ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLEGE OF SOCIAL SCIENCES
DEPARTMENT OF SOCIAL ANTHROPOLOGY

M.A Thesis

On

The Conceptualisation of Mental Illness and its Treatments: Views of Clients, Caregivers and Service Providers in Addis Ababa

By: Ermyas W/Yohannes Mallowa

Advisor: Guday Emirie (PhD)

A Thesis submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfilment of the Requirements for the Degree of Master of Arts in Social Anthropology

October 2016

Addis Ababa, Ethiopia

ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLEGE OF SOCIAL SCIENCES
DEPARTMENT OF SOCIAL ANTHROPOLOGY

M.A Thesis

On

The Conceptualisation of Mental Illness and its Treatments: Views of Clients, Caregivers and Service Providers in Addis Ababa

By

Ermyas W/Yohannes Mallowa

October 2016
Addis Ababa, Ethiopia

ADDIS ABABA UNIVERSITY

SCHOOL OF GRADUATE STUDIES

COLLEGE OF SOCIAL SCIENCES

DEPARTMENT OF SOCIAL ANTHROPOLOGY

The conceptualization of Mental Illness and its Treatments: Views of Clients, Caregivers and Service Providers in Addis Ababa

By

Ermyas W/Yohannes Mallowa

Approved by Board of examiners

______________________	______________
Chairman, Department graduate committee	Signature
Guday Emirie	
Advisor	Signature
Gebre Yntiso	
Examiner	Signature
Zena Berhanu	
Examiner	Signature

Dedication

This thesis is dedicated to all who supported me in one way or the other in my education ambition.

Acknowledgements

I am heartily thankful to my advisor, Dr. Guday Emirie, for her patience, constant advice and guidance throughout this study. I am lucky to have had the privilege to learn under her instruction.

I would like to express my deepest gratitude to Amanuel Mental Specialised Hospital (AMSH) administration for allowing me access to the mental health facility and cooperation in every aspect of the fieldwork there.

I am extremely grateful to the study participants from both Amanuel Mental Specialised Hospital, as well as those at Entoto Maryam who willingly shared their experiences and perspectives with me. This study would not have been possible without their active participations.

I wish to show my appreciation to Rafael HabteWold, Dr. Joachim Persoon, Adamu Legesse, Dr. Dan Levene, Jon Nykamp, Dr. Karen Salmon, Zola Tadesse and all who encouraged me to pursue this study.

Finally, I offer my regards and blessings to my dear brothers and sisters who supported me in any aspect during the completion of the project.

Table of Contents

Content **Page**

Acknowledgements........ i
Table of Contents........ ii
List of Figures........ iv
Acronyms and Abbreviations........ v
Glossary of Local Terms........ vi
Abstract........ vii

Chapter One
Introduction........1
1.1 Background of the Study 1
1.2 Statement of the Problem 1
1.3 Objectives of the Study........2
1.3.1 General Objective 2
1.3.2 Specific Objectives 2
1.4 Scope of the Study........3
1.5 Limitations of the Study........3
1.6 Significance of the Study 3

Chapter Two
Review of Related Literature........4
2.1 Conceptual and Theoretical Frameworks 4
2.1.1 Conceptualisation of Key Terms 4
2.1.2 Theoretical Frameworks 7
2.2 Review of Related Empirical Studies 12

Chapter Three
Research Methodology, Description of the Study Area and Mental Health Services........15
3.1 Research Methodology 15
3.1.1 Research Approach 15
3.1.2 Methods of Data Collection 16
3.1.2.1 Primary Data Collection Methods 16
3.1.2.2 Secondary Data Collection 19
3.1.3 Method of Data Analysis........ 19
3.1.4 Ethical Considerations........ 19
3.1.5 Fieldwork Experiences........ 20
3.2 Description of the Study Area 23
3.3 Biomedical and Religious Mental Health Services in Addis Ababa 24
3.3.1 Brief History of Biomedicine in Ethiopia 24
3.3.2 Amanuel Mental Specialised Hospital (AMSH) 25
3.3.3 Ethiopian Orthodox Tewahedo Church (EOTC) 26
3.3.4 Entoto Maryam Church 28

Chapter Four: Biomedical Therapy **30**
4.1 Conceptualisation of Mental Illness 30
4.1.1 Patients Conceptualisation of Mental Illness 30
4.1.2 Caregivers Conceptualisation of Mental Illness 33
4.1.3 Professional Health Workers Conceptualisation of Mental Illness 34
4.1.3.1 Causes of Mental Illness 36
4.1.3.2 Effects of Mental Illness on Patients' Life 37
4.1.3.3 Concerns Diagnosis Causes to Patients 38
4.2 Opinions and Attitudes towards Treatment and Care 40
4.2.1 Patients' Opinions and Attitudes on Forms of Care and Extent of Satisfaction 41
4.2.2 Caregivers' Opinions and Attitudes on Forms of Care and Extent of Satisfaction 43
4.2.3 Patients' and Caregivers' Point of Discontent 46
4.2.4 Professional Health Workers Opinions and Attitudes on Forms of Care and Extent of Satisfaction 48
4.2.4.1 Forms of Care/Treatment 48
4.2.4.2 Extent of Satisfaction – AMSH 50
4.2.4.3 Extent of Satisfaction by Care given by Others 51
4.3 Lived Experiences of Patients in Health Care Systems 53
4.3.1 Challenges in Seeking Care and Means of Solution 53
4.3.2 Agency among People with Mental Illness 57
4.3.2.1 Factors that Facilitate Patients' Involvement 59
4.3.2.2 Factors that Constrain Patients' Involvement 59

Chapter Five: Religious Therapy **62**
5.1 Conceptualisation of Mental Illness 62
5.2 Opinions and Attitudes towards Treatment and Care 66
5.2.1 Forms of Care and Officiating Personnel 66
5.2.2 The Interaction inside the Healing Hall and around *Tsebel* Site 69
5.2.3 The Use of Psychiatric Medication at *Tsebel* and the Prevailing Worldview 70
5.2.4 Extent of Satisfaction by Others 75
5.3 Lived Experiences of Patients in Health Care Systems 76

Chapter Six: Summary and Conclusion **79**
6.1 Comparative Summary of Major Findings from AMSH and Entoto Maryam 79
6.1.1 Conceptualisation of Mental Illness 79
6.1.2 Opinions and Attitudes towards Treatment and Care 80
6.1.3 Lived Experiences of Patients in Health Care Systems 82
6.2 Concluding Remarks 83

References **86**
Appendices **91**
Appendix 1: Fieldwork Research Guiding Questions – English **91**
Appendix 2: Fieldwork Research Guiding Questions – Amharic **95**
Appendix 3: List of Patients and Caregivers Interviewed at AMSH.......... **100**
Appendix 4: List of Psychiatric Health Workers Interviewed at AMSH.......... **102**

List of Figures

Figure 1: Location Map of Addis Ababa City and the Sub-Cities 24

Acronyms and Abbreviations

AMSH	Amanuel Mental Specialised Hospital
ART	Antiretroviral therapy
CSA	Central Statistics Authority
DSM	Diagnostic and Statistical Manual of Mental Disorders
E.C	Ethiopian Calendar
ECT	Electroconvulsive therapy
EOTC	Ethiopian Orthodox *Tewahedo* Church
FDRE	Federal Democratic Republic Ethiopia
HIV	Human Immunodeficiency Virus
OCD	Obsessive-Compulsive Disorder
OPD	Out-Patient Department
WHO	World Health Organisation

Glossary of Local Terms

Abba	title used in Ethiopian Orthodox church to refer to a monk
Astemami	attendants found in *tsebel*
Atmaqi	the priest presiding over exorcism at *tsebel*
Balazar	Amharic term for spirit diviners
Birr	Ethiopian national currency
Chinket	literally stress
Debtera	it is a title used to refer to religious diviner in Ethiopian Orthodox Church and also scholars and servants of the tent tabernacle
Ibd	literally crazy or mad
Kebele	Amharic term used to refer to Ethiopian lower level administration unit, an association under Woreda administration
Markesha	is a kind of medicine provided by diviners to subdue the power of *medhanit*
Medhanit	literally medicine, it also means a potent concoction provided by diviners that can be used to harm a targeted individual
Tenqway	an indigenous medicine expert with capability of both healing and also inflicting illness on an individual
Tsebel	literally Holy Water, it is faith based healing practiced by Orthodox Christians, it is also used to refer to place where Holy Water therapy is based
Tsebeltegna	one who has come for the *tsebel* therapy
Tselot	literally prayer, also commonly used to describe Protestant's healing ritual
Woreda	is an Amharic term, which represents the Ethiopian government administrative body next to Zonal administration, equivalent to district.

Abstract

The mental health has long been neglected in Ethiopia, most sufferers resort solely to indigenous religious healing therapies, and there is an extreme lack of awareness of mental related issues. In order to improve the provision of mental health care we need to understand better how mental health is perceived and how the indigenous religious and the biomedical therapies interact with each other. Thus, the primary purpose of this study is to explore the conceptualisation of mental illness and its treatments from the perspective of clients, caregivers and service providers, in specific sites in Addis Ababa from an ethno-medical perspective. Use was made of an ethnographic approach, i.e. a sub-branch of the qualitative approach, employing primary and secondary data collection methods. The former including informal conversation, in-depth interviews, and participant observation the latter was based on critical review of related literature and documents. All data were organized thematically and analysed using inductive thematic analysis.

There was a period of intense field research including total immersion in the life context of two specific carer communities, one providing professional psychiatric care and the other a holy water therapy centre. This facilitated gaining in depth insights concerning indigenous concepts and their relation to biomedical care. The motivating idea of the study is that in depth knowledge of the life experience of care communities is the key to improving them.

The study found that the conceptualisation of mental illness varied according to the individual's context. The mentally ill were initially cared for by family members, followed mainly by religious therapy and perhaps subsequently by biomedical treatment. Hospital treatment is based on a biopsychosocial model, stressing on supplying medicine to patients, although the continuation of religious therapy was not prohibited even after admission to the hospital. Factors facilitating the involvement of patients in their own care were found to induce agency and the absence of such factors constrained agency. Thus, based on the research, one can conclude that religious therapy is inherently agency oriented and the most accessed form of therapy for mental illness. Consequently, there is a need to integrate biomedicine with religious therapy in order to provide mental health services that is culturally appropriate and patient-centred.

Chapter One

Introduction

1.1 Background of the Study

Mental illness, as understood by biomedical psychiatry, is highly prevalent worldwide, with hundreds of millions of sufferers. It is estimated that 80% of persons with mental health problems live in low and middle-income countries (WHO, 2010). Around 90% of these individuals have no access to biomedical care.

Current trends such as very rapid urbanisation and international migration are thought to have increased the potential and extent of the problem (CSA, 2007; Harpham and Blue, 1995). At the same time, the response to mental illness and the treatment offered reflects the changing tides of political, economic and social trends. The records of the global burden of disease mention high incidence of mental disorders as much as 14% (WHO, 2010).

My interest in this topic was aroused when I read an article (Addis Standard, January 5, 2015) describing the involvement of psychiatrists with people with mental illnesses at the local Ethiopian Orthodox Tewahedo Church (EOTC) *tsebel* (holy water) sites in Addis Ababa, the capital city of Ethiopia. Consequently, I realized that this is an important area of study, the results of which could be used to make mental health services culturally appropriate and patient-centred.

1.2 Statement of the Problem

The interface between mental health and religion has scarcely been explored. The existing body of research on mental illness in Ethiopia has mainly focused on issues such as: the association between poverty and common maternal mental disorders (Yosef, 2014); barriers to care for physical co-morbidities among severe mental illness patients (Desalegn, 2015); types and extent of mental and behavioural disorders of children in Addis Ababa city (Menelik, 2008); psychotic disorders among semi-nomadic Borana and the chewing of *khat* among the mentally ill (Solomon, 2011); perceived challenges and opportunities arising from integration of mental health into primary care in South-West Ethiopia (Mubarek et al., 2014); challenges and prospects

of mental hospital rehabilitation centres (Yitbarek, 2015); prevalence, determinants and effects of mental disorder among university students (Galmessa, 2005); and the economic burden of schizophrenia and bipolar disorder in rural Ethiopia (Ababi, 2008) among others. Although many of these studies have been undertaken at either community or institutional level, less focus has been given to the socio-cultural aspects of mental illness with reference to integrating religious therapy with psychiatric therapy to raise the level of effectiveness of mental health care systems in Addis Ababa in particular and in Ethiopia at large. Yet religion plays an influential role in the life of most Addis Ababa residents as it does in the whole country. Moreover, even residents of Addis Ababa often have recourse to services offered by religious healers for relief from their maladies especially mental illness.

This ethnographic study aspires to contribute towards filling the gap, created by the absence of studies that explore the conceptualisation of mental illness and its treatments from the perspective of clients, caregivers and service providers at both Amanuel Mental Specialised hospital and Entoto Maryam *tsebel* in Addis Ababa from a medical anthropological perspective.

1.3 Objectives of the Study

1.3.1 General Objective

The overall objective of this study was to explore the conceptualisation of mental illness and its treatments from the perspective of clients, caregivers and service providers, specifically at Amanuel Mental Specialised Hospital and Entoto Maryam *tsebel* in Addis Ababa from ethno-medical perspective.

1.3.2 Specific Objective

This study specifically attempted to:

1. investigate how mental illness is conceptualised based on the ethno-medical context within which patients' illnesses are located;
2. examine the opinions and attitudes towards treatment and care in the research settings; and
3. explore the lived experiences of patients with mental illness in the research settings.

1.4 Scope of the Study

This study focused mainly on the ethno-medical aspects of perceptions of mental illness in both psychiatric and religious therapeutic care-centres in the city of Addis Ababa. Addis Ababa had been chosen as the study area because it hosts the country's main psychiatric services, which is Amanuel Mental Specialised Hospital; as well as major religious centres for healing, at Entoto Maryam *tsebel* which also had a reputation of being particularly effective in cases of mental illness.

1.5 Limitations of the Study

The researcher made an effort to produce a first-hand data empirical study on care centres for people with mental illness in Addis Ababa city. Nevertheless, the study has the following limitations: there was a scarcity of related empirical studies done both locally and globally on biomedicine and religious therapy pertaining to mental care. Another limitation concerned difficulty in translation of the transcripts, evidently due to difference in cultural, social and habitual expressions in Amharic and English languages.

1.6 Significance of the Study

Exploring and understanding the perceptions of mental illness among people in need of care, their caregivers, and the mental health professionals is of great potential benefit in dealing with the observed on-going deteriorating situation, characterized by the high number of mentally ill who remain unattended. Consequently, such knowledge could be vital for the development of public health initiatives and the promotion of engagement in all quarters according to the policy propagated by the Ethiopian Federal Ministry of Health's (FMOH) National Mental Health Strategy (2012/13-2015/16).

The results from this ethnographic study will stimulate further research in the field, ultimately contributing to the informed advanced integration of both religious and psychiatric therapeutic care and thus decrease the number of unattended cases of mental illness in the city of Addis Ababa. This study will help bring awareness on the nature of mental illness and the need to conduct studies that incorporate the voices of the mentally ill individuals.

Chapter Two

Review of Related Literature

2.1 Conceptual and Theoretical Frameworks

2.1.1 Conceptualisation of Key Terms

Health

There is a gradual acceptance that health has psychological and social dimensions in addition to biological ones. 'Health' was defined by the World Health Organization in 1978 as "not merely the absence of disease and infirmity but complete physical, mental and social wellbeing" (Baer, Singer, and Susser, 2003:4). Scheid and Brown (2010) describe mental health as not merely the absence of disease or disorder, but rather as encompassing self-esteem, mastery, and the ability to maintain meaningful relationships with others. Among medical anthropologists, 'health' is regarded as a cultural construction with considerable variation in meaning from society to society or from one historical period to another (Baer et al., 2003).

Disease, Illness and Sickness

Disease, illness and *sickness* are concepts of great significance in medical anthropologists' study of *health* and related issues in human society. Scholars with experience in both biomedicine and the social sciences: Andrew Twaddle, Arthur Kleinman, Leon Eisenberg, among others; have come up with a clear demarcation of the use of these conceptual terms.

Disease is defined by Twaddle (1980) as an 'objective' phenomenon that can be measured through laboratory tests, direct observation, or other 'signs'. He states that it is what happens to individuals when their physiological functioning departs from 'normal' or they become hosts to other organisms which limit life expectancy or capacities. Twaddle considers *Illness* to denote the more subjective or psychological dimensions of non-health that are generally of more immediate concern to the people experiencing them. *Illness* is what worries people either because of immediate discomfort, its effects on capacities for social functioning, or what they think it may signify in their lives.

According to Twaddle (1980), *sickness* refers to the social dimension; the result of being defined by others as 'unhealthy' due to one's failure to meet social obligations as the result of *disease* or *illness*.

Kleinman (1980, 1986) adds to this understanding by stating that the medical profession considers *disease* as an alterations or dysfunction in biological and/or psychological processes; while *illness* is about how one perceives, experiences, and copes with a *disease* or condition through personal, interpersonal, and cultural reactions. He considers sickness as a blanket term used to label events involving disease and/or illness.

In regard to these factors, people who are ill are usually assigned a complementary socially determined role that conveys a socially recognized set of expectations and obligations, since *illness* is placed within the social and cultural context of the patient (Parsons, 1991).

Kleinman urges medical anthropologists to recognize that their domain is *sickness*, even though their special contribution mainly regards issues surrounding *illness*. Furthermore, anthropologists emphasise that *illness* and *disease* should be understood within a holistic perspective that covers all forms of therapy within the health care system of a specific culture (Kleinman, 1980; Young, 1982). In this study, the researcher used the term *illness* instead of *disease*.

Mental Illness

The concept *mental illness* is difficult to define, since what constitutes mental health changes over time. And the subject is enshrouded by mystery, misconception, and misunderstanding (Thompson, 2007).

The mystery and misunderstanding behind the subject is due to several reasons ranging from: the conception of *health* and *illness* as a continuum, that is, *health* and *illness* are at opposite ends of the poles and most of us fall somewhere in between (Scheid and Brown, 2010); dispute among psychiatrists over the very existence of mental *illness* (Thompson, 2007); ethnocentric based studies done during the colonial era by which certain societies such as those of Asia and Africa were believed to be incapable of experiencing depression because their brains were less

health care conducted by sick persons themselves, their families, social networks, and communities and also including a wide variety of therapies, such as special diets, herbs, exercise, rest, and baths; the *folk* sector which encompasses diverse healers functioning informally, such as herbalists, massagers, bonesetters, midwives, mediums, *atmaqi*, and magicians and; the professional sector which encompasses the practitioners and bureaucracies of both *biomedicine* and professionalized heterodox medical systems, such as Ayurvedic medicine.

Biomedicine

This is the term commonly used by social scientists to distinguish the Western medical system that became globally dominant during this century eclipsing alternative systems. It is also known under a variety of labels, such as regular medicine, allopathic medicine, scientific medicine, modern medicine, and cosmopolitan medicine. Biomedicine's primary tenets are mind/body dualism and physical reductionism; that means that its main focus is upon human physiology and even more specifically on human pathophysiology (Hahn, 1983).

Religion

Religion has continued to intrigue specialists and lay people alike. The definition given for *religion* varies depending on the focus of emphasis, such as: social involvement with deities; cognitive and ritualistic aspects; existential dilemmas; involvement with symbols, rituals and beliefs; cognitive, interactional and ritualistic dimensions among others. Scholars generally agree that *religion* should be understood as a multifaceted form of behaviour with endless potential modes of expression and not a homogenous whole (Schumaker, 1992).

Agency

Agency is the capacity of individual to act independently of structural constraints (Rapport and Overing, 2000).

2.1.2 Theoretical Frameworks

Theoretical perspectives used in medical anthropology are complicated by variations in theory categorization. In their theory building, medical anthropologists have been influenced by varying approaches ranging from functionalism, structuralism, ecological perspectives, interpretive/

symbolic theory and political economy (Baer et al. 2003). Below is a brief overview of the common theoretical perspectives that are used in studying mental illness.

Ethno-medicine

The term *ethno-medicine* first emerged in the 1960s, and was used to refer only to non-Western health systems which were initially considered to be *primitive*. Currently the term encompasses all health systems as practiced everywhere, even the dominant biomedicine which is practiced in urban hospitals, for it too represents a 'culture of medicine' with its own values, beliefs, and social organization. Thus ethno-medicine is the study of health systems of specific cultures (McElroy and Townsend, 2009).

The focus of the ethno-medical perspective is on health beliefs and practices, cultural values, and social roles. Consequently, health ethnographies encompass beliefs, knowledge, and values of specialists and lay people; the roles of healers, patients or clients, and family members; the implements, techniques, and pharmacopoeias of specialists; legal and economic aspects of health practices; and symbolic and interpersonal components of the experience of illness (Levinson, 1997; McElroy, 2002).

Arthur Kleinman (1980), a renowned medical anthropologist and psychiatrist introduced a key concept in ethno-medicine known as the 'explanatory model', further developed by Helman (2007). This approach is based on the belief that reality is socially constructed. Explanatory models (EMs) are notions about the causes of illness, diagnostic criteria, and treatment options. Kleinman's EM distinguishes illness from disease as well as healing from curing. His concept shows that individual cultures provide people with ways of thinking that are simultaneously models of and models for reality. Thus, EMs concurrently create order and meaning, give plans for purposeful action, and help to produce the conditions required for their own perpetuation or revision. Kleinman also attributes EMs to individuals, rather than cultures. Since he states that EMs are unlikely to be homogeneous even within the same community. Moreover, a person's EM is likely to alter over time, in response to his particular medical experiences and to the clinical encounters in which he becomes acquainted with practitioners' EMs (McElroy, 2002; Young, 1982).

Since this framework was initially introduced from studies conducted on mental illness, it is reliable for its empathetic nature and familiarity on the grounds of related studies. EM's generally provide a means of promoting empathy, respect and therapeutic alliance among those involved with people suffering from mental illness (Weiss and Somma, 2007).

This study employed the ethno-medical perspective to explain the local perceptions of mental illness among people seeking care, their caregivers and the mental health professionals in Addis Ababa in relation to the cultural values, causes of mental illness, treatment options, and the roles of patients and their caregivers in the decision-making process of seeking treatment.

Symbolic Interpretive Approach

The symbolic interpretive approach was developed in the 1960s as an alternative theoretical perspective in the field of Anthropology. Its main proponents are Clifford Geertz and Victor Turner. This approach engages in inquiry concerning the meaning of symbols and how symbols shape people's way or patterns of life (Geertz, 1973).

For Geertz, culture manifests itself as a scheme of symbols and meanings visibly portrayed in both objects and actions. Geertz encourages anthropologists to excavate (dig out) the meaning of the symbols that constitute the cultural whole rather than merely describing the culture, since culture is an abstract concept that can only be understood through the symbols used in the social actions of day to day life (Geertz, 1973).

The symbolic interpretive approach views culture as something embodied in public symbols through which members of society communicate their view, rather than something locked inside people's head. Geertz illustrating from his classical work on 'the Balinese Cockfight,' shows how symbolic events can be used to expose and explain culture layer by layer until it gives significant meaning in accordance with its context (situation, time, condition) (Geertz, 1973).

According to the symbolic interpretive approach, human behaviour is basically symbolic and has meaning for social actors. Thus, an ethnographer should seek to understand the webs of significance which people themselves have spun by seeking to understand the culture within the

same context as the informants through observation and questioning the interpretations offered by specialists and laymen in order to become knowledgeable of the local meanings (Geertz, 1973; Turner, 1967). Geertz proposes that in order for anthropologists to understand how people think, act and live, anthropologists must get as close to the people they study bearing in mind that 'the essential vocation of interpretive anthropology is not to answer our deepest questions, but to make available to us answers that others, guarding other sheep in other valleys, have given, and thus to include them in the consultable record of what man has said' (Geertz, 1973:30).

This is to mean that anthropological study aims at not answering life's greatest mysteries but seeks to study, comprehend and depict the way certain cultures have answered such questions for themselves.

Symbolic interpretive approach proponents, such as Geertz advocate for the use of 'thick description' in interpreting the meaning of behaviour and in explaining actions and attitudes that appear puzzling (Geertz, 1973). Geertz understands culture as a 'context' that consists of socially established structures of meaning. Thus, his approach can be significant in showing how people with mental illness and those giving care to them perceive and relate to mental illness. After all, the symbolic interpretive approaches have often helped in explaining indigenous healing rituals, and also acquainted biomedical practitioners with the practical usefulness of explanatory models, illness meanings and the cultural construction of illness (Kleinman et al. 1978; Kleinman, 1979). This study employed symbolic interpretive approach to understand the meanings and interpretation of symbols used in healing and medical practices, and the interaction between religious healers, mental health professionals and their patients.

Cognitive Medical Approach

The Cognitive medical approach is a broad field of study immensely influenced by cognitive anthropology, which regards culture as knowledge. D'Andrade (1995) defines cognitive anthropology as a discipline that studies the relation between human society and human thought.

This approach examines how people from various societies use their knowledge in their everyday life, and the way they conceptualize and organize this knowledge in their minds, passing it on through consensus as part of their cultural tradition. Hence, cognitive anthropology addresses the ways in which people conceive of and think about events and objects in the world (D'Andrade, 1995; Trajtelova, 2013).

Cognitive anthropology considers knowledge to be present in thoughts, words or objects; and that it is learnt, acquired, preserved and shared within a certain social community. Additionally it is true that no experience is acquired in absolute isolation, but rather influenced by a wider cultural cognitive context (Trajtelova, 2013).

The Cognitive medical approach can be used in health oriented decision-making in addressing questions such as; what do people do when faced with illness? And insight gained by giving careful consideration to how people talk about treatment and decisions. Hence, cultural knowledge is understood as referring to how illness is evaluated and decisions made for treatment among different alternatives (Garro, 2004). Cognitive medical approach was used to understand how different parties involve with the care of the mentally ill make decision on the level of contribution each can possibly make in caring for the ill.

Critical Medical Approach

Critical medical approach (CMA) is a theoretical perspective within medical anthropology that focuses on the political economy of health and health care. It is a set of theories that consider the philosophical, cultural, and moral systems that are embedded in health practices. This approach understands that the body and the patient are impacted by larger, unseen social forces to which individuals respond by developing their own individual and collective understanding and responses to illness (Baer, Singer, and Susser 2003; Singer, 2004).

This perspective emerged in response to the assumed neglected aspects of the wider causes found in the structure of social relationship as determinants of human decision making and behaviour, such as restricted account for health-related issues on the influence of human personalities and on culturally based motivations and understandings (Singer, 2004).

This approach pays close attention to 'vertical links' that connect the social group of interest to the larger regional, national, and global human society and also to the formation of social relationships that contribute to the patterning of human behaviour, belief, attitudes, and emotions. Since the critical medical approach explores both macro and micro level impacts of health, it can be useful in gaining holistic understanding of a particular problem such as belief about mental illness in a given context (Singer, 2004). Critical medical approach was used in this study to analyse the logistics of availability and allocation of the mental hospital in the city, yet a big number of Ethiopians are living in rural.

2.2 Review of Related Empirical Studies

Scholars of different disciplines have for many centuries sought to explore the ways in which human beings attempt to understand the world, interact with it and eventually give meaning to their lives. Psychiatry as well as religion draws upon rich traditions of human thought and practice. They both are concerned with how the self is defined and how this definition is affected by interpersonal and social processes. Psychiatry which is a discipline in biomedicine and religion which relates to folk, popular and philosophical systems, provides the framework for understanding and describing the human experience and human behaviour (Boehnlein, 2000).

In the last century the prevailing assumption in health professions and in academia was that folk and popular systems of health beliefs and practices would inevitably decline with the advancement of societies and gradually be replaced by modern biomedical healing systems. However, on the contrary, certain systems especially those with religious foundation have persisted steadily alongside the burgeoning medical establishment, especially in Africa (O'Connor, 1995).

Biomedicine has the position of being the officially preferred health system of many countries including Ethiopia and enjoys the approval, cooperation, and protection of the government. Despite being dominant in terms of usage, the local indigenous health systems are assigned the position of alternative therapies inferior to biomedicine. Thus many studies have tended to dismiss the contribution of folk and popular health belief systems to society, and the possibility of integrating them for ultimate benefit (O'Connor, 1995; Dejene, 2013).

The use of indigenous medicine in Ethiopia, as in the world as a whole, has gone on since time immemorial. Almost 80% of the population depends on indigenous medicine for primary health care services (Kebede et al., 2006; WHO, 2006). Traditional medicine is defined by the World Health Organisation (2006) as health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being.

Like other African countries, Ethiopia is rich in folk beliefs, even in highly urbanised and Christianised areas, there exists a wide variety of indigenous belief systems on health care (Boylston, 2012; Finneran, 2003). Indigenous medicine was the main source of health care systems in Ethiopia before the introduction of biomedicine, which emerged as an alternative and became the official health care system (Dejene, 2013).

Healers involved in indigenous medicine are of diverse orientations. Indigenous healers just as psychiatrists are socialised to their roles and their behaviour is likewise influenced by social and cultural values that both precede and coexist with their professional life (Boehnlein, 2000; Kebede et al., 2006).

According to Levinson (1997), every health care system consists of the following basic components: definitions of health and illness; belief of causes of illnesses; a system of diagnosis and techniques of appropriate therapy; the healers involved and decision making process for using the health care system.

Historically, indigenous medicine in Ethiopia has tended to emphasise the supernatural aspects of maladies. Among the reasons for this is the religious influence in education and the way that healers are socialised into the dominant religious worldview (Dejene, 2013). The EOTC the dominant religious institution (and other religions depending on the area) have a strong social and cultural impact on Ethiopian society (Boylston, 2012; Young, 1975). Dejene (2013) goes on to explain that this ought not to be taken as blind obsession or superstition rather emphasising

those aspects of health care such as bone-setting and indigenous birth attendance which do not accentuate supernatural aspects to give a wider perspective.

In Ethiopia where cultural and religious beliefs are deeply ingrained in the day to day activities of residents, religion is believed to provide a clear explanation for life events and also meaning for individuals in the society. Consequently, it is important to understand the cultural belief systems as well as religious thought and practice that relate to mental health and illness (Boehnlein, 2000). The practice of biomedicine would be more effective if it at least takes into account or is combined with the indigenous healing therapies which the majority of the population subscribe to, especially with regard to mental illness.

Chapter Three
Research Methodology, Description of the Study Area and Mental Health Services

3.1 Research Methodology

3.1.1 Research Approach

Research is a process in which one engages through a successive set of logical steps. This study is based on constructivist inquiry, using an ethnographic a sub-branch of the qualitative approach. The notion of quality is essential to the nature of things. Quality is a term used to refer to the what, how, when, and where of a thing, its essence and ambience. Qualitative research therefore refers to meanings, concepts, definitions, characteristics, metaphors, symbols, and descriptions of things. This differs from quantitative research which is concerned with counting and measuring things (Berg, 2001).

A qualitative research methodology was chosen for this study because of its distinct character, allowing the researcher to investigate phenomenological details of lived experience, behaviour, emotions and feelings (Strauss and Corbin, 1998). Insights through processes and emotions are difficult to understand through quantitative means. Experiences cannot be meaningfully expressed through numbers.

A qualitative research approach emphasises seeing through the eyes of the people who are being studied; providing detailed descriptions and analysis of the social settings under investigation; understanding events, behaviour and the like in their context; examining social entities as wholes and the meaning they have for participants and; reflecting on the reality of everyday life in its form of streams of interconnecting events (Bryman, 1988).

Qualitative procedures provided means of accessing unquantifiable facts about the actual people the researcher observed and talked to. Through the use of qualitative techniques, I was able to understand the perceptions of the participants and explore how they made sense of themselves

and their situation; and also, how they structure and give meaning to their daily lives. Thus, meanings they attach to things in their lives and the nature of the phenomena in a natural setting became apparent (Berg, 2001; Silverman, 2008).

Anthropologists choose the appropriate methodology to use, by looking at the aim of the study and the nature of the research problem (Gray, 2009; Strauss and Corbin, 1998). Qualitative methods have often been used in researching sensitive topics, such as mental health issues which may not be explicitly understood. Qualitative research is well suited to understanding the subjective constructions investigated when researching people's life stories, attitudes and experiences (Hammersley and Atkinson, 2008; Silverman, 2008).

As the label 'qualitative research' covers a heterogeneous field (Hammersley, 2013), this study specifically employed an ethnographic approach to explore perceptions of mental illness among those suffering from mental health related problems, their caregivers, and the professionals involved in their treatment. An ethnographic approach is considered appropriate for studying how social structures, relationships, and processes produce cultural forms that in turn shape individual consciousness and practices. It entails examining social practices and discourses, as well as institutional structures (Cerwonka and Malkki, 2007). The following methods have special significance for such ethnographic research; participant observation, informal and in-depth interviewing.

3.1.2 Methods of Data Collection

Both primary and secondary data collection methods were used in this study. Primary data were collected from people with mental illness, their caregivers, *atmaqi* and professional health workers through interviews and observation.

3.1.2.1 Primary Methods of Data Collection

Informal Interviewing

Informal Interviewing is highly recommended for anthropologists embarking on field-research at the preliminary stage of participant observation fieldwork. Such interviewing is characterized by a total lack of structure or control. It is also used throughout ethnographic fieldwork to build

greater rapport and to uncover new topics of interest that might have been overlooked (Bernard, 2006). Such methods take precedence during the initial stages of fieldwork, and are commonly applied throughout the study.

I employed the use of informal interview in embarking on the field study before gradually applying in-depth and key informant interviews. This method was effective in approaching, building rapport and selecting informants. It was also used concurrently in cross-checking data collected through other methods. Informal interviews were made at both Amanuel Mental Specialised Hospital and Entoto Maryam *Tsebel* with diverse individuals found at both sites.

Participant Observation

Participant observation entails participation of the researcher in the social world under study in whatever role is appropriate and reflecting on the products of that participation. Even though it is claimed that all research directly or indirectly involves participant observation, this method of data collection is a distinct characteristic of anthropological studies. In fact it is considered as a rite of passage to becoming an anthropologist (Hammersley and Atkinson, 2007).

Participant observation involves getting close to people to observe and record information about their lives. It is both a humanistic and scientific method of carrying out research on sensitive issues such as mental illness whereby one is expected to empathise with sufferers, gather information and also to propose ideas that could help improve their situation (Bernard, 2006).

Participant observation is a method that makes a researcher into an instrument of research. It has become a popular research method for gathering data on human behaviour. Participant observation was useful in this study since it facilitated understanding the cultural knowledge informants used to organise their behaviour and interpret their experiences. This method suits the exploratory nature of the study questions and the objectives addressed in this study. I spent a considerable time with the patients and their caregivers, basking over the sun, performing some simple duties alongside at the gardening project, participating in group therapies by encouraging participation and raising questions and by attending sermons at the *tsebel* place and also partaking of the holy water and other related rituals such as kissing cross, sharing of the bread,

chanting prayers and hymns. I made field notes concerning that which I saw and heard and used it for cross-checking the validity of data collected through in-depth interview method. This was effective in relating actions to thoughts and constructing the meanings inferred.

Key Informant Interview

Key informant interview was used in this study for it is considered appropriate in seeking detailed information and opinions on particular aspect of a culture from informed individuals (Bernard, 2006). This method was used to understand the perception of the religious community on mental illness and the religious therapy rituals.

In-depth Interview

In-depth interviewing, also known as ethnographic or semi-structured interviewing method, was used for this study. This constitute of data collecting method based on a schedule and with minimum intention to control informants' responses. The idea is to get the informants to open up and express themselves on their own terms, and at their own pace (Bernard, 2006).

Thirty two semi-structured interviews lasting between 45 minutes to one hour each were carried out with the group of informants constituting of health professionals at various levels within the public health care system; *atmaqi* (orthodox religious leaders); mentally ill individuals themselves; and their caregivers (family members or *astemami*). The focus of the semi-structured interviews was toward understanding how mental problems are recognised and acknowledged, how they are explained, and the kind of treatments that are sought accordingly. Among the health professionals and *atmaqi*, the interviews concentrated on their professional as well as personal understanding of mental illnesses, the treatment or healing they could offer, their reaction toward patients who combined different kinds of treatments, and finally their personal experiences with working in this area.

Most of the interviews conducted at the religious site were more or less in a natural set up where I could observe participants and participate with them in the ritual or engage in their day to day conversation along the way when they are returning to their residence. Since I had become familiar to them due to my regular visits and participation, I would easily decide whom to spend

with time interchangeably. And at times when I inquire on particular aspect I would be guided to one more versed on it.

3.1.2.2 Secondary Data Collection

The secondary data were used in addition to primary data for relevant and related concepts, theoretical frameworks, document review, descriptive and statistical information on the research topic. This allowed for extending, validating and refining knowledge in the field.

3.1.3 Method of Data Analysis

Ethnographic data analysis begins at the very onset of the study, during the pre-fieldwork phase, in the formulation and clarification of research problems, and continues through to the process of writing field reports. The formal part starts to take shape in analytic notes and memoranda; while the informal part is embodied in the ethnographer's ideas and hunches (Hammersley and Atkinson, 2007).

The data gathered through informal conversation and in-depth interviews were digitally recorded and transcribed verbatim for analysis. In addition, the field notes maintained by the researcher also informed the analysis. An inductive thematic analysis was used to analyse the interviews' transcript. The analysis revealed an overarching theme of the central role of religion and culture in shaping the informants' perspective of mental health. Triangulation of various data sources was implemented on the analysis to maintain the reliability and validity of the findings.

3.1.4 Ethical Considerations

'Research ethics' is a term used to refer to a form of occupational ethics, concerning what social researchers ought, and ought not, to do as researchers, and/or about what counts as virtues and vices in doing research (Hammersley and Traianou, 2012).

In anthropological study, moral and ethical decisions are made at all stages of research, from the selection of topic, area or population, source of funding, to publication of findings and disposal of data (Ellen, 1984). Anthropologists are encouraged to commit themselves to the people they study. And, hence the researcher sought permission from the concerned authorities to enter the

sites of the study (Amanuel Mental Specialised Hospital and Entoto Maryam *tsebel* site) by both presenting the recommendation letter from the department of Social Anthropology at Addis Ababa University and also the research proposal to show what the study entails. Once entrance to the research sites was granted, the researcher also sought the informants' personal consent to participate in this study. All information collected during fieldwork was treated with the confidentiality they deserve. No participant is mentioned by name, instead varied pseudonyms have been used and some personal details have been omitted or altered not to disclose the identity of the informants.

3.1.5 Fieldwork Experiences

Embarking on fieldwork was preceded by days spent poring over different articles and books on mental illness. The first visit to Amanuel mental hospital, engendered a sense of being thrilled yet at the same time a fear of being at a mental hospital. After passing the guards manning the hospital gate, there was an expectation of an uncertain reception for my unexpected visit. Only later were there indications of being perceived as one who came for treatment, maybe for addiction problems. Striding between the patients scattered all over the yard, there would be cries of '*rasta, bunna'*, as they pestered me to buy them coffee.

A positive reception by the administration was accompanied by advice on what was required to conduct study within the facility. There was an obligation to bring a number of thesis proposal copies and a recommendation letter from the university's department. On producing the specified items on 3rd February 2016, there was notification of a few weeks wait while the committee presiding over the research project confirmed the ethical worthiness of the project proposal. Frequent visits, seeking to know if the request had been accepted facilitated striking up a rapport with a number of patients. A simple appearance, resulted in being approachable and queries from various patients concerning attending treatment offered at the hospital. At first there was no obvious reason to reveal my status, due to being unsure of reactions. There was a comfortable, feeling of basking in the sun enjoying open spaces within the hospital yard conducive to chatting. It was unsure when final permission would be granted to carry out research, despite frequent visits to the institution since receiving the recommendation letter on 2nd February 2016. The consequent state of limbo facilitated an appropriate moment to adapt to being in a mental

hospital set-up. The approval letter had to be signed by a number of officials, and it so happened that some of them had gone abroad for meetings, leaving the others overloaded with responsibility for covering their colleagues' duties. There was a period of waiting for a while. But discouragement did not prevail, regular visits to the institution averaging three times a week enabled following up the enquiries.

On receiving finally approval to conduct fieldwork on 3rd March 2016, no time was wasted. The approval was accompanied by an official acceptance letter. It was now possible to enter the various offices and wards (except for the forensic ward which accommodates mental patients who have committed crimes and have been brought by prison guards).

Most of the staff at AMSH were friendly and willing to participate in the study despite their busy and stressful working conditions. Patients with whom there was previous acquaintance gradually became familiar with my status as graduate student in the course of the constant introductions while attending group therapy. The group therapy included the coordinators, patients, caregivers and Master's degree students studying at AMSH. All in attendance would be introduced in order to create a conducive atmosphere for group therapy, it was only after gaining the approval of patients and caregivers that those who fell into the category of students were allowed to attend. After the introduction, my role was limited to observation. Occasionally I would help by guiding late-comers (patient or caregiver) to vacant seats. Normally at the end of group therapy the coordinators would be very friendly and brief me on unclear aspects on the conducted therapy. During the group therapy there were possibilities to glean a lot of information on patients', caregivers' and health workers' perception and experience of mental illness. Moreover, it was a ready opportunity to discern whom to engage subsequently in in-depth interviews. At times it was barely possible to follow the group therapies due to the noise of traffic and the blaring sermons from nearby church whenever there were religious celebrations. Participation in group therapy empowered me to adapt to the mental hospital situation by facilitating opportunities to meet health workers, caregivers and patients and gaining insight from them. Simple attentive following of discussions enabled gaining access to views from diverse categories of individuals which were essential for this study.

The earlier intention to overlook the mentally ill on the assumption that they are vulnerable, fragile and unreliable source of information was thwarted by professional health workers who explained that there were a number of patients who having been hospitalised for an extended period of time were now able to articulate themselves at an unhurried pace. So to honour the voices of the mentally ill which is a fundamental goal of medical anthropology, I decided to dispel some of these stereotypes and stigma by incorporating the mentally ill in this study. Beside I ensured that I confirmed their narration from either their caregivers or health workers who were familiar with their stories.

After becoming a common figure at the hospital, the initial hassling from patients for *bunna* or cigarettes became minimal despite arriving early in the morning and leaving late. In the morning a number of patients, caregivers and even health workers who were Orthodox Christians could be observed kissing the church walls (Amanuel Orthodox Church shares the same fence with the hospital). Some of them could be seen clad in their *natala* prayer shawls, holding water in plastic containers, which on inquiry were described as *tsebel*. At other times Muslim patients could be encountered prostrating in prayer at any convenient place within the hospital precincts. One could not avoid paying attention to the frequent outbursts of episodes at the crowded corners of the hospital.

After gaining familiarity with AMSH, the next step was to go to Entoto Maryam. At Entoto Maryam, there was no difficulty in gaining access other than the scary steep uphill drive and the isolated paths in the dense eucalyptus forest on the way to *tsebel* sites. Most members of the clergy were familiar, partially due to shared time as students together in various religious schools previously attended in different parts of the country. Thanks to the kindred spirit it was possible to explain to them the objective of the research according to the required norms and to be immediately welcomed in. Hence it was possible to frequently attend the rituals at the site, partake of the *tsebel*, and interact with the care-seekers, attendants and *atmaqi*. It was an uplifting experience to participate in the familiar rituals and interaction within the religious sphere, but now with a new focus of critical attention on academic research.

The main problem encountered was to design a plan which juggled interviews on both sites giving due consideration to the fact that some of my participants were mentally ill. Due to the preference for adhering to the ethics of the study, interview of participants had to be done according to their own convenience with regard to time and place, which involved constant movement over a wide area including both AMSH and Entoto Maryam. Transport was a problem, it was untimely and sometimes required making use of several connections. One had to struggle through busy market places while staying on one's toes, and being alert not to lose fieldwork tools. Retaining a clear view of the situation, required adhering to the agenda, including jotting down the time and place of interviews. The fieldwork came to an end on 27th April 2016, after almost 2 months in the field.

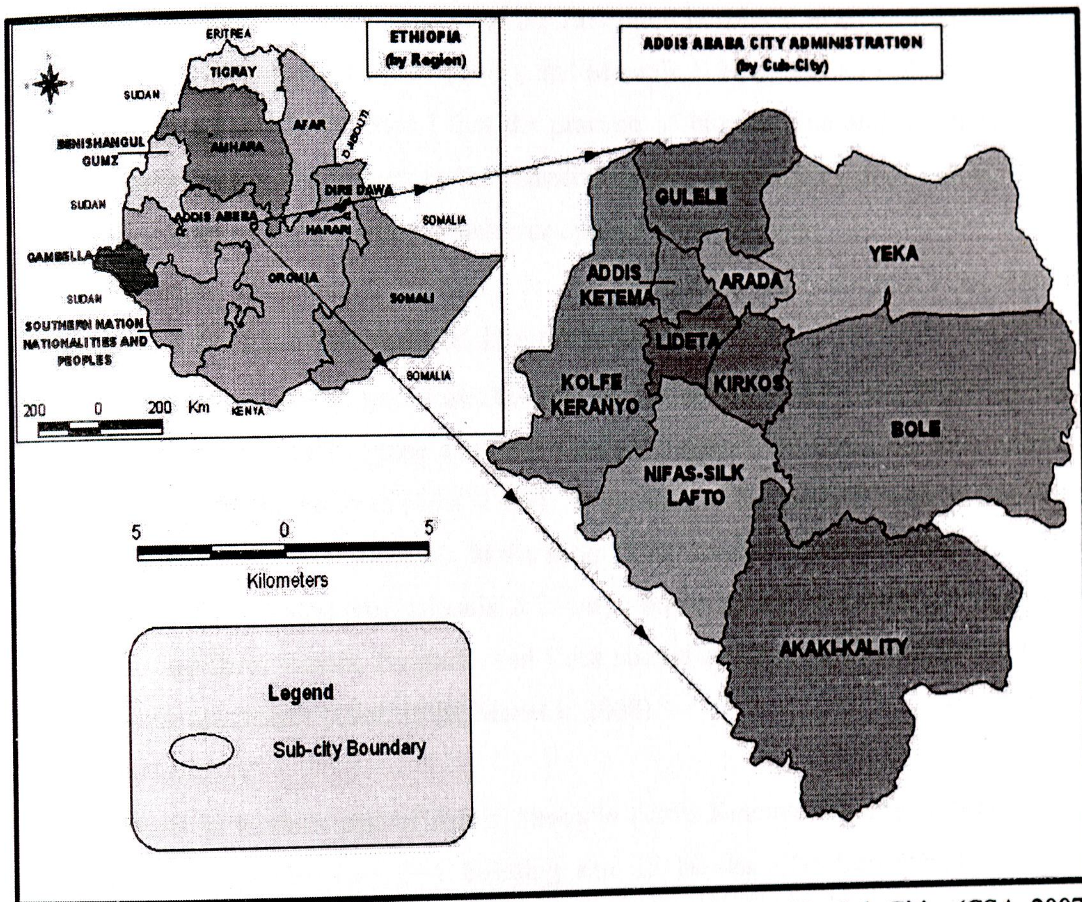
3.2 Description of the Study Area

This study was conducted in Addis Ababa, capital and seat of the government of the Federal Democratic Republic of Ethiopia. Addis Ababa was established in 1886, it is one of the oldest and largest cities in Africa and is also situated at the highest average altitude of 2,400 meters (UN-Habitat, 2007). The total area of the city is about 527 sq. km^2. It is geographically located in the centre of Ethiopia, and more endowed with social and economic infrastructure than the majority of the country (UN-Habitat, 2007). This has caused it to become a melting pot of hundreds of thousands of people, coming from different ethnic groups from all corners of the country in search of better employment opportunities and services. This high rate of rural urban migration accounts for about 40% of growth, making Addis Ababa into one of the fastest growing cities in Africa. In 1994, the total population was 2,112,737, and from 2007 it was estimated to be 4 million (UN-Habitat, 2007). The city serves as the social, economic and political centre of the country. It is also the diplomatic centre of Africa, hosting the African Union, United Nations Economic Commission for Africa, and other international organizations (Uli, 2008; UN-Habitat, 2008).

Administratively, Addis Ababa is a chartered city having three layers of government: city government, sub-city administrations, and *Woreda* (district) administration. According to CSA (2007:7), Addis Ababa has 10 sub-cities: (1), Akaki Kaliti (2), Nefas Silk-Lafto (3), Kolfe

Keranyo (4), Gulele (5), Lideta (6), Kirkos (7), Arada (8), Addis Ketema (9), Yeka (10), Bole (see the location map below)

Figure 1: Location Map of Addis Ababa and the Sub-cities



Source: Central Statistics Authority, Map of Ethiopia, Addis Ababa and Its Sub-Cities (CSA, 2007)

3.3 Biomedical and Religious Mental Health Services in Addis Ababa

3.3.1 Brief History of Biomedicine in Ethiopia

The quest for biomedicine in Ethiopia can be traced way back during the reign of Emperor LebneDingil in the 16th century, when the emperor appealed to the Portuguese king for physicians to help alleviate prevalent illnesses in his dominion and Joao Bermudes, a member of the first Portuguese mission to Ethiopia responded. And during Emperor Fasilidas reign when a German missionary, Peter Heiling (1632-1667) served as a court physician (The Manual on

Ethiopian Medical History, 2012). This was later on pursued strongly during the reign of Emperor Menelik II after the Battle of Adwa in 1896 which brought about an organised and sustainable biomedical practice despite fervent opposition from the national Ethiopian Orthodox church (*ibid*). This saw the establishment of the first three hospitals, namely, Russian Hospital (1896), Harar Ras Makonnen Hospital (1903), and Menelik II Hospital in (1906). It was during the reign of Emperor Haile Selassie I that the practice of biomedicine and public health was broadly introduced. This can be seen by the establishment of the Ministry of Health in 1948 and the first medical school in the country which was opened in 1964 (*ibid*).

3.3.2 Amanuel Mental Specialised Hospital (AMSH)

AMSH is one of the oldest hospitals in Ethiopia. It was established in late 1930s during the Ethio-Italian war for general purpose and later used as a quarantine camp for very aggressive mentally ill individuals in the town (Giel, 1999). At the time of the study it was the only referral hospital specialising in mental illnesses. In the early 1940s, mental health services were mainly given by low level psychiatric professionals. It is only later on in late 1940s that the treatment by specialised doctors from Russia, Bulgaria, and Cuba started and then in 1976 native specialised doctors took over the mantle (Giel, 1999; Menelik, 2008).

AMSH is located in western part of Addis Ababa in Addis Ketema sub-city *Kebele* 08, on an area of 15,660.6 km^2 with two G+1 building and 15 blocks. The hospital is working on increasing the efficiency and effectiveness of the services in order to be the centre of mental healthcare excellences by giving core mental clinical services, conducting research and trainings and other administrative services. The hospital plays a pivotal role as a training institute for middle level psychiatric professionals so as to expand the service throughout the country by introducing psychiatry services to the primary healthcare system of the country. It is a training centre for psychiatric nursing and currently it is facilitating Masters of Science programme in integrated clinical and community mental health in collaboration with the University of Gondar. It also serves as a residency centre for the department of Psychiatry, Addis Ababa University (Bruni, 2014; Sintayehu et al, 2015).

of other African countries, animistic religion was dominantly practiced before the Abrahamic monotheistic religions were embraced. Animistic religion encompasses the belief that all natural objects are pervaded by spirits and they are also personified and worshipped. These spirits were considered responsible for both the society and individual wellbeing and disharmony. They were seen to be the causative agents of a whole range of human misfortunes, such as famine, illness, and deaths. And consequently every kind of assistance was sought from the endowments of nature (Finneran, 2003; Messing, 1958; Reminick, 1976; Shelemay, 1992).

With the introduction of Abrahamic religions, and Judaism in particular, a pantheon of devils and demons gradually permeated Ethiopian religious sphere, with most personal and social misfortunes being attributed to the malevolence of these supernatural beings. This made it possible for variety of magic-religious techniques to flourish in fight against evil spirits. And it also immensely affected the Orthodox Church view over all rational therapeutic efforts to consider them as Satanic (Pawlikowski, 1971; Young, 1975).

Christianity was introduced in Ethiopia during the 4th century through evangelistic efforts of Frumentius and conversion of king Ezanas (from the indigenous belief) which saw the establishment of Ethiopian Orthodox Tewahedo Church as empire's religion. Later on the fleeing "Nine Saints" who came from greater Syria toward the end of the 5th century helped proselytise the natives into the new faith. This contributed extensively to the Orthodox Church becoming the main religious institution and others being relegated to a point of indifference by the authority regardless of their perpetual influence of general Ethiopian cosmology (Hansberry, 1974; Pawlikowski, 1971; Sergew, 1972).

The dominant spirit before the introduction of Abrahamic religions was *Zar*, a former sky-god of the Cushitic Agaw and its spiritually inspired practitioners referred to as *balazar*. Even after Christianity had assumed spiritual predominance in Ethiopia, this practice has continued to exist with wider influence that transcends both geographical areas and religious spheres (Boylston, 2012; Messing, 1958; Young, 1975).

Various human maladies and tribulations were attributed to this spirit. Whenever an intrusion of disease-causing spirit was suspected, *balazar*, an expert who was able to serve as a spirit medium and communicate with the spirit causing the sickness would be consulted immediately. The *balazar* would conduct a healing ritual on which the *Zar*-spirit through its human medium would identify the troubling spirit, including Jinn and evil-eye spirits, diagnose the illness, and recommend a therapeutic solution for the physical ailment, or psychological disturbance and any other personal or social problems (Edelstein, 2002; Finneran, 2003; Reminick, 1976).

Atmaqi and *dabtera* are the healers found in Ethiopian Orthodox Church. *Debtera* are known to possess wide range of medical knowledge based on the use of esoteric medical texts and the use of herbal remedies. They are able to treat broad range of ailments. They can invoke and exorcize evil spirits; cast and break magic spells; make divinations; provide herbal treatments; and produce written amulets and talismans. Though their healing services are not officially acknowledged by the church administration, it is the *atmaqi* who preside over the *tsebel* therapy (Eliana, 2009; Finneran, 2003; Young, 1975).

3.3.4 Entoto Maryam Church

Entoto was established by Emperor Menelik II as his permanent camp in early 1880s after remains of an old town believed to have been the capital of 16th century monarch Lebna Dengel were discovered there, and of which Menelik considered as a divine and auspicious sign (Pankhurst, 1961).

In Entoto, emperor Menelik II built a church in keeping with the tradition of Ethiopian monarchy (and there he was crowned as emperor of Ethiopia in 1889). The church he built is locally known as Entoto Maryam (St. Mary's church). Entoto Maryam is situated nine kilometres north of the city centre. It is found on the centre of Entoto Mountain between the Blue Nile to the north and Awash River to the south. The surrounding area is covered with dense eucalyptus forests. With its high altitude of 3200 metres above sea level, Entoto tends to be more cold and windy compared to other parts of Addis Ababa. Administratively, Entoto is located within Gullele sub-city. The site is bounded by Oromiya region, Sululta district to the north, Arada and Addis Ketema sub-cities in the south, Yeka sub-city to the east and Kolfe-Keranyo sub-city in the west.

The *tsebel* site is a 30 minutes' walk from the church. People from Addis Ababa, other parts of the country and even from abroad come here for religious healing for their diverse problems ranging from physical ailments, disabilities, personal problems such as family disputes to mental illness. When they come some take residence near the church while others come only for a day. The service at the *tsebel* site starts at 6am unlike other *tsebel* sites that open by 3am, this is due to its deep location in forest infested with wild animals such as hyenas and monkeys (Ribka, 2014).

Chapter Four
Biomedical Therapy

4.1 Conceptualisation of Mental Illness

How mental illness is conceptualised among various individuals involved with the care of mentally ill and the mentally ill individuals themselves varied depending on the context the individuals were during the study period. But as the following statements show from all the groups it was apparent that they all had the knowledge and conceptions of mental illness across health care systems found locally and how it rarely happens accidently.

When I first embarked on fieldwork it struck me that the mentally ill are referred of differently based on knowledge about the illness. Those in the hospital were being referred to as *yeaemro himemtegna* (mentally ill) while those at *tsebel* as *aganint yaderebet* (demon possessed) and those in the neighbourhood as *ibd* and *qewus* (crazy). The terminology seemed to change based on knowledge about the illness from place to place so also the attitude. In this study, how *mental illness* is conceptualised is understood through how it is described, noticed or diagnosed, attributed causes and its effect.

4.1.1 Patients' Conceptualisation of Mental Illness

In an interview with Frez, a single woman past her mid-thirties with bachelor's degree, and have been in and out of medical treatment for the past 20 years, the mixed conception of mental illness is captured well. Frez is the firstborn to both her divorced parents from northern regions of Ethiopia. Her father married another woman and her mother likewise got married to another man. So, she was brought up by her mother and the step-father in Addis Ababa city. She became depressed in her early teenage of which she attributes to the separation of her family and subsequent death of her father. She had her first encounter with psychiatric care two years later after several religious therapy attempt. Frez was able to continue with her studies in Addis Ababa city where she sat for matric exam and got admitted in one of the government universities to the joy of her parents. Frez explains that she became an in-patient in 1997 e.c (Ethiopian Calender).

She was by then 26 years. That is when she was informed that she has bipolar disorder (an episodic mood swing that is easily triggered by anything). Till then she was receiving out-patient treatment. Doctor told her that she has a mood problem (feeling extreme happiness at one time and subsequently extreme sadness) and that she should have received psychotherapy treatment (from psychologists) from the very onset of her illness. The illness began when she was still a little child but it was in 1997 e.c. that she had an episode that led to her admission to a mental hospital. Frez explains the cause of her episode to be to the failure to get a job in the field that she had graduated in while her friends were already settling down on their new working stations. And the suicidal feelings she at times has for failure to be a productive member of her family at her age. Frez explains, "I feel bad that at my age when I am supposed to support my mum it is my mum that supports me. Whenever I sit down and think about all these I feel like getting rid of myself, for I have become useless not only for me but also for my family."

In the interview, Frez who is professing a Protestant faith also narrates to me how her Orthodox father too became mentally ill and the care he was given. She narrated,

> My father is said to have been mad for a period of time. He became well after using indigenous medication. My father became ill after divorcing my mother and marrying another woman. At night when they sleep he would call my mum's name and this made this woman envious to the point of putting *medhanit* (a kind of medicine that can make one ill) for my father to get mad. My father thus went to "tenqway" indigenous healer who also happened to be my father's relative. The *tenqway* told my father that this woman has over-dosed him with *medhanit* and gave him *markesha* a medicine to subdue the power of *medhanit*. He became well and resumed back his work.

She continues to explain that, *ena lela degmo, yemenfes aserar wust, tinqola minamin, yemejemeryawu lidg yifelgal. Wede ene liyarf nebere, keziya degmo, Pente sle'neberkugn, begilts teqawumut. Abate wede tsebel ayhedim nebere. Bezih amliko wust nebere.* "in the spirits' world, the firstborn is required to be sacrificed. The spirit was to find aboard in me from my dying father but I openly rebuked it in our congressional prayer. My father did not go to *tsebel*, he was involved in this indigenous ways ..."

Frez like most of other participants interviewed had been ill for many years and was trying to give a context to her illness. Though she attributed the cause of her illness to depression, from her expression she also suspected according to the local moral universe, her illness to have

something to do with spirit inheritance or possession from her dead father. Frez's narration of what might be the cause of her illness in medical context would be considered as having genetically cause. As the professional health workers informed me on the diagnosis done on patients to consist on inquiry of family history if one in family has ever been mentally ill.

Most of the patients interviewed in Amanuel Mental Specialised Hospital described their illness to have biopsychosocial causes but also mentioned some supernatural causes beside. For instance, Abate a single male, aged 37 years old, a Protestant follower and has been ill for the past 19 years, attributed the initial cause of his illness to witchcraft and excessive study. He expounds, "There are two causes for my illness, one is that there was a certain individual in my home area who was very clever, one day he borrowed my exercise book and bewitched it, when he returned it back and I read it, I developed mental problem… At one time, I happened to have read my books the whole night and when morning came, I became unconscious and restless." This time Abate had been readmitted for what he calls *chinqet* (depression) and feeling of hopelessness. He explains that, "At first when I had been given medication I would adjust the dosage according to my own desire not according to the doctor's prescription …"

Bruk an Orthodox youth aged 23 years, experiencing biomedical treatment for the first time after several unsuccessful *tsebel* therapy attributed the cause of his illness to both biological causes and spiritual causes due to its uncertain nature. He explained to me, "I am not stable, my emotional feelings fluctuate. I came to realize that I have a problem two years ago when I noted that I was lagging behind in everything I participated on. I perceive the cause of my illness to be spiritual. I don't know the reason why I became ill. I am not able to live a normal life, my illness keeps me from participating well in social life."

Lub a Protestant aged 26 years and living with his divorced mother in Addis Ababa city, explained his situation as a victim of witchcraft to addiction. "I was veıy depressed, because I was bewitched by somebody from somewhere. I was bewitched to become a drug addict. My mum got sad of my disruptive behaviour and then she decided to bring me here." Lub expounds further the experience of his illness and its cause: "I hear sounds (voices) that disturbs me that can lead one to commit suicide or even destroy oneself with drugs. This witchcraft is from devil

and you need God's protection against it." Lub narrates how drug addiction affected his aspiration, "I wanted to join university and be a psychologist. I cannot achieve it because of my drug addiction. This addiction hurts me a lot."

The uncertain nature of mental illness leaves Bruk's like other participants with no doubt that it has its cause not only in his biological make up but also a supernatural cause, something beyond scientific comprehension. For Lub, it is also the same as most of the participants interviewed. Though he is admitted at AMSH for addiction problem, he is strongly convinced that it couldn't have just happened if not for having been bewitched. Consequently, he attributes his addiction to a supernatural phenomenon. For participants believe that anything that keeps them from progressing as others or to fulfil their aspirations in life must be something beyond the physical realm. In summary, patients conceptualised their illness as to have both biopsychosocial and supernatural causes. Supernatural causes being witchcraft, spirit or demon possession.

4.1.2 Caregivers' Conceptualisation of Mental Illness

Among the caregivers interviewed at Amanuel Mental Specialised Hospital the same feelings of the cause of mental disturbance to have something to do with spirits beside biopsychosocial causes was likewise eminent.

Makonnen, a 29 years old Muslim married man from Dessie, giving care to his 25 years old brother at AMSH, explained to me how his brother became ill: My brother having schooled to 9th grade came to Addis Ababa where he was a casual worker for 4 years. My brother had proposed to a certain lady and she refused him. That's when he became ill. We came to know that he was ill three months ago (Tir 10/2008 e.c) when he became very disruptive. The people in our area told us it is *menfes new, yemenfes neger new* (it is a spirit possession).

Almaz a 58 years old Orthodox woman with elementary level of formal education, and the caregiver of her daughter aged 19 years since two years ago when she first became ill, had a strong feeling that her daughter's friends did *something* on her in school to ruin her bright academic future. Her daughter does not eat. She weeps a lot, so she explains gloomily.

4.1.3 Professional Health Workers' Conceptualisation of Mental Illness

The data collected from professional health workers was a little bit extensive. This is because the health workers hold an influential position in biomedicine as agents of culture and were thus able to articulate some of the aspects that patients and caregivers felt pain to reveal such as concerns the patients have after diagnosis. And it was apparent that their view to a certain extent reflected on both the patients and caregivers interviewed in Amanuel Mental Specialised Hospital.

Among the professional health workers interviewed at AMSH, most had the same view on mental illness as the patients and the caregivers as to be biopsychosocial related, however they showed an understanding of patients and caregivers who held beliefs on spiritual causes of mental illness. On diagnosis of mental illness health workers applied biomedical concepts according to their professional background to explain it. Awet a psychiatrist nurse explained to me:

> To begin with, patients are rarely brought to us immediately they become mentally ill rather it is after a period of time that may range from months to years and after trying other locally available treatments therapies. In our society mostly people don't consider mental illness as illness rather they consider it as *ibd, baid, amliko telekfo* (crazy, bewitched). So they will take the ill to *tsebel* and other various indigenous healing therapies: such as; for Muslims it is Dua and Quran reading (*yiqeretsal*); for Orthodox, *tsebel* and for Protestants, *tselot* (prayer). They mostly consider mental illness as *baid likift* (bewitched). And it is after all these processes that they finally come to us (AMSH). So they are already familiar with their situation before coming to us. Nevertheless when the patients come to us we diagnose from what they tell us, from the history that the relative gives us pertaining the patient. We collect the historical background of the patient. Ours has got nothing with examining urine or blood.

Since the professional health workers at AMSH were also from the same socio-cultural background as the other participants in this study, they were familiar to the dominant view of mental illness as having supernatural causes. They appreciated the patients' and caregivers' perceptions on mental illness and to a certain extent their indigenous health seeking behaviour (Kleinman, 1980). They had to find a way to balance both seemingly diverse perspectives on mental illness depending on their situation. This is a kind of double-thinking well elaborated by George Orwell in his work 1984 on which he explains doublethink to be the power to hold two contradictory beliefs in one's mind simultaneously, and accepting both of them. And as in case of the professional health workers, they knew which direction to alter their perceptions and when.

This clearly shows that both biomedical and religious therapy can be integrated in mental health care. This is supported by the work of Cinnirella and Loewenthal (1999) on religious and ethnic group influences on beliefs about mental illness.

The health professionals at Amanuel Mental Specialised Hospital are so attuned to biomedical concepts that any kind of mental disturbance from observation and inquiring from the patients' caregivers they could easily categorise them into medical classifications. I was informed that they use the criteria of DSM (*Diagnostic and Statistical Manual of Mental Disorders*) for diagnosis. It is a psychiatric volume published in United States of America and contains various classifications of mental illness. And the need of at least presence of two symptoms for one to be considered mentally ill. Hirut a psychiatrist nurse with masters' degree described to me:

> We classify mental illness into two main categories: psychotic and non-psychotic. Psychotic patients are those who do not have insight, mostly they are brought here by their families. Psychotic patients talk alone, they laugh alone, wear dirty clothes or even go about naked. They don't know about their problems even they don't want to come to the hospital. Within psychotic category, there are still many sub-divisions. Psychotic: schizophrenia, schizotypal, delusion disorders, those who have false believe, those who even without being ill would say they are ill. Non-psychotic are like anxiety, obsessive complexity disorder (OCD), social phobias, sexual disorders, adjustment disorders. They know about their illness they come themselves for treatment.

On diagnosis, Hirut explained the procedure as follows:

> We observe and inquire, and get response from the patients and their relatives (families). Even just at the door where they sit and wait for their turns to be seen by the professional, I could understand what kind of illness a patient might be suffering from. They talk, laugh alone, they are aggressive, fighting with each other. It is by observation and interviewing, there is no laboratory test. We examine them more or less like police investigating a crime, by questioning and by observing them (their response). When you ask them a question sometimes they mixed things up, they don't answer you according to the question asked. Diagnosis is hence done through communication.

Amanuel Mental Specialised Hospital currently works according to mental health strategy charter which seeks to integrate the service from primary health care level to specialized hospital. Before when it was lacking, a psychiatric nurse at AMSH as in regional hospitals would prescribe medication. But now AMSH psychiatric nurse mainly work at the in-patient unit where they administer drugs. In regional areas where specialized psychiatrists and masters holders in psychiatric are lacking, psychiatric nurses have more responsibilities to perform.

4.1.3.1 Causes of Mental Illness

On causes of mental illnesses, the health professional workers informed me that the cause is unknown but there are various factors attributed to it such as stress, genetic, economic (poverty), substance abuse, and loss of a beloved one through death, rejection in love, life hardship, and loss of something. A pharmacist at AMSH aptly described to me the professional understanding of the cause as follows, "most of mental illness causes are the imbalance of chemicals in the brain. So the medications are used to balance those chemicals..."

Patients and caregivers at the psychiatric care come to know the nature of illness through the descriptions they get from the professional health workers at AMSH. The professional health workers communicate the nature of the illness to family members mainly after diagnosis. As explained by Hirut:

> We ask if there is anybody in the family who has ever been mentally ill. If there is we write, family history of mental illness. We examine patients in Amharic but we write the diagnosis in English, and then communicate the results to the family. We can only communicate the results to the patients after they have used medication and gained insights. We don't tell the family about diagnosis results using scientific terms such as schizophrenia and the like.

Giza further expounded to me on how the symptoms are described and classified in a manner that a layman can understand easily:

> Mostly we discuss with them the symptoms they have and what it indicates. Mainly we communicate with symptoms and try to explain them in Amharic for example we would ask the patient: Do your hear voices in your head? If the patient says he does, then we explain to him that this is a sign of severe mental illness. Hearing of voices in absence of external stimuli is a symptom for schizophrenia. And if it is depression which in Amharic we refer to as *dibirt*, we would classify it for them into three categories as high, medium, or low.

From my observation, it was clear that most of the patients had information of their illness' scientific categories since along the corridors there were signs written of psychotic, mood, and addiction cases. And some patients mostly in addiction case team were quick in denying whether they are mentally ill. As Eyob told me, "we are handled differently, the workers do not relate to us like to other patients..." Zola, a professional health worker, explained to me how drug addicts fall into category of mentally ill thus saying, "... it is not only the symptoms even though these

are the manifestations of mental illness but the main thing is whether an individual is able to function properly in day to day life."

Since drug addicts were considered to be functionally impaired for their failure to assume control of their detrimental addictive habits, they are considered according to psychiatric classifications as mentally ill.

4.1.3.2 Effects of Mental Illness on Patients' life

On effects of Illness on patients' life, all the interviewed participants stated that the mentally ill are often excluded or exclude themselves from participation in social life. This comes about through their consistent failure to work (contribute economically) or involve in productive projects hence people isolate and discriminate them. The illness makes them always dependent upon others for care. And prolonged stay without receiving proper treatment to exacerbate their situation.

Health professional workers described the effects of mental illness on patients' life as follows:

Awet: They don't function as normal in work, in school, in society (social life). The illness causes stress to others too for it also creates dependency and thus a socio-economic burden to the family.

Taye: Illness causes tension in family, patient becomes very violent and aggressive. This makes people to fear involvement with them. Mostly it is during the productive age that illness strike and this has a great direct impact on economy, since these people are not able to work when they become ill. If one member of the family is affected, all bear the consequences of the illness. In mental illness a patient becomes so depressed to the point of committing suicide.

Medication was also stated to have a side effect on patients' life as Selam, a psychiatrist nurse described to me: "Medication by itself has an effect on patients' health and life in general. The drugs have side effects. Drugs affect concentration because some medicine make one high while others make one low."

4.1.3.3 Patients' Worries about the Results of Diagnosis

Health professional workers described patients' worries about the results of diagnosis as follows:

Awet: Most of the time it is on medicine that patients worry about. For how long will I be taking this medicine? I will not take it. They don't have the insight to their illness. They don't accept that they are ill. Will I get well? Will I go back to my work? These questions they are able to ask after gaining insight.

Hirut: After seeking treatment the society isolate them and would often state *yitchin eko abda neberetch* (she had become mad). Hence, they opt to isolate themselves and adapt a unique behaviour. And this limits their chances of integrating with other members of the society. People also don't believe what they are doing (even be it right), people doubt their actions. People's perspective rarely changes even after the individual has recovered. Even at the working place people isolate them. For this reason even after being cured they get depressed (depression symptoms are observed in them) and become sad and lonely. But after diagnosis and receiving treatment they are happy. It is after they have been cured or in state of gaining their full health that worries come in. They start to fear that people will isolate them, people will not accept them as before, "they no longer see me as Hirut but rather as a mental patient." This causes them to have a low self-esteem and lack confidence in themselves, and become suspicious of others.

Taye: The ailment by itself may cause depression, being isolated, some feel that they will not be able to recover from the ailment. Some may be tempted to think that even if I take medicine I will not be able to get well. This thought by itself may cause anxiety.

It was apparent from the interviewed professional health workers that diagnosis brought along some concerns. The main concerns were on the medication. It was feared that medication demands a prolong use, ranging from months to years. And the medication usage also had a negative reaction from some of society members who would isolate the patients or get them labelled. Even though the medication helped the patients to gain insight and thus understand the state of health they were, it also at the same time brought fear for patients to understand the state they had been and how they will be perceived by others. It was as the patient had been assigned a

lifetime role of being mental patient and his/her behaviour, thoughts and feelings to be viewed under those spectacles. Parsons (1991) describes it as the ill being assigned a complementary socially determined role that conveys a socially recognized set of expectations and obligations. In this case, those who had once been diagnosed as mentally ill, were also perceived that they will continuously at different time shows tell-tale signs of their condition.

Summary

Mental illness was conceptualised by participants according to the context they were during the study period. At AMSH to begin with, patients were being referred to as *ye'aemro himemtegna* (mental patient) and the phrase *ye'aemro himem* (mental illness) used to describe the condition of the health. It was from how mental illness is described, noticed or diagnosed and the attributed causes and the effect of mental illness that the view of participants became apparent.

Among patients interviewed, from their narration, it was clear that their conception of their mental health state and its cause was influenced by both their socio-cultural background and their contact with professional health workers. This was according to how Kleinman (1980) explained that explanatory model of an individual is bound to change over time in response to medical experiences and encounter in which one becomes acquainted with practitioners explanatory model. A typical case among patients was that of Frez. Frez having been ill for many years, and having had exposure to both biomedical and religious health care systems, she had a multiple ways to conceptualise her mental health condition. Frez described her first condition before coming into contact with any health care system to have been depression. But since Frez comes from society that has its own way of perceiving the condition she was in, this local moral universe also influenced Frez to believe that her condition might have been caused by some supernatural phenomenon. And consequently the appropriateness of seeking a form of religious therapy.

Frez had explained that her father at one time had become mad, having been bewitched. Frez also stated that her father went for *tenqway* (indigenous healing). And also that when her father died, she being the elder child, she was to inherit a *menfes* (spirit) from him, as it is believed from the community she comes from. When Frez was finally brought to mental hospital, she

came to understand her condition as bipolar mental disorder, a condition explained by health workers to be chemical imbalance in brain.

Like Frez, all patients interviewed attributed their illnesses to various biopsychosocial factors, such as depression, hopelessness, excessive study, mood fluctuation, drug addiction, in addition to supernatural causes which are witchcraft, spirit possession.

The caregivers' conceptualisation of mental illness was exactly according to the patients interviewed. Caregivers perceived mental illness to have biopsychosocial causes beside supernatural causes. The caregivers too were influenced by their encounter with professional health workers' explanatory model.

Though professional health workers at Amanuel Mental Specialised Hospital predominantly described mental illness to be a chemical imbalance on brain, it was apparent that they shared to a certain limit some of the patients and caregivers perception of mental illness to have a supernatural cause. This can be attested to the fact that all of professional health workers interviewed, identified themselves with religions found in Ethiopia, which also dominantly believe on supernatural beings and their influence in human beings affairs. Professional health workers also informed me that the cause of mental illness is unknown, rather, there are various factors attributed to it such as genetics, economic, substance abuse, among others.

4.2 Opinions and Attitudes towards Treatment and Care

Various sub-themes emerged from the data in regard to care. They are classified in this study as: forms of care and providers; extent of satisfaction with care provided; extent of satisfaction with care provided by others (indigenous healers).

It was apparent from the study that the first care given to the mentally ill was from the family members who happen to be close to them and are also involved in making decision on which further care and treatment their beloved should be provided with. The care given by the family members was widely considered to be of great importance in the healing process of the patient by all parties involved. On the next level of care/treatment which is given by the health

professionals or religious leaders, opinions and attitudes varied depending on all the avenues of care previously sought and their success since most of the participants had been ill for a long period of time.

4.2.1 Patients' Opinions and Attitudes on Forms of Care and Extent of Satisfaction

Participants interviewed at Amanuel Mental Specialised Hospital explained the different forms of care they receive at the mental health institution and their involvement with other forms of care. As elaborated by Frez, "I am using both medication and spiritual therapy simultaneously. I go to church for *tselot* (prayer) and also I take my medication… The health professionals give us medication and explain to us the benefits of using them and also how we should be feeding ourselves… Since admittance I have now improved. I have gained hope in life again. This is because I have taken medication ... If you are not given treatment on time your situation exacerbates. It makes the treatment process not to be as such successful and thus prolong your healing process." Frez continues to explain on her recurring illness and care she would prefer to be given, "I am happy when I am cared for whenever I am not able to work due to my episodes. Doctor has greatly helped me by advising my relatives on what if they do for me, my situation can improve to a better condition."

Eyob, a drug addict, is among patients that are provided medication and psychotherapy in scheduled manner. I have been seeing him with others performing various chores such as gardening since I started my fieldwork at AMSH. I was told it is part of rehabilitation programme to help integrate them back to society. He stated that: "Besides taking the tablet medication, I participate in various psychotherapies offered in the institution such as group therapy and male therapy. This affords me the knowledge on relapse which is essential if I am to stick to my goal of abstinence from addiction. And also I work in gardening to keep myself occupied." Eyob has a dilemma on whether to attribute his improving state of health to psychiatric care he was receiving at the time of interview at AMSH or religious therapy that he had previously attended at *tsebel* before finally being brought in here. He explains, "I first went to *tsebel*, but *menfes* (spirit) was not found on me. Since childhood *Dirsane Mikael* and *Dirsane*

Gabreal had been tied on my neck (he shows me a kitab (amulet) on his neck). This protects me against any kind of evil spirit attack… when I went to *tsebel* I believe I was cleansed from my addiction."

Since most of the patients had been ill for a long time, they had also tried other forms of care such as *tsebel* and *tselot* besides using medication. It seems from the response of the informants that religious based therapy was a continuous activity attended with or without episodes occurrence. And most of the participants stated that be it medication or *tsebel*, all need faith in them to be effective.

It was evident from the response of most participants that proper and timely use of psychiatric medication and psychotherapies was beneficial despite the relapses. Ahmed aptly expounds this as follows:

> I was given both psychotherapy and medicine. I took medicine according to doctors' advice until I completed my studies and graduated in 2001e.c. I experienced the next episode some years later at my working place and that's when I saw it necessary to consult religious therapy. I went to *sheikh* who read a *Quran* for me and I felt a small relieve. That's when I decided to ask my relatives to bring me to AMSH. In AMSH I was admitted into private ward and provided with the tablets for 3 to 4 days. I felt better as you can see me now. Though I had gone for religious therapy, my state did not improve tremendously. This is not due to religion's failure rather it is the problem of religious leaders who are profit-oriented and bothered not to read for me the Quranic verses that could have healed me rather simply read what they desired regardless of my interest. So I simply came to AMSH and I am now improving. I hope the medication that I receive in AMSH will enable me to go back and achieve more at my working place.

Most of the participants recognise the importance of religion in mental health care, the point of discontent is mostly not in religion per se but on individual religious leaders who due to misinformation try to impose their own attitude on the care of the mentally ill in the name of the institutions they represent.

This is illustrated by one of the participants as follows:

> One *sheikh* told me it is not good to use psychiatric medication rather I should consult religious healing - reading of *Quran*. But people have different opinions, for another Sheikh advised me to come to AMSH and take medicine for my situation. Religious leaders have no clear perspective on treatment options. I believe religion has a big role to play in an individual's mental wellbeing, but this can only be possible if the religious

leader is conscious and uses well the religious writings. In *Quran* there are a lot of healing verses. A caring *sheikh* can help by reading the relevant verses that can bring healing to one."

He then gives me example to elaborate the importance of reading the right verses of Quran for mental illness. "If you are mentally ill and you go to Tikur Anbassa do you expect to get the appropriate drugs for your case? For sure not, it is preferable to go to the specialized hospital for your treatment to be guaranteed so the same applies to the reading of Quranic verses."

The same comment on religious leaders and their divided attitude towards psychiatric medication was eminent across participants from various religious backgrounds. This clearly shows that people identifying with same religion are not influenced by it in the same manner.

4.2.2 Caregivers' Opinions and Attitudes on Forms of Care and Extent of Satisfaction

Among the caregivers as patients, it was clear that the anguish mental illness brings makes individuals so desperate to the point of consulting any source of healing in hope of recovery. Abdul, a Muslim aged 60, a father of seven children and the caregiver of his firstborn son aged 37 who has been ill for the past 6 years, describes with frustration in his voice on the kinds of therapies they have sought:

> My son has been ill for 6 years now and all the treatments we tried failed. We took him to *tsebel*, at Weliso and even here in Addis but his situation did not change. Then after we switched to *habesha medhanit*. In Addis he spent 10 days in *tsebel*. We had forcefully took him there. He escaped from us and went back to our home in Weliso. By then, he was still better, he had not started to waste money. In Weliso, he continued with his trading while his sister helped him attend the *tsebel* therapy but he didn't get well completely. It is when he started to chase and attack people on the road, taking stuffs from home and also from neighbours and dumping them in the forest, in unknown places, causing me to pay that we finally decided to chain and bring him to AMSH where he has improved remarkably within short time.

In group therapy Abdul had said that it is because he has faith that mental illness can be cured that he brought his mentally ill son to AMSH.

It was evident from most participants that decision to take patients for psychiatric care was often made after pursuing other forms of therapies and also when the illness has been noted for its

adverse effects ranging from physical violence to wastage of resources to inflicting economic damages to others with family members being held responsible.

The relapses that commonly occur with the mentally ill also is a driving force for individuals to try other forms of therapy in hope that finally the ill will permanently be healed. This was eminent even among those who had brought the mentally ill to the hospital on the very onset of illness. Hassan a 60 years old Muslim man with elementary level of formal education and the caregiver of his youngest daughter Lefisa aged 26, described to me with sadness in his voice on how Lefisa became ill at her mid teenage (16 years old) in Dubai where she had gone for work and care being provided for Lefisa: "She had barely stayed in Dubai for a year (11 months) when her employer called to inform us that Lefisa is ill and they cannot afford to take her to hospital. So, they sent her back to Ethiopia."

Hassan in an unsecure voice explains to me:

> We don't know what happened to our daughter for when she left home for Dubai, she was completely well... Immediately she came from Dubai, we brought her to AMSH. It is after that, that we took her to *Quran* reading and then later to *tsebel*. It is because we brought her immediately here at AMSH before it worsen that she got well soon. This is the third time she has been readmitted in AMSH. We went to religious healing without stopping her medication. I know of two people who had gone to *Quran bet* and to *Kes* (*tsebel*) and even *bahilawi medhanit* (indigenous medicine) whose situation even worsened... Amanuel's medication is helpful... If only there can be a medication once given then a patient can stay well for even 2 or 1 month, it could be good. Lefisa's situation, I don't think, can be cared for without medication. So the way drug is provided should be improved. As it seems to me when Lefisa stops medication she will get just worse.

It is remarkable how decision for care is made in this situation. It was rational for this Muslim family to take their child directly to AMSH instead of religious therapy, for their daughter became ill while working for a Muslim family and in an Islamic country yet her employees stated that they can't afford to take her to hospital, which was according to them the proper place for Lefisa. This influenced Lefisa's family on thinking immediately of AMSH. It is with the relapse that the family thinks of other alternatives and takes their daughter according to their religion to Quranic reading. When this failed, being influenced by their Orthodox Christian neighbours, they decide to give *tsebel* a trial for their desperate situation. This was the common trend of care seeking among informants interviewed.

Among some participants, it was evident that the supernatural cause of the mental illness had taken sway of them despite their access to psychiatric medication. Almaz one of the caregivers interviewed in AMSH, explains how the relapse happened the same time as the previous episode, and among the locals this cannot be just a mere coincidence rather it is an evidence that her suspicion of her daughter's school friends having done *something* to her daughter is confirmed. Almaz illustrated:

> When my daughter first became ill she stopped school to attend *tsebel* and medication. We took her to *tsebel* and also to St. Paul hospital and she did improve. So, I changed the school for her. Later on the episode repeated once again on the same day and month as previously. She had stopped to take her medication to attend only to *tsebel*. We once again took her to St Paul hospital and they asked why we stopped the medication. So, we decided to bring her here at AMSH to be admitted as in-patient. It was doctor's decision for her to be admitted for drugs to be taken accordingly.

Almaz believes that AMSH offers good services due to the improvement she has observed in her child. And that there is no any conflict between her religion and medication provided at AMSH.

As the professional health workers explained the cause of mental illness according to the institutional perspective to be biopsychosocial and the care provided to be likewise, biopsychosocial, so was it the same with both patients and the caregivers. Most of the patients and caregivers stated the cause of the mental illness to be both biopsychosocial and supernatural. And thus they believed it necessary to consult the biomedicine as well as religious therapy simultaneously.

Wondu a 38 years Orthodox man with 12th grade level of education and 8 years of experience working as a caregiver at AMSH explained to me that both medication and religious therapy is vital in care of the mentally ill. He stated:

> I don't believe mental illness is wrath of God, to me it is just like any other form of illness which if treated can improve and get well. Medicine cures them and *tsebel* or their religion heals them too. If the two can be integrated then it could help improve their situation. They find a lot from spiritual therapy, inner peace. Medicine is appropriate for mental illness too as it is to physical ailment. This knowledge has been given to human beings by God. As a Christian I believe in existence of *aganint* (in demon possession) but also I believe that there are cases which are purely mental illnesses. Formerly *yemitil beshta* (epilepsy) was considered as demon possession but at the moment they are being treated well in the hospital. At the *tsebel* I know people who have been healed and since it is my faith I believe too.

Wondu further described the chronic nature of mental illness and the role of both science and religion in caring for the mentally ill: Mental illness is a long term illness. There are patients who have been attending medication for even 20 years. I don't think science has attained full understanding of mental illness but it tries to manage and control it. Unless God prevails, I am not sure whether they can get fully well. Medicine mostly makes them numb and sleepy, to prevent them from being violent. I believe in religion, whenever people are stressed and go to religious places they get inner satisfaction. I don't think such kind of satisfaction can be found anywhere else. Religion gives hope. Religious things are hard to explain. The religious logic is different from science where you can examine things.

All participants interviewed subscribe to one of the religions found in Ethiopia. And all these religions have a spirit dominated cosmology. Hence, many were at a crossroad in deciding where medicine comes in since these religions perceived mental sphere to be the realm of supernatural entities. So they preferred to gain from both without letting go the other.

4.2.3 Patients and Caregivers Discontent on Care provided at AMSH

Participants interviewed were mainly not contented by the care provided at AMSH on aspect of nourishment. Among the patients, caregivers and professional health workers food provided was repeatedly mentioned as not sufficient. One of the participant exemplified as follows:

> The patients are only given a piece of bread for a breakfast this can barely sustain them. Most of conflict in AMSH is on food issue. The food they are given can barely sustain them. Relatives (caregivers) get fed up and leave the patients to the hospital. And since follow up is not done, patient can end up taking drugs on an empty stomach. I have witnessed two patients getting well and then deteriorating again. This is because they don't get enough food, there is no one to take care of them. The care given by relatives is important. If the patient is not cared for I don't think one can get well through medication alone.

Frez told me that if they are well cared for especially on food then they believe medication can be effective too. She stated, "The care we are given here is good. It is on food that we have problem, a piece of bread for breakfast can barely sustain you until lunch. And our relatives are not able to come daily to bring us something to eat. If only we can be given full care then our situation can improve and we may reach better health state soon…"

Beside food also clothing, admission process, and aggressive attitude of some health workers were mentioned to be wanting. One of the participants aptly summarised this as follows: "the attire we are provided with have a side effect ... It is hard to find a bed for in-patient it takes long. Because there are a big number of people who are waiting to receive treatment. When I don't receive treatment on time, I get very stressed up and I can in the process harm other people, I can harm myself, I can even kill a relative. It is necessary to give mentally ill people quick medical attention."

Some participants grumbled on how health professionals perceive their lot, "they think we became addicts out of our own desire." This also is what *Abba* had told me, this shows that in a society where most people can barely obtain the basics for survival, an addiction is perceived to be a luxurious habit, and professionals likewise are influenced by their socio-cultural context to cling to such an attitude. Ethiopian Orthodox Tewahedo Church through its feasting and fasting seasons emphasises a lot on self-control.

Summary

In summary, participants (patients and caregivers) interviewed at AMSH described the diverse forms of care they receive at the institution as ranging from medication, psychotherapy and also involvement with other forms of locally provided care. The participants partook of different therapies provided by religious organisations such as *tsebel* by Orthodox Church, *tselot* by Protestant congregational meetings and Quran reading by Muslims. Most participants regardless of their religious background had tried beside the medication they were receiving at AMSH also the *tsebel* therapy found at various holy springs in Ethiopia. And also most of them had a form of amulet for protection. Most of the participants emphasized on the importance of medical treatment and the need of timely medical intervention.

In patients' group therapies, participants stated that support from family, community, health-workers and above all the connection, good relationship with God is important for the ultimate mental health.

Patients referred to as psychotic and mood cases were of the benefits of timely medication especially during the relapses moments. While those of addicts cases pointed on the importance of psychotherapy in managing their situation.
The patients interviewed stated the necessity of involvement in activities either work or studies to improve their condition.

Patients who were experiencing AMSH for the first time were in many aspects pleased with the care provided despite some shortcomings. They stated that it was to their surprise as if they were expecting the worse with their admittance to this national institution of mental care. To show their appreciation some of the participants stated that their previous religious care and psychiatric care were compatible for they both help them get better. Others explained that though medicine is human knowledge endowed by God and *tsebel* is natural spring, both need faith on them to be effective.

Since most of the patients were relapse cases, they had in between sought religious care and only finally came to AMSH when their condition had got serious. So AMSH was a kind of a referral care centre for both Ethiopia regional hospitals and also indigenous forms of care.

Participants main points of discontent with care provided at AMSH was on nourishment, clothing, admission process and some health workers' aggressive attitude in handling them.

4.2.4 Professional Health Workers Opinions and Attitudes on Forms of Care and Extent of Satisfaction

On opinions and attitudes on care for people with mental illness among professional health workers, the data are classified on the following sub-themes: forms of care/treatment provided, extent of satisfaction by care provided at AMSH and extent of satisfaction by care given by others.

4.2.4.1 Forms of Care/Treatment

Professional health workers at AMSH described to me the forms of care provided at the hospital as starting from the registration of the patients, diagnosis, assigning of the case team and the continuous follow-up thereafter.

Hirut a psychiatrist nurse aptly described it as follows:

> When patients are brought to the hospital the first thing is to get them registered (giving card) then we assess the patient on whether to give him care as an out-patient or in-patient. Chief complaint (one who has brought them) gives the reason of bringing the individual. Family history (of illness) and individual history are all inquired. In our clinical judgement if we assume that the patient is not harmful to himself, harmful to others and his clinical condition is not deteriorating, generally he is not severe then we decide to follow-up the patient as an out-patient. If the patient fulfils the hospital admission criteria we admit him as an in-patient. The new in-patient would be taken where the relevant treatment is given. Psychotic would be taken to psychotic case team, and so are non-psychotic, mood and geriatric. All are taken to their right places. They are sent to their various appropriate ward (places) with their names, age, marital, religion, where they come from, occupation and diagnosis made. Also advice is given on the importance of taking medication and how to take them. We create a close relationship with the patient and their relatives and urge them to keep in contact. This enables the follow up to be easy.

The informants told me that though the hospital is based on biopsychosocial model of treatment, it is medicine that is mostly provided to patients and that psychotherapy which was recently (some four years ago) introduced in the institution is now catching up with a clinical psychologist stationed in each of the 11 case teams/wards. Social workers too are at hand to provide for patients' social needs, such as those who are not able to pay they guide on how they can receive the free government funded treatment.

For out-patients, there is a follow–up done in 15 days or 30 days. That is according to the progress the patient has shown. The effect of medicine is observed in the process and if there is no progress, the medicine may be changed. For in-patients, they are daily checked by the psychiatrists and also by both MSc psychiatric nurses and B.Sc. psychiatric nurses.

In various psychotherapies, I attended at AMSH I was able to observe how patients are encouraged to participate in individual and group therapy. These therapies I was told are meant to empower individuals in aspects of assertiveness, emotional tolerance, and communication skills. The clinical psychologists would inquire of the patients' and their caregivers' understanding of mental illness and then after explain to them the professional understanding of mental illness and how to cope up with their specific disorder.

This form of therapy provided in AMSH is not extensively known, especially among the out-patients for mostly they would attend to medication only, as one of the participant explained to me: "Treatment offered at AMSH is not only medicine based but also there is psychotherapy. Informed individuals especially those who are outpatients would always request to be given psychotherapy. Since most patients don't know the available options they are left to psychiatrists to decide for them and since psychiatrists' background is medicine what immediately comes to their mind is medication. Habit die hard, if you are used to prescribing drug, no matter the case, you will always find a drug for it."

4.2.4.2 Extent of satisfaction – AMSH

There was a mixed feeling among health professional workers on extent of satisfaction on care provided to patients at AMSH. Participants' view on AMSH as the only referral psychiatric hospital in the country drew different expectations, while others saw it as the reason for overflow of patients and thus reduced quality of care, others stated that it being the only referral hospital it should deliver more and high quality care. I was told that it is a psychiatrist who is supposed to see the patients but due to limited human-power the psychiatrist nurses with master's degree would assume the psychiatrist role and only refer to the few psychiatrists available in the hospital on cases beyond their scope. Some of the participants also were doubtful of the biomedical understanding of mental illness. This they attributed to the repeated relapses they often observe from patients. There was also decrying among health workers on the dominance medication held in the institution. This I was told has led to the institution to be known even to the public as only providing drug at the cost of other available therapies that can help in advancing the knowledge of mental illness to the patients and their caregivers and also in integrating the patients back to the society. Other basic needs such as better clothing, meals and medication were mentioned to be necessary for alleviating the patients' situation.

Taye: AMSH being the only referral psychiatric hospital in the country has an overflow of patients. Hence the quality of service has gone low. Routinely I often see the same patients repeatedly being readmitted for the relapses... Biomedical knowledge of mental illness is still limited, consequently the probability of getting completely well is also limited... patients have to use their medication for a long period of time.

Giza: We have a lot of patients compared to the hospital capacity – 280 beds. And still there are many who demand admission. Due to this, we have load of care. If you are loaded with your job it is difficult to some extent to say I am very much satisfied with the care of the patients. Most of the patients who come to us are at severe level, it being a referral hospital, our role is mainly to control the symptoms and to stabilize the patient to live to normal routine life. E.g., if he left education - for him to continue; if work- to resume back work. We are not supposed to address all aspects because of limitation on resources and time.

Selam: The patients' clothing, meals, medication and general professional service should be improved... With the exception of giving drugs a lot is left undone... *ye'aemro himem yidnal* (mental illness is curable). If the patients take the medicine accordingly they can be productive members of society.

4.2.4.3 Extent of satisfaction of care given by Others

The health professional workers at AMSH were aware of the presence and in fact predominance, the other health care systems have on the care of the mentally ill in Addis Ababa and even the country as a whole. Most of the participants appreciated the role others especially religion has in the care of the mentally ill. The grievance the participants had against others was on timing and care of the ill. Some of the participants complained that patients are rarely brought to them on onset of illness rather after it has become severe while exhausting other locally available therapies and this makes it hard for patients to respond well to medication once they are brought to hospital. And also at times patients are discouraged from taking their medication. Participants moreover mentioned that they don't forbid the use of the local therapies but rather encourage it to be implemented beside medication.

Giza: Most patients before coming to the hospital already have visited other multiple support groups, such as spiritual care, and indigenous healing care. Even after admission or assuming biomedical care most would still maintain the spiritual care they have been receiving. Since in the definition of *health* we have a spiritual component, we sometimes encourage some patients to have a contact with their various religious leaders. If we have support from religious leaders sometimes the stress and other things would reduce. Religious leaders have a certain role to play

in the care of the patients. Since the community at large accepts the role of religious leaders and considers them supportive, our interest is to integrate and educate them about mental illness.
Awet: People don't understand how hormones work in our body, so whenever there is chemical imbalance they will attribute it to supernatural causes. *Yih sew telekfo beSatan* (literally meaning, this person has been possessed by Satan) so they take them to spiritual therapies. It is only when they fail to see any change that they decide to give AMSH a trial. We don't forbid patients to use both forms of therapies, we encourage them to use the religious therapy without abandoning their medication... Medicine has more promise if compared to others. Others are not scientifically proved, they are just based on belief.

Hirut: Most of the mental illness cases are taken to holy water. Others having tried several times our treatment and fail to get well, also end up going to *tsebel*. All go for spiritual treatment according to their religion. When the religious therapy fails they come here and other time when the medication fails they go for religious therapy. After getting bored with medication they go for religious therapy. One can get bored of using medication because they become under medication for a long period of time. Medication period ranges from 2 to 5 years and even lifelong. I personally believe and trust in God. So, I believe that God can heal them. Therefore, the advice we often give those who are going for religious therapies is to take the medication alongside.

Zola: Religious rituals can help manage mental illness. After all science has not fully understood mental illness, it is still in process... In the past (7 years ago) at AMSH a health professional would be heard telling a patient not to go to *tsebel* for fear that patient's situation may worsen but currently patients are encouraged to get involved with religion and medicine to be taken alongside.

Ruf: Most of the patients can be found attending therapies especially at *tsebel* sites, and it is only a few who really come to biomedical centre, of which also biomedicine cannot take care of due to its very limited skilled human power. At the time being, they are very helpful for us. The integration between religion and biomedicine is good, because patients having stayed at *tsebel*

and are not improving are sent to the hospital. AMSH is a referral hospital for both those from the other hospitals and also for those from other forms of therapies.

Marc Khan in his research entitled "*The interface between Western mental health care and indigenous healing in South Africa: Xhosa psychiatric nurses' views on traditional healers,*" founded that nurses tended to give priority to the psychiatric model of which they made the centre around which they imagine various possible forms of association with indigenous therapies and thus relegating indigenous healing to ancillary status to Western mental health care rather than as a parallel system. This was evident among many of the health workers I interviewed at AMSH. But the professional health workers providing psychotherapy care and those with social science background were of different perspective to their counterparts. They stated that it is undeniable the role and influence indigenous healing especially religion has among Addis Ababa residents even Ethiopia as a whole and thus to be imposing to insist on biomedicine as the sole determining factor particularly on issues pertaining to mental illness.

4.3 Lived Experiences of Patients

The data on lived experiences of patients in health care systems is organised into two main themes, namely: Challenges in seeking care and means of solution and agency among people with mental illness.

4.3.1 Challenges in Seeking Care and Means of Solution

Challenges encountered by patients in seeking care ranges from economic, social and cultural related barriers to organisational limited services. They are discussed below.

On question posed on problems one encounter to find care, diverse responses emerged but the most prominent among the participants was on lack of information and knowledge about mental illness. It is aptly elaborated by Frez as follows:

> The biggest problem is lack of information, knowledge and awareness about mental illness. I became ill when I was 14 years old (1984). I stayed for 4 years with the illness without anyone knowing even my mum didn't know. I would always go to church, I would be greatly depressed but no one knew. It is my mum who would ask me *minhoneshal* (what has become of you). Yet, she did not know where particularly she

> should be taking me for treatment. It was later on that my problem was known and then I was brought to AMSH. It is people who advised my mum that if I am brought to AMSH I will find a solution to my problem. Lack of information can stress you on what action people are planning for you next.

The challenge Eyob encountered on deciding whether to attend a psychiatric care was kind of a spiritual warfare in the mind between evil and good as he puts it. He expounds, *Saytan balege new* (literally meaning, Satan is bad mannered) he would whisper in my ears are you going to Amanuel *min yaderglihal?* We came in the morning with my brother then I disappeared and left. What made me to disappear from my brother?, I think is a *menfes* that does not want me to get well. There are two powers: one that takes me to good places and the other that takes me to destruction. For me to enter or not to enter though influenced by these two giant rivalry spirits, it is decided by *aemro weym lib*. So it is on my second day that I made my personal decision to come here."

Balege is a common abusive term used among Addis Ababa residents to refer to a rustic person. Its combination use to refer to supernatural being shows the religious dominated thought pattern, a society where supernatural beings are as much part of society. Later on in a discussion, Eyob told me that he first thought coming to AMSH is a compromise to his Orthodox faith that advocates for *tsebel* therapy for many forms of ailment affliction, especially for mental related cases.

Some participants especially those who often had relapses stated the need of cooperation with *kebele* administration support in order to access government mental care funding. As Abate explained to me, "... since my father is poor kebele had to write a recommendation letter for me to get admitted in AMSH."

Among participants especially those experiencing psychiatric care for the first time, the greatest challenge they had to overcome was stigmatisation that comes with associating with Amanuel. It was apparent from the group therapies and family therapies I attended that Amanuel was a feared place and also identified with severe mental illness. And just a knowledge of one having been

there could affect the individual's future prospect. This was also mentioned to be the reason why some hesitated to seek psychiatric care at AMSH.

Among caregivers and professional health workers, less awareness of mental illness among the public was explained as the reason to keep away from seeking psychiatric care and be the cause for society to scorn, make fun of the mentally ill and gradually isolate them from participation in social activities. The participants mentioned the poor communication the mentally ill individuals have made them susceptible to various kinds of discriminations and prejudice. And for patients, to be considered as a burden in most aspects of life. The isolation, in turn, causes them to be left unattended and even more depressed causing them to move to streets and assume a different survival mechanism that is contrary to societal norms.

Participants explained that AMSH being the only referral hospital specializing on mental illnesses and since it is based in Addis Ababa city, most of the care seekers have to come from afar. Most of the participants mentioned the distance and the cost of traveling with the patient to be unbearable. Also it was mentioned that though the treatment is offered mainly free of charge, the admission process was time consuming since the hospital has very limited bed space. So, the patients had to wait for some days to finally get admitted as in-patients. Meanwhile, they had to pay for the hotel lodging cost. From the informal interview I gathered that due to high cost of lodging some caregivers from rural areas who had no relatives in the city opted to stay for a while at *tsebel* place where they could find more affordable accommodation and try *tsebel* therapy until they are given a call from AMSH when bed is available.

From the critical medical anthropology perspective the roles logistics and availability, allocation, and access to biomedical resources played to the less economically privileged Ethiopian was evident. Though the treatment was free but those from other parts of the country had some expenses to pay for in order to finally get to the hospital.

Most of participants seeking psychiatric care for the first time were unaware of the free care provided by AMSH, so they stated that as also a reason to refrain from bringing the mentally ill. And this unawareness and long process of admission were explained to aggravate the patients'

situations and also endanger the life of their caregivers whom they may harm in the process. Hence caregivers often resort into chaining the patients.

The role of relative in caregiving was consistently mentioned as necessary not only in providing the basic needs of the mentally ill but also as a guide to psychiatric care and social support the patient dearly need during the illness period. Some families were believed to refrain from bringing their mentally ill not due to the expected cost but in fear of losing esteem in community. Still those brought after discharge were discouraged from taking medication on the claims that drugs will make them fat and that their problems are not even biological but rather a spirit possession. All participants understood mental illness to be a kind of illness that needs the whole society's cooperation and not specifically restricted to psychiatric hospital care of which patience admission is often only for a short time. As Garro (2004) states, from a cognitive perspective a recurring decision situations, those who are involved in it come to have a shared understanding on how to tackle it.

The following interview excerpts from the professional health workers summarise other participants' views on challenges patients encounter in seeking care and means of solution.

Hirut: Mostly patients are helped through by their families, who brings them and get them registered (given card) and follow them up. If one has no family, he might even from the start not be able to come. Lack of relative is a great hardship to a mental ill patient. Lack of family (relative), poverty - unable to raise transport cost for long distance places and the cost of living until the treatment is over. These give the caregivers an easy option of taking the patient to *tsebel* therapy. Some even though they have money they don't bring the mentally ill for treatment for fear that neighbours will talk about it and they might lose their "good" reputation. They don't want it be said that in their family there is a mental patient. Some families fear that once one of their own has been identified as *ibd* (mad), people will isolate the whole family from social participation. They would simply chain them at their homes in secret places. Not wanting it to be known that among them there is a mental patient. Some who are rich would take them to private clinics, fearing to bring them at AMSH (for AMSH by itself is known specifically for mental cases). Even though recently (some 8 years ago) through government integration project AMSH

has opened also ART and Maternal care units, people still often associate AMSH mainly with mental illness and majority who come to AMSH are mental illness cases. We tell the patients that anybody can become mentally ill and any family can face such a situation and that they should follow medication well.

Giza: Psychiatric services are mainly situated in Addis Ababa city yet we have 9 regions in the country which equally needs the services. Patients thus come 1000 kilometres to get service here. And this has an impact on their economy and time. For they suffer a great deal to reach here AMSH. Most patients are not able to come for follow-up due to the great distance and financial problems. Absence from work leads to some of them to lose their jobs. Stigmatization at the work place is also a contributing factor to relapse... The treatment is given free at AMSH. Almost 90% of the patients receive free treatment. (10% private ward). Patients bring recommendation letters from *Kebele* stating their poverty status. Based on this recommendation letter, the government funds the patients' medication. The patients only have to pay for the traveling and hotel costs to get to AMSH. This cost also is a challenge to most of the patients and their caregivers. At one time, there was a massive communal service for the homeless on which we took in more than 200 patients from the 10 sub-cities found within Addis Ababa. Other times, it can be very hard just for an individual from the street to get admission because a caregiver is necessary, one who takes the responsibility of the patient.

4.3.2 Agency among People with Mental Illness

On agency among people with mental illness, the study tried to focus on how people with mental illness are involved in their care and both the facilitating and constraining factors.

The patients interviewed described various ways they are involved in their care and the importance of one's own initiative to enhance recovery. Frez explains these aspects by stating that, "Though one can receive care from family, from society, from health professional, but the main part lies with the individual herself/himself. The care others give may not amount a lot unless one has her/his own initiative."

Most of the participants stated how medication helps them control their behaviours. Hence respond well to health workers care. One of the participants aptly explained:

> I take medicine as prescribed and explain entirely my problems to the doctors for them to be able to help me fully. I heed doctors' advice. Before I used to chew *khat*, now I don't, I stopped smoking cigarettes and drinking coffee or tea after 10pm according to my doctors' advice. This has improved my state of health. If I become well, first it serves me, then my family and society and country at large. I become a productive member."

I observed a number of patients engaging themselves in studies. Eyob would often study journal articles and books on drugs and brain functioning, trying to have a profound understanding of his situation while Lub was more interested on general knowledge. He would often juggle his time between gardening and studying. Eyob explained to me his resolution, "Without good health you can't accomplish anything. In the future I have decided to abstain from anything addictive. Once I get out of here I want to be clean from drugs. I have quitted smoking completely even though around here some smoke. I want to be a better person. I refrain from peer pressure."

Most of the participants explained to me the significance of engaging in activities and restraining from stressful situations. It is illustrated eloquently by one of the participants as follows:

"My future plan is when I get out of here, to find work to do. If you are mentally ill you need something to concentrate on, if you don't find one then your situation worsens. I mostly read books. Once you become a mental patient, you have to be careful, if not you get so much stressed. I am careful now on taking my medication and avoiding stressful situations."

Even though most of the patients I interviewed showed signs of their involvement in their healthcare of which, of course, made it possible for me to engage them in this study, others were restless that no any form of approach could made them participate in any constructive venture at the time of the study. They were the lot that could be found hanging about seeking people to hassle for cigarettes and money for *buna* (coffee). Whenever this lot became unbearable they were threatened with injection. "This injection sends them to 24 hour sleep and they are scared of it."

4.3.2.1 Factors that Facilitate Patients' Involvement

Participants interviewed reported medication, psychotherapy, relatives' presence and religious leaders' guidance and rituals to be the most important factors that facilitate patients' involvement in their own care. Relatives' presence was stated to be important for its unceasing social and economic support during episodes experiences while religious leaders' guidance was considered as the determining factor on whether to use medication or not. Religious rituals were mentioned to be effective for uplifting the morale of the patients and giving them sense of purpose and belonging.

Hirut: after taking medication a patient knows her/his problem that s/he is mentally ill. S/he start to ask who am I? At what state am I in? Am I functioning well what kind of problem am I in? Now that s/he knows her/his problem s/he has a goal to solve it, and s/he follows medication accordingly. These all are possible only if s/he got the insight which enables her/him to attend to follow-ups. Insight is the first thing in our institution.

Giza: It is very difficult for the patient to recover unless we involve both the patient and family (caregiver) in the treatment process. For example; if a patient uses substance, this may lead to relapse, so not to take substance is the responsibility of the patient. The patient may not know that substance affects her/him, so we educate them. Once the symptoms are controlled (the patient gained insight) we tell the patients the precipitating factors of the illness such as if the substance is the case. So, when the patient stops taking the substance s/he is involving in her/his own care (indirectly). We also educate both the family members and patient in group therapy. In the therapy we only tell the patient how to modify her/his behaviour, while the responsibility lies with her/him to implement it. In psychological aspects the main roles are implemented by the patients themselves.

4.3.2.2 Factors that Constrain Patients' Involvement

Most of the participants (patients and caregivers) interviewed at AMSH reported that others' perception on mental illness, boredom from long-term medication usage, absence of a relative and economic difficulties to be the constraining factors to patients' involvement in their own

care. Distance from psychiatric centre in order to make a follow-up at stipulated time was also mentioned to hamper patients' involvement.

Selam: Lack of insight makes one incapable to do anything productive... If family fails, due to long term boredom of many years of treatment then the whole care fails... What people say, makes patients to isolate themselves. If one is irritated and raises his voice, people immediately comment, "He is mad." There are people who are mentally ill but couldn't come for treatment here (AMSH) for fear of being classified as *ibd* (mad) even those who have just anxiety fear to come for people might see them and get them labelled "*ibd*". And to be called mad or crazy is painful, the proper name is mental patient.

Giza: The type and nature of illness may affect the patient's involvement. If the patient persistently believes that the cause of her/his illness is evil spirit, then chances are very high that s/he might stop the treatment any time. If an influential person tells the patient the cause of her/his illness to be spiritual and got nothing to do with biopsychosocial the patient will stop the treatment.

On agency among people with mental illness, professional health workers interviewed stated that their intervention on patients care is only limited to the number of days the patients are hospitalised which ranges from 40 days to 2 months and that care is predominantly family responsibility who tends to be with the patient most of her/his life time. Nevertheless, beside medication other forms of therapies such as occupational therapy, play therapy, relaxation therapy, and training skills were mentioned to primarily involve patients in their own care. Participants stated that whenever patients have insight (which happens after taking medication), they are able to create a good relationship with their families and other people and also respond well to advice given such as to abstain from things or situations that tend to aggravate their illnesses.

Participants reported that during patients' presence in AMSH they would take their medication accordingly and thus enhance their recovery and agency but once out they don't, so they relapse and come back again. And that most of the patients are relapse cases, because they stop using

medication to continue or start the use of addictive substances (*khat, haraqe* (local liquor), and cigarette) which often aggravate their situation. Professional health workers also stated that some individuals are committed into getting well. They would call and inquire about certain mental issues, come for follow-ups, while others immediately they get out of the gate all things are left behind.

Professional health workers efforts in involving the patients in their care and the frustrations at times they encounter is best illustrated in the following excerpt of the interview:

Hirut: I encourage the patients to take their medication as prescribed to them and as any illness as diabetic or hypertension to do the follow-up. And to perceive their illness as any other illness and not to have low self-esteem. You wholeheartedly, tirelessly offer your service to the patient and then they stop taking medication. This makes you sad. They might have stopped because of economic reason or due to what people say *eziya eko medhanit yelem, medhanit ayadihinim yemiyafez new. Sew lemefez new medhanitu yemisetu new* (literally meaning, there is no cure at mental hospital, they only provide medicine to make people passive), you feel it when people talk in this manner. For to begin with, they don't take medication as ordered them, they don't come for follow up at the right time, they don't accept what has been told them. You give them a month appointment, they come after 6 months. They come as they want not as ordered so we ask the families why they do so. They come after 6 months having stopped the medication, and developed another illness. Such a situation makes one sad.

It was apparent that for medication to be effective it has to be taken according to professional health workers' guidance of which in most cases was hardly followed by some patients and caregivers. Consequently, this was attributed for the frequent relapses. Hence, among most health workers interviewed, the blame laid on medication to be ineffective was unguaranteed.

Chapter Five
Religious Therapy

5.1 Conceptualisation of Mental Illness

Participants interviewed at the religious site described mental illness in various ways and attributed its causes to both biopsychosocial and supernatural phenomenon. Though generally they perceived that even the biopsychosocial has an ultimate cause from supernatural phenomenon.

The clergy at *tsebel* described mental illness as *aemroatchew teyizowal* (literally meaning, their brain has been occupied/captured) and the categories to be; one group by Satan the other group by the stress of life and another by substance abuse. Those who become ill due to stress were explained to be due to the fact that they were born with less abilities to persevere tribulation or stress and so one get out of line. And also it was believed that when one does that which is not acceptable before God or being in certain places at certain time then chances are very high that one will get ill. It was explained to me that according to Ethiopian Orthodox Church when one is accustomed to doing evil he becomes the aboard of demons.

Abba Kidan one of the priests presiding over the holy water therapy in Entoto Mariam and has been serving there as atmaqi for the past 17 years described to me the cause of mental illness as follows: "It is the substance (*hashish*, cigarette, *khat*) *yemiyadenezezatchew* (that makes them numb)... *Debtera* helps your envious friend or relative to get you ill by giving her/him something to place in your drink. This service *debtera* gives at a fee. *Yemiyasabedu aemro yemiyatemedu* (they make people mentally ill by using certain herbs and by invoking demons)." A number of participants also told me how bad-minded people consult *debteras* to get their rivals ill. *Abba* described to me how *Satan* and *demons* are reality, for they observe them in *tsebel* saying, *hejalehu; altchalkum* (I have left, I am unable to resist). *Aqatelegn*, (am burnt).

Mental illness and demon possession are both *ye'aganint sira* (works of devil) according to Orthodox Christian clergy. *Abba* told me how devil through substance abuse causes mental

illness. But when I inquired of the ladies who are mentally ill yet they are not drug addicts, *Abba* stated that they become ill by *metet* (a kind of a witch drink) provided to *gorebet* (neighbour) by *debtera*. And there are also certain stuffs that the envious neighbour is given to bury at the entrance to the house of the targeted person. These kind of acts are done by those very close to the victim, such as a neighbour, sister, and aunt out of envy. In *tsebel silefalef* (when the spirit screams, it would confess the whole story) we would know how the victim became ill and who is behind it. *Abba* also decry the declining religious inclination to be a contributing factor to mental illness, he exemplified: "In this age and place (Addis Ababa), most of the ladies do not fast (prevention against evil attack). They also go uncovered in the street, exposing themselves to demons who find easy access to them. It was not so in old times. Now that they imitate an alien lifestyle from abroad considering it as civilised, they become mad. Ethiopians have *emnet* (faith) and if Ethiopians go against the expectation of *emnet, asalfo yisetenal* (it leaves us to the mercy of demons)." Definition of madness varies from time to time and also from place to place, but generally it is considered as a behaviour, attitude or emotion that is strange in a given socio-cultural context. So even just dressing scantily in a conservative society may be seen by others as a form of madness.

One of the participants eloquently illustrated the causes of mental illness as follows: People become mad after going to *tenqway* who gives them a medicine to help them in their rivalry with their friends or neighbours (*medhanit yibelatchwal*). Others have union with *kifu menfes* (evil spirit) that enables them to attract evil. This they are able to do at any moment even without having conflict with others. So it is believed that out of this union they might as well get ill. Others in desiring to become rich and successful in their endeavours, go to *tenkola* and later on when they need to stop their relationship, it turns against them rendering them mad. Others due to life stress; loss of wealth, separation of family, and failure to make it in any aspect of life, go mad. Others through substance abuse become mad. These kind of people are not said to be demon possessed rather they are *abdwal* (gone crazy). And also there are actions and places that predisposes one to spirit attack.

Adane, one of my participants, was formerly *tsebeltegna* who had specifically came for treatment 6 years ago. Then later on he became *astemami*, assuming work of caring for others

who are coming for treatment, as he explained, the mentally ill and the demon possessed patients. He has been performing this work for the past 4 years. Adane explained how he first came for *tsebel* therapy and the reason for his long stay, "I was stressed, I was possessed by *Zar* and chicken would be slaughtered to procure my health. And often I would be ill there (in that form of indigenous treatment). But when I came here (*tsebel*) I am alright. I don't want to leave the *tsebel* site because there is nothing greater or worthy than health, it is only at *tsebel* that I experience peace, if I leave *tsebel* place it often strikes me."

Melkam a female patient on her early 30s was brought up by adopted parent in Debre Markos, *Gojam*. She became ill when she was 19 years old and brought on chain to the *tsebel* place 13 years ago. She said *yaschohegnal* (it makes me scream) to describe her ill health status. She has never been to hospital at any time of her illness claiming that she was brought up by Orthodox Church so whenever she is ill she goes to *tsebel*. The *astemami* and priests informed me that whenever Melkam has an episode she would be violent attacking people and screaming. When I probed her to know the cause of her illness, she told me *sew digmt adergobign, yazorub'hal* (I have been bewitched, someone can bewitch you). And that whenever she is being baptised the spirit will confess saying that *buda negn* (I am *buda*) and would scream like hyena. She went on to describe how *asmat* (magic) is a universal phenomenon. "Can't you see all these chained people, they scream, their educational life has been ruined, some have come from abroad possessed by spirits." All these are ill. *Menfes new, Saytan new* (it is spirit, it is Satan). Satan does all these, it is *erkus menfes* (evil spirit).

Daniel a 28 years old single Orthodox male, lives with his parents in Addis Ababa city. At the time of interview, he had taken residence at the *tsebel* site seeking religious therapy. Attendants described to me how Daniel was brought in chains and handed over to the *tsebel astemami*. Daniel narrated how his attendant would often beat him up thinking that he is a drug addict case. Daniel explained that though this episode started after he had drunk alcohol, by then he had not drunk a lot, and he only drinks moderately during feast periods. Daniel does not know the exact cause of his ailment but it started when he was a student at college. He thinks it might be stress or studying for a long time. The trend of the illness is it comes and goes. It is now the third time

when he experienced the episode. Daniel explains to me the effect of his illness to his health and life:

> Sometimes it makes me to have suicidal feelings. Recently, I broke the car's window with my head. When this happened my family panicked and decided to bring me to *tsebel*. It is now 3 months in total since I began to seek healing for this episode. I first attended Tekle Haymanot *tsebel* in Merkato for 15 days. Then Tsadkane Maryam for a number of days before finally coming here (Entoto Maryam). In 2006 E.C, I attended AMSH. It was my first time when I sought psychiatric treatment. They inquired of my situation and gave me drugs. The reason for going to AMSH is that when I was ill I had a conflict with a neighbour and had stabbed him repeatedly.

Participants at the religious site attributed the cause of mental illness to various factors ranging from stress to suicidal feelings to witchcraft and also mentioned the repetitive nature of their ailments. Some participants described how violent they become when experiencing their ailments.

Diagnosis made on the ill at the *tsebel* is to distinguish whether one is mentally ill or spirit possessed. As participants informed me that there is no clear distinction between one who is demon possessed and one who is mentally ill for both are considered to be under the devil's influence. This is why all try *tsebel* first.

Abba Petros explained it as follows:

> Demon possessed patients are mostly normal until when they are baptised, that is when it becomes apparent by their screaming. It is at the *check-up* (*tsebel)* that many things are revealed. The demon possessed patients do not like to go to church and participate in liturgy, the incense irritates them. They are negative to all religious/spiritual activities. But mentally ill persons participate. The demon possessed person functions normally in social life while the mentally ill through their actions of violence and disruptions, people tend to fear and avoid them. And this worsens their situation.

One of the participants seeking healing at the *tsebel* site described the diagnosis as follows:

> We know the presence of Satan in an individual when one becomes ill, when one is baptised by the *tsebel* when he screams, when God's mighty power strangle it, it screams. And also when an individual's brain fails to work. Be it *buda, zar,* whatever they are called, they are all *Saytan*. That which thinks not good for human beings is Satan. That which leads human beings to destruction. That which leads human beings to sin. That which leads human beings to fall into sea are considered as *irqus menfes* (evil spirit). For us not to get into cliff and die, God bounds him. Our Lady Mary bounds him. It burns.

Astemami at the *tsebel* site described the difference between mental illness and demon possession as, "The demon possessed are only out of their mind for only a short period of time. It is the mentally ill persons that cause trouble because they stay for long in that state while the demon possessed persons are only for an episode."

It is from the local moral universe which is both socially embedded and morally satisfying that people often find the underlying causes for their illnesses. This is exemplified in Evans-Pritchard's work on *Witchcraft, Oracles and Magic among the Azande* (1976 (1937)) on which he argues that witchcraft is rational in the context of Azande social structure that uses witchcraft to explain every unfortunate events. In Ethiopia, fasting and the use of *tsebel* is considered as a main identity of Orthodox Christian believer and being in contrary is thought of as exposing oneself to the looming dangers in the realm of spirits.

5.2 Opinions and Attitudes towards Treatment and Care

On opinions and attitudes on care for people with mental illness at the religious therapy, the data are classified on the following sub-themes: forms of care and officiating personnel, the interaction inside the healing hall and around *tsebel* site, the use of psychiatric medication at *tsebel* and the prevailing worldview, extent of satisfaction by care provided by others.

5.2.1 Forms of Care and Officiating Personnel

Participants at the religious therapy described the first care of the mentally ill to begin at home and later on followed by invitation of the *yenefs abat* (spiritual father) who is available in most of the EOTC households. So whenever one becomes ill it is the *yenefs abat* that is first informed outside the family members. And it is the *yenefs abat* that helps in arranging for the accommodation of the ill person at the churchyard (the grave-houses) or other related activities pertaining to the spiritual therapy. Whenever one is ailing or there is a problem in the family, a priest would be called. Even though among the clergy also *debteras* are known for their healing therapies, rarely or openly do people confer with them in the city not to be scandalised. *Debteras* have no officially acceptable role in treatment of the ill. Though they are known to possess esoteric knowledge, their healing power is only practiced in privacy for they fear the negative

reaction of the public that mistrust them. *Debteras* are highly respected in northern part of Ethiopia and their knowledge of medicine makes them to be feared. But in town they are perceived differently, their healing practice is considered as part of *baid amliko, kifu menfes, tenqway* (idolatry, evil spirit, witch). *Debteras* are known to have knowledge and power which has come along the ages and for their practice of *digimt* (Boylston, 2012; Eliana, 2009; Reminick, 1976).

Abba Petros a middle aged monk serving at Entoto Maryam church, described to me the types of *timqet* (baptism) in order to distinguish the *tsebel* ritual from the other forms of rituals which have same appearance but different meanings and significance:

> *Ye'Kristina (Ye'lidgnet) timqet* this is performed for one to become an Orthodox Christian; *Ye'qeder (Ye'nissiha) timqet* is performed for one who having been baptised as an Orthodox Christian but at one time converted to another religion and wish to come back to Orthodox faith; *Ye'dewe timqet*, pertains everyone no matter the religious affiliation, it is like hospital, it is meant for healing of infirmities.

Abba went on further to explain to me the forms of therapy the church provides to be: fasting, prostration, worship, *emnet*, *tsebel*, *tsilet* (vow-making), *meskel le'metashet, mesalem* (cross for massaging and for blessings) and also dialogue with the confessor priest to be a form of therapy and hence a healing method. The priest will give *nissiha* (repentance) which consists of a number of days to fast, prostrate, pray.

Abba told me the *fewus agelglot* that is healing service, has components of prayer namely *limena* (beseeching God) and *misgana* (thanksgiving). *Abba* added on, *tselot* (prayer) is a ladder, a link between God and human being. Church father is called to pray for the ill at home, and he anoints the ill person with holy oil (*qendil*). And *tsebel* (holy water) is used to cleanse both internal and external body (internal, stomach, mental, etc.; external – wound). Whenever *tsebel* is taken, one gets the healing. Belief in *tsebel* is important for healing to happen. An individual should go for *nissiha* (confession) and be prepared to partake of *tsebel* therapy.

Whenever the individual is taken for *tsebel*, the spirit that has possessed them will confess saying, *buda negn* "I am buda," in others it will say, *zar negn* "I am zar," while on others it will

say *metet tedergobgnal, satan negn*. Then the priest will ask him *yet new yeyazkew?* where the victim was when he invaded him. Some will say next to the river, *Min sisera?* What was he doing? The priest will ask. *Tileqaleh, atleqim?* Will you get out of him or not? *Andand gize eleqalehu, andand gize qetero sitegn yilal::* (Sometimes the *menfes* is willing to leave the victim and other times it would ask for appointment). When it is ready to leave then it screams thrice and sometimes seven times and then goes away. If the appointment has been given, then the victim has to come to *tsebel* on the day assigned and then the ritual is re-enacted.

As *Abba* Hayle explained, this *agelglot* (service) can only be done effectively with individual(s) who fulfil certain criteria such as: One should have a grace from God, otherwise it can end up becoming a *dibdib* (a fight), an episode where the *atmaqi* (religious healer) says *wuta* (get out) and the *menfes* (spirit) responds *alwetam* (I will not). *Gibgib yifetral* (it becomes a tug of war). Priest should have good ethics – for there are moments the priest is left alone with the naked *tsebeltegna* (one who has come for the *tsebel* therapy). *gulbetegna sayhon, tibebegna* (Priest should be patient and wise rather than being forceful). If one has no grace, then the ritual may end in a tug of war. If there is both grace and wisdom then all is simply solved. A deacon can baptise but since he has no power to bound or release, he is not as such effective in performance of this ritual as a priest. It is only in emergency cases where a priest is not available that a deacon by invoking the name of God can perform this ritual.

At the *tsebel* there is a priest who has been assigned by the church to administer the *tsebel* therapy, he is commonly known as *atmaqi.* There is an *adarash* (hall) where the ritual is performed. *Atmaqi* first reads from the book of *Tamre Maryam* (Miracles of St. Mary) and thereafter people will sit down. There are specific *tsebel* ritual place for men and also another for women. Number will be given of which all in their turn will get in and be baptized.

There are also *astemami* (attendants) who get paid by the relatives of the ill persons to take care of them. The *tsebeltegna* might have come for *and subae* (7 days retreat) *or hulet subae* (14 days retreat) *or even sost subae* (21 days retreat), but majority with severe cases prolong their stay at *tsebel* site. Whenever a "demon possessed" comes to the *tsebel,* he will start to scream and that's when the *atmaqi* would have dialogue with him (the spirit), inquiring whether, he is *Satan, buda*

or *zar*. Then it will respond either as one and then the priest would ask in which part of the body it is situated on (head, heart, any part of the body). After responding by stating where he is situated on the ill person then the priest will order him to come out.

5.2.2 The Interaction inside the Healing Hall and Around *Tsebel* Site

In the hall at the *tsebel*, women are seated on the right side while men are on the left. All are facing the clergy who preside over the *tsebel* therapy. Various prayer books are read by priests. And then after the exorcism ritual starts. While those who have come for the therapy are waiting for their turn, they listen to the preaching sermon and at times they would be involved in singing. All who have come for the therapy would get into a separate room where they remove all their clothes and squat in small groups waiting for their turns. Then the presiding *atmaqi* would collect the *tsebel* from the big container and splash it over one group at a time. Those whose case is observed to be serious as in being possessed by a spirit would be singled out and then the *atmaqi* would hold a kind of a dialogue with the embodied spirit. After prayer in the hall is finished people would come out and drink *tsebel* at the open space. The clergy along the way to their residence (atmaqi, astemami and the ill individuals live in the same quarters) would often engage in pastoral counselling. I would often observe *Abba* counselling various individuals. He would call them by names and inquire of their health, to some he would counsel saying *rasishn tebeki; rasishn aregagi, eshi* (keep yourself well). To some he would advise to be careful not to let one's temper flare up and that whenever one has sensed a conflict brewing to respectfully withdrew and take cover for a while until one has completely calmed down.

Abba Kidan explained to me why some people are baptised along the way and not inside the *tsebel* place. He says *tsebel* place is *betemekdes* that is, a holy place, and if women are in their monthly menstruation or men had "*tetsewo, hilme lelit* (a wet dream), they are not clean to enter until they have completed the period stated. For if they enter "*yireqsal botaw*" it makes the place impure. They would bring their own water which we pray over and then baptise them *yewoha timket* outside the *tsebel* site. If you happen to have a wet dream or menstruation, you are baptised outside the *tsebel* site). This is how we keep the *tsebel* pure and holy. This is why in the *tsebel* place demons scream. It is the holiness of the place that makes the demon to scream and be exorcised.

When the ill is finally taken to *tsebel*, spiritual therapy will begin as described by *Abba* Petros:

> When patient is brought to us, the relative would explain to us the nature of the patient's illness. For one to be exorcised of the demon, it depends on the individual's effort and the will of God. If one fasts and prays so much then the demon gets burnt and gets out immediately while one always in feast, it takes longer *tesmamtoal* (they are in agreement, the demon and the individual's lavish lifestyle). *Megref lemindnew, lemaswetat malet new:: Ya menfes temar'ro tesaqayto endiweta malet new::* We use *twaff* (a form of waxed rope) to tie up disruptive and uncompliant patient and also to whip the evil spirit that has taken possession of the individual. Whipping alone is not a form of therapy, it is only in conjunction with the ritual (*tsebel*, priest cross) is it considered as a therapy.

One attendant explained to me that the healing process depends with the nature of ailment. Some patients get well soon and others, it takes a while. Those whose brains have been affected by addiction get well soon and leave. And if they use the addictive substances then again they are affected. But those who are involved in *baid amliko* (idolatry) in their homes don't get well soon. And that this might be due to the long generation of the practice and the attachment they have with the *menfes* (spirits).

In *tsebel* therapy, patience is considered as an important virtue if one is to be healed. A story is often narrated of a man in the Holy Scripture who had to wait for 38 years finally to get healed. In this aspect, it seems strange that religious people are aware and refer this to religious healing and not to psychiatric treatment. But this can be due to general public understanding that most medical treatment cures within short time. So the same is expected of mental illness as it is claimed by psychiatrists to be of biological nature as any other physical ailments.

5.2.3 The Use of Psychiatric Medication at *Tsebel* and the Prevailing Worldview

Of the project to integrate both psychiatric care and religious therapy, *Abba* Kidan explained to me how the doctors at Tikur Anbassa came to them and they had a discussion on which they came to an agreement that psychiatrists will be sending to them the mentally ill who are not improving under their medication and priests likewise will be sending to psychiatric care those in their care that are not getting well. This is what Elialilia and Musisi (2006) described as African duality, which is the tendency to believe that illnesses have a supernatural cause while at the same time accepting biomedicine as effective in relieving the symptoms of the illness.

A project at Good Samaritan clinic just next to Entoto Maryam church has been started with intention to integrate both biomedical and religious therapy. Psychiatric residents from Tikur Anbassa are in regular consultations with the *astemami* and *atmaqi* in Entoto Maryam to implement this new model (Ribka, 2014). A similar model has been advanced by Phillips and Laken (2002).

Abba explained that those at *tsebel* who are using ART medication including psychiatric medication would first take the *tsebel* and after an hour or two when the *tsebel* has had its healing effect they would use their medication. This is a symbolic use, first it shows that priority is given to spiritual therapy which is socially and culturally acceptable in their context. The second reason is that in case a healing occurs, it would be attributed to the religious therapy. Others may consider it appropriate to use the medicine when the water consumed has subsided to avoid the situation when the medicine is washed out or vomited.

Abba explained to me that most of the mentally ill at *tsebel* use the psychiatric medication but those experiencing mental problems for the first time don't. Those who have had this problem for a long time have tried other alternative methods of treatment. *Abba* further described to me the effect medication has on the users and the clergy's viewpoint:

> Those who use the medicine get addicted to it and so they don't get well soon. So we do encourage those who have mental problems to abstain from using *ye'aemro qinin; medenzeziya* (the psychiatric medication). For when they use the medicine they get addicted to it forcing them to continue in state of being ill without its use. But if they come to *tsebel* before using these medicines they get well soon. And those who don't get well, we would direct them to use these medicines. This is how we agreed with the physicians at the meeting. At the meeting, we discussed the efficacy of *tsebel* and agreed it is effective for the treatment of mental illness and also agreed that there are illnesses that are better treated by the medicine, for example, medication for a wound is appropriate, it hasten the healing process. But for mental illness, to use medication, it only makes the individual numb, and thus less disruptive or violent. It keeps patient from hitting people. These medicines are more effective in these aspects of numbing patients to make them more tolerable. It is only when we observe a mental patient not getting well after a given period in *tsebel* do we direct them over to physicians. In using *tsebel* we would get *awure* (strange kind of beasts) out from the patients. We recommend that one drinks five litres of *tsebel*. This amount stresses the beast making it to come out due to suffocation. When an individual eats, the beasts are nourished. The beast makes one to have a great desire to eat.

From the finding it is apparent that clergy are not totally against the use of psychiatric medication but prefer its usage on serious state of mental illness. And also the strong view of mental illness to be a supernatural phenomenon deserving a religious orientated therapy for successful outcome.

A patient seeking healing for her mental problems stated where one ought to go when ill as follows: To hospital you take wounds, that which needs to be done operation on. Even still these (wounds and the like), unless God prevails even if you go to hospital you will not get well. But the *Satan* issue can only be addressed by *tsebel* therapy. In *tsebel,* the devil screams, "I have been burnt" and then it flees away leaving individual in normal state.

A patient attending both psychiatric and religious therapy explained how he balances the two: "I am attending AMSH treatment as an out-patient beside *tsebel* therapy. I would periodically go and be provided with *ye'amanuel medhanit* (psychiatric drugs). Though I strongly believe that *tsebel* helps improve my situation so I am focusing more on it.

Adane's patients' vary in the care they are provided with, as he explains, "Among the 6 patients I take care of, 2 are treated at the clinic. Their involvement with the clinic treatment depends on their relatives' permission. I am the one who takes them to the clinic, but I have to get the permission from their relatives since some are not willing for their mentally ill to be given treatment other than the religious therapy. The 2 use both psychiatric medication and *tsebel* while the rest (4) only use *tsebel.*"

Adane told me that those who use the psychiatric medication are those who are mentally ill and their relatives are willing for them to be provided with such care/treatment and that also they had previously been at AMSH. He called the psychiatric medication as *ye'amanuel medhanit*. Adane further explains the state of those who use the psychiatric medication and the condition for its use, "they are getting well but the Amanuel medicine has to be used alongside *tsebel* for full recovery to be realised. The psychiatric clinic is offered after every 15 days. During that time, I would take them personally to the clinic because they are unable to go by themselves. Treatment

and drugs would be provided, and for the unavailable drugs, I will be given prescriptions of which I call patients' relatives who would buy them for the patients."

The most important results that the patient hope to get from religious therapy was illustrated in comparison to cares provided by others. One of the *atmaqi* aptly summarised it as follows:

> *Tsebel* is for everybody regardless of religious background... Biomedicine is acceptable, it is the herbal medicine that is not as such acceptable because unlike science which has philosophy and open for examination, herbal medicine is practiced with great secrecy... While medicines may have side effects or even in the process of curing one organ, affect the other, *tsebel* is appropriate for every part of the body and has no side effect. To get a biomedicine treatment it requires money and a lot of process while *tsebel* therapy's expense is very limited maybe just to transport cost to the site. *Tsebel* is spiritual for God's spirit was floating over the water at the beginning of creation. Medical doctors give a lot of prescription, but *tsebel* is simple, people come and get healed and abandon all the drugs they have been given by medical doctors. Every illness is believed to have its source from devil. In our church, it is strongly believed that the source of mental illness is devil.

Most African societies include mental illness within the scope of problems that are addressed by indigenous healers who mainly consider it as a supernatural phenomenon and consequently apply spiritual therapy (Nicole and Shyngle, 2013). In Ethiopia those who are taken to psychiatric care often are at serious state (psychotic cases), non-psychotic are discouraged by religious leaders from using psychiatric medication out of fear that it may get them addicted to it, hence aggravate their situation and also from the belief that it can be managed by religious therapy.

Abba explained to me that God needs us to tire our bodies through fasting and prayer. For it is through this way that one can be healed or be safe from demonic attacks that come through indulging carnal nature which, in turn, make one a playing toy for *aganint* (demons). He added on to say that clergy would alongside patients abstain from food until when the liturgy is over in late afternoon (around 3pm to 6pm). For those who are ailing are in need of clergy's intervention through prayer and fasting. This they do that God may have mercy upon them. Hence the religious therapy intimately involves all participants in all aspects of care given to the mentally ill.

Abba stated that God's spirit hovers over the water. And through *Kidan* (Covenant) prayer the demons are exorcised. He also emphasised on the importance of conducting the ritual and sending the demons to the right place for safety of others. He thus described:

> The demons do not have any other place they can be sent to other than the *Sheol* (hell). They would request to be let to hung on a tree or be sent back to one who had sent them to the victim. But we send them only to *Sheol* because if allowed to hang on the tree, tomorrow they will trap another person. So through the help of saints and angels Gabriel and Mikael we send them straight to Sheol. And after sending them safely to *Sheol* we would pray *tselote Maryam* (prayer of St. Mary). And this is how many people have been healed.

There are places and time that it is believed that spirits can attack an individual. Since this is a society consisting of both human beings and supernatural beings, it is believed that illness happens when human beings encounter maleficent spirits and the same applies to healing. For healing to take place a benevolent supernatural beings must intervene in the illness situation. And their intervention is mostly possible through the medium of *tsebel*, *atmaqi*, and individual's agency.

Abba Kidan told me that one who has an objective to get healed should thoroughly partake of *tsebel*. He advises one to take five litres at once and if not possible at least to take three litres otherwise a mere cup of *tsebel* might not really be helpful. He elaborated, stating the medication given by doctors, "unless the dose is taken as ordered, the medicine might not be effective so is *tsebel*."

Participants at the religious therapy site regardless of their status during the time of study, had prior experience of *tsebel* hence they were familiar with the common narratives of the miraculous healing that they claimed happened to people they know or of people known to people they know. Most of the *atmaqi* had been healed of their ailments by use of *tsebel* and their frequent narration of healings coupled by their occupation was so harmoniously ironed out to fit their social-cultural context of which the physical world of material things and the spirit world though distinct, co-exist. Human beings interaction was thus considered incapable of existing independently of both of these realms. John Mbiti (1969) an expert on African religion, described African culture and religion as so intertwined that religion permeates into all the facets of life so fully that it is not easy or possible always to isolate it. In Ethiopia it is evident with how

cosmology consisting of supernatural beings is described. Since Ethiopian Orthodox church believers depend on the clergy's interpretation of the scripture, they are familiarised to numerous narratives of the other beings that are involved in day to day activities of human beings. And the precaution to make against affliction. The narrative of the spirits is well-known as how they (*buda, zar, digimt menfes, ayne tila*) originated from Garden of Eden. It is said that Adam and Eve had thirty children. And one day when God came visiting and started to count the children, Eve in apprehension tried to hide fifteen most beautiful and intelligent ones. God being angered by Eve's action, condemned the fifteen to remain invisible for eternity. And the fifteen uglier and weaker that were not hidden were blessed to become the ancestors of humanity incurring envy of their condemned siblings. This finding is consistent with other studies done on Ethiopia on folk belief (Baye, 2015; Boylston, 2012; Edelstein, 2002; Eliana, 2009; Finneran, 2003; Messing, 1958; Reminick, 1976).

5.2.4 Extent of Satisfaction by Others

On extent of satisfaction by care/treatment provided by others, participants at the religious site preferred the use of *tsebel* therapy and to a limited extent the medication provided by AMSH. Participants were not as such pleased by services provided by local herbalists and *debteras* perceiving it as idolatry.

One of the *atmaqi* expounded it as follows:

> With the exception of the spiritual and biomedicine treatment, I am not quite aware of the benefits of therapy offered by the others (herbalists and *debteras*). As a priest, I can only address and promote the use of *tsebel* related therapy. Concerning AMSH, I don't have concrete evidence, to my understanding we often have people coming to *tsebel* who tell us that they have tried (have been to) AMSH for long time yet they are still not well. Even those who come from AMSH we all perceive them as demon possessed for that is the church's understanding. The church perceives mental illness to be one of devil's tactics to manipulate humankind. Even though there might be some few differences on mental illness and demon possession, what has caused *aemro* (the mind) to be in such a state is considered to be devil.

Some of the *atmaqi* went on to remind me that Luke the evangelist was a doctor. So, medical treatment is not in contrary to religion since it is God who has given human beings the knowledge to manage their health. The *atmaqi* also stated that some years ago former EOTC Patriarch Abune Paulos had recommended the use of ART alongside *tsebel*. And that once an

individual has already started the medication, it is hard to tell him to stop it and only to use the *tsebel* therapy for this has already been ingrained in her/his consciousness. "To make him stop the medication it requires a level of faith that is much higher. It needs *ye'emnet biqat* (higher level of faith mastery)." But from the *atmaqi's* experience, he believes that both psychiatric medication and *tsebel* can be used simultaneously. "The individual has to be considered, his level of faith, before he can be encouraged to base her/himself only on *tsebel*. Otherwise, it is unnecessary to stress an individual who is already ill to stop the medication."

Most of the participants also stated that most of the time they observe those coming from AMSH coming out with a load of drugs. And whenever they stop using them they relapse. And rarely do they come by one from AMSH who has fully become well. Unlike in *tsebel* where some get well in a week time, while others a month, a year or even up to 6 or 10 years, but they get well and are at peace.

From my observation, I encountered individuals who have tried various *tsebel* unsuccessfully and stayed even for long periods without any change. One of the participants who is a clergy and whose mother had mental problem, after several unsuccessful *tsebel* therapy decided to go for psychiatric care of which she got better after a month stay in AMSH. He explained to me the influential role the church has on believers and the need of priests to be educated on biomedicine perspectives:

> The Church has great role to the majority of population who cannot afford the cost or get access to hospital. They get hope and sense of purpose by using widely available therapies offered by the church. The Church needs to collaborate with the biomedical professionals in order to improve the situation of the ill in our society. The priests should guide those who are ill and unable to improve through the use of *tsebel* therapy to go to hospital. For I have witnessed situations where some die when they could have got well through medication. Priests should be educated for they are influential in religious world (society) and if they have a misconception on science it in turn reflects on the religious followers.

5.3 Lived Experience of Patients - Agency among People with Mental Illness

The nature of *tsebel* therapy I was informed by all participants at the religious site to demand the amount of *tsebel* to drink and the individual's active involvement for it to be effective. The amount of *tsebel* to drink and the

regulations pertaining participation in the ritual in general were considered as agency oriented. One of the participants summarised it as follows:

> The Church's role in caring for the mentally ill is by employing the clergy to preside over the exorcism ritual. The clergy mainly use *tsebel* for healing, for God's power and wisdom is over the water. Hence, *tsebel* has power to heal any kind of ailment be it HIV or mental illness. But individuals have to be resolute not to go back to their former lifestyle or else their ailments will remain with them. For example, if one is cured of HIV and goes back to fornication /adultery (the believed cause of HIV) then their situation worsens for from the very beginning the Church teaches against this kind of lifestyle. If one after being healed from addiction goes back to the use of substance, then they are left at devil's control. But if one wholeheartedly forsakes these lifestyles and turn to God, they are healed.

Most participants explained to me the dual nature of *tsebel* as being both an immunisation dose and also a cure. They explained that after one has been baptised s/he becomes resistant to demons' attacks, one doesn't go to sin or do that which saddens God. All the time, one just meditate upon the regulations required of a *tsebeltegna*. And it is through this way that God's Holy Spirit protects one during these hours. Unlike the worldly person who will abstain from going to *tsebel* and gradually expose herself/himself to spirits assault and consequently get mad.

This viewpoint my participants supported by stating their firm belief on Jesus Christ teachings that there are different nature of ailments and that some can be healed only through a special way, (Matthew 17), 'this cannot get out without fasting and prayer.' This kind of demon was so accustomed to the person that without fasting and prayer it couldn't be exorcised. As long as an individual is within God's boundary, serving God wholeheartedly then her/his wellbeing is safeguarded, it is only when people indulge in ways that are contrary to God's will that they are in danger of being attacked by demons.

The participants in this study therefore did explain the agency among people with mental illness to include their involvement in fasting and other activities acceptable by Orthodox Church. I was able to observe those using the *tsebel* therapy at their living quarters and I noticed that those who had stayed long at the *tsebel* place were involved in various socio-economic activities. Some had settled down in marriage and others were in turn providing service for the new comers for wages while others would make and sell *enjera*. All these they would do without ceasing their religious therapy.

Melkam one of the patients who had stayed long at the *tsebel* site elaborated: Now I am better compared to my former state. Formerly, I would go naked in the public. I would beat people. I would tear off clothes given to me and scratch my face badly. Now, I am well, I work and support myself. It is almost 3 years since I became well (in this current state). It is only at times that I experience episodes. Sometimes, I do feel it *srk srk yadergal* (a feeling of being about to relapse) but here when I prostrate and beseech for St Mary's mediation I get better. When I am up here in Entoto where Satan has been bounded I am well, it is only when I go down to Addis Ababa that I experience illness. The devil first entices me to leave this place and go down to Addis Ababa, and when I go the devil comes and attacks me. The priest told us not to go until we get better). If we go without getting completely well we get ill added on Melkam.

Adane, the attendant, explained that his work was beneficial not only for spiritual purposes but also for material wellbeing as the job had been created for him to take care of the ill. He went on further to explain that it benefited him as an attendant because it enabled him to attend both the prayer that is done in the morning and also to be baptised along with the patients as he is still not completely free from *Zar* possession.

It was evident from both the interviews and observation that the participants at Entoto Maryam were adjusted to community life in such a way that they could participate in social life without any apparent form of discrimination. In fact they even contributed in socio-economic aspects.

Chapter Six
Summary and Conclusion

6.1 Comparative Summary of Major Findings

6.1.1 Conceptualisation of Mental Illness

The conceptualisation of mental illness among the various individuals involved in the care of the mentally ill and the mentally ill individuals themselves varied according to the context in which the individuals found themselves based on knowledge about the illness. Those in the hospital were referred to as *ye'aemro himemtegna* (mental patient), while those at the *tsebel* were referred to as *tsebeltegna* (user of holy water therapy) or as *aganint yaderebet* (demon possessed). Professional health workers stated that the direct cause of mental illness is unknown but various factors contribute towards it such as biological (genetics, substance addiction), psychological (stress frustration) and social (poverty, lack of employment, inability to fulfil expectations). Patients and caregivers at Amanuel Mental Specialised Hospital attributed the cause of mental illness to psychological and social causes (depression, excessive study, addiction) and supernatural phenomenon (witchcraft, spirit or demon possession). They gradually became familiar with the bio-medical aspect of mental illness through the descriptions they received from the professional health workers at AMSH who described mental illness as an imbalance of chemicals in the brain. While the supernatural causes of mental illness were mainly associated with the dominant prevailing religious views.

Professional health workers hold an influential position in biomedicine as agents of culture. Their view to a certain extent reflected on both the patients and caregivers at AMSH. Professional health workers too, shared the same views on mental illness as the patients and their caregivers as being both biopsychosocial and spiritual related, but some did not make such associations although they showed an understanding of patients and caregivers who held such beliefs. When diagnosing mental illness they applied biomedical concepts according to their professional background to explain it. The professional health workers at AMSH were from the same socio-cultural background as the other participants in the study, consequently they were influenced by the same dominant culture. They showed an understanding of patients and

caregivers who held beliefs on spiritual causes of mental illness and to a certain extent their indigenous health seeking behaviour.

Religious healers, caregivers and patients at the Church related sites described mental illness in various ways and attributed its causes to psychological, social and supernatural phenomenon. Although it was commonly believed that ultimately all their causes were supernatural. *Tsebel* therapy participants classified the mentally ill into a number of categories namely; one group had become mentally ill through supernatural phenomena, another by stress of life and another by substance abuse.

The diagnosis of those seeking healing at the *tsebel* was mainly intended to distinguish between those who were mentally ill or spirit possessed. Though it was believed that demon possession could be identified mainly during the *tsebel* ritual and that it was difficult to identify at other times. The demon possessed were said to be out of their minds only for specific short periods of time and also to be against any spiritual intervention whereas the mentally ill were considered to be in a state of illness for a prolonged period of time. Nevertheless, it was said that there is no clear distinction between one who is demon possessed and one who is mentally ill for both are considered to be under the devil's influence.

6.1.2 Opinions and Attitudes towards Treatment and Care

With regard to opinions and attitudes towards treatment and care, the study found that the initial care given to the mentally ill was from the family members. Family would make decision on which further care and treatment their beloved should be provided with. Decision to take patients for psychiatric care was often made after pursuing other forms of therapies and also when the adverse effects of the illness were noted. Most of the patients had been ill for a long time, they had also tried other forms of care such as *tsebel* and *tselot* besides using medication. The religious based therapy was a continuous activity attended with or without episodes occurrence. The effectiveness of medication or *tsebel*, according to patients and caregivers depended on their faith in it. Proper and timely use of psychiatric medication and psychotherapy were beneficial despite relapses. The relapses that commonly occurred among the mentally ill constituted a driving force for individuals obliging them to seek other forms of therapy in hope of finally

being permanently healed. *Tsebel* was used by all regardless of religious background. The anguish brought by mental illness made individuals so desperate that they consulted whatever form of therapy that might bring healing or hope of recovery. AMSH functioned as a referral care centre for both Ethiopian regional hospitals and also practitioners of indigenous forms of care. Patients and caregivers main points of discontent with the care provided at AMSH concerned nourishment, clothing, admission process and some health workers' aggressive attitude while handling them.

This study found that though the hospital is based on biopsychosocial model of treatment, it is medicine that is mostly provided to patients and that psychotherapy which was recently (some four years ago) introduced in the institution is not yet firmly established. On the extent of satisfaction by health professional workers on the care provided at AMSH, this study found that since there was limited human-power, the psychiatrist role was mainly accomplished by the psychiatrist nurses with master's degree who would assume the psychiatrist role and only refer to the few psychiatrists available in the hospital on cases beyond their scope. Some of the health professional workers also were doubtful of the biomedical understanding of mental illness. This they attributed to the repeated relapses they often observe from patients. There was also decry among health workers on the dominance medication held in the institution. This I was told has led to the institution to be known even to the public as only providing drug at the cost of other available therapies that can help in advancing the knowledge of mental illness to the patients and their caregivers and also in integrating the patients back to the society.

This study found that the professional health workers at AMSH appreciated the role religion has in the care of the mentally ill. The grievance the health workers had against others was on timing and care of the ill. It was stated that patients are rarely brought to the hospital on onset of illness rather after it has become severe while exhausting other locally available therapies and this makes it hard for patients to respond well to medication once they are brought to hospital. And also at times patients are discouraged from taking their medication. Professional health workers moreover mentioned that they don't forbid the use of the local therapies but rather encourage it to be implemented beside medication.

This study found that the first care of the mentally ill among Ethiopian Orthodox believers began at home and later on followed by invitation of the *yenefs abat* (spiritual father). Finally the ill was taken to *tsebel.* At the *tsebel,* spiritual therapy will be performed. Some will be well soon while others will prolong their stay.

Whenever mentally ill were being taken to either *tsebel* or mental hospital, their caregivers would often resort into chaining them. At the mental hospital there were a number of ways to manage the patients during the episodes, such as administering psychiatric medication or ECT, while at *tsebel* it was mainly chaining though *atmaqi* would refer the serious cases for psychiatric medication which they appreciated for its potent to calm the mentally ill. There were patients who attended both AMSH treatments as an out-patient beside *tsebel* therapy. Biomedical was acceptable on the grounds that Luke the evangelist was a doctor. Hence, biomedical treatment is not in contrary to religion and also through former EOTC Patriarch Abune Paulos recommendation on the use of ART alongside *tsebel.* But there was condition for use of medication. Psychiatric medicine was recommended mostly for the serious mental illness and also it had to be taken after the *tsebel* therapy for healing was attributed to supernatural sources.

6.1.3 Lived Experiences of Patients in Health Care Systems

The third research objective addressed in this thesis was the lived experiences of patients in health care systems. In relation to this, my findings show that there were challenges encountered by patients in seeking care and factors attributed for agency among patients. The challenges included lack of information and knowledge about mental illness, stigmatisation that is associated with treatment at AMSH. Poor communication has made mentally ill individuals susceptible to various kinds of discrimination and prejudice. Treatment is offered mainly free of charge, but the admission process is time consuming since the hospital has very limited bed space and patients often had to travel a great distance to come for treatment, AMSH being the only referral hospital specializing in mental illnesses. As a result patients sometimes had to wait some days for admission, meanwhile they often opted to attend *tsebel* therapy where accommodation was affordable and even they would resort to chaining patients.

This study found that the presence of factors facilitating the involvement of patients in their own care induced agency and the absence of such factors constrained agency. Medication, psychotherapy, relatives' presence and religious leaders' guidance and rituals, were found to be the most important factors that facilitated patients' involvement in their own care. Relatives' presence was stated to be extremely important for it expressed unceasing social and economic support which carried the mentally ill through difficult episodes and experiences, while religious leaders' guidance was considered a determining factor concerning use of medication. Religious rituals were mentioned as being effective in uplifting the morale of the patients and giving them a sense of purpose and belonging.

Concerning agency among people with mental illness at Entoto Maryam *tsebel*, this study found that the nature of *tsebel* therapy demands the individual's active involvement in fasting, prostration, and worship, for it to be effective. The amount of *tsebel* the patients are required to drink and the regulations pertaining to participation in rituals in general cause the therapy to be considered as agency oriented. Furthermore, individuals are required to be resolute in their determination not to go back to their former lifestyle and to turn to God otherwise their ailments will remain with them. All kinds of patients at all times frequently make use of *Tsebel* since it has a dual nature being considered effective as an immunisation dose and also as a cure,

6.2 Concluding Remarks

This study was intended to provide an ethnographic account regarding beliefs about mental illness at both psychiatric and religious care centres, specifically Amanuel Mental Specialised Hospital and Entoto Maryam *tsebel* in Addis Ababa from ethno-medical perspective. The following are the implication of the findings.

6.2.1 Implication of Findings on Conceptualisation of Mental Illness

The conceptualisation of mental illness varies a lot according to context in which the individuals found themselves as do its causes. Mental illness still remains an enigma with everyone involved engrossed on what and how to tackle it with a long run success. This requires a certain amount of re-education, awareness raising and promoting cooperation among religious healers at *tsebel* and mental health practitioners of each kind of health care system.

6.2.2 Implication of Findings on Opinions and Attitudes towards Treatment and Care

With regard to opinions and attitudes towards treatment and care, the role of family in caregiving takes a prominent place. Hence caregivers should be informed on the nature of mental illness and the possible ways they can be more effective in their responsibilities of caregiving. Since religion plays an influential role in the health of the patients, the religious healers should be encouraged to cooperate with the professional health workers. Proper use of psychiatric medication should be encouraged beside the use of psychotherapy and religious therapy. Furthermore, treatment should be holistic not orientated exclusively to biochemical medicines. The interests of the patient must have priority and that means not relying only on one form of therapy, but finding the right combination of therapies which really furthers the healing process of the individual patient. Another problem which needs to be dealt with is the stigma associated with mental health institutions, and how this can be lessened so as not to discourage patients and carers from making use of their services.

Since the religious establishment plays a major role in the treatment of mental illness, they need to be made aware of its existence and the possibility of treating it through biomedical means. While combining both systems is good, initial reliance only on the religious system until all hope is exhausted and only then turning to the biomedical system must be discouraged, rather both systems need to be used from the very beginning, giving each its due importance. This calls for intervention in clergy training, offering courses in theological colleges clergy training centres etc, Equally, biomedical practitioners need to be made aware of the advantages of cooperating with the indigenous medical systems in a way which shows acceptance and respect.

6.2.3 Implication of Findings on Lived Experiences of Patients in Health Care Systems

The lived experience of patients in health care system show us that they face a lot of challenges. Such as poor communications making them susceptible to various kinds of discrimination and prejudice. Problems experienced in the practical provision of treatment which create unnecessary hurdles, rather than facilitating ease of receiving care. Stigmatization of those receiving mental

health treatment is also a big problem. Familiarity with the lived experience of sufferers and carers indicates very clearly the importance of the involvement of the patients in finding a solution to their own problems, and being engaged in the healing process themselves in a positive and proactive way. Furthermore, the engagement of not only the patients themselves but also their families, relatives and friends can be decisive in empowering them to weather the storms of their personal life and progress towards a better future.

The implications of these circumstances are very clear, communication and knowledge about mental health in the sphere of public space needs to be dramatically improved. Provisions need to be made to minimize discrimination and prejudice and to lessen the stigmatization of mental health patients.

A beneficial holistic approach to mental health issues needs to involve all the patients themselves, and all those associated with them in the process of healing. Family, relatives, friends can play an enormous proactive role, if they are engaged in the right way. Spiritual therapies can play a big role in promoting agency and the individual engagement.

References

Baer, H., Singer, M., & Susser, I. (2003). *Medical Anthropology and the World System.* (2[nd]ed.). Westport, CT: Greenwood Publishing.

Baye B., Asfaw. (2015). "Demonic Possession and Healing of Mental illness in the Ethiopian Orthodox Tewahdo Church: the Case of Entoto Kidane-Mihret Monastery." *American Journal of Applied Psychology*, vol. 3, no. 4: 80-93.

Bernard, H. R. (2006). *Research Methods in Anthropology: Qualitative and Quantitative Approaches* (4[th]ed.). Oxford, UK: AltaMira Press

Boehnlein, J., K. (2000). *Psychiatry and Religion. The Convergence of Mind and Spirit.* Washington, DC and London: American Psychiatric Press.

Boylston, T. (2012). *The Shade of the Divine: Approaching the Sacred in an Ethiopian Orthodox Christian Community.* London: London School of Economics and Political Science. Available at: etheses.lse.ac.uk/339/.

Bruni Andrea. (2014). Assessing the efficacy of the Mental Health Gap Action Programme (mhGAP) training for non-specialized health workers in Ethiopia. Master's thesis, Universidade Nova de Lisboa, Lisbon.

Carothers, J. C. (1953). *The African mind in health and disease: A study in ethnopsychiatry.* Geneva, Switzerland: World Health Organization.

Cerwonka, Allaine and Malkki, Liisa. (2007). *Improvising Theory: Process and Temporality in Ethnographic Fieldwork.* London: University of Chicago Press.

D'Andrade, Roy. (1995). *The Development of Cognitive Anthropology.* Cambridge: Cambridge University Press.

Dejene, T. (2013). *Persistence and Change in the Practice of Medical Pluralism in Addis Ababa.* PhD thesis, Andhra University, Visakhapatnam.

Edelstein, Monika (2002). "Lost Tribes and Coffee Ceremonies: Zar Spirit Possession and the Ethno-Religious Identity of Ethiopian Jews in Israel". Journal of Refugee Studies. 15 (2): 153–170.

Eliana, P. (2009). *Aynä* té *la*: the Shadow of the Eye: Healers and Traditional Medical Knowledge in Addis Ababa. (eds. Svein E., Harald A, Birhanu T., & Shiferaw, B.). 337-348. Trondheim.

Elialilia, S.O., & Musisi, S. (2006). Depression as a clan illness (eByekika): An indigenous model of psychotic depression among the Baganda of Uganda. *World Cultural Psychiatry Research Review, 1*(2), 60-73.

Ellen, R. F. (1984). *Ethnographic Research: A Guide to General Conduct*. (Ed.). London: Academic Press.

Finneran, N. (2003). Ethiopian Evil Eye Belief and the Magical Symbolism of Iron Working. *Routledge Journals*; Taylor & Francis Ltd. Folklore 114 (2003):427–433

Garro, Linda. (2004). Cognitive Medical Anthropology. In *Encyclopedia of Medical Anthropology*, eds. Carol Ember and Melvin Ember, pp. 12-23. New York; Kluwer Academic/Plenum Publishers.

Geertz, Clifford. (1973). *The Interpretation of Cultures*. New York: Basic Books, Inc.

Giel R. The prehistory of psychiatry in Ethiopia. Acta Psychiatr Scand Suppl 1999;397:2–4.

Hahn, Robert A. (1983) Biomedical Practice and Anthropological Theory: Frameworks and Directions. *Annual Review of Anthropology* 12:305-333.

Hammersley, M. (2013). *What is Qualitative Research?* London; New York: Bloomsbury Publishing.

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in Practice*. London; New York: Routledge.

Hammersley, M., & Traianou, A. (2012). *Ethics in Qualitative Research*. London; Washington DC: Sage Publications.

Hansberry, William Leo. (1974). *Pillars in Ethiopian History*. Washington D.C. Howard University Press.

Harpham, T., & Blue, I. (1995). Urbanization and mental health in developing countries: An Introduction. In T. Harpham & I. Blue (Eds.), *Urbanization and mental health in developing countries* (pp. 3–14). Aldershot, UK: Avebury.

Helman, C. (2006). Why medical anthropology matters. *Anthropology Today* Vol. 22 No. 1 February 2006.

Helman, C.G. (2007). *Culture, health and illness*. London: Hodder Education.

Kahsay, W. H. (2015). Perceived Causes of Mental Illness and Treatment Seeking Behaviors among People with Mental Health Problems in Gebremenfes Kidus Holy Water Site. *American Journal of Applied Psychology, 3*(2): 34-42.

Kebede, D. K., Alemayehu, A., Binyam, G., and Yunis, M. (2006). A historical overview of traditional medicine practices and policy in Ethiopia. *Ethiop J Health Dev* 2006, 20(2):127-134.

Kleinman, Arthur, Leon Eisenberg, and Byron Good. 1978 Culture, Illness, and Care. Clinical Lessons from Anthropologic and Cross- Cultural Research. *Annals of Internal Medicine* 88:251-258.

Kleinman, A. (1979). *Patients and Healers in the Context of Culture*. Berkeley: University of California Press.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry.* Berkeley, Los Angeles, London: University of California Press.

Kleinman, A. 1986. Concepts and a model for the comparison of medical systems as cultural systems. In: C. Currer & M. Stacey (ed.). *Concepts of Health, Illness and Disease. A Comparative Perspective* (pp. 29-47). Oxford: Berg Publishers.

Levinson D. and Gaccione L. ed. (1997). *Health and Illness: A Cross-Cultural Encyclopedia.* Santa Barbara, California: ABC-CLIO, Inc.

Mbiti, John. (1969). *African Religions and Philosophy*. London: Heinemann. LUMINA, Vol. 22, No.2, ISSN 2094-1188 18

McElroy, Ann, and Patricia K. Townsend. 2009. *Medical Anthropology in Ecological Perspective,* 5th ed. Boulder, Colorado: Westview Press.

Menelik, Desta. (2008). Epidemiology of child psychiatric disorders in Addis Ababa, Ethiopia. PhD thesis, Umea University. Umea.

Messing, S.D. (1958). *Group Therapy and Social Status in the Zar Cult of Ethiopia.* American Anthropologist 60:1120-1 126.

Nicole, M., & Shyngle, K. (2013). Urban and Rural Perceptions of Mental illness in Ethiopia. *8*(3), *43-51*. Retrieved from http://www.Iosrjournals.Org.

O'Connor, B., B. (1995). *Healing Traditions: Alternative Medicine and the Health Professions.* Philadelphia, Penn: University of Pennsylvania Press.

Pankhurst, Richard. (1961). "Menelik and the Foundation of Addis Ababa" in Journal of African History, 2:1, pp 103-117.

Parsons, T. 1991. *The Social System*. New edition. London: Routledge.

Pawlikowski John,T. (1972). "The Judaic Spirit of the Ethiopian Orthodox Church", *Journal of Religion in Africa* 4, 178-99.

Rapport, N., and Overing, J. (2000). Social and Cultural Anthropology: The Key Concepts. New York, NY: Routledge.

Reminick, Ronald A. (1976). The evil eye belief among the Amhara of Ethiopia. The Evil Eye, Clarence Maloney, ed., pp 85-101. New York: Columbia University Press.

Ribka, Birhanu. (2014). Collaboration between Spiritual (Holy Water) Treatment and Biomedical Treatment at St. Mary church outreach program, Entoto: Pattern of Service Utilization and Attitude of Holy Water Attendants. Master's thesis, Addis Ababa University, Addis Ababa.

Scheid, Teresa & Brown, Tony. (2010). *A Handbook for the Study of Mental Health.* (2nd ed.). New York: Cambridge University Press.

Sergew Hable Selassie. (1972). Ancient and Medieval Ethiopian History to 1270. Addis Ababa: United Printers.

Shelemay, Kay Kaufman. (1992). 'The Musician and the Transmission of Religious Tradition: the Multiple Roles of the Ethiopian *Däbtära*.' *Journal of Religion in Africa*, Vol. XXII (3), pp. 242-260.

Singer, Merrill. (2004). Critical Medical Anthropology. In *Encyclopedia of Medical Anthropology,* eds. Carol Ember and Melvin Ember, pp. 23-30. New York: Kluwer Academic/Plenum Publishers.

Sintayehu M, Mulat H, Yohannis Z, Adera T, Fekade M. Prevalence of mental distress and associated factors among caregivers of patients with severe mental illness in the outpatient unit of Amanuel Hospital, Addis Ababa, Ethiopia, 2013: Cross-sectional study. J Mol Psychiatry. 2015; 3:9.

Strauss, Anselm and Corbin, Juliet. (1998). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* California; London: Sage Publications.

Thompson, Marie. (2007). *Mental Illness.* West, Westport, CT: Greenwood Press.

Trajtelová, Jana. (2013). *Cognitive Anthropology: Selected Issues.* Centre of Cognitive Studies at Trnava, Slovakia.

Turner, Victor W. (1967). *The Forest of Symbols: Aspects of Ndembu Ritual.* Ithaca and London: Cornell University Press.

Twaddle, A. C. 1980. Sickness and the Sickness Career: Some Implications. In: *L. Eisenberg and A. Kleinman (eds.), The Relevance of Social Science for Medicine*, 111-133. D. Reidel Publishing Company

Uli Wessling Tolon (2008), *Comparison of Urban Upgrading Projects*. United Nations Human Settlements Programme (UN-HABITAT).

UN Habitat. (2008). Ethiopian Urban Profile Report

Weiss, Mitchell G and Daryl Somma. 2007. Explanatory Models in Psychiatry. In *Textbook of Cultural Psychiatry*, eds. Dinesh Bhugra and Kamaldeep Bhui, pp.127-140 Cambridge; Cambridge University Press.

Winkelman, M. (2009). *Culture and Health. Applying Medical Anthropology*. San Francisco, CA: Jossey-Bass.

World Health Organisation. (2001). *The world health report, 2001; Mental health: New understanding, new hope*, Geneva: World Health Organisation.

World Health Organization. (2006). *Traditional medicine promotion efforts*. World Health Organization Tech monitor. Geneva.

World Health Organisation (2010). *Mental health and development: Targeting people with mental health conditions as a vulnerable group*. WHO Press: Geneva.
http://www.who.int/mental_health/policy/development/en/index.html and
http://www.psychiatry.uct.ac.za/mhapp/

Young, A. (1975a). 'Magic as a Quasi-Profession: the Organization of Magic and Healing among the Amhara.' *Ethnology*, Vol. 14(2), pp. 245-265.

Young, A. (1975b). 'Why Amhara get kureynya: sickness and possession in an Ethiopian Zar Cult.' *American Ethnologist*, Vol. 2(3), pp. 567-584.

Appendices

Appendix 1: Fieldwork Research Guiding Questions in English

A. Interview Guide for people with mental illness

Participant's identification (pseudonym)

Socio-demographic data

1. Gender
2. Religious affiliation
3. Marital status
4. Age
5. Occupation/main source of income
6. Highest level of formal education
7. Years of illness (and seeking psychiatric care)

Conceptualisation of mental illness

1. How would you describe your state of health?
2. When and how did you notice that you had this state of health?
3. What do you think caused this state of health?
4. Why do you think your state of health/sickness started when it did?
5. How does this state affect your health in particular and life in general?
6. How severe is your illness?
7. What concerns do you have regarding your state of health?

Opinions and attitudes towards treatment and care

1. What forms of treatment/care do you receive for your state of health?
2. Who provides care that you receive and how?
3. To what extent are you satisfied with the way care is provided and why?
4. How do you hope to benefit from treatment/care which you receive?
5. What additional care would you like to receive for your state of health?
6. Who should provide this care? Why?
7. How else can the care which you receive be improved?

Challenges and means of solution among people with mental illness

1. What are the main difficulties, which you encounter in seeking care?
2. How do such difficulties affect your health in particular and life in general?
3. How do you try to overcome these difficulties?
4. How successful have you been in dealing with these difficulties?
5. How else can such the above difficulties be overcome?

People with mental illness as agents of their own care

1. How are you involved in managing your state of health?
2. To what extent are you satisfied with involvement in your own care?
3. What factors do facilitate involvement in your own care?
4. What factors do constrain involvement in your own care?
5. Is there anything else you would like to add?

Thank you for your valuable information.

B. Interview Guide for Families (Caregivers) and Religious Healers

Participant's identification (pseudonym)

Socio-demographic data

1. Gender
2. Age
3. Marital status
4. Religious affiliation
5. Number of working years/involvement in health care
6. Occupational category and position
7. Highest level of formal education attained

Conceptualisation of mental illness

1. What is the name of your patients' health problem?
2. How do you conceptualise this state of health?
3. How did you notice that your patient has this health problem?
4. Timing for onset of the above health problem and why? Circumstances surrounding patients' seeking your care?
5. What causes the above health problem?
6. What does the above health problem do to your patient? (How does it work?)
7. How severe is the above health problem? (Does it have short or long course)
8. What does your patient fear most about the above health problem?

Opinion and attitudes towards treatment and care

1. What forms of care do you provide to your patient(s)? How is the care provided?
2. What are the most important results that the patient should hope to get from your care?
3. Who else contributes to care of your patient and how?
4. How do you assess the ways in which care is being provided by other providers?
5. What additional care do you wish to see your patient getting for his/her health problem?
6. Who should provide this care? Why?

Challenges and means of solution among people with mental illness

1. What are the main problems which the sickness causes to your patient?
2. What other problems does your patient experience in seeking/receiving care?
3. How have such problems affected your patient's health in particular?
4. How have such problems affected your patient's life in general?
5. How does your patient deal with such problems?
6. To what extent does your patient succeed in dealing with such problems?

People with mental illness as agents of their own care

1. How do you involve your patient in managing his/her health problem?
2. To what extent are you satisfied with your patient's involvement in managing his/her health problem?
3. What factors do facilitate your patient's involvement in his/her health care?
4. What factors do constrain your patient's involvement in his/her health care?
5. Is there anything else you would like to add?

Thank you for your valuable information.

C. Interview Guide for Psychiatric Health Workers

Participant's identification (pseudonym)

Socio-demographic data

1. Gender
2. Marital status
3. Age
4. Religious affiliation
5. Occupational category and position
6. Highest level of formal education

Conceptualisation of mental illness

1. Briefly, how do you describe mental illness?
2. How do you diagnose mental illness?
3. What is common age for onset of mental illness? and why?
4. How do you communicate the diagnoses in Amharic with your patients and their significant others?
5. What causes mental illness?
6. What effects do these state of health have on your patients' health and lives in general?
7. How severe are these health problems?
8. What concerns do these diagnoses commonly cause to your patients?

Opinions and attitudes on care for people with mental illness

1. What forms of care do you provide to your patients?
2. To what extent are you satisfied with the way care is provided in Amanuel Mental Hospital?

3. Who else contributes to care of your patients and how?
4. To what extent are you satisfied with the ways care is provided by those other providers and why?
5. What additional treatment/care do you wish to see your patients receive because of their state of health? Who should provide this treatment/care and why?

Care-seeking challenges among people with mental illness

1. What are the main difficulties which people with mental illness encounter in seeking care?
2. How do such difficulties affect your patients' health in particular and lives in general?
3. How do your patients deal with such difficulties?
4. To what extent do your patients succeed in dealing with such difficulties?
5. How else can such difficulties be overcome?

Manifestations of agency among people with mental illness

1. How do you involve patients in managing their state of health?
2. To what extent are you satisfied with your patients' involvement in their own care?
3. What factors do facilitate your patients' involvement in their own care?
4. What factors do constrain your patients' involvement in their own care?
5. Is there anything else you would like to add?

Thank you for your valuable information.

Observational Checklist

Religious elements and behaviours in psychiatric hospital (*tsebel*, amulets, attire)

How the ritual is conducted at religious therapy site

The nature of relationship religious healer has with the seekers of religious therapy

Appendix 2: Fieldwork Research Guiding Questions in Amharic

A. Interview Guide for people with mental illness

ሀ. በአእምሮ ህመም ዙሪያ ያሉ ሀሳቦች

1. አሁን ያለህበት የጤና ሁኔታ ምን ተብሎ ይጠራል/ይባላል?
2. አሁን ያለህበትን የጤና ሁኔታ መቼ እና እንዴት ልትረዳ ቻልክ?
3. አሁን ያለህበትን የጤና ሁኔታ /ችግር በምን ምክንያት / ቶች የመጡ ይመስልሃል?
4. አሁን ያለህበትን የጤና ሁኔታ ለምን ተከሰተ?
5. በዚህ የጤና ሁኔታ ምክንያት በአጠቃላይ በጤና ላይ በተለይ ደግሞ በህይወትህ ላይ እያደረሰ ያለውን ተጽእኖ እንዴት ትገልጻቸዋለህ?
6. በአሁኑ ሰአት የምትገኝበትን የጤና ሁኔታ /የህመሙ ደረጃ ምን ይመስላል?
7. ስለ ጤንነትህ ሁኔታ ምን ታስባለን?

ለ. በአእምሮ ህመም ህክምና ዙሪያ ያሉ አመለካከቶች እና አስተያየቶች

1. በአሁኑ ወቅት በምን አይነት መልኩ ህክምና / እንክብካቤ እየተሰጠ ይገኛል?
2. በአሁኑ ወቅት/ እንክብካቤ እያደረገልህ ያለው ማን ነው? በምን አይነት መንገድ?
3. እያገኘ ባለው ሕክምና / እንብካቤ ምን ያህል እርካታ ይሰማሃል?
4. ከምታገኘው እንክብካቤ ምን ያህል ጠቀሜታ አገኛለሁ ብለህ ተስፋ ታደርጋለህ?
5. ለጤንነትህ ሁኔታ ምን አይነት ተጨማሪ እንክብካቤ እንዲደረግልህ ትፈልጋለህ?
6. ማን /የት ጋር ይህን እንክብካቤ ማግኘት ትፈልጋለን ለምን?
7. የምታገኘውን እንክብካቤ እንዴት ማሻሻል ይቻላል?

ሐ. የአእምሮ ታካሚዎች የሚገጥማቸው ችግሮችና የተቀመጡ የመፍትሔ እርምጃዎች

1. የአእምሮ ህክምና / እንክብካቤ አገልግሎት ለማግኘት የሚያጋጥሙ ዋና ዋና ችግሮች ምን ምን ናቸው?
2. ከላይ የተጠቀሱ ችግሮች በአጠቃላይ በሕይወትህ በተለይ ደግሞ በጤና ሁኔታ ላይ እንዴት ተጽእኖ ሊያመጡ ይችላሉ?
3. እነዚህን ችግሮች በምን አይነት መንገድ ለማሸነፍ /መቋቋም ትሞክራለህ?
4. ምን ያህል እየተሳካልህ ይገኛል?
5. ከላይ የጠቀስካቸው ችግሮችን ለመቋቋም ምን አይነት ሌላ ዘዴ አለህ ብለህ ታስባለን?

መ. በአእምሮ ህክምና እንክብካቤ ሂደት ላይ የታካሚውን የግል አስተዋጽኦ/ ሚና

1. የጤንነትህ ሁኔታን ለማስተካከል/ማሻሻል ያለህ ተሳትፎ ምን ይመስላል?
2. የጤና ሁኔታህን ለማሻሻል እያደረክ ባለው ተሳትፎ ምን ያህል እርካታ ይሰማሃል?
3. በጤንነት እንክብካቤ እንድትሳተፍ የሚያስችሉ ነገሮች ምንድን ናቸው?
4. በጤንነትህ እንክብካቤ እንዳትሳተፍ የሚያደርጉ ነገሮች ምንድን ናቸው?

በጣም አመሰግናለሁ!!

B. Interview Guide for Families (Caregivers) and Religious Healers

ሀ. የሕክምና / እንክብካቤ አገልግሎት ለሚሰጡ አካላት የተዘጋጀ መጠይቅ

1. የታካሚው አሁን ያለበት የጤና ሁኔታ / ችግር ምን ተብሎ ይጠራል?
2. አሁን ያለበትን የጤና ሁኔታ / ችግር እንዴት ታየዋለህ?
3. ታካሚው በዚህ የጤና ሁኔታ ላይ እንደሚገኝ እንዴት ለመለየት ቻላችሁ?
4. ከላይ የተጠቀሰው የጤና ሁኔታ አጀማመሩ ምን ይመስላል? ታካሚው እንክብካቤ እንዲደረግለት በምን አይነት ሁኔታ ላይ ይገኛል?
5. ከላይ የተጠቀሱት የጤና ችግሮች መንስኤዎች ምንድን ናቸው?
6. ከላይ የተጠቀሱት የጤና ችግሮች ምን አይነት ተጽእኖ ይፈጥራሉ?
7. ከላይ የተጠቀሱት የጤና ችግሮች ምን ያህል ከብደት አለው?
8. ከላይ ከተጠቀሱት የጤና ችግሮች ውስጥ ታካሚውን በጣም የሚያስጨንቀው ምንድን ነው?

ለ. በአእምሮ ህመም ህክምና ዙሪያ ያሉ አመለካከቶችና የሚመጡ አስተያየቶች

1. ለታካሚ እየሰጠ ያለው ህክምና/ እንክብካቤ ምን አይነት ነው? በምን አይነት ሁኔታ እንክብካቤ / ህክምና እየተደረገለት ይገኛል?
2. ከምታደርግለት እንክብካቤ /ህክምና ታካሚው ምን አይተን ለውጥ /ውጤት ይጠብቃል?
3. ለታካሚው ለሚደረግልት እንክብካቤ / ህክምና ሌላ አስተዋጽኦ ማድረግ የሚችል ሰው አለ? እንዴት?

4. ሌሎች ሰዎች ለታካሚው የሚያደርጉለትን እንክብካቤ እንዴት ታየዋለህ?
5. ለታካሚው ምን አይነት ተጨማሪ የጤና እክብካቤ /ህክምና ቢደረግለት ደስ ይልሃል?
6. ይህንን እንክብካቤ / ህክምና መስጠት ያለበት ማን ነው? ለምን?

ሐ. የአእምሮ ታካሚዎች የሚጋጥማቸው ችግሮችና የተቀመጡ የመፍትሔ እርምጃዎች

1. ታካሚው በህመሙ ምክንያት ያጋጠመው ዋና ዋና ችግሮች ምንድን ናቸው?
2. በሕክምና እንክብካቤ ሂደት ላይ ታካሚው እያጋጠመው ያሉ ሌሎች ችግሮች ምንድን ናቸው?
3. ከላይ የተጠቀሱት ችግሮች በታካሚው ጤንነት ላይ ያሳደሩትን ተጽእኖዎች እንዴት ትገልጻቸዋለህ?
4. አሁን ያለበትን የጤና ሁኔታ በአጠቃላይ በታካሚው ህይወት ላይ እያደረሰ ያለውን ተጽእኖ እንዴት ትገልጸዋለን?
5. ታካማው እነዚህን ችግሮች እንዴት አድርጎ ለመፍታት እየሞከረ ይገኛል?
6. ታካሚው ችግሮቹን ለመፍታት ምን ያህል ተሳክቶለታል?

መ. ታካሚው ያለበትን የጤና ሁኔታ ለማሻሻል እያደረገ ያለው ተሳትፎ

1. ለታካሚው በምታደርግለት እክብካቤ /ፈውስ / ህክምና / ሂደት ላይ በምን አይነት መንገድ ተሳታፊ እንዲሆን እያደረክ ትገኛለህ?
2. በህክምና ሂደቱ ላይ በታካሚው ተሳትፎ ምን ያህል ረክተሃል?
3. ታካሚው በሚደረገው የጤና እንክብካቤ ላይ ተሳታፊ እንዲሆን የሚያስችሉ ነገሮች ምንድን ናቸው?
4. ታካሚው በሚደረገው የጤና እንክብካቤ ላይ ተሳታፊ እንዳይሆን የሚያደርጉ ነገሮች ምንድን ናቸው?

በጣም አመሰግናለሁ፡፡

C. Interview Guide for Psychiatric Health Workers

ሀ. ለአእምሮ ህክምና ባለሞያዎች የተዘጋጀ መጠይቅ

1. ስለ አእምሮ ህመም ምንነት ግለጽልኝ?
2. የአእምሮ ህመምን እንዴት ነው የምትለየው?
3. አሁን ያለበት የጤና ሁኔታ/ ህመሙ አጀማመሩ ምን ይመስላል?
4. ከታካሚዎቹ እና ከቅርብ ዘመዶቻቸው ጋር ተለይቶ ስለ ታወቀው የጤና ሁኔታ በአማርኛ እንዴት ነው የምትግባቡት?
5. የአእምሮ ህመም መንስኤዎች ምንድን ናቸው?
6. በአጠቃላይ ህመሙ በታካሚው ጤና እና ሕይወት ላይ ያመጣው ተጽእኖ / ችግሮች ምንድን ናቸው?
7. እነዚህ የጤና ችግሮች ምን ያህል ከብደት አላቸው?
8. ከምርመራ ውጤቱ ጋር ተያይዞ ከተገለጹት ችግሮች ውስጥ በጣም የሚያስጨንቀው ምን ነበር?
9. ምርመራ ከተደረገ በኋላ /ህመም ከተለየ በኋላ / ታካሚዎችን የሚያስጨንቀው ምንድን ነው?

ለ. በአእምሮ ህመም ዙሪያ የሚሰጡ አመለካከቶች እና አስተያየቶች

1. ለተካሚዎች ምን አይነት ህክምና/እንክብካቤ ይደረግላቸዋል?
2. በአማኑኤል ሆስፒታል በሚሰጠው የአእምሮ ህክምና/እንክብካቤ አገልግሎት ላይ ምን ያህል እረከተዋል?
3. ለአእምሮ ህሙማን እንክብካቤ እያደረገ የሚገኝ ሌላ አካል/አካላት (ሰው) አለ? እንዴት?
4. ከላይ የተጠቀሱት አካል/ላት እያደረጉት ባለው አስተዋጽኦ ምን ያህል እረከተሃል?
5. ለአእምሮ ታካሚዎች ምን አይነት ተጨማሪ ህክምና/እንክብካቤ እንዲደረግላቸው ትመኛለን? ይህንን እንክብካቤ ማቅረብ ያለበት ማን ነው? ለምን?

ሐ. የአእምሮ ታካሚዎች እያጋጠማቸው ያሉ ችግሮች

1. የአእምሮ ህክምና / እንክብካቤ አገልግሎት ለማግኘት ህሙማኑ የሚያጋጥሟቸው ዋና ዋና ችግሮች ምንድን ናቸው?
2. ከላይ የተጠቀሱት ችግሮች በአጠቃላይ በታካሚው ህይወት በተለየ መልኩ በጤናው ላይ እንዴት ተጽእኖ/ችግሮች ሊያመጡ ይችላል?
3. ታካሚው እነዚህ ችግሮች በምን አይነት መንገድ ለመቅረፍ እየሞከረ ይገኛል?
4. ምን ያህል ተሳክቶለታል?
5. ከላይ የተጠቀሱትን ችግሮች ለመፍታት ምን አይነት ሌላ መንገድ አለ ብለህ ታስባለህ?

Appendix 3: List of Patients and Caregivers Interviewed at AMSH

Frez is a single woman past her mid-thirties with B.A in linguistic and literature, and have been in and out of medical treatment for the past 20 years.

Eyob is an Orthodox, single, 23 years old and a drop-out at a business college. He had worked for a while as a mobile maintenance specialist. Eyob was on his 46th day since being admitted in AMSH for substance addiction. He had started experimenting with drugs some eight years ago due to peer pressure. Eyob coming from a staunch orthodox family had tried tsebel therapy before coming for psychiatric care.

Abate is a single male, aged 37 years old and of Protestant faith. He managed to complete his 12 grade level education and for sometimes he was employed as English teacher at a private elementary school. Abate has been ill for the past 19 years. He left his job when he became sick. At the time of interview it was his thirteenth time to be admitted at AMSH. He lives with his old father in Debre Zeyt. Abate attributes the initial cause of his illness to witchcraft and excessive study.

Bruk an Orthodox, single man aged 23 years, became sick when he was in campus. It is now two years since he became sick. This is the first time he has been admitted in AMSH. He was brought to the hospital by his family after trying several holy water springs unsuccessfully.

Lub a Protestant aged 26 years and a 10th grade drop-out living with his divorced mother in Addis Ababa city, had worked as a vendor (of largo liquid soap) before his medical nurse mother decided to bring him to psychiatric care for his addiction problem(cigarettes, harake, hashish). It was on his 26th day in AMSH that I got to interview him. Lubo explains his situation as a victim of witchcraft to addiction.

Ahmed is a 31 years old Muslim, married with 3 children is a Master's degree drop-out. He teaches at a High school. It is now more than a month since he was readmitted to AMSH.

Maryamawit is an orphan aged 23 years and also an H.I.V patient. She was born to Orthodox parents but at the moment inclining to Protestant faith. She had a formal education to secondary level (10+1) and worked as a saleswoman for sometimes before she had a mental problem. At the time of the interview she was on her 17th day in AMSH and the third time to be readmitted there for bipolar disorder.

Abebaw is a single Orthodox man aged 48 years. He is a graduate employed by the government. He has been an in and out-patient at AMSH for the past 20 years. He is a substance addict (cigarettes, khat, harake) patient at private ward. It is 2 months since he was admitted for hearing

voices (hallucinations) and his substance addiction. His habit makes it hard for him to attend to work (ሥራ ፈት) and participate in social life.

Abdul is a Muslim aged 60. He is a father of seven children and the caregiver of his firstborn son aged 37. It is 6 years since his son became ill. Before coming to AMSH they had tried various therapies found locally.

Makonnen is a 29 years old Muslim married man from Dessie is the caregiver of his 25 years old brother, Abdi. At the time of the interview it was their 15th day at AMSH. **Abdi** having schooled to 9th grade came to Addis Ababa where he was a casual worker for 4 years. He became sick after his marriage proposal was rejected. The people in their area told them it is a spirit phenomenon and they tried tsebel therapy and later brought him to AMSH when he became very very disruptive some 3 months ago.

Hassan is a 60 years old Muslim with elementary level of formal education. He is the caregiver of her youngest daughter Lefisa aged 26. Lefisa became sick at her mid teenage (16) in Dubai where she had gone for work. She had barely stayed in Dubai for a year (11months) when her employer called to inform us that Lefisa is sick and they cannot afford to take her to hospital. So they sent her back to Ethiopia and her brothers picked her from Bole.

Almaz is a 58 years old Orthodox woman with elementary level of formal education and recently retired from government employment. She has been the caregiver to her daughter aged 19 years since two years ago when she first became ill.

Wondu is a 38 years Orthodox single man with 12th grade level of education and 8years experience working as caregiver at AMSH.

Appendix 4: List of Psychiatric Health Workers Interviewed at AMSH

SN	Pseudonyms	Gender	Marital Status	Age	Religion/ Denomination	Education Level	Occupation	Years of contact with patients
1	Giza	Male	Single	30	Protestant	Master's Degree	Coordinator	8
2	Rahel	Female	Married	29	Orthodox	Master's Degree	Psychiatrist	1
3	Ruf	Male	Married	54	Orthodox	Master's Degree	Psychiatrist	20
4	Keb	Male	Married	32	Orthodox	Master's Degree	Clinical Psychologist	4
5	Zola	Male	Single	29	Orthodox	Master's Degree	Social Worker	7
6	Taye	Female	Single	31	Protestant	Bachelor's Degree	Clinical Nurse/Social Worker	7
7	Selam	Female	Single	25	Protestant	Bachelor's Degree	Clinical Nurse	1
8	Awet	Female	Married	27	Orthodox	Bachelor's Degree	Psychiatric Nurse	5
9	Hirut	Female	Single	28	Protestant	Master's Degree	Psychiatric Nurse	5
10	Abiot	Male	Married	52	Orthodox	Bachelor's Degree	Social Worker	17
11	Dechu	Male	Married	33	Protestant	Master's Degree	Pharmacist	7

Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for degree in other university and that all sources of materials used for the thesis have been duly acknowledged.

Candidate

Name: ______________________________

Signature: ______________________________

Date: ______________________________

Place: ______________________________

Confirmed by Thesis Advisor:

Name: ______________________________

Signature: ______________________________

Date: ______________________________