neighborhood and wander somewhere else. [Female community health worker, age 27]

Though few, there were some rare instances when women with SMI were described as exhibiting aggressive behaviours by their caregivers.

She used to rip her clothes off of herself. There was a time when she broke the hospital building glass. [Female caregiver, age 70]

Last time she hit me with a paint can over here...It is stitched up now. It spun in the air and broke my skin over here. [Female caregiver, age 45]

Community responses to SMI

Responses to males and females with SMI—In Butajira, variations in the visibility of symptoms of SMI elicited different community responses, which were both explicit and implicit. When asked to describe how the community deals with mental illness, participants explained that exposure to community stigma occurred as soon as individuals with SMI were seen outside their homes, regardless of gender.

People will start gossiping the moment when a mentally ill person goes outside the house. Laughing at mentally ill people. Mocking mentally ill people. These things which you see in society are bad. [Female community health worker, age 22]

Participants also identified gendered variations in community responses to SMI, including differences in social acceptance and inclusion.

Responses to females with SMI—Despite some respondents' use of the word 'empathy,' participants most frequently described feelings of sympathy and pity towards women who were visibly ill in public spaces. When asked why society was more sympathetic towards women, community members described their shared understanding of the impact of a woman's mental illness on her domestic role and her ability to have children and care for her family.

When she fails as a woman to lead her life properly and have children... When her life worsens and she is maltreated, people empathize more for a woman. [Male patient, age unknown]

A woman can be a mother. She can also be a sister. She can also be a wife. A baby comes from a woman's womb. Men do not give birth. I think that is why it is shocking when a woman strips off her clothes and goes out naked in public. A woman can be many things. She can be everything to someone. [Male religious leader, age 85]

Others also explained that women with SMI were rarely seen outside of the home due to their limited engagement in social activities as compared to men.

Women usually don't go outside of the house... They don't indulge themselves in the same (harmful) activities as men and stay inside the house most of the time. But, men, they usually spend their time outside of the house. They meet many people. But women are always in the house. People might find it difficult to recognize that she has a problem. [Female community health worker, age 27]

In instances where women were seen outside of their homes, another community health worker noted that women were more likely than men to comply with orders to return home if they were found wandering the town or being publicly disruptive.

The other difference is that women usually calm down or go to their houses and stay there if someone reprimands them for their behaviour... But men usually tend to say no. A (mentally ill) woman will get in to the house and stay there if someone tells her to go back home. [Female community health worker, age 22]

Despite these trends in community responses, one female with SMI described her social life as follows:

I visit my friends and hang-out and drink coffee with them. I also make coffee to my friends when they give birth. [Female patient, age 28]

Another female patient stated that she had a supportive relationship with her neighbours because her symptoms were well controlled.

They will give me what I want when I am ill. They will buy me soft drink and food, if I ask them to. My family and neighbours take care of me. [The people in] Butajira feel sorry for me. My teachers, the doctors and everyone who knows me loves me because I have a very good behaviour. [Female patient, age 34]

Responses to males with SMI—In contrast to the observed expressions of sympathy towards women with SMI, community members consistently reported a greater sense of fear and avoidance of men with SMI as they were more likely to attack people and exhibit hostile behaviours. A community health worker explained her experience with individuals with SMI as follows:

The community thinks that they are both mentally ill. But with regards to how they behave... People are not afraid of (mentally ill) women as they are afraid of (mentally ill) men. Society thinks that mentally ill women are less hostile than men.

But (mentally ill) men might try to attack people at times. People might be scared and stay away from them, if they are aggressive. But (mentally ill) women might have the tendency to approach people. I know of two women and they are approachable. (Mentally ill men) are not approachable, from what I have observed. [Female community health worker, age 22]

A notable difference between men and women with SMI was that, unlike the visibly aggressive behaviours of males, which could not be hidden from the community, the diagnoses of females were often kept secret or concealed within the home. Yet, despite their diagnoses, women with mental illnesses were still responsible for their family and household obligations.

I think it is [mentally ill] women who face more problems. This has something to do with the community's attitude towards [mentally healthy] women. Although it is changing these days, [mentally healthy] men cause a lot of problems for [mentally healthy] women, especially on issues related to household management... Women bear all the responsibility in the house. [Male government official, age 30]

Since differences in community attitudes were closely tied to the visibility of the symptoms of individuals with SMI, women with mental illness who were hidden from the community were less frequently observed as receiving timely medical treatment compared to their male counterparts. When asked about gender differences in the experiences of individuals with SMI, one community health worker described both the unintentional and deliberate invisibility of women's mental health status, which hindered them from being detected within the current sociocultural environment.

Women are usually stoic... And this might lead other people to think that they are healthy. But the illness will be apparent in men right away. But a mother, when she is busy with her children...might forget to treat her illness. Perhaps it might not be recognized, if she didn't reach the final stage (of the illness). [Female community health worker, age 27]

One man with SMI responded to the same question by acknowledging the family's role in the delay to detect women's mental illness due to gendered interpretations of the severity of mental illness.

Maybe it is because their families discount their (mentally ill women's) problems. It is because they think the illness is severe in men and will get better if he gets treatment. [Male patient, age 45]

Family support—Gender differences in community responses to SMI also translated to gender-specific experiences in the home. Many participants in Butajira spoke of the importance of family support in the detection and treatment of individuals with SMI. Given that they experienced high levels of stigma and exclusion from society, families often took on the burden of caring for relatives with SMI.

Society might not have the same attitude towards them as their families. Because it might take a very long time to approach and bring the ill people to normalcy. It requires a lot of patience and time to bring them to the point of normalcy.

Awareness is also very important in this case. That could be the reason why society has the tendency to alienate them. [Male teacher, age 24]

Positive family support—Common examples of positive family support that emerged from the interviews included emotional and financial support, as well as seeking treatment. Almost all respondents spoke of the family's responsibility in taking their relatives with SMI to treatment, which included religious leaders, holy water sites, and/or a psychiatric hospital or medical clinic. Some respondents explained that where families sought treatment depended on their personal beliefs rather than the gender of the individual with SMI.

They might, for instance take him to the holy water places, if they believe that it could help him recover... They don't discriminate between men and women. [Male caregiver, age 25]

Others noted clear differences between where men and women were taken for treatment.

It is women [who usually come here to get holy water treatment]... Their families bring them when they become troubled. [Male religious leader, age 72]

It is men who usually go immediately to health institutions... The illness will worsen in women over time because they give priority to the problems in the house... The illness will spread in their body when they procrastinate (from seeking treatment) because they think that the illness will go away from them. [Female patient, age 38]

Respondents identified several factors to explain why men go to medical institutions more frequently upon becoming ill compared to women, including differences in access to finances, household responsibilities, and prioritization of needs.

If the illness is not in a critical stage in him... and if he knows he has to get treatment, he will get it faster. Because he has money. But she has to ask him to take her to hakim beth ... Therefore, I think he will go (to seek treatment) more immediately. I mean, from a financial perspective. Another thing is ... she gives priority to household affairs even through illness. They (women) don't usually stop housework even through illness. [Female community health worker, age 27]

Respondents also explained that treatment through a psychiatric hospital or medical clinic was sought out when one or more family members felt desperate for help or physically threatened by their mentally ill relative. Due to the reported rarity of observing symptoms of physical aggression in women with SMI, medical treatment for females typically was not considered until later stages of illness. Instead, physical restraint was the most commonly used strategy to deal with women with SMI.

It is difficult to restrain men. Men try to break the rope or chain and... they get bruises and scratches. Women are similar but they are not usually as strong or as difficult as men. [Male religious leader, age 85]

Physical restraint within the home was described as the family's way of protecting women with SMI from harm that existed outside the home, namely, sexual assault, unintended pregnancy, and sexually transmitted infections.

I tie her up and keep her behind closed doors. Because I fear that she might go in a harm's way... Someone might beat her if she attacks him. Another person might rape her. He (the assailant) could be ill. Or he might have AIDS. I would rather die than let her go outside. [Female caregiver, age 70]

A police officer and a religious leader elaborated on the community's role in supporting the families of individuals with SMI in seeking appropriate care.

If families tie up and restrain them, we will call and advise them to seek medical treatment. We will not be silent. Families have responsibilities. But we will help them if they have difficulties in taking the ill people to the places where they can get medical treatment. But tying up and restraining...the law states that it is not appropriate. [Male police officer, age 24]

The court rules about restraining them and taking them to Amanuel (hospital). The court also asks support from the government...(the jury in the Sharia Court) will facilitate financial support from the community to take the patient to the hospital. [Male religious leader, age 85]

Negative family support—Some participants acknowledged that the most consequential challenges people faced were within the home. When asked to describe the most difficult problem individuals with SMI had to deal with, one respondent answered with the following:

Lack of proper family care...I think this is the most serious. Their families don't provide proper care for them. They say "He is crazy" or "He is mentally ill" and will abandon the person. This will exacerbate their illness. [Female community health worker, age 22]

Overall, women with SMI were observed as receiving less social support from their families. A lack of family support was particularly relevant as immediate family was frequently described as bearing the responsibility to care for those suffering from SMI. Without this support, participants explained that women with SMI became increasingly vulnerable to social isolation. One female with SMI spoke of a lack of acceptance from both her brother and her spouse, leading to alienation and divorce.

I have one brother, but he doesn't support me. It has been almost six months since we saw each other. He warned me not to get close to him. He used to love me in the past. But he despised me, after I became ill. He told me not to ask him [money] for food and clothes.

My husband was going to the hospital with me for three months, but he was mocking me all those times. Then I told him not to accompany me and I started going there with the children. We divorced after that. They (neighbours) said that I might kill him or cause him other problems. They decided that I should sit with my children and that he should marry another woman. I don't have relatives. [Female patient, age 50]

Participants also expressed that a lack of family support increased female vulnerability to neglect and abuse, including sexual exploitation, making it more difficult for women with SMI to live out on the streets as compared to men.

Being a woman by itself might expose one to some problems. She might for instance become pregnant. As long as she goes outside looking for men... But if it is a (mentally ill) man... They might not dare to come close to him. He might scare them. People might be scared or afraid of him. But a (mentally ill) woman might face sexual assault. [Female community health worker, age 22]

In one rare instance, a male patient with SMI was observed to seek treatment at a health centre on his own. A lack of family support did not prevent him from seeking treatment, which he explained improved his symptoms immediately after receiving care.

I came here by myself. I had no sleep. I was sitting when everyone was sleeping. Everyone else worked...but, because I didn't sleep at night, my mind and my strength failed me... That was the reason I came here... (My symptoms) improved immediately. [Male patient, age unknown]

Discussion

Findings from this qualitative study contribute to our understanding of the gender-specific experiences of individuals with SMI in rural Ethiopia. Our data suggest that the substantially unbalanced gender ratio in the local prevalence of schizophrenia in Butajira might be due in part to the cumulative effects of various sociocultural factors. A breakdown of these effects highlighted three important factors contributing to gender differences in the detection of SMI: the visibility of symptoms, community responses to SMI, and varying levels of family support towards individuals with mental illness. Overall, participants of this study explained that gender-specific behaviours and vulnerabilities differentially isolate women with SMI, ultimately limiting their detection and access to timely mental health treatment.

A central finding of our study was that in Butajira, community responses to individuals with SMI were reported to vary according to the visibility of their symptoms in public spaces. Stigma theory explains that stigmatized characteristics (such as psychiatric symptoms, physical appearance, or social skills) that are easily identified are less concealable, therefore allowing society to stigmatize differentially based on the visibility of individuals and their mental illness (Corrigan, 2000; Goffman, 1963). As a result, individuals with less disruptive and more stable mental disorders are considered more likely to experience less stigma compared to disorders that are highly disruptive. A number of studies provide supporting evidence of this theory as public attitudes have generally been reported as being more stigmatizing towards schizophrenia in comparison to mental illnesses with less visible symptoms, such as major depression (Ahmedani et al., 2013; Imhoff, 2015; Nordt et al., 2006; Rössler, 2016).

In our study, men with SMI were expected to face worse consequences due to the increased visibility of their aggressive behaviours to the public; however, women with SMI were observed to experience worse consequences as evidenced by their physical and social isolation. Our findings demonstrate that this may be due in part to how individuals with

SMIs are viewed by their communities. Rather than being feared, women with SMI in Butajira received expressions of sympathy more frequently compared to their male counterparts. Community members were not afraid to tell women who were visibly ill to return home, where family members often dealt with the burden of their mental illness. In the absence of fear, community responses to women with SMI further isolated them from society. Though few, previous studies have reported evidence of gender differences in the social consequences of SMI in LMICs (Cohen et al., 2007; Maselko, 2017; Saxena et al., 2007). In a recent qualitative study in North India, Mathias et al. (2019) reported similar gender dynamics among caregivers of individuals with mental illness. Authors observed that social exclusion was differentially experienced by female caregivers of people with a psychosocial disability compared to male caregivers, who did not report experiencing community critique or social isolation (Mathias et al., 2019).

Our study also found that gender played an important role in determining the type of family support individuals with SMI received. Though physical restraint may be interpreted as a lack of family support, participants were clear that supportive families of women with SMI restrained or hid their female relatives at home in an effort to protect them from their physical vulnerability in the community, and to protect them from exposure to the increased community stigma they face compared to men. Without family support, women with SMI were believed to be at increased risk for neglect, abuse, and sexual assault. However, the unintended consequence of the physical and social isolation of women with SMIs was the prolonged duration of untreated mental illness, which is associated with worse mental health outcomes (Shrivastava et al., 2010). Supportive families of men with SMI responded to the physically threatening symptoms of their male relatives by seeking out care, which translated to earlier case detection and access to medical treatment.

Our findings are consistent with other studies that report varying levels of family support towards individuals with SMI due to stigma (Iseselo et al., 2016; Quinn & Knifton, 2014). In Uganda, families were found to go to great lengths to hide the mental illness of their relatives due to consequences of disclosure related to marriageability, social support, and abuse/sexual exploitation (Quinn & Knifton, 2014). Similar findings regarding the physical and social isolation of individuals with SMI were also reported in Lagos, Nigeria. In a study sample where the majority of respondents were female (64%), individuals living with schizophrenia most frequently experienced unfair treatment by family members in the form of physical restraint (Ibukun Adeosun et al., 2014). In a previous study conducted in Butajira, 75% of relatives of individuals with schizophrenia or mood disorders reported experiencing stigma due to the presence of mental illness in the family (Shibre et al., 2001). It was thus unsurprising that in our data, women with SMI showed a trend of running away or leaving their communities. The migration of women with SMI is likely associated with the shame of their mental illness and its negative social effects, particularly on their families. Similar experiences of shame about self and blame from others have been reported in a number of LMICs as a major contributor to the inhibition to seek treatment for mental disorders (Saxena et al., 2007).

Overall, our study highlights key sociocultural factors that may limit the detection of women with SMI in Butajira. Differences in the visibility of symptoms, community attitudes, and

family support towards individuals with SMI contributed to gender-specific experiences, greatly affecting community-based health care providers' ability to identify and provide care to women with SMI. Our findings also confirmed the need for novel methods for detecting cases of schizophrenia and other SMIs in Butajira and similar rural regions in Ethiopia. Indeed, in a study among residents of Butajira, Shibre et al. (Shibre et al., 2002) used a two-stage design to identify cases of schizophrenia. In the first stage, a Composite International Diagnostic Interview (CIDI) and key informants were used to identify possible cases. Clinical diagnosis of schizophrenia was then established using a psychiatrist-administered tool, the Schedules for Clinical Assessment in Neuropsychiatry (SCAN). The authors noted that key informants performed better in detecting cases of schizophrenia than the CIDI (Shibre et al., 2002). It is therefore critical that future mental health training efforts in rural districts of Ethiopia integrate informal providers such as family members in community-based case detection systems.

Limitations

A number of limitations should be considered in interpreting the results of this qualitative study. Since the data presented are based on a small, purposive sample of community members in a rural region of Ethiopia, the opinions and perceptions expressed may not be representative of the entire population of Ethiopia, particularly those living in more urban areas. Nevertheless, the aim of our study was to respond to the need for increased attention in rural areas. The gender of the Ethiopian interviewers may have also influenced the form and content of participant responses, though the data collection team included one female and one male interviewer in order to minimize potential censorship due to gender relations between the interviewers and the study participants. The primary data analysis team was not of Ethiopian origin; however, thematic analysis included review by co-authors of Ethiopian origin who have worked in Butajira to ensure the cultural context was not misinterpreted or misrepresented. It is also possible that nuanced opinions of some respondents may have been more accurately captured if interviews were conducted in the different dialects of the region, though this would pose additional challenges of feasibility, such as hiring and training additional staff from exceedingly rural areas of the country. Finally, it is possible that transcription and, more importantly, translation of the interviews may not have accurately captured certain expressions or words that differ in meaning between Amharic and English. We attempted to mitigate this potential concern through explanation of Amharic words or idioms that had no direct translation in English. To avoid these limitations, future efforts should focus on developing the research capacities of local communities in LMICs through training and education in qualitative methods to assess SMI. Future studies should also aim to evaluate gender differences in SMI prospectively in order to improve our understanding of individuals' mental health experiences globally.

Conclusion

Our study findings highlight the importance of taking into account the sociocultural contexts when seeking to understand the experiences and consequences of SMI in LMICs. This study suggests that in Butajira, various sociocultural factors subject women with mental illnesses to higher levels of physical and social isolation relative to their male counterparts. As

sociocultural factors play an increasingly important role in understanding the global burden of mental illness, future research must pay close attention to the potential for gender-specific experiences that limit case detection among those suffering from mental illness. In rural Ethiopia and settings with similar gender dynamics, case detection methods should involve family members as they interact with women with SMI early on in the development of their symptoms and play an essential role in their path to mental health care.

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Figure 1.
Cultural explanatory models, community responses, and consequences of serious mental illness (SMI) as described by community members from Butajira, Ethiopia

Figure 2.
Gender-specific visibility of symptoms of serious mental illness (SMI) as described by
community members from Butajira, Ethiopia

Table 1.

Demographic characteristics of study participants from Butajira, Ethiopia in 2015

	Total N (%)	Female N (%)	Male N (%)
Participants	39 (100)	16 (41)	23 (59)
Patients	11 (28.2)	9 (81.8)	2 (18.2)
Caregivers	12 (30.8)	2 (16.7)	10 (83.3)
Religious leaders	6 (15.4)	0 (0)	6 (100)
Community health workers	4 (10.3)	4 (100)	0 (0)
Police officers	2 (5.1)	0 (0)	2 (100)
Teachers	2 (5.1)	0 (0)	2 (100)
Government officials	2 (5.1)	1 (50)	1 (50)
Age categories (years) ^a			
18-24	5 (13.5)	2 (40)	3 (60)
25-34	13 (35.1)	7 (53.8)	6 (46.2)
35-44	6 (16.2)	2 (33.3)	4 (66.7)
45-54	8 (21.6)	2 (25)	6 (75)
55+	5 (13.5)	2 (40)	3 (60)
Marital Status ^b			
Married	26 (68.4)	9 (34.6)	17 (65.4)
Not married	12 (31.6)	6 (50)	6 (50)
Educational attainment ^c			
Cannot read/write	9 (23.1)	6 (66.7)	3 (33.3)
Primary school	14 (35.9)	4 (28.6)	10 (71.4)
Secondary school or greater	15 (38.5)	6 (40)	9 (60)
Religion ^d			
Muslim	22 (59.5)	6 (27.3)	16 (72.7)
Ethiopian Orthodox	9 (27)	7 (70)	4 (40)
Catholic	2 (5.4)	1 (50)	1 (50)
Protestant	2 (5.4)	1 (50)	1 (50)

Missing data:

^{a)} n=2;^{b)} n=1;^{c)} n=1;^{d)} n=2