Interpretation of Challenges and Treatment among Secular and Religious Counselors in Ethiopia

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Honors Thesis

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December 2023

Acknowledgments

This exploration was an incredible learning journey and I'm deeply grateful for the people that made this possible. At my home institution, Drs. Cristine Legare and Theresa Jones relentlessly guided me in getting the most out of this exploration, and Zachary Taylor and Faiz Hashmi also enormously supported me through the entire process. In Addis Ababa, Dr. Meseret Molla, Nurelegn Mengistu, and other community members helped me navigate the context and the community. Thank you to all the counseling providers that participated in this study. I was amazed by the various ways they aimed to contribute to people's wellbeing, and I am very privileged to have learned from their understandings. They inspire me to continue exploring cultural and local strengths that we can leverage to create the home we aspire to have. I would also like to express my gratitude to the Obama Foundation and Airbnb for funding this project and allowing me to learn in ways that build bridges across systems and understandings. Most importantly, my family's incredible support and encouragement also keep me inspired to keep learning. Lastly, thank you to the God who keeps us hopeful and strong especially when everything else doesn't.

Abstract

Mental health issues can include or be associated with a wide variety of challenges. Prevalent cognitive-level mental health issues like common mental disorders or associated functional-level challenges like interpersonal problems can effectively be treated by counseling methods. In the Ethiopian context, evidence-based secular counseling was recently introduced and coexists with the widely used religious care system. This paper explored how secular counselors and Orthodox Christian leader counselors interpret and counsel for the most common challenges they encounter. This exploration elicited multiple themes including (1) secular counselors' prominent focus on treating cognitive challenges and religious counselors' prominent focus on treating functional challenges, (2) low help-seeking for secular counseling and high help-seeking for religious treatments, (3) a presence of cultural and linguistic nuances in locally conceptualized mood-related challenges, (4) prominent environmental and psychological causal explanations among both counselor groups; physiological causal explanations among secular counselors, and supernatural explanations among religious counselors, and (5) use of psychotherapy by secular counselors, and the incorporation of guidance, consolation and religious features by religious counselors.

Mental Health Issues in the Ethiopian Context

Mental distress is noted as having a high prevalence in the Ethiopian context (Gelaye et al., 2012; Dachew et al., 2017). Common Mental Disorders (CMDs) like depression and anxiety disorders are some of the most common and burdensome mental illnesses among the Ethiopian population. The pooled prevalence of these disorders is found to be about 1 in 3 among individuals with other illnesses, and about 1 in 4 among the general population (Kassa & Abajobir, 2018). CMDs have one of the greatest negative effects on life satisfaction, even compared with common physical illnesses like arthritis and diabetes or compared with common negative live events like debt and unemployment (Bikjaer et. al, 2020).

CMDs and other mental health issues like stress are associated with a range of other functional-level personal challenges as well. Khat and alcohol addiction, financial distress, poor social support, traumatic experiences, unemployment, and family and marriage conflicts are examples of personal challenges documented to have significant associations with mental health issues in the Ethiopian context (Dachew et al., 2017; Tariku et al., 2017; Sahile et al., 2020; Kebede et al., 1999; Behanu, 2008). CMDs also greatly decrease an individual's ability to productively contribute to the economy. In turn, increased poverty also leads to greater mental health difficulties (Knifton & Inglis, 2020).

Perceptions of Mental Health Issues in the Ethiopian Context

In lower-middle-income countries (LMICs) like Ethiopia, there is a lack of awareness of the value of mental health for economic development and a lack of public interest in promoting greater mental well-being (WHO, 2007; Patel et al., 2018). This could possibly be due to a variety of factors. According to a few studies that have been conducted, many Ethiopians do not categorize CMDs like depression as mental illnesses. Instead, the symptoms tend to be viewed as normal reactions to the various forms of life's stressors (Tekola et al, 2021; Monterio, 2014).

Even when recognized as mental illnesses, CMD symptoms are viewed as the least important health difficulties. Instead, only severe mental illnesses like schizophrenia are categorized as mental illnesses and receive greater public interest (Alem et al., 1999).

According to studies conducted to explore perceptions of mental illnesses among community members, many Ethiopians believe that a range of mental disturbances are caused by spiritual or supernatural causes. Examples include the entry of evil spirits or the result of witchcraft attacks (Jacobsson, 2002; Hailemariam, 2015; Asfaw 2015). Partly due to these explanations and the lack of formal care, mental illnesses are viewed as generally untreatable by formal care even among health professionals (Mekonen et al., 2022). However, most of the research on the perception of mental illnesses in the Ethiopian context focuses on severe forms of mental illness. To better understand the specific attitudes, causes, expressions, and treatments of CMDs, further explorations need to be conducted.

Some of the studies conducted on the perception of CMDs in the Ethiopian context directly explore people's perceptions of "Clinical Depression" or "Generalized Anxiety Disorder" (Monterio, 2014; Tekola et al., 2021). However, it is important to note that these disorders are western psychological and psychiatric concepts. Based on enormous amounts of research, various symptoms were grouped into the diagnoses found in the Diagnostic and Statistical Manual of Mental Disorders (DSM) used in psychological and psychiatric care. This does not mean that cross-culturally, communities conceptualize the symptoms the ways that the DSM does (DSM, 2013). These groups of symptoms are one way of understanding serious psychological distress, or mental health problems severe enough to cause impairment in social, occupational, or school functioning and to require treatment (Pratt et al., 2007). Similarly, it is

essential to understand the ways psychological distress is interpreted in the local and traditional context.

Secular Mental Health Care in the Ethiopian Context

Evidence-based counseling or psychotherapy techniques are established as very effective in reducing depression and anxiety symptoms, and there is a greater need to implement them in LMICs like Ethiopia (Health Quality Ontario, 2017). However, most of the attempts to create an evidence-based mental health care system have focused on psychiatric frameworks. Focusing on treating severe mental illnesses like schizophrenia, the psychiatric care system has mostly focused on pharmacological treatments (WHO, 2020). As of 2020, there were 0.86 mental health professionals per 100,000 Ethiopians, with the majority of them being mental health nurses and psychiatrists (WHO, 2020).

In regard to psychologists working in the sector, only 46 existed nationally by 2020(WHO, 2020). In attempts to spread awareness and implement mental healthcare infrastructures, the use of counseling and psychotherapy has not been prioritized (Zeleke et. al, 2019). However, it has recently been introduced and is in development. It is also noted that the development of psychotherapy practices in the Ethiopian context has faced challenges with the largest ones being traditional beliefs and poverty (Wondie, 2014). These challenges result in really low help-seeking behaviors and neglect of its development.

In terms of help-seeking, about 50% of Ethiopians with CMDs seek any type of help at all (Bifftu et. al, 2018). For those who do seek help, formal care is often the very last choice (Hughes et al., 2020). A study conducted in Jimma, a diverse urban Ethiopian city, revealed that only about 17% of those with CMD seek formal care. Of the 17%, only 7% seek care from mental health professionals. But the large majority (83%), seek care from informal or traditional

influencers. Ranked in order of influence, those include family members, religious leaders, traditional healers, and other influencers like friends and teachers (Kerebih et.al, 2017).

Religious Mental Health Care in the Ethiopian Context

If individuals seek care outside their homes and families for their psychological distress, traditional healing methods are usually the first option (Alem et. al, 1995). This could be because traditional beliefs are widely held by the affected individuals and family members. Generally, the WHO estimates that more than 80% of the African population seeks health treatments from traditional healers, and within that percentage, 40-60% of the population is estimated to seek treatment for mental illness (WHO, 2002). If and when help is sought in the Ethiopian context, traditional care can mean a lot of different things. However, the diverse groups of providers mostly share the beliefs surrounding the spiritual and supernatural causes of the symptoms and the illnesses (Jacobsson, 2002).

Around 98% of Ethiopians identify as religious and religions are very strong influencers across the Ethiopian culture. Although a variety of faiths are practiced in the nation, the religions with the largest followings in order are Orthodox Christianity, Islam, and a group of other Protestant Christian faiths (MRG, 2023). When experiencing distress including CMD symptoms, people seek counseling and advice from local faith leaders such as priests, pastors, and imams (Law, 2021). To treat and alleviate their symptoms, individuals practice religious rituals including attending holy water treatments, reciting Quran prayers, fasting, or wearing religious amulets (Jacobsson, 2002).

These religious practices are widely practiced and visible in Orthodox Christian contexts like holy water healing sites (Fekadu & Mulat, 2015). There is a considerable amount of research exploring severe mental illness healing within these sites(Hailemariam, 2015; Asfaw, 2015;

Anderson, 2007). It has also been noted that around 40-50% of those getting treatments at some of these holy water healing sites have CMD disorders, but to understand the broader religious care system for people with CMDs, much more research needs to be conducted (Belete et al., 2021; Mossie & Tesfay, 2020).

Coexistence of Secular and Religious Care

Secular and religious beliefs and practices can integrate and promote greater well-being. For example, for religious people, psychotherapy that incorporates religious or spiritual components is more effective than psychotherapy that does not (Captari et. al, 2018, Hefti, 2011; Henri, 2015). Religious rituals and practices are also incredibly valuable in allowing people to cope with their distress, manage a range of symptoms, find greater meaning in life, and generally promote greater well-being (Lowewenthal & Dein, 2015).

The use of evidence-based counseling and psychotherapy practices is not only greatly effective but can also bridge the various gaps between biomedical and traditional beliefs and practices (Zeleke et. al, 2019). It is noteworthy that Evidence-based counseling and psychotherapy techniques do not even have to be conducted by psychotherapists. For example, concepts like peer or religious counseling can be incredibly effective at reducing symptoms and can be especially cost-effective in low-resource contexts like Ethiopia (Chibanda et al.,2015).

The National Mental Health Strategy published by The Ethiopian Federal Ministry of Health emphasizes the need to develop “accessible, affordable, and acceptable” care that includes traditional healers (Giorgis & Sime, 2013). Many of the obstacles to the implementation of evidence-based care center around the traditional attitudes and practices of the communities. Therefore, research and practices that are supported by the local values and understandings of mental illness and care are incredibly necessary (Cohen et al., 2008; White, 2013). For a

beneficial coexistence, exploring the various local perceptions and interpretations of various mental health-related challenges is essential.

Conclusion

The literature highlights the prevalence and burden of mental health issues and associated challenges in the Ethiopian context. As a solution, it discusses the coexisting secular and religious mental health care systems. It is also noted that prevalent religious and other traditional beliefs and practices pose a challenge to the development of the newly introduced secular care system. However, coexistence and possible integrations of these counseling systems are emphasized for the greater well-being of individuals experiencing mental health issues and associated challenges. For this, an enormous need for understanding these diverse belief systems is highlighted. The study below explores the interpretations of challenges and counseling care approaches among secular and religious counselors in the Ethiopian context.

Methods

Participants

A total of 39 counselors participated in this study. 19 of them were secular counselors, 17 of them were Orthodox Christian religious leaders who counsel, and 3 of them were Orthodox Christian religious-secular counselors. Different types of demographic data were gathered from the participants. Table 1 provides data on employment roles and Table 2 provides additional data on age and counseling roles.

Table 1
Types of Employment Roles in % by Participant Groups

Participant Groups	Roles	Numbers(n)	Percent (%)
Secular Counselors	Psychologist	9	47%
	Counselor	3	16%
	Social Worker	2	10.5%
	Psychiatrist	2	10.5%
	Other Secular Counselor	3	16%
Religious Counselor	Priest	12	70%
	Monk/Nun	3	18%
	Teacher	2	12%
Religious-secular Counselor	Priest and Psychologist	3	100%

Note. Counselors are categorized based on self-report. “Psychologist” in this context can include counselors with a bachelor's, master’s, or doctorate level degree and clinical training. Educational attainment is described below.

Table 2

Demographics by Participant Group

Factor	Type	Mean	SD	Min	Max
Age	SC	29.9	4.38	23	43
	RC	55.1	14.88	39	88
	RSC	50.5	3.37	46.6	53
Years of practice (yrs)	SC	5.3	2.94	.5	11
	RC	22.57	13.98	3	60
	RSC	20.33	8.96	10	26
Patients per week	SC	11.2	8.32	2	27
	RC	6.56	7.85	0	21.5
	RSC	20.33	7.23	12	25

Note. SC = Secular Counselors, RS = Religious Counselors, RSC = Religious-secular Counselors

Additional demographic data was also collected. In regard to gender, the participant pool was mostly male. 13 secular counselors were male and 6 were female, 15 religious counselors were male and 2 were female, all 3 religious-secular counselors were male and none were female. Data on religiousness was also collected. There was a high degree of religious affiliation among the secular counselors. 16 identified as affiliating with a religion, 2 identified as not affiliating with a religion, and 1 identified as spiritual but not identifying with a religion. Out of those affiliating with religion, 40% were Orthodox Christian, 25% were Protestant Christian, 15% were Muslim, and 5% were Catholic.

In terms of educational attainment for secular counselors, 43% held bachelor's degrees. In this context, this includes degrees in social work or psychology with clinical training and degrees in medical practice. 47% held master's degrees in areas like clinical or counseling psychology, and 10% held doctorate-level degrees. In terms of the religious counselors, 29% held bachelor's degrees, 35% held other diplomas or certificates, 17% held high school diplomas, and 18% didn't graduate high school. However, the religious leaders have a variety of informal religious education. In terms of the religious-secular providers, two of them held a master's in counseling psychology, while one of them held a bachelor's in psychology. In terms of industries, secular counselors predominately (90%) worked in for-profit companies, and religious leaders predominately (94%) worked in both religious institutions and were self-employed while not charging for counseling. All three religious-secular counselors were also self-employed while not charging for counseling.

Procedure

This study was approved by the International Review Board at The University of Texas at Autin. The eligibility criteria for participants included providing formal or informal counseling to the greater public in Addis Ababa, Ethiopia.

The secular counselors were contacted and recruited in two different ways. One, the researcher contacted secular counselors via the career social media site of LinkedIn. Two, participants were recruited through snowball sampling. Once they reviewed information about the study and confirmed their eligibility criteria, they scheduled virtual interviews. Then, they were interviewed via secure video conferencing.

The Orthodox Christian religious counselors as well as the Orthodox Christian religious-secular counselors were recruited in three different ways. This included the passing of the study

information by community members, through Orthodox Christian religious institutions, and snowball sampling. Once they reviewed the study and confirmed their eligibility criteria via phone call or in person, they were scheduled for interviews at a time and secluded place convenient for them.

The semi-structured interviews lasted an average of 59 minutes, with a minimum of 34 minutes and a maximum of 1 hour and 32 minutes. All participants were provided with consent forms before the start of the interview, and they had to verbally assent to their participation before the researcher could start the interview. All participants were compensated 500 ETB for their time.

After verbally collecting demographic information, the researcher conducted a semi-structured interview in the local language of Amharic. This interview started with the researcher asking the participants to list two to three challenges that they most persistently provide counseling for. Then, as time allowed, the same questions were asked about the challenges the participants listed. Participants didn't always have enough time to discuss all the challenges they listed. The amounts of challenges they had the opportunity to discuss as compared to the amounts of challenges they listed depended on the length of time it took for them to get through the discussion around each challenge.

The interview asked about various aspects of each challenge. It asked about the prevalent demographic, the duration and development, the perceived causes and effects, the counseling approach, the help-seeking behavior, the perceived effectiveness, and the other possible treatments and providers for each challenge. These interviews were recorded via a manual audio recorder.

Data Analysis

First, the Amharic interview audios were transcribed verbatim and translated into English transcripts by a team of paid transcription and translation experts. Then, the researcher read through 20% of the interview transcripts and created question-by-question summaries for each transcript. The summaries were used to create reappearing categorizations of answers for coding purposes. With the help of the faculty supervisor and grad student mentor, the coding manual was developed. Using the coding manual, frequencies of various categories were counted to elicit prevalent themes across and in between the provider groups as discussed in the results section below.

Results

The coding resulted in the eliciting of prevalent themes across and between the groups of counselors. Overall, five categories of themes were identified. The categories were: (1) treatment focal points, (2) help-seeking, (3) cultural and linguistic interpretations, (4) causal explanations, and (5) counseling approaches.

Category 1: Treatment Focal Points

Theme 1a: Types of Challenges

Both the secular and religious counselors discussed counseling for a range of cognitive and functional level challenges. However, the challenges they most commonly deal with differed between the groups. The secular counselors mostly focused on treating cognitive level challenges. This largely included common mental disorders like depression and anxiety disorders. To some degree, it also included other cognitive level challenges like stress and hopelessness, developmental disorders, and severe mental illnesses. The religious counselors on the other hand, mostly focused on functional level challenges. This largely included marriage conflicts. It also included other interpersonal conflicts and unemployment. Figure 1 illustrates the relative frequencies of different groups of challenges discussed by the providers.

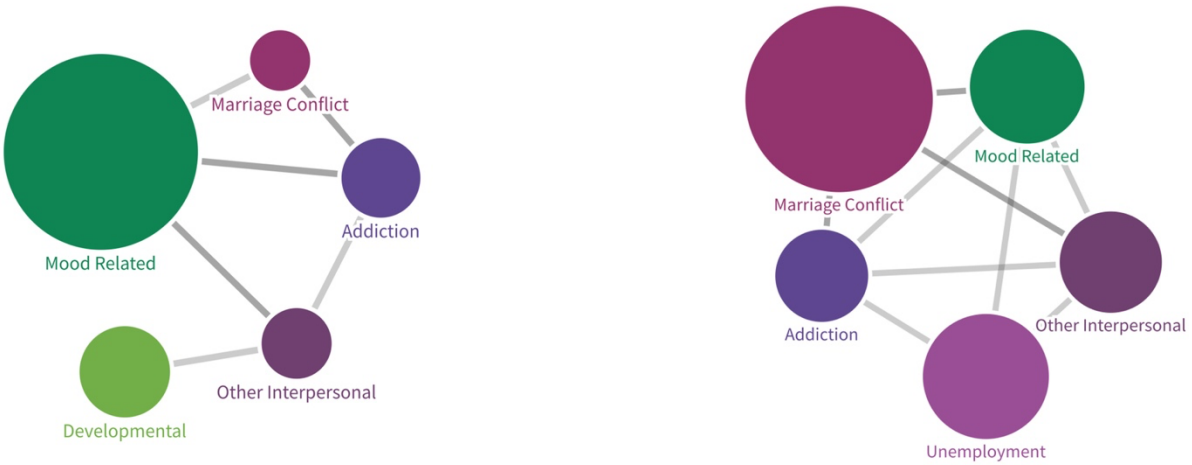
Theme 1b: Intersections

The perceived cause-effect relationships between the cognitive and functional level challenges were apparent. (12 of 17) secular counselors who treated CMDs or other mood-related problems cited interpersonal challenges in areas like marriage, parenting or others contributed to causing CMDs or other mood-related problems. (13 of 17) of the secular counselors also discussed that mood-related problems affect the functionality of people regarding

their interpersonal relationships, work, or other parts of their daily lives. Figure 1 illustrates the perceived ranges of cause-effect relationships of the challenges as discussed by the counselors.

Figure 1

Prevalence of Challenges by Secular Counselors (Left) and by Religious Counselors(Right)



Note. The figures represent groups of the most common challenges the counselors discussed as treating. The relative sizes of the circles correspond to the frequencies they were discussed by the groups of counselors. In regard to the color coding, the different shades of green indicate cognitive level challenges and the different shades of purple indicate functional level challenges. The lines illustrate cause-effect relationships as perceived by both groups of providers.

(10 of 17) secular counselors who discussed mood-related problems mentioned that those they treat with the most common challenges don't initally tend to come to get treatment for mood-related problems as conceptualized by the secular counselors. Instead, these individuals

tend to come to get treatment for other challenges like interpersonal conflict, physical illness, or what they perceive to be ailments caused by supernatural factors like spirit possession or curses.

> When they come for [anxiety], they come because there is a problem in their functionality. One is their social interactions maybe starting from their families. (Secular Counselor)

> In our society, there isn't an acceptance of mental illness as illness. Saying it is a mental illness is difficult in itself, and they don't accept it. They raise arguments like "its sleep problems that bother me, I don't have another illness". (Secular Counselor)

Category 2: Help-seeking

Theme 2a: Low help-seeking for Psychotherapy

In addition, (8 of 17) secular counselors who discussed mood problems mentioned that people seek help with them as their problems become unmanageable or as they lose daily function where components like academics, work, or interpersonal relationships are greatly affected. They emphasized the fact that as individuals do seek care with them, it is simply not to increase the quality of their lives, but to be able to gain some function in their daily lives.

> For most [with depression], it would be two years of having it until they contemplate and seek care with us….they come for help when they can't function anymore. (Secular Counselor)

> After the traumatic experience, trauma gets worse and worse and they come three to ten, or even twenty years after that. (Secular Counselor)

Theme 2b: High Help-seeking for Religious Treatments

(10 of 17) secular counselors who discussed mood-related problems mentioned that the individuals they counseled for these problems also sought care from religious sources. The providers mostly discussed that individuals previously or concurrently received religious treatments like holy water treatments, Kuran readings, prayers, and forms of religious counseling in their respective religions. However, religious counselors rarely mentioned care-seeking of individuals from secular counselors.

> A lot of times they think [depression] has spiritual or religious connotations so by the time they come to me, they have spent a lot of time in prayer, at holy water places, in Dua around Mosques for a long time, they go from church to church from religious place to religious place….in all the places that are said to have solutions they try and try. When it is unmanageable, usually they come to us as the last resort. (Secular Counselor)

Category 3: Cultural and Linguistic Interpretations

Theme 3a: Locally Conceptualized Mood-Related Problems

(2 of 5) religious counselors and (2 of 17) secular counselors that treated mood-related problems titled the mood-related problems that they discussed *Chenket(ጭንቀት)*. The locally conceptualized

challenges of *Chenket(ጭንቀት)* and *Debert* or *Debate(ደብርት/ድባቴ)* were also discussed within interviews. However, the use of these terms as related to Western psychological diagnoses or challenges was unclear. Their translations to English terms varied and the words they interchangeably used alongside them varied.

> A lot of them understand depression as Chenket, they come and say they are in Chenket. in our society, there is difficulty telling Chenket and debert or debate apart. (Secular Counselor)

Theme 3b: Translating Psychological Concepts

(9 of 19) secular counselors discussed the difficulties of communicating Western psychological concepts to the individuals they treat. This included difficulties when encountering English terms without direct Amharic translations, differentiating between different words that are categorized together in Amharic, or even managing the expectations around the ideas and goals of "*Mikir*", the word for both counseling and advice.

> So for example, we tell [middle aged, older or uneducated people] to write down automatic thoughts when some event happens. Then, they don't write their automatic thoughts but they write about the event…they don't understand the [concept of] automatic thoughts… it is also hard for them to understand working on distortions. (Secular Counselor)

> Let me ask you, what is emotion in Amharic? what is feeling in Amharic? what is mood in Amharic? What is sense in Amharic? It's all "Semet". So, the client doesn't understand which "Semet" we're talking about. (Secular Counselor)

Category 4: Causal Explanations

Theme 4a: Environmental and Psychological Explanations

All three groups of counselors largely included environmental or psychological causal explanations for the range of challenges discussed. The state of the country including conflict, displacement, and economic situation was mentioned for both cognitive level challenges like anxiety, and functional level challenges like unemployment.

> The state of the country is disheartening…when students heard the government didn't have the capacity to hire, they lost hope. (Religious Counselors)

> There was war in Tigray and those whose families live there and died because of war come affected [with depression]....especially in Addis Ababa right now, the economic pressure is very high, this pressure is the most on the young adults…and can cause depression. (Secular Counselor)

Individual-level environmental causes were also discussed as causes. For functional challenges like marriages, this included stressors like financial issues or interpersonal factors like

outside meddling. For cognitive level challenges like depression, this included causes like the effects of parenting or bullying on cognitive level challenges like depression.

> Marriage conflicts can happen because of different problems…not getting to the economic place they want to get to or getting stressed about the cost of living. (Religious-secular Counselor)

> Sometimes the youth that have depression have abusive families or get bullied at school and they can't express that, so they express it through [feelings or behaviors]. (Secular Counselor)

In highlighting the role of personal accountability, religious counselors also tended to include a mix of cognitive and behavioral causes. For example, (9 of 13) religious counselors who counseled for marriage conflicts cited causes like dishonesty, arrogance/ego, the want for novelty, or having unrealistic expectations as possible causes for marriage conflicts.

> For example, the income of a person is one thousand. If he says he has to be like someone else that makes ten thousand, where would he get the nine thousand? At that time, he gets Chenket. They get it by thinking they can be what they are not. (Religious Counselor)

> The hurdle for a lot of marriages is saying “only what I say goes”. (Religious Counselor)

Theme 4b: Physiological Explanations

(9 of 19) secular counselors ascribed a range of possible physiological causes to the various challenges. These included factors like genetics, chemical imbalances, physical illness, other mood disorders, vitamin deficiencies, and more. These ascribed causes were prevalent in all groups of cognitive challenges they treated including mood-related challenges, addiction, developmental disorders, and severe mental illnesses. These causes were not ascribed by any of the religious or the religious-secular counselors.

> Similar to depression, substance use has biopsychosocial causes. it is said to have some degree of genetic deposition. If some family had it, this young man depending on his upbringing circumstances, stressors, and coping mechanisms, the probability he will get into it is higher. (Secular Counselor)

> Causes [of Chenket] usually could be biological or genetic causes like the imbalance of chemicals or neurotransmitters. (Secular Couselor)

Theme 4c: Supernatural Explanations

(4 of 5) religious counselors that treated mood-related challenges gave supernatural causal explanations of spirit possession caused by witchcraft curses or other factors like spiritual estrangement. This was also further emphasized by mentions of individuals who come for these challenges displaying exorcism-related bizarre behaviors even when they tend to behave normally in their daily lives. There were also mentions of evil spirit causing or exacerbating

functional challenges like interpersonal conflicts. Although (6 of 19) secular counselors mentioned individuals they treat having similar perceptions of supernatural causes, none of the secular counselors discussed the role of supernatural factors possibly causing the challenges they treat.

> Satan leverages the person's aggressiveness and makes [the married couple] conflict…satan gets in people that aren't strong in their faiths…satan slides in like melted butter and makes us desire adultery, tells us to say [negative] things. (Religious Counselor)

> Satan makes them lose hope to not do their business, to not marry the person, to not finish their school. The spirit's work is to interrupt a person from getting grace and honor. (Religious Counselor)

Category 5: Counseling approaches

Theme 5a: Secular Counseling

(19 of 19) the secular counselors mentioned providing different types of psychotherapies or using psychotherapy features as appropriate to the challenges and goals of individuals seeking care. Largely, these techniques focused on cognitive levels as they aimed to resolve or improve the challenges of individuals by altering the ways they perceive and understand different components. This also included the diagnosis of various disorders or psychological ailments and psychoeducation aiming to interpret these challenges. The secular counselors also mentioned

including factors like setting and assessing goals or assigning therapeutic assignments that aim to have individuals exercise and evaluate the counseling they are receiving.

> For anxiety, I use cognitive therapy or exposure therapy…instead of avoidance, they can challenge… I also use the slightly different systematic desensitization therapy. (Secular Counselor)

> [For married couples] we separate elements that prevented them from solving problems…we psycho-educate their emotions, then after we practice that, we talk about the problems. (Secular Counselor)

Theme 5b: Religious Counseling

In their counseling approaches, religious counselors generally discussed focusing their counseling on the functional level of individuals. (16 of 17) discussed focusing on guiding individuals to improve the outcomes of their challenges by taking control and accountability for the various actions that cause or exacerbate the challenges they seek treatment for. To do this, they discussed reprimanding negatively consequential behaviors, giving orders, advice, and recommendations that aim to help solve the problem. They also aimed to empower individuals to take a variety of actions perceived to improve or resolve their challenges.

> I tell the man “Don't expect her to be like when she was during dating. She is carrying one hundred percent of your burden. For her, you are one husband, but she is also taking care of her other husbands who are her children. (Religious Counselor)

> I tell [person experiencing family conflict] if you have enough money for rent, live on your own and God will provide. (Religious Counselor)

(15 of 17) religious counselors also discussed including religious components that aim to support these techniques. This largely included religious teachings and messaging that aim to provide an ideal framework for how individuals should navigate these challenges. In encouraging efforts to get closer to God or increase participation in religious services and rituals, this aimed to have individuals increase adherence to God. Through that, they are perceived to help individuals feel comforted or equip them to resolve or improve the variety of challenges they treat individuals for.

> When Job(a biblical figure) lost his health, wealth, and children, and when he said God takes what he gives, satan was embarrassed and [God] gave Job double the grace. So he will give it to you also. The main thing is don't be out of God's will and love. (Religious Counselor)

> I invite him to listen to spiritual songs…he can hear about the kindness, compassion, and mercy of God, about the lovingness of Mary so he'll slowly return to thinking he won't stay like that and that he has a God that will heal him.. I tell him to read spiritual books….to go to monasteries. (Religious Counselor)

(14 of 17) religious counselors also mentioned aiming to console or comfort the individuals who came with a variety of challenges. To do this, they used a variety of techniques including the normalization and reframing of the individuals' challenges aiming to lessen the perceived burden, abnormality, or feelings of isolation related to their challenges. They also aimed to give hope and faith both in natural possibilities and in the power of God.

> [For addiction] we show the life experience of others so they can see. A lot of them don't come because they lack knowledge, they want to see the experience of how others were able to do it. (Religious Counselor)

> We're in a world that wasn't even comfortable for Christ….he went through tests that we are also bound to be tested by. For example, when you learn at school, you have tests. You got to this point because you passed those tests….Just like you wouldn't get here if you didn't pass those tests, there are always tests while living with God. (Religious Counselor)

Theme 5c: Religious Secular Counseling

The religious secular counselors combined features that were present among both of the other two groups of providers. All 3 of these providers did not mention using types of psychotherapies but included psychotherapy techniques like drawing solutions from clients and assigning assignments. (2 of 3) of these counselors also mentioned aiming to change the internal perceptions of the individuals. These counselors also included counseling techniques prevalent among the religious counselors' group. (1 of 3) religious-counseling providers mentioned giving

recommendations to taking personal responsibility, and all 3 of these providers included religious components like religious teachings and giving hope in the deities that the individuals worship.

> I give client-focused assignments because I think a person is his own doctor. (Religious-secular Counselor)

> They lose hope and they cry, and with the therapy, we tell them to think of God. If he is a protestant we say "You have a God you worship, don't you? How did you worship? So where did that go? If it doesn't console you now, when will it console you?" If he is Muslim, we say "You believe in Allah, don't you? What does your faith say to you? How does your faith tell you can solve these things?" (Religious-secular Counselor)

Theme 5d: Additional Treatments

(15 of 17) religious counselors discussed providing a range of additional services for the individuals they counseled. These services included religious treatments like prayer and holy water, as well as counseling supporting components like religious teachings they use to exemplify the ideal ways of feeling, thinking, and behaving in ways that are perceived to resolve or improve the various challenges. They also discussed providing interpersonal-related services like reconciliation between couples and connecting the individuals experiencing unemployment with other people who may be able to get them employed.

> The big thing is prayer, we prioritize prayer on whatever thing…it is to counsel with God as his will is necessary. (Religious Counselor)

> When those who can't find work come, if there are people able to get work for them according to their professions…we have them connect through us. (Religious Counselor)

The secular counselors identified additional treatment as related to medication. The (2 of 2) secular counselors practicing psychiatry mentioned prescribing medication, and overall, (4 of 4) secular counselors who commonly treated severe mental illnesses discussed working on medication management with the individuals experiencing these challenges.

[For depression], a lot of the time we start with the medication then the counseling comes next. (Secular Counselor)

[For psychosis], we talk about what could happen if they stop taking the medication…how they have to continue taking it after being discharged, what things can help them with that. (Secular Counselor)

Discussion

The study's findings revealed that although the different groups of providers mostly treated similar range of challenges, the secular counselors most commonly treated cognitive level challenges while the religious counselors most commonly treated functional level challenges.

The most common challenges treated by the secular counselors were common mental disorders, and the most common challenges treated by the religious counselors were marriage conflicts.

Through their perceived cause-effect relationships, the intersectionalities of the various groups of challenges were also highlighted. This is consistent with other research highlighting associations of common mental disorders or other cognitive level challenges with functional challenges like marriage conflicts, addiction, or unemployment in the Ethiopian context (Mokona et al., 2020; Dachew et al., 2017; Tasew & Getahun, 2021). Even in broader contexts, the associations between functional challenges like interpersonal issues and cognitive challenges like common mental health disorders are well documented (Salzer et al., 2010; MckeeRyan et al., 2005; Paul & Moser, 2009).

This study also revealed insights about help-seeking behaviors of individuals. The secular counselors revealed that individuals tend to seek help with them as their challenges are in the the most advanced ltages, and they also discussed that the individuals seek a variety of religious care prior to or concurrently with the care they provide. Religious leaders however, rarely mentioned that the individuals they treated sought any form of secular counseling or mental health care. This is consistent with the high help-seeking for religious treatments and low help-seeking for secular treatments for mental health related issues in the Ethiopian context (Alem et. al, 1995; Jacobsson, 2002; Law, 2021).

Findings also included cultural and linguistic nuances related to cognitive level or mood related concepts in the cultural context. One, all groups of counselors discussed the common mental health challenges termed *Chenket(ጭንቀት)* and *Debert* or *Debate(ደብርት/ደባቴ).* The direct English translations of these terms were unclear and different among the providers. Two, among secular counselors, there were mentions of having difficulties communicating psychological

concepts to clients because of the lack of direct translations and awareness which also affected interpretations. Local conceptualizations of mental health challenges are apparent in different contexts and can give insights into how mental health is interpreted (Osborn et al., 2021; Kirmayer & Groleau, 2001).

Both groups primarily gave environmental and psychological causal explanations for various challenges. Environmental challenges or stressors including the state of the country, interpersonal challenges within and outside the household, as well as financial and other stressors were included as causes for various challenges by all secular, religious, and religious-secular groups. Psychological causal explanations included factors like coping mechanisms among the secular counselors and factors like perceptions and traits among religious counselors. This is also consistent with other studies in the context that cited perceptional causes for marriage and other interpersonal conflicts (Tasew &Getahun, 2021; Berhanu, 2008).

There were also causal explanations exclusively apparent in each provider group. The secular counselors included physiological explanations largely for cognitive challenges like common mental disorders and severe mental illnesses, as well as for the functional challenge of addiction. This included factors like genetics, hormone imbalances, or other physical illnesses, This is consistent with existing literature that incorporates physiological causal explanations for these groups of challenges (Smoller, 2015; Levison, 2006). The religious counselors exclusively included supernatural explanations largely for the cognitive level challenges and to some degree for functional level challenges. This included causes like evil possession in mood related challenges and the meddling of evil spirit in interpersonal relationships like marriages. Although none of the secular counselors included these supernatural explanations, there were mentions that the individuals they treated had similar supernatural interpretations. This is also consistent with

the existing literature noting the prevalence of supernatural explanations for mental health issues in the Ethiopian context (Jacobsson, 2002; Hailemariam, 2015; Asfaw 2015).

In regard to the counseling approaches, the secular counselors provided psychotherapy and used psychotherapy features like working to change perceptions and setting and assessing various goals. The religious counselors largely provided guidance that focused on aiding individuals problem solve by taking control and accountability of their various challenges. They also aimed to console and empower individuals to resolve or improve their challenges. In that, the religious counselors included religious teachings and recommended greater adherence to spirituality and religious features like rituals and practices. This could be beneficial for wellbeing as participation in religious practice is associated with a lower risk of mental distress in the Ethiopian context (Dachew et al., 2017). The religious-secular counselors combined features from both groups as they worked on perceptions and also used religious components like teachings and encouraged the greater adherence to spirituality and religious rituals and practices.

Limitations and Future Directions

This study should be interpreted in ways that consider its limitations. First, there is limited generalization to the broader counseling provider groups. This is a result of convenience-based participant recruitment based on the researcher's limited access, the exploratory nature of the study, and the small sample sizes. For example, only recruiting secular counselors who are users of the social media site LinkedIn excludes groups of nonusers. Also, demographic data regarding age differs in between the groups and may have implications on the interpretations within the study. Second, due to its exploratory and qualitative nature, there is a possibility of subjectivity bias present during the data collection, analysis, and interpretation processes. The analysis method also utilized manual coding and that allows the possibility for human error.

Although the researcher is fluent in the language the interview was conducted in and is a native of the cultural context, it is possible that cultural or linguistic nuances were incorrectly interpreted.

Future research should continue exploring a variety of essential aspects of the coexisting care system. This includes exploring counselors' perceptions of the counterpart group of counselors along with their interpretations and counseling approaches. The local interpretations or conceptualizations of mental health issues could also be explored further to highlight their implications within the context's understanding. Future explorations would also benefit from studying the interpretations and treatment approaches through quantitative approaches that utilize themes such as the ones elicited in this study. Including larger sample sizes, especially of counselors that bridge secular and religious counseling features, would be essential to further emphasize what integrations of these belief and care systems could look like. Due to the incredible diversity of the Addis Ababa or Ethiopian context, future research should also explore interpretations of challenges and counseling approaches among religious counselors within different religious communities, as well as among other non-religious traditional providers.

Conclusion

This study contributes to the understanding of coexisting evidence-based and traditional mental health care systems in the Ethiopian context. The different counselor groups had both similarities and differences in the ways they interpreted and treated a variety of challenges that individuals receive counseling for. The elicited themes in this study further highlight the need to explore the local conceptualizations of different challenges and approaches that aim to promote wellbeing to individuals and communities.

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