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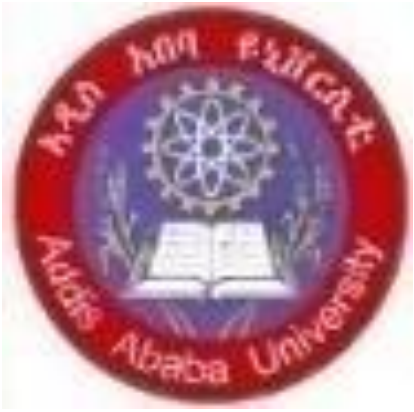
SCHOOL OF MEDICINE

DEPARTMENT OF PSYCHIATRY

EXPLORING THE EXPERIENCES AND ROLES OF RELIGION AND SPIRITUALITY IN THE LIVES OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER: A QUALITATIVE STUDY

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A THESIS SUBMITTED TO THE DEPARTMENT OF PSYCHIATRY, SCHOOL OF MEDICINE, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY FOR THE PARTIAL FULFILMENT OF THE SPECIALTY CERTIFICATE IN PSYCHIATRY

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MARCH 2026

III. ACRONYMS AND ABBREVIATIONS

ABBREVIATION	Full Form
AAU	Addis Ababa University
BA	Bachelor of Arts
B-RCOPE	Brief Religious Coping Scale
COVID-19	Coronavirus Disease of 2019
DSM	Diagnostic and Statistical Manual of Mental Disorders
ENT	Ear Nose Throat
FICA	Faith, Importance/Influence, Community, and Address (Spiritual History Tool)
HIV	Human Immunodeficiency Virus
HOPE	Health Objectives, Personal spirituality, and Expectations (Spiritual Assessment Tool)
ID	Identification
JCOPE	Jewish Religious Coping Scale
MDD	Major Depressive Disorder
NRC	Negative Religious Coping
PGY	Post Graduate Year
PI	Principal Investigator
PRC	Positive Religious Coping
RCOPE	Religious Coping Scale
REC	Research Ethics Committee
SOM	School of Medicine
TASH	Tikur Anbessa Specialized Hospital
WHO	World Health Organization

IV. ACKNOWLEDGMENTS

First and foremost, I want to pay my gratitude to the Almighty God for giving me the strength through my residency and this thesis. I then want to thank Dr. Yonas Baheretibeb and Dr. Eyerusalem Solomon for giving me the guidance and feedback starting from the proposal up to this finished thesis.

I also want to thank the Psychiatry department of Addis Ababa University College of Health Sciences for giving me the opportunity and support to make this thesis happen. Also, I want to thank the nurses working at the outpatient department of psychiatry at Tikur Anbessa Specialized Hospital for helping me during the data collection by facilitating choosing the appropriate participants. I especially want to thank the participants who were willing to share their life experiences and participate in this research without hesitation. I want to thank my family and friends for encouraging me throughout the process.

And finally, I want to give my heartfelt gratitude to my husband and son for being my support system through all of this.

V. OTHER PRELIMINARIES

TABLE OF CONTENTS

III. ACRONYMS AND ABBREVIATIONS i
IV. ACKNOWLEDGMENTS ii
V. OTHER PRELIMINARIES iii
LIST OF TABLES vii
LIST OF FIGURES viii
VI. ABSTRACT ix
1. INTRODUCTION 1
1.1. Background of the Study 1
1.2. Statement of the Problem 2
1.3. Rationale of the Study 3
1.4. Literature Review 3
1.4.1. Global Literature Review 3
1.4.2. African Literature Review 6
1.4.3. Ethiopian Literature Review 7
1.4.4. Critical Review of Existing Literature and Identified Gaps 8
1.5. Conceptual Frameworks 11
1.5.1. Conceptual Framework Diagram 11
1.5.2. Explanatory Notes of the Framework 12
2. RESEARCH QUESTION 14
2.1. General Research Question 14
2.2. Specific Research Questions. 14
3. OBJECTIVES 15
3.1. General Objective 15

3.2. Specific Objectives 15
4. MATERIALS AND METHODS 16
4.1. Study Setting 16
4.2. Study Period 17
4.3. Study Design 17
4.4. Source Population 18
4.5. Study Population and Eligibility Criteria 18
4.6. Sample Size Determination 18
4.7. Sampling Technique 19
4.8. Operational Definitions 19
4.9. Instruments for Data Collection 20
4.10. Data Collection Procedures 21
4.11. Data Processing and Management 22
4.12. Data Analysis 22
4.13. Data Quality Assurance 23
4.14. Ethical Consideration 24
4.15. Role of the Researcher (Reflexivity) 24
5. RESULTS 25
5.1. Socio Demographic Characteristics of Participants 25
5.2. THEME 1: THE PSYCHOSOCIAL BURDEN OF MDD 26
5.2.1. Psychological Impact and Symptom Manifestation 26
5.2.2. Social and Interpersonal Consequences 27
5.2.3. Socio-Environmental Stressors 28
5.3. THEME 2: ENGAGEMENT WITH PSYCHIATRIC CARE 29
5.3.1. Medical Journey and Diagnosis Discovery 29
5.3.2. Resilience and treatment Outlook 30
5.4. THEME 3: ADAPTIVE COPING THROUGH SPIRITUAL PRACTICES 32

5.4.1. Rituals as Emotional Regulators 32
5.4.2. Spirituality Fostering Self Compassion and Meaning 34
5.4.3. Integration with Professional care 35
5.5. THEME 4: AMBIVALENCE AND CONFLICT IN SPIRITUAL BELIEFS 35
5.5.1. Existential and Theodicy Questioning 35
5.5.2. Perceived Divine Neglect and Rejection 36
5.5.3. Tension Between Spiritual and Biomedical Explanatory Models 36
5.6. THEME 5: BARRIERS AND DISENGAGEMENT FROM RELIGION/SPIRITUALITY 37
5.6.1. Stigma of Spiritual Diagnosis 37
5.6.2. Clerical Minimization and Harmful Religious Advice 38
5.6.3. Institutional Disillusionment and Betrayal 38
5.6.4. Intellectual Gatekeeping 39
6. DISCUSSION 40
7. STRENGTHS AND LIMITATIONS 45
7.1. Methodological Strengths 45
7.2. Limitations and Challenges 45
8. CONCLUSIONS 46
9. RECOMMENDATIONS 47
9.1. Recommendation for Clinical Practices 47
9.2. Operational and Policy Recommendations 48
9.3. Recommendations for Future Research 48
10. REFERENCES 50
11. APPENDICES 56
Appendix A: Participant Information Sheet (English and Amharic) 56
Appendix B: Informed Consent Form (English and Amharic) 62
Appendix C: Qualitative Interview Guide (English and Amharic) 65

12. DECLARATION 68

LIST OF TABLES

Table 1: Socio-demographic characteristics of the study participants 25

LIST OF FIGURES

Figure 1: Conceptual Framework for Religious and Spiritual Coping 12
Figure 2: Flowchart of the Research Process 19

VI. ABSTRACT

Background: In Ethiopia, religion and spirituality (R/S), play parts in the lived experiences of patients with mental illness. They play major role in shaping patients' interpretation and navigation of their recovery. Major depressive disorder (MDD) is the main cause of functional impairment. But patients' day-to-day experiences and role of R/S in their lives are not well studied.

Objectives: This study explores the personal meaning patients with MDD give their faith, and the role R/S plays from helping deal with their illness, up to causing psychological distress. It tries to distinguish between different spiritual coping mechanisms, cultural factors and evaluate how they affect the relationship with formal psychiatric care.

Methods: The study used a qualitative design and purposive sampling method to choose 11 patients with the MDD on follow up at Tikur Anbessa Specialized Hospital, psychiatry outpatient clinic. Data was collected using semi structured, in-depth interviews, then transcribed verbatim. To find meanings in the interview, thematic analysis was applied that was then categorized into themes.

Results: Five themes emerged: Psychosocial burden of MDD, Engagement with psychiatric care, Adaptive coping through spiritual practices, Ambivalence and conflict in spiritual beliefs, and Barrier and disengagement from R/S. R/S gave emotional relief but negative spiritual appraisals delayed medical help seeking.

Conclusions and Recommendations: R/S either causes remission or distress. The recommendation is, for health care workers to include spiritual history taking in evaluations and collaborating with religious leaders to improve care and reduce stigma.

Keywords: Major Depressive Disorder, Religion, Spirituality, Coping, Ethiopia, Qualitative Study, Psychiatric Care, Lived Experience, Tikur Anbessa Specialized Hospital

1. INTRODUCTION

1.1. Background of the Study

Major Depressive Disorder (MDD) is a severe mental illness which more than 280 million people around the world have(1). It is also among the most common reasons people are unable to work (1). What could help many people with depression in improving functioning and quality of life are combinations of medications and psychological treatments(2), but despite these treatments, there are patients that continue to have daily functioning impairments and low quality of life(2). In low- and middle-income countries such as Ethiopia, there are insufficient resources, stigma is common, and cultural issues can affect getting a proper diagnosis and treatment(3–5).

Religion and Spirituality (R/S) are central to lives of majority of Ethiopians, which are the source of their hope, meaning and social support mainly during difficult times(6). “Religion provides resources for coping with stress that may increase the frequency of positive emotions and reduce the likelihood that stress will result in emotional disorders such as depression…” (7). One international research has found that religious coping, using religious beliefs and practices, could be both good and bad(8). People who managed to practice PRC (i.e. seeking spiritual coping and finding meaning of their suffering) tended to experience fewer depressive symptoms and coped better with their emotions(8–11). In contrast, NRC was related to more severe symptoms and negative consequences(8). This created a sense of being punished or left alone by God(8).

It had not been easy to discuss religion as people still didn’t know how to process it. Several international systemic reviews and meta-analysis and research studies showed that R/S might influence a person’s mental health in various ways (10,13–17). Some studies have investigated how religious coping may benefit Africans with mental health problems, but doing more studies was important to have a better understanding(18,19). Researchers in Nigeria found out that people with depression or diabetes who used PRC, related to patients that used NRC had milder symptoms

and less disability.(19). The suggestions for these findings were that how you address problems could influence the outcome and that religion might not always be the best way to address those problems. But these studies were conducted only on Nigerians with mental or physical health challenges, so more studies were needed to understand the full impact of the problem in the rest of Africa.

According to a recent study in Northwest Ethiopia, which show that nearly 40% of individuals with depressive symptoms found religious places as the most helpful place of support, and like any healthcare providers, religious and traditional healers were valued as much(4). According to many people in Ethiopia, mental illness can be caused by spiritual matters such as being cursed or possessed which made patients length of treatment and the type of care they received change(3,5). Even though many Ethiopians claim to be religious, not much was understood about how religion might help people with MDD heal. Existing Studies in Ethiopia considered how people received help or how they understood their illness(20,22) instead of directly comparing PRC and NRC or how these groups were associated with symptom severity(20,22,23).

1.2. Statement of the Problem

Major depressive disorder (MDD) is highly prevalent in Ethiopia(22), but there are limited culturally informed mental health interventions(3,24). Even though religion and spirituality play an important role in many people's lives(6,7), there was limited understanding of patients with MDD in how they used religious or spiritual coping mechanisms for episodes of depression(20).

Without this understanding of how Ethiopian patients diagnosed with MDD used R/S to cope, mental health services could fail to address culturally responsive care, and spiritual resources might have been undervalued by health care professionals or policy makers that could lead to inadequate care(3,4,20,24).

Most quantitative tools were developed in Western countries to study religious or spiritual coping(12,28,29) and they might not reflect the lived experiences of patients in Ethiopia, which raised concerns about the cultural validity of those tools. This

study approached the topic with neutrality, seeking to understand the full spectrum of R/S experiences, including both positive aspects that provided comfort as well as negative aspects, such as spiritual struggles or religious guilt.

1.3. Rationale of the Study

Even though R/S are a major part of many Ethiopians(6,7), there were limited studies that had qualitatively explored the nuanced ways in which patients with MDD in Ethiopia used R/S to cope with their condition. Most of the studies that had been done until then had either looked at help seeking behaviors(4,5) or focused on broader community depression understanding rather than to specifically focus on ways patients used religion and spirituality to cope(20).

Despite there being treatments, many patients still had relapses, because of factors such as delayed treatment, poor medication adherence, and cultural/psychological dynamics according to a study done in Northwest Ethiopia(32). Studies from all over the world showed that religious coping could help people with mental illness deal with their problem supported by their community(7,10,13,14), but the effects of R/S were not clear cut. PRC was often linked to better outcomes, and NRC made symptoms worse(8,9,15,19,33,34). Understanding how these dynamics played out in the Ethiopian context required direct exploration of subjective experiences.

This study at TASH tried to fill this gap by looking into how Ethiopian adults with MDD used religion and spirituality to cope. Clinicians are now better able to include spiritual aspects in care to improve engagement and outcomes.

1.4. Literature Review

1.4.1. Global Literature Review

Major Depressive Disorder (MDD) is a major global health concern that the World Health Organization (WHO) identifies as a leading cause of disability worldwide contributing to the global health burden and it is characterized by persistent feeling low mood with a lack of interest or happiness in a usually rewarding or enjoyable

activities for people(1). MDD's burden on patients is not only limited to them but also affects social cohesion, occupational output and overall quality of life in their surroundings(2). Standard treatments like psychotherapy and pharmacotherapy have shown efficacy in managing depressive symptoms and improving functioning(2) but still many individuals continue to experience remaining symptoms, some relapse or face problems to accessing formal mental health care(4,5). This pointed out the need to study diverse and culturally acceptable coping mechanisms that patients could access to manage their condition.

In low-income countries like Ethiopia, the limited resources allocated for mental health problems, the societal stigma and the society's tendency to rely on traditional and religious healing practices intensified the challenge(3–5). Bitew(22) investigated the prevalence and risk factors of depression in Ethiopia and found that there is significant burden. It is very important to understand how patients in such contexts deal with their illness, especially using religion and spiritualty. This literature review attempted to explore the already done studies on the role of religion and spirituality in the coping mechanisms of patients with MDD, identify gaps, and come up with evidence for qualitative research into the issues, primarily with in the Ethiopian context and beyond.

To understand how religion, spirituality and coping are related with each other it is important to define what they are first. Religion refers to an organized system of beliefs, practices, rituals and symbols that is shared by a group of people, usually involving supernatural dimension(7,21). Spirituality is a broader concept that is described as a more personal search for meaning and purpose and it may or may not be exercised with a certain religion(7,21,35). Even though they are different, these two concepts often overlap and are used interchangeably in research. Coping mechanisms are the thought and behaviors individuals use to deal with internal and external demands that are considered beyond their ability(9). In the context of mental health, coping strategies can be adaptive (e.g., problem solving, seeking social support, positive reappraisal) or maladaptive (e.g., avoidance, substance abuse). Religious and spiritual coping involves using religious and spiritual beliefs, practices and communities to deal with stressors, including illness(21). This can be seen as positive religious coping or negative religious coping, positive religious coping

comprises of seeking spiritual support, engaging in religious reappraisal and spiritual acceptance while negative religious coping includes spiritual struggle, feeling punished by God and questioning one's faith(8,12). To measure these dimensions tools like the Brief Religious Coping Scale (Brief RCOPE)(12,36) and JCOPE(29) were developed.

Many international literatures suggested complex but generally positive interaction between religion, spirituality and mental health especially when it comes to depression, which systematic reviews and meta-analysis indicated strong evidence for this link. Braam and Koenig(14), in their systematic review of prospective studies, found consistent evidence that higher levels of religiousness and spirituality were associated with lower rates of depression and quicker remission from depressive episodes. Similarly, Bonelli et al. (10) reviewed the research on religious and spiritual factors in depression, concluding that these factors often served as protective shields against depression and could enable a quick recovery.

In a systematic review and meta-analysis of studies focusing on young people, Aggarwal et al.(13), found out that religiosity and spirituality were strongly linked with better mental health outcomes, including decreased depression and anxiety. This protective outcome appeared to be found across different populations and contexts. For example, Miller et al.(28) conducted a ten-year prospective study on adults at high risk of depression and found out that religiosity was linked to lower recurrence of major depression. Dew et al.(37) also found similar patterns in adolescent psychiatric patients, where religion/spirituality was potentially connected to fewer depressive symptoms.

The role of religious coping was specially highlighted. Studies showed that positive religious coping was linked with better adjustment and lower levels of distress among various communities, including people dealing with stressful life events(9), people with HIV(8), and caregivers of children with type 1 diabetes(11). For example, Mahamid and Bdier(38) found that positive religious coping was involved to better deal with perceived stress and depressive symptoms during the COVID-19 pandemic. The systematic reviews by Pankowski and Wytrychiewicz

Pankowaska(15,39) indicated more on the protective role of religious coping on mental health during the pandemic.

However, it was important to recognize that the relationship is not always straightforward. Negative religious coping, characterized by spiritual struggles or questioning of faith, was frequently associated with poorer mental health outcomes, including increased depressive symptoms(8,12). Tepper et al.(40) found that religious coping was standard among persons with persistent mental illness, but the type of coping whether positive or negative, was key to understanding its consequences.

Religion and spirituality can affect mental health through various positive ways, including but not limited to, religious communities providing social support networks(6), giving one a sense of meaning and purpose(41), encouraging healthy lifestyles, and giving a framework for understanding suffering(7) which are beyond direct coping. Neugebauer et al.(41) studied the use of religion/spirituality and MDD to altruism, suggesting wider psychological benefits. Chen et al(42) found that older people's religious participation predicted mental health status and treatment outcomes which indicated its potential role in recovery.

There was a recognized need for qualitative research to look deeper into the how and why of relationships because most of the global literature was quantitative, looking into correlations and predictive relationships. Lucchetti et al.(35) indicated that more nuanced understanding of the how and why of religiousness and spirituality understanding was needed even though the scientific evidence of the positive impact on mental health was growing.

1.4.2. African Literature Review

In many African societies, including Ethiopia, serving as primary sources of meaning, identity, and social support, religion and spirituality are usually deeply rooted in daily life and cultural practices(4,6). For mental health issues, including depression, traditional or religious healers are usually the first point of contact for people

reaching out for guidance, because these mental health issues are frequently understood through spiritual or religious lenses(4,5,20).

Studies done in various African countries showed the significant role of religion on coping strategies. Amadi et al.(18,19), looked at the relationship between religiosity, religious coping, and socio-demographic variables among patients receiving outpatient care for depression or diabetes mellitus in their studies from Nigeria. In their findings religious coping was found to be an important strategy, and religiosity could influence results in these populations. The importance of religious beliefs and practices as a cultural resource for managing mental health issues had been indicated in different African settings. Across many African countries, the reliance on spiritual systems for healing mental illness and seeking support was a common finding even before seeking help from medical professionals.

1.4.3. Ethiopian Literature Review

In Ethiopia, the role religion and spirituality play in health and illness is very noticeable and connected with cultural identity. The major obstacle that drives individuals to religious and traditional healers is mental health stigma(3,4). Yimer et al.(4) investigated and found out the major role religious and traditional healers played in the treatment seeking behavior and barriers to mental health service utilization in Northwest Ethiopia. Similarly, Kasa and Kaba(5) looked at preferences for healthcare among mentally ill patients in Oromia, Ethiopia, further showing the reliance on informal care.

Studies done in Ethiopia also tried to explore the connection between religion, spirituality and wellbeing. Hamren et al.(6) investigated older Ethiopians in Addis Ababa to find that religion, spirituality, and community support were major predictors of quality of life, which suggested a general positive association between these factors and overall well being within the Ethiopian population.

Several studies done in Ethiopia gave valuable insights about coping specifically. Girma et al.(25) investigated COVID-19 pandemic related stress and coping strategies among adults with chronic disease in Southwest Ethiopia, the study

identified various coping mechanisms, which, given the cultural context, likely included religious ones. Azale and Fekadu (43) looked into strategies used to cope with postpartum depression symptoms among women in rural Ethiopia, showing community-based and traditional approaches that often had spiritual foundations. Zeleke et al.(26) an investigation of coping strategies for depression among HIV positive women in Gondar, illustrated diverse coping methods where religious and spiritual elements were often present.

More specifically linked to mental illness, Birhan and Eristu(23) studied positive religious coping and associated factors among participants with severe mental illness in Bahir Dar, Ethiopia, and found out that positive religious coping was used by individuals with severe mental illness in this setting, supporting the general global trend. Kebede et al(27) did a study in Hawassa, Ethiopia, in adult cancer patients and their spiritual well being, which their finding showed the importance of spiritual factors in managing chronic illness and distress.

When it came to Ethiopian context, one unique aspect was the prominent role religious institutions ad healers had in the society. Baheretibeb et al.(24) did a case study on transformative learning in the setting of religious healers in Ethiopia, highlighting their influence and potential for collaboration in mental health interventions. A qualitative study was done in rural Ethiopia by Tekola et al.(20) on the understandings of depression among community members and primary healthcare attendees, which showed spiritual explanations for mental illness being common, and significantly influenced coping strategies and help seeking behaviors. This work was very important for understanding the cultural perspective through which mental health challenges were perceived and managed.

1.4.4. Critical Review of Existing Literature and Identified Gaps

Even though the reviewed literature strongly suggested a positive association between religion/spirituality and mental health, specifically in coping with depression, several key observations and gaps emerged.

Majority of studies that linked religion/spirituality to depression and coping were quantitative, and these studies mostly employed surveys, scales, like brief RCOPE, and statistical analysis(8,9,11,13–17,19,23,29,37,42,43–45). The strength of these quantitative studies was that they offer a broad understanding of the association between religion/spirituality to depression and they provide important data on prevalence, correlations, and predictive relationships. Systematic reviews and meta-analysis(10,13–15,39,46) combined extensive evidence, increasing generalizability and statistical power. Prospective studies(14,28,37,45) offered convincing proof for causality. But, even if quantitative methods were strong for identifying associations, they failed to capture the interrelated, lived experiences of individuals. They revealed what was happening, like higher religiosity associated with lower depression, but not how or why religion and spirituality served as coping mechanisms from the patient's perspective. It was difficult to quantify the subjective nature of spiritual experiences and the diverse ways individuals merged their faith into coping. Also, cross-sectional studies(11,16–18,23,26,27,38,43,44,47) could not establish causality. Relying on self-report measures for both religious/spiritual coping and mental health symptoms had a potential for social desirability bias. Even though Studies from Ethiopia provided essential context(3–6,20,22–25,27,32,43) they either did broader qualitative exploration that did not specifically focus on MDD patients coping mechanism via religion/spirituality, or, they had a methodological learning towards quantitative surveys. For instance, Tekola et al(20) did a qualitative study to explore the understandings of depression, which was foundational, but did not deeply focus on religious/spiritual coping mechanisms. Birhan and Eristu(23) confirmed the presence of positive religious coping by doing a quantitative study that assessed positive religious coping in those with severe mental illness, but not their specific lived experience.

The literature frequently cited stress and coping theories like Lazarus and Folkman's transactional model of stress and coping, in which religion and spirituality were viewed as resources or strategies to manage stressors(9,21). Some studies also agreed with the Biopsychosocial Spiritual Model, which recognizes spirituality as a primary dimension of human experience equal with biological, psychological, and social factors in health and illness(7,35). This model provided a strong framework for understanding the broad impact of religion and spirituality. However, specific

conceptual frameworks explaining the methods through which religion and spirituality translated into effective coping for MDD patients were less clearly expressed or empirically tested qualitatively.

What was known was that MDD is prevalent and a disabling disorder globally and in Ethiopia(1,46), specifically in group oriented and religious societies like Ethiopia, it was known that religion and spirituality were widely used coping mechanisms(4,6,18,19,23). Positive religious coping was usually associated with better mental health outcomes, including reduced depressive symptoms and improved quality of life(8–11,13,15,28,38,39), and negative religious coping could worsen distress(8,12). Religious institutions and healers played an important role in mental illness stigma was high in Ethiopia, influencing help seeking behaviors(3,4).

Even though there was many quantitative evidence, there was a significant gap in the in depth, qualitative understanding of how patients with MDD in Ethiopia perceived, experienced, and utilized religion and spirituality as coping mechanisms. One major unknown was the lack of lived experience. Studies did confirm the association, but they rarely dug into the lived experience. How did patients with MDD described their spiritual struggles and find strength in the face of depression? What specific religious practices or beliefs did they find most helpful, and why> How did these practices translate into concrete coping mechanisms? Although, although the literature broadly discussed “religious coping”, the specific, the studies hadn’t really looked closely at different ways. Ethiopian patients with MDD diagnosis coped using their culture and religion. For example, how did specific prayers, rituals, or community support within Ethiopian Orthodox Christianity, Islam, or other religions help people cope with depression? Another gap was in understanding how people combined R/S coping with formal mental health care, how did patients use religious/spiritual coping with formal mental healthcare, if they could access it ? Were there conflicts or did they work well? While Yimer et al.(4) and Kasa and Kaba(5) touched on treatment seeking, the qualitative experience of combining these approaches was not well understood. Also, while some studies understood the cultural context(6,20), a focused qualitative study focusing on how Ethiopian patients with MDD used religious/spiritual coping to uncover specific cultural ways and understanding that quantitative studies or broader qualitative studies might have

missed. For example, what role the local religious leaders or traditional practices had in coping with depression. Lastly, we didn't know much about patients' feelings about the efficacy, how did patients themselves evaluate if their religious/spiritual coping strategies were effective or not? From their point of view, what made some strategies more effective than others?

The reviewed literature demonstrated the general importance of religion and spirituality in mental health and coping providing a solid base, both globally and within the Ethiopian context. But a critical review showed a large gap in the qualitative understanding of MDD patients in Ethiopia, their lived experiences and specific mechanisms through which they used religion and spirituality as coping strategies. It was known that people used religion and spirituality to cope, and that positive religious coping was usually helpful, but we don't have the deeper, more personal understanding from the patients' perspectives that could make sense of these ways of coping strategies.

The new problem identified was that there was not enough qualitative understanding of the specific religious and spiritual coping mechanisms, deeply rooted in culture, used by patients with Major Depressive Disorder in Ethiopia, nor how these patients experienced and perceived these mechanisms. This study offered helpful insights into the patients' own perspectives, added to existing quantitative research, and helped guide the creation of mental health interventions that are culturally sensitive and more holistic in Ethiopia.

1.5. Conceptual Frameworks

1.5.1. Conceptual Framework Diagram

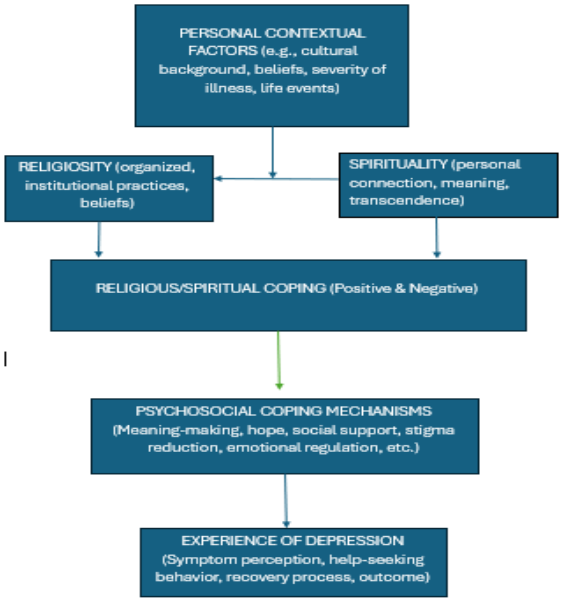


Figure 1: Conceptual Framework for Religious and Spiritual Coping

1.5.2. Explanatory Notes of the Framework

This conceptual framework was derived from the Theory of Religious coping by Pargament, and it differentiated between positive religious coping (PRC), like praying for strength, feeling supported by religious community, and understanding problems that occur as part of God's plan, and negative religious coping (NRC), like spiritual struggle, having conflicts with others about religion, religious guilt, or thinking that God was punishing them.

The model placed an individual's religiosity (in terms of religious belief systems, practices and affiliations) and spirituality (sense of purpose, relationship, and transcendence) as key components that influenced how people understood their depressive episodes and developed coping strategies.

These kinds of belief systems affected religious/spiritual coping, which were either adaptive (e.g., finding comfort through prayer, letting go of control to a higher power) or maladaptive (e.g., feeling punished or abandoned by God). These coping strategies also played a role in how people dealt with problems emotionally and socially like making sense of their problems, regulating their emotions, protecting themselves from stigma, and help seeking. But these things didn't happen on their

own, instead, they were shaped by individual and situational factors, such as culture, degree of religiosity/spirituality, previous trauma history, and the severity of their depressive symptoms. Combined, these connected factors influenced how people experienced, made sense of, and responded to MDD.

This theoretical framework supported a qualitative exploratory approach to deeply understand how Ethiopian patients with MDD applied religious and spiritual resources to cope and how those coping mechanisms in turn shaped the lived experience of illness and recovery.

This framework guided how data were collected (detailed interviews) and analyzed (thematic, based on Pargament's model). The goal was to reach a culturally sensitive understanding of the Spiritual side of coping with depression.

2. RESEARCH QUESTION

2.1. General Research Question

1. How do patients with MDD receiving follow up care at Tikur Anbessa Specialized Hospital use religion and spirituality to cope with their illness and what meanings do they attach to these practices in the circumstances of their recovery?

2.2. Specific Research Questions.

1. What specific religious and spiritual practices (e.g., prayer, Holy water, fasting) do patients with MDD use to manage depressive symptoms?
    a. How do cultural beliefs and religious traditions shape these coping practices?

2. How do patients interpret the effects of positive and negative religious/spiritual coping on their mood and overall wellbeing?
    a. How do religious and spiritual understandings influence patients' attitudes toward, engagement with, and adherence to formal psychiatric care?

3. OBJECTIVES

3.1. General Objective

1. To explore the experience and the roles of religion and spirituality in the lives of patients with Major Depressive Disorder (MDD) on follow up at Tikur Anbessa Specialized Hospital.

3.2. Specific Objectives

1. To explore the ways patients with MDD used religious and spiritual coping mechanisms to manage their symptoms
2. To explore how the cultural factors and religious traditions shape these practices
3. To describe patients' understanding of how their positive and negative religious and spiritual coping mechanisms affected their experience of depression
4. To examine how religious and spiritual understandings influence patients' attitude toward, and their engagement with formal psychiatric care.

4. MATERIALS AND METHODS

This study, using a qualitative approach, explored the lived experiences of patients with MDD regarding their religious and spiritual coping mechanisms. The study followed a phenomenological research process to accomplish the objectives. This process allowed what quantitative measures often fail to capture, which is allowing patients to give a deep, subjective and narrative based explanation of their spiritual phenomena.

Since the goal was to prioritize patients' firsthand experience and also their sociocultural contexts of faith, the most suitable approach was found to be this qualitative methodology.

The research process started from purposive sampling of patients at Tikur Anbessa Specialized Hospital (TASH), then continued with semi-structured in-depth interviews followed by thematic analysis using OpenCode 4.03 software.

To ensure the trustworthiness of the data collected, enough time was spent with the participants during the data collection, and the data was checked carefully during coding. After getting the official approval and participants' willingness, the safety of the data was ensured by keeping all information private.

4.1. Study Setting

This study was conducted on outpatients at Tikur Anbessa Specialized Hospital (TASH) in Addis Ababa, Ethiopia. TASH is the largest comprehensive specialized hospital in Ethiopia. During the study period, it was serving as a national referral and teaching hospital, and it had different specialized departments within it, including the psychiatric department. It serves a diverse range of populations from different religious, social and economic backgrounds so participants of the study were from a large catchment area from the hospital. So, the aim was for this study to provide a great opportunity to closely examine religious and spiritual coping in a well- defined group of individuals that got diagnosed with MDD.

The outpatient psychiatric department at TASH functions as a high-volume clinical environment. Given the hospital's status as a tertiary referral center, the clinic sees a significant diversity in terms of ethnicity and religious affiliation, including Orthodox Christian, Muslim, and Protestant patients. This setting is ideal for this study because, it allows to find patients having a modern psychiatry follow up and at the same time that have different types of backgrounds regarding religion and cultural aspects giving meaning to their mental illness.

4.2. Study Period

The data collection period was from November 2025 to February 2026.

4.3. Study Design

This study used a constructivist qualitative study with phenomenological sensitivity, analyzed using reflexive thematic analysis(30). Using this approach, findings were interpreted considering how people diagnosed with MDD utilized R/S coping strategies, both negative and positive, in their struggle with mental health.

Philosophical stance

This study is based on the constructivist framework, which assumes that reality is socially constructed through people lived experiences and their interpersonal relationships. This perspective helps to understand how patients with MDD give complex and subjective meaning to their religious and spiritual lives. This study used reflective thematic analysis to align with this philosophical stance. This approach acknowledges the active role the researchers' subjectivity in the analytical process. The researcher, as a psychiatry resident, engaged in ongoing reflection on how their clinical training might influence the study. By acknowledging the researcher's role in shaping the meaning of the data, the study was able to get a deeper understanding of the participants' real-life experiences.

4.4. Source Population

The source population included all the adult cases, age 18 years or older, with the diagnosis of MDD on follow up at the outpatient clinics of Tikur Anbessa Specialized Hospital (TASH) during the study period. The diagnosis was confirmed using the DSM-5 criteria.

4.5. Study Population and Eligibility Criteria

The people that took part in the study were patients who met the following criteria's inclusion criteria.

- Adults (≥18 years)
- Diagnosed with Major Depressive Disorder using the DSM-5 criteria.
- Currently on follow up at the outpatient psychiatric clinic at Tikur anbessa Specialized Hospital (TASH)
- Capable of giving informed consent
- Fluent in Amharic
- Willing to participate and actively engage in in-depth qualitative interviews.

Exclusive criteria

- Patients with comorbid psychotic disorders, substance induced mood disorders or severe cognitive deficits.
- Patients currently at high risk of suicide
- People who could not participate in qualitative interviews because of the communication difficulties

4.6. Sample Size Determination

The research focused more on depth of experience than a wide numerical range. The principle of thematic saturation is what determined the sample size, which was operationalized through a "stopping rule" where after three consecutive interviews generated no new themes or sub-themes, the data collection ended. Even if the initially expected interviews were 15-20 participants, data saturation reached after 11

in-depth interviews. With the help of the research advisors, emergent themes were reviewed to confirm that no new themes were being generated, at which point recruitment stopped.

4.7. Sampling Technique

A purpose sampling method was used to ensure different participants were included in the study in terms of sex, age, religious affiliation, and symptoms severity. Participants suitable for this study were identified by mental health care workers at Tikur Anbessa Hospital (TASH) outpatient department. After selecting suitable participants and giving them a detailed explanation of the study objectives, patients were invited to participate voluntarily. The flowchart below (Figure 2) illustrates the systematic progression of the study, starting from recruitment to analysis.

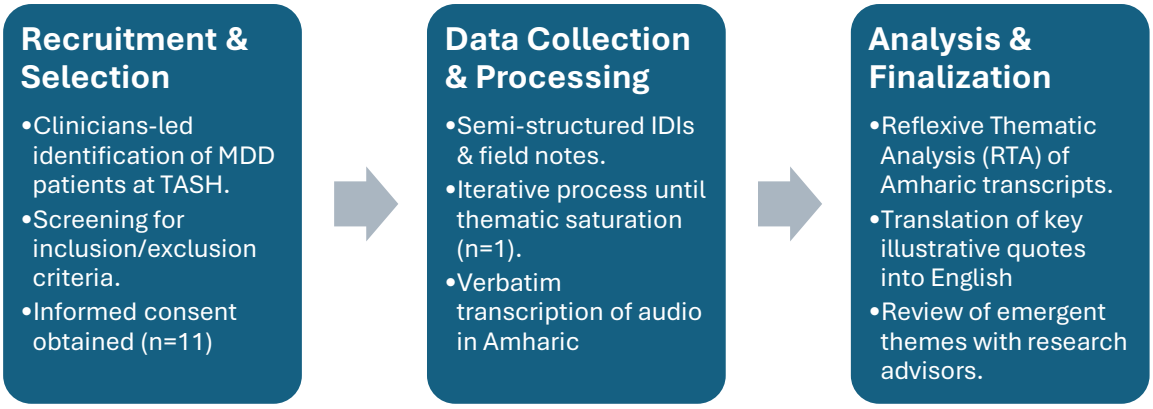


Figure 2: Flowchart of the Research Process

4.8. Operational Definitions

- Major depressive disorder (MDD): A mental illness characterized by 2 weeks of continuous low mood or loss of interest; changes in appetite and sleep fatigue and loss of energy; and difficulty in thinking concentrating or making decisions, diagnosed by a psychiatrist using DSM-5 (32).

- Religious Coping: The process of turning to religious beliefs or practices during periods of stress or difficulty. It is comprised of positive religious coping (PRC) (e.g., seeking spiritual support, meaning seeking) and negative religious coping (NRC) (e.g., spiritual discontent, punishing God image) (33).

- Spirituality: An awareness of the connections among people, to a higher being, or to the purpose of life, that may or many not be related to an organized religion (34).

- Data saturation: This refers to the point in qualitative data collection at which no new themes or information emerge (35,36).

4.9. Instruments for Data Collection

Data were gathered through semi-structured in-depth interviews, using a well-prepared interview guide. The guide used open ended questions and supportive follow up questions to explore:

- Positive and negative religious coping
- The role spirituality had in dealing with depressive symptoms
- Personal views of prayer, religious practices, clergy support and finding meaning through faith

Even if the interview guide offered a structured framework, it was flexible. This makes the interviewer/researcher follow the natural flow of each participant's story. The researcher, as a third-year psychiatry resident, used clinical interviewing skills to build rapport, and at the same time stayed mindful of how the professional background might influence participants responses (such as social desirability bias). To alleviate this, the researcher approached each interview session as a researcher seeking to understand their lived experience rather than as a treating physician. This enabled the researcher to follow up unexpected insights, to dig deeper into what really matters to each participant, and to also make sure that the interview captured

the full depth and nuance of their lived experiences with religion and spirituality in coping with MDD.

To ensure the cultural appropriateness and understandability of the questions, they were first tested with 3 participants. But no major adjustments were made to the phrasing of the questions so, these 3 interviews provided rich data and were included as part of the total 11 participants. The interviews were conducted in Amharic and were audio recorded with the patient's permission, followed by verbatim transcription. A short form was also created to gather basic background information about each participant.

4.10. Data Collection Procedures

After getting an ethical approval from Tikur Anbessa Specialized Hospital (TASH), the participants were recruited by the Principal Investigator (PI) who were on follow up at the outpatient psychiatric department. The list of patients on follow up was screened to identify potential participants then the PI personally approached those who were eligible in a private setting to explain the study's purpose.

Before any interview was held, each participant was made sign a detailed informed consent. This process involved explaining to the participants in detail about the study, focusing mainly on the participation being voluntary, including their right to stop at any time, and their privacy being fully protected. Participants were given plenty of time to ask questions, to make them feel comfortable before making any decisions.

The PI conducted the interview in one of the TASH outpatient clinics privately, and each interview lasted an average of 45 minutes. The best room was chosen from the available rooms so that it's private and with few interruptions, which allowed the participants to discuss sensitive spiritual matters without fear of being overheard. The interviews were audio recorded with the participants' clear permission. The PI also took observational notes during or immediately after the interview. All audio recordings and written observational notes were stored in a safe place to ensure participants privacy.

4.11. Data Processing and Management

Audio recordings were transcribed verbatim. The recordings were securely transcribed and stored by the Principal Investigator. To ensure that no meaning was lost through early translation, the transcripts were processed and analyzed in their original Amharic form. The recordings then were coded using OpenCode version 4.03, with the labels of the coding's being written in English. To keep the participants information anonymous, any personal details such as names, specific locations, unique personal details were removed during the transcription process, and participants were assigned a unique ID number. The codes were then kept anonymous to prevent identifying participants from the study results.

4.12. Data Analysis

Thematic analysis was carried out through the six steps method of Reflective Thematic Analysis proposed by Braun and Clarke (2006,2021):

- Familiarization with data
- Generating initial codes
- Searching for themes
- Reviewing themes
- Defining and naming themes
- Producing the report

Both inductive (data-driven) and deductive (theory-informed) coding were used. To balance these, the researcher first performed inductive open coding to capture the raw experiences of participants. Then, a deductive approach was used to map these codes onto Pargament's religious coping domains. The analysis was done directly on the Amharic transcripts, so that the cultural and religious nuance of the participants' narratives are maintained, while the resulting codes were documented in English.

To understand and organize the themes created, Pargament's religious coping theory played a big role. However, given that this model was developed in a Western

context, the researcher acknowledges that this Pargament's model might not capture something that is unique to the Ethiopian cultural and spiritual landscape. The study prioritized an inductive approach to make sure that themes emerged directly from participant stories, especially those that may challenge or contradict existing theories.

The coding process in OpenCode 4.03 went through several cycles. After some of the first transcripts were reviewed by research advisors to ensure consistency, the initial coding was done by the PI. The verbatim transcription was first given primary code. These codes were then grouped into categories based on conceptual similarities. With the discussion held with my supervisors, categorization and naming of the themes were rearranged. Finally, these categories were synthesized into the overarching themes presented in the results. Throughout this process, the researcher kept a reflexive journal, which was an important tool that allowed the researcher to actively monitor and question personal assumptions to acknowledge how clinical training and professional identity might shape the interpretive process. Since the study was based on a constructivist philosophical view, the trustworthiness of the analysis was maintained by strictly following systematic coding procedures to ensure that the final themes were a transparent reflection of the raw data.

4.13. Data Quality Assurance

The study addressed the trustworthiness of the qualitative data. To ensure the results were valid and reliable, the following steps were used:

- To ensure credibility and dependability, the PI consulted the faculty advisors focusing on the sampling process, the recruitment of potential participants, and determination of the thematic saturation so that the data collection process was accurate.

- To ensure confirmability, and the interpretations or the findings stayed true what the participants originally said, the PI directedly linked the original Amharic interview to the English codes.

- The study stopped after 11 participants were interviewed, because that was the saturation point which was carefully monitored to ensure that the research questions were answered sufficiently with the depth of information found in the interview.

- To ensure transferability, the PI provided a detailed description of the study context and the participants lived experiences.

4.14. Ethical Consideration

Ethical clearance was obtained from the Department of Psychiatry, College of Health Sciences of Addis Ababa University and the Tikur Anbessa Specialized Hospital (TASH) Research and Ethics Committee. Each participant was given a detailed information sheet and were asked to sign an informed consent form. The researcher also declares that there was no conflict of interest in the conduct of this study. Potential harm might have involved distress during the interview. To help reduce this.

- The interviews were conducted with sensitivity, empathy and respect
- Immediate support was available

No monetary incentive was given. But the participants received transport money. All information shared during the study was strictly confidential.

4.15. Role of the Researcher (Reflexivity)

The researcher recognized that multiple factors could influence the meaning making process, such as, having a clinical background as a third-year psychiatry resident at TASH, also the researcher's own religious background, personal spiritual beliefs, and cultural background as an Ethiopian. The researcher, with continuous reflexivity of the interviews, insured that rather than the interpretations of the interview being clinical assumptions, they were contextual and grounded in the participants lived experiences. By acknowledging the researcher's role as a "co-creator" of knowledge, the researcher reflected on how professional identity, religious background, and cultural context might shape the dynamics of the interview and the subsequent analysis of religious and spiritual coping.

5. RESULTS

The results of this qualitative analysis are shown in this section. They are structured around five major themes, which are, the psychosocial burden of MDD, engagement with psychiatric care, adaptive coping through spiritual practices, ambivalence and conflict in spiritual beliefs, and barriers and disengagement from religion/spirituality.

5.1. Socio Demographic Characteristics of Participants

The study included 11 participants that are on follow up for MDD at TASH outpatient department. The participants that are from 18 to 68 years of age, represent Orthodox Christian, Muslim and Protestant Christian faiths. Their educational and occupational backgrounds also varied, including university graduates to those in labor intensive roles. All of these participants lived in Addis Ababa, some going through housing instability and rapid redevelopment that seem to exacerbate their depressive symptoms.

Table 1: Socio-demographic characteristics of the study participants

ID	Age	Gender	Religion	Marital Status	Education	Occupation
TASH01	30	Male	Muslim	Single	Grade 5	Bakery Worker
TASH02	42	Female	Orthodox	Single	Grade 12	Chef/Decorator
TASH03	56	Female	Orthodox	Single	BA Degree	Unemployed
TASH04	29	Male	Protestant	Single	BA Degree	Govt. Employee
TASH05	32	Male	Protestant	Married	BA Degree	Govt. Employee]
TASH06	28	Female	Muslim	Married	Grade 9	Housewife
TASH07	68	Female	Orthodox	Married	Basic Literacy	Housewife
TASH08	62	Male	Muslim	Married	Grade 12	Driver
TASH09	21	Male	Orthodox	Single	University (Yr 2)	Student
TASH10	18	Female	Muslim	Single	Grade 9	Unemployed
TASH11	22	Female	Protestant	Single	University (Yr 3)	Student

5.2. THEME 1: THE PSYCHOSOCIAL BURDEN OF MDD

This theme captures the cognitive, emotional, somatic, social and environmental impact depression has on participants' lives. This context is upon which both spiritual coping and spiritual struggle later emerged. Thus, this theme shows that these people carry heavy weights and go through deep pain. And this suffering eventually drives them to lean on their faith to search for relief and meaning to help them keep going.

5.2.1. Psychological Impact and Symptom Manifestation

Cognitive Fog That Blocks Prayer: Many participants reported difficulty concentrating, which is interfering with their ability to read or pray. This "cognitive fog" was one of the main barriers to their spiritual practice. TASH05 described an inability to retain what he read, making spiritual reading impossible.

> *TASH05 (32, Male, Protestant): Once I read, it's just, I mean, a matter of letting go, there's no such thing as adapting it… I mean, it is something that makes me not give it attention, and after reading, there's no such thing as saving it more.*

A Muslim participant described how her mind would wander during Salah, leading her to stop praying.

> *TASH06 (28, Female, Muslim): During Salah, my mind drifts somewhere else… and sometimes I don't even realize how much of the Salah I've already finished. When that happens, I often get frustrated and stop.*

The "cognitive fog" created a vicious cycle, depression impaired spiritual practices that might have offered relief, increasing feelings of spiritual inadequacy and despair. This shows the impact depression has on the main practices people use to help with regulating their emotions. This takes away the primary coping resources of participants when they need them the most.

Somatic Manifestations: Depression was deeply embodied. TASH02 described a heavy weight on her back.

TASH02 (42, Female, Orthodox): When I feel like this, it's as if there's a heavy pressure on my back… and when they told me, I was extremely shocked.

TASH08 used a striking metaphor of spiritual suffering leaving a permanent "scar" on the nerves.

TASH08 (62, Male, Muslim): When the devil leaves, it destroys your nerves… it causes nerve related illness.

Sleep disturbances: were nearly universal. TASH03 described hypnopompic hallucinations upon waking.

TASH03 (56, Female, Orthodox): I see it, when I wake up suddenly from sleep… something that isn't actually on the wall appears to me.

Suicidal Ideation and Self Harm: For many participants, the emotional burden escalated to thoughts of death. TASH04 described multiple suicide attempts, including ingestion of household chemicals.

TASH04 (29, Male, Protestant): Yes, one time I thought about taking medicine and mixed it to drink it… another time, I locked my door from the inside, took bleach, and drank it

TASH11 expressed a wish for non-existence.

TASH03 (22, Female, Protestant): I had anxiety, after that I was like I don't want this to exist, meaning not to harm myself, but just, I was like, if I didn't exist, and...

5.2.2. Social and Interpersonal Consequences

Social masking: Participants described "wearing a mask" to hide their suffering, which they use to survive in a stigmatizing environment. TASH01 described how outward appearance and internal state differ.

TASH01 (30, Male, Muslim): People can't tell, but I am in depression, though people don't understand that. But I was in depression at that time, even while I was with people.

What pushes people to wear this mask is fear of being labeled “crazy” and cultural expectations to appear strong. TASH03 talked about the isolation, even in the hospital waiting room.

> *TASH03 (56, Female, Orthodox): I don’t talk to people; I sit by myself and get into my phone… I can’t even bring up or talk about my treatment, or about my situation; I just came… with the doctors.*

Stigma and Secretiveness: fear led many to keep their condition a secret. TASH03 hid her psychiatric follow-up from family. Internalized shame was also common

> *TASH03 (56, Female, Orthodox): Yes, they know that I was sick, but they don’t know about this abroad thing, about the process and all that… They don’t know I have a follow-up here.*

TASH04 expressed feeling “less than” others as a human being due to the illness.

> *TASH04 (29, Male, Protestant): Yes, sometimes I mean I think that I am below others…*

These social consequences act as a critical barrier role. Even though the participants could benefit from the social support of religious communities and psychiatric care, it prevented them from accessing that care due to fear of stigma and internalized shame.

5.2.3. Socio-Environmental Stressors

Economic Hardship: TASH04 described how financial worries affected every aspect of life.

> *TASH04 (29, Male, Protestant): Everything is with money, and if there is no money, nothing can be done… The salary I earn and the money I spend don’t help me at all, and because of that, I get very disturbed.*

Forced Displacement: TASH03 described her distress due to forced displacement due to eviction with short term notice.

> *TASH03 (56, Female, Orthodox): Right now we don’t say where; it was here in front of this immigration, now in that area called Bole Arabsa, they demolished*

it for the development… it has only been a week, they haven't discussed it with them, they haven't done anything, and they don't give you a choice, then just as they were going to demolish it on Wednesday, I mean, on Friday…

This stressor has impacted on them negatively, leading them not to attend medical services, and spiritual activities that help them cope. This shows religious institutions' stabilizing role. When someone loses their home or their social stability gets affected, these institutions are the ones that provide a sense of meaning. But the more someone's life falls apart, the harder it becomes for them to reach those institutions during the time they need them.

5.3. THEME 2: ENGAGEMENT WITH PSYCHIATRIC CARE

This theme captures participants' clinical course, from initial recognition of distress to current engagement with psychiatric treatment. This shows how religious and spiritual understandings shape attitudes towards psychiatric treatment. Varied ways are shown serving different roles. Such as, a motivational role facilitating adherence, a barrier role delaying help seeking and a cognitive integration role harmonizing faith and medicine.

5.3.1. Medical Journey and Diagnosis Discovery

Pathways to Care: Most participants did not initially recognize their symptoms as psychiatric. Their pathways were indirect. It involved multiple consultations for physical complaints. For some, physical symptoms were direct expressions of depression; for others, they sought help for a medical condition that caused their illness. TASH01's referral came through a chronic illness center where he was evaluated for infertility. The infertility diagnosis led to depression, showing how major life stressors can trigger depressive episodes.

TASH01 (30, Male, Muslim): They sent me here from the diabetes center to get treatment. I had a hormonal treatment follow up, and when they asked me if I had seen a psychiatrist or something like that, I told them I hadn't; so, they sent me, saying I must be seen there.

TASH04 was referred from ENT after multiple surgeries for a chronic ear condition, his physical and psychological distress were comorbid.

TASH04 (29, Male, Protestant): It was sent from ENT… I only came because they sent me…

Discovery and Acceptance: Their diagnosis gave name to their suffering. TASH02 reported that she was not aware of her psychiatric condition up until she was diagnosed.

TASH02 (42, Female, Orthodox): I didn't notice it; they were the ones who noticed it. I thought I was healthy… I didn't know I was in depression until I came here.

For TASH08, understanding his condition was more complex, he combined spiritual and medical explanations, saying Quranic healing was for spiritual illness while psychiatric treatment addressed the residual "neurological scar"

TASH08 (62, Male, Muslim): Initially, I thought it left me through the Quran, but when that leaves you, since it stayed with you for a long time, there is a problem that is created in your mind; to deal with that problem, modern medicine is a necessity.

Duration and Chronicity: Participants lived with symptoms for years before treatment. TASH11's depression began nearly a decade before she received care.

TASH11 (22, Female, Protestant): I think it has been two years, or a year and something, it will be two years in May… that is since I started the follow up, not since the depression started. It has been about ten years since the depression illness came.

5.3.2. Resilience and treatment Outlook

Positive Appraisal: Participants viewed treatment as lifesaving. TASH01 described medical care as giving him "hope" and "rest"

TASH01 (30, Male, Muslim): It's good, the treatment. I mean, the treatment being given to me gives me rest because it is also giving me hope

TASH04 emphasized that treatment prevented destructive decisions.

TASH04 (29, Male, Protestant): I am using the medications here… everything I prepared and the way it prevents the pains has helped me not to go toward other decisions, and this is something to be thankful for.

Dual-Track Healing: A key finding was participants' integration of faith and medicine as complementary paths. TASH01 explained that medicine and Doctors exist because God created them, faith comes first then medical treatment follows.

TASH01 (30, Male, Muslim): Because he is the one who gave me the treatment here. Because a reason is needed, if a person gets sick and just sits there saying 'God will heal me', it does nothing, because our Creator is also the one who caused medicine to be created. He is the one who made doctors be doctors, isn't he? Therefore, we must necessarily reach out to people.

TASH02 compared psychiatric counseling to religious confession, which helped her to normalize therapy within her spiritual worldview.

TASH02 (42, Female, Orthodox): Call it the same kind of therapy. I take both, the holy water is like the medicine to me… I think of the prayer you go for and the talk you have with the clergy like therapy, just like the medicine given to me when I go to a psychiatrist.

TASH11 described treatment as "the path God prepared," which is her reason for adherence to medical treatment.

TASH11(22, Female, Protestant): I think I consider it a path God prepared for me… I have prayed many times for this anxiety to disappear, and I think maybe this is one of the ways God has prepared for me.

Resilience Through Integration: Those who integrated faith and medicine showed greater resilience. TASH04 stated without prayer, he would not have survived. Not because prayer replaced medicine, but because it gave him strength to continue.

TASH04 (29, Male, Protestant): Thank God, if I didn't have prayer, I mean, if I wasn't a person of faith, I can say it would have been over, it would have been finished for me.

Three Patterns of How Religious Understanding Shaped Engagement with Psychiatric care

First, positive integration (motivational role) occurred when treatment is seen as a part of God's plan by the patients. TASH11 talked about how she sees care as " the path God prepared", and TASH02 gave meaning to religious confession as therapy. This way of giving meaning led them to be adherent to their treatment by removing the conflict between faith and medicine.

Second, delayed engagement (barrier role) occurred when symptoms are interpreted through spiritual lenses. Many participants first went to religious or traditional healers before seeking psychiatric care, which led to extended time from them starting to have symptoms to being diagnosed because of believing their distress was spiritual in origin. TASH08's reliance on Quranic healing before seeking treatment could be an example of this.

Third, ongoing conflict (stigma role) shown when patients feared of the religious communities, they belong to labeling them as "possessed" or spiritually weak. This led them to be isolated and hid their follow-up from their family and faith communities which complicated their integration of care that they valued.

5.4. THEME 3: ADAPTIVE COPING THROUGH SPIRITUAL PRACTICES

This theme explores how participants used faith to manage the burden of depression, a spiritual toolkit for finding meaning, regulating emotions, and sustaining hope. In the healing process of the participants each practices had clear roles such as, emotion regulation, meaning making, and integration with professional care.

5.4.1. Rituals as Emotional Regulators

Supplicatory Prayer: Instead of ritualistic repetition, the way participants described their prayer was as a dialogue with God. TASH01 admits his limitations and describes relying totally on divine assistance, which helps him to externalize the burden and also reduce isolation. This practice was helpful for the emotion regulation role which helped the participants to place their overwhelming feelings in God's hands instead of internalizing their burden.

> *TASH01 (30, Male, Muslim): Yes, and I plead with Him, I ask the Creator to ease the situation I am in, saying 'You are my only help, you are my helper' and so on.*

Quranic Auditory Coping: Muslim participants reported feeling internal "rest" (Ereft) and distraction from rumination while listening to the Quran. TASH06 described peace nothing else could reach. This practice had a sensory regulation role. The steady rhythm of prayer or chanting helps with the brain fog of depression to provide immediate somatic relief.

> *TASH06 (28, Female, Muslim): Yes, it is as I told you. When things get heavy and I fall into despair, that is what I do. And when I think about how He is above everyone else, even when there seems to be no solution, I feel a bit of peace inside… I listen to either the Quran or maybe Menzuma.*

TASH10 noted how depression, by making sustained attention difficult, attacks highly valued coping mechanisms.

> *TASH10 (18, Female, Muslim): I open it a little and listen to it, and then when I look back at something else… I also listen to the Hadith, switching between them.*

Spiritual Songs: Across Orthodox and Protestant backgrounds, religious songs helped create a "safe space" for crying and relief. TASH11 described certain songs helping her cry, providing relief. This functioned as a cathartic release role for patients who have a hard time expressing their emotions.

> *TASH11 (22, Female, Protestant): When I listen to spiritual songs, some of the songs I hear help me to cry more; specifically, some songs help me cry, and after I cry, there is a bit of a relief.*

TASH04, to help him "escape" depression, used spiritual songs, but acknowledged it's limitation. It worked during the day, but not during the night.

> *TASH04 (29, Male, Protestant): I try to pray, and I listen to spiritual songs. I listen to spiritual songs to get out of this depression and anxiety… but if it is at night, it won't come out of me.*

Holy Water (Tsebel) as Sacred Healing Ritual: Orthodox participants described tsebel (holy water) as a central spiritual practice which made the feel emotionally new and like a sense of burden is lifted. TASH03 talked about how holy water sites provide sensory and emotional experiences and as if her burdens were lifted, which it served a purifying role, where the ritual and the cleanliness of the environment were experienced as spiritual and emotional cleansing.

> *TASH03 (56, Female, Orthodox): You go there early, you go in the morning and immerse yourself in the holy water. I haven't seen that kind of procedure in the other churches… the neatness and the cleanliness is very pleasing… when I go there, you feel a certain pleasant feeling; there is a lot that feels lighter for you. After staying there and coming back, you feel lightened.*

Importantly, TASH03 clearly so talked about how she kept taking her medication while still going to tsebel, showing these practices were complementary.

> *TASH03 (56, Female, Orthodox): No, even while taking the holy water, I was taking my medicine properly where I was. There was never a time I stopped… religion along with medicine.*

5.4.2. Spirituality Fostering Self Compassion and Meaning

Vicarious Hope Through Religious Narratives: Participants got their strength from biblical and Quranic figures who suffered trials like Job, David, and the Prophet Zachariah, which they viewed as a proof that their suffering was their path to relief instead of the Divine rejecting them. TASH01 changed his explanation of his infertility from personal curse into shared human-divine story because of a prophet who waited for hundreds of years to have a child. This had a meaning-making role, helping people find their purpose by giving meaning to their personal suffering into a sacred narrative about holding on and eventually being saved.

> *TASH01 (30, Male, Muslim): When I hear the stories of some people, those things give me hope again… like the story of, maybe who is it? A prophet who is said to have waited until nine hundred years without having a child… hearing that gives me hope.*

Religious Reappraisal: TASH11 learned to differentiate between the messenger, who is a clergy who might judge her and the message which is the divine word

offering grace. This served a protective role, allowing her to protect herself from harmful messages by helping her to maintain her faith.

> *TASH11 (22, Female, Protestant): As I told you, a church leader's perspective can be harmful; therefore, I shouldn't look at it from that perspective, but I should look at it from the word of God.*

5.4.3. Integration with Professional care

Participants saw their spiritual practices and their psychiatric treatment as complementary paths to healing instead of seeing them as separate roads, as explored in Theme 2. Which served an integrative role allowing participants to seek for treatment without affecting their religious identity.

5.5. THEME 4: AMBIVALENCE AND CONFLICT IN SPIRITUAL BELIEFS

While faith provided coping, significant "negative religious coping" and internal spiritual struggles also emerged, complicating the healing process. These struggles served a disruptive role, as faith is normally a source of comfort, it was found to be a source of additional stress such as, when participants were going through existential doubt, perceived divine rejection, and conflict between spiritual and biomedical explanations.

5.5.1. Existential and Theodicy Questioning

The severity of the depression led the participants to question fairness of God. TASH01 wondered why some are put in a higher place and others brought down if all are made by the same God. This questioning with cognitive conflict role, created a painful paradox because the trying to give meaning to their suffering contradicted with what they believed about divine justice.

> *TASH01 (30, Male, Muslim): How is it that He created human beings equally but makes them different? Why did He create everyone, yet make one inferior and another superior? I ask*

For younger participants like TASH09, questioning extended to God's existence. This questioning, and seeking understanding, was a painful paradox which had a spiritual anxiety role. It created fear that doubting intellectually by asking questions might destroy prospects, which felt like betraying faith.

> *TASH09 (21, Male, Orthodox): Uh, for example, when I question the existence of the Creator… uh, like, am I actively destroying my future chances, the chance of getting good things in the future?*

5.5.2. Perceived Divine Neglect and Rejection

Many felt God had "turned His face" away which served an abandonment role which participants felt abandoned not only by the society but by the divine because feeling abandoned by God made worse of the loneliness that comes from depression. TASH02 described a period of "slipping" where she believed God didn't love her.

> *TASH02 (42, Female, Orthodox): At first, there was a bit of a sliding thing… does God not love me, God is like this… and I was leaning toward another faith.*

TASH11 described not abandonment but God having "turned His face away". Which she implied remaining in His presence but not His gaze. This spiritual distancing role was distressing, that created a persistent feeling of being unworthy.

> *TASH11 (22, Female, Protestant): I used to say, 'The creator has left me', yes, not that I had Him and He left me, but that He has turned His face away from me… I had that feeling, yes.*

5.5.3. Tension Between Spiritual and Biomedical Explanatory Models

Some experienced internal conflict between religious explanations (sin and testing) and the biomedical model. TASH011 gave meaning to depression as a result of not believing in God. This led her to struggle with spiritual inadequacy. This served a self-blaming role, where participants give meaning to their illness as a spiritual failure rather than a medical condition because they internalized religious teachings about sin and divine punishment.

> *TASH011 (22, Female, Protestant): Especially church programs, some laws, rules, there are these God channels, right? … sometimes when ministers say that anxiety and this feeling of [something] comes from not believing in God, that if we had believed in God this wouldn't have happened, I enter into a total [thing], into self-blame, thinking it is because I didn't believe in God…*

Those who interpreted suffering as divine punishment might delay treatment, and those who found meaning through religious narratives were better able to combine faith and medicine. Which means that the same religious framework had an either a barrier role or a facilitative role based on how it was applied.

5.6. THEME 5: BARRIERS AND DISENGAGEMENT FROM RELIGION/SPIRITUALITY

Participants identified significant external challenges that led them to withdraw from the religious communities. These external challenges or barriers were mainly because of religious leaders' actions, which represented institutional failure. These barriers had a silencing role and a disengagement role, where because of fear of being judged, they are held back from telling their truth, and where the negative experiences they went through led them to be distant from the very communities that were supposed to offer support subsequently.

5.6.1. Stigma of Spiritual Diagnosis

Participants feared being labeled spiritually. They feared the psychiatric symptoms they had would be dismissed as "demonic possession" or "evil spirits", such as Jinn or Sihir. TASH11 said it was impossible for her to be honest because of the tendency of the clergy to give mental illness a spiritual meaning. This served a stigmatization role, which made participants to hide their true struggles by making it impossible to ask for help with in the faith communities.

> *TASH11 (22, Female, Protestant): I think even if I don't go to a religious father, mostly from their talk… this kind of thing is dismissed by being called 'Satan.' So if I talk to these people, there is a fear of being told I have a demon, so I don't want it to be like that.*

5.6.2. Clerical Minimization and Harmful Religious Advice

Participants reported religious leaders minimizing their suffering. TASH05 described religious people pressuring him about his faith, suggesting depression was a lack of commitment, which served an invalidation role, where judgment was a response instead of compassion which worsens the participant's sense of failure.

> *TASH05 (32, Male, Protestant): When people ask me, 'Why don't you go to religion?' or when they say, 'Uh you don't believe' and so on, I feel it very much.*

TASH04 described a priest ignoring his request for help because he was a government employee. He described his emotional and spiritual needs being completely dismissed. He stopped sharing his struggles with anyone. This served a rejection role, where participants completely withdrew from seeking help from their spiritual support systems because the religious authority figures, expected to be supportive, actively turned away those seeking help.

> *TASH04 (29, Male, Protestant): There are religious fathers, I went and consulted them. When I asked, 'At least you are supporting me through prayer; why don't you also support me financially?' and so on, there was a priest who chased me out of the compound, saying, 'Go, aren't you a government employee? Go, let your staff gather money and get you treated'.*

5.6.3. Institutional Disillusionment and Betrayal

Some became deeply disappointed after negative experiences. TASH09 recalled negative childhood experience when he was eight years old. He described a priest accusing him of driving his father away from home. This served a betrayal role, leaving lasting scars in the participants, which made it hard for them to trust a faith community again and affected the subsequent engagement.

> *TASH09 (21, Male, Orthodox): When I went, the first priest I met in the church said to me, 'You are very cruel, you chased your father out of the house'… as a priest, saying this to an eight year old child in such a hostile way, this man certainly didn't have good intentions for me, right?*

TASH09 made a devastating conclusion, which is, the church was “deeply corrupted” and offered nothing of value. This served a disillusionment role, leaving the participants without a spiritual community during the time they need it the most because the negative experiences cumulate and leads them to completely reject religious institutions as sources of support.

> *TASH09 (21, Male, Orthodox): I have lost hope in the church… I already know that nothing can be done within the church, that it is a very deeply corrupted institution.*

5.6.4. Intellectual Gatekeeping

Participants were disconnected from their spirituality because of the unwillingness of the religious leaders to engage with mental illness complexities. TASH11 said leaders gave simple answers to complex questions, calling doubts “demonic”. This served a silencing role, where instead of engaging with the genuine questions and struggles the participants had, they were dismissed.

> *TASH11 (22, Female, Protestant): Like, sometimes as I said before, a ministers perspective can be harmful… like, this kind of thing is dismissed by being called ‘Satan.’ So, if I talk to these people, there is a fear of being told I have a demon.*

This shows communities that were meant to provide support are failing. This reinforced social masking and complicated the dual-track integration. Overall, the external barriers mentioned are stigmatization, invalidation, rejection, betrayal and silencing, And these barriers show how the religious institutions push participants away when they fail to fulfill their supportive role. This leads them to be pushed away from their faith as well as seeking medical help they needed.

6. DISCUSSION

This qualitative study explored the role of religious and spiritual coping in patients with Major Depressive Disorder (MDD) at Tikur Anbessa Specialized Hospital (TASH). The findings show that faith not only is a primary source of resilience, but it is also found to be a place where people experience serious psychological struggles. Participants talked about “Dual-Track” healing process, this means they integrated psychiatric treatment and spiritual practices so that they get better. However, in the Ethiopian context, social stigma usually affected this integration, including clerical minimization, and the somatic nature of depressive symptoms played a major part. This study by focusing on an area that is previously under explored, addresses a critical gap in the literature by providing an in-depth qualitative evidence on how patients with MDD in an Ethiopian tertiary care setting, explore the link between psychiatric treatment and religious/spiritual practices in the region. The following discussion interprets the findings mentioned based on the current literature and psychiatric theory.

The Somatization of Depression and the Seeking of “Ereft”

In this study, how participants give meaning to their psychological distress is by often describing somatic metaphors like “heaviness”, and weakness of the heart”. This shows the sensory role of spiritual practices, when coping emotionally and cognitively fail, they offer a tangible bodily relief. This reflects the findings of the existing literature on mental health in non-Western cultures, that talk about emotional sufferings being expressed through physical complaints, and that it’s not easy to clearly separate or understand the distinction between mind and body(20). In Ethiopia, getting a relief from physical pain and when the troubling thoughts stop, the participants used the term “ereft” (rest/peace) to describe it. This phrase captures how spiritual practices offer “complete rest” physically, emotionally and spiritually. This aligns with Tekola et al. (2023), who found that depression is more explained through somatic and social sufferings rather than a psychological one(20). Similarly, most commonly cited reasons for people to avoid or delay professional care in Yimer et al. (2023) among Ethiopian participants with depressive symptoms are, attitudinal barriers, such as the belief that the problem would resolve on its own, a preference

for self-management, and a preference for alternative care from traditional or religious healers(4).

A key finding in this study was that depression was experienced through the body. The participants' focus on somatic distress, compared to the Western emphasis on "low mood" or "anhedonia", explains their indirect pathways to care. Many of them initially went to other departments like ENT or diabetic clinics for physical complaints before being referred to psychiatry. This suggests that in the Ethiopian clinical setting, a culturally meaningful "Somatic Appraisal" acts as a way of expressing distress. For the psychiatrist, this means that spiritual coping is not just about thoughts or beliefs. It is also a physical experience, in which practices like listening to sacred music provide "sensory relief" to settle a physically "heavy" heart. Thus, spiritual practices served a sensory regulation role that directly addressed the embodied nature of depression.

The "Dual-Track" Model: Harmonizing Science and Spirituality

One of the most important findings of this study is that participants did not see science and religion as opposing factors. Many participants viewed their psychiatric medication as a "divine provision" (sebeb), believing that God is the one who provides the knowledge to doctors to create medicine. This way of thinking allows patients to remain adherent to their treatment without feeling that they are betraying their faith. This shows the motivational role of faith. Giving spiritual meaning to treatment adherence rather than just another medical obligation.

This finding challenges the older psychiatric assumption that highly religious patients may be less likely to follow medical treatment and is consistent with more recent global evidence. A systematic review found that in the majority of the studies, the more participants were involved in their religion, the better treatment adherence and lower suicide rates(10). For the Ethiopian patient, the medical and the spiritual are two sides of the same coin. For example, one participant viewed the "Niseha Abat" (spiritual father) and the psychiatrist as having similar therapeutic roles. This shows that there is a strong preference for integrated care. Here, faith played an integrative role, bringing together the spiritual beliefs and the medical treatments. Another study done in Oromia, Ethiopia, that found the most preferred means of care for mentally ill

patients were traditional and religious healers(5). This underscores the need for collaboration between biomedical and traditional/religious systems. This also suggests that their reason for treatment gap in Ethiopia is not religion itself, but rather not being able to fully recognize and incorporate patients' spiritual beliefs into routine clinical practice.

The Shadow of Spiritual Labeling: Stigma and "Jinn" Narratives

Even if there is a positive role of faith, the difficult side of religious influence is also shown in this study. Which is the fear of being labeled spiritually. Participants like TASH11 expressed worry that their symptoms would be dismissed as demonic possession, such as Sihir or Jinn or spiritual weakness. This fear often led to "Social Masking", where patients chose to withhold information about their psychiatric follow up from their religious communities because they feared being labeled as "mad" or "possessed". This reveals a silencing role of religious stigma, where patients refrained from accessing both spiritual and medical support due to fear of being spiritually labeled. This finding is consistent with the Ethiopian mental health literature, which stated, in their evidence synthesis on mental health stigma in Ethiopia that the reasons for social exclusion and avoiding treatment were because of spiritual or supernatural explanation of their mental illness, particularly beliefs about evil spirits and divine punishment(3).

This interpretation suggests that the religious community in Ethiopia can play two roles at once. On one side, they offer strong religious social support, and on the other side, they can create pressure to meet certain religious devotion standards, which can then lead to misunderstanding mental illness. This shows that the same community had both a supportive and stigmatizing role. Religious leaders exacerbate the sense of shame the patients already feel when they give depression a meaning as a lack of prayer or demonic attack. This gives the clerical authority an unintentional harmful role, because framing mental illness as a moral or spiritual failure will deepen the patients distress. Globally, research has identified feeling abandoned by God or attributing illness to demonic forces as a 'negative religious coping", which across diverse population consistently predicts a poorer mental health outcome(21). This finding emphasizes that it is not going to be enough to only

educate the patients but also for the Ethiopian mental health strategy, to engage religious leaders in mental health literacy is just as important.

Theodicy and the "Spiritual Struggle" in MDD

The study revealed that depression triggered a deep spiritual struggle for many participants, manifesting as struggling to understand the actions of a just God in light of personal suffering. Participants like TASH01 and TASH09 questioned why God allows inequality or why He has "turned His face" away. These "Spiritual struggles" should also be seen as real existential conflicts that a person goes through which worsens the prognosis. It is not only explained by depressive symptoms. Here, faith played an existential questioning role because they end up doubting while trying to give meaning to their suffering. This gap opened the possibility of deeper spiritual integration. This aligns with international literature on religious coping and depression, a meta-analysis which found that across longitudinal studies, negative religious coping was consistently associated with higher level of depression(30).

In psychiatric theory, "Negative Religious Coping", such as feeling punished by God, is associated with higher levels of depression and lower quality of life. Faith here, has a destructive role because beliefs become sources of additional distress instead of providing comfort. A Nigerian study of outpatients with depression, similarly found that negative religious coping was significantly associated with greater symptom severity(18). This research findings also confirms participants who felt neglected by God reported deeper despair. However, the study also found that "Vicarious Hope", which is getting their strength from the stories of suffering figures like Job (Iyob), helped them give meaning to their pain. Religious narratives here have a meaning-making role that transform they help turn a personal suffering into a sacred story of holding on and finally being saved. This suggests that religious narratives offer a framework that gives their suffering meaning.

Socio-Environmental Stressors: The Addis Ababa Context

Finally, the findings regarding "Urban Redevelopment" and "Forced Displacement" (TASH03) show that the environment people live in closely shapes spiritual coping. In Addis Ababa, rapid structural changes lead to housing instability, and the church or mosque often becomes the only stable and familiar space left for those affected.

This highlights a stabilizing role of religious institutions, by being a steady and sacred space when the rest of a person's life collapses. This finding highlights the way people use religion to handle hard times isn't just about their personal feelings but is also about the organized system they belong to, that is rarely addressed in the psychiatric literature. This suggests that religious institutions in Ethiopia serve as a critical structural role in mental health. When the state or the economy fails to provide security, the patients turn to the Divine as a source of fairness, stability, and meaning. Therefore, the psychiatrist must view the patient's spiritual life not as just some beliefs, but rather as a response to the social and economic pressures that have an impact on their daily lives.

7. STRENGTHS AND LIMITATIONS

7.1. Methodological Strengths

The major strength of this study is the qualitative design. It had rich and in depth semi-structured interviews that allowed the participants to express their own ways of describing distress, especially important in Ethiopian context, where experiences are often communicated through physical and spiritual metaphors. Even if the sample size was small (n=11), the study included Ethiopia's three major religious groups, which are Orthodox, Muslim, and Protestant, allowing for exploring how different belief systems relate to MDD. Conducting the study at Tikur Anbessa Specialized Hospital, it was ensured that the participants had confirmed MDD diagnosis, which adds diagnostic reliability. The thematic analysis using OpenCode software provided a step-by-step record of activities, ensuring themes were grounded directly in verbatim transcripts.

7.2. Limitations and Challenges

First, Participants, for the sake of pleasing the researcher may have focused on treatment adherence or faith and medicine harmonization. Those who agreed to participate in the study may also be more open about their mental health, which potentially excludes those with the highest internal stigma. Second, the study being done at TASH in Addis Ababa, makes the findings reflect on urban experiences and may not generalize to rural populations where traditional/religious healers may be the only care source. Third, the interviews and coding were conducted in Amharic, and only selected quotes were translated to English. This means that even if much of the cultural and contextual meaning was preserved during the analysis, some nuances may still have been lost in the translation of the selected quotes presented in the results. In addition, the researcher's clinical background may have influenced how spiritual struggles were interpreted. Finally, there is a limited understanding of how religious coping changes across different phases of the illness, such as during an acute episode verses remission, because this design captures the participants' perspectives at a single point in time.

8. CONCLUSIONS

This study at TASH explored the experiences and roles of R/S in the lives of 11 patients with MDD. Five major themes emerged. The psychological burden of MDD, engagement with psychiatric care, adaptive coping through spiritual practices, ambivalence and conflict in spiritual beliefs, and barriers to religious engagement.

The participants in this study believed, healing occurs through a “Dual-Track” process, viewing psychiatric medicine and spiritual devotion as complementary. The patients became adherent to treatment when they integrated faith and clinical treatment and viewed doctors and medication as “divine provisions”. This strengthened their hope. Spiritual practices such as supplicatory prayer, listening to the Quran, and sacred music played an important role in regulating emotions and providing a sense of “rest” (ereft) that clinical medicine alone could not fully address.

From the participants’ perspectives, religion also had a challenging side. They described faith provided resilience but the “Spiritual Labeling” created barriers. In some fear of being labeled led to “Social masking” and internalized shame, which they felt delayed help seeking and deepened the psychosocial burden. Participants described negative religious copings, such as feelings of being abandoned or punished by God, were described as ending up causing deeper distress. Through participants’ accounts, the importance of social environment emerged. They described how rapid urban changes and economic pressures affected their daily lives. During this time participants viewed religious institutions as a stable place when their lives were disrupted because of housing instability and financial hardship.

Overall, the participants’ narrative suggest that, only biomedical approach is not enough. For effective treatment, their experiences point to the need for a Biopsychosocial-Spiritual framework is required that recognizes the patients’ spiritual beliefs as their faith can either be their strongest ally in recovery or a significant barrier. By validating patients’ spiritual realities, alleviating NRC, and supporting dialogue with faith communities, Ethiopian psychiatry can provide a more holistic, and culturally meaningful care for patients with Major Depressive Disorder.

9. RECOMMENDATIONS

The following recommendations are proposed to improve the quality of psychiatric care, inform policy, and guide future research in the Ethiopian mental health context, based on the thematic findings of this study.

9.1. Recommendation for Clinical Practices

- **Integration of spiritual assessment into routine care:** Instead of assessing patients with just using a traditional biopsychosocial model, clinicians could add a spiritual history. Using brief, validated tools adopted for the Ethiopian context, such as the FICA or HOPE scales, can help clinicians identify whether they have a positive religious coping (e.g., Spiritual songs or Quranic listening) or are suffering from negative religious coping (e.g., feeling punished by God).
- **Validation of "Dual-Track" Healing:** To improve patients' adherence to treatment, clinicians could clearly validate the patients use of religious coping alongside pharmacotherapy. When the patients see medical treatment as a "divine provision" it can reduce their feelings of internal conflicts when they choose between their faith and medication.
- **Addressing Somatic Idioms of Distress:** Clinicians could learn to translate patients' physical complaints into psychological understanding without dismissing their physical experiences, because many patients present with physical complaints like "heaviness" or "back pressure". This prevents the circuitous pathways to care, where patients cycle through non-psychiatric clinics for years.
- **Targeting "Negative Religious Coping":** in cases where patients express existential guilt, fear or being abandoned by the divine, psychotherapy could be adopted to help these patients reframe these thoughts in a culturally and spiritually sensitive way, perhaps by applying familiar religious narratives of courage.

9.2. Operational and Policy Recommendations

- Improve mental health literacy among religious leaders: Since religious leaders are often the first point of contact when someone goes through a mental distress, the Ministry of Health and hospital departments could collaborate with the religious bodies to provide basic mental health training for clergy. This training, focusing on reducing spiritual labeling, which dismisses MDD as demonic possession, could encourage early referral to psychiatric centers.
- Creation of “sacred-Safe” Spaces in Hospitals: Spiritual practices have a role of supportiveness and creating calmness in recovery. Hospitals, by recognizing these roles could give access to prayer rooms or quiet spiritual spaces for patients.
- Anti-Stigma Campaigns Targeting “Madness” Myths: Public health campaigns could focus on the association with psychiatric care, focusing on the myth of “madness”. It could also focus on and give message to the public to work on the internalized shame that leads to “Social Masking” which emphasizes MDD being a manageable clinical condition.
- Policy inclusion of R/S care in national strategy: At the policy level, Ethiopia’s national mental health strategy could consider clearly stating that religious and spiritual care are a normal part of community-based services. Practical ways to put these into action include designating “sacred safe spaces” in hospitals where patients can pray or talk to religious leaders, training psychiatric nurses in assessing patients’ spirituality, and piloting collaborative care programs between religious places like churches or mosques and primary care facilities. Patients found these stabilizing and integrative roles faith has, important in their recovery.

9.3. Recommendations for Future Research

- Longitudinal Studies on Coping: To observe how spiritual coping mechanisms evolve through time as a patient moves from the acute phase of depression into clinical remission, future research could follow patients over time.

- Comparative Urban-Rural Qualitative Research: To address the limitations of this urban centered study, similar qualitative studies could be done in the rural part of Ethiopia. This helps understand how different stressors such as agricultural cycles, and urban redevelopment influence their spiritual coping.
- Development of an Ethiopian Spiritual Coping Scale: Researchers doing quantitative studies could develop and also validate a psychometric tool that is specific for the Ethiopian religious context by using the themes identified in this study (e.g., Spiritual song catharsis, Holy water as therapy, Quranic auditory coping).

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11. APPENDICES

Appendix A: Participant Information Sheet (English and Amharic)

A. English

Department REC Reference Number:_____

You will be given a copy of this information sheet

Title of the Project

EXPLORING THE EXPERIENCES AND ROLES OF RELIGION AND SPIRITUALITY IN THE LIVES OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER: A QUALITATIVE STUDY

Principal Investigator: Dr. Mahlet Teferi (Resident, Department of Psychiatry)

Supervisor 1: Dr. Yonas Baheretibeb

Supervisor 2: Dr. Eyerusalem Solomon

Coordinating Office: Addis Ababa University, School of Medicine, Department of Psychiatry

We would like to invite you to take part in a research study. You will only participate if you want to, and choosing not to participate will not disadvantage you in any way. Before you decide whether you want to participate in this research study or not, you need to understand what your participation will involve, and why the research is being done. Please take time to read or listen to the following information carefully and you can also discuss it with others if you like. If there is anything that is not clear or if you would like more information, please ask.

Aims of the Research

The purpose of this study is to explore how religion and spirituality influence the way individuals cope with Major Depressive Disorder (MDD). We are particularly interested in understanding the types of religious or spiritual beliefs and practices patients use to manage their emotional and psychological distress.

Who Are We Recruiting?

We are inviting adult patients who have been diagnosed with Major Depressive Disorder and are currently getting mental health care at Tikur Anbessa Specialized Hospital.

What Will Happen If You Agree to Take Part?

If you agree to participate, there will be a one-on-one, in-depth interview that will take about 45 to 60 minutes. The interview will be audio-recorded with your permission so that we can analyze your responses later. The recording will be kept safe and only the research team will be who will have access to it. All the information that could identify you will be removed before analysis or publication.

Risks of Being in the Study

There are no major risks involved in this study. However, you might feel uncomfortable temporarily talking about personal or emotional issues. You can pause or stop at any time if you by any chance become distressed during the interview. A mental health professional will be available for support if needed.

Possible Benefits

You might not be directly benefited from this study, but the hope hope is that this study will contribute to improving mental health services by helping us understand how religion and spirituality affect mental health. The findings may help improve mental health care in Ethiopia by making it more respectful of patients' spiritual needs and more culturally respectful.

Privacy and Confidentiality

Every information you share is going to be kept strictly confidential. Your name and personal details will not be included in any reports or publications. All the data available will be stored safely and will be destroyed after the study is finished based on ethical standards.

Voluntary Participation

To be a part of this study is completely your choice. You are free to say no or decide to stop at any time and that will not bring any consequences to your care or treatment.

What We Will Do with Your Data

Your anonymized responses will be analyzed as part of this study. The results may be published in academic journals or presented at scientific conferences, but no one will be able know which answers came from you.

Questions and Concerns

If you have any thing to ask or have concerns about the study or your participation, you can contact the principal investigator or the department directly:

Main Researcher Contact information:

Dr. Mahlet Teferi
Phone: +251910685739
Email: mahlett125@gmail.com
Available from Monday to Friday during working hours
It is your decision if you want to take part or not. Even if you decide to take part, you still have every right to withdraw at any time and without giving a reason.

If this study causes you any harm in any way, you can contact the Department of Psychiatry, College of Health Sciences, Addis Ababa University, with the details below for further advice and information:

- **Department of Psychiatry, School of Medicine, Addis Ababa University Telephone number:** +251118962052

- You may ask to remove your data from the study at any time.

- If you do decide to take part, you will be given a copy of this information sheet to keep and be asked to sign a consent form to show that you understand and agree

B. Amharic

የዲፓርትመንት የምርምር ስነምግባር ኮሚቴ መለያ ቁጥር: _____

የዚህ የመረጃ ወረቀት ቅጂ ይሰጥዎታል

የፕሮጀክቱ ርዕስ፡-

ከፍተኛ የድባቴ ህመም ያለባቸው ታካሚዎች የመቋቋሚያ ዘዴዎች ውስጥ የሃይማኖት እና የመንፈሳዊነት ሚና መመርመር

ዋና መርማሪ፡- ዶ/ር ማህሌት ተፈሪ (የአእምሮ ህክምና ክፍል ሰልጣኝ ሃኪም)

አማካሪ 1፡- ዶ/ር ዮናስ ባህረጥበብ

አማካሪ 2፡- ዶ/ር እየሩሳሌም ሰለሞን

ማስተባበሪያ ጽ/ቤት፡- አዲስ አበባ ዩኒቨርሲቲ፣ የሕክምና ትምህርት ቤት፣ የአእምሮ ሕክምና ክፍል

በምርምር ጥናት ላይ እንዲትሳተፉ ልንጋብዝዎ እንፈልጋለን። የሚሳተፉት መሳተፍ ከፈለጉ ብቻ ነው፣ እና ላለመሳተፍ መምረጥ በምንም መልኩ አይጎዳዎትም። በዚህ የምርምር ጥናት ውስጥ መሳተፍዎን ወይም አለመሳተፍዎን ከመወሰንዎ በፊት፣ ተሳትፎዎ ምን እንደሚጨምር እና ጥናቱ ለምን እየተሰራ እንደሆነ መረዳት አለቦት። እባክዎን የሚከተለውን መረጃ በጥንቃቄ ለማንበብ ወይም ለማዳመጥ ጊዜ ይውሰዱ እና ከፈለጉ ከሌሎች ጋር መወያየት ይችላሉ። ግልጽ ያልሆነ ነገር ካለ ወይም ተጨማሪ መረጃ ከፈለጉ እባክዎን ይጠይቁ።

የምርምሩ ዓላማዎች

የዚህ ጥናት አላማ ሰዎች ሃይማኖታዊ ወይም መንፈሳዊ እምነቶቻቸውን እንዴት ከፍተኛ የድባቴ ህመምን ለመቋቋም እንደሚጠቀሙባቸው መመርመር ነው። በዋነኛነት የምንፈልገው ሕመምተኞች ስሜታዊ እና ሥነ ልቦናዊ ጭንቀታቸውን ለመቆጣጠር የሚጠቀሙባቸውን የተለያዩ ሃይማኖታዊ ወይም መንፈሳዊ እምነቶች እና ልምዶች ለመረዳት ነው።

ማንን ነው የምንመለምለው?

በከፍተኛ የድባቴ ህመም የተመረመሩ እና በአሁኑ ጊዜ በ ጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል የአእምሮ ጤና አገልግሎት እያገኙ ያሉ አዋቂ ታካሚዎችን ነው።

ለመሳተፍ ከተስማሙ ምን ይፈጠራል?

ለመሳተፍ ከተስማሙ ከ45 እስከ 60 ደቂቃ የሚፈጅ አንድ ለአንድ ጥልቅ ቃለ መጠይቅ ይኖራል። በኋላ ላይ ምላሾችዎን ለመመርመር እንድንችል ቃለ መጠይቁ ከእርስዎ ፈቃድ ጋር በድምጽ ይቀዳል። ቀረጻው ደህንነቱ የተጠበቀ ይሆናል እና እሱን ማግኘት የሚችለው የምርምር ቡድኑ ብቻ ይሆናል። እነሱን ከመመርመር ወይም ከማተማችን በፊት እርስዎን የሚለዩ ሁሉም መረጃዎች ይወገዳሉ።

በጥናቱ ውስጥ እየተሳተፉ ሊፈጠሩ የሚችሉ አደጋዎች

በዚህ ጥናት ውስጥ ምንም ዋና ዋና አደጋዎች የሉም ሆኖም፣ ስለግል ወይም ስሜታዊ ጉዳዮች ማውራት ለጊዜው ምቾት ላይሰማዎት ይችላል። በቃለ መጠይቁ ወቅት በማንኛውም አጋጣሚ ከተጨነቁ በማንኛውም ጊዜ ማቆም ይችላሉ። አስፈላጊ ከሆነ የአእምሮ ጤና ባለሙያ ለድጋፍ ዝግጁ ይሆናል።

ሊሆኑ የሚችሉ ጥቅሞች

ከዚህ ጥናት በቀጥታ ላይጠቀሙ ይችላሉ፣ ነገር ግን ተስፋው ይህ ጥናት ሃይማኖት እና መንፈሳዊነት በአእምሮ ጤና ላይ እንዴት ተጽዕኖ እንደሚያሳድሩ እንድንረዳ በመርዳት የአእምሮ ጤና አገልግሎቶችን ለማሻሻል አስተዋፅዖ ያደርጋል። ግኝቶቹ ለታካሚዎች የመንፈሳዊ ፍላጎቶችን የበለጠ አክባሪ እና ባህል አክባሪ በማድረግ የአእምሮ ጤና እንክብካቤን ለማሻሻል ሊረዳ ይችላል።

ግላዊነት እና ምስጢራዊነት

የሚያካፍሉት እያንዳንዱ መረጃ በጥብቅ በሚስጥር ይጠበቃል። የእርስዎ ስም እና የግል ዝርዝሮች በማንኛውም ሪፖርቶች ወይም ህትመቶች ውስጥ አይካተቱም። ሁሉም የሚገኙት መረጃዎች በአስተማማኝ ሁኔታ ይከማቻሉ እና ጥናቱ ከተጠናቀቀ በኋላ በስነምግባር መመሪያዎች መሰረት ይወገዳሉ።

በፈቃደኝነት ተሳትፎ

የዚህ ጥናት አካል መሆን ሙሉ በሙሉ የእርስዎ ምርጫ ነው። እምቢ ለማለት ወይም በማንኛውም ጊዜ ለማቆም የመወሰን ነፃነት አለዎት እና ይህ በእርስዎ እንክብካቤ ወይም ህክምና ላይ ምንም አይነት መዘዝ አያመጣም።

በመረጃዎ ምን እናደርጋለን

ስምዎት ያልተገለጸባቸው ምላሾችዎ የዚህ ጥናት አካል ሆነው ይመረመራሉ። ውጤቶቹ በአካዳሚክ መጽሔቶች ላይ ሊታተሙ ወይም በሳይንሳዊ ኮንፈረንስ ሊቀርቡ ይችላሉ ነገር ግን የትኛው መልስ ከእርስዎ እንደመጣ ማንም ሊያውቅ አይችልም.

ጥያቄዎች እና ስጋቶች

ስለ ጥናቱ ወይም ስለ ተሳትፎዎ የሚጠይቁት ወይም የሚያሳስቦት ነገር ካለ፣ ዋናውን መርማሪ ወይም የህክምና ክፍሉን በቀጥታ ማነጋገር ይችላሉ።

የዋና ተመራማሪ መረጃ፡-

ዶክተር ማህሌት ተፈሪ
ስልክ: +251910685739
ኢሜይል፡ mahlett125@gmail.com
በስራ ሰዓት ከሰኞ እስከ አርብ ይገኛሉ

መሳተፍ ከፈለጉ ወይም ካልፈለጉ የእርስዎ ውሳኔ ነው። ለመሳተፍ ብትወስኑም በማንኛውም ጊዜ እና ምክንያት ሳይሰጡ የመውጣት ሙሉ መብት አለዎት።

ይህ ጥናት በማንኛውም መንገድ ጉዳት ካደረሰብዎ ለተጨማሪ ምክር እና መረጃ ከዚህ በታች ካለው ዝርዝር መረጃ ጋር የሳይካትሪ ዲፓርትመንት፣ የጤና ሳይንስ ኮሌጅ፣ አዲስ አበባ ዩኒቨርሲቲን ማነጋገር ይችላሉ።

- የሳይካትሪ ዲፓርትመንት፤ የህክምና ትምህርት ክፍል፤ አዲስ አበባ ዩኒቨርሲቲ
  የስልክ ቁጥር: +251118962052
- በማንኛውም ጊዜ መረጃዎን ከጥናቱ እንዲያስወግዱ መጠየቅ ይችላሉ።
- ለመሳተፍ ከወሰኑ፣ እርስዎ እንደተረዱት እና እንደሚስማሙ ለማሳየት የዚህን የመረጃ ወረቀት ቅጂ እንዲይዙ እና የስምምነት ቅጽ እንዲፈርሙ ይጠየቃሉ።

Appendix B: Informed Consent Form (English and Amharic)

A. Informed Consent Form

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study:

"EXPLORING THE ROLE OF RELIGION AND SPIRITUALITY IN THE COPING MECHANISMS OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER: A QUALITATIVE STUDY"

REC Reference Number: _____

Thank you for considering taking part in this research. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please read each statement and place a checkmark (✓) next to each if you agree:

☐ I understand that this research undertaking is a postgraduate degree partial fulfilment of a speciality certificate in Psychiatry.

☐ I understand that if I decide at any time during the research that I no longer wish to participate, or for my child to participate, in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data until they are published.

☐ I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the national data protection rules.

☐ If I am selected to be interviewed in more detail then I consent to that interview being audio-taped..

☐ The information you have submitted will be published as a report. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications.

☐ I agree that the research team may use anonymized data for future research.

Participant's Full Name: _____

Signature: _____

Date: _____

Researcher's Full Name: _____

Signature: _____

Date: _____

B. በመረጃ የተደገፈ የስምምነት ቅጽ

እባክዎን የመረጃ ወረቀቱን ካነበቡ እና/ወይም ስለ ጥናቱ ማብራሪያ ካዳመጡ በኋላ ይህንን ቅጽ ያጠናቅቁ።

የጥናት ርዕስ፡-

"ከፍተኛ የድባቴ ህመም ያለባቸው ታካሚዎች የመቋቋሚያ ዘዴዎች ውስጥ የሃይማኖት እና የመንፈሳዊነት ሚና መመርመር"

የዲፓርትመንት የምርምር ስነምግባር ኮሚቴ መለያ ቁጥር: _____

በዚህ ጥናት ውስጥ ለመሳተፍ ስላሰቡ እናመሰግናለን። ከመረጃ ወረቀት የሚነሱ ጥያቄዎች ካሉዎት ወይም አስቀድሞ የተሰጠዎት ማብራሪያ ላይ ጥያቄዎች ካሉዎት ፣ እባክዎን ለመቀላቀል ከመወሰንዎ በፊት ተመራማሪውን ይጠይቁ። በማንኛውም ጊዜ ለማቆየት እና ለመመልከት የዚህ የስምምነት ቅጽ ቅጂ ይሰጥዎታል።

እባክዎን እያንዳንዱን መግለጫ ያንብቡ እና ከተስማሙ ከእያንዳንዱ መግለጫ ቀጥሎ ቼክ ምልክት (✓) ያስቀምጡ፡-

☐ ይህ የምርምር ስራ የድህረ ምረቃ ዲግሪ በከፊል በሳይካትሪ የልዩ ሰርተፍኬት ማሟያ እንደሆነ ተረድቻለሁ።

☐ በምርምሩ ወቅት በማንኛውም ጊዜ መሳተፍ እንደማልፈልግ ወይም ልጄ በዚህ ፕሮጀክት ውስጥ እንዳይሳተፍ ከወሰንኩ ምንም ምክንያት ሳልሰጥ ለተሳተፉት ተመራማሪዎች ማሳወቅ እና ወዲያውኑ ከሱ መውጣት እንደምችል ተረድቻለሁ። በተጨማሪም መረጃዬ እስኪታተም ድረስ ማውጣት እንደምችል ተረድቻለሁ።

☐ ለተብራራልኝ ዓላማ የግል መረጃዬን ለማስኬድ እስማማለሁ። እንዲህ ዓይነቱ መረጃ በብሔራዊ የመረጃ ጥበቃ ደንቦች ውል መሠረት እንደሚካሄድ ተረድቻለሁ.

☐ በበለጠ ዝርዝር ቃለ መጠይቅ እንድደረግ ከተመረጥኩ ያ ቃለ መጠይቅ በድምጽ እንዲቀረጽ እስማማለሁ

☐ ያቀረቡት መረጃ እንደ ሪፖርት ይታተማል። እባክዎን ሚስጥራዊነት እና ስም-አልባነት እንደሚጠበቅ እና እርስዎ ከማንኛውም ህትመቶች ውስጥ መለየት እንደማይቻል ልብ ይበሉ።

☐ እኔ የምርምር ቡድኑ ለወደፊት ምርምር ስም-አልባ መረጃን ሊጠቀም እንደሚችል እስማማለሁ።

የተሳታፊው ሙሉ ስም፡ _____

ፊርማ፡-_____

ቀን: _____

ተመራማሪዎቹ ሙሉ ስም፡ _____

ፊርማ፡-_____

ቀን: _____

Appendix C: Qualitative Interview Guide (English and Amharic)

A. English

TITLE OF THE STUDY

EXPLORING THE ROLE OF RELIGION AND SPIRITUALITY IN THE COPING MECHANISMS OF PATIENTS WITH MAJOR DEPRESSIVE DISORDER: A QUALITATIVE STUDY

1. Age
2. Gender
3. Religion/Religious affiliation
4. Marital status
5. Highest level of education
6. Occupation
7. Place of residence (urban/rural)
8. Can you tell me how you have been feeling lately, both emotionally and mentally?
9. How would you describe your experience with depression?
10. When did you first start noticing depressive symptoms, and what was going on in your life at the time?
11. What do you think caused your depression?
12. Can you tell me about what your religious or spiritual beliefs are?
13. How important are these beliefs in your everyday life?
14. Have your beliefs changed since you started feeling depressed? If so, how?
15. When you feel emotionally overwhelmed, what do you do to cope?
16. Do you turn to religion or spirituality in those times? Can you give me some examples?
17. Have you prayed, gone to religious places, talked with religious leaders, or used religious texts while you were dealing with depression?
18. Do you feel that these mechanisms help you? In what ways?
19. How do you think your religious or spiritual practices have affected your depression?

20. Have there been times when religious or spiritual beliefs made you feel worse or guilty?
21. Have you ever felt abandoned by God or spiritually conflicted during this time?
22. Who supports you emotionally when you're feeling depressed?
23. Do people from your religious or spiritual community support you? How do they do that?
24. Have you discussed your emotional struggles with religious leaders? What was their response/what did they say?
25. Are you currently getting any mental health treatment? How do you feel about it?
26. Do your spiritual or religious beliefs affect how you see medical or psychological treatment?
27. What do you think/wish mental health professionals should understand about your beliefs?
28. Is there anything else you'd like to share about how religion or spirituality has influenced your experience with depression?
29. Do you have any advice for others in similar situations as yours?

B. Amharic

የጥናቱ ርዕስ

የከፍተኛ የድባቴ ህመም ያለባቸው ሰዎች በችግር መቋቋሚያ መንገዳቸው ውስጥ የሃይማኖትና የመንፈሳዊነት ሚና ምን እንደሆነ መመርመር

1. ዕድሜ
2. ጾታ
3. ሃይማኖት / የእምነት ተቋም
4. የትዳር ሁኔታ
5. የትምህርት ደረጃ
6. የስራ ሁኔታ
7. የመኖሪያ አካባቢ (ከተማ / ገጠር)
8. ከቅርብ ጊዜ ወዲህ በስሜትም ሆነ በአእምሮ ምን እንደተሰማዎት ሊነግሩኝ ይችላሉ?
9. ከድባቴ ህመም ጋር ያለዎትን ተሞክሮዎን እንዴት ይገልጹታል?
10. ለመጀመሪያ ጊዜ የደባቴ ህመም ምልክቶችን ማስተዋል የጀመሩት መቼ ነበር? በዚያን ጊዜ በህይወትዎ ውስጥ ምን እየተከናወነ ነበር?
11. የድባቴ ህመሞን ያመጣው ዋናው ምክንያት ምንድን ነው ብለው ያስባሉ?
12. ሃይማኖታዊ ወይም መንፈሳዊ እምነቶችዎ ምን እንደሆኑ ሊነግሩኝ ይችላሉ?
13. እነዚህ እምነቶች በዕለት ተዕለት ሕይወትዎ ውስጥ ምን ያህል አስፈላጊ ናቸው?
14. የድባቴ ህመም ከጀመሮት በኋላ እምነቶችዎ ተለውጠዋል? ከሆነ እንዴት?
15. የድባቴ ስሜት በሚሰማዎት ጊዜ ሁኔታውን ለመቋቋም (ለመቆጣጠር) ምን ያደርጋሉ?
16. በእነዚያ ጊዜያት ወደ ሃይማኖት ወይም ወደ መንፈሳዊነት ዘወር ይላሉ? አንዳንድ ምሳሌዎችን ሊነግሩኝ ይችላሉ?
17. የድባቴ ስሜት በሚሰማዎት ጊዜ ጸልየዋል፣ ወደ ቤተ እምነት ሄደዋል፣ ከሃይማኖት መሪዎች ጋር ተነጋግረዋል፣ ወይም ሃይማኖታዊ ጽሑፎችን ተጠቅመዋል?
18. እነዚህ ዘዴዎች እንደሚረዱዎት ይሰማዎታል? በምን መንገድ ነው የሚረዱዎት?
19. የሃይማኖት ወይም የመንፈሳዊ ልምምዶችዎ በድባቴ ስሜትዎት ላይ እንዴት ተጽዕኖ አሳድረዋል ብለው ያስባሉ?
20. ሃይማኖታዊ ወይም መንፈሳዊ እምነቶችዎ ሁኔታውን ይበልጥ እንዲከፋዎ ወይም የጥፋተኝነት ስሜት እንዲሰማዎ ያደረጉበት ጊዜዎች ነበሩ?
21. በዚህ ጊዜ ውስጥ በእግዚአብሔር/በፈጣሪ እንደተተዉ ተሰምቶ ያውቃል ወይስ ከመንፈሳዊነትዎ ጋር ግጭት ውስጥ ገብተው ያውቃሉ?
22. የድባቴ ስሜት ሲሰማዎት በስሜት የሚደግፍዎት ማነው?
23. ከሃይማኖት ወይም ከመንፈሳዊ ማህበረሰብዎ ሰዎች ይደግፉዎታል? እንዴት ነው የሚደግፉዎት?
24. ስለ ስሜታዊ ችግሮችዎ ከሃይማኖት መሪዎች ጋር ተወያይተዋል? ምላሻቸው ምን ነበር/ምን አሉዎት?
25. በአሁኑ ጊዜ የአእምሮ ጤና ሕክምና እያገኙ ነው? ስለ ህክምናው ምን ይሰማዎታል?
26. መንፈሳዊ ወይም ሃይማኖታዊ እምነቶችዎ የህክምና ወይም የስነ-ልቦና ህክምናን በሚመለከቱበት መንገድ ላይ ተጽዕኖ ያሳድራሉ?
27. የአእምሮ ጤና ባለሙያዎች ስለ እምነቶችዎ ምን እንዲረዱ ይፈልጋሉ/ይመኛሉ?
28. ሃይማኖት ወይም መንፈሳዊነት በድባቴ ስሜትዎ ላይ ስላለው ተጽእኖ ማጋራት የሚፈልጉት ሌላ ነገር አለ? እንደ እርስዎ ተመሳሳይ ሁኔታ ላይ ላሉ ሰዎች የሚሰጡት ምክር አለ?

12. DECLARATION

I, the undersigned, declare that this thesis report is my original work, where my work is indebted to the work of others, it has not been accepted or presented for a degree in this or any other university, and that all sources of materials used for the thesis have been fully acknowledged.

If proven otherwise, I understand that appropriate actions will be taken based on the Senate Legislation of Addis Ababa University and the Guidelines provided by the Ministry of Education.

Name of Investigator: _____

Signature: _____

Date of submission: _____

This thesis has been submitted for examination with my approval as University Supervisor

Name and Signature of the first Supervisor _____

Name and Signature of the second supervisor _____