ResearchGate

See discussions, stats, and author profiles for this publication at: https://www.researchgate.net/publication/326922733

Global Psychologies Mental Health and the Global South: Mental Health and the Global South

Book · June 2018

DOI: 10.1057/978-1-349-95816-0

CITATIONS
22

READS
4,560

2 authors:



Suman Fernando
London Metropolitan University
98 PUBLICATIONS **2,272** CITATIONS

SEE PROFILE



Roy Moodley
University of Toronto
73 PUBLICATIONS **510** CITATIONS

SEE PROFILE

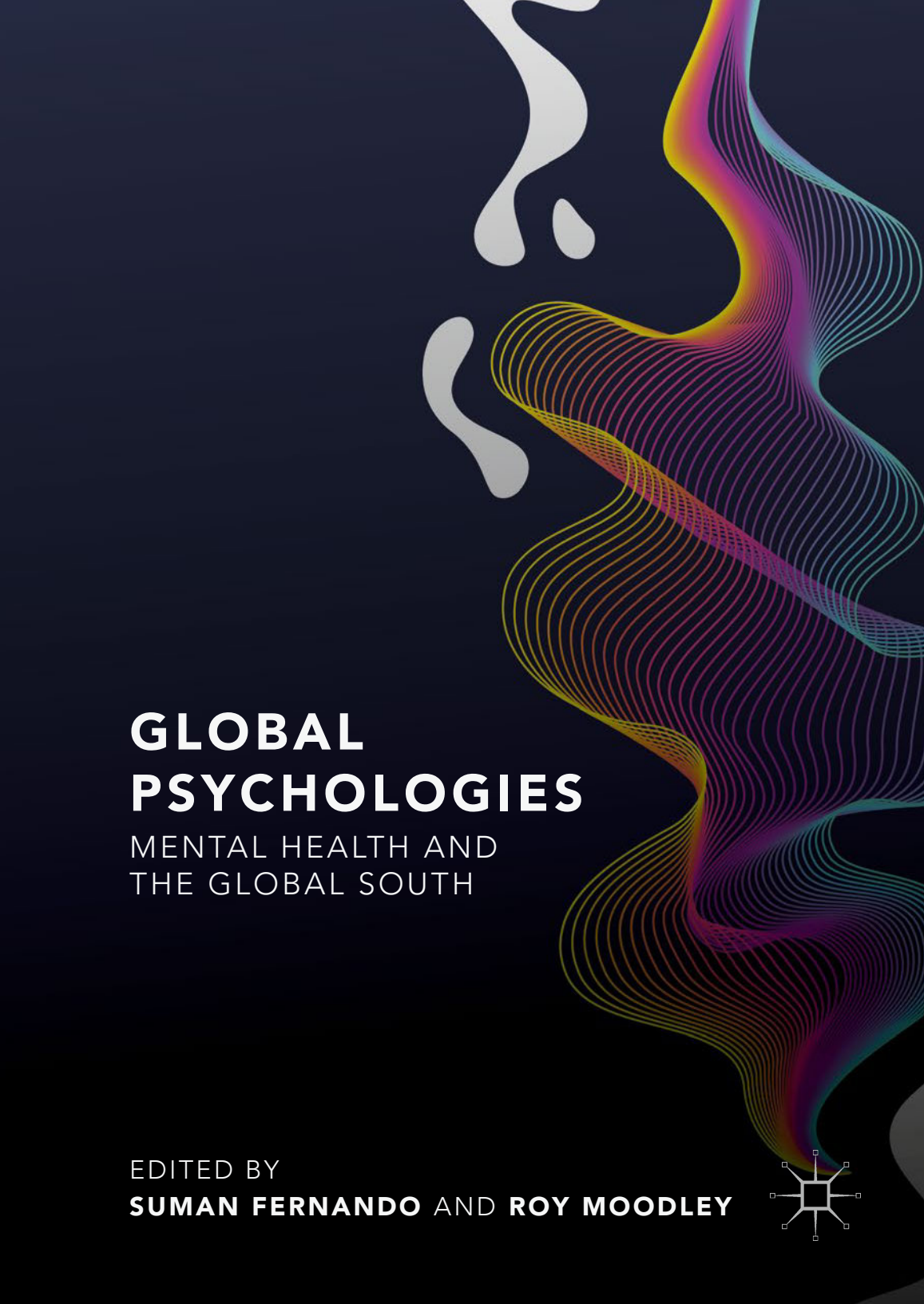
Some of the authors of this publication are also working on these related projects:

Currently working on a book edited jointly with Roy Moodley on 'Global Psychologies' and another on history of racism in the pys discilines - clinical psychology and psychiatry. View project

Book review View project

All content following this page was uploaded by Suman Fernando on 19 December 2018.

The user has requested enhancement of the downloaded file.


GLOBAL
PSYCHOLOGIES
MENTAL HEALTH AND
THE GLOBAL SOUTH
EDITED BY
SUMAN FERNANDO AND ROY MOODLEY

Global Psychologies

'A hard-hitting and timely challenge to reductionist conceptions of 'mental illness' currently dominating in the West, Global Psychologies demonstrates the importance of culture, context, and individual meaning in understanding human distress and well-being. This volume brings previously marginalised psychologies back to the heart of academic discussion. It will be essential reading for mental health scholars, students, and practitioners.'

—Bruce M. Z. Cohen, *Department of Sociology, University of Auckland, New Zealand*

'A prominent group of international authors introduce a broad variety of non-Western perspectives on human nature and link them to therapeutic endeavors, healing, and the practice of psychology and psychiatry. They argue convincingly that in order to be successful, mental health practices need to be connected to indigenous systems of meaning and psychosocial support systems.'

—Uwe P. Gielen, *Executive Director, Institute for International and Cross-Cultural Psychology, USA*

Suman Fernando · Roy Moodley
Editors

Global Psychologies

Mental Health and the Global South

palgrave
macmillan

Editors
Suman Fernando
London Metropolitan University
London, UK

Roy Moodley
Applied Psychology and Human Development
University of Toronto
Toronto, ON, Canada

ISBN 978-1-349-95815-3 ISBN 978-1-349-95816-0 (eBook)
https://doi.org/10.1057/978-1-349-95816-0

Library of Congress Control Number: 2018941895

© The Editor(s) (if applicable) and The Author(s) 2018
The author(s) has/have asserted their right(s) to be identified as the author(s) of this work in accordance with the Copyright, Designs and Patents Act 1988.
This work is subject to copyright. All rights are solely and exclusively licensed by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed.
The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.
The publisher, the authors and the editors are safe to assume that the advice and information in this book are believed to be true and accurate at the date of publication. Neither the publisher nor the authors or the editors give a warranty, express or implied, with respect to the material contained herein or for any errors or omissions that may have been made. The publisher remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Cover illustration: Aleksei_Derin/gettyimages

Printed on acid-free paper

This Palgrave Macmillan imprint is published by the registered company Macmillan Publishers Ltd.
part of Springer Nature
The registered company address is: The Campus, 4 Crinan Street, London, N1 9XW, United Kingdom

To:
Our families, friends and colleagues in Canada, South Africa, Sri Lanka and the United Kingdom

Foreword

The unquestioning privileging of a psychology developed in the global north, the assumption that this is *what psychology means and represents* and that this is generalizable across the world, is neither acceptable, appropriate nor just. There are multiple world views and indigenous psychologies and these need to be recognised, valued, taught and engaged with if psychology is to make a humanizing and useful contribution in peoples' lives across the globe. *Global Psychologies: Mental Health and the Global South* is a much needed contribution to the world of psychology, psychiatry, mental health and wellbeing. It brings together a wide range of experts from around the world who present their chapters in an engaging, accessible and informative manner.

The book deserves to be widely read and used by practitioners, theorists, policy makers, commissioners of services, trainers and politicians—not just in the West, but wherever 'psychology' and 'psychiatry' are recognised as disciplines that play a part in the field of 'mental health'. It makes a vital contribution to expanding the way we think about psychology and mental health and questions much of what needs to be examined including much of the taken-for–granted knowledge held by many practitioners in the Global North.

There is much to be learned from ideas and practices which have worked well for generations around the world, using what might be labelled indigenous psychology—systems that follow traditions that are sometimes under-valued. The imposition of a psychology developed in the Global North is known not to best serve those who are experiencing social suffering. More-over, this imposition of a psychology and its associated systems developed in the Global North may be viewed as a source of neo-colonialism and may lead to people not accessing the services that meet their needs.

This book provides a rich and informative source of information about a wide range of indigenous psychologies from around the world. It is usefully organised into four parts; Theoretical, Philosophical and Historical Contexts; Traditions of Psychology in the Global South; Liberation Psychologies; and Contemporary Movements. It covers a range of indigenous psychologies from a variety of countries and cultures. It is a landmark book which will make a major contribution to how psychology is considered and deserves to be widely read.

London, UK
March 2018

Rachel Tribe
Deanne Bell
University of East London

Preface

The editors of this book have been struck by the extent to which the education and training of clinical psychologists and psychiatrists who work in the field of mental health are dominated by knowledge derived in cultures of the West and how little practicing clinical psychologists and psychiatrists know about (e.g.) the psychologies embedded in religion and healing systems across the world. Nor about the diverse systems of psychology that have arisen in particular situations and places often based on the ideas propounded by outstanding people such as Frantz Fanon and Mohandas Gandhi.

What we see reflected in education and training of professionals is that Western systems tend to be the 'norm' or 'best available', and systems that have their origin in non-Western cultures very much 'the other' knowledge systems meant for 'The Other'. This has clearly occurred as a result of the colonial legacy of cultural imperialism with Western domination of educational systems; and continued in post-colonial times—even in former colonial countries—for a variety of reasons (which are beyond the remit of this book to explore). Although many forms of healing indigenous to African, Asian, and pre-Colombian American (as well as other non-Western) cultures still thrive and

currently inform indigenous practices in the field of mental health and wellbeing—often under other than the 'mental health' umbrella—the psychological knowledge inherent in them does not influence very much, if at all, the disciplines of psychiatry and clinical psychology (the 'psy' disciplines) as they are taught in universities and in the training provided for professionals in the field of mental health. Nor does psychological knowledge inherent within systems described as 'folk psychiatries' even get a mention in education and training in the psy disciplines.

The aim of this book is to make a start in redressing the imbalances and gaps within the literature informing the disciplines of clinical psychology and psychiatry by bringing to its readership—hopefully including trainees in clinical psychology and psychiatry and their teachers and trainers—global knowledge about psychologies from various sources, presented in ways that are easily accessible. One of the editors has already touched on some of this knowledge in earlier books published by Palgrave and Macmillan and the other has a long-standing interest in (and has edited several books on) exploring the place of religion and spirituality in the field of mental health. This book brings together in a single volume a variety of psychologies from around the world—global psychologies—in a form that would enable their incorporation into the education and training in clinical psychology and psychiatry, although in several instances they would require supplementing. Further, this book should make a significant contribution to providing sources of accessible knowledge from around the world in the field of psychology that would inform the practice of clinical psychology (and the part it plays in counselling and psychotherapy) and psychiatry.

London, UK — Suman Fernando
Toronto, Canada — Roy Moodley

Acknowledgements

The editors of this book, Suman Fernando and Roy Moodley, are very grateful to the 22 other authors who, coming from a variety of cultural backgrounds themselves, have collaborated in the project represented by this book, by drawing from their academic studies, research, and real-life experiences to reflect on what constitutes 'psychology' that either underpin the lives of people in various parts of the world or have driven movements of liberation and innovation. We thank them for their patience during the (sometimes prolonged) communications during the two or three years of its preparation. Also, we are grateful to many colleagues who have encouraged us in getting this book together and to Grace Jackson, Commissioning Editor and Joanna O'Neill, Editorial Assistant, at Palgrave Macmillan for support during the preparation of the book.

Contents

1 Introduction to Global Psychologies: Mental Health and the Global South 1
Suman Fernando and Roy Moodley

Part I Theoretical, Philosophical and Historical Contexts

2 Varieties of Global Psychology: Cultural Diversity and Constructions of the Self 21
Laurence J. Kirmayer, Ademola Adeponle and Vivian Afi Abui Dzokoto

3 Reflections on African and Asian Psychologies 39
Suman Fernando

4 Contexts, Epistemologies and Practices of Global South Psychologies 59
Roy Moodley and Jan van der Tempel

Part II Traditions of Psychology in the Global South

5 African Indigenous Knowledge Systems and Healing Traditions 77
Olaniyi Bojuwoye and Mokgadi Moletsane-Kekae

6 The Self in Hindu Philosophies of Liberation 99
Hillary Peter Rodrigues

7 Buddhist Orientations to Mental Health 119
Hillary Peter Rodrigues

8 Psychology from an Islamic Perspective 137
Amber Haque

9 Chinese Cultural Healing: Confucianism and Daoism 151
Kwang-kuo Hwang

10 Indigenous Psychology in Aotearoa/New Zealand and Australia 163
Waikaremoana Waitoki, Pat Dudgeon and Linda Waimarie Nikora

11 Respect and Relationship: A Perspective on Indigenous Mental Health from Turtle Island/North America 185
Michael Thrasher and Julian Robbins

12 Healing Systems of the Mapuche People in Chile 201
Ana Maria Oyarce

Part III Liberation Psychologies

13 Frantz Fanon's Psychology of Black Consciousness 215
Lewis R. Gordon and LaRose T. Parris

14 Gandhian Philosophy for Living in the Modern World: Lessons from the Psychology of *Satyagraha* 229
Vinod K. Kool and Rita Agrawal

15 The Black Consciousness Psychology of Steve Biko 245
Saths Cooper and Kopano Ratele

Part IV Contemporary Movements

16 Indigenous Psychologies and Approaches to Well-Being in East Asia 263
Boon-Ooi Lee

17 From Denial to Collaboration: Reflections on Shamanism and Psychiatry Based on a Case Study in Chile 279
Ana Maria Oyarce

18 Contemporary Applications of Confucian Healing 299
Kwang-kuo Hwang

Author Index 307

Subject Index 317

Notes on Contributors

Ademola Adeponle, MD, MSc is a Child and Adolescent Psychiatry Subspecialty Resident, University of Toronto and doctoral candidate in the Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University, Canada. He completed medical studies in Nigeria and worked as a psychiatrist in Nigeria prior to relocating to Canada. His research and academic interests are in immigrant mental health, culture and emotions, and cultural aspects of child development.

Rita Agrawal, Ph.D. is Director and Professor at the Faculty of Management and Technology, Harish Chanda Post Graduate College, Varanasi, India has taught for over 35 years, was Head of the Department of Psychology, Guru Nanak Dev University, India and has also taught at various other premier institutes. She has been recipient of a number of prestigious awards, including that of National Fellow, University Grants Commission, India and Senior Fellow, Indian Council of Social Science Research, India. Rita is author of four books, including *Stress in Life and Work* (Sage-Response) and *Psychology of Technology* (Springer International, Switzerland). She has contributed chapters in books published by leading international publishers such as Wiley, Oxford-IBH, Springer, Gallaudet University Press

and has over 80 research papers. She was Founder Member of the Research Committee on Nonkilling Psychology, Hawaii, and has contributed chapters to two volumes published by the Center for Global Nonkilling, an initiative of none other than Glenn Paige.

Olaniyi Bojuwoye, Ph.D. is a retired Professor of Educational Psychology. He is currently holding a position as a Professor in the Department of Special Education at the Kwara State University, Malete, Ilorin, Nigeria. He has previously worked in three South African Universities between 1998 and 2014, as Professor of Educational Psychology, before moving to Nigerian in January 2015. He was a Commonwealth Academic Fellow at the University of Reading, U.K. in 1990/91. His research and publication interests include cross-cultural counselling, African traditional psychotherapy and healthcare delivery practices, counsellor training, context-sensitive psychological practices, family dynamics and children development. He is a member of several psychology-related organizations including the International Council of Psychologists (ICP) and Counselling Association of Nigeria.

Saths Cooper, Ph.D. is President of the International Union of Psychological Science. Vice-President of International Social Science Council, President of the Pan-African Psychology Union, Extraordinary Professor at the University of Pretoria, Honorary Professor at the University of Limpopo and Visiting Professor, University of Johannesburg. He played a key role in the anti-apartheid struggle, was jailed for nine years—spending five in the same Robben Island cell-block as Nelson Mandela—and was declared a 'victim of gross human rights violations' by South Africa's Truth and Reconciliation Commission. The recipient of many citations and awards, including the inaugural International Union of Psychological Science 'Achievement Against the Odds Award', the American Psychological Association 'Award for Distinguished Contributions to the International Advancement of Psychology', Cooper chaired the regulatory Professional Board for Psychology at the Health Professions Council of South Africa, and was Vice-President of the latter—the first psychologist to assume such office—and the last Vice Chancellor and Principal of the University of Durban-Westville.

Pat Dudgeon is from the Bardi people of the Kimberly area in Western Australia. She is a psychologist/researcher at the Poche Centre for Indigenous Health, School of Indigenous Studies, University of Western Australia, Perth; and Fellow of the Australian Psychological Society. Her area of research includes Aboriginal and Torres Strait Islander social and emotional well-being and suicide prevention. Amongst her many commitments, she was a Commissioner of the Australian Mental Health Commission, is deputy chair of the Australian Indigenous Psychologist's Association, and co-chair of the ministerial Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group. She is currently the director of the *UWA Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention (CBPATSISP).* She has many publications in Indigenous mental health in particular, the *Working Together Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principals and Practice 2014*.

Vivian Afi Abui Dzokoto, Ph.D. is a clinical psychologist who is Associate Professor in the Department of African American Studies at Virginia Commonwealth University in Richmond, Virginia, USA. She is a cultural and clinical psychologist who specializes in research on populations of African descent. Vivian Afi Abui Dzokoto graduated with a BSc. in Psychology from the University of Ghana in 1996 and obtained a Ph.D. in Clinical and Community Psychology from the University of Illinois Urbana Champaign in 2005. She has two parallel lines of research. The first explores the intersection of culture, emotion and mental health. In her second area of research, she explores money behaviours within and across cultures.

Suman Fernando, MD (Camb), FRCPsych. was a Consultant Psychiatrist in the UK for over 20 years and is now Honorary Professor in the Faculty of Applied Social Sciences and Humanities at London Metropolitan University. He has lectured extensively in UK, Sri Lanka and Canada on issues of 'race' and culture in psychiatry and latterly on mental health development in the Third World. He has been involved in developing non-governmental services and, more recently, was consultant to a four-year research and capacity building program in Sri Lanka. He chaired the Standing Committee of Race and Culture

of the (British) Mental Health Act Commission between 1988 and 1995. He has written several books, the most recent being, *Mental Health Worldwide; Culture Globalisation and Development* (2014) and *Institutional Racism in Psychiatry and Clinical Psychology* (2017). He was given a Lifetime Achievement Award for Culture, Race and Mental Health by OISE (University of Toronto) in 2011.

Lewis R. Gordon, Ph.D. is Professor of Philosophy at UCONN-Storrs; Honorary President and Core Professor at the Global Center for Advanced Studies; and Honorary Professor at the Unit of the Humanities at Rhodes University (UHURU), South Africa. His most recent books are *What Fanon Said: A Philosophical Introduction to His Life and Thought* (NY: Fordham UP; London: Hurst; Johannesburg: Wits UP, 2015; in Swedish, *Vad Fanon Sa*, Stockholm: TankeKraft förlag, 2016), *La sud prin nord-vest: Reflecţii existenţiale afrodiasporice*, trans. Ovidiu Tichindeleanu (Cluj, Romania: IDEA Design & Print, 2016), and, with Fernanda Frizzo Bragato, *Geopolitics and Decolonization: Perspectives from the Global South* (London, UK: Rowman & Littlefield International, 2017). He is currently working on a book entitled *Fear of a Black Consciousness* (Farrar, Straus and Giroux). He edits the American Philosophical Association blog series *Black Issues in Philosophy* and co-edits the book series *Global Critical Caribbean Thought*.

Amber Haque, Ph.D. is Professor in the Department of Psychology and Counselling, UAE University, Al Ain, United Arab Emirates. He is also Program Coordinator for Postgraduate Program in Clinical Psychology. Previously, he was the Chair in Department of Psychology at International Islamic University, Malaysia. Professor Haque earned his higher education from the US where he practiced psychology in Michigan and New York State for more than 12 years. He has an extensive publication record in international refereed journals in areas including Islamic Psychology and Muslim mental health. He serves on the editorial board and review panel of many international journals.

Kwang-kuo Hwang, Ph.D. is currently National Chair and Professor at Kaohisung Medical University, awarded by the Ministry of Education, Republic of China. Professor Hwang has endeavored to

promote the indigenization movement in psychology and the social sciences in Chinese society since the early 1980s. He has published more than 150 articles on related issues in both Chinese and English in addition to eight books including *Foundations of Chinese Psychology: Confucian Social Relations* (English). He is past president of the Asian Association of Indigenous and Cultural Psychology (2010–2014), and the Asian Association of Social Psychology (2003–2005), and was the Principal Investigator of the research project *In Search of Excellence for Indigenous Psychology*, sponsored by the Ministry of Education, Republic of China (2000–2008).

Laurence J. Kirmayer, MD, FRCPC, FCAHS, FRSC is James McGill Professor and Director, Division of Social and Transcultural Psychiatry, Department of Psychiatry, McGill University and Director of the McGill Global Mental Health Program. He is Editor-in-Chief of *Transcultural Psychiatry*, and Director of the Culture and Mental Health Research Unit at the Institute of Community and Family Psychiatry, Jewish General Hospital in Montreal, where he conducts research on culturally responsive mental health services, the mental health of Indigenous peoples, and the anthropology and philosophy of psychiatry. He is a Fellow of the Canadian Academy of Health Sciences and the Royal Society of Canada. His publications include the edited volumes, *Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives* (Cambridge University Press, 2007), *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada* (University of British Columbia Press, 2008), and *Re-Visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health* (Cambridge, 2015).

Vinod K. Kool, Ph.D. is Ex-Professor of Psychology, SUNY Polytechnic Institute, New York, USA. He has taught in eight universities for over five decades and has been in the area of Gandhian nonviolence. Recipient of various awards including the prestigious Fulbright scholarships and his institution's Goodell Award for research and creativity, he is now a Fulbright Specialist in the area of Peace and Nonviolence. He is author of seven books, has contributed various

chapters to volumes published by leading international publishers and has dozens of papers in peer reviewed journals. He has been on the Editorial Board of the journal, *Peace and Conflict: Journal of Peace Psychology* published by the American Psychological Association and is among the founder members of the Research Committee on Non-killing Psychology, an initiative of the Center for Global Nonkilling, Hawaii.

Boon-Ooi Lee, Ph.D. is a senior lecturer and programme leader for the MA in counselling and guidance program at the National Institute of Education, Nanyang Technological University, Singapore. He holds a Ph.D. in psychology and received post-doctoral training in social and transcultural psychiatry at McGill University in Canada. His main research interest focuses on the relationship between culture and mental health, particularly, indigenous psychologies, indigenous healing systems, cultural psychopathology, health beliefs, and illness representations. Currently, he studies how healing symbols are related to embodiment and the concept of self in rituals, using East Asian spirit possession and mediumship as an example. His research is interdisciplinary drawing on knowledge and methodologies from psychology, cultural psychiatry, and medical anthropology.

Mokgadi Moletsane-Kekae, Ph.D. is Associate Professor in the Department of Educational Psychology at the University of the Western Cape in South Africa. She is a registered educational psychologist. Mokgadi obtained her Ph.D. in Educational Psychology from the University of Pretoria, South Africa. For many years she has been involved in the training of a number of programmes namely, B.Ed. Hons (Counselling), M.Ed. (Educational Psychology) and M.Ed. (Learning Support, Guidance Counselling). She also supervises and does co-supervision of Honours, Masters and Ph.D. students. She obtained Leadership Training for Women in Higher Education from HERS–USA Brawn Mawr College in USA. Mokgadi presents papers in local and international conferences, publishes articles, and writes books and book chapters. Her research interests include Child Development, Learning and Behavioural difficulties, Inclusive education, Psychological assessments and Intervention, Indigenous Knowledge in Psychology, and Multicultural counselling.

Roy Moodley, Ph.D. is Associate Professor of Counselling Psychology at the University of Toronto. He is the Director for the Centre for Diversity in Counselling and Psychotherapy. Roy's research and publications include critical multicultural counselling and psychotherapy; race and culture in psychotherapy; traditional healing practices; gender and identity.

Linda Waimarie Nikora, Ph.D. is professor and Co-Director for Ngā Pae o te Maramatanga, the National Maori Centre of Research Excellence. She has been involved in research about Tangi; Māori ways of mourning; traditional body modification; ethnic status as a stressor; Māori identity development; cultural safety and competence; Māori mental health and recovery; social and economic determinants of health; homelessness; relational health; social connectedness; and human flourishing.

Ana Maria Oyarce, Ph.D. is a medical anthropologist who is associate Professor of the Public Health School, Faculty of Medicine, University of Chile. She trained as an anthropologist and in medical and social sciences at the School of Medicine, University of Newcastle. Australia and obtained a doctorate in Medical Anthropology at the Department of Cultural Anthropology, University of Arizona, USA. She has worked on sociodemographic and Medical Anthropology, researching on health indicators of Indigenous Peoples and Populations in Latin America. She has worked in numerous universities in Chile, participating in international cooperation projects and institutions of N.U system; and has published outstanding books and articles on medical anthropology, intercultural health and public health in Chile, and also produced videos on these topics. She has been working for many years with Mapuche people in Chile.

LaRose T. Parris, Ph.D. is Associate Professor of English at LaGuardia Community College of the City University of New York where she teaches courses in African American Literature and Composition. Her first book, *Being Apart: Theoretical and Existential Resistance in Africana Literature* (2015), published by the University of Virginia Press, was awarded the Nicolás Guillén Prize for Outstanding Book in

Philosophical Literature by the Caribbean Philosophical Association in 2016. Her fiction and criticism has also appeared in *Callaloo*, *The Journal of Pan African Studies*, and *The Review of Education, Pedagogy, and Cultural Studies*.

Kopano Ratele, Ph.D. is at the Institute of Social and Health Sciences, Professor at the University of South Africa (UNISA) and researcher at the South African Medical Research Council-UNISA Violence, Injury and Peace Research Unit. He runs the *Programme on Transdisciplinary African Psychology* and *Research Unit on Men and Masculinities*. His work focuses on boys, men and masculinities in intersection with race, violence, tradition, sexuality and class. He is Past President of the Psychological Society of South Africa; member of a number of editorial boards, including those of *Feminism and Psychology*, *NORMA: The International Journal for Masculinity Studies*, and *Psychology in Society*, and a member of the national Ministerial University Transformation Oversight Committee. His books include *There Was This Goat: Investigating the Truth Commission Testimony of Notrose Nobomvu Konile* (with Krog and Mpolweni), *Liberating Masculinities*, and *Engaging Youth in Activism, Research and Pedagogical Praxis: Transnational and Intersectional Perspectives on Gender, Sex, and Race* (co-edited with Hearn, Shefer, and Boonzaier).

Julian Robbins, Ph.D. (born and raised in southwestern Ontario) is a mixed ancestry person with maternal Mi'kmaq heritage (New Brunswick and Nova Scotia). He completed a Ph.D. in January 2014 through the Indigenous Studies Department at Trent University where he focused on First Nations self-determination in the health field with particular emphasis on traditional health and healing. Julian Robbins holds a Research Affiliation status with the Indigenous Peoples' Health Research Centre (IPHRC) in Regina, Saskatchewan and E-KSS, a Canadian non-profit that predominantly partners on Indigenous health and wellness research projects with the Federação das Organizações Indígenas do *Rio Negro in the Brazilian Amazon*.

Hillary Peter Rodrigues, Ph.D. is Professor, Department of Religious Studies at the University of Lethbridge, Canada. Aligned with his project

on the pedagogy of Religious Studies, he has published *Introduction to the Study of Religion* and *The Study of Religion: A Reader*, and is the general editor of the series *Studying Religions in Practice*. Second editions of his *Introducing Hinduism*, and *Hinduism—The eBook* has recently been released, and he is co-editor of *Nine Nights of the Goddess*, a volume dedicated to the Hindu festival of Navaratri. He is currently working on a comprehensive study of the Hindu goddess Durga, and initiating a project on modern nondual spirituality. He has been honoured by his institution's Board of Governors Chair in Teaching and the Distinguished Teaching Medal.

Michael Thrasher, LLD HC is nationally recognized Métis teacher of Anishinabi First Nations philosophy, tradition and culture. He is widely credited for his ability to use traditional knowledge and viewpoints in contemporary contexts. In the early 1990s, through the invitation of the President of the Adler School of Psychology, Toronto, he was instrumental in developing and delivering a Master's level course in First Nations Psychotherapy program for the school. In June 2015, he received an Honorary Doctorate of Laws from Trent University in recognition for his service to the Indigenous community and has been an Adjunct Professor in Indigenous Studies Program at Trent for over 35 years.

Jan van der Tempel, MA, MPhil is a Dutch-Canadian doctoral candidate in clinical and counselling psychology at the University of Toronto. He grew up in Sri Lanka, Canada, Chile, USA, and the Netherlands, where he was a musician before pursuing mental health research and practice. Jan has been active in public health, clinical-, and cross-cultural psychology research at York University, University of Toronto, and the Centre for Addiction and Mental Health. His current research explores the psychology of anomalous experience in healing and illness across religions and cultures, most recently in his Master's thesis on spontaneous mystical experiences among atheists.

Waikaremoana Waitoki (Ngāti Māhanga, Ngāti Hako) is a co-convenor of the National Standing Committee on Bicultural Issues (NSCBI), and the Bicultural Director on the New Zealand Psychological Society Executive. She is a clinical psychologist with work and research interests in adult mental

health, child and adolescent mental health, and addictions. She is the Senior Research Officer for the Māori and Psychology Research Unit (MPRU) in the School of Psychology at the University of Waikato. Waikaremoana Waitoki edited the first *Indigenous Psychology* textbook for Maori (Te Manu Kai i te Matauranga—the bird that partakes of knowledge) in 2016.

List of Figures

Fig. 5.1	African model of personality (Adapted from Botha and Moletsane 2012, pp. 70–71)	86
Fig. 8.1	Circular causality of effects among the elements of the human being	148
Fig. 9.1	The Confucian ethical system of benevolence-righteousness-propriety for ordinary people (*Source* Adapted from Hwang 1995, p. 233)	154
Fig. 10.1	Social and emotional well-being diagram (*Source* Dudgeon and Walker 2015)	175
Fig. 11.1	Learning processes in the Anishinabi oral tradition (Thrasher et al. 1995)	188
Fig. 11.2	Symbolic representation (Adapted from Thrasher et al. 1995)	192
Fig. 14.1	Violence and nonviolence and the overlapping area between the two	231

List of Tables

Table 3.1	Scientific paradigm	43
Table 3.2	Medicalization across cultural traditions	43
Table 5.1	Indigenous African aetiological explanations	89
Table 8.1	Elements of the human being and its corresponding effects	147
Table 17.1	Mapuche culture and psychiatric nosology	285



1

Introduction to Global Psychologies: Mental Health and the Global South

Suman Fernando and Roy Moodley

Background

The rise of migration to Europe and North America (mainly from Asia and Africa) since the end of the second world war (WW2) especially during the past three decades, is resulting in growing interconnectedness between people around the world, while globalization of lifestyles, media, technology, as well as social and political systems (including health care and cultural pursuits) is resulting in conflict as well as collaboration across the world in many fields, including those around mental health and wellbeing—for example around the Movement for Global Mental Health (MGMH) (Summerfield 2012; Bemme and D'souza 2012; Das and Rao 2012; Shukla et al. 2012a, b). In some instances, geo-political power dynamics results in 'globalization' often meaning 'Westernization' (Petras and Veltmeyer 2001)

S. Fernando (✉)
London Metropolitan University, London, UK

R. Moodley
University of Toronto, Toronto, ON, Canada

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_1

rather than true sociocultural interchange between the West and the Rest (for discussion of what is meant by 'the West' and 'the Rest' see Hall 1996)—something evident in the field of mental health and well-being. Consequently Western ideologies and systems of 'mental health care' underpinned by (Western) psychology and psychiatry are being imposed and/or taken up in the Third World demonstrating a form of coloniality (Fernando 2014; Mills 2014). Meanwhile, in the West, diasporic communities of non-Western cultural origin are increasingly dissatisfied with psychiatry and clinical psychology encounter when they access—or are forced into—mental health services in the West (Fernando 2010; Littlewood and Lipsedge 1997). For instance, clients argue that psychologists and psychiatrists fail to understand individual cultural healing contexts (Bhugra and Bhui 1998); and that therapy has no benefit (Garfield 1986). This results in very low intake of psychology or psychotherapy services among clients from a non-Western cultural backgrounds. And if they do engage with these processes they tend to show significantly poorer outcomes from therapy, or drop out of therapy much earlier than the norm. It seems that the clinical psychology and psychotherapy models and approaches to understanding the human being is individualistic, Eurocentric and ethnocentric in nature (Moodley and Palmer 2006). Since the 1960s, there has been a concerted effort to address this issue in clinical and counselling psychology, psychotherapy and psychiatry (see Laungani 2005; Fernando 2010, 2014; Vontress 1991, 1999).

Laungani (2005) noted that psychologists and mental health practitioners are always influenced by the dominant epistemologies of the cultures within which they live and work, and hence, they will certainly have a bearing on their clinical practice. Working cross-culturally can result in tensions and conflicts when competing and, sometimes contradictory cultural values and healing practices are at odds with each other. He argued that, 'if one were to construct a solid counselling bridge across Eastern and Western cultures, it would be necessary to examine not only the cultural factors but also the epistemologies, which guide the professional work of counsellors and therapists' (p. 254). The need to examine the dominant epistemological frames will offer the opportunity to not only look critically at Western Eurocentric discourses

in mental health but will also make room for creative thinking about alternatives within Western healthcare practices. Indeed, there are several programmes and movements that are working to integrate ways of thinking about the human condition and traditional healing practices in the Global South into current Western psychiatric, psychological and counselling services (e.g., Moodley and West 2005). The rationale for these endeavours is often to develop culturally sensitive and culturally competent practices in the Global South, but still within the parameters of the Western scientific tradition as represented by (Western) psychiatry and clinical psychology.

The reason for the domination of Western psychology and psychiatry is, of course, historical—largely the result of geopolitical power dynamics that have resulted in Western economic and cultural dominance. There is a growing literature exploring this topic under the umbrella of indigenous psychology (Kim and Berry 1993; Ho 1998; Allwood and Berry 2006; Kim et al. 2006; Pandey 2011), although this process is not approved by some traditional Western academics (e.g., see Jahoda 2016). Also, it should be noted that innovative approaches to the study of (what amounts to) 'psychology' continue to arise in various settings and sometimes associated with particular individuals, such as Fanon, Gandhi and Martín-Baró (Watkins and Shulman 2008)—a matter considered later when chapters in Part III of the book are described.

The majority of people in the world today live in what is now called the Global South, mainly the regions of the World formerly referred to as the 'developing world' or 'Third World' (Tomlinson 2003)—a concept that arose post WW2 to encompass countries that, generally speaking, have a non-Western cultural backgrounds and suffered from underdevelopment and exploitation during the colonial era (Pomeranz 2000)—but 'Global South' also encompasses the cultures of indigenous people in regions of the world that were once (before Western colonization) dominated by their ancestors, for example, in Australasia and America. Although many aspects of their cultural traditions have been dismantled and others corrupted and hybridized, many people in the Global South are still informed for their day-to-day lives by ideologies and ways of thinking about the 'mind'—psychologies—that are different to that embodied in traditional Western psychology that stems from

post-Enlightenment thinking in Europe (Fernando 2014; Foucault 2006). Some of the ideologies—such as the Cartesian mind–body dichotomy and the rejection of spirituality—underpinning the nature of 'mental illness' that inform Western psychology and psychiatry are in many ways at odds with cultural traditions that influence the lives of most people of the Global South and, to some extent, diasporic communities of non-Western heritage living in the Global North.

The Cartesian mind–body dichotomy which has been the bedrock for the evolution of psychology and psychiatry is still the mainstay of knowledge production in these disciplines. From its earliest origins when Plato contemplated and cogitated about the psyche and soma, the focus in theory, research and practice has been on either the body or the mind, never the two as a whole, and certainly not including the spirit. The notion of the spirit has been marginalized and reduced to the periphery of psychological and psychiatric research. However, in recent decades, there has been a slow but intensive engagement by scholars investigating issues of spirituality, wellbeing, counselling and psychotherapy. They are calling for an inclusion of religion and spirituality in psychology and psychotherapy, and emphasizing that culture and race needs to be part of this conversation (see Nolan and West 2015; West 2011). For example, Nolan and West (2015) argue that, 'a careful consideration of spirituality and religion in a therapeutic context requires that culture and race or ethnicity be also kept in mind and that cultural differences are nuanced in the context of spirituality and religion' (pp. 1–2). Even Carl Jung who was regarded a racist (see Dalal 1988), in his later life said: 'our new psychology is in no way advanced enough to present a theory of the mind that would have universal application' (Jung 1931, para. 1298; cited in Stephenson 2009, p. 48). Clearly, it seems that many in this field recognize that Western psychologies with their mind–body dichotomy are not fully applicable to cultures globally.

Although there is a body of literature in the field of transcultural psychiatry (allied to social anthropology), cultural psychology, religious studies, philosophy and so on, all exploring the cultural diversity of concepts around the nature of concepts such as 'mind' health and ill-health (e.g., see Gaines 1992), little of this has influenced theory

and practice of (Western) clinical psychology and psychiatry. Thus, it is could be argued that these disciplines are less than fit for purpose in a globalizing world.

In modern Western thinking, psychology, religion and medicine are clearly demarcated. However, the division between bodies of knowledge are often very different (to the Western one) in non-Western cultures. Hence, in describing these subjects in this book, an artificial structure derived from Western thinking is inevitably being imposed in the case of all other cultures. Consequently, the descriptions are likely to be distorted to a lesser or greater extent; and the understanding of the conceptualizations within these cultures may well not be properly, or fully, presented. In our view, these limitations must be borne in mind by the reader when considering the accounts of 'global psychologies' in successive parts of this book.

Body of the Book

The book is divided into four parts, preceded by Chapter 1. Part I: Theoretical, Philosophical and Historical Contexts, consisting of three chapters. Part II: Traditions of Psychology in the Global South; consisting of eight chapters. Part III: Liberation Psychologies consisting of three chapters. And Part IV: Contemporary movements consisting of three chapters.

The chapters in Part I explore ways in which cultural, social, historical and religious ideas have been influential in the theories and philosophies concerning the 'mind' and 'self' that have evolved into a variety of psychologies that have underpinned civilizations in all regions of the world. In particular, they provide an oversight of ways of thinking appertaining to psychological insights and traditions derived in the cultures of the Global South, indicating differences overall between 'Western' and 'non-Western' approaches. In the first (Chapter 2, 'Varieties of Global Psychology: Cultural Diversity and Constructions of the Self'), Laurence Kirmayer, Ademola Adeponle and Vivian Dzokoto powerfully question the assumptions of Western psychology

presented as universal truths reflecting its contextual history; and then indicates equally powerfully the political constraints that continue to silence diverse voices. They argue that the (Western) psy disciplines are riddled with assumptions about the nature of the person and these are presented as universal truths rather than contextualized in space and time. Using a cultural constructivist and critical anthropological perspectives, the chapter explores the cultural construction of the self and selfhood arguing that they are shaped by local interpretive practices against a background of historical, economic, cultural and political events and contexts. The authors argue that the 'self' as a cultural phenomenon embodies both local and larger global experiences within which to make sense of the world.

In Chapter 3 ('Reflections on African and Asian Psychologies'), Suman Fernando, writing from the perspective of a clinical psychiatrist who has worked among people from diverse cultural backgrounds and later researched the history of Western psychology from a 'race' and culture perspective, outlines wide-ranging differences between African and Asian psychologies on the one hand and Western psychology on the other. Fernando describes the Cartesian-Newtonian model that has informed the way in which western psychologies have constructed the mind–body binaries. He argues that African and Asian psychologies constructs a different worldview which places holism, harmony, balance and the spirituality as key aspects of the person; in turn these ideas offer a creative way to understand health, mental health and wellness. In Chapter 4 ('Contexts, Epistemologies and Practices of Global South Psychologies'), Roy Moodley and Jan van der Tempel explore historical and cultural contexts in which varieties of psychology have developed and interacted to produce what we have today, a relatively recent Western psychology that in many ways stand contrasted to psychologies of the Global South.

The chapters in Part II of the book discuss ways in which traditional healing practices, religion and spirituality have been the foundation of theories concerning the 'mind' and mental matters (indigenous psychologies) as seen in healing practices and approaches to mental health and wellbeing in a diversity of cultures of the Global South; and describe underlying themes appertaining psychology in traditional cultures of

Africa and Asia, and indigenous peoples of America and Australasia. Each chapter is written by a specialist or group of specialists in the topic concerned. Inevitably (because psychologies themselves are diverse) the presentations vary in style and composition, and do not necessarily adhere to the style normally used when *Western* psychology is set out. Hence, we suggest that readers, used to the standard Western way of expressing matters appertaining to psychology and medicine, should not be put off by encountering a style that is seemingly strange to them, but instead go along with the style adopted by the author(s) of each chapter. In our view, it is important to recognize and respect the fact that globally, psychologies differ from each other and may sometimes do so in fundamental ways; and so the discourse about psychology would naturally vary from the 'standard' that readers used to narrow 'Western' modes may expect.

The first chapter in Part II, 'African Indigenous Knowledge Systems and Healing Traditions' (Chapter 5) is written by Olaniyi Bojuwoye and Mokgadi Moletsane-Kekae, academics from two countries of Africa—Nigeria and South Africa. The chapter fill in the details of how human nature from an African perspective is socially constructed and the self emerges from relationships between the individual and their environment comprising the physical, social and spiritual. These authors suggest that different cultures have evolved knowledge systems related to their specific geo-cultural environments, which in turn produce a set of practices that deal with diseases and restore health. The chapter explores collectivism and spiritualism as key components in establishing an African worldview that embraces a physical, social, psychological, spiritual, career and familial aspects of life. Thus health and illness are socially constructed. Since the self is multidimensional and holistic, health interventions engage the cultural, biomedical, psychosocial and the spiritual.

The next two chapters refer to the Indian subcontinent. Hillary Rodrigues, who has researched for many years in India, contributes two chapters. The first, 'The Self in Hindu Philosophes of Liberation' (Chapter 6) explores the Vedic tradition, now represented by the Hindu culture, drawing on written texts such as the *Sutra* of Patanjali and the *Bhagavad Gita* to point out how Hindu psychology sees the true self as

being at the root of psychological problems and hence 'self-realization' as an essential part of freeing the individual from a sort of bondage. This idea is explored by considering the construction of the self within the Sankhya, Yoga and Shankara's Vedanta systems. Despite differences and variations, all these systems suggest that misapprehension of our true selves is the cause of suffering and illness. Well-being, therefore, depends on liberating oneself from erroneous self-images by realizing our true natures. In his second contribution, Hilary Rodrigues writes about Buddhism. Chapter 7 titled 'Buddhist Orientations to Mental Health' explores the basic tenants of Buddhism that explain body–mind processes. Lack of knowledge of the self leads to unhealthy relationships to the world. This chapter presents some of the cardinal teachings of Buddhism, such as the Four Noble Truths, the Eightfold Path, Pratitya-samutpada, and the Anatman Doctrine. The current mindfulness meditation movement in health and mental health care practices illustrates how classical Buddhist meditation techniques have moved beyond a religious system into secular practices.

'Psychology from an Islamic Perspective' (Chapter 8) is authored by Amber Haque who is based in the United Arab Emirates. He discusses Islamic religious and spiritual concepts, such as the different types of fitrah, the nature of human soul, the cultural dynamics of the metaphysical, the Jinn, Satan and evil eye and their influences on human personality. These are discussed in relation to constructing an Islamic worldview. Kwang-kuo Hwang writes on 'Chinese Cultural Healing' in Chapter 9. This chapter explores how Confucian ethics and morality is the basis of establishing a worldview of Chinese people. The chapter considers the healing function of *morphostasis* formulated by pre-Qing Daoists' and Confucianists' interpretations on *I Ching* (classics of change). Then, three authors from Australasia (Australia and New Zealand/Aotearoa) all from indigenous communities themselves, come together to contribute Chapter 10 ('Indigenous Psychology in Aotearoa/New Zealand and Australia'). Their chapter looks at how Indigenous psychology and its developments are constructed in relation to both the colonial and post-colonial contexts. They explore the use of esoteric, ceremonial, environmental and relational knowledge suggesting that it acts as a counterbalance to the individualism and

ethnocentrism in western psychology. Connection to land, ancestors, language, customs and relationships are critical in shaping a worldview. Māori wellbeing includes healthy relationships between the physical, psychological, community, spirituality and environment domains. They discuss Dudgeon's Social and Emotional Wellbeing model as a transformative framework for addressing the inequalities that indigenous people experience.

Michael Thrasher, a Métis teacher of Anishinabi and Julian Robbins who has a Mi'kmaq heritage both from Canada, write mainly about the knowledge embedded in the indigenous culture of the Anishinabi people, one of the first nations of the North American continent, in Chapter 11, 'Respect and Relationships: A Perspective on Indigenous Mental Health from Turtle Island / North America'. This chapter discusses how Indigenous North American healing traditions, particularly of the Anishinabi Nation offer an understanding of health and mental health. The concept of the mind is explored as a holistic framework, which constructs itself through the interconnectedness of the individual, the community, and the natural world. The sweat lodge ceremony which is practiced by some First Nations in North America is discussed. This section of the book concludes with a chapter ('Healing Systems of the Mapuche People of Chile') by Ana Maria Oyarces Pisane, an anthropologist who has developed a deep understanding of the Mapuche people and their healing systems. Her work as an anthropologist with the Mapuche people of Chile has given the author a deep insight into the indigenous knowledge and healing systems. She reflects on the religious and spiritual nature of the Mapuche healing system which she suggests is built on the social and cultural fabric of the people. She also explores the tensions that exist between the western European psychological constructions of health and illness and those that are indigenous.

Liberation psychologies covered in Part III of the book attempt to understand the person within their social, economic, cultural and historical contexts. Unlike traditional Western psychology which attributes distress and psychopathology to individual and intrapsychic processes, liberation psychologies contextualize the subject within an anti-oppressive environment; consider power structures as templates

of distress rather than unconscious motivation of psychopathology; and 'teach that environments of injustice, violence and repression have powerful psychological effects on everyone, whether they are registered consciously or unconsciously' (Watkins and Shulman 2008, p. 53). The chapters in Part III offer analytic discussions of the ideas, writings and theories of just three of the most influential intellectuals of the freedom/liberation movements in the Global South, who were active when many countries in Asia and Africa were still 'colonies'. And once political liberation was achieved and 'colonies' became the 'developing world', development being 'promoted as a benign process of granting gifts from the "developed" to the "underdeveloped"' (Watkins and Shulman 2008, p. 33), the vision was constructed of the 'Third World' emerging with true liberation, something not yet fulfilled. The life's-work of Frantz Fanon, Mohandas Gandhi and Steve Biko are just three examples of inspirational and constructive psychologies associated with liberation movements that opposed European oppression of black-and brown-skinned peoples during the colonial era—and hence, their work is highly relevant in an age when neocolonialism (similarly in some ways to the old-fashioned variety) is appearing (Fernando 2014).

The editors regret not having been able to include chapters on the work of some well-known people who have contributed to the field of liberation psychology, such as Ignacio Martín-Baró (1994) scholar, psychologist philosopher and Jesuit priest who developed a psychology allied to liberation theology, one that was grounded in what he called the historic, the social and the desires and aspirations of individuals and communities; Paulo Freire (1972) who, while devoting himself to the advancement of impoverished people of Brazil, evolved a psychology in the form of a theory for education that liberated the downtrodden; and the work of some Western women who spoke with a 'different voice' to their male counterparts in parts of the British Empire during colonialism (see Jayawardena 1995). These must be left to another book, other writers.

Part III of the book begins with a chapter by psychologist and humanist Gordon Lewis, who holds professorial appointments in the USA and South Africa, and LaRose Parris, Associate professor of English who teaches courses in African-American literature, together exploring

the sometimes controversial ideas of Frantz Fanon in Chapter 13 ('Frantz Fanon's Psychology of Black Consciousness'). And they do so in a free-flowing subjective style that represents the writing of Fanon himself. In keeping with the kind of prose that Fanon's writing reflected, these authors undertake a critical exposure using a 'sociogenic analysis and decolonial method' to engage Fanon in the clinic. Citing Fanon's works, with particular reference to *Black Skin, White Masks* they explore Fanon's 'psychiatric, philosophical, and revolutionary thought' which nurtures 'individual and collective self-emancipatory' and 'liberatory self-actualization' that engenders 'revolutionary socio-political change'. In the next chapter, Chapter 14 ('Gandhian Philosophy for Living in the Modern World: Lessons from the Psychology of Satyagraha') Vinod Kool and Rita Agrawal describe the psychology underpinning the non-violence movement initiated by Mahatma Gandhi—something that has inspired, not just political and cultural liberation movements across the world, but initiated a counterpoint to the currently popular idea that violence is a necessary part of effecting sociopolitical change. These authors also explore how Gandhi's nonviolent technique (*Satyagraha*), engages psychological ideas of resilience and coping against adversity. They note that Gandhi's ideas on self-control, courage and social commitment are relevant to the ways in which we understand human behaviour, personality development, health and mental health.

In Chapter 15 ('The Black Consciousness Psychology of Steve Biko') two stalwarts of South African Liberation movement, Saths Cooper, who was a close associate of Steve Biko, and Kopano Ratele, both holding professorial appointments in South Africa, present Biko's psychological insights that inspired the liberation movement in South Africa. They reflect on Biko's work as a philosophical and psychological framework for understanding the constructions of the self. The discussion offers a rich tapestry of Steve Biko's Black Consciousness (BC) ideas in a historical context of Apartheid South Africa; suggesting that the principles of BC provided the 'basis of psychological inoculation against the degradation of apartheid … against unremitting brutality and repression and the insidious diminution of self and identity'. There have been many attempts during the past few decades to bring together psychological understanding from very different cultural traditions in order

to develop movements in 'mental health' that suit the mixed (hybrid) cultures that are prevalent in many parts of the world. The psychologies themselves are sometimes called 'indigenized' psychologies (rather than 'indigenous') (see Yang 2012).

Part IV provides examples of how some people have gone about bringing the amalgamation of psychologies from North and South (or East and West). In Chapter 16 ('Indigenous Psychologies and Approaches to Wellbeing in East Asia'), Boon Ooi Lee describes how he sees this field at present in East Asia. He discusses how the East Asian indigenous framework constructs the self and the worldview that shapes the various ways in which health, mental health and wellbeing are understood in East Asia. The chapter reiterates the Global South psychologies' paradigmatic structure of the psyche, namely that the self is non-binary and holistic—body and mind as not separated, but 'mutually constituted which are in turn parts of a larger whole consisting of physical and social environments' including the 'cosmic order'. These ideas are explored in several examples that the chapter discusses, such as *onmeum* counselling, *Morita* therapy, *Naikan* therapy, Chinese Taoist Cognitive Psychotherapy, and Tao psychotherapy. And in Chapter 17 ('Contemporary Applications of Confucian Healing') Kwang-kuo Hwang describes how one type of traditional Chinese (psychological) healing has been adapted for the contemporary world. Using the theoretical framework from his previous work *Confucian ethics for ordinary people* Kwang-kuo Hwang shows how the ethical healing practices of East Asia originated from Confucianism and Daoism. Ideas of self-cultivation, harmony, principles of psychosocial homeostasis are used in developing various types of psychotherapy.

Finally, in Chapter 18 ('From Denial to Collaboration: Reflections on Shamanism and Psychiatry Based on a Case Study in Chile'), Ana Maria Oyarce Pisani, an anthropologist who, having worked in the health field, has developed an interest in how the role of the shaman among Mapuche people of Chile can been transformed by the influence of (Western) biomedicine (and perhaps vice versa), describes a case history to illustrate how both approaches can work in collaboration. Using a client case vignette of a Mapuche woman's sufferings, the author explores how western psychological healthcare systems engage

psychiatric terms and in the process marginalizes and denies indigenous Mapuche ways of healing and understanding the self. The author argues for a more holistic approach that includes the social and the spiritual experiences of the people.

Conclusions

Although Western culture tends to dominate the world today in many ways because of the history of the past four hundred years (of military might associated with a desire to dominate, and sometimes exterminate, 'other' cultures), clearly, it has not always done so completely, and its dominance may well be eroded in the next few decades (see *When China Rules the World* by Jacques 2012). It is often the case that Western approaches in many fields (including psychology, philosophy and sociology) are assumed to be 'modern' and 'scientific' in contrast to others—and being modern/scientific tends to be contrasted with being spiritual. But such a dichotomy can be questioned: According to Capra (1982), the spiritual tradition of the East (evident in the psychologies of Asia and Africa) is akin to the approach of modern (late-twentieth and twenty-first centuries) physics—the Western tradition in psychology and psychiatry being more akin to nineteenth and early twentieth centuries science.

The historic past of a people forms the background to their worldview in the present day but current—and future—worldviews must incorporate two dimensions of change that are continuous. First, there is the effect of recent migration and movements of peoples resulting in groups of people identifying in terms of their background (their 'cultures'), wherever they live, while adapting to the 'cultures' of their residential ('adoptive') lands. And second, the assimilation and integration between cultures that is taking place all the time, especially in recent years with the easing of travel, movements of populations and the communication revolution that is taking place. Admittedly, there are tensions between groups (of 'different cultures') as well as a tendency—a necessity—for cultures and people to live together and hence to blend in many ways. The tensions are shown up in continuing racism,

neocolonialism and even armed conflict, and so on. But it is not clear to what extent and how the fusion of cultural traditions vis-à-vis mental health is taking place; the only certainly is that it must be happening. Yet, just as Western (traditional European) culture retains a worldview which incorporates a sense of power, Asian, African (and others such as Indigenous American and Māori) cultures retain the scars (and often more than mere scars) of imperial domination and persecution during the era in which genocide, slavery and colonialism flourished—added to which are the effects of current economic oppression and indirect political control, 'neocolonialism'. Yet, as Bob Dylan (1963) sang, 'The Times They Are A-Changing', and power dynamics are shifting.

Today, there is a distinct shift of power—at least in economic terms—towards Asia (especially India and China) away from Europe and the United States. The active stifling of Asian cultures appears to be in the past and the legacies from these cultures are permeating the rest of the world. But, African nations seem to retain the very deep scars of the holocaust that was slavery and of the colonialism that attacked its traditional values and ways of life, seemingly unable yet to pull themselves up as Asian nations appear to be doing. But sooner or later they will, releasing the enormous potential of very old and distinguished cultures. It is in this context that there is a greater interest in Europe and United States in Eastern religions and in attitudes towards mental health that are 'Eastern' and an apparent disillusionment with the 'Western'. The wave of new-age religious movements may represent a real cultural shift in Western tradition but more likely to be a cult-like fashion confined to a few people or merely a colonization (possession and disruption) of superficial aspects of Eastern cultural forms rather than their real meaning. Clearly, what is discernible in Western societies is confusion over the role of psychiatry and psychology as constructed currently and people looking to Eastern religion (including Islam), rather than Western Christianity, for some answers. It is no coincidence, that psychiatry is applied in multicultural and multi-ethnic societies in the West (see Bhui and Olajide 1999; Fernando 2010) and even more significantly, in formerly colonized low-income (Third World) countries (Fernando 2014; Mills 2014). The future is uncertain but it is likely to

belong to the sorts of psychology that still thrive in Asian and African continents and seem to be in line with twenty-first-century science, *away from* the so-called scientific (in the sense of nineteenth and twentieth centuries science) Western psychology.

References

Allwood, C. M., & Berry, J. W. (2006). Origins and development of indigenous psychologies: An international analysis. *International Journal of Psychology, 41,* 243–268. Retrieved November 10, 2017, from http://indigenouspsych.org/Resources/Allwood%20&%20Berry.pdf.

Bemme, D., & D'souza, N. (2012). Global mental health and its discontents. *Somatosphere*. Retrieved May 10, 2013, from http://somatosphere.net/2012/07/global-mental-health-and-its-discontents.html.

Bhugra, D., & Bhui, K. (1998). Psychotherapy for ethnic minorities: Issues, contexts and practice. *British Journal of Psychotherapy, 14,* 310–326.

Bhui, K., & Olajide, D. (1999). *Mental health service provision for a multicultural society*. London: Saunders.

Capra, F. (1982). *The turning point: Science, society, and the rising culture*. London: Wildwood House Publisher.

Dalal, F. (1988). Jung: A racist. *British Journal of Psychotherapy, 4,* 263–279.

Das, A., & Rao, M. (2012). Universal mental health: Re-evaluating the call for global mental health. *Critical Public Health, 22*(4), 183–189.

Dylan, B. (1963). *The times they are a-changing.* Title of song. Retrieved December 10, 2017, from https://bobdylan.com/songs/times-they-are-changin/.

Fernando, S. (2010). *Mental health, race and culture* (3rd ed.). Basingstoke and New York: Palgrave Macmillan.

Fernando, S. (2014). *Mental health worldwide: Culture, globalization and development*. London and New York: Palgrave Macmillan.

Foucault, M. (2006). *History of madness* (J. Khalfa, Ed., J. Murphy & J. Khalfa, Trans.). London and New York: Routledge.

Freire, P. (1972). *Pedagogy of the oppressed* (M. B. Ramos, Trans.). London: Sheed and Ward.

Gaines, A. D. (Ed.). (1992). *Ethnopsychiatry. The cultural construction of professional and folk psychiatries*. New York: State University of New York Press.

Garfield, S. L. (1986). Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behaviour change* (3rd ed.). New York: Wiley.

Hall, S. (1996). The west and the rest: Discourse and power. In S. Hall, D. Held, D. Hubert, & K. Thompson (Eds.), *Modernity: An introduction to modern societies* (pp. 84–127). Malden, MA, Oxford, and Carlton, VIC: Blackwell.

Ho, D. Y. F. (1998). Indigenous psychologies: Asian perspectives. *Journal of Cross-Cultural Psychology, 29,* 88–103.

Jacques, M. (2012). *When China rules the world* (2nd ed.). London: Penguin Books.

Jahoda, G. (2016). On the rise and decline of 'indigenous psychology'. *Culture and Psychology, 22*(2), 169–181. Retrieved November 10, 2017, from http://indigenouspsych.org/Discussion/forum/PDF/Culture%20Psychology-2016-Jahoda.pdf.

Jayawardena, K. (1995). *The white woman's other burden: Western women and South Asia during British rule*. New York and London: Routledge.

Jung, C. G. (1931). Foreword to Aldrich: The primitive mind and modern civilization. In *The symbolic life.* Collected Works 18. Princeton, NJ: Princeton University Press, 1954, 1980.

Kim, U., & Berry, J. W. (1993). *Indigenous psychologies: Research and experience in cultural context*. Newbury Park, CA: Sage.

Kim, U., Yang, K.-S., & Hwang, K.-K. (Eds.). (2006). *Indigenous and cultural psychology: Understanding people in context*. New York: Springer Science & Business Media Inc. Retrieved November 10, 2017, from http://indigenouspsych.org/Resources/Indigenous%20and%20Cultural%20Psychology%20-%20Understanding%20People%20in%20Context.pdf.

Laungani, P. (2005). Hindu spirituality and healing practices. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counselling and psychotherapy*. London and New Delhi: Sage.

Littlewood, R., & Lipsedge, M. (1997). *Aliens and alienists: Ethnic minorities and psychiatry* (3rd ed.). London: Routledge.

Martín-Baró, I. (1994). *Writings for a liberation psychology*. Cambridge, MA: Harvard University Press.

Mills, C. (2014). *Decolonizing global mental health: The psychiatrization of the majority world*. London and New York: Routledge.

Moodley, R., & Palmer, S. (Eds.). (2006). *Race, culture and psychotherapy: Critical perspectives in multicultural practice*. London: Routledge.

Moodley, R., & West, W. (2005). *Integrating traditional healing practices into counselling and psychotherapy*. London and New Delhi: Sage.

Nolan, G., & West, W. (2015). *Therapy, culture and spirituality*. London: Palgrave Macmillan.

Pandey, S. (2011, November 22–24). *Positive psychology: Blending strengths of Western, Eastern and other indigenous psychologies*. Talk presented at First International Conference on Emerging Paradigms in Business and Social Sciences organized by Middlesex University, Dubai. Retrieved November 10, 2017, from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2150585.

Petras, J., & Veltmeyer, H. (2001). *Globalization unmasked: Imperialism in the 21st century*. London: Zed Books.

Pomeranz, K. (2000). *The great divergence: China, Europe and the making of the modern world economy* (new ed.). Princeton: Princeton University Press.

Shukla, A., Philip, A., Zachariah, A., Srinivasan, C., Shatrugna, V., Phadke, A., et al. (2012a). Critical perspectives on the NIMH initiative 'Grand Challenges to Global Mental Health'. *Indian Journal of Medical Ethics, 9*(4), 292–293.

Shukla, A., Philip, A., Zachariah, A., Srinivasan, C., Shatrugna, V., Phadke, A., et al. (2012b). Grand challenges for global mental health. *Economic and Political Weekly*, *XLVIII*(42), 4–5.

Stephenson, C. E. (2009). *Possession: Jung's comparative anatomy of the psyche*. London: Routledge.

Summerfield, D. (2012). Afterword: Against 'global mental health'. *Transcultural Psychiatry, 49*(3), 1–12.

Tomlinson, B. R. (2003). What was the third world? *Journal of Contemporary History, 38*(2), 307–321.

Vontress, C. E. (1991). Traditional healing in Africa: Implications for cross-cultural counseling. *Journal of Counseling and Development, 70,* 242–249.

Vontress, C. E. (1999). Interview with a traditional African healer. *Journal of Mental Health Counseling, 21*(4), 326–336.

Watkins, M., & Shulman, H. (2008). *Toward psychologies of liberation*. Basingstoke, Hampshire and New York: Palgrave Macmillan.

West, W. (Ed.). (2011). *Exploring therapy, spirituality and healing*. London: Palgrave.

Yang, K.-S. (2012). Indigenous psychology, Westernized psychology, and indigenized psychology: A non-Western psychologist's view. *Chang Gung Journal of Social Sciences, 5*(1), 1–32.

Part I

Theoretical, Philosophical and Historical Contexts

The chapters in Part I explore ways in which cultural, social, historical and religious ideas have been influential in the theories and philosophies concerning the 'mind' and 'self' that have evolved into a variety of psychologies that have underpinned civilisations in all parts of the world. In particular, they provide an oversight of ways of thinking appertaining to psychological insights and traditions derived from the cultures of the Global South, indicating differences overall between 'Western' and 'non-Western' approaches.

2

Varieties of Global Psychology: Cultural Diversity and Constructions of the Self

Laurence J. Kirmayer, Ademola Adeponle and Vivian Afi Abui Dzokoto

Introduction

Psyche, self and person are the focus of the psychological sciences that seek to understand human behavior and experience through models of internal structure and interpersonal process. Throughout most of its history as an academic discipline, psychology has used Western subjects as the basis for research and theory building. Indeed, the great majority of studies have worked with university students who represent a limited range of social and cultural variation (Heinrich et al. 2010). The resultant models are shot through with assumptions about the nature of the person that are mostly presented in psychology textbooks as universal truths rather than contextualized in time

L. J. Kirmayer (✉) · A. Adeponle
McGill University, Montreal, QC, Canada

V. A. A. Dzokoto
Virginia Commonwealth University, Richmond, VA, USA

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_2

and place. In contrast, there are rich literatures in philosophy and social sciences on the self, and ethnographic studies that examine wide cultural variations in constructions and construals of the self and personhood that influence everyday functioning and that underwrite various forms of healing and psychotherapy. These local 'ethnopsychologies' are rooted in particular cultural ontologies—assumptions about what the world is made up of, the sources and kinds of agency, and available modes of explanation and understanding of human action and experience. Respecting the diversity of these traditions begins with recognizing the cultural historical origins and assumptions of academic psychology.

Western academic psychology developed against the backdrop of colonialism, which subordinated or suppressed the perspectives of other peoples, cultures, and communities in favor of the implicit norms and values of Euro-American individualism. This history of marginalization is inscribed deeply in the language and logic of psychology. At the same time, the forces of colonization have also shaped the psychological dynamics of colonizer and colonized. Of course, in addition to European and American colonialism, other regional ethnic, cultural, and religious groups have been colonizing powers or subordinated other peoples in Africa, Asia, and the global south. Moreover, inequality and inequities did not end with the formal end of colonization. Global regimes of domination continue to shape the lives and subjectivities of peoples in health and illness, but the new vehicles of domination include mass media and electronic telecommunications driven by the human appetite for novelty and the engines of consumer capitalism. Unraveling the knots and contradictions of the pathologies of power and domination requires cultural historical reflection to clear a space where the voices of the subjugated can be heard and where the diversity of traditions can provide alternate psychologies with different views of interiority, identity, and functioning in health and illness.

In this chapter, we interrogate some assumptions of Western psychology to open up a broader conversation about the diversity of human experience in health and illness. Our approach draws from cultural constructivist and critical anthropological perspectives that view notions of self as situated and shaped by local interpretive practices inscribed

within and constrained by larger histories and political economic contexts (Kirmayer 2006). We view notions of self as cultural constructions that reflect collective understandings of experience and behavior. These practices involve embodied experience, modes of discourse, and social contexts or institutions that provide the cultural affordances through which we navigate the world (Kirmayer and Ramstead 2017). By laying bare these contexts, we can show some of the building blocks of psychological structure and function, the range of methodologies needed to advance this exploration, and the political constraints that continue to marginalize or silence diverse voices and perspectives.

This chapter begins with an exploration of the social and cultural roots of Western (Euro-American) ideas of the self, and of academic psychology as a Western institution. We then review some current approaches in psychology to constructions of self. Next, we consider the ways that ideas of the self and personhood in non-Western cultures are linked to prevailing worldviews, ontologies, and epistemologies. We illustrate these cultural concepts of self and personhood with examples from African, Asian, and Indigenous North American cultures. In particular, we note the shift from viewing ethnopsychologies as variants of a fundamentally Western theory of the self, toward efforts to elaborate indigenous psychologies based on the different cultural premises. We conclude with some implications of globalization and cultural hybridization for understanding constructions of self, and what this portends for work in global mental health.

What Is Psychology?

Psychologies are stories of the self in time, ways of narrating our experience and behavior that explain the basis of our actions. As such, they mirror local concepts of the person. The sense of self is the interior experience of personhood, which may be reified as mind or 'the psyche' in everyday explanations, academic psychology, or therapeutic discourse. When it is congruent with expectations of the individual and their milieu, many aspects of the self are tacit or implicit. Problems in functioning, whether due to internal dysfunction (illness or

psychopathology) or social conflict lead people to mobilize available cultural models to make sense of their experience or the behavior of others.

Constructions of the self vary across cultures, in part reflecting differences in the ways individuals understand and experience personhood (Mauss 1985). Notions of the individual, self and person are key concepts in psychology and psychiatry and inform definitions of psychopathology and mental illness, norms for acceptable social behaviors, and approaches to managing conflict and healing (Kirmayer 2007). Concepts of self and personhood locate the individual in society, and underlie ascriptions of causality and agency in health and illness. In our usage, the *individual* refers to the person as a distinct entity; the *self* refers to individuals' awareness of their own identity, experience and consciousness; and the *person* refers to the social identity accorded to the individual in sociocultural context. An examination of the ways that notions of individual, self, and person are articulated and deployed in discourse about afflictions reveals cultural understandings of the etiology of mental disorders, their social consequences, and corresponding healing practices.

The Hegemony of Western Psychology: Colonial and Postcolonial Selves

European colonialism exerted profound effects on societies, devaluing, denigrating, and in many cases violently suppressing local culture and ways of life. In the process, colonizers installed hierarchies that created new kinds of identity and modes of being. A literature on the psychology of colonization has examined the deforming effect of these colonial regimes and critical postcolonial studies have explored their enduring traces and transformation with globalization (Lazarus 2011; Okazaki et al. 2008).

Appropriation of colonized lands, subjugation of Indigenous peoples, and institutions of colonialism, slavery and exploitation were justified by doctrines of the primitive, inferior, or subhuman status of others. Dominant group membership was associated with being a 'true' human,

while colonized groups were disparaged as being incomplete rather than 'full' persons, and were deprived of dignity, self-determination, social protection, and often robbed of life itself through systematic violence or genocide. The distinction between colonizer and colonized was marked by language (*barbarians* whose speech was coarse and unclear), culture (*uncivilized* people with crude or unrefined manners), and religion (*heathens*), but especially by physical appearance (skin color, hair, and facial features) through racialized identities treated as inherent or intrinsic to a group (Smedley and Smedley 2005). In the racial hierarchies set up by European colonization and imperialism, Whiteness was associated with a superior self, Blackness was the mark of otherness and inferiority, and gradations of skin color came to mark social status. The notion of moral, intellectual and cultural inferiority, framed in terms of biology in the scientific discourse of the time, justified the total domination and exploitation of the colonized and enslaved.

These societal forces have had profoundly damaging influences on the experience of colonized peoples, including deformations of the self. Selfhood for the colonized was experienced as in a state of internal division, resulting in self-doubt, self-deprecation, and inner turmoil. W.E.B. Du Bois (1903/2008) captured this phenomenon in the experience of the African American self, describing it as a state of double-consciousness, in which the person is constantly torn between two incongruent modes of awareness. Frantz Fanon (1967) described how this self-estrangement could arise from internalization of the misprisioning gaze of the other.

Though many of the institutions of colonialism have been dismantled—albeit only to be replaced by other local and global forms of exploitation and oppression—significant remnants of colonial hierarchies continue to shape subjectivities of self and personhood. The colonial mindset can be seen in everyday behaviors such as skin bleaching practices by women in Africa and the diaspora, as well as in less visible biases such as internalized stereotypes that influence everyday functioning (Steele 2010).

Postcolonial theorists and writers have stressed the importance of reclaiming and reconstructing the self beyond the constraints imposed by colonial perspectives (Césaire 1955). Ngũgĩ wa Thiong'ō (1986)

highlighted the importance of establishing agency of the self by communicating in one's indigenous language rather than the language of the colonizer. By choosing to communicate in one language over the other, he argued, one controls the cultural, political, and historical lens through which one sees oneself and engages with one's world. Many writers have discussed the complexities of navigating, challenging, transforming or transcending racialized, ethnic, national, religious, or other kinds of identities whose boundaries were shaped and defined by colonial histories (Loomba 2015). This literature makes it clear that attention to history and politics is essential for rethinking global psychologies.

Self-Construction and Construal

The premise that constructions of the self vary across cultural contexts is linked to understandings of differences in patterns of social relationships. Different histories, ecologies, cultural practices, and institutions within societies result in different social rules, expectations, and values or 'prevalent cultural mandates' (Kitayama et al. 2010, p. 1) that define what it means to be a well-functioning member of a society. These cultural ideologies or orientations result in implicit and explicit social norms and practices that influence how individuals see themselves and others and that serve as templates to organize everyday thoughts, feelings, and actions.

In a series of influential papers, Markus and Kitayama (1991, 2010) contrasted two markedly different templates through which individuals understand and experience personhood: the *interdependent self*, which they saw as typical of many cultures of East Asia, and the *independent self*, characteristic of Western (Europe and North America) settings. The interdependent construction of the self sees the person as strongly connected to others in the immediate social network, and these others are experienced as an important, even intrinsic, part of the self. As a consequence, while individual qualities, aspirations, and autonomy are important for the interdependent self, their expression is continually influenced by the actual and perceived presence, goals, and reactions of

others. Belonging to the group is a central component of interdependent identity, and fitting in (rather than sticking out), and avoiding (or minimizing) social friction or conflict are important drivers of behavior in such cultural settings. In contrast, while social others are important for self-evaluation in Western cultural settings, they are less central to the experience of self and performance of personhood. In Western contexts, the individual's uniqueness and reflexivity (individual-focused attention, self-knowledge, self-expression, self-direction, self-validation, and self-promotion) are key drivers of internal experience as well as expressed behavior. These differences result in variations in basic psychological processes including the fundamental attributional bias that emphasizes individual rather than contextual explanations for behavior and self-enhancement biases that are held to maintain self-esteem (Heine 2001, 2015).

While a large body of research on cultural differences involving the self has been based on this contrast of interdependence/interdependence, this approach has important limitations. A single dichotomous contrast seems woefully inadequate to capture the wide cultural variations in notions of self and personhood. Indeed, the simple dichotomy of East and West seems particularly misleading, since it tends to exaggerate differences in terms of poles on a continuum defined by an academic social and personality psychology heavily underwritten by Euro-American individualism. Of course, there is great variation within any culture or society and, across studies, East Asian samples do not consistently score as more interdependent than Western samples. Culture also intersects with other basic dimensions of social identity and position including socioeconomic status, gender, and ethnic minority status, all of which may also influence interdependence. Moreover, culture does not simply determine the self. Selves (and therefore associated internal psychological processes) and cultures (through institutions, cultural products, and ideologies) are mutually constitutive and continually interacting with each other (Markus and Kitayama 2010). Individuals may challenge, resist, and reframe cultural mandates to create new modes of being. At the same time, social, environmental, and technological changes reshape

cultures over time. Thus, Oishi (2010) found that in many contexts, residential mobility, rather than cultural group of origin, predicted the prominence of collective versus individual-focused modes of self because mobility shapes the perceived permanence of social relationships.

In a recent study, with a sample of 55 cultural groups drawn from 33 countries in different regions of the world, Vignoles and colleagues (2016) found that independence and interdependence were not unidimensional but could involve variations across seven different contexts or domains of functioning: self-definition (the degree to which an individual experiences and defines the self as different versus similar to others); self-experience (the degree to which an individual experiences and defines the self as self-contained versus connected to others); decision-making (the degree to which an individual's decision-making processes are influenced by others); looking after oneself (the degree to which an individual meets their needs through self-reliance versus dependence on others); the degree of consistency/variability when moving between contexts; the degree of focus on self-expression versus harmony when communicating with others; and when dealing with conflicting interests. This approach allows for a more nuanced exploration of cultural modes of self-construal and highlights the need for a multidimensional and contextual view.

Concepts of Self and Personhood in Non-Western Cultures

Discussions of self and personhood in non-Western cultures contrast Western psychology with local ethnopsychologies in terms of the qualities that define a good, well-functioning person. A common starting point is making explicit comparison to Western European *individualism* with its emphasis on the centrality of the individual and the values of independence, autonomy, and self-direction, and individual accomplishments. In contrast, people in many cultures construe the person in terms of an ethos of *collectivism* or *communitarianism*, which emphasizes

group orientation and sociability, through values of social relatedness, and connectedness to family, lineage, clan, or community (Triandis, et al. 1988). While the autonomous self of individualism is highly prized in the modern Western countries of Europe and North America, notions of a *sociocentric* self, defined in relational terms, are more central in many Eastern and African cultures as well as among Indigenous peoples in the Americas and elsewhere (Appiah 2004; Bharati 1985; Kitayama and Park 2007).

Many traditional East and Southeast Asian cultures emphasize relatedness with others in the definition of the person, and hold commitment to relationships as the ultimate expression of self and personhood. They affirm notions of self and personhood that emphasize values or traits, such as attentiveness, humility, respectfulness, dependence, empathy, self-control, moderation, nurturance, dutifulness, self-sacrifice, conformity, traditionalism, and cooperativeness (Church 2000). These values may be experienced and expressed in terms of culture-specific emotions that reference salient social situations and appropriate, normative, or ideal responses. In traditional Chinese culture, the word '*ren*' refers to character or personhood, and denotes a social being who expresses self through mature commitment to family or some larger social group (Tu 1985). Similarly, the Korean concept of *cheong* (a kind of lingering feeling of attachment to persons, objects, and places that the person has experienced) has been described as one of the most commonly felt dimensions of daily life (Choi and Choi 2001). As a cultural orientation, '*cheong* embodies the socioemotional links among individuals connected to each other by feelings of we-ness and exhibiting the humanistic side of their selves' (Choi and Choi 2001, p. 80). What is common to many of these value systems is an emphasis on the self in terms of its social embeddedness and connection to others. As a result, in sociocentric cultures, mental disorders are related to ruptures in social relationships with family, community, ancestors, or nonhuman agencies (e.g., spirits), and healing interventions are targeted at repairing relationships, affirming the person's connectedness to family and community, and restoring the social order.

Sociocentric notions of self and personhood are also found among African peoples and cultures (Mbiti 1969). Among the Yoruba, for example, the terms of '*omoluabi*' and '*iwapele*' describe a person of good character and inform the basis of moral conduct. An *omoluabi* is a person of integrity, who has respect for the rights of others, goodwill toward them, and gives to the community (Abimbola 1975). The Bantu term '*ubuntu*' ('humanity towards others') has been elaborated as a grounding concept for a kind of humanistic philosophy in southern Africa (Eze 2008). *Ubuntu* affirms that one becomes a human being by recognizing the humanity of others, and on that basis, establishes humane relationships with them. From the perspective of Ubuntu, it is participation in society that gives human beings their humanity.

Although the contrast between individualism and collectivism has been supported by a large body of research, there are many other concepts of personhood that inform local ethnopsychologies and shape experiences of suffering and healing. In addition to the many other versions of *ensembled* individualism (Sampson 2000), these include the *ecocentric* self that emphasizes connections to the land and the environment, and the *cosmocentric* self that emphasizes connection to the world of departed ancestors and spirits (Kirmayer 2007).

An ecocentric sense of self and personhood has been described among many indigenous peoples who view the individual as part of a much larger web of life (Kirmayer et al. 2008). In this framework, people understand themselves to be in constant transaction with the environment that includes nonhuman persons (e.g., animals and the elements), which have their own agency and perspectives (Kirmayer et al. 2008). As hunting or agrarian societies, indigenous peoples recognized their interdependence with the land and viewed the relationship as filial, essentially one of mutual caretaking rather than simply resource extraction. In consequence, illness and adversity could result from disruptions in the harmonious balance existing between humans and the land or other nonhuman agencies. In traditional shamanistic healing practices, associated with hunting cultures, the healer derived his powers from animal helpers, who allowed the healer to restore the necessary balance and reciprocity between the afflicted person or the

community and the natural world (Vitebsky 2001). The natural world also provides models and metaphors for recovery, which may then be viewed not so much as a personal achievement but rather as a gift from these other-than-human beings. Thus, compared with the individualist or collectivist accounts of recovery, agency includes a nonhuman order, with which humans must maintain good relations, in part, through ceremonial practices.

Cosmocentric notions of self and personhood are found in cultures that view the person as embedded in a larger cosmic order, which may include ancestors, spirits, or gods, as well as the forces of nature. Many ethnic groups in West Africa have cosmologies that locate humans as links between the natural world (inhabited by the physical elements, plants, and animals) and the supernatural world (inhabited by spirits, ancestors, and gods). These cosmic agents act as guardians of tradition, ethics, and the social order, and thus have a major influence on a person's life. They also protect against malevolent agents and inflict punishment for transgressions, which can account for many forms of affliction (Kpanake 2015). In Yoruba belief, for example, a person is comprised of three dimensions: the *ara* (body), *emi* (spirit/soul), and *ori* (essence), each of which is considered as agentic (Adeofe 2004). The individual's distinctive qualities and destiny come from the *ori*, also considered a deity, though distinct from the spirits of ancestors and religious deities. Ongoing relationships with these deities give rise to individual personality, as well as to afflictions and the process of healing. Similar notions of cosmic agencies contributing to personhood abound among many other African peoples. A major aspect of African traditional healing, then, is the understanding that illness is caused by external and supernatural agents and associated with ruptures in relationships (with family and extended kin, but also with ancestors or spirits). Hence, an important focus of healing is repair of these relationships, reordering the individual's social networks and ancestral relations (Bojuwoye 2015). Healing practices associated with cosmocentric concepts of the person may employ methods of divination to determine what has gone wrong in the relationship with gods or ancestors, and to identify appropriate actions to restore harmony with the cosmic order (Adeponle et al. 2012; Kpanake, in press).

Postcolonial, Indigenous, and Postmodern Psychologies

Recognizing the cultural diversity of concepts of the person is one step toward decolonizing psychology. Taking these ways of being seriously allows us to introduce new concepts into our theories of human nature and functioning. However, in many instances, the accounts generated by psychologists within diverse societies have been shaped by a dominant set of values derived from Western (Euro-American) societies. The consequence is that alternate ways of being human are discounted, ignored, or reduced to caricatures.

Recent years have seen efforts by academic psychologists and practitioners to articulate a variety of indigenous psychologies. The term *indigenous*, in this context, does not refer to Indigenous peoples, but to the effort to rethink human nature from alternate frameworks anchored in cultural values distinct from those that are central to Western psychology. Some of this work is implicit in the comparative study of varieties of personhood described above. However, in renaming this effort 'indigenous psychologies', the point is not simply to characterize alternate approaches by contrasting them with Western models, but to identify distinctive structures, dimensions, and processes that arise from indigenous worldviews and explore their implications for psychology (Moghaddam 1987). This alternate worldview may be articulated in terms of specific forms of life (characterized in terms of social institutions, values, and practices) and corresponding ontologies (notions of what the world is made up of, including, for example, particular elements and energies). The hope is that these approaches will yield psychologies that better fit the values and aspirations of each cultural community as well as contributing to a much richer and more diverse picture of the human condition.

Many of these approaches to indigenous psychology also make epistemological claims about the sources of knowledge and the ways in which we can come to know ourselves (e.g., Liu 2017). This poses challenges to the production of evidence in mental health (Kirmayer 2012). Ultimately, indigenous psychologies cannot be viewed as hothouse

flowers, nurtured in isolation, but as alternative modes of being that coexist in a complex global or planetary ecosystem, in which cultural diversity, hybridity, and mutual transformations are driven by powerful political and economic forces as well as new information and communication technologies that are changing the social landscape.

Conclusion

Constructions of the self are shaped by ontological assumptions about the kinds of entities there are in the world and epistemological claims about the ways we can know them. In this way culture, as a system of meanings and set of tools for self-fashioning, comes to shape individuals' experience, and provides vehicles for navigating, articulating, explaining, adapting to and challenging their reality or worldview. Attention to worldviews and to their ontologies and epistemologies is therefore essential to understanding how self-narratives—and corresponding psychologies—vary across cultures.

Social constructivist perspectives emphasize that the self is constituted and configured by social contexts and discursive practices, as well as cultural, historical, economic, and political dynamics (Bauman and Raud 2015). The crucial implication for global mental health is that the histories of colonialism and the political economy of globalization, with all of the inequities and possibilities they engender, as well as everyday engagements with hierarchies of power and privilege, all shape experiences of self and personhood, including the sense of agency, internal psychological dynamics, intersubjectivity, and social being. The resultant cultural variations in self and personhood can contribute both to the processes of psychological dysfunction and to modes of coping, adaptation, and healing (Kirmayer 2004).

Postcolonial critiques of a hegemonic Western psychology have contributed to the recognition of diverse ways of being human, each with its own virtues and limitations. Rebuilding psychological theory from indigenous perspectives can provide us with approaches that better capture the realities of people around the globe and allow mental health

practitioners and others to respond more effectively to their needs and concerns. At the same time, every cultural variation provides insights into human potentiality—both to current realities ignored by dominant ideologies and to future possibilities. We need to respect this diversity to work toward greater equity and to respond to the profound challenges we will all face on this planet in the years to come.

References

Abimbola, W. (1975). Iwapele: The concept of good character in Ifa literary corpus. In W. Abimbola (Ed.), *Yoruba oral tradition: Poetry in music dance and drama*. Ibadan: University of Ibadan Press.

Adeofe, L. (2004). Personal identity in African metaphysics. In L. M. Brown (Ed.), *African philosophy: New and traditional perspectives* (pp. 69–83). New York: Oxford University Press.

Adeponle, A. B., Whitley, R., & Kirmayer, L. J. (2012). Cultural contexts and constructions of recovery. In A. Rudnick (Ed.), *Recovery of people with mental illness: Philosophical and related perspectives* (pp. 109–132). New York: Oxford University Press.

Appiah, K. A. (2004). Akan and Euro-American concepts of the person. In L. M. Brown (Ed.), *African philosophy: New and traditional perspectives* (pp. 21–32). New York: Oxford University Press.

Bauman, Z., & Raud, R. (2015). *Practices of selfhood*. Cambridge: Polity Press.

Bharati, A. (1985). The self in Hindu thought and action. In A. J. Marsella, G. DeVos, & F. L. K. Hsu (Eds.), *Culture and self: Asian and Western perspectives* (pp. 185–230). New York: Taylor & Francis.

Bojuwoye, O. (2015). Counseling and psychotherapy in Nigeria: Dayo's story. In R. Moodley, M. Lengyell, R. Wu, & U. Mazablo (Eds.), *International counseling case studies handbook* (pp. 31–33). Alexandria: American Counseling Association.

Césaire, A. (1955/1972). *Discourse on colonialism*. New York: New York University Press.

Choi, S. C., & Choi, S. H. (2001). *Cheong*: The socioemotional grammar of Koreans. *International Journal of Group Tensions, 30*, 69.

Church, A. T. (2000). Culture and personality: Toward an integrated cultural trait psychology. *Journal of Personality, 68*(4), 651–703.

Du Bois, W. E. B. (1903/2008). *The souls of black folk*. Oxford: Oxford University Press.

Eze, M. O. (2008). What is African communitarianism? Against consensus as a regulative ideal. *South African Journal of Philosophy, 27*(4), 386–399.

Fanon, F. (1967). *Black skin, white masks*. New York: Grove Press.

Heine, S. J. (2001). Self as cultural product: An examination of East Asian and North American selves. *Journal of Personality, 69*(6), 881–905.

Heine, S. J. (2015). *Cultural psychology* (3rd ed.). New York: W. W. Norton.

Heinrich, J., Heine, S. J., & Norenzayan, A. (2010). Beyond WEIRD: Towards a broad-based behavioral science. *Behavioral and Brain Sciences, 33*(2–3), 111–135.

Kirmayer, L. J. (2004). The cultural diversity of healing: Meaning, metaphor and mechanism. *British Medical Bulletin, 69*(1), 33–48.

Kirmayer, L. J. (2006). Beyond the 'new cross-cultural psychiatry': Cultural biology, discursive psychology and the ironies of globalization. *Transcultural Psychiatry, 43*(1), 126–144.

Kirmayer, L. J. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry, 44*, 232–257.

Kirmayer, L. J. (2012). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. *Social Science and Medicine, 75*(2), 249–256.

Kirmayer, L. J., & Ramstead, M. J. (2017). Embodiment and enactment in cultural psychiatry. In C. Durt, T. Fuchs, & C. Tewes (Eds.), *Embodiment, enaction, and culture: Investigating the constitution of the shared world* (pp. 397–422). Cambridge, MA: MIT Press.

Kirmayer, L. J., Fletcher, C., & Watt, R. (2008). Locating the ecocentric self: Inuit ethnopsychology, identity and community. In L. J. Kirmayer & G. G. Valaskakis (Eds.), *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp. 289–314). Vancouver: University of British Columbia Press.

Kitayama, S., Karasawa, M., Curhan, K. B., Ryff, C. D., & Markus, H. R. (2010). Independence and interdependence predict health and wellbeing: Divergent patterns in the United States and Japan. *Frontiers in Psychology, 1*, 163.

Kitayama, S., & Park, H. (2007). Cultural shaping of self, emotion, and well-being: How does it work? *Social and Personality Psychology Compass, 1,* 202–222.

Kpanake, L. (2015). Counseling and psychotherapy in West Africa: Mazabalo's story. In R. Moodley, M. Lengyell, R. Wu, & U. Mazablo (Eds.), *International counseling case studies handbook* (pp. 23–30). Hoboken: Wiley.

Kpanake. L. (2018). Cultural concepts of the person and mental health in Africa. *Transcultural Psychiatry, 55*, 198–218.

Lazarus, N. (2011). *The postcolonial unconscious*. Cambridge: Cambridge University Press.

Liu, J. H. (2017). Neo-Confucian epistemology and Chinese philosophy: Practical postulates for actioning psychology as a human science. *Asian Journal of Social Psychology, 20*(2), 137–149.

Loomba, A. (2015). *Colonialism/postcolonialism* (3rd ed.). London: Routledge.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98,* 224–253.

Markus, H. R., & Kitayama, S. (2010). Culture and self: A cycle of mutual constitution. *Perspectives in Psychological Science, 5,* 420–430.

Mauss, M. (1985). A category of the human mind: The notion of person; the notion of self (Originally published in 1935). In M. Carrithers, S. Collins, & S. Lukes (Eds.), *The category of the person: Anthropology, philosophy, history* (pp. 1–25). New York: Cambridge University Press.

Mbiti, J. S. (1969). *African religion and philosophy*. London: Heinemann.

Moghaddam, F. M. (1987). Psychology in the three worlds: As reflected by the crisis in social psychology and the move toward indigenous third-world psychology. *American Psychologist, 42*(10), 912.

Oishi, S. (2010). The psychology of residential mobility: Implications for the self, social relationships, and well-being. *Perspectives on Psychological Science, 5*(1), 5–21.

Okazaki, S., David, E. J. R., & Abelmann, N. (2008). Colonialism and psychology of culture. *Social and Personality Psychology Compass, 2*(1), 90–106.

Sampson, E. E. (2000). Reinterpreting individualism and collectivism. Their religious roots and monologic versus dialogic person-other relationship. *American Psychologist, 55*(12), 1425–1432.

Smedley, A., & Smedley, B. D. (2005). Race as biology is fiction, racism as a social problem is real: Anthropological and historical perspectives on the social construction of race. *American Psychologist, 60*(1), 16–26.

Steele, C. M. (2010). *Whistling Vivaldi: And other clues to how stereotypes affect us and what we can do*. New York: W. W. Norton.

Triandis, H. C., Bontempo, R., Villareal, M. J., Asai, M., & Lucca, N. (1988). Individualism and collectivism: Cross-cultural perspectives on self-ingroup relationships. *Journal of Personality and Social Psychology, 54*(2), 323.

Tu, W. M. (1985). Selfhood and otherness in Confucian thought. In A. J. Marsella, G. Devos, & F. L. K. Hsu (Eds.), *Culture and self: Asian and Western perspectives* (pp. 231–251). New York: Tavistock.

Vignoles, V. L., Owe, E., Becker, M., Smith, P. B., Easterbrook, M. J., Brown, R., et al. (2016). Beyond the 'East–West' dichotomy: Global variation in cultural models of selfhood. *Journal of Experimental Psychology: General, 145*(8), 966–1000. https://doi.org/10.1037/xge0000175.

Vitebsky, P. (2001). *Shamanism*. Norman: University of Oklahoma Press.

wa Thiong'o, Ngũgĩ. (1986). *Decolonising the mind: The politics of language in African literature*. Portsmouth, NH: Heinemann.

3

Reflections on African and Asian Psychologies

Suman Fernando

Introduction

This chapter is written from the perspective of a psychiatrist who practiced for many years in a multicultural region of London (UK) and been deeply interested in issues of 'race' and culture in the mental health services of the UK (see Moodley and Ocampo 2014). It begins by discussing some of the underlying issues involved in exploring the varieties of psychology that have arisen in cultural settings outside the West (for discussion of the concepts 'The West' and 'The Rest', see Stuart Hall 1996, pp. 186–187). The understanding of what exactly is meant by health and illness tends to vary across cultures. First, general cultural issues are considered, in particular, the cultural tendency to medicalise social problems and to use an 'illness model' for analysing problems of living (see Fernando 2014). This leads naturally to consider three particular topics—holism, spirituality and the notion that health results from a balance of forces impinging on the human being—each dealt with separately.

S. Fernando (✉)
London Metropolitan University, London, UK

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_3

General Cultural Issues

Although many different cultural forms and systems have developed across the world, few, if any, cultures have grown up in total isolation from others. All the major cultural groups have influenced each other historically and continue to do so in the present. Generalisations about cultural difference or similarity inevitably oversimplify and do not do justice to the cultural variety in human society resulting from the propensity of human beings to socialise, trade and form personal relationships with each other—and of course, oppress or make wars for a variety of reasons—for as long as we know. Yet, some generalisations are necessary to make sense of our culturally diverse world, although caution is necessary in how these are applied. As a result of the forces of globalisation as well as the earlier colonial period, the culture of an individual today in many parts of the world is often hybrid/mixed and not tied up very strongly with what is seen as their 'heritage' or 'cultural background'. Today, the apparent locations of cultural origin of an individual, whether Eastern, Western, Asian, African and so on, should be seen (when applied to an individual) as a 'states of mind' rather than geographical regions—as (Kakar 1984), states about East–West difference (p. 5)—and great care should be taken in making cultural identification by visually apparent 'race', for example, by skin colour difference.

In spite of the problems inherent in making generalisations (and accepting their limitations), this chapter begins by comparing the traditions of 'Western culture' with two other groups of cultures, namely 'African' and 'Asian' (or 'Eastern') traditions. The Islamic culture (a culture that was dominated by a religious movement, just as European culture was dominated by Christianity) linked often to the geographical area called by Europeans the 'Middle East' (mainly western Asia to everyone else)—in effect just south of (and hence very near) Europe—is, for the purpose of this chapter, included within 'Asian' cultures although admittedly its influence spread into much of the African continent and parts of both Asia and Europe. The indigenous (pre-Columbian) cultures of America, cultures of indigenous Australians, the Māori people of Aotearoa/New Zealand and various other peoples, such as the

Polynesians, are not considered in this chapter in the interests of brevity. In fact, this chapter is in no way a comprehensive comparison (of cultures) but a limited one for the purposes of drawing together some ideas that may help readers to understand the wider topic of cultural diversity of what is generally referred to as 'psychology', which after all is about understanding the human 'psyche' or mind.

Western Cultures

The worldview of a people derives from both its historic past and its current functioning vis-à-vis other groups of people. Ancient Greece is the fountainhead of Western culture but its original tenets have undergone changes over the years. Very early on, the mystic vision of the ancient Greeks became distorted and fragmented (Graham 1986). By the time it was transformed into Western civilisation, via the Romans, measure came to denote 'mainly a process of comparison with some arbitrary external standard … [so that] knowledge or *scientia* … meant objective fact, and that such facts constitute[d] the only valid knowledge of the world' (p. 4, italics in original). So the intellectual heritage of Western culture 'has its foundations in a linear model of knowledge, implicit in which is the notion of absolute truth or fixed reality, and from its concepts of measure and ratio it also derives its emphases on measurement and standardisation, rationality and reason, all of which involve dissection' (p. 4)—the reduction of problems to the smallest possible components.

In the West, health is felt as something that is attained by control and domination, in keeping with a worldview that emphasises control—of emotion by reason, of nature by people, and of 'them' by 'us'. The Western concept of health is a matter of overcoming illness—destroying 'pathology'. The worldviews of Asia and Africa promote a sense of health arising from *acceptance*— of emotion, of nature, of 'others'. Together with this, there is a striving for harmony; both within a person and between people and their surroundings in 'nature', the spirits and the cosmos—a way of thinking that is often dismissed in the West as

'superstition'. In most cultures that developed outside the West, religion, medicine and ethics are integrated together and a sharp dichotomy between mind and body (in the Western sense) is not evident (Fernando 2010). Further, the distinctions between psychology, philosophy and religion are very recent developments even in Western cultures and their export to non-Western cultural areas were part of cultural imperialism during colonisation and more recent globalisation (Fernando 2014). For example, in Hindu culture as epitomised in the *Bhagavad Gita* —the most popular version in English is that translated by Swami Prabhavnanda and Christopher Isherwood (1947)—'[p]hilosophy and psychology are intermingled. Without the help of psychology—knowing, analysing and learning to use our inner potentials—we cannot fulfil the goal of human life: Self-realisation' (Rama 1985, pp. 1–2). Although Greek civilisation had Afro-Asiatic roots (Bernal 1987), its philosophy developed very differently to that in African and Asian cultures, mainly because Greeks excluded religion and morality in forming a 'secular worldly science' (Diop 1967, p. 231).

The Cartesian–Newtonian model and the scientific paradigm of the eighteenth and nineteenth centuries (Table 3.1) dominates traditional Western thinking in much of the discourse in (Western) psychology and psychiatry which developed during the eighteenth century (see Fernando 2010, 2014). The fundamental belief in Western culture that has persisted and still underpins its current illness models (of clinical psychology and psychiatry) is what Ryle (1963) calls the 'official doctrine which hails chiefly from [the theories of] Descartes … the dogma of the ghost in the machine … maintains that there exist both bodies and minds; that there occur physical processes and mental processes; that there are mechanical causes of corporal movements and mental causes of corporal movements' (pp. 13–23). In separating mind from matter, Descartes enabled scientists to study matter without reference to themselves as human beings. Then, Newtonian physics led to a mechanistic worldview. The natural world became a mechanical system to be manipulated and exploited; living organisms were seen as machines constructed from separate parts, each part being broken into further divisions. Finally, there emerged the view of mind as an objective 'thing' to be studied by objectified methods.

Table 3.1 Scientific paradigm

BELIEFS
POSITIVISM
Reality is rooted only in what can be observed
CASUALITY
Nothing occurs randomly
Natural causes for all events and effects
OBJECTIVISM
Feelings, thoughts etc. regarded as objects
RATIONALITY
Reason superior to emotion
All assertions verifiable by logical proof
APPROACHES
MECHANISTIC
Newtonian physics as opposed to modern physics
REDUCTIONIST
Sum of the parts equals to whole
LOGICAL REASONING
Intellectual exercise

From Fernando (2010), p. 54

Table 3.2 Medicalization across cultural traditions

Tradition	Location of illness	Causation of illness	Illness vs patient
Western	Mind or body individual	Genetic-bio-medical natural events	Separate
Ancient Greek	Mind plus body individual	Humoral	Integrated
Islamic	Mind plus body individual	Humoral-biological blended with spirituality and external influences	Partly integrated
Asian/African	Mind-body-spirit holistic	Humoral-imbalance spiritual influence	Integrated

Adapter from Fernando (2014), p. 28

Although medicalisation of human problems—problems of living—which are then seen in terms of 'illness' that requires intervention' (as 'treatments') has gone much further in the West than it has in other parts of the world, some degree of medicalisation is an universal phenomenon (Table 3.2).

Both African and Asian traditions are different in major overarching respects—the importance in the latter of spirituality in various forms,

their tendency towards holism and the primary place they give to the concept of *balance* in matters concerning health and ill-health. Holism and spirituality are discussed in separate sections (below). In simple shorthand, non-Western cultural traditions see health as a harmonious balance between various forces in the person and the social context, while Western traditions see health as individualized sense of well-being. So, the Chinese way of thinking sees all illness as an imbalance of *yin* and *yang* (two complementary poles of life energy), to be corrected by attempts to re-establish 'balance' (Aakster 1986); the Indian tradition emphasises the harmony between the person and their group as indicative of health (Kakar 1984); and the concept of health in African culture is more social than biological (Lambo 1969). Thus in non-Western traditions, balance—or rather its lack—is the crucial element in determining ill-health. A truly balanced person, balanced in terms of mind, body and spirit, is a healthy one.

African Cultures

A major problem for this section is that a reliable body of information on the background and traditions of Africa is not available for several reasons (Karenga 1982): The subject is vast and relatively un-researched; the sources of history in most parts of Africa were 'griots', professional oral historians who held the collective memory of a community or nation—a vulnerable form of record keeping; and European conquest led to the destruction of many documents and evidence of African achievement and (even more importantly) to the distortion of history to fit into racist models of African primitiveness. Before the appearance of Cheikh Anta Diop's (1967) book *African Origin of Civilization*, African culture was expounded by Western scholars enveloped in an ideology that distorted history and 'cast a fog over cultural understanding of the African people' (Asante and Asante 1990, p. ix). African studies that attempt to avoid racist assumptions and examine the evidence objectively are a recent phenomenon. Similar drawbacks (the distortions resulting from White supremacy ideologies and racist attitudes)—all be it to a lesser extent—are evident in

exploring other non-European traditions. For example, it is difficult to generalize about the thinking in traditional (Native) American cultures, either in the past or the present.

It is clear that the origins of African tradition are intimately connected with the wisdom of ancient Egypt, called originally 'Kemet', the black settlement, inhabited by Kemites, the black people (Carruthers 1986). Egyptian civilisation itself was derived from other black peoples to the south of Egypt (Williams 1974) and 'what emerges clearly from the evidence is that indigenous Black Africans developed the whole Nile valley including Egyptian civilisation' (Hilliard 1986, p. 135). Egyptian and Yoruba culture of West Africa have links in terms of religion, language and customs (Lucas 1948). M. K. Asante (1985) writes that the Wolof, the Yoruba, the Asante and the Ogiso of Benin are among the many tribes that have aspects of culture derived from ancient Egypt: 'The continent [of Africa] is replete with evidences of the influence of Egypt' (p. 6). There is evidence for a close relationship between the Egyptian language and languages to the south of Egypt (Wimby 1986); and, although widely separated from each other on the African continent, the languages of the Zulu (of South Africa) and the Yoruba (of West Africa) belong to the same language family, the Niger-Congo group of languages (Lawson 1984). Wimby (1986) reckons that Egyptian may be seen as the classical African language, equivalent to Latin as the classical language of Europe, with Swahili, Walaf and Hausa as the main contenders for being the *lingua franca* for African people. Although Egyptian civilisation has ceased to exist in its ancient form, it lives on in African culture; and African culture is not just in Africa, it extends across the Atlantic (Clarke 1985).

"Africa-consciousness", in varying degrees good and bad, has always been a part of the psyche of the African people, in forced exile in South America, the Caribbean Islands, and in the United States. There has always been a conflict within the Black American's 'Africa-consciousness'. This conflict was created early and was extended beyond all reasonable proportions by the mass media of the twentieth century through jungle movies, elementary textbooks on geography and history, and travel books written to glorify all people of European extraction—in essence, white people. These distorted images have created both a

rejection of Africa and a deep longing for the Africa of our imagination, the Africa that was our home and the first home of what man has referred to as "a civilisation" (p. 157).

According to Diop (1967), Kemetic knowledge was stripped of its moral values and religion (by the Greeks) to be secularised into becoming the European discipline of philosophy. But many Egyptian ideas were clearly absorbed into Greek civilisation and continue in the modern religions of Western Europe. For example, the doctrine of 'One God' and the concept that 'the Kingdom of God is within you' were taught in Egypt by Akhenaton around 1350 BC (Rogers 1972). The thinking of ancient Egypt gave pre-eminence to the notion of soul or spirit; and 'the Ka was the divine spirit which endowed all things and which survived past the physical life of the individual' (Nobles 1986, p. 110). The Ka was thought to have magical powers that could cause the dead to live again in the thoughts of the survivors and could animate a mummified being. In studying 300 peoples from all over Africa outside the traditionally Christian and Muslim communities, Mbiti (1989) found that 'without a single exception, people have a notion of God. … (I)n traditional life [all over Africa] there are no atheists' (Mbiti 1989, p. 29).

Karenga (1982) believes that religion has always been a vital part in the lives of African people in both Africa and the United States. The belief in one Supreme God as Father is widespread throughout Africa (e.g., Oludumare among the Yoruba, Nkulunkulu among the Zulu and Amma among the Dogon) and appears as Mother in matriarchical societies like the Ovambo in Namibia and the Nuba in Kenya. Africans engage in daily interaction with divinities, who are seen as God's intermediaries, 'both similar to and different from Jesus, angels and Catholic saints as intermediaries and assistants to the Supreme Being. It is this deference and exchange with the divinities which made the less critical assume African were polytheistic rather than monotheistic' (p. 162). Ancestors are venerated as the guardians of family traditions and ethics, and intermediaries between people and God. And, African traditional religion emphasises a balance 'between one's collective identity and responsibility as a member of society and one's personal identity and responsibility' (p. 162). In comparing contemporary Zulu and Yoruba

religions, Lawson (1984) finds that both show some similarities in their emphasis on ancestors as a source of power and the significance of sorcery and witchcraft. Other traditional themes in African religion noted by Karenga (1982) are the profound respect for nature and a belief in a collective immortality 'achieved through the life of one's people and through what one means to them' (p. 164).

Western Christianity came to influence Africans through the conversion of African slaves and the influx of missionaries into a continent where societies were being devastated by colonial conquest and internecine conflict. Although the church was clearly an arm of the slave-owning economy and racist colonialism, the doctrines of the Christian religion were gradually fashioned by Africans to be absorbed into their worldview. A distinctive Afro-American form of Christianity, a re-making of Christianity, has developed in the United States (Wilmore 1973) leading to a Black Liberation Theology allied to Black Power (Karenga 1982). And in South Africa, Black Theology as 'the perception that Jesus belonged historically in a situation of oppression, that he was a member of an oppressed people in an oppressive society, and that he came to set people free' (Stubbs 1988, p. 234), supports Black Consciousness in the modern African worldview.

Asian Cultures

The traditions of India, China and Western Asia ('Middle East') dominate the cultures that are generally termed 'Eastern', 'Oriental' or 'Asian'. In general, the traditions themselves remained for many centuries located in geographical areas—except for Islam. Although originating in the same area as Judaism and Christianity, Islam had, very early in its career, more contact with other traditions than any other major religion (Nasr 1980). The goal of all Eastern religions and psychology is enlightenment through individual striving and seeking, with emphases on personal, subjective experience and meditation. In general, the quest for understanding in Western thought is for facts, in the East for feeling. The Westerner seeks knowledge, the Easterner seeks to know. Systems of psychology/religion with a spiritual and mystical tradition

have flourished in the East for centuries giving rise to major religions that have spread worldwide; and the East continues to produce religious masters or 'gurus'. As Eastern ideas reach the West and get described in Western terms, they seem to become de-spiritualised and intellectualised—a drawback that may apply to much of the discourse in the English and other western languages.

Although the cultural traditions of the East, like those of Africa and (pre-Columbian) America, has been devastated by Western military might and economic greed, the basics of its cultural traditions have been maintained. Indeed, Islamic tradition appears to be vying with that of the West in terms of political influence, and the philosophies of India and China draw many Westerners seeking an alternative to the materialism of their scientific world. Although their origins are lost in time, they are not 'old' in the sense of being outdated or the opposite of 'modern'; according to Capra (1982), the spiritual tradition of the East is akin to the approach of modern physics. Writing for a Western audience, Graham (1986) states: 'Eastern culture and its institutions are traditionally humanistic in the sense that they are centred around the human potential for transcendence or becoming' (p. 11). But Eastern culture is not humanistic in the sense of worshipping the human being as being noble and all-powerful—the sort of thinking that forms the basis of Western culture. Religion and psychology are integrated in the traditional philosophies of Hinduism, Buddhism, Zen, Taoism and Islam. In the Eastern tradition, rationality is seen as *maya*—illusory and superficial. Chinese philosophy sees reality, whose ultimate essence is called *tao*, as a process of continual flow and change. Its *yin*/*yang* terminology represents a systems view—a general systems theory in Western terms. 'Systems theory looks at the world in terms of the interrelatedness and interdependence of all phenomena, and in this framework an integrated whole whose properties cannot be reduced to those of its parts is called a system' (Capra 1982, p. 26). Graham (1986) writes: 'Eastern culture, in its concern with intangibles rather than "facts", with emotionality rather than rationality, gives pre-eminence to the subjective and experiential' (p. 5).

Indian psychology (a major component of Eastern tradition) is a part of Indian philosophy that has a rich and extensive recorded literature.

Safaya (1976) calls it 'the science of consciousness' not just as a personal quality of an individual but a 'consciousness that pervades the entire universe and it animates all organic and inorganic matter' (p. 3). The earliest documentation of Indian psychological thoughts are in the *Vedas* which led to the doctrines in the *Upanisads* (1000–600 BC). There emerges the notions of an Ultimate Reality (*Brahman*), the pure Self (*Atman*) as the essence of individuality, the identification of Atman with *Brahman*, the individual personality that is bound by the phenomenal world, and the law of *Karma*. As the *Upanisads* discuss human personality as a whole, there is no separate account of mental functioning. Whatever references there are regarding particular aspect of mental functioning are incidentally mentioned with respect to any particular philosophical or theological viewpoint. Again, it is rather difficult to present an equivalence of Mind (used in Western philosophy) with any of the terms used in *Upanisads* (Safaya 1976).

Safaya (1976) describes mind, in Indian psychology, as an organ of action, not just of thinking, similar to body in that respect. 'So, both mind and body, working as a physical instrument of self, belong to the same class with only different shades of quality' (p. 24). Mind is substituted (superseded) in Indian psychology by Consciousness seen as being material but 'subtle' (as opposed to 'gross'). There are four states of consciousness at a personal level, namely the wakeful state, the dream state, the state of deep sleep and a fourth state in which the mind is non-functioning, a state of 'oneness with Brahman'—the 'Ultimate Reality': 'From Him do all things originate unto Him do they dissolve and by him are they sustained' (pp. 50–51). In the psychology of the *Upanisads*, the self is perceived as experiencing all these states except the fourth which is a 'superconscious state' beyond experience. The hierarchy of mental functions are given in the *Upanisads* as: (1) the five sensory organs; (2) *manas* or receiving mind, the coordinating organs of perception; (3) *buddhi* or *vijnana*, the intellect—the higher organ of thought, discrimination, reasoning and intelligence; (4) *ahankara*, the self-sense, the organ of personal ego; and (5) *citta*, the subconscious mind, the storehouse of past impressions. Some systems of Hindu philosophy deviate from the basis established in the *Upanisads* but the triune of soul, body and mind is generally accepted (Safaya 1976).

The human personality in Hindu psychology is the product of a pure Spirit (*Purusa*) and Matter (*Prakrti*); the constituents of Western mind are contained in the latter (see above). It is from their interaction that ego-consciousness, self-consciousness, intelligence and other aspects of Western 'mind', develop; but the equivalents of these concepts are seen in Indian psychology as being embedded at a cosmic or individual level. 'What the Westerners mean by mind, apart from the consciousness of the self [that is] reflected in it is not mystical or spiritual, but simply material. Hence, the true mind [that is] responsible for intelligent behaviour is nothing but consciousness … but the mind as organ or agent is purely material. Confusion arises because of the absence of the right terminology in Western psychology. Sometimes "psyche" was used, sometimes "spirit", and sometimes "mind" ….' (Safaya 1976, p. 25).

Buddhism developed from a Hindu tradition but, by transcending the boundaries of India, it has drawn on other Asian traditions. The differing emphases on ethical and metaphysical dimensions are responsible for differences between schools of Buddhism in their psychological speculations. Buddha said that there is no *Atman* (individual self) but that five *Skandhas* are transferred from one birth to the next to constitute a human identity. This identity is dispersed when the force that binds them is finally extinguished in *Nirvana*. Buddhist idealists believe in a series of momentary cognitions but no self. Tibetan Buddhism has a tradition of getting to know Mind and Consciousness through introspection—awareness and knowledge (Rinbochay and Napper 1980).

According to Bikkhu Nanajivako (1984) 'The idea of impermanence and of ceaseless change, due to the never-ending "chain" of causes and effects' is a fundamental tenet of Buddhism (p. 21). This, together with the rejection of a 'soul' or 'self' (in the concept of *anatta*), gives Buddhism a soul-less psychology that emphasises the here and now, a conscious self of the moment that changes all the time. The Buddhist view is that the world has no purpose to accomplish, although individuals may choose their own ends and thus make their lives purposeful (Jayatilleke 1984); the way to liberation in the attainment of *nirvana* forms the practical side of the philosophy-psychology-religion that is Buddhism.

The ultimate reality, according to all Indian philosophical systems, is a consciousness that pervades the entire universe. Individual consciousness is related to it as a spark is related to a fire (Safaya 1976). The eternal law of *karma*, unattachment as a means of deliverance and the ultimate goal of liberation through self-realisation are basic principles of Indian psychology embedded in its religion and philosophy. The Indian mystical tradition is mainly concerned with ways of liberation and transformation of consciousness. The Hindu looks to various types of yoga; the Buddhist emphasises meditation. In Sufism, the mystical dimension of Islam, the aim is the inner detachment of the individual without, necessarily, a withdrawal from the world (Nasr 1980). In all these psychologies, the rational and the mystical are blended together.

Holism

The term 'holism' is often used very loosely to designate an approach that incorporates the interrelationships between all aspects of bodily and mental functions in a sort of multifaceted approach to the human being. Lazlo (1972) identifies two kinds of holism—in a narrow sense, it sees the human organism as a living system whose components are interconnected and interdependent, while, in a broad sense, the holistic view sees the human organism as a part of larger systems: Not only is the individual organism integrated on bodily and mental functions and in continual interaction with its physical and social environment (that is being constantly affected by the environment) but also that it is constantly acting upon the environment and modifying it. But a very different approach to the notion of holism is not to recognise any division of the person into different parts in the first place; not to recognise the separation of mind from body nor the separation of person from the universe in which (s)he lives. The emphasis then is on integrated wholeness where units, such as body, mind and environment are seen as semantically convenient but misleading concepts (in that they are not 'real') which prevent a true understanding of reality. And the individual is merged in the Absolute (see Safaya, p. 202). This may be termed absolute (or total) monism.

Mind–body dualism, a denial of holism, is deeply embedded in Western thinking today. The approach of Western medicine is first to consider body and mind as separate entities; then fragments of body or mind, depending on objective findings in the case of general medicine and theoretical models in the case of psychiatry. In understanding the body, each part (each organ) is studied in greater and greater detail. Thus, for example, the brain, heart and liver are studied as separate organs and then particular functions of each of these organs are studied in relative isolation from each other. Finally, the different organs are studied in relation to each other, both anatomically (in terms of structure) and physiologically (in terms of function), in order to construct an understanding of the whole person as a body (a combination of its parts). This reductionist method has paid off in terms of the development of knowledge about the workings of the body and the argument (so far not justified) that sustains the same approach being applied to (Western) psychiatry is that it will pay off here too—one day. In the case of medicine, losing sight of holism, has meant that it is unable to investigate processes that are dependent on the person functioning as a *whole*. 'By concentrating in smaller and smaller fragments of the body, modern [Western] medicine often loses sight of the patient as a human being, and by reducing health to mechanical functioning, it is no longer able to deal with the phenomenon of healing' (Capra 1982, pp. 118–119). When healing occurs without a reason that is identifiable in a reductionist idiom, it is discounted as 'placebo effect' or 'spontaneous remission'. In the case of psychiatry, understanding the 'mind' holistically seems a long way off and unlikely to ever come about unless some of its basic tenets are abandoned.

In a seminal paper (Engels 1977) analysed the pros and cons of the biomedical model for both (Western) medicine and psychiatry and went on to suggest (from a systems perspective) a model better suited for both disciplines, calling it the 'biopsychosocial model' (p. 135). Many practitioners of (Western) psychiatry took this on and went on to analyse the causes of mental illness in terms of a variety of 'factors', psychological, biological, social, cultural and so on. This 'multi-factorial approach' sometimes called the bio-psycho-social approach has influenced many professionals in the mental health field in the UK—especially those who are critical of traditional biomedical approach. Unfortunately, it is

sometimes mistaken for a holistic approach although clearly very different. The holistic approach—the spiritual holism of Eastern philosophy and possibly the thinking that underlies many non-Western cultures—is more akin to what Torda (1980) calls holistic monism based on the post-Einstein physics as developed by David Bohm (2002/1980) that postulated the whole universe as 'an unbroken and undivided totality of spacial energy … [that is] enfolded in each of its parts'. After proving that many-body systems 'cannot be analyzed into independently existing parts', Bohm, found that the 'dynamic relationships of the parts depend in an irreducible way on the state of the whole system.' Although mind and consciousness are rooted in the implicit order, the 'human brain with its limited capabilities can only become aware of the explicate form of the enfolded implicate order' (Torda 1980, pp. 9–10).

A concomitant of holism is that a person's external and internal experiences are not just related to each other but they are *one and the same;* experience is both subjective *and* objective at the same time, nothing is separate from anything else. The *yin/yang* terminology of Chinese tradition represents such a view. What happens in mental health practice (being based on Western psychiatry and psychology) is that in attributing causation for deviance from health (in other words, cause of 'illness'), the origins of the 'illness' is seen as being *inside* the psyche (or brain) or if environmental 'causes' are postulated, the effect on mental health is only seen by way the psyche responds. This inside-outside division may not mean much in a tradition (invariably non-Western) where the two are interposed within each other; in which what happens out there is felt as within oneself. Viewed from a Western traditional outlook, the attribution of ill-health to (say) lack of education may be seen as a 'projection' of psychological problems on to the environment—a mistake that could easily be made in a multicultural setting where alternative traditions exist side by side.

In looking for an analogy in the Western tradition to holistic thinking, the closest one can get is systems theory 'which looks at the world in terms of the interrelatedness and interdependence of all phenomena, and in this framework an integrated whole whose properties cannot be reduced to those of its parts' (Capra 1982, p. 26). Graham (1986) writes: 'Eastern culture, in its concern with intangibles rather than

'facts', with emotionality rather than rationality, gives pre-eminence to the subjective and experiential' (1986, p. 5). This topic is important in contrasting the activity of introspection in Western culture with that of its counterpart in the Indian tradition. Sudhir Kakar (1984), Western-trained psychoanalyst who practiced his discipline mostly in India, notes that, in Western culture, definitions of self and identity are contingent upon 'examining, sorting out and scrutinizing the "events" and "adventures" of one's own life'; while in meditative procedures of 'self-realisation' in the Indian tradition, introspection dwells on the 'self … [that is] … uncontaminated by time and space' (1984, p. 7).

Spirituality

The term 'spirituality', like the term 'mental health', does not denote a precise concept but is used widely. Looked at cross-culturally, spirituality is basically about connectedness–of being, knowing and feeling that we are not just individuals but intimately connected in a variety of ways, not just with one another but with the world we inhabit, the earth we live on, the heavens above us, the universe around us. Some people may personify some or all of this as 'God' or a variety of gods and various religions have been built around such personifications; but others (such as Buddhism and Taoism) does not go down that road but yet acknowledge a spiritual dimension. To make any further generalisation about a cross-culturally applicable concept called 'spirituality' could be misleading. Admittedly, much more may be said *about* spirituality in poetry, music, art and storytelling, and perhaps in the 'scriptures' of various religions. However, spirituality appears to result from a communal setting linked to religion and culture. So to work with culture in therapy must be to work with spirituality.

In his classic co-authored book, Zen *Buddhism and Psychoanalysis* (Fromm et al. 1960), Erich Fromm proposes that psychoanalysis emerged in the late nineteenth and early twentieth centuries as an attempt in European thinking to find a solution to what Fromm calls 'western man's spiritual crisis' (1960, p. 80)—a crisis attributed by Fromm to Europe's 'abandonment of theistic ideas in the nineteenth

century' with 'a big plunge into objectivity' (1960, p. 79). Cultures in Asia and Africa did not undergo this crisis and, although undoubtedly influenced later by Western ideas, they appear to have maintained a spiritual dimension to their thinking in many ways until the present. Clearly, Asian and African (possibly as well as pre-Columbian American) cultures still carry spirituality as central to human experience—and this 'spirituality' is different to 'belief' or 'cognition' or 'emotional state'.

References

Aakster, C. W. (1986). Concepts in alternative medicine. *Social Science and Medicine, 22,* 265–273.

Asante, M. K. (1985). Afrocentricity and culture. In M. K. Asante & K. W. Asante (Eds.), *African culture: The rhythms of unity* (pp. 3–12). Westport, CT: Greenwood Press.

Asante, M. K., & Asante, K. W. (1990). Preface. In M. K. Asante & K. W. Asante (Eds.), *African culture: The rhythms of unity* (pp. ix–x). Trenton, NJ: First Africa World Press (First published by Greenwood Press, Westport, CT, 1985).

Bernal, M. (1987). *Black Athena: The Afroasiatic roots of classical civilisation* (Vol. 1). London: Free Association.

Bohm, D. (2002/1980). *Wholeness and the implicate order*. London: Routledge & Kegan Paul.

Capra, F. (1982). *The turning point: Science, society, and the rising culture*. London: Wildwood House.

Carruthers, J. H. (1986). The wisdom of governance in Kemet. In M. Karenga & J. H. Carruthers (Eds.), *Kemet and the African worldview* (pp. 3–30). Los Angeles: University of Sankore Press.

Clarke, J. H. (1985). African–American historians and the reclaiming of African history. In M. K. Asante & K. W. Asante (Eds.), *African culture: The rhythms of unity* (pp. 157–171). Westport, CT: Greenwood Press.

Diop, C. A. (1967). *Anteriorité des Civilisations Negre: Mythe ou Verité Historique?* Paris: Presence Africaine (trans. M. Cook *The African Origin of Civilization: Myth or Reality?* Westport, CT: Lawrence Hill, 1974).

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science New Series, 196*(4286), 129–136. Retrieved November 10, 2017, from http://www.jstor.org/stable/1743658?origin=JSTOR-pdf.

Fernando, S. (2010). *Mental health, race and culture* (3rd ed.). Basingstoke and New York: Palgrave.

Fernando, S. (2014). *Mental health worldwide: Culture, globalization and development*. Basingstoke, Hampshire and New York: Palgrave Macmillan.

Fromm, E., Suzuki, D. T., & de Martino, R. (1960). *Zen Buddhism and psychoanalysis*. London: George Allen and Unwin.

Graham, H. (1986). *The human face of psychology: Humanistic psychology in its historical, social and cultural contexts*. Milton Keynes, UK: Open University Press.

Hall, S. (1996). The West and the rest: Discourse and power. In S. Hall, D. Held, D. Hubert, & K. Thompson (Eds.), *Modernity: An introduction to modern societies* (pp. 184–227). Malden, Oxford and Victoria: Blackwell.

Hilliard, A. G., III. (1986). Pedagogy in ancient Kemet. In M. Karenga & J. Carruthers (Eds.), *Kemet and the African worldview: Research, rescue and restoration* (pp. 131–148). Los Angeles: University of Sankore Press.

Jayatilleke, K. N. (1984). Buddhism and the scientific revolution. In B. P. Kirthisinghe (Ed.), *Buddhism and science* (pp. 8–20). Delhi, India: Motilal Banarsidas.

Kakar, S. (1984). *Shamans, mystics and doctors: A psychological inquiry into India and its healing tradition*. London: Unwin Paperbacks.

Karenga, M. (1982). *Introduction to Black Studies*. Los Angeles: Kawaida Publications.

Lambo, A. (1969). Traditional African cultures and Western medicine. In F. N. L. Poynter (Ed.), *Medicine and culture* (pp. 201–210). London: Wellcome Institute of the History of Medicine.

Lawson, E. T. (1984). *Religions of Africa: Tradition and transformation*. San Francisco: Harper and Row.

Lazlo, E. (1972). *Introduction to systems philosophy*. London: Gordon & Breach (cited by Capra 1982).

Lucas, J. O. (1948). *The religion of the Yorubas*. Lagos: CMS Bookshop (cited by Diop 1967).

Mbiti, J. S. (1989). *African religions and philosophy* (2nd rev. and enlarged ed.). Harlow, Essex: Heinemann.

Moodley, R., & Ocampo, M. (2014). Introduction. In R. Moodley & M. Ocampo (Eds.), *Critical psychiatry and mental health: Exploring the work of Suman Fernando in clinical practice*. London and New York: Routledge.

Nanajivako, B. (1984). Aniccum—The Buddhist theory of impermanence. An approach from the standpoint of modern science and philosophy. In B. P. Kirthisinghe (Ed.), *Buddhism and science* (pp. 21–39). Delhi: Motilal Banarsidass.

Nasr, S. H. (1980). *Living Sufism*. London: Unwin Paperbacks.

Nobles, W. W. (1986). Ancient Egyptian thought and the renaissance of African (Black) psychology. In M. Karenga & J. H. Carruthers (Eds.), *Kemet and the African worldview: Research, rescue and restoration*, Part 3 (pp. 100–118). Los Angeles: University of Sankore Press.

Prabhavananda, S., & Isherwood, C. (trans.) (1947). *Bhagavad-Gita: The song of God.* Introduction by Aldous Huxley. London: Phoenix House.

Rama, S. (1985). *Perennial psychology of the Bhagavad Gita*. Pennsylvania, Honesdale: Himalayan International Institute of Yoga Science and Philosophy of the USA.

Rinbochay, L., & Napper, E. (1980). *Mind in Tibetan Buddhism*. Ithaca, NY: Snow ('The implications of African–American spirituality', in M. K. Lion Publications).

Rogers, J. A. (1972). *World's great men of color* (Vol. 1), New York: Macmillan (cited by Karenga 1982).

Ryle, G. (1963). *The concept of mind*. London: Penguin Books (First published by Hutchinson, 1949).

Safaya, R. (1976). *Indian psychology*. New Delhi: Munshiram Manoharlal.

Stubbs, A. (1988). Martyr of hope: A personal memoir. In A. Stubbs (Ed.), *Steve Biko: I write what I like: A selection of his writings* (pp. 174–239). Harmondsworth: Penguin.

Torda, C. (1980). *Memory and dreams: A modern physics approach*. Chicago: Walters.

Williams, C. (1974). *The destruction of Black civilizations*. Chicago: Third World Press (cited by Clarke 1990).

Wilmore, G. S. (1973). *Black religion and Black radicalism*. Garden City, NY: Anchor Books.

Wimby, R. (1986). The unity of African languages. In M. Karenga & J. H. Carruthers (Eds.), *Kemet and the African worldview: Research, rescue and restoration* (pp. 151–166). Los Angeles: Sankore Press.

4

Contexts, Epistemologies and Practices of Global South Psychologies

Roy Moodley and Jan van der Tempel

In this chapter, we explore the contexts, epistemologies and practices of Global South psychologies. According to Pedersen (1979), 'there are aspects of psychology that have been developed more extensively in non-Western cultures than in our own and that provide alternative systems of explaining behaviour' (p. 77). Although not constructed as a discipline of psychology as it is defined in the West, the principles and practices of deciphering human mind and behaviour are a cornerstone of all cultural practices in terms of survival and regeneration of groups, communities and societies. Indeed, as societies migrate, interact and encounter each other, the cultural boundaries and borderlines become pervious and permeable to all forms of cross-cultural engagement. Over time, through cross-cultural exchanges, cultural hegemony and adoption or appropriation of concepts, ideas and practices about what constitutes the mind and behaviour evolve and change. In turn, these self-reflective meanings and worldviews project themselves onto the sociocultural environment (and vice versa), in what Flint (2008) calls

R. Moodley (✉) · J. van der Tempel
University of Toronto, Toronto, ON, Canada

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_4

a 'polycultural amalgam that blends together various strands of influence, creating new and sometimes unexpected patterns in the cultural fabric' (p. 17), demonstrating a dynamic and evolutionary relationship between culture, society, mind and behaviour.

Throughout the centuries, the human mind (soul) has been alluded to literally, figuratively and metaphorically in the literature, painting, music, religion and even sport. These human productions and enactments were the templates for development of ideas about the mind. It is not so much that modern psychology arose out of thin air to explain human phenomena, but that human behaviour has embedded in it a psychology of the mind that gave rise to a method of understanding itself, long before the advent of modern psychology. For example, the iconography of cave paintings offered a narrative of human relations and behaviours in a specific context that not only reflected human activity within particular cultures and societies, but in its production also textualized and represented an archive of consciousness of the human. The iconicity of images, colours, movements and locations graphically expanded the ways within which humans were able to perceive the present, remember the past, forget painful moments and imagine a future. Moreover, humans, through a construction of a consciousness (and even an unconscious), were able to engage in ethics, social justice and human rights (to use terminologies of modernity). The abundance of life experiences were illustrated through the eloquence of birthing rites, death rituals, sexual desires, physical pain, emotional suffering and conflict. Indeed, differences in the gene pool and the variations within which the abundance of life experiences converge, compete and collide result in the ways in which thinking, emotions and feelings are enacted. Degrees of deviation from these variations and within different cultural contexts make individuals and groups to be suspect of non-compliance to the norm. They could be seen to be dangerous in relation to the welfare and wellbeing of the larger society, and were labelled 'insane,' 'mad,' 'unclean' or 'sinful.' According to Stone (1998), in the West, 'it was this fraction of the people, who evidenced behaviour that deviated from that of the majority, that was to become the domain of psychiatry'—which means, literally, the 'healing of the mind' (p. 3) or 'treatment of the soul' (p. 4), as the 'primary religio-philosophical ideas about the soul is the concept of

a mind, which we nowadays define as the set of all the functions of the brain' (p. 5). The mind and/or soul and all its synonyms, such as intellect, awareness, desire, imagination, emotion and so on were the basis to construct a human consciousness of self, other, god and the universe.

The profound representations of human consciousness and its associated behaviours and actions were pictorially and hermeneutically depicted in cave walls, rock faces, skins and parchments, canvases, musical instruments, etc., eventually leading to the evolution of the written word throughout the globe to ensure that a repository of human collective memory is archived. This trans-historical phenomenon has been the bedrock of all civilizations, and any investigations into the contexts of Global South psychologies must necessarily begin there.

Historical and Cultural Contexts

Historically, cultural and ethnic groups from across the globe have been engaging in complex and myriad ways to understand the human mind, body and spirit/soul. Indeed, most of the explanations of human behaviours in the Global South have evolved in cultural, religious, physiological and political contexts to the extent that the history of such explanations themselves are very different from the way in which Western psychology is currently understood (Pedersen 1979). For example, in Hinduism and Buddhism the mind and body were not conceptually separate, as seen in the Cartesian dualistic binary of mind and body in the West. The composite and holistic mind–body–spirit (the *atman* or self) is mutable and impermanent, and a 'vital principal' (*prana*) or energy. These ideas first appeared 500 BCE in the Hindu religio-philosophical Vedic literatures or scriptures of the Rig-Veda, Upanishads and the Bhagavad Gita, and have become the foundation for much of Indian psychology, while at the same time incorporating the principals of magic and mysticism in their early roots of engaging with the mind, soul (spirit) and matter.

The soul (old Proto-Germanic word: *saiwalo*, meaning 'belonging to the sea'—a stopping place for the spirit before and after death), it seems, was rooted in the concept of breadth which arrives from above

the earth (as in the Japanese, *shinrei*) and the Chinese versions of the superior soul (*ling-hun*) that ascends to heaven, and the inferior or animal one (*p'e*) that returns to the earth (see Stone 1998, for discussion). So it seems that the (soul) spirit exists before and after the mind and body come into existence; meaning that it is larger than the subject or self, and paradoxically at the same time, it is also an integral component of the individual's self. Seeing the soul as an integral part of the subject while at the same time belonging to a metaphysical place in the larger cosmos is succinctly elaborated in Kabbalistic thought; the three Hebrew terms that explain the soul are: *Nefesh*, *Ruach* and *Neshamah*. In this system of thought, *Nefesh* is the lowest level of the soul captured by the term 'bodymind,' while *Ruach* is referred to as the mundane human mind that is centred on the sense of the 'I,' and the *Neshamah* portion of 'God' is the divine soul that yearns to return to its source (Lancaster 2006). The individual as regarded as an emanation of God, and the 'inseparability of body and mind' (p. 102) is a cornerstone of the various Kabbalistic healing traditions that have evolved over time (Levin 2008).

Diverse cross-cultural contexts spurred the development of syncretized systems of healing in which core concepts of the self, mind or soul nevertheless survived. In many cultures in Africa, the notion of the soul or spirit is the larger or universal framework within which the self or subject is organized. The practice of Spiritism (ancestor reverence) then becomes the ritual (or religious) practice of not only honouring the spirit, but also calling on it (them) when a person is in a state of suffering, pain or disease. The spirits respond to the individual since they are an integral part of the self. Similarly, in the Caribbean, the notion of the spirit has its origins in the Yoruba tribe of West Africa, arriving in the Caribbean with African slaves. Writing on Jamaican folk medicine, Payne-Jackson and Alleyne (2004) suggest that, 'this was the kind of cultural item that, existing as it was in the minds of Africans, was less likely to be lost in the Middle Passage … that concepts of aetiology, and therapeutic alternatives (prayers, botanicals and so on), were part of the knowledge brought and retained by Africans and transmitted to successive generations' (p. 15). Indeed, enslaved Africans had to adapt to the religious customs and practices of other enslaved Africans from different African cultures. They were also interweaved with the

dominating theological practices of the slave masters. For example, to deal with Colonial racism and the brutality of slavery, African slaves in the Caribbean developed Voodoo religion (Moodley et al. 2018). In *Black Magic: Religion and the African American Conjuring Tradition*, Chireau (2003) suggests that, 'Black Americans utilized conjuring traditions not only because they saw them as valuable resources for resistance, but because they believed that the supernatural realm offered alternative possibilities for empowerment' (p. 18).

The complex process of encounters, adaptations, assimilation and syncretism with other practices and epistemologies in the social environment is referred to as creolization (Fernández-Olmos 2003). Creolization (used in many other disciplines, e.g., literature, sociology and so on) constructed a particular worldview for people of these cultures with a vast array of practices that informed their health and mental health care, for example, Santeria or La Regla de Ocha, Voodoo, Obeah, Shango, Spiritual Baptist and Espiritismo (see Sutherland et al. 2014, for discussion). The variegated manifestations of cross-cultural and other societal forces acting upon traditional systems of healing over time underlines the dynamic and contextual nature of evolving psychologies across the globe.

It seems that the current knowledge/s, ideas and technologies of the mind, body and spirit (soul) emerge from this inter- and transgenerational quest to fathom the depths of human existence and interaction within particular contexts and communities. Throughout the ages, various cultural and ethnic groups contemplated, debated and challenged ideas that attempted to explain the confounding human phenomena; having arrived at some kind of consensus they then experimented through trial and error to prove or disprove one theory over another. Clearly, this must have gone on for centuries with those ideas and methods that were useful and beneficial being repeated, while those that were unhelpful and negative to the group's harmonious existence were discarded. Over time those behaviours that were positive and beneficial to the welfare and safety of individuals and groups became the central pillars upon which theory of the mind (body and spirit) evolved and developed. In this way, in each epoch particular ideas and ideologies of understanding the human mind (body and spirit) were discovered, recovered, uncovered or even concealed.

This engagement of knowledge production about the human mind or soul was not only to maintain a harmonious balance between the individuals, groups and their environments, but also to answer larger questions that arose through the evolution of the human. For example, as awareness grew of a consciousness of mind, or body or soul, the need to understand human survival, health and social care arose. Perhaps, embedded in human genetics are the alleles of consciousness of empathy and caring for the other so that the human species can propagate and successfully regenerate. These understandings invariably lead to the existential and ontological concerns that become the primary forces underpinning human interaction and behaviours. Religion, culture and geopolitical foundations became the primary forces that evolved ideas and ideologies of the mind. From Western Christian and non-Christian magic and rituals, Eastern Mysticism, Native American spirituality and African Animism traditions, mental schemas were conceived. Daily rites, rituals and ceremonies such as ancestor worship to answer individual and group concerns and conflicts, consuming particular herbs and plants for alleviating pain and suffering, singing, drumming and dancing to enact and celebrate the spirit world, were activities that humans entered into for maintaining their existence in an unpredictable and dynamic world.

Historical, political and cultural contexts over time alter the nature of humanity. Depending on the transitions of change variables, ideas about what it is to be human also change. In the modern era, through the advent of European Colonialism, traditional knowledge and healing practices of many Indigenous American, Australian, Aotearoan (New Zealand), African, Caribbean, Hispanic and Asian practices were disavowed, banned and outlawed. Indeed, notwithstanding the oppressions and disruptions, many of these practices of wellness and wellbeing survived in one form or another. Many have been reconstituted and modified to suit the cultural, sociopolitical and economic contexts. So it seems that the ways in which historical, social and cultural factors emerged and interacted (or not) with each other provided the basis for how magic, religion, the supernatural or traditional healing practices were evoked, enacted and performed to produce a wide variety of Global South psychologies through the centuries.

Epistemologies, Cosmologies and Worldviews

Attributions of meaning about the self and its relationships to the larger group, environment and cosmos have been central to the development of psychological knowledge and healing. Communities of peoples bound by geographical and other boundaries gradually developed systems of meaning, or myths, that gave structure and context to the world and nature, maintained and legitimized systems of social organization and control, and prescribed rituals and models to help guide individuals through the progression from birth through childhood, adulthood, old age, death and beyond, shaping their development, behaviour and experiences according to the norms and values of the group (Campbell 2008 [1949]). At their core, these myths typically described dynamic relationships of interdependence and connection between the myriad dimensions and objects comprising human existence, by which individual and group health and illness often became defined in terms of harmony and balance.

The concept of holism, balance and harmony is a deeply embedded principle or practice in individuals and groups in the Global South, particularly, in early Chinese society with Confucianism and Taoism as the foundational principles. Confucianism contributed to the formation of a Chinese cosmology of balance and harmony of humans in three systems: humans and nature, humans and society, and humans and ego. To achieve this balance, harmony and dynamic equilibrium between the opposing forces of the *yin and yang*, humans would need to follow the Confucian theory of self-cultivation which is the basis of the ethical foundation for self and social order (Hwang 2018). Indeed, in many cultures of the Global South, the theory of balance and harmony can be understood as a dialectical and interdependent worldview where opposing forces reciprocally influence and transform each other as described, and are used in the East in therapeutic practices such as Traditional Chinese Medicine, acupuncture, acupressure, Morita Therapy, Naikan therapy, Chinese Taoist Cognitive therapy and others (see Moodley et al. 2018, for discussion). Taoism itself, with its origins in a blend of magicians and shamans existing since ancient China, and the expositions of philosophers of the Warring States (approximately 476–221 BC), offered a syncretic hybrid of philosophy, religion and mysticism

(Tien-Lun Sun 2018). Tien-Lun Sun argues that 'Taoism was a reaction toward the Confucian Tao of Humanity, which was deemed to be contriving and restrictive,' that 'social harmony could not be realized in the absence of a thorough appreciation of the Tao of Nature' (p. 16). Thus, it was not possible to conceive of human harmony and wellness without consideration for the connectedness of self and other.

In Global South cultures, the individual's self-construction is not singular but a constituency of several components, including the immediate family, the ancestors and the cultural, ethnic or linguistic group—resulting in a non-individualized subject. Self-consciousness, self-awareness and self-identity are mediated through membership and participation within a group; this, in turn, governs how individuals relate to each other, and with their immediate environment and the larger global or universal context. The Zulu term 'Ubuntu' (I am because we are, and because we are, I am) seems to sums up this notion. Ubuntu is an African worldview that constructs the self-other relationship. Bishop Desmond Tutu in *No Future Without Forgiveness*, puts it this way, 'My humanity is caught up, is inextricably bound up, in yours. We belong in a bundle of life. We say, "A person is a person through other persons". It is not, "I think therefore I am". It says rather, "I am human because I belong. I participate, I share"' (Tutu 1999, p. 31). Ideas of health and wellness are therefore grounded in a holistic understanding of the relational basis of identity.

This complex multiple relationship matrix acts as the foundation for the evolution and development of the personality, and a mind–body–spirit integration. It seems that this unity of the self-formation represents a holism of the subject, rather than the Cartesian body–mind dualism. A unity of mind, body and spirit or soul exists. This worldview of unity may extend to the cosmos itself, as in Animist traditions where the universe and everything in it derives from one source, and where the course of events is directed by spiritual entities that give rise to the spiritual, social or psychological causes of physical and mental ill health (Bojuwoye 2005). In systems involving ancestor reverence, such as Spiritism in Africa, the spirits of ancestors are invoked to share wisdom and advice to treat person's suffering. These procedures are initiated by a spiritual healer, shaman or medicine man/woman. The Shaman uses

the 'spiritual fluids' that surround the patient's body to initiate the healing (Hohmann et al. 1990) and engage the spirit, as people from the community believe that their 'problems' are caused by spirits as a punishment for wrongful deeds (Nicolas et al. 2001; Waldron 2003). This spirit-based healing practice is conducted also at the community level, for example, the Rab healing ceremonies in Senegal, and the group Zar healing tradition in Ghana, Ethiopia and Sudan. These practices, which have their roots in Islamic and pre-Islamic methods of healing (Awanbar 1982), have one basic objective, which is to integrate the disconnected body, mind and spirit.

Traditional and cultural ways of understanding the mind, body and spirit have been a part of the social, cultural and geopolitical landscape of the Global South and continue to do so to some degree in present times. The idea of the collective self or the non-individualized self, or the holistic subject with an integrated body–mind–spirit, has survived in various representations throughout history; even through major sociopolitical epochs, such as the pre-colonial, colonial and the post-colonial periods. Although these historical events have shaped how ideas of the mind and body are understood in everyday living in the Global South, the concept of the holistic self has remained the nucleus within which a psychology of the mind was constructed, represented and performed. For example, Confucian and Taoist ideas have for centuries been the building blocks of Chinese and Japanese ways of thinking and being in the world. Even the advent of Colonialism, Communism and modernism has not changed or transformed the principles that are foundational to the Asian people's ways of being in the world.

Practices and Principles of Global South Psychologies

Historically, most cultures from around the world engaged in religion, magic and supernatural forces to make sense of day-to-day existence. When a state of disequilibrium (illness, disease or discomfort) was experienced individually or collectively, magic was used to negotiate

with the supernatural forces, while religion attempted to deal with the sociocultural and political issues facing individuals and groups (Rosman and Rubel 1992). This distinction seems to suggest that magic and religion are separate, yet while this may have been the case in the West, historically, the two have always been connected in the Global South (Moodley 2005). Global South psychologies distinctly emerged from universal human process of contemplation, myth-making and trial-and-error learning in the face of unpredictable personal, social and natural circumstances. Cultural models of wellness and illness, and associated healing practices, developed in tandem with spiritual and religious traditions that described and organized the vicissitudes of human existence along dimensions of spirit, mind, body, community and cosmos, according to local circumstance and need. Individual bodies of knowledge and practice developed independently, though they often shared common principles such as holism and harmony, and frequently cross-pollinated with other traditions. Moreover, many traditions endured not only across generations, but also through large-scale upheavals and collective traumas such as colonization and slavery, which further shaped their practices and epistemologies.

In the colonial Caribbean, communities of (ex)slaves increasingly relied upon religion and folk medicine to treat health and mental health problems (Marshall 2005). Healthcare was managed using knowledge of herbs and plants and other medicines (for a discussion, see Handler and Jacoby 1993). In addition, healing and transformation took place by means of supernatural powers transmitted from the spirits of ancestors to humans, so that they may 'come into harmony with problem-causing spirits, to forgive them, and in so doing regulate emotions, lifestyles, physical complaints, and destiny' (Moodley and Sutherland 2009, p. 18). African-Caribbean and Latin American healing practices originate from the Yoruba people of West Africa, and strategic use of the colonial religion, Roman Catholicism, as a cover that allowed people to continue performing their cultural traditions and ceremonies. The interfacing of culturally disparate epistemologies gave rise to novel religious, spiritual and healing practices, such as Voodoo, Shango, Spiritism, Orisha, Santeria, Curanderismo, Spiritual Baptists and Espiritismo. These practices appear to share the same core elements: rituals that

blend African Animist and Western Christian traditions with healing schemas, such as plants and herbs, dancing and drumming, ancestor worship and material artefacts (Fernández-Olmos 2003).

The transmission of healing practices across generations of healers has allowed Afro-centric religious practices and healing traditions to endure and remain relevant in spite of colonization and its hegemonic influence across the centuries (Gibson et al. 2010). According to Payne-Jackson and Alleyne (2004), folk healers are a preferred option in Jamaica, where religion permeates people's lives and their understanding of personal, social and natural events. African-Caribbean healing practices are also brought to other parts of the world by immigrants. These communities tend to regard their traditional healing practices as separate from the frameworks of conventional medical and psychological practice of the West, which many members of these communities view as culturally insensitive, discriminatory or even racist (see Moodley and West 2005).

In other cultures, for example, in Asia, healing practices are more comprehensively influenced by religious thought and movement, such as the healing method of Bhuta Vidya (see Rao 1986), as well as Ayurveda, Sahaja, Bhakti and Siddha (Bhugra and Bhui 1998). It seems that Indian patients who seek out religious and magical techniques to remedy their mental maladies associate their troubles with supernatural influences, such as the devils and spirits that are described as the causes of illness in the Athara Veda (Moodley and West 2005). In contrast, therapeutic practice in China is influenced by Traditional Chinese Medicine as well as acupuncture, acupressure, Qigong and others which operate under the Chinese philosophy of Yin and Yang. Practitioners concern themselves with bringing the two universal sources of energy into harmony (Chen 2005; Hwang 2018). In addition, Chinese patients also experience a form of divination that emphasises the traditional Chinese orientation towards change, which involves patience, gentleness and acceptance (Tseng and Hsu 1979).

Aside from the spiritual or religious basis of many Global South psychologies, there are a number of common principles involved in the success of traditional healing practices. One of these is that healer and client share a common cultural context; when therapeutic agents

embody the culture of their clients, culture can become a medium for healing in and of itself (Vontress 2005: see also Vontress 1999). In addition, belief in the healer's powers is shared and not questioned, granting him or her legitimacy in the client's eyes (Finkler 1994). Clients feel understood and validated thanks to their awareness of the healer's own experiences of suffering and affliction prior to becoming a healer, which allows him or her to connect with clients through a subjectively known vulnerability. Furthermore, success of the healing intervention depends on the client's own readiness and his or her belief in the healer's spirits and techniques (McCabe 2007). The duration of the therapeutic experience and the therapeutic relationship between client and healer are also influential factors (Ross 2008). These basic principles of the healer's expertise, the client's readiness and faith in the healer, and a shared cultural understanding at the basis of the client–healer relationship, are commonly shared among healing practices of Global South psychologies, as well as those found in the West.

While this necessarily limited overview of traditional healing practices is by no means in-depth or exhaustive, it is intended to illustrate that common shared elements can be found across diverse traditions in the Global South. Specific schemas of health and illness, spiritual taxonomies, and uses of ritual, symbols and other healing methods may vary, yet the underlying philosophy of healing is largely the same. According to Koss-Chioino (2006), differences between practices reflect variations in content rather than process. At the centre of many traditions, spiritual or supernatural possession of the healer or shaman, the client, and sometimes both, is regarded as the basis for healing, such that their trance(-like) states allow access to a space in which solutions to problems come to the healer and client from the spirit world (Moodley 2005). In practice, spirit healing and transformation take the form of folk drama in which participants perform and embody spiritual agencies invoked by the healer (Koss 1979). Indeed, healing occurs in these contexts through the restructuring of ailments modelled in a mythic world that is shared by both client and healer (Dow 1986). This can take place within a 'psychic space' wherein the healer engages in a radically empathic process of subjectively experiencing the client's pain or distress

by means of a spiritual conduit (Koss-Chioino 2006). The intended outcome of these practices is a state of harmony with and between the client and the spirits or spiritual forces that gave rise to the problem, thereby bringing the client's life into balance.

Conclusion

Western psychology is a relatively new discipline when compared to the history of mind, body and spirit consciousness and the healing of conflicts, illnesses and diseases across the global cultures. Culturally appropriate and relevant ideas about the mind, brain, body, emotion and spirit are still available in every current culture and will change with each successive generation. The wave of new technologies that appear to be transforming our understanding of mind and brain will no doubt impact Global South psychologies. Globalization and internationalization will also contribute to this change; so will developments in neuroscience and the genome project engage new ways of reading and interpreting traditional and ancient healing literature and sacred texts.

In the Global South, the result of gaining independence from European Colonialism and the subsequent rise of nationalism led to the Indigenizing psychology movement (Hwang 2005); this is advancing race, ethnic and cultural ideas about health and mental health, as well as its relationship with Western psychology. Indigenous and traditional healing practices are being uncovered, discovered and/or recovered through sophisticated research and practice. While this process challenges the negative views of a Colonial past, it also addresses current practices of institutional racism and other forms of oppression that still appear to persist in health and mental health care, in the West and elsewhere. Indeed, Global South psychologies are not only bringing about a revival in spirituality and religion in the West, but are clearly offering communities of the diaspora possibilities of making health and mental health care choices that are consistent with people's ethnic, cultural and religious preferences.

References

Awanbar, D. (1982). The healing process in African psychotherapy. *American Journal of Psychotherapy, 36,* 206–213.

Bhugra, D., & Bhui, K. (1998). Psychotherapy across the cultural divide. In R. Moodley & S. Palmer (Eds.), *Race, culture and psychotherapy*. London: Routledge.

Bojuwoye, O. (2005). Traditional healing practices in Southern Africa: Ancestral spirits, ritual ceremonies, and holistic healing. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Campbell, J. (2008 [1949]). *The hero with a thousand faces* (3rd ed.). Novato, CA: New World Library.

Chen, C. P. (2005). Morita therapy: A philosophy of Yin/Yang coexistence. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Chireau, P. Y. (2003). *Black magic: Religion and the African American conjuring tradition*. Berkeley: University of California Press.

Dow, J. (1986). Universal aspects of symbolic healing: A theoretical synthesis. *American Anthropologist, 88,* 56–69.

Fernández-Olmos, M. (2003). *Creole religions of the Caribbean: An introduction from Vodu and Santeria to Obeah and Espiritismo*. New York: New York University Press.

Finkler, K. (1994). Sacred healing and biomedicine compared. *Medical Anthropology Quarterly, New Series, 8*(2), 178–197.

Flint, K. E. (2008). *Healing traditions: African medicine, cultural exchange, and competition in South Africa, 1820–1948*. Athens, OH: Ohio University Press.

Gibson, B. G., Morgado, A. J., Brosyle, A. C., Mesa, E. H., & Sanchez, C. H. (2010). Afro-centric religious consultations as treatment for psychotic disorders amongst day hospital patients in Santiago de Cuba. *Mental Health, Religion & Culture, 1*(1), 1–11.

Handler, J., & Jacoby, J. (1993). Slave medicine and plant use in Barbados. *Journal of the Barbados Museum and History Society, 41,* 74–98.

Hohmann, A. A., Richeport, M., Marriott, B. M., Canino, G. J., Rubio-Stipec, M., & Baird, H. (1990). Spiritism in Puerto Rico: Results of an island-wide community study. *British Journal of Psychiatry, 156,* 328–335.

Hwang, K.-K. (2005). A philosophical reflection on the epistemology and methodology of indigenous psychologies. *Asian Journal of Social Psychology, 8,* 5–17.

Hwang, K.-K. (2018). Confucianism and healing. In R. Moodley, T. Lo, & N. Zhu (Eds.), *Asian healing traditions in counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Koss, J. D. (1979). Artistic expression and creative process in Caribbean possession cult rituals. In J. Cordwell (Ed.), *The visual arts: Graphic and plastic*. The Hague: Mouton.

Koss-Chioino, J. D. (2006). Spiritual transformation, ritual healing and altruism. *Zygon, 41*(4), 877–892.

Lancaster, B. L. (2006). *The essence of Kabbalah*. London: Arcturus.

Levin, J. (2008). Esoteric healing traditions: A conceptual overview. *Explore: The Journal of Science and Healing, 4*(2), 101–112.

Marshall, R. (2005). Caribbean healers and healing: Awakening spiritual and cultural healing powers. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.

McCabe, G. H. (2007). The healing path: A culture and community derived Indigenous therapy model. *Psychotherapy: Theory, Research, Practice. Training, 44*(2), 148–160.

Moodley, R. (2005). Shamanic performance: Healing through magic and the supernatural. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Moodley, R., & Sutherland, P. (2009). Traditional and cultural healers and healing: Dual interventions in counseling and psychotherapy. *Counselling and Spirituality, 28*(1), 11–31.

Moodley, R., Lo, T., & Zhu, N. (Eds.). (2018). *Asian healing traditions in counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Moodley, R., & West, W. (Eds.). (2005). *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Nicolas, G., DeSilva, A. M., Grey, K. S., & Gonzalez-Eastep, D. (2001). Using a multicultural lens to understand illnesses among Haitians living in America. *American Journal of Orthopsychiatry, 77*(4), 702–707.

Payne-Jackson, A., & Alleyne, M. C. (2004). *Jamaican folk medicine*. Kingston: University of West Indies Press.

Pedersen, P. (1979). Non-western psychology: The search for alternatives. In A. J. Marsella, R. G. Thrap, & T. J. Ciborowski (Eds.), *Perspectives on cross-cultural psychology*. New York: Academic Press.

Rao, V. A. (1986). Indian and Western psychiatry: A comparison. In J. L. Cox (Ed.), *Transcultural psychiatry*. London: Croom Helm.

Rosman, A., & Rubel, P. G. (1992). *The tapestry of culture: An introduction to cultural anthropology* (4th ed.). New York: McGraw-Hill.

Ross, E. (2008). Traditional healing in South Africa: Ethical implications for social work. *Social Work in Health Care, 46*(2), 15–33.

Stone, M. H. (1998). *Healing the mind: A history of psychiatry from antiquity to the present*. London: Pimlico.

Sutherland, P., Moodley, R., & Chevannes, B. (Eds.). (2014). *Caribbean healing traditions: Implications for mental health*. London: Routledge.

Tien-Lun Sun, C. (2018). Taoism and healing. In R. Moodley, T. Lo, & N. Zhu (Eds.), *Asian healing traditions in counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Tseng, W. S., & Hsu, J. (1979). Culture and psychotherapy. In A. J. Marsella, R. G. Tharp, & T. J. Ciborowski (Eds.), *Perspectives in cross-cultural psychology*. New York: Academic Press.

Tutu, D. (1999). *No future without forgiveness*. New York, NY: Doubleday.

Vontress, C. E. (1999). Interview with a traditional African healer. *Journal of Mental Health Counseling, 21*(4), 326–336.

Vontress, C. E. (2005). Animism: Foundation of traditional healing in subsaharan Africa. In R. Moodley & W. West (Eds.), *Integrating traditional healing practices into counseling and psychotherapy*. Thousand Oaks, CA: Sage.

Waldron, I. R. G. (2003). Examining beliefs about mental illness among African Canadian women. *Women's Health and Urban Life: An International and Interdisciplinary Journal, 2*(1), 42–58.

Part II

Traditions of Psychology in the Global South

The chapters in Part II of the book discuss ways in which traditional healing practices, religion and spirituality have been the foundation of theories concerning the 'mind' and mental matters (indigenous psychologies) as seen in healing practices and approaches to mental health and well-being in a diversity of cultures of the Global South; and describe underlying themes appertaining to psychology in traditional cultures of Africa and Asia, indigenous peoples of America and Australasia.

5

African Indigenous Knowledge Systems and Healing Traditions

Olaniyi Bojuwoye and Mokgadi Moletsane-Kekae

> There is a rich body of indigenous knowledge embodied in Africa's cultural and ecological diversities, and African people have drawn on this knowledge for hundreds of years to solve specific developmental and environmental problems. (Mohamedbbai 2013)

Introduction

Human Nature as construed by traditional Africa can best be explained from the perspectives of the constructivists who assert that people shape and are shaped by the environment in which they live (Bronfenbrenner 1979). However, people also organize and cognitively engage their

O. Bojuwoye (✉)
Kwara State University, Malete, Nigeria

M. Moletsane-Kekae
University of the Western Cape, Western Cape, South Africa

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_5

environment and by so doing construct different realities (Freedman and Combs 1996). These realities make up the framework of culture—what defines or characterizes a particular group of people including language, religion, cuisine, social habits, music and arts (Zimmermann 2012). It is culture that provides the materials and symbolic tools by which people adapt to their ecological and social environment and construct images of the world and of themselves (Kashima 2000). It is through culture that people think, feel, believe and behave (Sheweder 1991; Segal et al. 1999). Embedded within the culture are all knowledge systems by which people respond to their environment including responding to diseases and restoring health to individuals who are ill (Mariach 2003). Since people experience stress and make sense of psychological problems depending on their cultural beliefs and practices, to explain a person's behaviour, therefore, an understanding of that person's cultural background is imperative (Castillo 1998). For example, in Zulu and Xhosa-speaking communities, *ukuthwasa*, with its bouts of depression and mania experiences, would be considered as symptoms of 'schizophrenia' from a Western psychiatric perspective. However, from Zulu and Xhosa cultural perspective, such symptoms of mood disorder are associated with an ancestral calling to become a healer (Cartwright 2008). Therefore, to avoid making incorrect diagnosis and ensure appropriate treatment, the cultural context of behaviour must be understood and taken into consideration.

Traditional African healthcare delivery, otherwise referred to as 'African traditional healing', has its roots in the foundations of African culture. Indeed, African healing traditions are integral parts of African cultures which represent the sum total of beliefs, attitudes, customs, methods and established practices all of which indicate African peoples' worldview. It is this African worldview that informed the meaning systems and cultural practices which indicate how people define human nature, 'ideal' human functioning, optimal quality of life or generally the conception of health and ill-health (whether physical or mental health, disordered thoughts, emotions and actions or behaviours).

Traditional African Cultural Worldview

Knowledge systems about human nature, whether Western or Non-Western, are informed by the way people of a culture perceive realities in their environment. Thus, Vontress (2000) asserts that the conception of person is a function of the worldview of a culture or that human nature is culturally defined. In terms of the African worldview regarding human nature, African researchers and philosophers are in agreement that there are widespread psychological and cultural themes or patterns of thought about human nature unique to Sub-Saharan Africa (Shutte 1993; Crafford 1996; Senghor 1966; Mbiti 1989). Researchers further opine that the two most important aspects of traditional Africa worldview, about human nature, are collectivism (the interconnectedness of phenomenal world) and spiritualism (or animism) (Shutte 1993; Senghor 1966; Nyasani 1997).

Collectivism

Collectivism is the notion that all elements in the universe are connected to, or dependent on, each other. It is the ideology that emphasizes the significance of, or place priority on, group over individual. Thus, collectivists' focus is on community, society or nation. In this regard Bodibe (1992) and Rudnick (2000) note that it is this notion of collectivism that informed the communal living, or the collective consciousness reality by which African people are known. The general African cultural worldview regarding human nature is that it is an interdependent, inseparable whole (Bojuwoye 2006). Humans are not separate from, but are part of, nature. Humans and the phenomena world are extensions of each other and influence one another. Thus in this connection, Makgoba (1997) contends that the psychological and moral characteristics pertaining to African identity, personality and dignity place emphasis on community rather than individual. A very crucial aspect of the traditional Africa's view of human nature is that the individual exists for the group, and that whatever happens to the group

happens to the individual (Mbiti 1989). Spinnelli (1994) also notes that by this notion each individual defines him/herself in relation to others and that the self is the product of, or that which emerges from, relational experiences. Thus, human nature from an African perspective is socially constructed. However, while the dominant entity of traditional African social order is community, Gyekye (1988) notes that this African social order manifests features of both collectivism and individualism. According to Owusu-Bempah and Howitt (1995) from traditional African perspective, individuals are obviously aware of themselves as individuals but this is relatively unimportant compared to one's sense of moral duty to the community which takes precedence over individual interests. Nyasani (1997) notes that from this socially constructed view of human nature have emerged personality characteristics inherent in African minds including those of sociality, patience, tolerance, sympathy and acceptance, thus making this socially constructed view of human nature to guarantee social cohesion, social harmony and mutual concern.

Spiritualism

Spiritualism is another important aspect of African cultural worldview. Spiritualism is a metaphysical belief that has various interrelated forms including that the world is made up of matter and spirit and the relationship between them; that the universe is populated by spiritual entities such as the spirits of the dead, or ancestral spirits, deities and mediums; and that which has to do with spiritual or religious aspect of human existence. All these dimensions are reflected in the spiritualism aspect of African cultural worldview. The belief that spirits dwell within people and objects is often referred to as animism (from the Latin *anima*, which means 'soul' or 'breath'). Animism is, however, not peculiar to traditional Africa, rather, it is found in many indigenous belief systems worldwide.

Traditional Africans belief is that the universe is not void but populated by various cosmic entities possessing spirit or life-force or core energy essence animating them (Bojuwoye 2006). This spirit or core

energy essence is believed to bind elements in the universe together in unity, harmony and totality to ensure that a firm balance or equilibrium is maintained between all elements in the universe (Crafford 1996). It is further believed that this spirit or life-energy essence is not equally distributed among the cosmic entities. There are some cosmic entities believed to have more power or are more powerful than others. For instance, some cosmic elements (e.g. ancestral spirits) are more powerful than humans while some humans are more powerful than other humans. There is, therefore, the existence of power imbalance or power relations among cosmic entities and this, in turn, has led to the belief that some entities have supernatural or high power than others.

Mbiti (1989) used the African religious ontology to explain power relations among cosmic entities. According to Mbiti, the African religious ontology (with cosmic entities arranged in hierarchical order) consists of the Supreme Being or God, considered the ultimate source of life-energy. The next category of entities comprises the spiritual entities including the spirits of ancestors. Traditional Africa believes that when a person dies the body disintegrates but the spirit lives on. Death does not make a person cease to belong to his/her social unit (family, clan or nation), but continues to lead similar life as spirit actively participating in the lives of the people influencing the latter's behaviours as they did while alive (Ngubane 1977; Gumede 1990). The ancestors are believed to possess more life-energy than living humans but not as much as God. The humans are at the centre of the African religious ontological hierarchy. The fourth category of cosmic entities are the animals and plants or the rest of the biological life considered to be imbued with lesser life-energy than humans. Phenomenal and objects without biological life make up the fifth category of cosmic entities and these include earth, sun, moon, stars, oceans and other bodies of water, mountains and rocks.

This traditional Africa religious ontology also explains the very religious nature of Africans who in their cultural imperatives incorporated the Supreme Being or God, the ultimate source of life-energy essence, and spiritual entities regarded as those of the ancestors. These two categories of cosmic entities are regarded as possessing higher power than humans. These cosmic entities with higher or supernatural power than

humans are believed to be capable of influencing events in nature for good or for bad. For instance, the ancestral spirits are believed to be capable of influencing virtually all aspects of life including bringing about good health, wealth, or illness to living humans as well as being capable of averting illness, disease and natural disasters, assisting in obtaining good fortune, interceding in interpersonal relationship conflicts and serving as intermediary between God and humans. There is, therefore, the belief that there is need for rapport with cosmic entities with higher powers which are revered and or worshiped. Thus to the African, the term 'spiritualism' is synonymous to religion. In fact, in many African cultures, religion, the spiritual, and medicine are almost indistinguishable from each other—religion is medicine and medicine is spiritual (Owusu-Bempha and Howitt 1995). Mbiti (1989) also asserts that the pursuit of health for the fulfilment of the whole of existence is part of religious affairs as it dominates every aspect of life, religion being one of these.

An important dimension of spiritualism is that which has reference to the 'soul' or the 'spirit' and the quest for insight into, or being in touch with, one's deep inner self or mind—the citadel where every thought originates, where all forces continually contend, and the realm where resources are cultivated for personal empowerment in dealing with all the contextual forces which people have to confront in everyday living (Bojuwoye 2001). As Tulku (1975) contends, being in touch with one's spirit is an indication of integration of the body with the spirit and without this spiritual aspect of the essence of oneself, it becomes natural to see and feel problem.

African Indigenous Health Care

Harley (2006) observes that every region of the world with their specific culture has a form of traditional or indigenous healing system, either formal or informal. According to the World Health Organization (WHO) (2001) traditional healing is the knowledge and practices, whether explicable or not, used in the diagnosis, prevention and elimination of physical, mental and social imbalances and relying exclusively

on practical experiences and observations handed down from generation to generation mostly verbally, but also, to some limited extent, in writing. Levers (2006) and Mpofu (2006) also assert that indigenous healing systems are those locally developed, recognized and used by most of the inhabitants of a historical community, which incorporate their health concepts and needs. African indigenous health care is often used interchangeably with African traditional healing to refer to systems of health care rooted in the socio-cultural contexts of the African communities (Mpofu et al. 2011). African traditional healing evolved from the beliefs, attitudes, customs, methods and established practices for improving human health conditions and elevating the quality of human life. 'African indigenous health care knowledge is characterized as *closed, non-systematic, holistic* rather than *analytical, without an overall conceptual framework*, and advances on the basis of new experiences, not on the basis of a deductive logic' (Odendaal 2010, p. 21). Indigenous health care knowledge is *oral, usually not written* and it views things as *wholes*.

Traditional African health care knowledge subscribes to a predominantly metaphysical explanation unlike the Western models of healing that claim to subscribe to 'scientific' (that is objective, rather than subjective) explanation. Indigenous health care knowledge incorporates techniques with potential roles of facilitating increased level of well-being, in one or more of the levels of the body, mind, emotions and the spirit (Atherton 2007). The techniques employed in traditional healing include intervention for the promotion of health and treatment for ill-health. A very important characteristic of indigenous healing in traditional Africa is what is often described as group healing—healing practices that involve not just the patient, but the patient's primary and associational groups and the community in general. Healing is also perceived as arising from belief in spiritual power. Traditional African healers believe that spiritual processes cause illnesses and direct treatment interventions. Thus, according to Mpofu et al. (2011), when a traditionalist African patient takes a herbal infusion, the patient experiences healing from the spiritual power of the medicine apart from any benefit from the bioactive properties of the remedy alone. In this connection, Kleinman (1980), anthropologist and psychiatrist, supports the

view that many patients who believe in the power of spirits to define the cause of illness and health problems find that an anamnestic investigation in the Western sense is uncalled for.

African Personality Theory

From traditional African cultural perspectives, human personality evolves from interpersonal interaction or in community. In African culture, a person exists because of other people. In *Sesotho* it is commonly known that '*Motho ke motho ka batho ba bangwe*', which means, a person is a person because of other people while in *isiZulu*, it is expressed as '*Umuntu ngumuntu ngabantu*'. These phrases demonstrate the importance of collective identity in African cultures (Moletsane 2011). Thus, for example, if a person does something good, the credit goes to the community not to the individual. Africans believe that there is a powerful being which supersedes all of us. This supreme power is invisible and can be seen as God or comprising more than one God (Moletsane 2011). Ancestors are people who have died but whose spirits are still alive and are among the living. The ancestors are watching and protecting their living relatives. It is believed that the ancestors play a crucial role in people's lives by communicating with God ('*Modimo*' in Sesotho) on behalf of the living. The ancestors use dreams, signs, or traditional or spiritual healers to deliver the messages from God (or the gods) to those who are alive. Louw and Edwards (1993) states that the relationship with the ancestors, and through the ancestors with God, permeates all beings.

The outer layer of the body is regarded a cover or container of the human's body. The body needs to be active in order to be in a good *physical* shape. There are other levels of functioning, such as the *physiological*, which focuses on the body's physiological functioning and the *psychological*, which focuses on the stability of a person's mind. The physiological and psychological levels of a person are important; for the body to survive and to be healthy it needs good nutrition and a stable mind. The *spiritual part* is the inner part or the seed of a person.

The spirit is regarded as the seed because it does not die even after the body has died. Berry et al. (2002) also regard the inner layer as the spiritual principle, which represents a soul that can never perish. It can leave the body during sleep and during trance states and leaves definitively upon death. Berry et al. (2002) further state that the spiritual principle does not give life to the body; rather, it has an existence of its own, belonging to the sphere of the ancestors and representing that sphere in each person. Every person has a connection or relationship with their environment; hence, people adapt to their own environment. If people do not adapt to their environment, they get sick. This happens because their state of equilibrium is weak. The firm connections between the gods or the supreme power, the ancestors, a person, the environment, the family, and the community. This connection represents the state of equilibrium or sanity (Fig. 5.1).

The Concept of Health and Ill-Health

In traditional Africa cultural perspectives human nature is socially constructed and this has led to health and ill-health being also socially constructed. In keeping with the traditional Africa worldview of collectivism (or the inter-collectedness of phenomenal world), health is viewed as closely linked to relationships. 'Good' health or 'ideal' human functioning is viewed in terms of harmonious relationships with the universe and the local ecology including plants, animals as well as in terms of harmonious interpersonal relationships with other humans (Straker 1994). For instance, the view of health in a number of African cultures is that of continuing balance in environmental and social relations within the family, peers, society, ancestors and deities (Edwards 2000). Thus success, comfort, affluence, pleasure and living harmoniously with family, peer-group and society in general, are signs of good health. The 'ideal' human functioning, from Africa cultural perspectives, is that of a person who integrates in and contributes to the community and continues to work at maintaining the balance, renewing order and recreating new forms of harmony (Edwards 2000). The psychologically healthy person

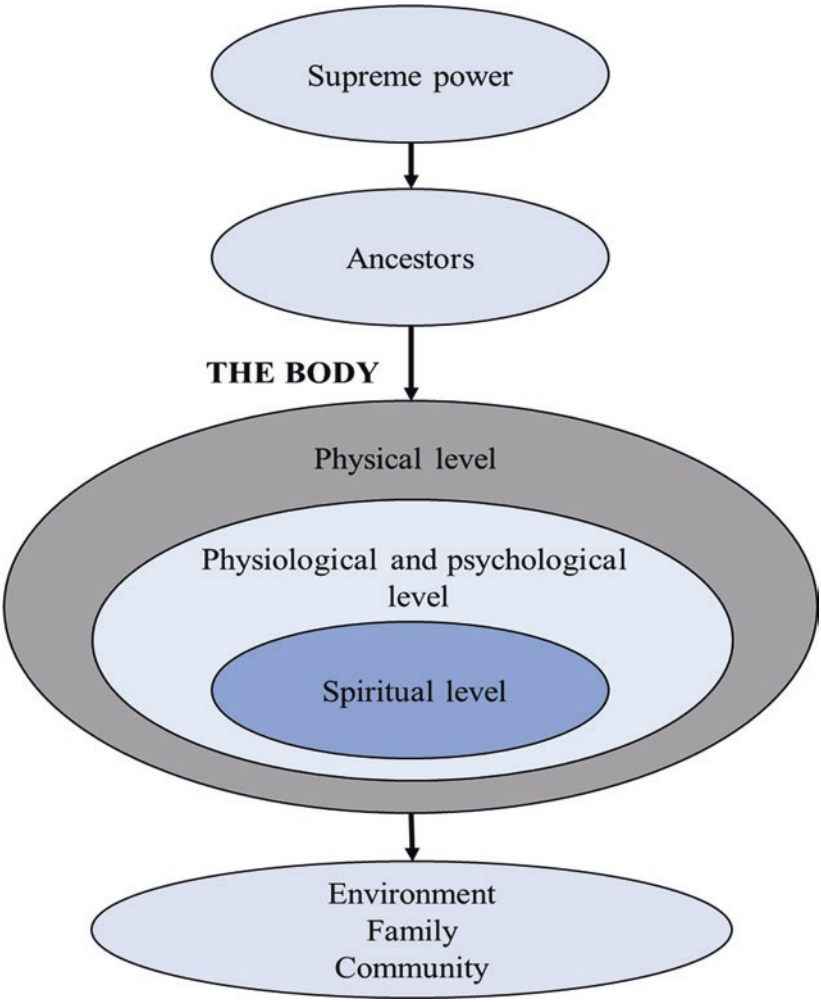


Fig. 5.1 African model of personality (Adapted from Botha and Moletsane 2012, pp. 70–71)

is one who strives to be in harmony with forces of nature impinging on him/her (whether these be from humans or non-human, seen or unseen). Therefore, health, from Africa cultural perspectives, has greater meaning, balance, connectedness and wholeness both within the individual and the environment (Vontress 1996).

Traditional African perspective of ill-health or disease is also socially constructed and is described as disharmonious relationships. Disharmony may be reflected by a break in relatedness, either intra-personal relatedness (a break between body and spirit) or interpersonal relatedness (such as disharmony between people, between people and their ancestors, between the individual and the rest of the universe, or generally a break in the reality beyond individual existence) (Atherton 2007). Disease or ill-health is said to make people feel isolated, anxious, tense, confused, frustrated and annihilated, and these feelings do manifest in the body, hurting quite literally in the entrails as life becomes empty when cut off from fellowship with others (Gilligan 1998). Like other non-Western cultures, traditional Africa cultures also see ill-health as affliction to further explicate the wider meaning of illness or disease (Comaroff 1980). Affliction is used frequently in place of illness in anthropological and ethno-medical literature to indicate that it is not just a matter of physical nature, but involves psychological, social, emotional, spiritual, career, and familial aspects of life. This multidimensional view of health and or ill-health parallels that of the World Health Organization (WHO 1993) which considers health as not just absence of disease and infirmity, but also including complete physical, mental, social, occupational and spiritual well-being.

Since ill-health or disease is considered to be largely of social construction, its aetiology or cause is also seen as interpersonal in nature rather than intra-psychic, or something only residing in the diseased person. Dryden (1984) also asserts that some indigenous cultures view ill-health as largely extra-psychic rather than intra-psychic and as reflection of acute or chronic disturbances in the balance of emotional forces in the individual's important relationship systems. This is also consistent with Comaroff's (1980) earlier contention that disease or ill-health is an affliction attributable to disruption in the individual's relationship with some spiritual entities or higher power. The perceived extra-psychic nature of disease is an offshoot of the notion of power relationships between elements in the universe. This notion, in turn, influences peoples' attitude or behaviour to diseases. Thus when people are afflicted with diseases, or are experiencing medical conditions, or other negative events, for which they have no direct control, or which they do not fully

understand, they tend to think that they are under the influence of a higher power greater than themselves and therefore they may become obsessed with the thoughts of being powerless, overpowered or being controlled by someone 'out there'. Although traditional Africa recognizes some illnesses as natural, or that they 'just happen', in the main, however, every disease is eventually traced to spiritual or human agents, usually perceived to have more life-energy essence, or higher power, than the afflicted. Ray (1993) is also of the view that the external causes of diseases is a product of the belief in the 'intentional stance' nature of the universe. Thus, traditional Africa believes that nothing happens by chance and that whatever happens to humans in nature has meaning and purpose. Disease is the result of active purposeful intervention of an agent—who may be human (witch, or sorcerer), non-human (a ghost, an ancestral or evil spirit), or supernatural (a deity, or other very powerful being) (Ray 1993). Illnesses, misfortunes, broken relationships and other interpersonal conflict, physical injuries and even death are attributable to inscrutable acts of the spirits because of violations of some cultural taboos, or ritual rules of conduct, disobedience or disrespect to the ancestors, or human agents, or generally the individual is not perceiving realities as culturally construed. This, as it were, makes the sick person literally a victim, the object of aggression or punishment directed specifically against him, or her, alone.

The life conditions of many indigenous communities could make plausible the theories of external causes of diseases (or as affliction by some human and spiritual agents). People live in circumstances where they have to compete for limited resources, as in polygamous families, in families with small land holdings, few resources or none at all. People live in marginalized and disenfranchised communities with diseases, deaths, and poverty as well as social, economic and political repressions, perceived inequality and all forms of injustices and unfairness. All these negative forces or influences breed rivalry, ill-feelings and ill-health. Individuals perceiving these negative forces experience inner crises of emotions and sensations that disrupt normal consciousness. Moreover, not adhering to culturally construed realities makes someone a rebel and an object of hate and ostracism. All these inevitably lead to inner crises which some construed as 'demons' of inner feelings manifesting as anger, fear, depressions, hatred, self-loathing, abuse, addictions and

compulsion—all symptoms of inner chaos, or apparent disconnection within the individual's deep self or soul which could also manifest in unpleasant somatic experiences. No doubt, perceived inequalities, social injustices and unfavourable economic conditions are all capable of putting people at risk of ill-health. Hayes (1986) asserts that social conditions and power relations contribute significantly to the formation of psychopathology. Essentially therefore, the basic principle underlying the traditional Africa view of ill-health is that individual life conditions, lifestyle choices and behaviour patterns can and do result to disease, discomfort or ill-health. In this connection Mpofu (2003) asserts that some African implicit theories of or aetiology of ill-health parallel those espoused by Western theoreticians (Table 5.1).

Table 5.1 Indigenous African aetiological explanations

Cause of illness	Explanation
Boloi (*Sesotho*) or *ubuthakathi* (*isi-Zulu*): to be bewitched	It can be described as sorcery/witchcraft or use of super-power to harm or even kill someone usually an enemy
Go roula (*Sesotho*)	A widow has to wear black clothes for 12 months to show that she is mourning for her husband. This only applies to wives not husbands. If this practice is not properly followed, it can cause illness
Sefifi/*senyama* (*Sesotho*) or *Isinyama* in *isiZulu*	A widow is regarded as contagious as she has '*senyama*' or '*sefifi*' which means bad luck due to her husband's death. The bad luck can be cured if the widow and the youngest child in the family are cleansed by bathing with a herb concoction as recommended by the traditional healer or a traditional community counsellor after the death of her husband. A person who is menstruating or who had sex that day is also regarded as having '*sefifi*'. Such people are not allowed to enter the same room as a new-born baby or a sick person because they might pass their bad luck or illness to the baby or aggravate the condition of the sick person

(continued)

Table 5.1 (continued)

Cause of illness	Explanation
Makgome (*Sesotho*)	After the death of the husband, a widow is prohibited from having a sexual relationship with anyone. Widows are supposed to abstain from sexual activities for a period of one year. If this practice is ignored, they can cause serious illness to themselves and to anyone who has sexual contact with
Go tlola (*Sesotho*) or *Ukudlula* in *isiZulu*	When a widow fails to abstain from sex during the mourning period, this can cause compulsion neurosis (the uncontrollable impulse to perform irrational acts)
Go lahlamaseko/setso (*Sesotho*) or *ukulahlaamasiko* in *isiZulu*	This is the failure to perform the traditional practices. For example, due to the Western cultural influence, people might not believe in African rituals. This might anger the ancestors which will cause ill-health or other types of problems in a person's life
Ba faseba re furaletse/ba-faseba re lahlile (*Sesotho*) or *Abaphansibasifulathele* in *isiZulu*	This means the ancestors have turned their backs against a person. Usually happens when people experience problems either with relationships, work, finance, health, etc., and they then think that ancestors are angry with them
Go thwasa (*Sesotho*) or *ukuthwasa* (*isiZulu*) (calling)	The calling by the ancestors to become a traditional healer. If ignored, it can cause illness or even death
Sejeso (*Sesotho*) or *isidliso* (*isiZulu*)	Growth or pain in the stomach due to sorcery/witchcraft
Tokolosi (*Sesotho*) or *Tokoloshe* (*isiZulu*)	Witchcraft through an animal-like witch. The witches can send 'tokolosi' to take part in bewitching another person
Letswalo (Sesotho) or *Uvalo* (*isiZulu*)	Anxiety attributed to witchcraft or sorcery

(continued)

Table 5.1 (continued)

Cause of illness	Explanation
Go gatiswa/mohlala (*Sesotho*) or *Umeqo* (*isiZulu*)	A disorder attributed to stepping on a concoction of herbs of sorcery. This can cause pain and swollen feet for the person who stepped on the concoction
Mafofonyane (*Sesotho*) or *Amafufunyane* (*isiZulu*)	Spirit possession as a result of witchcraft or sorcery

Adapted from Botha and Moletsane (2012, pp. 73–74)

Traditional African Healing Strategies

Evolution of ill-health can certainly not be separated from broader social issues including economic conditions and power relations within peoples' contexts since these contribute significantly to formation of psychopathology (Hayes 1986). Angelique and Kyle (2002) also observe that human sufferings often arise from group, community, social, cultural and institutional arrangements and not necessarily individual psychopathology. According to Vontress (1996), harsh environmental conditions certainly make people powerless necessitating rapport with 'higher power'. While people in the West may not define higher power or spirituality the same way as Africans, people in the West also appeal to 'higher power' (although this usually is not acknowledged) during the time of loss, trials and tribulations by praying and meditation (Vontress 2003).

Thus, one strategy of healing is appeal to higher power. However, appeal to higher power is not the only strategy for healing employed by Africans. On the contrary, many healing strategies by traditional Africa parallel those of the West. Epp (1998) observes that many African traditional healing strategies parallel those of existential counselling. For example, African traditional healing is holistic and Vontress (1996) also describes existential counselling as holistic intervention strategy focusing simultaneously on the psychological, sociological, physical and spiritual dimensions of human existence. African multidimensional view of ill-health informs the designs of holistic intervention model of

healthcare which facilitates well-being at many levels and many areas of life as it involves interactions and integration of body and spirit/mind, as well as integration of individual with his/her environment (Atherton 2007). The art and science of the holistic intervention model in African traditional healing involve the reconstruction of the physical, social and spiritual orders of the socio-cultural systems (Comaroff 1980). African traditional healing goes beyond symptoms removal as it also includes addressing deeper contextual as well as emotional and spiritual causes of ill-health and also helping patients to realize that certain forces in nature, which may be impacting negatively on people's health, are parts of essence of life not to be wished away, but rather to be negotiated and be accommodated (Bojuwoye 2001).

Just as in existential counselling, basic therapeutic technique of African traditional healing is good social networks, not only of fellow humans but also of ancestors and deities (higher powers). A common element of all successful therapies is positive interpersonal relationships which is positively related to therapeutic outcomes (Garfield 1995). The central vehicle for delivering care is the relationship between therapists and clients (Hannigan et al. 1997). Epp (1998) also notes that interpersonal relationship is the most potent therapeutic factor in existential counselling

Consistent with the principle of providing care within broad psycho-social framework, most African traditional healing practices are conducted in groups which bring people together for human interactions to procure health. According to Parrott (1999), using interpersonal relationships to address health problems is good strategy as group interactions guide and facilitate changes of behaviour, cognition and emotional state of those involved. Vontress (2000) also notes that African perspective on ill-health is not just that it is a condition affecting individuals but also the families and the collectives to which individuals belong. Being healthy and alive is a collective and communal rather than individual matter (Edwards 2000). Healthcare delivery demands group solidarity, a sense of shared fate or collective responsibility. Making healthcare group affair also implies that treatment is multidisciplinary involving many people all working collaboratively together to bring about wellness in different aspects of life.

Using social activities as intervention strategies (as in African traditional healing) is based on the principle that humans depend on themselves for development, exercise and enforcement of their healing power. According to Shutte (1993) spirit or life-energy essence needed for healing is not self-generated but comes through community with other people. Group activities, like ritual ceremonies and cultural festivals, offer people opportunities, to come together, for psycho-education in cultural belief systems regarding health promotion, the development of skills, attitudes and values in problem-sharing, problem-solving, decision making, resources sharing and better ways of coping. Group healing facilitates mutual emotional support and enhances self-esteem leading to people feeling empowered or being in control of themselves and functioning more effectively.

Perhaps a major factor in the potency of African traditional healing is its high energy characteristic. High energy level activities of healing include dancing, singing and praying. Therapies which provide vigorous activities and interpersonal interactions are perceived to be more effective than those which fail to engage the body actively to generate healing energy (Bojuwoye 2001). Music, in particular, is an important tool that makes African traditional healing active as the music triggers dance and singing which in turn lift the spirits of clients thus serving as emotional arousal and strong impetus for development of powerful morale and expectation for successful outcomes. The roles of music in African traditional healing, according to Vontress (2003, p. 23), include: '… *promoting curative process. It profoundly affects muscle tone, body rhythms, and emotions and respiration, heartbeat, digestive peristalses, and brain waves* [which] *become synchronized……. Music draws people together and creates a joyful, and therapeutic sense of unity*' (p. 23, italics inserted). It is further asserted that:

> *Music acts as a healing function for individual and the group. A remedy for human imbalance, it facilitates communication with the ancestral spirits and Creator. It harmonizes forces of the visible and invisible worlds, …….captures the movements of the human body, its sensations and nature itself…the sound* [of music] *is the force of change…music triggers dance and dance is magnetic. They are both contagious and important ingredients for healing.* (Vontress 1999, p. 33, italics inserted)

As people express themselves in dance their spirits are freed from contamination of destructive negative emotional feelings, by which self-discovery is facilitated and a pleasant, positive, appreciative and affirming environment is created (Atherton 2007). The collective, consensual actions of cultural group dances enhance group consciousness (solidarity), promote acceptance and appreciation of one another. Therefore, as opined by Comaroff (1980) the essential outcomes of African traditional group healing are changes in the dynamics of human relationships from being competitive to being collaborative. As emotions are expressed, in dance, catharsis is achieved, realities from cultural perspectives are accepted as people embrace new values and behaviours in efforts to reduce deviations from existing culturally defined standards.

Conclusion

African Indigenous Knowledge Systems have been ignored due to Africa's political history of suppression of human rights based on race and culture and partly from accelerating globalization (DST 2011). Human nature, from a traditional African perspective, is socially constructed as people define themselves in relation to others; and the 'self' is a product of that which emerges from relational experiences. In the same vein, health is also socially constructed as the evolution of health cannot be separated from the broader social context of the culture of a people. Moreover, health, to traditional Africa, is multidimensional, incorporating the physical, social, psychological, spiritual, career, and familial aspects of life. This multidimensional view of health makes for holistic healthcare delivery involving biomedical and psycho-social treatments. The holistic model of intervention in health matters as espoused by African traditional healing is the reconstruction of the physical, social and spiritual orders of the socio-cultural systems. The holistic model of healing by African traditional healing parallels existential counselling intervention. African traditional healing employs interpersonal relationships to address health problems. African traditional healing practices are usually conducted in groups which bring people together for human interactions to procure health. To the Africans

being healthy and alive is a collective and communal rather than individual affair. This strategy also parallel existential therapy which uses interpersonal relationship as potent therapeutic strategy. The basic principle underlying traditional Africa view of ill-health is that individual life conditions, lifestyle choices and behaviour patterns can and do lead to disease and or ill-health. This aspect of African traditional healing also parallels some Western theoreticians. African traditional healing also possesses factors attributable to most efficacious therapies (Western or Non-Western) among which are interpersonal relationship and emotional arousal. The high energy levels of activities (dancing, singing and praying) which characterized African traditional healing are perhaps major factors in its potency.

References

Angelique, H., & Kyle, K. (2002). Monterey declaration of critical community psychology. *The Community Psychologist, 35*(1), 35–36. Retrieved January 7, from https://www.academia.edu/749230/The_concepts_values_and_ideas_of_critical_community_psychology.

Atherton, K. (2007). *Holistic healing*. Pindari Herb Farm. Retrieved May 21, 2007, from http://pindariherbfarm.com/healing/holiheal.htm.

Berry, J. W., Poortinga, Y. H., Segall, M. H., & Dasen, P. R. (2002). *Cross-cultural psychology: Research and applications* (2nd ed.). Cambridge, MA: Cambridge University.

Bodibe, R. C. (1992). *Traditional healing: An indigenous approach to mental health problems*. Cape Town: Maskew Miller.

Bojuwoye, O. (2001). Crossing cultural boundaries in counselling. *International Journal for the Advancement of Counselling, 23,* 31–50.

Bojuwoye, O. (2006). Training of professional psychologists for Africa—Community psychology or community work? *Journal of Psychology in Africa* (Special Edition on Community Psychology)*, 16*(2), 161–166.

Botha, K., & Moletsane, M. (2012). Western and African aetiological models. In A. Burke (Ed.), *Abnormal psychology. A South African perspective* (2nd ed., pp. 80–99). Cape Town: Oxford University Press.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design*. Cambridge, MA: Howard University Press.

Cartwright, D. E. (2008). Compassion and solidarity with sufferers: The metaphysics of *Mitleid*. *The European Journal of Philosophy, 16*(2), 292–310.
Castillo, R. J. (1998). Culture and schizophrenia. In R. J. Castilllo (Ed.), *Meanings of madness* (pp. 245–247). Pacific Grove, CA: Brooks/Cole.
Comaroff, J. (1980). Healing and the cultural order. The case of Baralong Boo Rashidi of Southern Africa. *American Ethnologist, 7,* 637–657.
Crafford, D. (1996). The African religions. In P. Meiring (Ed.), *World of religions: A South African perspective*. Pretoria: Kagiso.
Department of Science and Technology (DST). (2011). *DST annual report 2010–2011*. Pretoria: DST.
Dryden, W. (1984). Therapeutic arenas. In W. Dryden (Ed.), *Individual therapy in Britain* (pp. 1–22). London: Harper and Row.
Edwards, S. D. (2000). Developing community psychology in Zululand, South Africa. In S. N. Madu, P. K. Baguma, & A. Pritz (Eds.), *Psychotherapy and African reality* (pp. 149–159). Pietersburg: UNN Press.
Epp, L. R. (1998). The courage to be an existential counselor: An interview of Clemmont E. Vontress. *Journal of Mental Health Counseling, 20*(1), 1–12.
Freedman, J., & Combs, G. (1996). Narrative therapy: The social construction of preferred realities. New York: Norton.
Garfield, S. L. (1995). *Psychotherapy: An eclectic-integrative approach*. London: Wiley.
Gilligan, S. G. (1998). Listening to our demons: When new identities struggle to emerge. *Family Therapy Networker, 22*(5), 41–45.
Gumede, M. V. (1990). *Traditional healers: A medical doctor's perspective*. Braamfontein: Skotaville.
Gyekye, K. (1988). *The unexamined life: Philosophy and the African experience*. Accra: Ghana University Press.
Hannigan, B., Barlet, H., & Clilverd, A. (1997). Improving health and social functioning: Perspectives of mental health service users. *Journal of Mental Health, 6*(6), 613–619.
Harley, D. A. (2006). Indigenous healing practices among rural elderly African Americans. *International Journal of Disability, Development and Education, 53*(4), 433–452.
Hayes, G. (1986). Intervening with political psyche. In *Organization for appropriate social services in South Africa* (pp. 44–48). Johannesburg: Organization for Appropriate Social Services in Southern Africa.
Kashima, Y. (2000). Conception of culture and person for psychology. *Journal of Cross-Cultural Psychology, 31,* 14–32.
Kleinman, A. (1980). *Patients and healers in the context of culture*. Berkeley: University of California.

Levers, L. L. (2006). Traditional healing as indigenous knowledge: Its relevance to HIV/AIDS in southern Africa and the implications for counselors. *Journal of Psychology in Africa, 16,* 87–100.

Louw, D. A., & Edwards, D. J. A. (1993). *Psychology: An introduction for students in Southern Africa*. Johannesburg: Lexicon.

Makgoba, M. W. (1997). *MOKOKO, the makgoba affair: A reflection on transformation*. Florida Hills: Vivlia Publishers and Booksellers.

Mariach, L. (2003). Psychotherapy in Africa—The mental health of indigenous and tribal peoples of Africa. In N. S. Madu (Ed.), *Contributions to psychotherapy in Africa*. Sovenga: University of the North Press.

Mbiti, J. S. (1989). *African religions and philosophy* (2nd ed.). Oxford: Heinemann Educational Books Inc.

Mohamedbbai, G. (2013). Indigenous knowledge must be harvested for development. *University World News.* Global Edition. Issue 262, March 9. Retrieved March 9, 2018, from http://www.universityworldnews.com/article.php?story=20130307121157 48.

Moletsane, M. (2011). *Indigenous African personality and health theories*. Seminar presentation paper presented at Psychology Department, University of the Western Cape, Cape Town, Bellville.

Mpofu, E. (2003). Conduct disorder: Presentation, treatment options and cultural efficacy in an African setting. *International Journal of Disability, Community and Rehabilitation* (Canada Edition), *2*(1). Retrieved November 22, 2017, from http://www.ijdcr.ca/VOL02_01_CAN/articles/mpofu.shtml.

Mpofu, E. (2006). Majority world health care traditions intersect indigenous and complementary and alternative medicine. *International Journal of Disability, Development and Education, 53*(4), 375–379. Retrieved January 7, 2018, from http://www.tandfonline.com/doi/full/10.1080/10349120601008340.

Mpofu, E., Peltzer, K., & Bojuwoye, O. (2011). Indigenous healing practices in Sub-Saharan African. In E. Mpofu (Ed.), *Counseling people of African descent* (pp. 3–21). Cambridge: Cambridge University Press.

Ngubane, H. (1977). *Body and mind in Zulu medicine*. London: Academic Press.

Nyasani, J. M. (1997). *The African psyche*. Nairobi: University of Nairobi and Theological Printing Press.

Odendaal, N. (2010). *Exploring indigenous stone play as a projection medium in child psychological assessment*. Unpublished Masters Dissertation, University of Pretoria.

Owusu-Bempah, J., & Howitt, D. (1995). How Eurocentric psychology damages Africa. *The Psychologist, 8*(10), 462–465.

Parrott, C. (1999). Towards an integration of science, art and morality: The role of values in psychology. *Counselling Psychology Quarterly, 12*(1), 5–24.
Ray, C. B. (1993). Aladura Christianity: A Yoruba religion. *Journal of Religion in Africa, 23,* 266–291.
Rudnick, H. (2000). *Traditional healing in South Africa*. Johannesburg: Rank Afrikaans University Press.
Segal, M. H., Dasen, P. R., Berry, J. W., & Poortinga, Y. H. (1999). *Human behaviour in global perspective: An introduction to cross-cultural psychology*. New York: Pergamon.
Senghor, L. (1966). Negritude and African socialism. In K. Kirkwood (Ed.), *St Anthony's papers no. 15* (pp. 16–22). London: Oxford University Press.
Sheweder, R. A. (1991). *Thinking through cultures: Expeditions in cultural psychology*. Cambridge, MA.: Harvard University Press.
Shutte, A. (1993). *Philosophy of Africa*. Rodenbosch: University of Cape Town Press.
Spinnelli, E. (1994). *Demystifying therapy*. London: Constable.
Straker, G. (1994). Integrating African and Western healing practices in South Africa. *American Journal of Psychotherapy, 48*(3), 455–467.
Tulku, T. (1975). *Reflections of mind: Western psychology meets Tibetan Buddhism Nyingma Psychology Series*. Emeryville, CA: Dharma Publishing.
Vontress, C. E. (1996). A personal retrospective on cross-cultural counseling. *Journal of Multicultural Counseling and Development, 24*(3), 156–166.
Vontress, C. E. (1999). Interview with a traditional African healer. *Journal of Mental Health Counseling, 21*(4), 326–336.
Vontress, C. E. (2000, May 4–7). *Cross-cultural counselling in the 21st century*. A keynote address presented at the International Association for Counseling, Thessaloniki, Greece.
Vontress, C. E. (2003). On becoming and existential cross-cultural counsellor. In F. D. Harper & J. McFadden (Eds.), *Culture and counseling* (pp. 20–30). Boston: Allyn and Bacon.
World Health Organization (WHO). (1993). *World health statistical manual: 1992*. Geneva: World Health Organization.
World Health Organization (WHO). (2001). *Legal status of traditional medicines and complementary/alternative medicine: A world review*. Retrieved November 12, 2010, from http://whqlibdoc.who.int/hq/2001/WHO_EDM-TRM-2001.2.pdf.
Zimmermann, K. A. (2012). *What is culture: Definition of culture*. Live Science, Human Nature. Retrieved January 7, 2018, from https://www.livescience.com/21478-what-is-culture-definition-of-culture.html.

6

The Self in Hindu Philosophies of Liberation

Hillary Peter Rodrigues

You know what I mean by the self? By that, I mean the idea, the memory, the conclusion, the experience, the various forms of nameable and unnameable intentions, the conscious endeavour to be or not to be, the accumulated memory of the unconscious, the racial, the group, the individual, the clan, and the whole of it all, whether it is projected outwardly in action or projected spiritually as virtue—the striving after all this is the self. In it is included the competition, the desire to be. The whole process of that is the self, and we know actually when we are faced with it that it is an evil thing. I am using the word evil intentionally because the self is dividing; the self is self-enclosing; its activities, however noble, are separated and isolated. We know all this. We also know that extraordinary are the moments when the self is not there, in which there is no sense of endeavour, of effort, and which happens when there is love. (Krishnamurti 1952, p. 76)

H. P. Rodrigues (✉)
University of Lethbridge, Lethbridge, AB, Canada

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_6

Introduction

This chapter primarily deals with the notion of the 'self' in a few of the major schools of Indian philosophy. One might reasonably wonder why one should examine ideas about the 'self' in a volume that is concerned with mind and mental health. A succinct response is simply that in several of the most influential Hindu philosophies, mental health is directly related to a proper apprehension of one's true self, which when unexamined is at the root of our psychological problems.[1] This correct apprehension is sometimes called 'self-realization,' and although we will see that ideas about what the self actually is and how one can realize it vary considerably, all the philosophical schools that we shall examine agree that such realization frees one from a sort of psychological bondage. This is why these are called philosophies of spiritual liberation (*moksha*). Although individual Hindus may not adhere strictly to any of these philosophies, their worldviews are substantially shaped by features within these systems, which have circulated on the Indian subcontinent for millennia. Moreover, key notions about the self and liberation have begun to permeate the worldviews of non-Hindus, particularly in the West, through the influences of Yoga and modern nondual spirituality philosophies. It is therefore crucial to have a nominal understanding of these systems if one wishes to understand not only a Hindu's core psychological framework, but that of anyone who is aligned with these philosophies.[2]

Hinduism is a complex religious and cultural tradition, because it really is not a single system of beliefs.[3] The term Hinduism was crudely applied to the rich assortment of beliefs and practices of people on the Indian subcontinent that were not part of other more readily defined religions, such as Jainism and Buddhism. The processes that shape Indian society began over three millennia ago when the migrating Aryans entered the region from the northwest frontier. As they moved deeper into the subcontinent, they intermingled with the indigenous high culture, sometimes called the Dravidians (Southerners). These were likely the descendants of a vast civilization with many urban centres that had flourished along the Indus River, but which had been abandoned prior to the Aryan arrival. In a process that continues today, both

Aryan and Dravidian cultures affected each other, and were influenced by the indigenous tribal communities they encountered as they populated more remote regions of the subcontinent.

Over the centuries, various worldviews (*darshanas*) developed through the intermingling of these communities.[4] Early in this process, Indian society had stratified into four major classes: Brahmins (priests), *kshatriyas* (kings and soldiers), *vaishyas* (merchants), and *shudras* (workers). The most orthodox members of the priestly classes began to categorize the differing worldviews, thereby initiating a process of Hindu self-definition. Orthodox philosophies accepted the class system, which privileged the priestly class. And they did not reject the belief that the sacred scriptures of the Aryans, the Vedas, were divinely composed. As a result, Buddhism and Jainism, which were overtly critical of the class system, and the sacrosanct status of the Vedas, were eventually regarded as heterodox systems and in time constituted distinct religions. Three of the most enduring of the orthodox systems (*darshanas*) are Sankhya,[5] Yoga, and Vedanta, and they will be the primary focus of this discussion, although we will also discuss related systems.[6]

The Self in the Sankhya *Darshana*

Although most people in the West are quite unaware of the Sankhya philosophical system, its influence on Hindu ways of thinking is significant.[7] This is because Sankhya is a very ancient *darshana*, many of whose ideas were utilized in the construction of other metaphysical systems. Tradition attributes the creation of Sankhya to the sage Kapila, about whom only legends abide. The term Sankhya means 'enumeration,' perhaps because the philosophy attempts to categorize the key elements that constitute reality. Just as modern physicists might assert that the world is composed of energy and matter, the ancient Sankhya thinkers claimed that reality is composed of two primary constituents. These are known as Purusha and Prakriti, and they are fundamentally transcendent. That is, they are beyond or transcend knowledge through the conventional epistemological categories, such as perception. We cannot normally see or feel Purusha or Prakriti in their intrinsic states.

However, simply due to Purusha's presence, Prakriti leaves its transcendent state and becomes manifest. Consequently, in this system Purusha is a passive principle that, in effect, does nothing, even though its mere presence sets Prakriti on a dynamic trajectory of manifestation.

Although Prakirti may be translated as Nature or Materiality, it is evidently akin to a mysterious principle that both underlies nature as well as constitutes its actual material manifestations. Just as the science of chemistry catalogues the elements of matter in the periodic table, the Sankhya metaphysicians discerned that Prakriti manifests as 23 *tattvas* or elements, some grosser than others. The grossest of these are five primary elements, namely, earth, water, fire, air, and space. The five subtle elements, of colour/shape, sound, flavour, texture, and odour, are mediate between the gross elements and the five senses of sight, hearing, taste, touch, and smell. Subtler than these are the action *tattvas*, namely, appropriation, excretion, locomotion, communication, and reproduction. These are akin to the categories that modern biologists might equate with animate matter, or life.

Even more subtle than these are the final three elements, which are collectively called the inner actor (*antah karana*), or thought (*citta*). *Citta* is made up of heart/mind (*manas*), ego (*ahamkara*), and discriminating intellect (*buddhi*), which is the subtlest element. With regards to the concerns of this volume, *citta* is a particularly significant category, because it constitutes what in the West is typically called mind. So, let us examine it in more detail. *Manas*, the grossest of these three inner or mental elements, is what we often consider to be 'mind' and the real 'me' in many western psychological foundations. However, in the Sankhya system, *manas* is merely the sixth or inner sense organ. It collectively encapsulates feeling and thinking processes, as well as the 'sense organ' that registers thoughts and feelings. Hence it is often translated as heart/mind. Just as our ears and our sense of hearing register sound, so too *manas* registers our thoughts and feelings, but is indistinguishable from our thoughts and feelings. Hence *manas* collapses both the registering inner sense organ and the thoughts/feelings into a single *tattva*. The underlying logic is that there must be an organ that makes us aware that we are feeling sad or happy, or that we are remembering, fantasizing, deducing, and so on.

In the West, we typically regard thoughts and feelings as manifestations of our true selves, while in the Sankhya system these are not. In most Western psychological formulations, it is I who feel sad, who hold an allegiance to a political party, believe in God, and so on. Sankhya metaphysics simply regards these thoughts and feelings as phenomena that arise and pass, much like sounds and sights, due to various influences to which we have been exposed. We are not fundamentally our thoughts and feelings. It is the next mental *tattva*, *ahamkara* (literally, the I (*aham*)-maker (*kara*)) that causes attachment to these thoughts and feelings. *Ahamkara* is subtler than *manas*, and is at the hub of our problems and false identifications. *Ahamkara's* nature is to construct 'self' through identification with any of the elements that are grosser than it. As babies, we may incorrectly identify 'self' with objects we perceive around us, but as we grow we shed those false identifications. At less mature stages of our development we may continue to identify 'self' with our possessions, or with our bodies and our appearance. However, even if we outgrow the notions that we are not the kind of car, house, or smartphone we own, we rarely shake our tendency to identify 'self' with our feelings and thoughts. *Ahamkara's* proclivity to construct 'self' through identification with whatever comes its way is generally unabated until it is deeply affected by the third inner *tattva*, *buddhi*, which is the subtlest of Prakriti's manifestations. Often translated as 'discriminating intellect,' *buddhi* is the mental faculty that can distinguish between things. It enables us to know the difference between a dog and a doughnut, and between what is true and false. According to Sankhya metaphysics, it is *buddhi* that enables us to notice *ahamkara's* identifying tendencies, and also enables us to see that these identifications are mostly fickle or haphazard. They are repeatedly erroneous, attaching willy-nilly to this and that of Prakriti's grosser elements, and most certainly do not constitute the real self.

In the Sankhya system, Prakriti is composed of three fundamental qualities, known as the *gunas*. Each and every of Prakriti's 23 manifest elements possesses the three *gunas* to a greater or lesser extent. The grossest fundamental elements have the *tamas guna*, which has the quality of heaviness, opaqueness, turbidity, and so on, in the highest proportion. The mental elements, such as *manas* and *buddhi*,

have higher proportions of the *sattva guna*, which has the quality of luminosity, purity, clarity, and so on. The third *guna*, *rajas*, has qualities of dynamism and activity. As the subtlest element in Prakriti's manifestations, *buddhi* is rich in the *sattva guna*. This quality is at play in Prakriti's dynamic series of manifestations. Essentially, once it leaves its transcendental state, Prakriti's play consists of a series of material manifestations, in which some of its elements identify with each other, creating nominal selves through the agency of the *ahamkara* (I-maker). While our nominal selves are necessary for life in the world, mistaking our adopted 'personas' for our true selves can be a source of deep psychological distress. Fortunately, *buddhi's* operations, when functioning optimally, begin to note these proclivities and recognize this play of false identifications. This is the beginning of a spiritual journey to self-realization.

The Yoga *Darshana*

Although we have not completed our description of the Sankhya *darshana*, it is appropriate that we turn to discussing the Yoga *darshana*, which in its earliest writings was closely linked with Sankhya. For while Sankhya laid out a description of embodied existence (namely through its *tattva* scheme), and the cause of human suffering (attributed to misidentification of 'self' with material components of reality), Yoga accepted this description but articulated methods through which one might accomplish the self-realization to which Sankhya pointed. It is probably necessary to point out that the ancient Indian philosophical school of Yoga differs substantially from the popular practice of yoga in studios throughout the West.

The earliest systematic description of the Yoga *darshana* is the *Yoga Sutra* (*Aphorisms on Yoga*), attributed to the sage Patanjali.[8] In about 200 aphorisms, Patanjali presents a succinct treatment of what was evidently a pre-existing *darshana*. So, although his work is the oldest extant study, and still enormously influential, he is not regarded as Yoga's founder.[9] Yoga's origins are far more ancient, and likely derive from body-mind practices prevalent in the Indus Valley civilization.

Over time, commentaries were written on Patanjali's text, and yoga techniques were adopted by other *darshanas*.[10]

Patanjali's first aphorism simply states that he is about to explicate Yoga. His second aphorism succinctly defines Yoga by its prime objective. Yoga, he states, is the stopping (*nirodha*) of the turnings/movement (*vritti*) of the *citta* (thought). This definition likely comes as a great surprise to the large numbers of people in yoga studios throughout the world, which emphasize bodywork through posture, which is truly a very small portion of what constitutes the Yoga *darshana*. In his third and fourth aphorisms, Patanjali goes on to state that only then (that is, if the movement of *citta* is stopped), does the observer abide (*avasthanam*) in his/her true nature. Otherwise, one takes up the form (*sarupya*) of the turnings (*vritti*). Although other aphorisms elaborate upon Yoga's metaphysical system, these first aphorisms get right to heart of the matter, and we can easily recognize the parallels to the Sankhya *darshana*.[11] Essentially, the 'turnings of thought' to which Patanjali refers, are the activities of the heart-mind (*manas*), the ego (*ahamkara*), and even the discriminating intellect (*buddhi*). All of these must stop their activities for the turnings (*vritti*) to end. Here, in particular, is where Yoga differs from Sankhya, because it offers some practical methods for stopping thought.

One of the most influential presentations of Patanjali's method is through what are known as the eight limbs (*ashtanga*) of Yoga. These are to be developed systematically and begin with moral restraints and observances. This moral foundation in these first two limbs entails practicing non-harming, non-stealing, non-lying, and so on. One is also expected to cultivate cleanliness, contentment, a modicum of austerity, and a focus on the goal. Although Western manifestations of yoga practices centre primarily on posture-work, Patanjali treats this third limb perfunctorily. Posture (*asana*) should simply be steady and relaxed/comfortable. Other texts on Yoga, of later vintage, elaborate upon the various types of stretching and balancing postures practiced in Western yoga studios. Control of the vital energy (*pranayama*) is the fourth limb, and this is mostly accomplished through a variety of breathing exercises. Breath is a crucial vehicle for the vital energy, and other Yoga texts outline a variety of ways to inhale, hold, and exhale the breath.

The next item is *pratyahara*, which is the restraint of the senses. It consists of learning how to focus on a particular sense, while shutting off the input from other senses. It is the sort of process that occurs naturally when we are focussed on reading, for instance, and do not hear music in the background. The last three limbs are concerned with focussing the mind. *Dharana* or concentration involves giving one's complete attention to a focal object, such as a sound or an image. The sonic vibration Aum/Om is often used for this purpose. The deepening of concentration into a smooth, unbroken flow is meditation (*dhyana*). In meditation, one may shift the focus from external objects to dynamic mental processes, such as the rising and falling of feelings and the movements of thoughts. In essence, concentration (*dharana*) and meditation (*dhyana*) are the means through which one becomes progressively aware of the turnings of the *citta*. As meditation deepens one may enter into deep states of contemplative absorption, known as *samadhi*. In *samadhi*, the division between the observing self and that which is observed may disappear. This leads to crucial insights, because the ego (*ahamkara*) has in effect ceased its function. It does not identify 'self' with any item perceived, because the separation between perceiver and perceived collapses. Even so, the absorption is still tied to the movements of thought, which continue to act as seeds which sprout as subsequent thoughts.

At this stage, the discriminating intellect (*buddhi*) has clearly discerned all of *ahamkara's* tendencies, undercutting its capacity to deceive with its false identifications. In its highest act of discriminating insight, known as *viveka*, *buddhi* realizes that it too is one of Prakriti's manifestations, and ceases its own activities. The Sankhya/Yoga system views this as Prakriti returning to its transcendent state. It is only now that the true observer is fully revealed. This observing consciousness is Sankhya's second transcendent component, Purusha, which is regarded as the true self. Purusha has always been the dispassionate observer of all of Prakriti's machinations. However, its true nature was obscured by the activities of the ego, with its incessant attachments to the movements of thought and the other *tattvas*. Only when Prakriti ceases its activities, which is akin to the stopping of the turnings of feeling-thinking (*manas*), ego attachments (*ahamkara*), and even discriminating intellect (*buddhi*), can Purusha know itself as the true self, namely pure observing consciousness.

Prakriti can never know Purusha according to these *darshanas*. This realization of Purusha as the true self, which is the dispassionate observer, is the fulfilment and goal of Yoga and Sankhya. It is the result of a contemplative absorption without any object in consciousness, and thus sometimes known as Samadhi without any seed. It is pure awareness, without any attachment to any external element. In the Yoga *darshana* this 'liberation' of Purusha from the obscuration caused by manifest Prakriti is called *kaivalya*, or isolation. It constitutes spiritual liberation or self-knowledge. Ultimately, only this self-knowledge can free one from psychological duress and suffering, which is rooted in spiritual ignorance. While many early Western interpretations portrayed Yoga philosophy as promoting disdain for and escape from society, Whicher's (1998) study effectively argues just the opposite, that Yoga refines individuals thereby enhancing their relationship with the world.

Self in the Vedanta *Darshana*

Before we embark on a discussion about the crucial implications of these philosophies about the self, there is one other influential philosophy that needs to be explored. This is Vedanta. Vedanta concerns itself with interpreting the Upanishads, a series of texts of speculative philosophy that form the final portion (*anta*) of the corpus of the most sacrosanct Vedic literature. Although the Upanishads vary in length and content, they share a philosophical concern with the nature of the true self, true reality, and the relationship between these. In their interpretations, Vedanta philosophers also include Hinduism's most popular religious scripture, the *Bhagavad Gita*.[12] Novice western students of Hinduism often think that Vedanta is *the* philosophy of Hinduism. In part, this is because western audiences were first introduced to Hindu philosophy through the teachings of Swami Vivekananda, a charismatic teacher who represented Hinduism at the World's Parliament of Religions in Chicago in 1893. Vivekananda was an eloquent spokesman for Vedanta philosophy.[13]

In the over 2500 years since the composition of the principal Upanishads, a number of Vedanta schools emerged, which vary in their

understanding of the self and reality. One of the most highly regarded schools of Vedanta centres on the interpretations by the philosopher Shankara (c. 8th to 9th century CE).[14] Shankara's Vedanta is sometimes called radical nondualism (*advaita*), because it proposes that there is only one thing in reality. This is quite different from the dualistic realism of Sankhya philosophy, which proposes two transcendent realities, namely, Purusha and Prakriti. In Shankara's radical nondualism, the sort of cognitive and conceptual errors that Sankhya philosophy attributes to Prakriti's manifestations are attributed instead to an illusory power known as Maya. The true self in Shankara's system, known as Atman, is said to be identical with Absolute Reality, known as Brahman. In other words, Atman and Brahman are synonyms in this philosophical system. This because there is only one reality, indivisible, and beyond conceptualization. Brahman's essential nature is existence (*sat*), consciousness (*chit*), and bliss (*ananda*).

To resolve the seeming dualism that might thwart his nondualist philosophy, namely that Maya appears to be different from Brahman, Shankara utilized the analogy of a piece of rope mistaken for a snake. This is the doctrine of superimposition (*adhyasa*). This is an example of the workings of Maya, which superimposes an incorrect perception, the illusory snake, upon the rope, preventing one from seeing the rope's true nature. So too, Maya superimposes a world of multiplicity, of concepts, and so on upon Brahman, distorting our perceptions and concealing its reality from us. However, Maya is itself not different from Brahman. Just as a close inspection of the illusory snake reveals that it derived its semblance from the rope, and just as its illusory power vanishes when the reality of the rope is seen, so too Maya's illusory power dissolves when one realizes Brahman's true nature.

The *Bhagavad Gita* describes three main approaches that can be taken to cut through this key, self-obscuring illusion. One method is through meditative practices that refine one's transcendental knowledge (*jnana*). The other approach is through the selfless performance of actions (*karma*), without attachment to their outcomes. And the third approach is through the practice of loving devotion (*bhakti*) to the divine. The *Bhagavad Gita's* popularity partly stems from its promotion of *bhakti*, which endorsed the worship of the hundreds of gods and goddesses in

Hinduism today.[15] In all of these approaches, the 'self' as we conventionally think of it, is abnegated in order to discover a truer and higher 'Self,' which in nondualist Vedanta philosophy is none other than Absolute Reality itself, Brahman. This is liberation, and this is why it is sometimes known as Self-realization.[16]

Unpacking Philosophies of the Self

We have seen that Sankhya promotes a dualistic vision of reality, with Purusha as the real 'self' or pure consciousness, and various components of Prakriti, subject to the activities of the ego (*ahamkara*), generating a tentative, but false self. Each entity has its own Purusha, although the implication is that these Purushas are virtually identical in their intrinsic natures. In nondualistic Vedanta, however, there is no multiplicity. The real 'self' is Brahman/Atman, concealed due to the actions of Maya, a principle of illusion that generates a false self and the world of seeming multiplicity and variation. The earliest extant yogic writings were aligned with the Sankhya worldview. However, Yoga was eventually adopted by other philosophies, including Vedanta, because it offered some practical suggestions, such as the "eight limbs," on how one might transcend the illusory self to realize the true Self.

Despite these variations, a key feature shared by these systems is that we do not see the world or ourselves correctly. This is intrinsic to the human condition, for we are born ignorant of our true natures, and this ignorance causes us suffering. Most Hindus accept the notions of metempsychosis, namely transmigration or reincarnation, as well as the doctrine of *karma*.[17] To generalize somewhat, to Hindus, all actions have consequences. The word *karma* literally means 'action.' Quite early in the history of Indian thought, *karma* had come to mean more than simply action, but referred to a moral principle of causality. In the doctrine of *karma*, every act has a moral value. While many acts are neutral, good actions on behalf of others produce good results, while evil actions will certainly bring painful results to the doer. Closely tied to this doctrine is a belief in reincarnation, because a life full of good deeds or evil deeds cannot go unaccounted for merely because of death. Hinduism does not

postulate a god-like deity who acts as a judge, evaluating one's actions after death, and doling out punishment or reward. *Karma* is hard-wired into the fabric of the creation; no action can go unaccounted. Our appearance, our gender, our class/caste, talents, attributes, and even many of our thoughts, words, and other deeds are simply the 'effect' of previous actions. *Karma* spans lifetimes, and serves as an explanatory mechanism for why good things happen to bad people and vice versa.

It is important to recognize that this is not a doctrine of fatalism, because through awareness or other activities one can override the pernicious effects of *karma*. Hindus use the term *dharma* to refer to activities that are in alignment with the cosmic order. This is righteousness, and by following injunctions passed down from antiquity, in code books on *dharma*, one may minimize the effects of bad *karma*, and maximize good *karma*. These codices, known as the Dharma Shastras, present teachings on morality, class/caste duties, religious festival celebrations, injunctions on how to maintain ritual purity and avoid impurity, and so on.[18] Put succinctly, a Hindu's moral compass is circumscribed by *dharma*, articulations on righteous living to be followed in order to minimize future misfortune, and hopefully secure a better rebirth. Nevertheless, one can see that merely following *dharma*, thereby enhancing good *karma* and avoiding bad *karma*, is inadequate for spiritual liberation (*moksha*). Essentially, adherence to *dharma* will at best result in a fortunate rebirth. In traditional Hinduism, this meant probably being born as a male in the priestly, Brahmin class. However, such a birth was no guarantee that one would attain liberation, which requires a penetrating insight into the true nature of the 'self.'

Although the philosophies we have discussed vary in their notions of what constitutes the 'real self,' they all agree on the value of realizing what it is. Classical Hinduism values four main goals worthy of pursuit in life. These include righteousness (*dharma*), pleasure (*kama*), power/accomplishment/expertise (*artha*), which are appropriately pursued at various points in one's life. A householder, for instance, engaged in working for a livelihood and raising a family, is best suited to pursue the goals of *artha* and *kama*. But the most highly valued goal is self-realization (*moksha*). Crucially relevant to the concerns of this volume,

these philosophies impute that without the insight that leads to *moksha*, one is subject to a nearly endless round of psychological anguish that derives from misunderstanding who or what one really is.

In the Sankhya and Yoga *darshanas*, the real self or Purusha is the dispassionate observer of Prakriti's machinations, to various features of which the ego (*ahamkara*) mistakenly identifies. In the Vedanta *darshana*, the true self, which is Brahman/Atman, also goes unnoticed as one is wrapped up in the creative play of Maya. But as noted in the analogy of the rope mistaken for a snake, *ahamkara's* false identifications and Maya's play can have dire effects. Just as we may be terrified by the illusory snake, our lack of self-understanding may have deadly consequences for ourselves and others. Instead of recognizing a fundamental similarity or even unity among all beings (as these religious philosophies impute), we construct and cling fast to our own self-images, which we may sharply distinguish from those of others. We may identify as Hindus, Muslims, Christians, brahmins, *shudras*, and so on, and saddle ourselves with a host of responsibilities and expectations attached to these personas. These identifications may dictate what we should or should not eat, and with whom we should or should not interact intimately. More perniciously, these identifications may lead us into self-destructive states of psychological anxiety and depression, or into acts of violence towards others.

There are evident similarities between these Hindu philosophies of liberation and Buddhist teachings, insofar at both sets of traditions promote the attainment of a penetrating, liberating insight into the true nature of the self. However, while the Hindu systems uphold the existence of some sort of core 'self,' be it the Purusha of the Sankhya and Yoga philosophies, or the all-encompassing Atman/Brahman in nondualistic Vedanta, Buddhism does not promote such notions. In effect, in Buddhist philosophy, a fundamental error and the root cause of psychological suffering is clinging to a belief in some sort of permanent, independent core 'self' or 'soul.' This rejection is known as the Anatman Doctrine in Buddhism. In most Buddhist teachings, not only is the idea of a core inner self or soul like the Purusha an error, so is the idea of a large, all-encompassing Self, such as Brahman.[19]

Implications of Hindu Philosophies of the Self

Although the vast majority of Hindus do not wholeheartedly adhere to any of these philosophies, these notions contribute substantively to Hindu religious culture, which informs Hindu values and drives behaviors. For instance, the Sankhya categories of the three *gunas*, namely *sattva*, *rajas*, and *tamas*, affect the way that Hindus think about nutrition. It played a significant role in the classical Indian system of medicine, known as Ayurveda. Certain foods, such as clarified butter (*ghi*) and yoghurt are classified as pure or sattvic. Other items such as meat are regarded as tamasic, the quality that dulls the mind, and these along with stimulating or rajasic foods are believed to impede our ability to understand our true natures.[20] Despite such cultural influences, most Hindus do not whole-heartedly pursue the goal of self-realization, particularly through most of their lives. Orthodox Hinduism promoted the notion of pursuing the worthwhile goals in life systematically in appropriate relationship to one's stage in life. As a result, self-realization or *moksha* was held to be best pursued after retirement, after one had satiated the pursuits of righteousness (*dharma*), power (*artha*) and pleasure (*kama*). Ancient texts had implied that social renunciation was vital to enable one to be freed from the temptations and travails of worldly life, and Buddhism had even created a monastic system of organized renunciation.

However, the *Bhagavad Gita*'s teachings reflect a dramatic alteration in the notion of renunciation and its role in the attainment of liberation. Not only could one remain a householder, engaging in worldly duties with an attitude of non-attachment to the outcomes of one's actions, but that scripture also promoted loving devotion to a personal god as a vehicle for spiritual liberation. This approach of loving devotion, known as *bhakti*, is by far the dominant form of religious practice in which most Hindus currently participate. They may make daily visits to temples, or perform short rituals of worship at home shrines dedicated to a host of Hindu deities.[21] It would be erroneous to insinuate that most Hindus who engage in *bhakti* practices are seeking self-realization rather than more mundane benefits (for example, jobs,

marriage, offspring) that they believe can be conferred by the deities they worship. However, most will acknowledge that *moksha* is indeed the ultimate goal that they pursue, even if spiritual liberation may only move more to the centre than the periphery of their concerns later in their lives.[22]

Clearly, the implications of valuing self-realization cannot be understated. For although Hindus may worship a dizzying array of gods and goddesses, through a plethora of worship rites, and engage in a rich assortment of practices, including pilgrimages and fasting, there is a vibrant strand in their worldviews that undercuts the ultimate value of a good portion of their religious activities. This is because the notion of self-realization deems worldly existence as fundamentally illusory or potentially misdirecting one from what is truly relevant, namely, knowing one's true nature. Moreover, belief in *karma*, the moral principle of cause and effect, coupled with reincarnation, may lead to lifestyle choices and behaviors markedly different from people who subscribe to religious worldviews of single lives in which to prove one's moral character in order to gain or avoid an eternity of reward or punishment.

A particularly significant social and psychological dimension of these Hindu philosophies, and one that has been inadequately examined, is their growing popularity among Western populations. Of course, people in the West are not embracing Hindu religious culture in its entirety, but the growth in popularity of yoga, and nondual spirituality, is certainly noteworthy. Although the type of yoga practiced in studios in the west is preponderantly focussed on posture-work and physical fitness, one should not discount its association with mental and emotional tranquillity and stress-reduction. Western practitioners sometimes grow curious about the cultural origins and the deeper dimensions of yogic practice, and therefore studios, websites, and so on provide information on Yoga philosophy to those who are interested. As a result, there is a growing population in the West that is influenced by a Yogic philosophical worldview and its values.[23] Such values might include preferences for bodily cleanliness, mental equilibrium, and for the eating of sattvic foods, for instance, which dispose one towards vegetarianism and veganism. In time, perhaps notable numbers might even embrace the Yogic value of seeking self-realization.

Similarly, the Modern Nondual Spirituality (MNS) movement has vibrant resonances with the classical nondual Vedanta philosophical teachings of Shankara and others.[24] Influential voices in this movement have been Ramana Maharsi, Nisargadatta Maharaj, and J. Krishnamurti.[25] The newer generation of teachers, such as Eckhart Tolle, Ramesh Balsekar, Gangaji, Adyashanti, and Mooji offer either a direct or tacit homage to the older generation.[26] However, a distinctive feature of the MNS movement is that members may be quite unaware of the Eastern philosophical heritage. They may be unaware of terms such as Purusha, Atman/Brahman, or *moksha*. They may not believe in *karma* or reincarnation, and almost certainly do not identify as Hindus. However, they are as deeply oriented towards the goal of self-realization as any Hindu adherent of Shankara's nondual Vedanta.[27] In an interconnected world, where religious and philosophical notions from all corners can and do intersect, it is vital that educators and counsellors remain informed about what are soon becoming trans-cultural worldviews, so that they may better understand and serve others.

Notes

1. An early discussion of this relationship is found in Akhilananda (1952). Tolle's (1997) *The Power of Now* is the most popular of these writings by modern nondual teachers, whose representative works include Balsekar (1992), Adyashanti (2004), Gangaji (2005), and Mooji (2008).
2. Swartz (2009) critiques the approaches of many of the modern teachers, who appear to undercut the value of discipline and other foundational efforts.
3. A comprehensive introduction to the Hindu tradition's history, its key thinkers, philosophical schools, myths, and practices is found in Rodrigues (2017).
4. In order to simplify reading and pronunciation for non-specialist readers, I have avoided diacritic marks that most scholars conventionally use to transliterate certain Sanskrit letters. Instead I have used phonetic spellings. So, you will see *darshana*, *kshatriya*, *vaishya*, *shudra*, and so on.
5. Sankhya is often also transcribed as Samkhya.

6. Hiriyanna (1995) presents a succinct introduction to Indian philosophies in general, while a comprehensive classic account is found in Dasgupta (1922–1955).
7. Larson and Bhattacharya (1987) offer and excellent treatment of Sankhya philosophy.
8. There are innumerable translations of the *Yoga Sutra*. A succinct and accessible translation is Miller (1998), while Bryant (2009) offers a more recent translation with extensive commentary.
9. White's (2014) "biography" of the *Yoga Sutra* is an intriguing study of this text's influence from the time of its composition.
10. An authoritative, comprehensive study of the Yoga tradition, its origins, and intersections with other aspects of Indian philosophies and culture is found in Eliade (1958).
11. Hariharananda Aranya's (1984) presentation of the *Yoga Sutra* includes one of its earliest Sanskrit commentaries by Vyasa, which he unfortunately does not translate. However, as a Swami from within a living Sankhya monastic tradition, Aranya's own commentary ably draws out connections between the Sankhya and Yoga *darshanas*.
12. The *Bhagavad Gita* is arguably the most influential and most widely read of Hindu religious writings, and has been translated into more than seventy-five languages. Davis (2014) traces the story of some of its translations and influences on figures from Shankara to Thoreau and Vivekananda through history. Edgerton's (1944) scholarly translation was, for long, one of the standard texts used in university classes on the *Gita*.
13. Fort (1998) provides an excellent survey of traditional perspectives on the nature of the embodied liberated state (*jivanmukti*) in Advaita Vedanta. He also discusses its adoption into a 'Yogic Advaita' in the hands of Yoga philosophers, and its transformations through the influences of Swami Vivekananda and others into Neo-Vedanta with a stronger humanistic focus, often involving social engagement.
14. In opening his discussion of Shankara's nondual Vedanta, Deutsch (1973, p. 3) states, "[it] has been, and continues to be, the most widely accepted system of thought among philosophers in India, and it is, we believe, one of the greatest philosophical achievements to be found in the East or the West."
15. Swami Bhaktivedanta's (1968) translation of the *Bhagavad Gita*, with a strong interpretive orientation of loving devotion (*bhakti*) to Krishna, circulates widely due to the efforts of his organization.

16. White (1971) presents an excellent analysis of the *Bhagavad Gita*'s teachings on what constitutes the highest human good (*paramartha*), and what the character of the perfected person and his/her actions would likely be.
17. An excellent collection of essays on the doctrine of *karma* in various Indian philosophies has been compiled in Doniger (1980).
18. A recent authoritative survey of readings from the Dharma Shastras is found in Olivelle (2017). Olivelle has been one of the most prolific translators and scholarly interpreters of Dharma Shastra literature in the last several decades.
19. Kuznetsova et al. (2016) compiles a useful collection of essays on Buddhist and Hindu notions of the self.
20. A fascinating collection of essays on how classical Ayurveda has been appropriated and transformed, impacting cultures in both the East and the West, is found in Wujastyk and Smith (2013).
21. Prentiss (1999) presents an intriguing analysis of the history of interpretations of the term *bhakti*, which she asserts might be better translated as "participation," rather than "devotion," since it calls on participants to engage bodily in their worship.
22. Perrett's (2001) collection on topics in Indian philosophy offers several papers on the notion of *moksha* and its relationship to the four goals of life.
23. Coward (2012) traces some of the influences of classical Yoga philosophy on Western psychologists such as Freud and Jung, pointing out that it has not always been unilaterally embraced.
24. An excellent analysis of nondual teachings within classical Asian philosophy from Vedanta to Zen is presented in Loy (1988). Loy also forges comparisons with Heidegger's notion of nonduality.
25. There are various volumes that present the writings or teachings of these "patriarchs" of the modern nonduality movement. Godman's (1985) title, *Be As You Are*, presents an excellent collection of Ramana Maharshi's teachings. Frydman's (1973) *I Am That* is regarded as the classic presentation of Nisargadatta Maharaj's teachings. Rodrigues (2001) is a scholarly analysis of J. Krishnamurti's extensive collection of teachings on insight and religion.
26. Tolle's (1997) *The Power of Now* is the most popular of these writings by modern nondual teachers, whose representative works include Balsekar (1992), Adyashanti (2004), Gangaji (2005), and Mooji (2008).
27. Swartz (2009) critiques the approaches of many of the modern teachers, who appear to undercut the value of discipline and other foundational efforts.

References

Adyashanti. (2004). *Emptiness dancing*. Boulder, CO: Sounds True.
Akhilananda, S. (1952). *Mental health and Hindu psychology*. London: George Allen and Unwin.
Aranya, Swami H. (1984). *Yoga philosophy of Patanjali [with the commentary of Vyasa]*. Albany: State University of New York Press.
Balsekar, R. (1992). *Consciousness speaks: Conversations with Ramesh S. Balsekar* (W. Liquorman, Ed.). Redondo Beach, CA: Advaita Press.
Bhaktivedanta Swami, A. C. (1968). *The Bhagavad Gita as it is*. New York: Macmillan.
Bryant, E. (2009). *The yoga sutras: A new edition, translation, and commentary*. New York: North Point Press.
Coward, H. (2012). *Yoga and psychology: Language, memory, and mysticism*. Albany: State University of New York Press.
Dasgupta, S. (1922–1955). *A history of Indian philosophy* (5 Vols.). Cambridge: Cambridge University Press.
Davis, R. H. (2014). *The "Bhagavad Gita": A biography*. Princeton: Princeton University Press.
Deutsch, E. (1973). *Advaita vedanta: A philosophical reconstruction*. Honolulu: University of Hawaii Press.
Doniger, W. (Ed.). (1980). *Karma and rebirth in classical Indian traditions*. Berkeley: University of California Press.
Edgerton, F. (1944). *The Bhagavad Gita*. Harvard Oriental Series (2 Vols.). Cambridge, MA: Harvard University Press.
Eliade, M. (1958). *Yoga: Immortality and freedom*. Translated from French by Willard R. Trask. London: Kegan Paul [Reprint, with corrections and new material. Princeton: Princeton University Press, 1969].
Fort, A. O. (1998). *Jivanmukti in transformation: Embodied liberation in advaita and neo-vedanta*. Albany: State University of New York Press.
Frydman, M. (Trans.). (1973). *I am that: Talks with Sri Nisargadatta Maharaj*. Durham, NC: Acorn Press.
Gangaji. (2005). *The diamond in your pocket: Discovering your true radiance*. Boulder, CO: Sounds True.
Godman, D. (Ed.). (1985). *Be as you are: The teachings of Sri Ramana Maharshi*. London: Penguin Arkana.
Hiriyanna, M. (1995). *The essentials of Indian philosophy*. Delhi: Kavyalaya [Reprint. Delhi: Motilal Banarsidass, 2005].

Krishnamurti, J. (1952/2010). Reflections on the self. Fifth talk in Madras, January 19, 1952. In J. Krishnamurti, *The first and last freedom*. New York: HarperCollins.

Kuznetsova, I., Jonardon, G., & Chakravarthi, R.-P. (Eds.). (2016). *Hindu and Buddhist ideas in dialogue: Self and no-self*. London: Routledge.

Larson, G. J., & Bhattacharya, R. S. (Eds.). (1987). *Samkhya: A dualist tradition in Indian philosophy*. In *Encyclopedia of Indian Philosophies* (Vol. IV). Princeton: Princeton University Press.

Loy, D. (1988). *Nonduality: A study in comparative philosophy*. New Haven: Yale University Press.

Miller, B. S. (1998). *Yoga: Discipline of freedom*. The Yoga Sutra attributed to Patanjali; a translation of the text with commentary, introduction, and glossary of keywords. *The Journal of Asian Studies, 57*(2), 584–586.

Mooji. (2008). *Before I am: The direct recognition of our original self: Dialogues with Mooji*. Cochin, Kerala: Stone Hill Foundation Publishing.

Olivelle, P. (Trans. & Ed.). (2017). *A dharma reader: Classical Indian law*. New York: Columbia University Press.

Perrett, R. W. (Ed.). (2001). *Theory of value. Indian philosophy: A collection of readings*. Milton Park, Oxon: Routledge.

Prentiss, K. P. (1999). *The embodiment of bhakti*. New York: Oxford University Press.

Rodrigues, H. (2001). *Krishnamurti's insight: An examination of his teachings on the nature of mind and religion*. Varanasi: Pilgrims Publishing.

Rodrigues, H. (2017). *Introducing Hinduism* (2nd ed.). London and New York: Routledge.

Swartz, J. (2009). *How to attain enlightenment: The vision of non-duality*. Boulder, CO: Sentient Publications.

Tolle, E. (1997). *The power of now: A guide to spiritual enlightenment*. Vancouver: Namaste Publishing.

Whicher, I. (1998). *The integrity of the yoga darshana: A reconsideration of classical yoga*. Albany: State University of New York Press.

White, D. (1971, January). Human perfection in the Bhagavadgita. *Philosophy East and West, 21*(1), 43–53.

White, D. G. (2014). *The yoga sutra of Patanjali: A biography*. Princeton, NJ: Princeton University Press.

Wujastyk, D., & Smith, F. M. (Eds.). (2013). *Modern and global ayurveda: Pluralism and paradigms*. Albany: State University of New York Press.

7

Buddhist Orientations to Mental Health

Hillary Peter Rodrigues

> What do we imagine will make us happy? A canny, self-seeking, resourceful selfishness, the selfish protection of ego, which can, as we all know, make us at moments extremely brutal. But in fact the complete reverse is true: Self-grasping and self-cherishing are seen, when you really look at them, to be the root of all harm to others, and also of all harm to ourselves. (Rinpoche 2008, p. 192)

It is important at the outset of this chapter to indicate that my focus will not be on the wide-ranging variations in regional configurations of Buddhism, and how these manifest among local populations. After all, for over two millennia in much of Asia Buddhism has been a significant religious tradition, whose influence has waxed and waned over those many centuries. It was affected by the indigenous religions of the regions where its missionary impulses carried it, and was similarly transformed as rival faiths gained ascendency in places where it was once dominant. The land of Tibet exemplifies the first process, for there Buddhism entered and merged with the indigenous Bön traditions,

H. P. Rodrigues (✉)
University of Lethbridge, Lethbridge, AB, Canada

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_7

resulting in its distinctive Tantric Vajrayana (Thunderbolt Vehicle) form. Indonesia offers an instance of the second process, for in a land where Buddhism once flourished—the ruins of Borobodur, the world's largest Buddhist monument, are on the island of Java—it was strongly influenced by Hinduism, and ultimately supplanted by Islam. Just how these modified and syncretized Buddhist metaphysical notions play out among indigenous healers at the village level in various Asian communities would make for enormously rewarding studies, and some work in this area has already been undertaken.[1] Here, I wish to present in broad strokes some of the fundamental principles of Buddhist teachings, which are shared by virtually all of its subdivisions, despite their seeming differences and regional variations. Surprisingly, these fundamental teachings of one of the world's great religious traditions are not at all well-known in Western societies. Moreover, and pertinent to the concerns of this volume, from a Buddhist's perspective, to implement and fully apprehend the teachings of Buddhism is essentially to embark upon a journey to integrated mental health and well-being.

A bit of historical context is necessary before we can proceed. Buddhism began with the teachings of Siddhartha Gautama, who was reputedly a prince from a Himalayan foothill kingdom of the Shakyas.[2] Although scholars have not reached consensus on the date of his birth, Siddhartha is generally thought to have been born in Lumbini (in modern day Nepal) some centuries before the rule (c. 268–232 BCE) of the emperor Ashoka who left behind more firmly dateable inscriptions. Buddhist literature tells us that at the age of 29 Siddhartha renounced his princely inheritance and took up the life of a wandering seeker, striving for spiritual self-realization, which was a highly valued goal. After six years of study and intense practices, including some dangerously misguided forms of asceticism, Siddhartha finally attained the pivotal realization he sought. The Mahabodhi temple and a descendent of the pipal tree under which he sat for his climactic meditations are now central features of Bodhgaya, the site of his spiritual enlightenment (*nirvana*, literally the 'extinguishing' of ignorance). *Nirvana* had transformed Siddhartha Gautama into a Buddha, an Awakened One. Deciding to share his realization with others, the Buddha traveled to a forest park at Sarnath, near the Hindu holy city of Banaras, and

delivered teachings to five fellow seekers, who became his first disciples. The Buddha continued an itinerant lifestyle for 45 years, accruing more disciples and some patronage from royalty and wealthy laypersons. His growing community was known as the Sangha, composed of the monks and nuns, who follow a codified set of institutional regulations, although initially and broadly the Sangha included both laymen and women. The Buddha's final passing is referred to as his *parinirvana* ('further *nirvana*'), and occurred in Kushinagar, in the Indian state of Bihar.[3] *Parinirvana* is not a higher state of realization, but merely an eventual relinquishing of the physical body after the attainment of *nirvana*, which is regarded as a state that transcends the otherwise inexorable cycles of birth, death, and rebirth. The emperor Ashoka's conversion to Buddhism, his subsequent patronage of the religion throughout his vast empire, and his missionary outreach to neighboring kingdoms, as recounted in his inscriptions, accounts for Buddhism's initial surge into the global tradition it is today. There are two main branches of Buddhism. The Mahayana (Great Vehicle), arguably including Vajrayana, which sometimes construes itself as a distinct branch, is characterized by its regional diversity. It is dominant in Japan, Korea, China (with Tibet), and Vietnam.[4] Of the many non-Mahayana schools that once existed, only the Theravada (Doctrine of the Elders) survives. Regarded as more conservative, it is the major school of Buddhism in Sri Lanka, Myanmar, and Thailand.[5]

Trying to present the essential teachings of a religion with such a rich diversity, accumulated as it spread throughout Asia over two thousand years would be a daunting task, were it not for crucial features that circumscribe the core of Buddhist teachings. The well-known parable of the poisoned arrow is an apt starting place for our discussion, because it effectively emphasizes the ridgepole of the Buddha's teachings.[6] Once, when the Buddha was residing near Shravasti, in the Jetavana forest grove donated by the wealthy patron Anathapindada, a monk named Malunkyaputra finally mustered the courage to approach his teacher. Malunkyaputra was frustrated that during all the time he had been a member of the Sangha, the Buddha had not answered, and repeatedly deflected, a number of fundamental questions about the nature of reality and spiritual enlightenment. When the opportunity presented itself

that evening, Malunkyaputra gave the Buddha an ultimatum. Either the Buddha clearly answer a number of questions or Malunkyaputra would leave the Sangha. Malunkyaputra wanted to know whether or not the cosmos is eternal, whether or not the body and soul are different entities, whether or not a Buddha exists after death, and whether or not the Buddha actually knew the answers to these questions. The Buddha's answer was instructive. He simply asked the monk to remember that he was never promised answers to those questions when he joined the Sangha. Imagine, the Buddha explained using the parable, that a man was shot with an arrow thickly smeared with poison. When his family and friends sought to aid him, he protested, refusing treatment until they first answered a number of questions. He wanted to know from which of the four classes of Hindu society—warrior, priest, merchant, or worker—the man who wounded him was. He wanted to know his assailant's name, height, complexion, and hometown. Then he wanted to know details about the kind of bow that fired the arrow, characteristics of the bowstring, the arrow, the feathers on the shaft, the arrowhead, and so on. The Buddha explained that if the wounded man's family responded to his unreasonable prerequisite wishes, he would clearly be dead from the fast working poison, and those many questions would still remain unanswered. So, too, the Buddha implied by this parable was that our painful human condition, marked by sorrow, is as if we too were shot with a poisoned arrow. Idle speculation on a host of metaphysical questions is not the concern of Buddhist teachings. The Buddha's focus is on the immediacy of suffering (*duhkha*) and its cessation, for only this leads to freedom from bondage and the peace associated with self-awakening.

Thus, in no uncertain terms, the parable of the poisoned arrow highlights that despite the many complex rituals, meditative practices, and philosophical arguments developed by its schools and sects over the centuries, Buddhism is centered on understanding something essential about the causes of human sorrow and thereby bringing sorrow to an end. Its focus is not on the ending of physical pain, but the psychological suffering that often plagues humanity. The implications of Buddhism's teaching are broader, of course, because out of that psychological suffering we often act out in ways that may physically harm

those around us. Thus, Buddhist teachings point us in the direction of mental understanding and harmony to alleviate the dis-ease of psychological disequilibrium caused by ignorance. What then are these teachings? A simple formulation of the Buddha's teachings was reputedly delivered to his first disciples in Sarnath, and is aptly known as the First Sermon. It sets forth the Four Noble Truths, regarded as the core principles of Buddhism.[7] Let us examine these next.

The Four Noble Truths

When the Buddha began to preach to his five fellow-strivers, he set in motion the beginning of Buddhism, a perspective on life known in Sanskrit as a *darshana*. In a posture known as the Wheel-turning Gesture, he is symbolically represented counting out the Four Noble Truths, thereby setting in motion not the chariot wheel of a world-conquering emperor, but a wheel of liberating spiritual teachings that initiated a different type of worldly conquest. The truths are noble (*arya*), insofar as they are worthy of respectful consideration. And they are truths (*satya*) in that they are believed to be aligned with reality, the way the world actually is, apart from opinion, belief, fantasy, and so on. In a nutshell, the solution to the enigma of human sorrow offered by Buddhism is a mature understanding of reality.

The first Noble Truth is the reality of *duhkha* (sorrow). It implies that any sentient being—entities with senses and feelings—will eventually and inevitably experience sorrow. In contrast to its opposite, pleasure (*sukha*), *duhkha* refers not to physical pain, but the existential angst or pain that one feels when reflecting on embodied existence. One realizes that one will grow old, lose one's strength, beauty, health, and eventually one's life. One does not always get what one wants. Moreover, as we grow in our awareness of the world around us, the sorrow experienced by others also causes us sorrow. When we see our loved ones—and even strangers and other creatures—suffer, we, too, are emotionally distressed by this aspect of existence. One cannot begin to understand and appreciate Buddhist teachings if one has lead a pampered and self-centered life, because the first Noble Truth cannot then be adequately grasped.

The seeming meaninglessness of embodied existence, in which we see those around us grow old, get ill, and die, as we ourselves face the same fate is a fundamental fact of life. But why is it thus? Is there something else about existence of which we are unaware? This is what Siddhartha set out to discover, and which in Buddhist belief he actually achieved, and compassionately decided to teach about.

The second Noble Truth is that *duhkha* is fundamentally related to our insatiable thirst (*trishna*) or craving for the endurance of things that give us pleasure, while wishing for the non-existence of whatever causes us displeasure. In essence, we do not accept the fundamental transience or flow of life, often clinging to illusory and misplaced notions of permanence, while not accepting fundamental facts about reality that are unpleasant. The third Noble Truth states that we can end this self-created sorrow if we merely relinquish our attachment to this thirst after illusory notions. The extinguishing of these illusions is *nirvana*, articulated as this third fundamental truth about reality, available to anyone willing to end their attachments to illusions. While the first Noble Truth states that sorrow is inevitable, these next two truths articulate key factors at the source of sorrow, but also significantly claim that *duhkha* can end. Scholars (for example, Gethin 1998) have noted that the four Noble Truths parallel a visit to a physician in which one first presents the symptoms of one's ailments, which in this case is *duhkha*, the fundamental unsatisfactory nature of human existence. The second Noble Truth is the diagnosis of the cause of the ailment, while the third indicates that the ailment is not incurable, but can be healed by attending to the causal factors of *duhkha*.

Aligned with that analogy, the fourth Noble Truth is akin to the prescription. It is called the Noble Eightfold Path, because it prescribes attention to and cultivation of eight dimensions in one's lifestyle and behavior to enable one to attain the nirvanic realization that grants freedom from existential psychological suffering. These eight dimensions are depicted as the eight spokes on the preeminent symbol of Buddhism, the Dharma-chakra, the wheel of Dharma, the teachings of the Buddha. The first item (#1) of the prescribed path, best rendered as appropriate views (*samyak drishiti*), essentially endorses a healthy skepticism toward one's current beliefs. Buddhism is strongly oriented

to self-reliance in the discovery of truth, and does not promote blind belief in any religious teaching, philosophy or ideology. Essentially, the prime directive in Buddhism is not to become a good Buddhist, by embracing and blindly believing in its teachings, even though such beliefs and behaviors do form the basis of moral education in Buddhist societies. The goal in Buddhism is to become a Buddha, an awakened being. In Mahayana Buddhism, that objective of personal attainment is arrested in favor of the compassionate goal of liberating all other sentient beings. Even so, clinging to an erroneous worldview merely because it aligns with one's desires and attenuates one's fears, exemplifies the second Noble Truth and will prevent one from attaining Buddhahood. Such clinging is often at the root of most religious systems grounded in spiritual revelations granted to someone else, which cannot be personally replicated and verified. Even most Buddhists are not immune to the propensity for blind belief in the Buddha's teachings, and remain content with living a life aligned with Buddhism's basic moral precepts, such as non-harming, and not stealing. Buddhist teachings do point out that it is vital to develop a moral foundation in one's life. Truthfulness in communication (#3), and earning a livelihood (#5) that does not enhance human misery are among the values promoted in the Eightfold Path. Moreover, successful attainment of Buddhahood requires that one have a firm commitment to the goal (#2), that one vigorously do what is needed to attain the goal (#4), and that one persevere (#6) diligently in spite of any setbacks and obstacles encountered along the way.

Significantly, mere good intentions and a moral lifestyle will not result in *nirvana*. Quite crucially, spiritual emancipation requires engaging in the appropriate meditative practices, which provide glimpses into the nature and mechanisms of one's psyche. Inappropriate methods could lead one astray. Siddhartha's legendary life story illustrates how his misguided determination almost led to his death. Buddhism is sometimes called the Middle Way, because it requires a harmonious balance between extremes of self-indulgence and self-mortification. One of the most widely promoted kinds of meditation found in Buddhist milieus is *smiriti*, or mindfulness (#7). Mindfulness is the continuous sensitive observation of all body-mind processes as they occur, without judgment.

Such mindfulness can lead to powerful states of contemplative absorption, known as *samadhi* (#8), the highest of which results in the liberating *nirvanic* insight.

Pratitya-Samutpada and the Anatman Doctrine

In essence, *nirvana* is the result of a profound insight into a psychological process constantly underway in our psyches, of which we are only superficially aware. The process is sometimes likened to a constantly turning wheel, driven by factors such as ignorance, desire, and revulsion. The crucial feature of this process is that it repeatedly constructs notions of 'self' as a result of a variety of contributing factors. This is why the process is called *pratitya-samutpada*, which may be translated as 'dependant (*pratitya*) arising/origination (*samutpada*).'[8] The sense of 'self' arises in relationship to and in dependency on a host of contingent factors, and has no independent self-sustaining existence of the sort one might attribute to a 'soul'. The contingent factors include perceptions, karmic dispositions, conceptual construction faculties, and grasping tendencies.

Since these notions seem somewhat abstract and philosophical, and evidently contribute to why Buddhism is poorly understood, an illustrative example might help. Imagine traveling in an unfamiliar region and coming upon an attractive house. One is struck by the aesthetic beauty of the design, its landscaping, and so on. The perceptions, mediated by our senses, produce pleasant sensations in our consciousness. One next sees the householder, his lovely spouse, and their children contentedly playing in the garden in what appears to be a perfect image of worldly happiness. Indeed, this entire scenario and the conception of the happiness it signifies is the result of ideas and concepts to which we have been previously exposed. These, we could regard as karmic accretions and dispositions. It is at this point that we are likely to automatically construct a 'self' in which we imaginatively transpose ourselves into the place of the householder or his spouse. There is nothing particularly surprising about this process, which we and advertisers the world round, intellectually understand and strategically utilize.

We are marketed cars, clothes, and shampoos through this process. The psychologically created self that I have constructed through the perception of the attractive home may lead me to desire such a home, spouse, and children for myself, and may lead me to engage in a range of behaviors in order to realize my 'dream'. Whether or not I actualize this dream and transform it into reality may contribute to my general happiness or sorrow. But more to the point, the 'self' that was put together by the conjunction of the various factors such as my perceptions, thoughts, and desires will eventually dissipate, regardless of whether or not I have actualized my dream. They will 'grow old and die' so to speak, as will the psychologically created 'self' whose existence depends on them. We constantly construct such 'selves', sometimes purposefully but mostly incidentally, in a naturally arising relationship to the phenomena we encounter in our daily lives. None of these selves have the intrinsic capacity to survive, and thus we are constantly experiencing sorrow, through the 'deaths' of our dream selves. The debris of our shattered dreams serves as material for subsequent self-constructions. We need a different type of house, different neighbors, a different spouse, and so on, to realize the enduring happiness we seek, and thus the wheel continues to spin. Tibetan Buddhists symbolize this process in the Wheel of Life cosmogram gripped by Mara, a sort of demonic figure who represents death and illusory desire, and depict Buddhas as having transcended the wheel entirely.[9]

Although we may intellectually grasp and appreciate the processes delineated above, we are not immune to their effects, particularly in relationship to self-images that we especially cherish and cling to desperately. We may not fall prey to believing that a big house, high-status job, or attractive loving partner are permanent remedies for our existential angst in the face of our own vulnerabilities to aging, disease, and death. However, we may cling to notions of a noble, personal self-image, or of a soul that might survive after death in some eternal paradise. The Buddhist position is that all such ideas about the self are simply that, ideas, which refined attentive meditation reveal to be insubstantial. Just as a candle flame appears to have an independent existence, when it is actually the result of a dynamic interplay of heat, wax, wick, air, and so on, so too we are dynamic processes, with no

permanent 'soul' or 'self' at the core. This is known as the Anatman (No-self (*atman*)) doctrine, and is at the heart of Buddhist philosophy and psychology.[10]

Mental Health in Buddhism

Evidently, the cornerstone of Buddhism is a psychological realization about the nature of the self, which if ignored is at the root of our sorrow. It would not be an exaggeration to assert that from the Buddhist perspective, unless and until we attain nirvanic insight, which awakens us to our true natures, all of us psychologically ail. Our psychological illness plays itself out in a variety of ways, with different degrees of painful consequences for ourselves and those around us, who are similarly ailing. In less pernicious manifestations of our waking slumber, we live our lives nominally building tentative self-images, gently yielding them as they disintegrate, and constructing progressively more realistic ones crafted through life's lessons. I may no longer think of myself as a super spy or princess as I did in my youth, but may end up thinking of myself in my old age as a somewhat wise, respected elder. Indeed, our communities expect us to adopt particular self-images, with commensurate appearances, moral constraints, and behaviors, and we must comply if we wish to find comfortable places within society. We expect our policemen to dress in uniform, uphold the law, courageously confront offenders, and so on. These positions, as parent or child, employer or employee, teacher or student, and so on, require us to adopt various personas within their respective social contexts. And, like actors off stage, most of us are adept at shedding or shifting our roles as the contexts change. We do not act like children with our children, or like soldiers or policemen at home when we are off-duty, at least we probably ought not to. However, underlying such overt identities that are easier to shed, we generally cling to a core identity that we identify with as the real 'me'. In the privacy of solitude, and within our own thoughts, we struggle to construct, maintain, and craft a personal sense of self. This constitutes our cherished or habitual character and personality.

Initially, the self-construction process may be haphazard, shaped by our day to day experiences and influences. However, due to social pressures and the concomitant search for a meaningful sense of identity, we exercise our wills to shape our identities more purposefully. We may adopt dietary and exercise regimens, espouse political and other ideologies, become environmentalists, capitalists, and on. If we belong to a particular religious tradition, we may try to emulate the ideal qualities of human beings espoused by that religion. A Christian may try to be Christ-like, or be inspired by the life and character of a saintly ideal, such as Francis of Assisi or Mother Theresa. The Mahayana branch of Buddhism, for instance, promotes the *bodhisattva* ideal.[11] *Bodhisattvas* are beings (*sattva*), whose primary concern is enlightenment (*bodhi*), not merely for themselves, but for all sentient beings, in all existing realms. Adopting the *bodhisattva* way entails a commitment to a heroic, selfless lifestyle grounded in extraordinary patience and generosity of spirit, vigor, and emotional equilibrium. Thereby, one's compassion (*karuna*) for all beings is constantly augmented, as is one's wisdom (*prajna*), and one's skill in enabling others to attain liberation.

For the most part, in societies throughout the world one would regard the mental condition of a Christian or Buddhist, who nominally aspired to and moderately embodied the extraordinary ideals of their saintly models, to be quite healthy. Most societies evaluate a person's mental health by their possession of an integrated sense of self or ego, together with a modicum of altruistic inclinations. Alternately, the absence of debilitating psychological aberrations, such as depression, anxiety, delusions, and so on, is another indicator of mental health. However, from the perspective of the Buddhist principles examined earlier, these are all inadequate markers of mental health. This is because they are intrinsically built upon attachments to conceptual constructions of 'self', which are illusory and tentative at best. As these begin to crumble, as they inevitably must with old age, illness, and so on, the sorrow sublimated by the façade of these identities may re-emerge. We may grow despondent as our strength, memory, and comely appearances diminish as we get older. We may fear death, worry about the fate of our souls, or despair about whether we have squandered away our lives.

This is why there is a crucial soteriological difference between devout Christians' saintly behavior and Buddhist *bodhisattvas*, even though their expressions of loving and compassionate behavior toward others may be similar. Of course, regardless of the ultimate 'truth' of either, adherents of both religious systems do generally live socially commendable lives in the world. However, while the former are motivated by the firm belief in their souls' salvation and an eternity in heaven, the entire structure of a *bodhisattva's* path is built upon a strategy, or what is known as a skillful means (*upaya kaushalya*).[12] We have seen how at the center of the nirvanic realization is the recognition there is no intrinsic, permanent and independently existing soul or self (*atman*). To cling to any such notion is fundamentally erroneous, and thus inevitably linked to sorrow. Thus, the *bodhisattva's* endeavor to construct a heroic, compassionate self and to take up a lifestyle to save innumerable beings in countless realms is itself a stratagem for nirvanic realization. Otherwise, it would be counterproductive and misdirected, simply leading both *bodhisattvas* and the beings they hope to liberate inextricably deeper into illusion. Instead, the *bodhisattva* path and its skillful means take both the *bodhisattvas* and the beings they strive to liberate into realms of illusion primarily to reveal the underpinning mechanisms of such fanciful creations. Like a magician's apprentice, they are first subjected to the illusion, and then led 'behind the curtain' as it was to discover how the magic trick is put together. By passionately attempting to construct a selfless-self that is determined to save an infinite number of other selves, one may come upon the penetrating insight into the illusory and contingent nature of 'selves' and the process of their construction. This is why although the stunning array of rituals and meditative practices that have developed in various Buddhist sects over the centuries undoubtedly aid in the cultivation of range of laudable human virtues, these practices need to be situated within and exercised in relationship to the overarching goal of *nirvana*. They should not become ends in themselves.

By way of conclusion, it is worth recognizing the growing popularity of the so-called 'mindfulness movement', which has its roots in the most common form of Buddhist meditation practices.[13] The *Satipatthana Sutta* and *Mahasatipatthana Sutta* (*Great Discourse*

(*sutta;* Sanskrit*: sutra*) *on Establishing Mindfulness* (*sati*; Sanskrit: *smiriti*)) are two major discourses attributed to the Buddha that present the rudiments of mindfulness. These teachings point out the four main areas toward which there should be mindfulness, or sensitive awareness without judgment. The first is on the body (*kaya*), its functioning, nature, and impermanence. The next is on sensations and feelings (*vedana*), both pleasant and unpleasant. The third is on the general tenor of mental phenomena (*citta*), such as confused, distracted, focused, and so on. And finally, it is on the actual content (*dharma*) of mental phenomena. The term '*dharma*' is sometimes rendered as the teachings of Buddhism, such as the Four Noble Truths, and so on. Although these are clearly to be included as the content of mental phenomena, in this context *dharma* is a broader, more generally encompassing term for any and all thought forms. Essentially, even the most sublime of Buddhist teachings must be recognized as 'concepts', which undercuts attachment to them. This is articulated in the *Heart Sutra*, one of the most succinct and widely circulating texts belonging to the Perfection of Wisdom literature in Mahayana Buddhism.[14]

There is a growing literature of studies on the benefits of mindfulness on mental health, and various techniques and applications that draw upon mindfulness developed by Western psychologists to treat specific types of psychological problems. For instance, Sorbero et al. (2015) conducting a review of reports on mindfulness-based cognitive therapy (MBCT) found it to be notably effective in the treatment of depression. However, a similar examination of studies on MBCT's effectiveness on reducing relapses in substance abuse was inconclusive (Grant et al. 2015). Hoge et al. (2012), in an article for the *British Medical Journal*, noted that 'the use of mindfulness mediation training for GAD [Generalized Anxiety Disorder] is validated by a recent small randomized controlled trial, which found significant benefits compared with an active control class' (p. 39). Such findings are instructive, and the suggestive successes of these methods indicate that a Eurocentric psychology is finally beginning to open to teachings that have effectively served people in the Global South for millennia. It bodes well for more mutually beneficial exchanges in the decades ahead.

Notes

1. An intriguing work dealing with Buddhist healing practices melding with other medical systems in medieval Japan is found in Goble (2011), while McBride II (2011) discusses the influence of esoteric Buddhism on remedying spirit induced illness in medieval China. Such syncretic features of Buddhist medicine in Tibet are also traced in Gyatso (2015). Zhao (2015) discusses the contemporary use of Buddhist sacred utterances (*mantra*) in healing contexts in a Chinese village.
2. I have mostly used Sanskrit transliterations for Buddhist terms and names of persons. Scholars may often use transliterated Pali, the language in which early Buddhist literature was first written. Thus, I write Siddhartha Gautama instead of Siddhattha Gotama, and *nirvana* instead of *nibbana*. I have also eliminated most diacritic marks, and spelled words phonetically when transliterating Sanskrit, for ease of pronunciation by non-specialist readers.
3. I travelled to Kushinagar and Bodhgaya in the summer of 2017, completing my efforts to visit the four major sites related to the life of the Buddha. On previous journeys to India and Nepal, I had visited Lumbini (where Siddhartha was born) twice, Bodhgaya (where he attained Buddhahood), and Sarnath (where he preached his first sermon) on several occasions.
4. Williams (1989) presents an excellent introduction to the philosophical distinctions among schools of Mahayana Buddhism.
5. Gombrich (1988) is still one of the best overviews of the historical development and spread of Theravada Buddhism.
6. The parable is found in the *Cula-Malunkyovada Sutta* (The Shorter Instructions to Malunkya). It belongs to the middle-length discourses (Majjhima Nikaya; Sanskrit: Madhyama Agama), within the Sutta (Sanskrit: Sutra) Pitaka (The Basket of Discourses), which is one of the three main sections of the Theravada Buddhist Pali Canon, known as the Tipitaka (Sanskrit: Tripitaka).
7. The Buddhist monk and scholar Walpola Rahula's *What the Buddha Taught* offers one the most influential presentations of the fundamental teachings of Buddhism since it was first published in 1959.
8. Substantive scholarly studies of dependent origination are found in Cox (1993) and Elder (1993).
9. An accessible and authoritative introduction to this diagram and its meaning is found in the XIVth Dalai Lama's (2016) book on the topic.

10. Collins (1982) presents a definitive study of the Anatman (Pali: Annatta) doctrine in Theravada Buddhism.
11. Dayal (1932) offers a classic study on the *bodhisattva* doctrine, while Nyanatusita (2013) provides a more recent collection of essays by six scholars on the concept of the *bodhisattva* ideal.
12. One of the early systematic studies of the concept of *upaya kaushalya* is Pye (1978), while an entire Buddhist scripture entitled *The Upayakaushalya Sutra* is dedicated to the topic (see Tatz (1994) for a translation and analysis).
13. A comprehensive collection of essays on the Buddhist roots of mindfulness, including its relevance to suffering is found in Williams et al. (2013). Also Kabat-Zinn and Davidson (2013) presents a conversation with the Dalai Lama, one of the best-known representatives of Buddhism, on the benefits of meditation (primarily, mindfulness) and mental health.
14. An excellent examination of *The Heart Sutra's* history, content, and scholarship on it is found in Tanahashi (2014).

References

Collins, S. (1982). *Selfless persons: Imagery and thought in Theravada Buddhism*. Cambridge: Cambridge University Press.

Cox, C. (1993). Dependent origination: Its elaboration in early Sarvastivad in Abhidharma texts. In R. K. Sarma (Ed.), *Researches in Indian and Buddhist philosophy: Essays in honour of Professor Alex Wayman* (pp. 119–142). Delhi: Motilal Banarsidass.

Dalai Lama (Tenzin Gyatzo). (2016). *The wheel of life: Buddhist perspectives on cause and effect* (J. Hopkins, Trans.). Somerville, MA: Wisdom Publications.

Dayal, H. (1932). *The bodhisattva doctrine in Buddhist Sanskrit literature*. London: Routledge and Kegan Paul. [Reprint, Delhi: Motilal Banarsidass, 1999].

Elder, G. R. (1993). Dependent origination in Buddhist tantra. In R. K. Sarma (Ed.), *Researches in Indian and Buddhist philosophy: Essays in honour of Professor Alex Wayman* (pp. 143–162). Delhi: Motilal Banarsidass.

Gethin, R. M. L. (1998). *The foundations of Buddhism*. Oxford: Oxford University Press.

Goble, A. E. (2011). *Confluences of medicine in medieval Japan: Buddhist healing, Chinese knowledge, Islamic formulas, and wounds of war*. Honolulu: University of Hawaii Press.

Gombrich, R. F. (1988). *Theravada Buddhism: A social history from ancient Benares to modern Colombo*. New York: Routledge.

Grant, S., Hempel, S., Colaiaco, B., Motala, A., Shanman, R. M., Booth, M., et al. (2015). *Mindfulness-based relapse prevention for substance use disorders: A systematic review*. Santa Monica: The RAND Corporation. Retrieved December 3, from https://www.rand.org/pubs/research_reports/RR1031.html.

Gyatso, J. (2015). *Being human in a Buddhist world: An intellectual history of medicine in early modern Tibet*. New York: Columbia University Press.

Hoge, E., Ivkovic, A., & Fricchione, G. L. (2012, December 1). Generalized anxiety disorder: Diagnosis and treatment. *British Medical Journal, 345*(7885), 37–42.

Kabat- Zinn, J., & Davidson, R. J. (Eds.). (2013). *The mind's own physician: A scientific dialogue with the Dalai Lama on the healing power of meditation*. Oakland, CA: New Harbinger.

McBride, R. D., II. (2011). Esoteric Buddhism and its relation to healing and demonology. In C. Orzech, H. Sørensen, & R. Payne (Eds.), *Esoteric Buddhism and the tantras in East Asia* (pp. 208–214). Leiden: Brill.

Nyanatusita, B. (Ed.). (2013). *The Bodhisattva ideal: Essays on the emergence of Mahayana*. Kandy: Buddhist Publications Society Inc.

Pye, M. (1978). *Skilful means: A concept in Mahayana Buddhism*. London: Gerald Duckworth and Co. Ltd. [Reprint, London: Routledge, 2003].

Rahula, W. (1959). *What the Buddha taught*. New York: Grove Press.

Rinpoche, S. (2008). *The Tibetan book of living and dying* (P. Gaffney & A. Harvey, Eds.). London: Rider.

Sorbero, M. E., Ahluwalia, S., Reynolds, K. A., Lovejoy, S. L., Farris, C., Sloan, J., et al. (2015). *Meditation for depression: A systematic review of mindfulness-based cognitive therapy for major depressive disorder*. Santa Monica: The RAND Corporation. Retrieved December 3, 2017, from https://www.rand.org/content/dam/rand/pubs/research_reports/RR1100/RR1138/RAND_RR1138.pdf.

Tanahashi, K. (2014). *The heart sutra: A comprehensive guide to the classic of Mahayana Buddhism*. Boston: Shambhala Publications.

Tatz, M. (Trans.). (1994). *The skill in means (Upayakausalya) sutra*. Delhi: Motilal Banarsidass.

Williams, P. (1989). *Mahayana Buddhism: The doctrinal foundations*. New York: Routledge.

Williams, J., Mark, G., & Kabat-Zinn, J. (Eds.). (2013). *Mindfulness: Diverse perspectives on its meaning, origins and applications*. London and New York: Routledge.

Zhao, D. (2015). Power-laden words: Taoist and Buddhist healing mantras in Jinzhuang Village. In J.-G. A. Goulet, L. D. Murphy, & A. Panagakos (Eds.), *Religious diversity today: Experiencing religion in the contemporary world* (pp. 113–130). Santa Barbara CAL: ABC-CLIO.

8

Psychology from an Islamic Perspective

Amber Haque

> Know, O beloved, that man was not created in jest or at random, but marvelously made and for some great end. (Al-Ghazali 1964, p. 17)

Introduction

As the name implies, Islamic psychology is based primarily on Islamic theology and worldview. Therefore, this chapter discusses Islamic perspectives of psychology based on the Qur'an and Hadith traditions of Prophet Muhammad. The early Muslim scholars also wrote extensively about human nature and some of their works are also introduced in this chapter. The written accounts on the description of human nature by early Muslim scholars can be found as early as 800 AD and then onwards until year 1100. The key element in Islamic psychology was its emphasis on findings ways to cure and heal rather than just theorize and

A. Haque (✉)
United Arab Emirates University, Al Ain, United Arab Emirates

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_8

the works of the early Muslim scholars underpin many of the modern techniques. While there are many who contributed in the debates on philosophy of mind and soul, a few names given below deserve mention (for details see Haque 2004).

Al Kindi wrote his books *On Sleep and Dreams*, *First Philosophy*, and *The Eradication of Sorrow*, on how to use cognitive strategies to combat depression. Al Tabari was a pioneer in the field of child development, which he elucidated in his book *Firdaus Al-Hikmah*. Al Farabi wrote his treatise on social psychology, most renowned of which is his *Model City*. Ibn Sina in his famous book *Al Shifa* discussed mind, mind-body relationship, sensation, perception, and other related aspects. Ibn Sina also gave psychological explanations of certain somatic illnesses. Ibn Bajjah based his psychological studies on physics. He explained intelligence as the most important ability and wrote many essays on sensation and imagination. Ibn Tufail gave a unique concept of man as *Hayy bin Yaqzam* which shows that man has enough powers to reach the ultimate truth with the help of The Holy Qur'an and Sunnah. Al-Ghazali examined human nature in great detail and found that all psychological phenomena originate with the self. He described in detail the nature of soul and causations of psychopathology. Yahya Ibn Massawayh, Abu Zayd Hunayn, and Ishaq bin Imran, all wrote monographs on melancholia, emphasizing the benefits of psychotherapy. Al-Razi wrote Kitab al-Hawi discussing different types of melancholia, hypochondria, and effects of temperament on personality, lethargy, madness (*junun*), schizophrenia (*hadhayan*), various forms of insomnia, mental confusion (*iqtitlat*), and delirium. He described in great detail the causation, symptoms, and treatment of these disorders and is credited for coining the term '*ilaj-al-nafsani*.' Ali Ibn Abbas Al Majusi in his book, *Kitab al-Malaki* (or Complete Book of the Medical Art, a textbook on medicine and psychology) wrote about sleeping sickness, loss of memory, and coma. Abu Bakr Rabi wrote a book named *Al Muta'alimuna fi al-Tibb* in which he discussed nerves, nature of the brain, its form and functions, symptoms of brain disorders, emotional disorders, and sleep disorders. Al-Balkhi wrote in detail about rational and cognitive therapies for anxiety, depression, anger, panic, and obsessive disorders. In Islamic perspective, the ability to maintain a positive occupational, familial, and social life may not be equated with positive mental/spiritual health.

However, the presence of positive character traits and behaviors are indicative of positive mental health. Additional symptoms of mental illness that are not equated with mental disorders in Western literature may include addiction to wealth, fame, status, ignorance, arrogance, cowardice, cruelty, lust, avarice, deceit, etc. hence, a large part of Islamically adherent lifestyle includes the necessity of gaining self-awareness into the internal experiential realities of the self.

The term 'psyche' refers to soul and 'ology' means 'subject of study' according to the concise Oxford English Dictionary (Soanes and Stevenson 2008), so psychology was originally meant to study the soul, but later as scientific psychology developed, its subject matter changed. However, psychology still retained its original name. Psychology was initially a branch of philosophy and was therefore studied primarily by philosophers. The Arabic equivalent of the term psychology is *Ilm an-nafs* (literally 'knowledge of the soul or self'). The key difference between Western and Islamic psychology is that while Western psychology studies the physical aspects of behavior and mental processes, Islamic psychology concentrates on their spiritual aspects. The physical and material aspects of behaviors are secondary in Islamic psychology because Islam considers matter secondary to spirit. In Islam, human beings possess a dual nature, as they are both a body and a soul. However, the body is not as important as the soul because the latter consists of inner structures of personality that influence the body until it is perished. In Islamic psychology, the metaphysical elements that influence human behaviors are the soul (*al-nafs*), the heart (*al-qalb*), the spirit (*al-ruh*), and the intellect (*al-aql*). The concept of al-fitrah which is the inherent knowledge combined with the human soul is the most essential aspect of human behavior, so it is essential that in order to understand psychology from Islamic perspective, we understand the concept of al-fitrah. It is also essential to know that the Islamic creed or *aqeedah* mandates that believers unravel the mysteries of nature not only through science and speculation but also through Divine words and wisdom by reflecting on the verses of the Qur'an. Scientific knowledge keeps developing, while the divine words are infallible and final. Knowledge of the 'self' is especially important in Islam as narrated in one of the sayings of the Prophet: 'whoever knows himself/herself,

knows his/her Lord.' So psychology in Islam has great significance if it is studied from Islamic indigenous perspectives.

The Concept of *al-Fitrah*

Islamic scholars have written in much depth about al-fitrah and there are at least four interpretations of *fitrah* but for the sake of brevity and purpose of this chapter we will discuss only the 'positive' interpretation of *fitrah*, namely that human beings are innately good (Mohamed 1996). There is also the 'dualistic' view, which proclaims that humans are both innately good and evil. There are three dimensions in the positive view of *fitrah*: linguistic, religious, and pre-existential. The linguistic meaning of *fitrah* refers to a person's *tabiya* or *mizaj*, which is the innate nature that exists in all human beings and is unalterable. In the religious dimension, *al-fitrah* is considered as a natural predisposition of a person to accept the Oneness of God (Al-Tawhid) or that a person is born with an innate faculty to know God. The pre-existential or metaphysical dimension refers to the notion that fitrah existed before the creation of humans meaning that God created *fitrah* so humans could acknowledge Him as the One and Only God who has power over everything. The Qur'an testifies that God brought forth from the loins of the children of Adam and made them testify that He is their Lord (Qur'an 7:172). There are many translations of the Holy Qur'an, the most common one being by Ali (2000). Islamic psychology stresses that nothing can erase human *fitrah* and for those who have buried it, it can be revived. Man's pre-existential *fitrah* is superior to his earthly existence because the physical is ephemeral and spiritual permanent. The spiritual condition of man also affects his physical condition in various ways. The dualistic dimension of *fitrah* indicates two equal tendencies of good and evil that are dynamic and have potentials to take humans to higher levels in harmony with the pre-existential *fitrah* and also to lower levels that may wipe out the purity inherent in one's original *fitrah* as a result of negative thinking and social influences. Ibn Khaldun (d. 1406), the celebrated Arab philosopher and sociologist,

attributed the rise and fall of Arab civilizations to *fitrah* and maintained that religion alone can bring humans closer to their pre-existential nature.

The Nature of the Human Soul

The Qur'an testifies that humans are both body and soul or a physical and spiritual being at the same time. The knowledge of soul given to humans is very little (Qur'an, 17:85), yet (s)he is capable of arriving at some knowledge of God as the object of worship (3:81) What this means, is that true knowledge has to do with the realization of the covenant which bounds human beings to God and to the primordial covenant taken by all offspring of Adam to be duty bound to One God (7:172). This is *al-fitrah* as discussed above. The word human in Arabic translates to *insan*, which is derived from *nasiya* meaning forgetfulness. Humans, therefore, forget their covenant with God and this is the cause of disobedience to God in this world leading to all kinds of problems in life including certain kinds of psychological distress. God has equipped humans with powers and faculties to distinguish between right and wrong. These characteristics distinguish humans from other creatures that do not possess that level of intellect (*aql*) and free will (*iradah*). The terms heart, soul, spirit and intellect convey two meanings. The first refers to the physical entity and the second to the non-material or spiritual entity of human existence. Also from the first quality originates the 'animal instincts' that may come in conflict with intellectual and spiritual instincts. The Qur'an states that humans are created in the best of molds but without true faith and good works they can become worse than the beasts (7:179 or/and 25:44). It is against these animal instincts that Prophet Muhammad cautioned humans asking them to fight against the evil inside oneself, calling it *jihad al-akbar* or the greater struggle. The second meaning of heart, soul, spirit, and intellect refers to the ultimate and metaphysical reality of humans and their essence, hence the tradition that "whoever knows himself knows his Lord." It is said that when the soul inclines towards *al-fitrah*, peace descends upon it and this state in

the Qur'an is called the tranquil soul or *nafs al-mutmainnah* (89:27). The soul also vacillates between spiritual qualities affirming loyalty to God and at the same time is drawn towards lower animal instincts. This vacillation of the soul is called the *nafs al-lawwamah* (75:2). It is possible by means of knowledge and good works to tame the animal instincts and attain the angelic nature and if one cannot do this, a person may appear human in shape and construction but cut-off from *fitrah*, thus enticing soul to the depths of bestiality and this condition of the soul is called *nafs al-ammarah bissu* (12:53). This understanding of the nature and dynamics of human soul is essential to appreciate the indigenous Islamic perspectives of psychology. Some scholars (for example, Al-Ghazali 1986) have also elaborated on the different levels or stages of *nafs* as follows:

Nafs Lawwamah (the blaming self): the second step in the development where one becomes aware of one's actions and differentiates between right and wrong yet unable to stop oneself from wrongdoing.

Nafs Mulhima (the inspired self): the third stage in which the good begins to predominate in the constant struggle of the previous two levels but the dangers of reverting back to the earlier stages is possible.

Nafs Mutmainnah (the secure self): the fourth stage in development where one has entered the first station of spiritual development and has completed one's faith and level of self. In this stage, the evil forces of nafs shrink and purity dominates the heart so it becomes the secured self.

Nafs Radiyyah (the content self): the fifth stage wherein as the secure self ascends to Allah, the lights of the heart increase and it is totally content with its Lord. Hardships and ease are same to it as it is happy that every action is from Allah alone. There is perfect harmony of which he is aware and there are no possibilities of error as he is the master of his nafs.

Nafs Mardiyya (the gratified self): the sixth stage where the nafs is not only content with its Lord but gratified by Him.

Nafs Kamiliya/Nooraniyah (the purified self): this final stage of development of the self, which is the level of completeness of servant hood to Allah and called the station of beauty or *Maqam al-Ihsan*.

Significance of the Heart, Intellect, and Free Will

The heart (*al-qalb*) in Islamic psychology is the metaphysical entity that is symbolically the seat of the true self, the repository of the soul and the core of human personality (Haque and Mohamed 2009). It is the heart through which an individual grasps the ultimate knowledge and metaphysical truth; it is our true existential and intellectual center, where contemplation takes root and is therefore, considered more significant than intelligence. It is also referred to as the organ of volition and intention. Human behaviors are considered reflections of the psycho-spiritual processes taking place in the heart, where sense perception can be supplemented to glean the true meaning of what we see physically. The ultimate object of all sensory observations is to open the eyes of the heart so it can perceive the Reality of the Oneness of God, hence there are those who have hearts with which they understand not, eyes with which they see not, and ears with which they hear not… (7:179). In another verse, the Qur'an asks 'Have they never journeyed about the earth, letting their hearts gather wisdom, and causing their ears to hear. Verily it is not their eyes that have become blind—but blind has become their hearts that are in their breasts…' (22:46). The Qur'an asserts that it came down upon the 'Prophet's Heart' (2:97) and God reveals Himself to the heart, which knows Him, the spirit which loves him, and the soul that contemplates Him.

There are various terminologies used in Qur'an regarding the characteristics of the human heart. *Qalb mutmainnun bil-iman* (a heart pacified with faith), *qalbim-munib* (a heart moving towards God), *qalbin-saleem* (the righteous and the pure heart) are expressions of a healthy heart, and the negative conditions are called *amraz al-qalb* or diseases of the heart. Humans carry within themselves good and evil tendencies and they are in constant struggle due to opposite dispositions. If the heart is not God-conscious, the evil disposition becomes strong. The complacency of the good and dominance of the evil can destroy the capacity for spirituality and inner vision to realize one's *fitrah* and improve one's self. According to some Muslim scholars, the heart is divided into three types: the healthy heart, the dead heart, and

the sick heart. A healthy heart is cleansed from passion for all things that God forbids and follows the injunctions given in the Qur'an. The dead heart does not know or worship its Creator in the way it is commanded by Him and the sick heart knows the commandments of its Creator but it suffers from illnesses resulting from a lust for the fleeting pleasures of this world. Thus the Islamic saying (hadith), 'there is a piece of flesh in your body (referring to the heart) that if it is sick, the whole body is sick' (Sahih Al-Bukhari, 52, 1995).

It is said that the intellect and evil in humans work simultaneously to regulate the material desires (*shahwa*) but in opposite directions. The intellect also works towards the growth and development of the self and if the functions of heart and intellect are compatible with *al-fitrah*, they will subdue the animal forces within us, but in cases where evil tendencies prevail, the intellect gets weakened and its functions and potentials are paralyzed. In such scenarios, human intellect is used to fulfill the impulses and gratifications of the material world and in the end, veiled over by animal passions; the heart becomes totally blind, losing sight of the real and the ultimate good for one's self. Thus a direct command from the Qur'an is that (is:) '…don't be like those who forgot God and eventually He caused them to forget themselves…' (59:19). The terms used in the Qur'an are *ta`aqqul* and *tadabbur* with respect to the heart's cognitive processes. A heart that does not engage itself in deep and reflective thought is described as one that has 'gone blind.' Free will (*iradah*) is another concept that refers to the choice of belief and actions in accordance with fitrah and the accountability for not doing so. The purpose of all these concepts and their dynamic interplay is to demonstrate their existence and relation to human behaviors and mental processes from Islamic perspectives.

The Concept of Man as a Small World

Based on the Islamic worldview of the Oneness of God (*Al-Tawhid*), the spirit, the soul and the material world, some notable Islamic scholars considered humans as a microcosm of the universe as their physical and spiritual nature corresponds to that of the universe and once the

humans realize this, they will come to know the world and its Creator (Mohamed 2007). Humans as possessors of both body and soul have both animal and angelic qualities. The animal nature is reflected in behaviors of certain animals and the purity of soul is reflected in angelic character and aspects akin to the rational faculty by which reality can be apprehended. Implicit in this concept is a respectful attitude of the universe because the universe reflects something of the divine; the contemplation of it will lead oneself to the knowledge of God.

The Concept of Jinn, Satan, and Evil Eye

The belief in Jinn, Satan and evil eye is part of Islamic creed and its influence on psychological processes and mental health is seen throughout the Muslim world. Jinn is part of God's creation, separate from man and the angels, but share certain human qualities like intellect, freedom to choose between true and false, right and wrong, good and bad, and so on. Among the Jinn, there are believers and non-believers. According to Islamic belief, Jinn are made of smokeless fire and dwell generally in deserted places, ruins, in the air and in fire and also possess bodily needs similar to humans. Jinn is mentioned in the Qur'an and the possibility of possession by the Jinn is also mentioned in verse, for example in, 52:29, 68:2, 81:22. The treatment of possession by Jinn is very common in the Muslim world.

Satan (*Shaitaan*) is the Arabic name of Devil, whose primary work is to incite humans to commit evil through deception. This is known as "whispering into the hearts" and referred to in many places in the Qur'an and Islamic texts. While all humans are created with a pure soul and in a positive state of fitrah, it is through one's own free will that humans fall prey to the enticements of Satan. This leads humans to not only deviate from fitrah but invite all kinds of psychological and emotional distress and disorders. This happens with all people including the believers who relinquish their beliefs and surrender to the temptations from Satan.

The concept of evil eye is based on the Islamic doctrine and backed by traditions of the Prophet. The idea of evil eye is that when someone looks at something beautiful and fails to recognize the Creator by

offering some form of verbal praise, such as *subhan Allah* (Glorified is God), or is envious, God can create harm in that particular thing. It affects an individual in the same manner as poison or any harmful medicine and the person needs to seek a cure from and protection against it. When it does not afflict the envied, it is because of the preventive methods taken by the person in reciting the last three chapters of the Qur'an and a verse entitled *ayat al kursi* in advance before going to bed and after the morning prayers.

The Dynamics of *Nafs*, *Aql*, *Ruh*, and *Qalb*

On the conceptualization of the human soul, Al-Ghazali (1986) explained that there are four aspects of a person that signify his/her spiritual identity. These are the *nafs*, *aql*, *ruh* and *qalb*. All of these are intertwined and influence man in their behavior, present and future (see Table 8.1; Fig. 8.1). The *nafs* is like the ego that gives rise to reactions to the environment that have been acquired through the lifespan. They may be reflective of an animalistic side of the individual at their lowest untrained level. Many spiritual healers liken the *nafs* to an animal that, if it is untrained, may not be very pleasant. However, if one were to train an animal it can be of service to its master. The *nafs* is somewhat similar to Freud's conception of the id. However, from the Islamic perspective, the *nafs* is not intrinsically bad. Rather, it acquires an automaticity stemming from the development of the self. That is, if it learns good habits, it will be of service to the individual, and if it learns bad ones, it can be a barrier to his growth.

The *aql* is the rational faculty of man and it is home to logic, reason, and acquired intellectual beliefs. The *ruh* is the spirit of man that, if kept healthy, allows one to live a meaningful and wholesome life. Finally, the *qalb* is the heart, sometimes used synonymously with 'self' and 'soul.' Sicknesses of the heart are often indications of sickness of the whole. The heart is where the effects of the other three elements manifest. The heart may also contain hidden blemishes such as jealousy, envy, and pride, that are results of the evil inclinations of the *nafs*,

Table 8.1 Elements of the human being and its corresponding effects

Parts of the human being/soul	Effects
Aql—Cognition • Reason • Logic • Thoughts • Beliefs • Knowledge *Nafs*—Acquired automatic tendencies of the human being • Eyes • Hands • Genitalia • Mouth • Ears • Appetite • Desires *Ruh* (spirit)—Experiential, transcendental elements • Emotions—adaptive emotions that propel toward the good • Unconscious - Dreams - Visions - Catharsis - Sudden awareness • Wisdom • Purpose • Meaning	Heart—The holistic consolidation and expression of all three elements. Manifest personality. Sicknesses or the perfection of any one of the elements to the left will cause blemishes or enhancements of personality in the heart and effect self-presentation - Narcissism - Arrogance - Jealousy - Envy - Deceit - Self-consciousness - Kindness - Openness - Shyness - Modesty - Etc.

the *aql* remaining either dormant to the *nafs*, or lacking good reason and malnourishment of the spirit. In order to remove these sicknesses of the heart, one must work toward modifying the inclinations of the *nafs* toward good, restructuring, and acquiring positive/moral thoughts in the aql, and feeding the spirit through remembrance of God. The objective is to have an intrinsically motivated holistic manner of being as opposed to the selfishly motivated desire to avoid God's punishment or social sanction by doing what is minimally acceptable. This would be working toward the adornment of faith by attempting to exemplify the garb of the life of the Prophet (sunnah) by acting upon supererogatory worship and behavior.

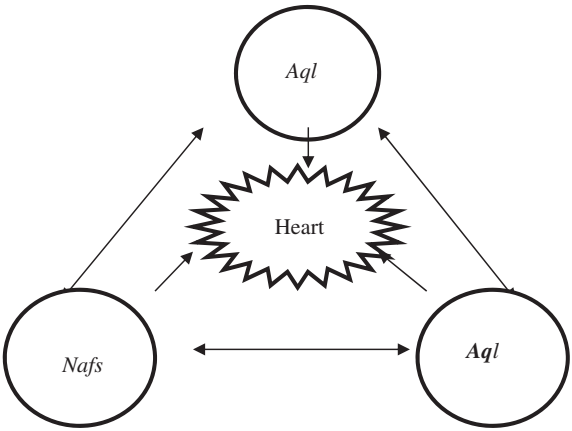


Fig. 8.1 Circular causality of effects among the elements of the human being

Six-Step Model for Self-Improvement

So while there are consequences of negative effects of the *nafs* on the heart, what can one do to improve the condition of one's *nafs*? Al-Ghazali (1986) suggested the following a six-step method of treatment: first, make *Musharata* or an agreement with oneself toward meeting the identified goals, second, *Muraqabah*, guard or reflect over one's actions, third, do *Muhasabah* or take an ongoing self-account of one's actions, fourth, make *Muaqabah* or consequate oneself for failing to keep up with the self-agreement or contract, fifth, do *Mujahadah* or strive to overcome the desire of the lower *nafs*, and sixth, make *Muataba* or regret for making an error and vowing not to make the same mistake(s) in the future.

Al-Ghazali's emphasis is on keeping a watchful eye on one's thoughts and behaviors to ensure success of the self-contract. He explained that one can view one's life as a 'business,' which can bring gain or loss depending on one's conduct in relation to the six steps. The more conscious one is and the more one applies these stages in one's daily life, the more positive gains one can make in one's thoughts, feelings, and behaviors, thereby improving the overall quality of *nafs*.

Conclusion

This chapter covered a brief outline of the major concepts in Islamic psychology and the contributions of some early Muslim scholars on human nature and ways of treating distressful psychological conditions. It is unfortunate that Islamic psychology as a discipline got completely overshadowed by mainstream Western psychology and did not even make a significant impact even in the Muslim world. This is now changing as there is a growing interest in multiculturalism and growth of indigenous movement in psychology. A recent review paper on recent trends in the integration of Islamic psychology and Western psychology discusses specific recommendations for the growth of the discipline (Haque 2016). One can only hope that with increasing interest in indigenous psychologies around the world, proponents of Islamic psychology will continue their research on the valuable works of early scholars and Islamic texts in order to synthesize, analyze, and develop a comprehensive theoretical model for understanding and treating psychological conditions from an Islamic perspective.

References

Al-Ghazali, A. M. (1964). *The Alchemy of happiness* (C. Field, Trans.). Lahore, Pakistan: Muhammad Ashraf (cited by R. Frager 1999).

Al-Ghazali, A. M. (1986). *Revival of religious learning* (F. Karim, Trans.). India: Kitab Bhavan (original work published 1853).

Ali, Abdulla Yusuf. (2000). *The Holy Qur'an: English translation, commentary and notes with full Arabic text*. Birmingham: Wordsworth Publishers.

Frager, R. (1999). *Heart, self, & soul: The Sufi psychology of growth, balance, and harmony*. Wheaton, IL and Chennai, India: Quest Books Theosophical Publishing House.

Haque, A. (2004). Psychology from an Islamic perspective: Contributions of early Muslim scholars to psychology and the challenges to contemporary Muslim psychologists. *Journal of Religion and Health, 43*(4), 367–387.

Haque, A., & Mohamed, Y. (2009). *Psychology of personality: Islamic perspectives*. Boston, MA: Cengage Learning.

Haque, A., Khan, F., Keshvarazi, H., & Rothman, A. (2016). Integrating Islamic traditions in modern psychology: Research trends in last ten years. *Journal of Muslim Mental Health, 10*(1), 75–100. Retrieved November 10, 2017, from http://quod.lib.umich.edu/j/jmmh/10381607.0010.1*.

Mohamed, Y. (1996). *Fitrah: The Islamic concept of human nature*. London: Ta-Ha Publishers.

Mohamed, Y. (2007). The concept of man as a small world. In A. Haque & Y. Mohamed (Eds.), *Psychology of personality: Islamic perspectives*. Boston, MA: Cengage Learning.

Qu'ran, The Holy, originally written in the Arabic language and has been translated into most African, Asian and European languages.

Sahih Al-Bukhari, 52, Book 2, Hadith 45. Birmingham: Dar us Salam Publications. Birmingham.

Soanes, C., & Stevenson, A. (Eds.). (2008). *Concise english dictionary* (11th Rev. ed.). Oxford: Oxford University Press.

9

Chinese Cultural Healing: Confucianism and Daoism

Kwang-kuo Hwang

> What makes me liable to great calamity is my having the physical body; if I had not the physical body, what calamity could come to me? (Laozi 2008 in *Daode Jing*)

Cosmology of Daoism and Confucianism

I Ching (Wilhelm 1960; Huang 2010) was originally a divination manual in the Western Zhou period (1046 B.C.–A.D. 771). Over the course of the Warring states period (500–200 B.C.), it was transformed into a cosmological text with a series of philosophical commentaries known as the 'Ten Wings' which enable us to understand the cosmology of Confucianism and Daoism at that time.

The author was supported by a grant from Ministry of Science and Technology, Republic of China, 106-2410-H-037-004-MY2.

K. Hwang (✉)
Kaohsiung Medical University, Kaohsiung, Taiwan

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_9

In Chapter 42 of *Daode Jing* Laozi (2008) states:

> the Way begets one ; And the one begets two ; Then the two begets three ; And three begets all things.
>
> All things bear the yin (shade) on their backs and embrace the yang (sun) in their arms ; By the blending of breath, equilibrium comes to the world. (p. 89)[1]

The cosmology of Daoism was inspired by the philosophy of *I Ching*. The basic unit of *Zhou yi* is the hexagram(卦, *qua*), a figure composed of six stacked horizontal line(爻, *yao*). Each line (one) is either broken or unbroken, which represents *yin* and *yang* respectively (two). Both the upper and lower parts of each hexagram are composed of three lines (a trigram), which means Heaven and Earth with Human being standing in between as one of all things. The changing structure of a hexagram composed of two trigrams enable us to infer one's state of being at a particular space and time. Based on such a cosmology, the Daoists tried to learn the nature of change for all things in the universe, which was the origin of organic science in traditional China (Needham 1954).

It was said that Ten Wings of *I Ching* was written by Confucius and his disciples during his old days, when Confucius returned to the State of *Lu* at the age of 68 after traveling around various warring states of China for a period of 14 years without being appointed by any feudal King (Ten Wings) is a collection of commentaries to *I Ching* (*Book of Changes*). In the canonical *I Ching*, the hexagrams are arranged in an order dubbed the 'King Wen sequence' after King Wen of Zhou, who formed the Zhou dynasty. In order to explain the meaning of the orderly sequence of the hexagrams, Confucius and some of his followers wrote *Xuquazhuan* (序卦傳) to illuminate the cosmology of establishing the *Way of Heaven* on the *Way of Humanity*.

> Heaven and Earth exist; all [material] things exist. After all [material] things existed, there came male and female. From the existence of male and female there came husband and wife. From husband and wife there came father and son. From father and son there came ruler and minister. From ruler and minister there came high and low. When [the distinction of] high and low existed, the arrangements of propriety and righteousness came into existence (I Ching, Ten Wings).[2]

In the *I Ching*, the universe was presented as being formed of Heaven and Earth, corresponding to *Yang* and *Yin*. Human beings are conceptualized as one of the myriad things existing in the world. When males and females came into existence, it created a social world. Their unification gave birth to a second generation, providing grounds for constructing social relationships between father and son, and sovereign and subordinates. The arrangement of social relationships between oneself and others (*the Way of Humanity*) therefore corresponds to the *Way of Heaven*.

Confucian Ethics for Ordinary People

The *Way of Humanity* should be followed by everyone, including scholars. According to Confucian ethics (for ordinary people), interpersonal relationships should be based on benevolence (*ren*), righteousness (*yi*), and propriety (*li*):

> Benevolence (ren) is the characteristic attribute of personhood. The first priority of its expression is showing affection to those closely related to us. Righteousness (yi) means appropriateness, respecting the superior is its most important rule. Loving others according to who they are, and respecting superiors according to their ranks gives rise to the forms and distinctions of propriety (li) in social life. (Hwang 2012, p. 108)

In addition to emphasizing the importance of benevolence (*ren*), righteousness (yi) and propriety (*li*), this quotation from *The Doctrine of the Mean* (中庸)[3] points to the dimensions along which Confucians assess role relationships in social interaction (Fig. 9.1). The differential order of interpersonal relationships is indicated by the notion of loving others according to who they are and respecting superiors according to their rank.

Specifically, Confucians propose that when interacting with other people, one should first assess the relationship between oneself and the other party along two cognitive dimensions: intimacy/distance and superiority/inferiority. The former refers to the closeness of the relationship while the latter indicates the relative superior/inferior positions of the two parties involved. Once the assessment is done, favoring people

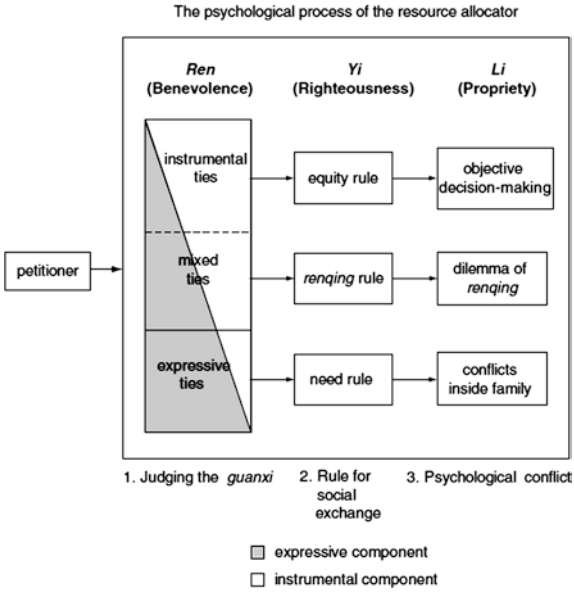


Fig. 9.1 The Confucian ethical system of benevolence-righteousness-propriety for ordinary people (*Source* Adapted from Hwang 1995, p. 233)

with whom one has a close relationship can be termed benevolence (*ren*), respecting those for whom respect is required by the relationship is called righteousness (*yi*), and acting according to social norms is propriety (*li*).

The proposition of *The Doctrine of the Mean* has an important implication for comparison with the justice theory in Western psychology, which divides the concepts of justice in human society into two categories: procedural justice and distributive justice. Procedural justice refers to the steps that should be followed by members of a group to determine methods of resource distribution. Distributive justice is the particular method of resource distribution that is accepted by group members (Leventhal 1976, 1980).

According to Confucian thinking, procedural justice in social interaction should follow the principle of respecting the superior. The person who occupies the superior position should play the role of resource allocator. The resource allocator should then follow the principle of

favoring the intimate in choosing an appropriate rule of resource distribution or social exchange. When the petitioner requests the resource allocator to allocate the resource under his/her control in a way beneficial to the petitioner, the resource allocator tends to interact with the other party in terms of need rule, *renqing rule* (of dong forever) and equity rule, respectively. In the psychological process of the resource allocator, the judgment of *guanxi* (relationship), rule for exchange, and explicit behavior correspond to the Confucian ethical system of benevolence (*ren*)-righteousness (*yi*)-propriety (li) for ordinary people: the judgment of guanxi corresponds with benevolence (*ren*), rule of exchange with righteousness (*yi*), and explicit behavior with propriety (*li*). All are substantial rules to be considered in taking such kind of corresponding actions.

Interaction Between Five Cardinal Ethics and Three Bonds

Based on the deep structure of ethics for ordinary people, Confucians of pre-Qin period proposed five cardinal ethics with the core value of benevolence (*ren*), requesting one to fulfill one's role obligations in dyad interactions (i.e. the five significant relationships) in the lifeworld. Nevertheless, since the Martial Emperor of the Han Dynasty (158–87 B.C.) accepted the proposal of Dong Zhong Shu (179–104 B.C.) and adopted the principles of Confucianism as the orthodox state philosophy for his empire, the three bonds (*sangang*) had been frequently and closely linked to five cardinal ethics (*wuchang*), which delineated the absolute authority of the ruler over the minister, the father over the son, and the husband over the wife, and have had profound influence over Chinese culture in general.

Confucians consider the relationships between father and son, sovereign and subordinate, husband and wife, elder and younger brother, and friends to be the most fundamental relationships in a society, which are termed the five cardinal relationships (*wu lun*). According to Confucianism, each relationship among the five entails an appropriate type of interaction in accordance with the relative superior/inferior positions as well as with the intimacy/distance of the relationship. In fact, it

is along these two dimensions that Confucian scholars of the pre-Qin period evaluated the role characteristics of these five relationships, and proposed the most appropriate ethics for each of them. For example, Mencius maintains:

> Between father and son, there should be affection; between sovereign and subordinate, righteousness; between husband and wife, attention to their separate functions; between elder brother and younger, a proper order; and between friends, friendship. (Mencius, Teng Wen Gong, I, Ch. 4) (see Note 3)

Confucians set appropriate ethical principles for a given role relationship according to superior/inferior positions and the intimacy/distance of the relationship. This system can be interpreted in terms of justice theory in Western psychology. When a person initiates social interaction with others, the dimensions of intimacy/distance and superiority/inferiority concerning the relationship between the two parties should be carefully considered in order to achieve procedural justice and distributive justice, respectively.

After an assessment of superior/inferior status in the relationship, the principle of respecting the superior should be adhered to, thus indicating who should play the role of resource allocator:

> What are the things which humans consider righteous (yi)? Kindness on the part of the father, and filial duty on that of the son; gentleness on the part of the elder brother, and obedience on that of the younger; righteousness on the part of the husband, and submission on that of the wife; kindness on the part of the elders, and deference on that of juniors: benevolence on the part of the ruler, and loyalty on that of the minister. These are the ten things that humans consider to be right. (Liji, Li Yun)[4]

Although the interaction between each of the five cardinal relationships should be based on benevolence (*ren*), the values and ethics emphasized in these relationships differ due to their various role functions. The reason the ten things of righteousness are specifically defined in *Li Chi* is that there exists a differential order within the five sets of roles involved. In accordance with the ten things of righteousness (*yi*), father, elder

brother, husband, the elderly, or ruler should make decisions in line with the principles of kindness, gentleness, righteousness, kindness, and benevolence, respectively. And for son, younger brother, wife, junior, or minister, the principles of filial duty, obedience, submission, deference, loyalty, and obedience apply.

From the modernist point of view, the three bonds are primarily based on power and domination; such exploitative relationships can hardly be redeemable as either social or family ethics. Therefore, Tu (1998, p. 130) suggested that it is necessary to differentiate and to study the complex interaction between the authoritarianism of the three bonds and the benevolence of the five cardinal ethics at the cultural system level. As the politicized Confucian ideology of control, the institution of three bonds was a deliberate attempt to utilize Confucian values for the maintenance of a specific social order. It is detrimental to human flourishing. On the contrary, the five cardinal ethics deliberated by Mencius with the idea of self-cultivation is not only compatible with but also essential to personal growth. Therefore, he argued that a sophisticated critique of the three bonds must involve adequate appreciation of the Mencian conception of the five cardinal ethics.

Numerous empirical evidence indicated that relative ethics and absolute ethics are coexisting in the social life of contemporary Chinese people, both of them may be emerged as one's habitus of living interacting with other parties formulated in a particular environment of family, community or society. This is the reason why ethical healing is still an important lesson of self-cultivation for many Chinese people.

Self-Cultivation in Confucianism and Daoism

The Great Learning, one of the Four Books of Confucian classics, proposed three guiding principles for self-cultivation at its very beginning:

> The way of great learning consists in manifesting one's bright virtue, consists in renovating the people by resting in the highest Goodness. (see Note 3)

It explained the renovating of the people in its commentary chapter by giving a list of examples:

> As sovereign, he rested in benevolence. As a minister, he rested in reverence. As a son, he rested in filial piety. As a father, he rested in kindness. In his interactions with the people, he rested in trustworthiness. (see Note 3)

All the examples designated the self-evident virtue to be pursuit by each social role in his interaction with other party in the dyad of the five cardinal relationships which can be explained in terms of *Confucian ethics for ordinary people* (Fig. 9.1). One may be confused by the complicatedness of Confucian ethical system, but Analects also provided simple rules of thumb for people to follow. Once Confucian told his young disciple Zeng Shan, who authored *The Great Learning* summarizing and integrating Confucian teachings afterwards:

> "Shan, my doctrine is that of an all-pervading unity."
> The disciple Zeng replied, "Yes."
> The Master went out, and the other disciples asked, saying, "What do his words mean?"
> Zeng said, "The doctrine of our master is loyally and compassion— and nothing more." (Analects, Li Ren, Ch. 15)

Zhu Xi interpreted *loyalty* as 'to exert oneself to the principle of sincerity,' and comparison as 'the exercise of benevolence to others.'

Following the three guiding principles, *The Great Learning* also proposed six steps for practicing any of those Confucian virtues:

> When you know where to rest, you have assurance,
> When you have assurance, you can be calm.
> When you are calm, you can feel anchor at ease,
> When you feel anchored, you can engage in deliberation,
> When you can deliberate, you can attain your goal. (see Note 3)

Contemplation in meditation has long been the most important practice of self-cultivation for Confucianism, Taoism, as well as Buddhism which had been transplanted into China since Han dynasty in the first

century. But the content and orientation of contemplation was very different for each of them. Confucianism encouraged social-oriented reflection to formulate proposal for future action:

> There is a proper sequence of doing thing,
> Affairs have their end and beginning.
> To know what is first and what is last.
> Will lead to what is taught in The Great Learning. (see Note 3)

Daoists' Contemplation

In opposition to the social orientation of Confucian meditation, pre-Qin Daoists advocated for another type of world-oriented contemplation which conceived human beings as one of all things existing in the universe.

> Being the state of vacancy to the utmost extent,
> Guard that of silence and clarity with unwearying vigour.
> All things alike go through their processes of evolving,
> As I watch the trajectory of their life cycles,
> No matter how luxuriantly they flourish,
> Each must go back to the origin where it comes from,
> Returning to the origin is called quietness,
> It is the fulfillment of one's destiny,
> Fulfilling one's destiny is its eternal pattern,
> To know the eternal pattern is to be illuminated,
> He who knows it will not be withered by misfortune. (*Daode Jing*, Ch. 16) (see Note 1)

Notes

1. For a classical English translation of Daode Jing, see James Legge (1891). For a modern translation, see Laozi (2008). All English quotations from Chinese Classics were translated by the author with a consideration to fit with the context of this chapter.

2. Xuguazhuan (序卦傳) is literally translated as the orderly sequence of the hexagrams. For a full text of English version I Ching or The Book of Changes, see the Wilhelm (1960).
3. Analects, the Great Learning, the Doctrine of the Mean and the Works of Mencius are the Four Books of Confucian classics. For a classical English translation of its full text, see James Legge (1861).
4. *Liji*, or the *Book of Rites*, literally the Record of Rites, is a collection of texts describing the social norms, administration, and ceremonial rites of the Zhou dynasty as they were understood in the Warring States and the early Han periods. For a English translation of its full text, see James Legge (1885).

References

Huang, A. (2010). *The complete I Ching*. Rochester, Vermont, and Toronto: Inner Traditions.

Hwang, K.-K. (1995). *Knowledge an action: A social-psychological interpretation of Chinese cultural tradition* (In Chinese). Taipei: Sin-Li.

Hwang, K.-K. (2001). The deep structure of confucianism: A social psychological approach. *Asian Philosophy, 11*(3), 179–204.

Hwang, K.-K. (2012). *Foundations of Chinese psychology: Confucian social relations*. New York: Springer.

Hwang, K.-K. (2015). Culture-inclusive theories of self and social interaction: The approach of multiple philosophical paradigms. *Journal for the Theory of Social Behaviour, 45*(1), 39–62.

Laozi. (2008). *Daode Jing*. A new translation by E. Ryden. Oxford and New York: Oxford University Press.

Legge, J. (1861). *The Chinese classics* with a translation, critical and exegetical notes, prolegomena, and copious indexes (Vols. 1 & 2). London: Trubner, reprinted by SMC Publishing, Taipei, Taiwan, 1991.

Legge, J. (1885). *The sacred books of the east* (Vols. 27 & 28) (M. Müller, Ed.). Oxford: Clarendon Press.

Legge, J. (1891). *The sacred books of the east* (Vol. 39) (M. Müller, Ed.). Oxford: Clarendon Press.

Leventhal, G. S. (1976). Fairness in social relationships. In J. Thibant, J. T. Spence, & R. T. Carson (Eds.), *Contemporary topics in social psychology* (pp. 221–239). Morristown, NJ: General Learning Press.

Leventhal, G. S. (1980). What should be done with equality theory? In K. J. Gergen, M. S. Greenberg, & R. H. Willis (Eds.), *Social exchange: Advance in theory and research* (pp. 27–55). New York: Plenum Press.

Needham, J. (1954). *Science and civilization in China* (Vol. 1): *Introductory orientations*. Cambridge: Cambridge University Press.

Tu, W. M. (1998). Probing the three bonds and five relationships in Confucian humanism. In G. A. De Vos (Ed.), *Confucianism and the family* (pp. 121–136). Albany, NY: State University of New York Press.

Wilhelm, R. (1960). *The I Ching or book of changes* (C. F. Baynes, Trans.). London: Routledge and Kegan Paul.

10

Indigenous Psychology in Aotearoa/New Zealand and Australia

Waikaremoana Waitoki, Pat Dudgeon and Linda Waimarie Nikora

> The discipline of psychology in Australia [and Aotearoa/New Zealand] has a history of domination over Indigenous Australians [and the people of Aotearoa/New Zealand] that is still evident today. Psychology colonises both directly through the imposition of universalising, individualistic constructions of human behaviour and indirectly through the negation of Aboriginal knowledges and practices. (Dudgeon and Walker 2015, p. 276)

> When we find ourselves trapped in the embrace of a western psychology that smothers our self-determination, we need to find ways of letting in the light, fresh air, and new horizons …. (Waitoki 2016, p. 295)

W. Waitoki (✉) · L. W. Nikora
University of Waikato, Hamilton, New Zealand

P. Dudgeon
University of Western Australia, Crawley, WA, Australia

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_10

Introduction

Globally, Indigenous psychology has emerged as a vibrant, cutting-edge discipline representing a vast range of peoples who have survived colonisation and retained their own therapeutic knowledge systems. Fundamental elements of the term 'Indigenous' includes: self-identification as indigenous peoples at the individual level, acceptance by the community as a member, historical continuity with pre-colonial and/or pre-settler societies; strong links to territories and surrounding natural resources; distinct social, economic or political systems, distinct language, culture and beliefs; and a determination to maintain and reproduce ancestral environments and systems as distinctive peoples and communities (Cobo 1986).

Indigenous psychology can be understood as a form of cultural reclamation and cultural survival. The practice, theory and science of Indigenous psychology unsettle colonisation while re-centring Indigenous knowledge, or epistemology. Although the discipline of Indigenous psychology is relatively recent, the therapeutic Indigenous knowledge base has been refined over the centuries preceding colonisation (Levy 2016). Definitions of psychology including the study of nature, the human mind and human behaviour, existed well before the colonisation of Aotearoa/New Zealand, and undoubtedly existed in other cultures throughout the world. Such complex knowledge systems were vital to the flourishing of communities and practitioners were respected healers and the guardians of culture.

By supporting and developing culturally appropriate healing, Indigenous psychology is engaged in restoring therapeutic practices and knowledges which have been marginalised and suppressed through centuries of colonisation. Foley (2006) argued that the fencing-in of Indigenous knowledge and Indigenous minds happened at the same time that land and resources were taken, 'the result was the entrapment of our psychic and our thought processes in a cruel educational vacuum that we now call civilization' (p. 26). An Australian and Aotearoa/New Zealand Indigenous psychology can be argued to share Franz Fanon's commitment to liberating the colonised mind from 'the arsenal

of complexes that has been developed in the colonial environment' (Fanon 1986, p. 30). The freedom that comes with intellectual emancipation allows deep exploration of Indigenous therapeutic systems that enable cultural connections and transformation.

This chapter relates to the reclamation of Indigenous psychology in Aotearoa/New Zealand and Australia, in particular, the revitalisation of traditional therapeutic knowledge, the de-colonisation of Western psychology, and the focus on self-determination for enhancing the well-being of Indigenous peoples. The need for Indigenous psychology is clear: the impact of colonisation the world over is evident in the significant disparities in the way Indigenous peoples, compared to dominant nationalities, access economic, social, political, educational, geographical and psychological capital (Anderson et al. 2016). The ongoing effects of inequities and the structural violence that maintain them are widespread, resulting in significant challenges to Indigenous peoples attempts to preserve their cultural heritage and Indigenous knowledge systems.

Indigenous Psychological Paradigms

Australian Indigenous psychology explicitly promotes a holistic form of well-being which recognises that self-determination and autonomy, at every level of life, influences the social determinants of health. Aotearoa/New Zealand offers a Māori way (kaupapa Māori) of Indigenous psychology that includes principles of interrelationships, traditional knowledge, language, autonomy and self-determination.

Social and Political Determinants of Well-Being and Historical Trauma

The social determinants of health have, at their core, the reality that groups of people are affected by sociopolitical and economic influences such as low education, lack of a living-wage, affordable and safe

housing, nutritious food, health services; equitable participation in society and political representation (Marmot 2013; WHO 2012). Social and political inequality between Indigenous and non-Indigenous populations in Aotearoa/New Zealand and Australia are apparent in the significant gap between the two groups. For example, the *Overview of the Australian Indigenous Health Status 2013*, Australian Indigenous Health*InfoNet* (2014) found that between '2012–2013, 69% of Indigenous adults experienced at least one significant stressor in the previous 12 months' (p. 22). Recognised stressors are early family deaths caused by health-related problems; early and repeated incarceration, breakdowns and illness, serious accidents, lack of employment and insecure housing. A prevailing feature of these determinants for Indigenous peoples is the lack of recognition of the effects of structural violence and colonisation and the ongoing depletion of Indigenous peoples resources—see also, #DAPL Dakota Access Pipeline and #handsoffourtamariki (*hands off our children*) in response to forced removal of children (Bedoe 2016).

In Aotearoa/New Zealand, mainstream psychology has been slow to recognise, or research, the impact of historical trauma despite being alerted that Māori were dealing with the consequences of a *holocaust* within our own country (Turia 2000). The 'historical continuity with pre-invasion and post-colonial societies' (UN 2007: 4) contributes significantly to the legacies of risk and ongoing inequities experienced by Indigenous individuals, families, and communities. The notion of 'historical trauma' was developed in North America to explain Indigenous mental health problems as a result of post-colonial stress, to destigmatise Indigenous peoples, and to reclaim Indigenous therapeutic cultural practice (Baskin 2016; Cajete 2008). Indigenous researchers have steadily increased our understanding of historical trauma and the pivotal role of Indigenous therapeutic interventions (Pihama et al. 2014).

While a relatively recent term in Australian psychological literature, Indigenous Australians also experience historical trauma. It is well known that the collective mental health of Indigenous Australians has been impacted through the often violently oppressive process of colonisation. To refer to a landmark document, the 1997 inquiry into the

forced separation of children from their families, *Bringing Them Home: Report of the National Inquiry into the Separation of Aboriginal and Torres Strait Children from their Families* (Wilkie 1997) provided evidence that Indigenous people in Australia have been subjected to genocide as defined by international law (p. 231). The Sydney Aboriginal Mental Health Unit commented that the forced removal of children and the psychological consequences, across several generations, resulted in incalculable trauma, depression and major mental health problems for Aboriginal people.

> …initially the systematic forced removal of children and now the continuing removal by Community Services or the magistracy for detention of children has been tantamount to a continuing cultural and spiritual genocide both as an individual and a community experience and we believe that it has been the single most significant factor in emotional and mental health problems which in turn have impacted on physical health. (Wilkie 1997, p. 171)

Despite the numerous barriers Indigenous peoples face, they thrive and resist, signaling a renaissance of visible Indigenous culture within Aotearoa/New Zealand and Australia. One of the more significant gains made has been the rapid growth of an Indigenous mental health movement which is actively reforming policy, contributing to public awareness of the social determinants of Indigenous well-being, and restoring the authority of cultural healers. Recognition of the impact of historical trauma is necessary across psychology if Indigenous worldviews are to find a firm foothold in the profession.

In 2016, the Australian Psychological Society offered a formal apology to Indigenous people for the ways in which the discipline, psychologists, researchers and academics, had actively discriminated against the traditional custodians of the land. The apology ended with the expectation of a future 'where Aboriginal and Torres Strait Islander people enjoy the same social and emotional well-being as other Australians' (NACCHO 2016). Aotearoa/New Zealand psychology professions have yet to recognise their complicit role in contributing to abuses perpetrated by psychological theories and practices.

Kaupapa Māori Psychology: An Indigenous Psychology

While the Treaty of Waitangi is an important local instrument in our New Zealand context, internationally, the United Nation's *Declaration on the Rights of Indigenous Peoples* (UNDRIP) (Cobo 1986) provides pathways for Indigenous peoples to self-determination and self-governance with health contexts. Indigenous psychology in New Zealand is closely aligned with the Māori development agenda, the goal of which 'is to create psychologies to meet the needs of Māori people in a way that maintains a unique cultural heritage, and makes for a better collective Māori future' (Nikora et al. 2006, pp. 254–255).

An important feature of Indigenous psychology in Aotearoa/New Zealand stems from the understanding that Māori resist their exclusion, as Māori, from participating in therapeutic spaces. The term *kaupapa Māori*, refers to the philosophy and practice of being and acting Māori (Smith 1999) where Māori values, and worldviews about relationships are central. *Kaupapa Māori* theory is the operationalisation of self-determination—*tino rangatiratanga* and through its alignment with critical theory, has elements of conscientisation, resistance and praxis (Pihama 2001; Smith 1999). Māori epistemologies provides a lens to view the relational phenomena of the world, taking into account Māori methods of comprehending, observing and experiencing those things that exist, has existed, and may yet exist (Waitangi Tribunal 2011). A Māori scientific lens applied to exploring phenomenon is problematic in Western contexts as positivism and reductionism prevail.

An Indigenous psychology in Aotearoa/New Zealand has firm foundations in mātauranga Māori—Māori knowledge (Levy and Waitoki 2016). Reclaiming that knowledge allows us to theorise a pathway in psychology that meets our Indigenous needs. Māori understandings of well-being are similar to Indigenous Australians where relationships and healthy connection to others, either family, friends, or communities, is central. *Whānau Ora*, 'healthy families', is a Māori-led initiative where Māori families are supported to achieve, and assess, their maximum health and well-being (Office of the Auditor General 2015).

The *Whānau Ora* philosophy recognises that families are a collective entity, with the capacity for self-determination; that family is built on a Māori cultural foundation, and that families can have a positive role within society (Boulton and Gifford 2014).

Understanding the relational nature of health and well-being is pivotal, as is understandings of Māori cultural knowledge and practice. Research conducted by Māori psychologists, show that Māori knowledge is being incorporated into every facet of psychology: clinical, community, education, neuropsychology, teaching and research (Waitoki 2016; Love and Waitoki 2007). Despite the lack of sufficient course content in University psychology training programmes, Māori consumers are being treated with either culturally-adapted Western psychological therapies, or Indigenous Māori practices (Waitoki 2016). Although both forms of practice use distinctly Māori processes, in the culturally-adapted approach, Western psychology is part of the assessment and treatment modality. Indigenous knowledge and practice include: *Manaakitanga*—hospitality, sharing food, sharing resources and showing genuine care and support; Using *karakia*—ceremony/prayer/protocols to create a culturally safe space that settles clients, opens connections, affirms cultural worldviews, and embraces the client's language and values; *Whakawhanaungatanga*—building relationships relating to open disclosures about genealogical and cultural links that may exist between clients and therapists. Such disclosures enable a shift in power, and confirms the importance of relationships between people, and the importance of connections via land and sea, history, and language, time and space. The salience of building relationships is embedded in Māori identity as Māori, and is based on tribal affiliations and family links, which are not typically seen in Western psychology (Valentine 2016).

Indigenous practices used to engage with clients include extensive engagement processes such as: *mihimihi* (ceremonial greetings); *tikanga* (ethics and moral codes); self-disclosure of genealogical links—*whakapapa*; and *karakia*—invocations, Māori arts and technologies, and physical and environmental connections. Indigenous psychology for Māori, incorporates the use of social connections, Māori language, and personal contact, sharing intimate stories, and using strategies to enhance cultural identity and raise potentiality (Macfarlane and Macfarlane 2012;

Pitama et al. 2014). These practices underpin Māori cultural practices essentially establishing a relationship that is based on shared knowledge about each person in the therapeutic relationship, thereby countering the notion of the psychologist as the sole holder of knowledge. Furthermore, the deep connections established in the engagement process establishes a reciprocal relationship that is based on possible genealogical, geographical and community interests.

Māori relational worldviews have played a vital role in reshaping therapeutic interventions while maintaining the cultural dignity of those involved in situations where risk and vulnerabilities exist, such as drug and alcohol abuse, sexual violence and suicidality (Emery et al. 2015; Lawson-Te Aho 2016). Although personal disclosure is seen as ethically unsafe within Western psychology, Māori people build trust and respect through open disclosure about family, geographical links, schooling, and other personal connections. Issues of safety are also important and Māori therapists ensure that their disclosure is bound within the cultural worldviews of Māori engagement processes, so that deep personal details that may be used inappropriately are avoided.

Blending traditional and contemporary knowledge of Māori creation stories (Kopua and Rangihuna 2015) and new technologies in psychology is an important feature of Indigenous psychology. Cherrington (2016) offers a Māori-focused intervention based on *pūrakau*/storytelling: '[T]raditionally, *pūrakau* have been handed down from generation to generation to provide advice and insights to the thoughts, actions, and feelings of our ancestors' (p. 118). The principles contained within the *pūrakau* method are *wānanga*—discussion and debate, power-sharing and talking story (Taitimu 2016). The end-user decides which method they use to tell their story which typically includes the use *waiata*—songs, body adornment, or traditional tattoo; and *haka*—creative performance; poetry, drama, weaving, sculpting, painting, drawing, storytelling, and/or writing.

The role of Māori processes in therapeutic interventions is to facilitate a secure cultural identity, to develop balanced relationships, and to enhance well-being. The reclamation of Indigenous practices means that the knowledge derived from ancestral origins and handed down through the centuries are drawn on to reframe psychology. Smith et al. (2016) comment on the importance of recognising the expertise in our

communities, particularly the knowledge holders who possess a level of skill that is not valued, or understood by mainstream spaces.

> … those extraordinary, metaphysical tasks, such as mediating the material and spiritual world, escorting a spirit on a physical and spiritual journey, binding ancient genealogies with contemporary realities, sustaining relationships while healing collective grief, seeking visions and teachings from our ancestors, or cleansing people and spaces. (p. 132)

The knowledge systems embedded in the above statement point to a reality in Western psychological spaces: Indigenous peoples who speak of deceased ancestors, esoteric beliefs or spiritual events are pathologised and labelled as deficit and psychotic. Indigenous psychologists understand the role of metaphysics and can artfully blend bicultural knowledge systems to avoid exposing consumers to continued colonisation in systems that overlook the importance of such systems (Wirihana and Smith 2014).

An emerging Indigenous health framework for Māori based on the *Meihana model* (Pitama et al. 2014) and '*te whare tapa wha*' (the four-sided house) developed by Mason Durie (1994) is gaining traction with health settings. The refined model, '*Te waikare o te waka o Meihana*'—the rippling waters from the Meihana canoe, is an Indigenous health framework comprising elements of engagement (*hui*) formal greetings, establishing connections, attending to the purpose of the encounter, and closing protocols. The connections made via a therapeutic context extend beyond formalised, Western processes of non-disclosure, and detachment. The second part of the Indigenous health framework shows a metaphoric representation of consumers as a double-hulled, ocean vessel with six crossbeams representing elements integral to Māori well-being: physical (*tinana*), psychological (*hinengaro*), service connections (*iwi katoa*), spirituality (*wairua*) and environment (*taiao*).

The double hull of the ocean vessel represents the client on one side and family on the other. The contextual factors that influence consumer well-being such as colonisation, racism, migration, and marginalisation are represented by the four winds. The metaphors of ocean currents enable practitioners to consider personal connections to Māori culture, adherence to Māori cultural principles, interpersonal relationships, and

connections to land. Navigation relates to setting an appropriate course for clients that takes into account all the features described within a Māori worldview and taking into account relevant clinical features. The goal of the model is for health practitioners to consider, clinically and culturally, the multiple influences that impact decisions made about, and for Māori clients. The Meihana model was recently redeveloped for clinical psychology and called the 'Hauora model' (the wellbeing model, Pitama et al. 2017). The model has synergies with Australian health models indicating the common features of Indigenous experiences and well-being goals.

Australian Context and Emerging Therapeutic Knowledges

> For Indigenous people, cultural identity is the foundation of who we are. Despite years of assimilationist policy, and the loss of so many of our customs and languages, Aboriginal people have demonstrated extraordinary cultural resilience. (Dudgeon 2014, p. 6)

Indigenous Australia is made up of two distinct cultural groups, the majority, mainland Aboriginal people and a minority, Torres Strait Islander people. This chapter uses the term Indigenous to refer to both groups. Indigenous Australians belong to the oldest living culture in the world, and indeed the oldest sustainable, equitable and harmonious culture in the world. According to estimates by archaeologists, the Indigenous Australian culture is between 60,000 and 70,000 years old (Australian Science Media Centre 2016). The colonisation of Australia in 1788 has had a lasting impact on the social and emotional well-being of Indigenous peoples. Forced displacement from land, massacres, introduced diseases, sexual violence, enslavement, and the systemic destruction of cultural life have resulted in complex forms of trauma and socioeconomic deprivation (Dudgeon et al. 2014). In the late eighteenth century some two hundred and fifty languages and six hundred dialects were recorded but by the early twenty-first century only approximately one hundred and fifty language groups remained, with approximately 20 in everyday use and 13 near extinction (Obata and Lee 2010). This attrition is a clear indication of the destructive impact of colonisation.

Indigenous Australians and Māori, have survived several waves of institutionalised racism (Dudgeon et al. 2016b). The Protectionists era began in the late 1800s: The colonising government, under instruction from the British Empire, sought to preserve from extinction a people viewed as primitive and without culture. The Aboriginal Act of 1905 in Western Australia, for example, placed all Indigenous people under surveillance and state control, restricting movement, employment, and the right to partner (Dudgeon 2008). The Assimilationist era, which overlapped, is often recognised as officially starting with a decision made at a national 1937 Commonwealth Government conference where it was agreed that Indigenous children, who were not 'full blood,' would be removed from their families and placed in orphanages and white foster homes (Dudgeon et al. 2015).

Resistance against colonial dispossession is ongoing. Among many landmark achievements is the 1966 Northern Territory Wave Hill strike by the Gurindji people which mobilised the Indigenous land rights movement, a movement which is central to self-determination. The 1967 referendum granted the semblance of self-determination by being counted as citizens in the consensus. During what some political historians describe as the self-determination era, the Aboriginal and Torres Strait Islander Commission (ATSIC) was established as the first national self-governing Indigenous body in 1990 (although abolished by a Conservative government in 2005). The Australian High Court 'Mabo' decision of June 1992 recognised the rights of the Meriam people of Murray Island (Mer) over their own land—the colonial fiction of 'terra nullius' was replaced by Indigenous self-determination. The Native Title Act of 1993, and the 1996 'Wik' Indigenous land rights decision, also strengthened self-determination.

Social and Emotional Well-Being and Indigenous Therapeutic Knowledges

Social and emotional well-being is an emerging paradigm within Australian Indigenous psychology, informing a range of policy interventions, research, and therapeutic practices. This emerging paradigm has

both de-colonised dominant white mental health policy and practice (Dudgeon and Walker 2015), and re-centred Indigenous therapeutic epistemologies as the foundation of praxis and theory. The Australian Indigenous mental health movement has promoted a recognition of social and emotional well-being through key mental health policies (Fig. 10.1).

The concept of Indigenous social and emotional well-being was first developed in 1989 by the National Aboriginal and Islander Health Organisation (NAIHO) which defined Aboriginal health as:

> The social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their Community. It is a whole-of-life view and includes the cyclical concept of life-death-life. (National Aboriginal Health Strategy Working Party 1989)

This concept of health was taken up in the 1989 National Aboriginal Health Strategy which identified nine principles for Aboriginal and Torres Strait Islander social and emotional well-being, which have since guided practice and policy in the area. For example, these principles are contained in the National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Well-being 2004–2009. The Framework defined Indigenous social and emotional well-being as a holistic connection to the domains of 'land, culture, spirituality, ancestry, family and community' (SHRG 2004, p. 9).

Protocols for the delivery of social and emotional well-being and mental health services in Indigenous communities were released in 2009 (Haswell et al. 2009). Since then the psychology of Indigenous social and emotional well-being has evolved into a composite of seven inter-connected domains: country, mind and emotions, body, family and kinship, community, culture, and spirituality (Dudgeon and Walker 2015). Together these domains can be said to describe Indigenous selfhood. Flourishing connections between these domains can be understood as the dynamics of Indigenous thriving. The result of a lack of balanced connection between the seven domains is impaired health which 'may be manifested in a physical, social, emotional, mental or



Fig. 10.1 Social and emotional well-being diagram (*Source* Dudgeon and Walker 2015)

spiritual manner' (Haswell et al. 2009, p. 3). Intergenerational trauma caused by the forced removal of children has been identified as a significant disruption to Indigenous social and emotional well-being (SHRG 2004, p. 9).

Central to Indigenous social and emotional well-being psychology is the recognition that well-being has been compromised through colonisation, and that self-determining therapeutic practices are most effective in healing historical trauma, and other consequences of colonisation. Here it is acknowledged that social and emotional well-being although an emerging paradigm, is rooted in the cultural history of Indigenous life:

> Aboriginal social life has provided a framework for social, psychological and economic security, in which well-being was socially determined through the organisation of relationships with the land and with people within frameworks of law and ceremony, family organisation and systems of belief known as 'The Dreaming'. (CRCAH 2009, p. 3)

Spirituality is recognised as a bedrock of Indigenous mental health (Riley 1997). 'Aboriginal well-being relies on a belief system, that philosophical basis of ontologies and epistemologies known as Spirituality' (Grieves 2009, p. 42). The focus on Dreaming and spirituality significantly enhances our understanding of how Indigenous knowledge has informed our psychology. A common term for Aboriginal philosophical ontologies and epistemologies is The Dreaming which is sometimes called the Law or the Lore. The Dreaming holds life in place and together.

Indigenous words for the complex spiritual (and sociopolitical) system are numerous, for example, the Aranada use the term *Altjiringa*, the Altjidja people refer to the *Djugar*, the Karadjeri people call this past, present and future Lore; the *Bugari*, the Ungarinyin describe the *Unggud*, and the Wiradjeri call the synthesis between human and non-human, seen and unseen, the *Maratal* (Elkin 1969). The philosophy of the Dreaming encompasses a connection to the more-than-human, the intermingling of the past, present and future, and to the seen, and unseen (Grieves 2009, p. 17). This philosophy is referred to as the Law because it is the foundation of 'morality, ethics, governance, natural resource management, and social and familial relationships that are designed to ensure sustainability and effective governance and sociality' (Grieves 2009, p. 12). Moreover, the purpose of this Law is to guard and nurture life: '*Mission: keep all alive*' (Sveiby and Scuthorpe 2006, cited in Grieves 2009, p. 15, emphasis added).

During the last few decades once suppressed therapeutic practices have re-emerged across the nation, and various Indigenous mental health policies now acknowledge their importance in closing the mental health gap between Indigenous and non-Indigenous peoples. For example, the landmark Australian 2015 *Gayaa Dhuwi* (*Proud Spirit*) *Declaration* requests that traditional healing become a central part of

culturally appropriate practices: 'building access to cultural healers and cultural healing' is the primary task for implementing the *Declaration* (Dudgeon et al. 2016a, p. 7). *Gayaa Dhuwi* emerged from the 2010 *Wharerata Declaration* created by mental health leaders from Canada, Australia, New Zealand, Samoa and the United States with the support of the International Initiative for Mental Health Leadership. There are five central themes in the *Wharerata Declaration*: Indigeneity; best practice; best evidence; informed, credible, strategic, connected sustainable leadership; influential and networked leadership (Sones et al. 2010).

The 2014, West Australian Mental Health Act also acknowledges the right of Indigenous people to have access to cultural or traditional healers: Principle 7 states that Aboriginal and Torres Strait Islander people must be provided with access to traditional healers and also to Elders in their community during the process of assessment, treatment, and care (Dudgeon 2014). This is also part of a cultural renaissance in which the engagement of Elders in Indigenous mental health is now recognised as vital to the healing benefits of cultural continuity and the survival of cultural practices. The 2014 release of the results of a nation-wide consultation with Elders about the epidemic of youth suicides People Culture Environment and One Generation Media (2014), advised repeatedly that the role of Elders in reconnecting youth to cultural practices is important in overcoming the alienation, social isolation and cultural disconnection which are a pathogenic outcome of colonisation.

Traditional healing practices are complex and varied and are referred to by many language names. For example, the western desert name is *Ngangkari*, and in Arnhem Land traditional healers are called the *Marrnggitj* (Elkin 1969). The Ngangkari group of healers have become more visible in the last couple of decades. As Dudgeon and Walker write, the traditional spiritual healers, the Ngangkari, 'have nurtured the physical, emotional, and social well-being of Indigenous people across 350,000 square miles of the remote western desert of Australia for thousands of years' (Dudgeon and Walker 2015, p. 290). Across this vast area, the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) (2013) Women's Council have practiced spiritual healing, and done much to strengthen a national awareness about traditional therapeutic practices.

Conclusion

Indigenous psychology is the search by Indigenous peoples for a voice in their own futures and well-being. The reclamation of Indigenous psychology enables the creation of new, dynamic paradigms within which psychological distress can be addressed. In Aotearoa/New Zealand, Australia, or any other colonised nation, Indigenous peoples are a family, and as such, have a bond based on indigeneity, and survival. Indigenous psychology is in its formative years, and in some places is still marginalised by mainstream health and education systems. However, Indigenous and non-indigenous practitioners, researchers and scholars have moved towards changing the status quo so that it is possible to have Indigenous psychology institutions offering qualifications, assessment and intervention protocols, and to have a robust literature base. The goal of an Indigenous psychology is for Indigenous peoples to see their worldviews reflected back to them when they seek help for themselves, their families or their communities.

References

Anderson, I., Robson, B., Connolly, M., Al-Yaman, F., Bjertness, E., King, A., et al. (2016). Indigenous and tribal peoples' health (The Lancet–Lowitja Institute Global Collaboration): A population study. *The Lancet, 388*(10040), 131–157.

Australian Indigenous Health*InfoNet.* (2014). *Overview of Australian Indigenous health status, 2013*. Retrieved from http://www.healthinfonet.ecu.edu.au/health-facts/overviews.

Australian Science Media Centre (Ed.). (2016). Aboriginal gnome reveals new insights into early humans. *Australasian Science*, Nov/Dec 2017. Retrieved September 5, 2017, from http://www.australasianscience.com.au/article/issue-november-2011/aboriginal-genome-reveals-new-insights-early-humans.html.

Baskin, C. (2016). *Strong helpers' teachings: The value of indigenous in the helping profession*. Toronto: Canadian Scholars' Press.

Bedoe, L. (2016). Hands off our tamariki: An open letter. Retrieved September 5, 2017, from http://www.reimaginingsocialwork.nz/2016/10/hands-off-our-tamariki-an-open-letter/.

Boulton, A., & Gifford, H. (2014). Conceptualising the link between resilience and whanau ora. *MAI Journal, 3*(13), 112–129.

Cajete, G. (2008). Seven orientations for the development of indigenous science education. In N. Denzin, Y. Lincoln, & T. Smith (Eds.), *Handbook of critical and indigenous methodologies* (pp. 487–498). Thousand Oaks: Sage.

Cherrington, L. (2016). Re: "I just want to heal my family". In W. Waitoki & M. Levy (Eds.), *Te manu kai i te mātauranga: Indigenous psychology in Aotearoa/New Zealand* (pp. 115–133). Wellington: Roopu Mātai Hinengaro, New Zealand Psychological Society.

Cobo, M. (1986). *Study of the problem of discrimination against indigenous populations*. UN Doc.E/CN.4/Sub.2/1986/7/Add.4, paras. 379–380.

CRCAH (Cooperative Research Centre for Aboriginal Heath). (2009). *Spirituality and Aboriginal people's social and emotional wellbeing: A review*. Darwin: CRCAH.

Dudgeon, P. (2008). *Mothers of sin: Indigenous women's perceptions of their identity and gender*. Unpublished doctoral thesis, Murdoch University, Perth, Australia.

Dudgeon, P. (2014). Introduction. In People Culture Environment and one Generation Media (Ed.), *The Elders' report into preventing Indigenous self-harm and youth suicide*. Retrieved September 5, from http://www.cultureislife.org/wp-content/uploads/2015/10/Elders-Report.pdf.

Dudgeon, P., Calma, T., Brideson, T., & Holland, C. (2016a). The Gayaa Dhuwi (proud spirit) declaration—A call to action for Aboriginal and Torres Strait Islander leadership in the Australian mental health system. *Advances in Mental Health, 14*(2), 1–14.

Dudgeon, P., Cubillo, C., & Bray, A. (2015). The Stolen Generations: The forced removal of First Peoples children in Australia. In C. Newnes (Ed.), *Children in society: Politics, policies and interventions* (p. 5081). Ross-on-Wye: PCCS Books.

Dudgeon, P., Darlaston-Jones, D., Nikora, L. W., Waitoki, W., Pe-Pua, R., Tran, L., et al. (2016b). Changing the acculturation conversation: Indigenous cultural reclamation in Australia and Aotearoa/New Zealand. In D. L. Sam & J. W. Berry (Eds.), *The Cambridge handbook of acculturation psychology* (2nd ed., pp. 115–133). Cambridge: Cambridge University Press. https://doi.org/10.1017/cbo9781316219218.009.

Dudgeon, P., Milroy, H., & Walker, R. (2014). *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice* (2nd ed.). Canberra: Commonwealth of Australia. Retrieved September 5, 2017, from https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/working-together-aboriginal-and-wellbeing-2014.pdf.

Dudgeon, P., & Walker, R. (2015). Decolonising Australian psychology: Discourses, strategies, and practice. *Journal of Social and Political Psychology, 3*(1), 276–297. Retrieved December 11, from https://jspp.psychopen.eu/article/view/126/html.

Durie, M. (1994). *Whaiora: Maori health development*. Auckland: Oxford University Press.

Elkin, A. P. (1969). Elements of Australian Aboriginal philosophy. *Oceania, 40,* 85–98.

Emery, T., Cookson-Cox, C., & Raerino, N. (2015). Te waiata i roto i a Te Arawa: A Māori suicide research project. *AlterNative: An International Journal of Indigenous Peoples, 11*(3), 226–239.

Fanon, F. (1986). *Black skin, white masks* (C. L. Markmann, Trans.). London: Pluto Press.

Foley, D. (2006). Indigenous standpoint theory. *International Journal of the Humanities, 3*(8), 25–36.

Grieves, V. (2009). *Aboriginal spirituality: Aboriginal philosophy, the basis of Aboriginal social and emotional wellbeing* (Discussion Paper No. 9). Darwin: Cooperative Research Centre for Aboriginal Health. Retrieved November 12, 2017, from https://www.lowitja.org.au/sites/default/files/docs/DP9-Aboriginal-Spirituality.pdf.

Haswell, M., Hunter, E., Wargent, R., Hall, B., O'Higgins, C., & West, R. (2009). *Protocols for the delivery of social and emotional wellbeing and mental health services in Indigenous communities: Guidelines for health workers, clinicians, consumers and carers* (1st ed.). Cairns: University of Queensland and Queensland Health. Retrieved November 30, from https://www.health.qld.gov.au/__data/assets/pdf_file/0029/378731/acknow_foreward.pdf.

Kopua, M., & Rangihuna, D. (2015). *Mahi a atua: Te ara a Tāne & moko as healing*. Oral presentation. Tairawhiti District Health Board, 27th August, Gisborne.

Lawson-Te Aho, K. (2016). He waka eke noa—Māori and indigenous suicide prevention: Models of practice, lessons and challenges. In W. Waitoki, J. Feather, N. Robertson, & J. Rucklidge (Eds.), *Professional practice of psychology in Aotearoa/New Zealand* (3rd ed.). Wellington: New Zealand Psychological Society.

Levy, M. (2016). Kaupapa Māori psychologies. In W. Waitoki & M. Levy (Ed.), *Te manu kai i te mātauranga: Indigenous psychology in Aotearoa/New Zealand* (pp. 29–41). Wellington: New Zealand Psychological Society, Roopu Mātai Hinengaro.

Levy, M., & Waitoki, W. (2016). Our voices, our future: Indigenous psychology in Aotearoa. In W. Waitoki, J. Feather, N. Robertson, & J. Rucklidge (Eds.), *Professional practice of psychology in Aotearoa/New Zealand* (3rd ed.). Wellington: New Zealand Psychological Society.

Love, C., & Waitoki, W. (2007). Multicultural competence in bicultural Aotearoa. In I. Evans, J. Rucklidge, & M. O'Driscoll (Eds.), *Professional practice of psychology in Aotearoa New Zealand* (pp. 265–280). Wellington: New Zealand Psychological Society.

Macfarlane, S., & Macfarlane, A. (2012). Diversity and inclusion in early childhood education: A bicultural approach to engaging Māori potential. In A. Smith & R. Bishop (Eds.), *He Ao Tūroa Tātaki. Inclusive early childhood education: Perspectives on inclusion, social justice and equity from Aotearoa/New Zealand* (pp. 21–38). Wellington: New Zealand Council for Educational Research.

Marmot, M. (2013). *Health inequalities in the EU—Final report of a consortium*. Consortium lead: Sir Michael Marmot. Brussels: European Commission Directorate-General for Health and Consumers. Retrieved November 10, 2017, from https://ec.europa.eu/health//sites/health/files/social_determinants/docs/healthinequalitiesineu_2013_en.pdf.

NACCHO. (2016). *Australian Psychological Society issues a formal apology to Aboriginal and Torres Strait Islander people*. Retrieved September 5, 2017, from https://nacchocommunique.com/2016/09/15/naccho-aps2016-australian-psychological-society-issues-a-formal-apology-to-aboriginal-and-torres-strait-islander-people/.

National Aboriginal Health Strategy Working Party. (1989). *A National Aboriginal Health Strategy*. Canberra: National Aboriginal Health Strategy Working Party.

Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation. (2013). *Aboriginal corporation: Working together, traditional healers of central Australia: Ngangkari*. Broome, WA: Magabala Books.

Nikora, L. W, Levy, M., Masters-Awatere, B., & Waitoki, W. (2006). Global development and characteristics and local development. In C. M. Allwood & J. W. Berry (Eds.). Origins and development of indigenous psychologies: An international analysis. *International Journal of Psychology, 41*(4), 243–268 (pp. 254–255). Retrieved November 10, 2017, from http://indigenouspsych.org/Resources/Allwood%20&%20Berry.pdf.

Obata, K., & Lee, J. (2010). Languages of Aboriginal and Torres Strait Islander peoples—A uniquely Australian heritage. *Yearbook Australia, 2009–2010.*

Retrieved November 10, 2017, from http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/1301.0Feature+Article42009%E2%80%9310.

Office of the Auditor General. (2015). *Whānau Ora: The first four years* (Report Issued by the Audiotr-General). Wellington, New Zealand. Retrieved November 16, from https://oag.govt.nz/2015/whanau-ora/docs/whanau-ora.pdf.

People Culture Environment in Partnership with Our Generation Media (Ed.). (2014). *The Elders' report into preventing Indigenous self-harm and youth suicide*. Retrieved September 5, from http://www.cultureislife.org/wp-content/uploads/2015/10/Elders-Report.pdf.

Pihama, L. (2001). *Tihei mauri ora: Honouring our voices. Mana wahine as a kaupapa Māori theoretical framework*. Unpublished Ph.D. thesis, University of Auckland, New Zealand.

Pihama, L., Smith, C., Reynolds, P., Smith, L. T., & Te Nana, R. (2014). Positioning historical trauma theory within Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples, 10*(3), 248–262.

Pitama, S., Bennett, S., Waitoki, W., Valentine, H., Haitana, T., Pahina, J. … McLaughlan, A. (2017). Hauora Māori clinical guide for psychologists: Using the Hui process and the Meihana model in clinical assessment and formulation. *New Zealand Journal of Psychology, 46*(3).

Pitama, S. G., Huria, T., & Lacey, C. (2014, May 2). Improving Māori health through clinical assessment: Waikare o te waka o Meihana. *New Zealand Medical Journal, 127*(1393), Viewpoint Article. Retrieved November 10, 2017, from https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-126-no-1393/viewpoint-pitama.

Riley, R. (1997). *From exclusion to negotiation: The role of psychology in Aboriginal social justice* (Discussion Paper [Curtin Indigenous Research Centre] No. 1/1997). Perth, WA: Gunada Press, Curtin University.

SHRG (Social Health Reference Group). (2004). *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2004–2009.* Canberra: Australian Department of Health and Ageing. Retrieved November 10, from http://www.ahmrc.org.au/media/resources/social-emotional-wellbeing/mental-health/328-national-strategic-framework-for-aboriginal-and-torres-strait-islander-peoples-mental-health-and-social-and-emotional-well-being-2004-2009/file.html.

Smith, L. T. (1999). *Decolonising methodologies: Research and Indigenous peoples*. Dunedin: University of Otago Press.

Smith, L. T., Maxwell, T. K., Puke, H., & Temara, P. (2016). Indigenous knowledge, methodology and mayhem: What is the role of methodology in producing indigenous insights? A discussion from mātauranga Māori. *Knowledge Cultures, 4*(3), 131–156.

Sones, R., Hopkins, C., Manson, S., Watson, R., Durie, M., & Naquin, V. (2010). The Wharerata Declaration—The development of indigenous leaders in mental health. *The International Journal of Leadership in Public Service, 6*(1), 53–63.

Taitimu, M. (2016). A new moon. Talking story with Ripeka to support the healing of soul wounds In W. Waitoki & M. Levy (Eds.). *Te manu kai i te matauranga: (Indigenous psychology) in Aotearoa/New Zealand* (pp. 141–153). Wellington: New Zealand Psychological Society.

Turia, T. (2000). *Keynote address*. New Zealand Psychological Society Conference 2000 at Waikato University, 29 August.

UN (United Nations). (2007). *United Nations declaration on the rights of indigenous people*. New York: United Nations. Retrieved September 5, 2017, from http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf.

Valentine, H. (2016). Wairuatanga. In W. Waitoki & M. Levy (Eds.), *Te manu kai i te mātauranga: Indigenous psychology in Aotearoa/New Zealand* (pp. 155–169). Wellington, New Zealand: New Zealand Psychological Society, Roopu Mātai Hinengaro.

Waitangi Tribunal. (2011). *Ko Aotearoa tēnei: A report into claims concerning New Zealand law and policy affecting Māori culture and identity* (Wai 262: Waitangi Tribunal Report). Wellington: Waitangi Tribunal. Retrieved November 10, 2017, from https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_68356054/KoAotearoaTeneiTT1W.pdf.

Waitoki, W. (2016). Ngā kete mātauranga: The baskets of knowledge, a curriculum for an indigenous psychology. In W. Waitoki & M. Levy (Eds.), *Te manu kai i te mātauranga: Indigenous psychology in Aotearoa/New Zealand* (pp. 288–299). Wellington: New Zealand Psychological Society, Roopu Mātai Hinengaro.

WHO (World Health Organisation). (2012). *Social determinants of health* (Report by the Secretariat, EB132/4). Geneva: WHO. Retrieved November 10, 2017, from http://www.who.int/social_determinants/B_132_14-en.pdf.

Wilkie, M. (1997). *Bringing them home: Report of the national inquiry into the separation of Aboriginal and Torres Strait Islander children from their families*. Sydney, NSW: Human Rights and Equal Opportunity Commission.

Retrieved November 10, 2017, from https://www.humanrights.gov.au/sites/default/files/content/pdf/social_justice/bringing_them_home_report.pdf.

Wirihana, R., & Smith, C. (2014). Historical trauma, healing and well-being in Māori communities. *MAI Journal, 3*(3), 197–210. Retrieved September 5, 2017, from http://www.journal.mai.ac.nz/sites/default/files/MAI_Jrnl_3(3)_Wirihana02.pdf.

11

Respect and Relationship: A Perspective on Indigenous Mental Health from Turtle Island/North America

Michael Thrasher and Julian Robbins

Preface (Julian Robbins)

When approached to write this Chapter, the only way I (Julian Robbins) could see doing it in a meaningful way was to attempt to speak from a place that is centred from within a specific Indigenous oral tradition. In doing so, I asked a person that I respect as a keeper of traditions (Michael Thrasher) to co-author the paper. The discussion of topics in this chapter result from specific conversations that we have had about this subject matter (in the short term) as well as some general understandings arrived at in within the context of a 15-year learning relationship. We wish to extend our appreciation to all other Indigenous elders and traditional teachers (Anishinabi and/or other) who have largely informed the philosophical approach put forth in this chapter.

In the Indigenous world, knowledge is about relationships. According to Betty Bastien (2004), "knowledge is relational and dependent upon the

M. Thrasher · J. Robbins (✉)
Trent University, Peterborough, ON, Canada

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_11

> relationships that are learned in childhood" (p. 77). Shawn Wilson (2008) speaking about the affirmation of one's reality states, "… reality is relationships or sets of relationships" (p. 73). Knowledge, accordingly, is not something contained in a book, a CD or other memory mechanisms. Knowledge, from an Indigenous perspective, is the relationships one has to "all my relations (meaning relationships with everything in creation)". (Little Bear 2009, p. 7)

Introduction

It is common in Indigenous traditions to take a humble approach when asked to share knowledge. In addition, it is also common practice to acknowledge the teachings and kindness of our forefathers and foremothers. Therefore, as with all of those who trod this path before us, we are compelled to say in all honesty that we know very little. We will share with you a meagre learning and caution you that we only have only a fraction of what the Elders who passed before us carried in their everyday lives. We are grateful to those who passed on this trail before us, they were kind and generous of mind and spirit with us—without them we truly would be wandering in the wilderness we were born into. What we have been able to comprehend and have retained has served us well and perhaps our small contribution of their vast knowledge will be useful to you as well on your life's journey.

What follows from here are some insights, intended to increase your awareness, stemming from what ***we*** have learned within our own traditions with respect to understanding a relationship between Indigenous philosophy, traditional healing methodologies and mental health and well-being.

In this chapter, we set the stage by describing the critical importance of Indigenous oral tradition versus a tradition of writing in the validation and understanding of knowledge. Second, we give a brief overview of mental health and well-being from an expansive, holistic perspective that emphasizes being in 'right relationship' with the Self, the community and natural law. Next, we discuss the practice of traditional healing as a vehicle that can facilitate bringing the mind, body and spirit back into balance.

Oral/Aural Knowledge Traditions

In mainstream approaches to health and healing, a written record of documentation is important to getting a method of healing recognized or regulated as a health profession. For example, in Ontario (Canada), the Health Professions Regulatory Advisory Council (see HPRAC 2012) is an organization that advises on whether unregulated health professions should be regulated, whether regulated professions should no longer be regulated, quality assurance and patient relations programs of Ontario's health regulatory Colleges, and on other matters referred to it by the Minister of Health. A representative from HPRAC indicated that:

> [To determine] whether a particular culture has a domain of knowledge in most Western type professions, such as medicine or dentistry, there is most often a long history of written documentation. When you go back to Chinese traditions or homeopathy, you also see a history of documentation. (Embuldeniya 2011)

Our teachings, however, are oral/aural (i.e. involve both speaking and listening) and, in this respect, this is how knowledges of our forefathers and foremothers are passed on from one generation to the next. For Indigenous Peoples, oral transmission plays a large part in how knowledge is shared. With writing, some Indigenous elders fear that their words will be used out of context because the writer or reader might lack experiences to properly interpret or understand. For example, with respect to traditional healing:

This means that direct experience with healers and traditional healing is one of the most important factors in being able to grasp the nature of traditional healing. Often, an examination of research literature only allows one to formulate concepts and opinions about traditional healing (Robbins and Dewar 2011, p. 1).

At the same time, Eurocentric academic styles of referencing can be limited in the way they establish the significance of information passed by Indigenous knowledge keepers within an oral tradition. Therefore, in this paper, the standard 'personal communication' for referencing oral communication in research is replaced with 'traditional teaching'.

In addition, the sources of these teachings are listed in the References as 'authors' rather than merely 'key informants'.

Some cultures that have a great deal of written texts continue to note the value of oral tradition in the transmission of knowledge. For example, in Tibetan Buddhism (for all of its texts) there is more emphasis put on oral transmission than understanding of written commentary because it prepares a person for the direct realization of knowledge through experience (Conze 1993, p. 23). The point that is illustrated here is that 'preferencing' written traditions of healing as a most important signifier of validating knowledge can also be regarded, at least in part, as a cultural preference. Oral tradition involves a component of active listening, meaning that it's not about just hearing it and understanding conceptually. You eventually have to find a way to apply what you've learned in your experience of daily life.

Thrasher et al. (1995, p. 5) indicate that a way to view the learning process of human beings expressed through Anishinabi oral tradition is an interactive whole. This is illustrated in Fig. 11.1.

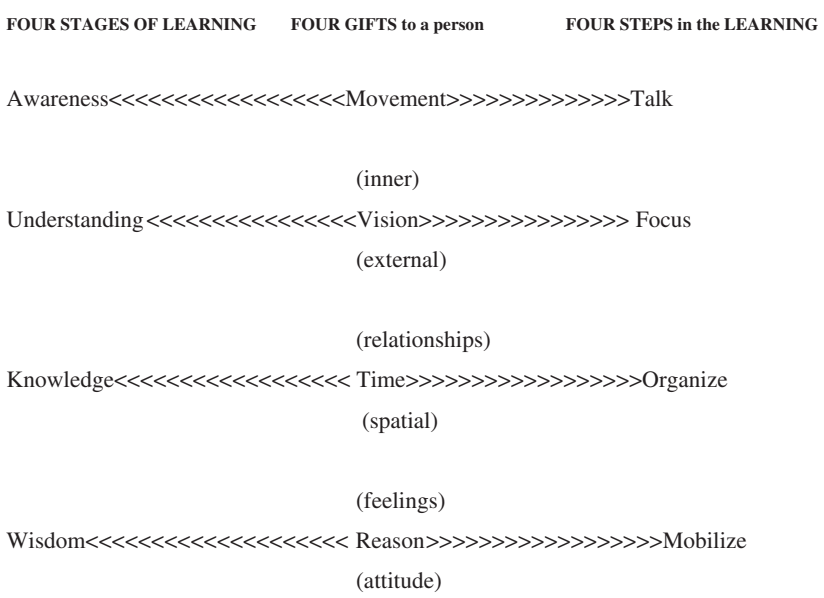


Fig. 11.1 Learning processes in the Anishinabi oral tradition (Thrasher et al. 1995)

Understanding Mental Well-Being from a Holistic Perspective

A definition of traditional healing developed by Velimirovic (1990) and modified by Royal Commission on Aboriginal Peoples (RCAP), (1996) describes traditional healing as 'practices designed to promote mental, physical and spiritual well-being that are based on beliefs, which go back to the time before the spread of western scientific bio-medicine' (Velimirovic 1990; RCAP 1996; Wagemakers-Schiff and Moore 2003). Thus, from the perspective of traditional healing, mental well-being is interdependent with physical and spiritual well-being. In addition, the expression 'all my relations' in many ways encompasses an Aboriginal worldview of interconnectedness that Indigenous Peoples have with family, community, nation and creation (McCormick 2009, p. 3). Mental well-being is good or enhanced when one is in (or continues to strive to be in) 'right relationship' with these interconnected parts.

The Individual

One way that the Anishinabi express this understanding is through *mino-bimaadzawin*—a way of being in everyday living known as 'the good life' (Thrasher 2016a). Mino-bimaadzawin is a standard to live by (healthy living and healthy choices) which continues to be passed down from one generation to the next orally and experientially through ancestral lines. As a human being, the Creator gave us all the gifts we need to strive towards this mino-bimaadzawin standard during the finite time we spend here on earth. At the same time, in this context, striving to understand our mind and apply behaviour that keeps/makes us mentally healthy is non-static and considered to be a lifelong endeavour.

It is understood in our traditions that a human being is given the gifts of a mind, body and spirit from the Creator. It is also understood that there is an interrelationship between these three parts. We can also utilize caring and compassion in combination with our free will in order to keep these parts in balance as we make our way through life's experiences. An example of these interrelationships is that if we are not able to

consistently eat nutritional food, this can negatively affect our mental health and weaken our life force (spirit). Or to quote another example, indulgence in addictions can cause an imbalance in our minds and our spirits as our value systems and our ability to physically care for ourselves or others become compromised. Alternatively given our free will, we can sacrifice food, through fasting supervised by an elder, in an effort to further strengthen and/or clear our mind and spirit so we become more thankful and aware of that which sustains us in life. These are some simple examples of this holistic approach with respect to our mental health.

The Community

Holistically, maintaining a healthy state of mind can also be understood within the quality of relationship between an individual, their community and the Creator. If this relational triangle becomes unhinged, then the individual's mental (or physical or spiritual) health can suffer (Marshall 2016a). Understood another way, there is no Indigenous spirituality without Indigenous community and culture. Therefore, it follows there is no Indigenous psychological perspective (at least within the context of Indigenous traditional health and healing), without experiencing what this entails from within a particular Indigenous community (Thrasher 2016b).

Community mind

Community members who may not necessarily be endowed with the title of 'knowledge carrier' or even consider themselves to be 'traditional' may have knowledge about healing traditions and their relationship to mental well-being. Family/community ties and cultural knowledge (such as Creation stories, ceremonial knowledge, knowledge of medicines, etc.) form a web of relationships that, in turn, cause individuals to be more receptive to traditional teachings and practices.

I remember having a certain medicine made for me when I was a child. I remember going and picking some of those medicines, but not being given the whole teaching of 'this is what you are doing and this is why you are doing it'. We just had this cultural sensitivity training and, I don't know, it is difficult to differentiate between something that is just within

us and natural and we don't realize it as being 'cultural' or 'traditional'. It's who we are and we don't see the difference (personal communication in focus group, 24 November, cited in Robbins 2014, p. 170).

These basic types of understandings represent a collective community memory about traditional healing practices. Although there are recognized keepers of ceremony and knowledge carriers within communities, the quote illustrates that knowledge of health and healing is not necessarily 'privileged' knowledge that has to be exclusive to a designate 'healer'. In addition to ceremonies associated with learning the protocols of traditional knowledge, teachings about traditional medicines and transmissions of healing techniques can also be passed and received orally through mundane, every day family activities (for example identifying medicines while going for a walk in the bush as a child with your grandmother or a discussion with an elder over many cups of tea).

Natural Law

Ni'knaaganaa (Anishinabi), *Kahkiyaw niwahkomâkanak* (Nêhiyaw), *Msit No'kma*q (Mi'kmaq), *Mitákuye Oyás'i*n (Lakota) are few examples of how different Indigenous Nations express their acknowledgement and/or gratitude to 'all my relations' that exist within the natural world. This expression is to be taken quite literally and it acknowledges that there are natural laws that exist of which a human being is a part. Operating outside of those natural laws can eventually have a negative impact on one's mental, physical and/or spiritual health and well-being.

With respect to a common sense expansion of the concept/understanding of 'holistic health', there is often an emphasis in Indigenous traditional healing focussing on the connection that a human being has to the earth's environment (Robbins and Dewar 2011, p. 3). For instance, Arvol Looking Horse (Lakota, Dakota, Nakota) emphasized that Indigenous health systems 'view the earth as a *source* of life rather than a *resource*' (Looking Horse 2009). Thus, in the holistic science of Indigenous traditional healing, the health of the planet is very much connected to human health (ibid. 2009).

Within the particular traditions of the Anishinabi it was important to establish these relationships to natural law from an early age

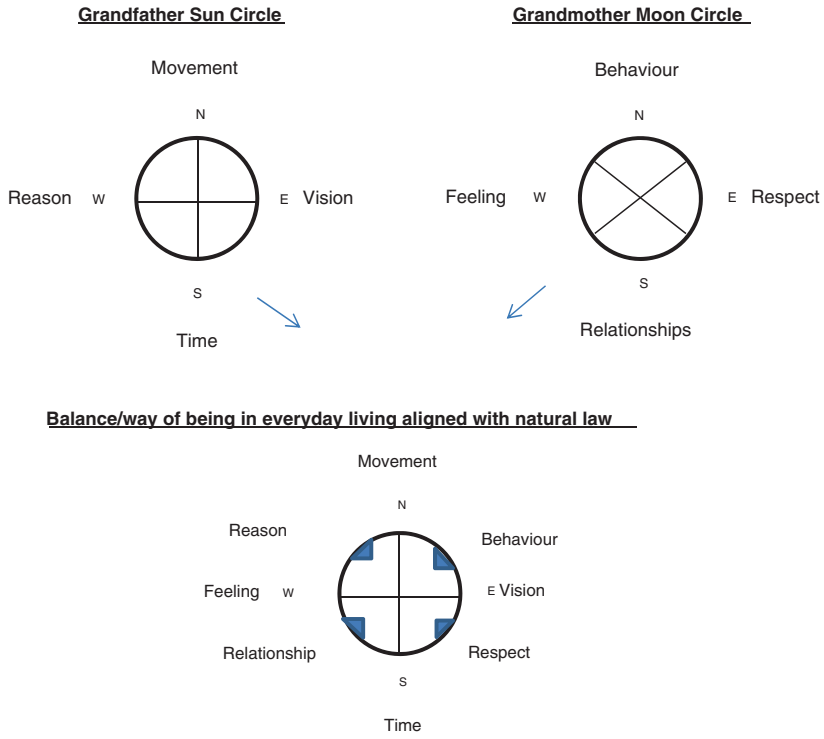


Fig. 11.2 Symbolic representation (Adapted from Thrasher et al. 1995)

and further one's understanding of them over the course of a lifetime. In a traditional setting, the child (around 2 years old) is given a name which expresses who that child was in relationship to the natural world. When the child is named and introduced to their relatives, they are beginning to become aware of these relationships that are reflected within the immediate environment of their family relations. At around the age of 7, a child is introduced to traditions from older family members in the community through helping out (for example learning about and helping with what was necessary to build a fasting lodge). At the age of about 14, individual confirmation is sought and the youth would then undergo a first fast in which they would commence their understanding about how they relate to the laws of nature. This is done by introducing elements of the natural world as relatives (for example grandfather sun, grandmother

moon, mother earth, and so on.). Through these sorts of activities that promote an experiential understanding, the individual becomes permanently connected to the natural world and is able to deepen their understanding about what 'all my relations' means into adulthood and old age (Thrasher 2016b). Figure 11.2 is a symbolic representation adapted from Thrasher et al. (1995) showing how our 'family like' relationships can extend outward to reflect a holistic understanding and union of universal principles contained within the laws of nature.

Thoughts About Restoring Balance

The physical, mental and spiritual aspects of the human being are all interrelated; incongruities that exist in any of these areas may cause a person to become unbalanced. For example, physical manifestations of illness may continue to appear until the individual accepts the teaching of how their illness ties into the laws of the universe or natural law (Lee 1996, cited in Robbins and Dewar 2011, p. 3). Facilitators of healing may use certain traditional medicines and/or ceremonies in their work to keep away illnesses and/or improve physical, mental or spiritual health (Cooke 2010, cited in Robbins and Dewar 2011, p. 3).

Helping to Facilitate Healing: A Humble Role

When it comes to assisting people with respect to helping them restore mental, physical or spiritual balance, an Indigenous knowledge carrier might play a role in facilitating the healing—but this role, while important, is considered small in the 'all my relations' grand scheme of things. Humility becomes a necessarily embodied quality in a helper/facilitator who acquires deeper understandings about 'all my relations'. In a talk about plant-based medicines, a Nêhiyaw Knowledge Carrier (2013) illustrated the importance of this when referring to how the 'old man' (their Blackfoot teacher) taught them. Even with Indigenous plant-based medicines the fusion with mental and spiritual elements becomes an important part of the 'whole person' remedy.

The 'old man' that trained this individual said that none of this making of medicine would work if we didn't give acknowledgement to the Creator first and foremost. He also indicated that, medicine people do ceremony differently all across the country, but it still all starts with the Creator. In that way everything is sacred because we are all of the Creator—this comprises the largest part. Next, always make an offering (such as putting tobacco down), apologize, give thanks, and talk to the plant and ask the plant permission to use it. Explain to it why you are going to use it because that which you are taking is alive. Only after that can you begin to harvest it. Without that, our Native plant medicines are not possible. The 'old man' that trained her also said that by learning about medicine you are not going to heal people and that he had a hard time with the term 'traditional healer'. Next of importance is the sincere request and willingness from the person who is requesting the help. The person should offer tobacco or something that the person involved in helping may need. Next, the person who requested the help needs to do what is necessary in order to get well/restore balance (for example go to a doctor, see a counsellor, attend a ceremony, drink a medicine, etc.). The role of a Knowledge carrier in helping to facilitate this process comprises the smallest piece. 'The old man said that we need to have humility and we are not supposed to boast about it' (Nêhiyaw Knowledge Carrier 2013).

The Sweat Lodge as a Tool for Restoring Mental Health and Well-Being

We honour the four directions
Enter each doorway in personal reflection
Receive ritual direction, gain spiritual protection
Achieve heartfelt connection

East, South, West and North
Passage through these doors gives us courage to go forth
Go forth into the world to do our best

To give our doubts and fears a much needed rest
Round by round songs are sung
And with the help of those sacred sounds inner battles are won

Yet day by day, challenges return
And that's why soon again the fires will burn
The grandmothers and grandfathers will heat the lodge again
Many spiritual victories will be experienced then
Steam will rise, rocks will spark
And a strong gathering of like souls will offer prayers in the dark.
(McGovern, 2017 *Fall Equinox* unpublished poem).

The paraphrased story in the section 'Helping to Facilitate Healing: A Humble Role' is one of many on Turtle Island (North America) about how knowledge of Indigenous plant-based medicines are transferred from one generation to the next. However, when Indigenous people refer to traditional healing, reference is made not only to the use of plant-based remedies. Also, specific ceremonies and rituals are also used to promote spiritual, physical and psychological well-being (RCAP 1996).

While it is important to hold in our awareness the holistic nature of Indigenous healing; however, it is also possible to speak about the benefits of traditional healing that specifically relate to mental health. The following explanation about the sweat lodge ceremony and a story about its outstanding potential to restore mental well-being are paraphrased from a conversation between the authors of this chapter that occurred in the late summer of 2014 (Thrasher 2014).

Sweat lodges are unique and indigenous to some (but not all) of the original peoples of Turtle Island (North America). In the translation into English, a sweat lodge is referred to as a 'lodge' so as to differentiate it from a 'sweat bath', 'house', 'structure' or any other similar types of shelters designed for the purpose of sweating. There are various traditions and stories as to the origins of this lodge and there are also various traditions amongst Nations as to the shape and size of the lodge. Nonetheless, in general terms, it is a dome-shaped structure built from saplings that are put in the ground in a circle format. Saplings are placed in holes in the shape of a circle and then bent and tied together

to form a dome over the circle. A shallow pit is dug in the centre of the circle and the tied saplings were covered with animal hides in traditional times and with tarps in contemporary times. Rocks are heated in a fire and then taken inside and placed in the hole. Participants go into the lodge through a lifted doorway. Participants sit in a circle around the rocks in complete darkness. The conductor pours or splashes water on the rocks to create steam. Various instruments and sacred objects are also brought into the lodge. Songs, meditations, prayers and council occur at various stages of the ceremony.

Trained properly, a keeper of sweat lodge is capable of helping a person who might be struggling with mental health issues. Psychiatry in the sweat lodge is like a fine art. It is equivalent to psychotherapy at its very best with respect to the way that it can help give a person insight into negative attitudes, thinking feeling, instincts and behaviour. If the ceremony is properly conducted it can result in significant changes in a relatively short period of time—as well as 'locking' those changes into place. The sweat lodge is an excellent tool for positive mental health especially when it is coupled with spiritual energies. Unfortunately, there are currently very few people left who know much about how to use it in its fullest capacity. It takes a lifetime to learn it. One of the elders who instructed in conducting sweat lodges indicated that there were over 500 different sweat lodges that he knew about. Even though he is considered fairly knowledgeable by some, M. Thrasher indicated that he knew very little compared to the old people. The sweat lodge has so many purposes to them and it takes a lifetime of absolute focus to acquire only some of what our old knowledge keepers new because they lived in circumstances that allowed them to do it (Thrasher 2014).

Conclusions

We have noted in this chapter that, given the vast number of Indigenous peoples and communities on Turtle Island and out of respect for them, it would be a disservice to try to speak about all of them in discussing relationships between Indigenous philosophy, traditional

healing and mental health and well-being. What we could do, however, is to centre our writing in teachings from within the particular oral traditions that we are most familiar with. In this respect, in relationship to Michael Thrasher (and other elders/teachers), I (Julian Robbins) am an *oshkabaywis* (helper) whose task here was to help express in writing some basic oral understandings presented in this overview (meant only to increase the readers awareness).

We overviewed mental well-being and emphasized the importance of it being understood holistically. For the individual, we spoke about the relationship between a person's mind, body and spirit. We also referenced the Anishinabi term *mino-bimaadzawin* to give meaning to how the Creator provided the gifts necessary to strive towards a healthy 'good life' that our ancestors taught us about. Expanding outward, we also talked about mental health and well-being insofar as how it relates to a particular Indigenous community and natural law ('all my relations'). Thus, understanding mental well-being holistically means understanding that the mental state is dynamic (not-static) and that striving for greater balance is a lifelong endeavour. Across one's lifespan, working towards 'attuning to' and finding value in one's self, family, community, Nation, country, natural world and Creator means that you will be on a good spiritual ground and that your corresponding mental state of being will also be wholesome (Marshall 2016b).

With respect to thoughts about restoring mental health and well-being from a perspective of traditional healing, it was noted that in addition to plant-based remedies, people who help facilitate healing also use specific ceremonies and rituals to promote physical, spiritual and psychological well-being. We noted that when a facilitator of healing is aware of how 'all my relations' impacts their personal lives (in other words, their interconnectedness in the web of life), that their approach to healing is a humble one where the role of facilitation is rather small in the grand scheme of things. In addition, we briefly explain how the sweat lodge ceremony parallels mainstream psychology and psychotherapy with respect to its effectiveness in addressing a person having mental health issues. These parallels extend into the arduous training/apprenticeship undertakes to eventually become responsible for conducting such a ceremony.

References

Bastien, B. (2004). *Blackfoot ways of knowing: The worldview of the Siksikaitsitapi*. Calgary, AB: University of Calgary Press.

Conze, E. (1993). *A short history of Buddhism* (2nd ed.). London: Oneworld.

Cooke, W. (2010, February). Aboriginal peoples health within the health sciences: A Métis, Inuit & First Nations specific health series. In M. Anderson (Keynote Speaker), *First Nations health session.* Hamilton, ON: McMaster University.

Embuldeniya, D. (2011, August 31). Personal interview. Cited in Robbins, 2014, p. 229.

HPRAC (Health Professions Regulatory Advisory Council). (2012). *About HPRAC*. Retrieved November 4, 2012, from http://www.hprac.org/en/about/mandate.asp?_mid_=2247.

Lee, G. (1996). Defining traditional healing. *Justice as Healing: A Newsletter on Aboriginal Concepts of Justice, 1*(4), 1–5.

Little Bear, L. (2009). *Naturalizing indigenous knowledge synthesis*. Paper, Canadian Council on Learning. Retrieved December 20, 2017, from https://www.afn.ca/uploads/files/education/21._2009_july_ccl-alkc_leroy_littlebear_naturalizing_indigenous_knowledge-report.pdf.

Looking Horse, A. (2009). Indigenous philosophies and ceremonies as the basis for action.

Marshall, G. (Yellowhawk). (2016a, October 17). *Relational triangle teaching*.

Marshall G. (Yellowhawk). (2016b, August). *Finding value in 'all my relations' teaching*.

McCormick, R. M. (2009). *'All my relations', mentally healthy communities: Aboriginal perspectives* (pp. 3–8). Ottawa: Canadian Institute for Health Information.

McGovern, C. (2017). *Fall Equinox.* Unpublished poem.

Nêhiyaw Knowledge Carrier. (2013, March 22). *As told by their Blackfoot teacher paraphrased from culture as treatment symposium*. Wabano Health Centre, Ottawa. Cited in Robbins 2014 pp. 53–55.

RCAP (Royal Commission on Aboriginal Peoples). (1996). Traditional Health and Healing, Appendix 3A. *Report of the Royal Commission on Aboriginal Peoples*, Volume 3, Chapter 3. Indian and Northern Affairs Canada, Ottawa. Retrieved March 3, 2018, from http://caid.ca/RRCAP3.3.A.pdf.

Robbins, J. (2014). *Maintaining balance in times of change: An investigation into the contemporary self-regulatory dynamics that operate in and around first nations traditional healing systems.* Doctoral dissertation, Trent University, Peterborough, Ontario, Canada.

Robbins, J. A., & Dewar, J. (2011). Traditional indigenous approaches to healing and the modern welfare of traditional knowledge, spirituality and lands: A critical reflection on practices and policies taken from the Canadian indigenous example. *The International Indigenous Policy Journal, 2*(4), Article 2. Retrieved December 24, 2017, from http://ir.lib.uwo.ca/iipj/vol2/iss4/2 https://doi.org/10.18584/iipj.2011.2.4.2.

Thrasher, M. (2014). *Restoring mental health and well-being through the sweat lodge teaching*.

Thrasher, M. (2016a, October 30). *Mino-Bimaadzawin teaching*.

Thrasher, M. (2016b, May 18). *Life stages, ceremony and natural law teaching*.

Thrasher, M. (Kawhywaweet) with Douglas, V. and Rickett, K. (1995). *First Nations school of Toronto: A culture based perspective on the development of a curriculum framework*. Native Child and Family Services of Toronto, Toronto.

Velimirovic, B. (1990). Is integration of traditional and western medicine really possible? In J. Coreil & J. D. Mull (Eds.), *Anthropology and primary health care*. Boulder, CO: Westview Press.

Wagemakers-Schiff, J., & Moore, K. (2003). The impact of the sweat lodge ceremony on dimensions of well-being. *American Indian and Alaska Native Mental Health Research (Journal of the National Centre American Indian and Alaska Native Programs), 13*(3), 48–69.

Wilson, S. (2008). *Research is ceremony: Indigenous research methods*. Winnipeg, MB: Fernwood Publishing.



12

Healing Systems of the Mapuche People in Chile

Ana Maria Oyarce

There is a growing demand for a kind of health care that does not bridle syndromes with drugs that reduce the need for environmental change and block the healing properties of symptoms. The mapuche medical system can contribute to the development of the biopsychosocial or socio-biological approach presently proposed by the Public Health doctrine. The mapuche conception of an "open body" makes it impossible to isolate physiology from social environment- including the ethical regulation of human behaviour. This viewpoint enables us to understand that health and disease are not just internal states of the body but rather the reflection of its "being in the world". (Solar 2005, p. 144)

A. M. Oyarce (✉)
Faculty of Medicine, University of Chile, Santiago, Chile

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_12

Background

The Mapuche of southern Chile are one of South America's largest contemporary indigenous populations, and is estimated to be between 800,000 and 1,000,000 people. Broadly speaking, Mapuche people maintain a strong sense of ethnic identity. They resisted the Inca expansion for four centuries and fought back against Spanish and Chilean domination, finally succumbing to the imposition of a reservation system in 1884. The Mapuche social organization is based on patrilineal principles which govern descent, residence rules, inheritance and succession. Although women (unlike men) do not hold position of power, traditional knowledge of medicine herbs and healing is largely a matter for women.

Chile today is a society highly stratified ethnically and socially. Broadly speaking minority ethnic groups bear stigma and discrimination; and Mapuche people belong to the lowest, poorest and most marginalized strata. In the last few decades Mapuche society and communities are facing rapid change: in socioeconomic and demographic levels with growing impoverishment produced by division of land, lack of state support and over exploitation of the soil having resulted in migration to cities from rural areas. In addition, the modern world via education and media have impacted communities raising expectations—especially on youth—to leave rural communities searching for better employment and life opportunities in urban regions of Chile. Also, new legislation and expanding capitalism have reinforced individuality, contributing to increase in land inheritance problems within families and communities. Inter-marriage between and Mapuche people is more common; and yet, generally the Mapuche worldview persists, each family having a special feature expressed as 'trunk' or 'blood'.

Some lineages are heirs to special power: *perimontun* is a spiritual/physical/social force lived as an extraordinary experience or involuntary possession. It is believed that this power comes from *Ngenechen* (the human being's creator) and can be expressed as illness, dream, possession and trance. Although 'running in families' and for 'all life', *perimontun* is manifested in persons with special personality, in special landscapes, and at specific times (mainly adolescent women in wild rural spaces).

When the *perimontun* is accompanied by *pewma* (dreams with shamanic symbology), Mapuche people suspect shamanic power. According to indigenous ideas, it is given by *Ngenechen* (one of the most important Ngen spirits within traditional Mapuche religion) to maintain the Mapuche health and wealth. As a divine gift, it is impossible to avoid or denied. Also, it is believed that if the 'chosen' person does not became a *machi* (traditional healer and religious leader, a shaman) (s)he will suffer sickness, madness and death. An experienced shaman must train the novice and she/he must be legitimated by a collective ritual named *machiluwun*. After this ritual, *perimontun* becomes *kuymun*, intentional spirit possession and trance.

Not everyone who experiences *perimontun* is a shaman. Some become *pelom* (diviners), *meicas* (lay healers) or others who perform different roles in their communities. However all shamans would have experienced both: *perimontun* and *kuymun*. Yet, not all shamans perform a typical shamanic role; and the spouse of a shaman must become a *dungunmachife* (translator or liaison between the shaman´s spirits and the human world).

In Mapuche understanding of health and illness, the epistemological model is holistic (Marileo 1995a, b; Ibacache et al. 2001) where the human being, together with the environment and the forces that populate that universe, form an indissoluble and harmonious whole that is kept in balance through the maintenance of *az mapu* (code of ethics that regulates the relations of human beings in that universe, which includes the relations with spirits and forces). A transgression of this rule, such as passing a boy or girl through a *menoco* (place of standing waters where they swarm forces and negative spirits) can cause a *trafentun* and eventually death. The method of validation of this diagnosis (model) is through communication with the divinities in *pewma* (sleep) or *Kuymin* (shamanic trance), since only they can know what made the minor sick.

Cultural matrices carry their own logic (to look for possible causes, therapies and preventions). What is different is in the cultural premises on which medical models and validation tests are based. In this respect it should also be noted that biomedical diagnostic systems are symptomatic and dichotomous; on the contrary, the Mapuche model

(like many indigenous models) is aetiological, continuous and presents multicausal dimensions that derive from the integrality of indigenous worldviews. This is how the mother of a child with bronchopneumonia can understand that a bacterium or a virus entered the body (regardless of what is understood in the Mapuche culture), but what is recognized as the 'true cause' was transgression of a space, norm or behavior (Oyarce 1989).

Concepts of Health and Illness

The notion of well-being in the Mapuche world is expressed in the concepts of '*küme mongen*' or good life—being well is complementary to being bad (*kümelkalen* or *weza felen*) Being well (*kümelkalen*) means that the individual is in balance with himself/herself and also with peers, family, and others close or dear them, as well as the environment which includes spirits of ancestors, the *meli witran mapu*, and the forces which inhabits and owns specific spaces (non domestic spaces such as wild forest–). The balance of the person is also reflected in the harmony with their *lof* (community), their social, productive, cultural, political, environmental, territorial, religious and cosmic environment. If that equilibrium is upset then a state of *weza felen* (Cuyul 2008) is reached.

Thus, there is an integrated or holistic concept of well-being. An important aspect to point out is that the concept of health as such, in other words as a state opposed to that of disease, is not found in the Mapuche conceptual repertoire, because health forms an indissoluble whole with all the phenomena of life itself: 'People do not conceive health as a sphere apart from the whole of social life, but rather as a connected, determinate and determinant space in the other spheres of economic, religious, political, educational, historical life, and so on' (Boccara 2004, p. 121).

A second aspect is that *kümelkalen* (well-being) is a state that is achieved (or lost) in relation to other human beings and, what is more distinctive, with other forces and beings that populate the Mapuche world, forces and spirits that Mapuche people are related to socially.

This means that, if something or someone in the community is in poor condition, if the crops and harvest are not good, if the animals do not have enough food, then the person is not healthy (Cuyul 2008). In short, this well-being is achieved by a state of dynamic equilibrium through relations of reciprocity and balance between living beings, spiritual beings and forces of context.

Although the disease can have multiple forms, the origin always comes from the behavior of the individual, the family or the community. For this reason, it is in the family space where the first diagnoses are made and diseases are identified, a process known as *pewütun*. Once this process is carried out, medicines are applied based on medicinal herbs, barks, plant or animal fluids according to the social and empirical knowledge of families. 'Western' drugs also enter the therapeutic repertoire by playing a complementary role to traditional practices (Cuyul 2008).

Currently in the Mapuche communities and in the territory of Araucania, there are several Mapuche medicine specialists: *machi* (shaman), *lawentuchefe* (person who makes remedy and diagnosis based on medicinal herbs), *ngütamchefe* (bone finder), doctor or *meika* (person who is dedicated to heal specific diseases through herbs) and sometimes by *kuimin* (trance) and *püñenelchefe* (midwife).

Some basic concepts of Mapuche health (according to Cuyul 2008) are:

- *Itrofillmongen*: This term refers to the environment in which the life of the Mapuche community is inserted, containing its own material and spiritual aspects such as living beings, plants and inert objects, which are in constant relation with the person, family and community directly.
- *Kimün*: Refers to Mapuche knowledge constructed and transmitted orally in Mapuche families and communities. Included in this category is the use of *Mapudungun* (Mapuche language) and social devices such as the *Pentukun* (Mapuche salute). It is a dynamic and continuous process that includes the apprehension of practices and cultural loans proper to the development of the Mapuche culture and that has allowed its subsistence.

- *Lawen*: refers to the medical material, i.e. the herbs, stems and roots found in rural areas in their natural state, as well as the various preparations derived from them that are used, in a daily and extraordinary way, by Mapuche families and in a more specialized way of Mapuches healers.
- *Kutran*: It is the illness and also the pain, it is understood as an imbalance of the person and also the family with respect to the forces in which life is inserted in the earth, it includes social, economic and political of the social fact of the disease.
- *Küme Mongen*: A term widely used to refer to the state of individual or collective harmony that refers to good living. Good life is evaluated on a daily basis based on the analysis of the socio-spiritual and psycho-biological aspects of individuals and families.
- *Kümelkalen*/*Wezafelen*: These concepts synthesize the state of 'being well' or 'being bad', respectively.

Since Mapuche diseases are provoked by phenomena and forces clearly explainable and identified within the Mapuche culture, they, therefore, must be treated in accordance with the Mapuche medical system. No Mapuche illnesses should be treated in a Western way. Mapuche choose whether a treatment must be carried out by a *machi* or a doctor (Citarella 1995). The majority of the Mapuche people consider diseases as *Mapuche kutran*, but if there are biological symptoms (such as virusses of bacterial infections), people decide to go to a doctor, since these kind of diseases are classified as being a *winka* disease.

The Mapuche world is composed of three vertical dimensions inhabited by different forces and spirits: The *wenu mapu*, the upper land where ancestor, good spirits and deities live; the *minche mapu*, the opposite land of the *wenu mapu* which is located under earth and inhabited by bad forces and spirits; And finally, between both is the *nag mapu*, the earth of everyday life (Marileo 1995a, b).

Machi uses traditional Mapuche notions of good and bad, always in relation to Mapuche codes of behavior and morality, sometimes re-elaborated by the *machi* in a Christian cultural script. According to traditional Mapuche logic, all deities and spirits have a good and a bad side. Reciprocity is the equilibrium rule which regulate this world.

In this manner, they punish Mapuche with illness and suffering if they fail to behave according to the Az mapu (ethical Mapuche code). On the contrary, if Mapuche people live and perform in a right way, spirits and deities will give them *kume mongen* (good life or well-being) (Citarella 1995).

The *Machi* (Shaman/Traditional Healer)

The shaman (called *machi* in *mapudugun*, the native language) is the intermediate between the Mapuche and the deities and forces that habits Mapuche world. The *machi* possess power that has been granted to them by familiar spirits that are usually inherited by the mother's side. The *machis* are 'called' through various illnesses, symptoms and signs called *machi kutran*. The machi works mainly by re-elaborating the relational and symbolic world of the patient, the family, and often suggests behavioral changes that can be extended to the community or to communities beyond the patient's home (for a description of the therapeutic elements used by the *Machi*, see Pérez-Sales 2004). What is central in a medical setting is the *rewe*, a special kind of personal altar, where according to the Mapuche worldview, the *nag mapu* join with the *wenu mapu*.

During the *Kuymin (trance)* the *machi* ascends to the *Wenu mapu* to receive the deities and the spirits message. The *kultrun* (ritual drum) symbolizes a microcosm (Grebe 1973) which is controlled and used by the shaman to achieve healing. Contrary to the commonly held notion of the 'wounded healer', the *machi* is physically, emotionally and socially resilient because he/she must travel through dangerous spiritual paths and resist attacks from bad spirits (Citarella et al. 1995; Cuyul 2008; Quidel 2001). During this ritual, the machi is helped by a *dungunmachife*, who translates the information given by the spirits, which the *machi* expresses in an incomprehensible language during her trance (Citarella 1995).

A machi's ability to diagnose the correct cause of an illness is central to its cure. Natural illnesses remain localized in the body and can be cured by a variety of Mapuche and non-Mapuche traditional healers.

They are produced by an excess of work, sadness, negligence, digestive or nutritional problems and the malfunction of organs. The most common types of natural illnesses cured by *machi* are *empacho* (indigestion); *nervios* (nervousness), related to distress; and a feeling of being out of control; 'la sangre que sube' ('rising blood', postpartum or from menstruation), which is believed to generate tumors, cysts, cancer and hematomas; 'enfriamiento' (chills), related to rheumatism, arthritis, pain in the bones, swelling or inability to move; 'la orina atrapada' (trapped urine), which is produced by the cold and causes urinary tract infections, fever, and pain in the sides; and various kinds of epidemics that produce fever and diarrhea (Oyarce 1989).

When the balance between the society of humans and the spiritual and natural world is broken, Mapuche experience different types of social/spiritual illness. *Wenumapukutran* (often shortened to *wenunktran*) is caused by good spirits as punishment for transgressions or sins of a spiritual nature, such as *machi kutran* (shamanic illness)—thus, *machi kutran* is an expression of social spiritual transgression to *az mapu* (the rule of Mapuche world).

Mapuche Healing

Most of the literature on shamanism and about Mapuche healing consider healing as a spiritual matter. However, this reduces Indigenous healing to an ontologically different level, an 'exotic' practice with no room for effective collaboration and shared learning between shamanism and other types of healing. Hence, Mapuche healing is best seen as being basically *social* because there is a social relation with spirits and the shaman's work in re elaborating and changing social relations—social relationships refer to the multitude of interactions between Mapuche people and interaction with forces which inhabit the Mapuche world, regulated by every day and rituals rules. These social relations configure social complex behavior, ritual acts, interactions and so on because they form the basis of the Mapuche social organization. Thus, interactions and relations with spirits come from the process of

socialization; and they modify behavior in a sequence of relationships, that fosters perception, motivation, learning and adaptation through the exchange of rules and beliefs.

The social elements used by traditional healers result in re-contextualization of problems because the *machi* offers an explanation and a frame of reference to the problem consistent with the culture. Such an understanding is comprehensive and empathetic and carried out in a manner consistent with the appropriate cultural norms. In other words, a Mapuche therapist will not get a positive effect if the 'treatment' does not have a cultural base that serves to anchor the therapist's explanation—just as the explanations of Western therapist can only be accepted when they are compatible with cultural roots.

Throughout the ceremonies that comprise healing, the *machi* explains and insists on the origin of the disorder that is always based on a transgression. And the machi uses powers of persuasion to induce an understanding that this is the origin of the problem and to prescribe future behaviors. Since all healing ceremonies are carried out in the presence of, and with support of, the family and the community, family/community support is ensured. This is especially so in the ceremonies where the shouting and singing by those present help the healing process. In addition, in the final phase of the ritual, each participant greets and advises the patient to follow the instructions of the *machi* and behave in an appropriate manner so that he or she does not become ill again. Any behavior from then on will be judged by the whole community. It is important to note that if the disruptive event changes the status of the person, the previous status can be recovered for example, by ritual of purification after a violation, rebalancing with natural or supernatural forces after a transgression of norms, resolution of a conflict of envy, and so on.

Since a structured social environment is provided for healing ritual, the prescribed treatment reinforces the link with the community and culture. Most traditional healers deal specifically with family problems or other social problems. And, many beliefs related to diseases in different cultures maintain that the disease comes from disturbances in social relationships. There are numerous ethnographic examples of peoples

who find the origin of the disease in the rupture of the balance of man with other beings, with nature, with other people or with the community. The cure, in this case, is to reintegrate the patient into a situation of balance, advising him what to do about it. In some cases, this goes to the extreme that the entire community must be restructured (Pérez-Sales 2004).

References

Boccara, G. (2004). Del buen gobierno en territorio Mapuche. Notas acerca de una experiencia de Salud Complementaria. *Cuadernos de Antropología Social, 20*, 113–129. Buenos Aires.

Citarella, L. (Ed.). (1995). *Medicina y cultura en La Araucanía*. Santiago de Chile: Editorial Sudamericana.

Cuyul, A. (2008). *Prácticas culturales familiares y colectivas que protejen las salud en comunidades Mapuche en Chile y Argentina.* Tesis, Maestria de Salud Pública UBA.

Grebe, M. E. (1973). *El Kultrun Mapuche: un micocosmo simbólico Apartado de Revista Musical Chilena año XXVII, Nros. 23 y 24 julio-deciembre 1973*. Retrieved December 22, 2017, from http://www.eumus.edu.uy/amus/GIDMUS/archivos/Mapuche_kultrun_MGrebe.pdf.

Ibacache, B. J., Chureo, F., McFall, S., & Quidel, L. J. (2001). *Promoción de la medicina y terapias indígenas en la atención primaria de salud: el caso de los Mapuche de Makewe-Pelale de Chile* (Serie Salud de los Pueblos Indígenas, 16). Washington, DC: Organización Panamericana de la Salud.

Marileo, A. (1995a). *Mundo Mapuche, En Medicina y cultura en La Araucanía*. Santiago de Chile: Editorial Sudamericana.

Marileo, A. (1995b). Editorial in *"Mundo Mapuche". Medicinas y Culturas en la Araucanía.* Santiago, Chile: Sudamericana.

Oyarce, A. (1989). Sistemas médicos que coexisten en la Novena Región, PAESMI, 18 (45–50).

Pérez-Sales, P. (2004). *Psicología y Psiquiatría Transcultural: Bases prácticas para la acción. Bilbao, España: Desclee de Brower* [Transcultural Psychology and Psychiatry—practical basis for action Desclee de Brower, Bilbao (Text in Spanish)]. Bilbao: Desclee de Brower. Retrieved March 3, 2018, from http://www.pauperez.cat/en/thematic/books/7-psicologia-y-psiquiatria-transcultural-bases-practicas-para-la-accion/file.

Quidel, J. (2001). Cosmovisión mapuche y etiología mapuche de la salud. Promoción de la medicina y terapias indígenas en la atención primaria de salud. El caso de los mapuche de Makewe-Pelale de Chile; serie *Salud de los Pueblos Indígenas*, N° 16; Washington, OPS-OMS.

Solar, M. A. (2005). Atención de Salud, Medicina Moderna hipocrática y medicina tradicional mapuche. *Cuadernos Medicos Sociales. Colegio Médico Chile, 45*(2), 144–149.

Part III

Liberation Psychologies

Liberation psychology attempts to understand the person within their social, economic, cultural and historical contexts. Unlike traditional psychology which attributes distress and psychopathology to the individual and intrapsychic processes, liberation psychology contextualizes the subject within an anti-oppressive environment; considers power structures as templates of distress rather than unconscious motivation of psychopathology. The chapters in this part of the book offer analytic discussions of the ideas, writings and theories of some of the most influential intellectuals of the freedom/liberation movements in the Global South.

13

Frantz Fanon's Psychology of Black Consciousness

Lewis R. Gordon and LaRose T. Parris

The importance of Frantz Fanon's contributions to psychiatry and psychology is still unfolding in the critical literature (Bulhan 1985; Cherki 2006; Gordon 2015; Gibson and Beneduce 2017). Central to his work but also an obstacle to it has been the extent to which his thought addresses the form of unreason (reason taking flight) occasioned by the emergence of 'the black' in psychological study. The norm and, indeed, the normal are premised on such a figure's exclusion, which makes the black's appearance one of disruption and, indeed, negation. Fanon explains the negative rupture of the black's presence through the black's mutual ontological exclusivity with rationality itself. 'When I was there, it [reason] was not; when it was there I was no longer' (Fanon 1952, p. 95).[1] With this philosophical analysis, Fanon articulates the perceived conundrum of the black's presence for Western

L. R. Gordon (✉)
University of Connecticut, Storrs, CT, USA

L. T. Parris
Laguardia Community College of the City University of New York, New York, NY, USA

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_13

thought and praxis; additionally he primes readers for the decolonial methodology that informs his practical training in psychology and forensic psychiatry.

Background

Fanon brings to his analysis his training in philosophy, psychiatry, and psychology, as well as his experience as a political activist and soldier. Our focus will be on the second and the third contextualized by the first.

Fanon's psychiatric and psychology training was threefold. The first two aspects of his professional preparation were in positivist clinical psychiatry and forensic psychiatry. He was trained in the first proverbially kicking and screaming, as his humanistic convictions challenged many of its premises. His first book, *Peau noir, masques blancs* (Fanon 1952), translated as *Black Skin, White Masks* (Fanon 1967a), was actually composed as his doctoral thesis under the title '*Essai sur la désaliénation du Noir*' (Essay on the Disalienation of the Black). His advisor at Lyon, Jean Dechaume, rejected it as supposedly unscientific because it wasn't a study of a psychophysical condition, so he quickly wrote within two weeks a dissertation on the neurologically debilitating Friedreich's ataxia: '*Altérations mentales, modifications caractérielles, troubles psyciques et deficit intellectual dans l'héredo-dégénération spino-cérébelleuse. À propos d'un cas de maladie de Friedreich avec délire de possession*' (Mental Alterations, Characteristic Changes, Psychic Disorders and Intellectual Deficit in Spino-cerebellar Hetero-degeneration: About a Case of Friedreich's Disease with Delusion of Possession). The thesis, accepted by his advisor in 1951, is now available in the collection: *Frantz Fanon: Écrits sur l'aliénation et la liberté* (Fanon 2016, pp. 168–232). Friedreich's disease involves the progressive degeneration of the spinal cord and consequently the nervous system without destroying cognitive functioning. The ultimate argument of the accepted dissertation was, however, consonant with the originally posed one, except that his focus became the study of a degenerative physical condition and the problem of a physician's establishing a humane relationship with the patient, one in which there is preservation, if not cultivation, of dignity. *Black Skin,*

White Masks included a meticulous examination of Western psychiatric practitioners' failure to establish a human relationship with *le nègre* (no real equivalent in English as it could be interpreted as 'Negro' and 'nigger') and the black's transformation into the Black despite the racism manifested in the human sciences. The error, Fanon argued, is the presumption of *le nègre* and especially the Black as a disease of the body instead of a human being struggling against a social malediction. Racism and specifically antiblack racism are, in Fanon's language, *sociogenic* (socially generated). They are produced by a social world that offers their meaning and perpetuates their ideological and material manifestations in hegemonic discourse and cultural institutions. Such a world is one of colonization and dehumanization of groups of people designated 'black.'

Fanon's third training was an expansion of theses he inaugurated in his accepted dissertation and *Black Skin, White Masks*, which was published under the editorship of Francis Jeanson, one of the philosopher Jean-Paul Sartre's protégés, a year after Fanon's achieving his doctorate. It was Jeanson who retitled 'On the Disalienation of the Black' into 'Black Skin, White Masks.' Fanon's main thesis, that the human sciences were complicit in the project of colonization and, as a consequence, made the Black a 'problem' through narcissistic disavowal of their own failure to make the Black 'fit' (except as the black), found a receptive ear in the Catalan psychiatrist François Tosquelles (2012). Fanon interned with Tosquelles at the Hôpital de Saint-Alban in preparation for his chef de service, which qualified him to head psychiatric facilities in the French-speaking world. The two psychiatrists devoted their energy to disentangling the social conditions of mental illness from neurological disorders.

In his years at Lyon, Fanon had also trained as a forensic psychiatrist. At the methodological level, that training came to the fore in all his writings. When encountering a disorder, Fanon's approach was that of a medical detective. His stratagem with regards to antiblack racism and colonialism was, then, to investigate their sociogenic conditions. In his writings from 1951 through 1954, that search included finding the source of so-called phantom illnesses such as the 'North African Syndrome,' (translated into English and reproduced in *Toward*

the African Revolution (Fanon 1967b, 1979)) in which degraded North African immigrant subjects of colonization were expected to be at home with their degradation, which would make their maledictions, their suffering, seemingly unfounded and thus unaccountable. As Fanon's studies progressed, this recurring pattern of imaginary pathologies of the colonized led him to realize that he was basically an investigator brought into investigate a crime in which the perpetrators turned out to be the very administrators who commissioned the investigation. In each instance, as with *Black Skin, White Masks*, he raised the existential question of what was going on 'inside' the lives of those who suffer.

Fanon subsequently addressed concerns of dehumanization not only at theoretical levels but also institutional ones. His work in Algeria and subsequently in Tunisia, with investigations in other countries such as Ghana and the Soviet Union, included building the first outpatient psychiatric facility on the African continent. This innovation, inaugurated in the city of Tunis was, by the way, premised on an understanding of mental illness that no doubt informed critiques of asylums from Michel Foucault's to James Comer's and Alvin Poussaint's. Fanon's analysis, in other words, raised questions of a 'sick' society, which is one of the impetuses for his revolutionary commitments. He wished to change the game and its conditions of possibility instead of furthering the continued adjustment of players within that ailing system.

Lived Reality of Blackness

The black's contingent metaphysical existence, which Fanon characterizes as mutually exclusive with reason itself, has emerged out of historical, traumatic circumstances that transformed whole groups of people not only into the category of a color but also a transformation of that color in specific pejorative language in European terms. The French *le nègre* offers ambiguity always marked by dysfunction that is also juxtaposed onto *le Noir* (the Black). Notice the movement from the lower case to the upper case in the two terms. The former exemplifies an absence that the latter challenges. Not all blacks are Blacks.

So long as the analysis of the black and the Black remains in the third person, no proper psychology emerges except for a perspective of legitimacy premised on the absence of those two terms—in short, a white or perceived white perspective on an external character, which Fanon characterized in *Black Skin, White Masks* as one locked in an 'epidermal schema' of behavior instead of agent-oriented action. Fanon, however, raises the internal question of *l'expérience vécue* (lived experience), which raises the issue not only of the experience of the third-person as the first-person but also the reality status of what is involved. Lived experience, after all, is that *of* something, which places *le nègre* and *le Noir* in relation to a system whose legitimacy depends on a lack of relationship beyond that of an object of study. The radicality of Fanon's turn, then, is to raise the lived reality of the Black *as a conscious one,* a Black *consciousness*, which contradicts and problematizes a system based on blacks as objects (bodies) without points of view. The Black both signifies and reaches beyond the racial term. The black is limited to racial designation.

In *Les Damnés de la terre* (Fanon 1961/1991), 'The Damned of the Earth,'—more popularly known in its English editions as *The Wretched of the Earth* (Fanon 1967c)—published a month after his death, Fanonian psychiatry and psychology return to the pressing issue of lived-reality through pointing out the forms of violence emerging from the colonial notion of the black's illicit appearance. Where it is illegal or illegitimate for the black to appear as an agent and, worse, appear at all, the logic of Black appearance must ineluctably become a lived reality of violence. This violence is imposed through colonial commitments to racist contraries (Manichean binaries in which the colonizer becomes the embodiment of 'good' and the black/native the quintessence of 'evil') instead of dialectical interaction (Gordon 2015; Parris 2015). The thesis of addressing a sick society returns as well through Fanon's closing demand to set afoot a 'new man' or, better, a new humanity.

Critics often misunderstand this closing observation. The argument is related to the Nietzschean notion of the last man and the overman. The last man, according to Friedrich Nietzsche, clings to negative values through which he polices his own freedom. He despises life-affirming values of creativity and responsibility for values. The *Übermensch*

(overman) is, in effect, an adult who takes on life-affirming values of possibility. The last man imagines himself as the conclusion of humanity, which makes the overman a feared idea. Instead, crushed by his fears, the last man makes his quest for security govern him in a cesspool of life-negating values. Fanon transformed this argument to the level of states and nations. The 'last nation' embodies the sick values of Euromodern nation-states, saturated with nationalism, racism, xenophobia, and a variety of other negating values as the conclusion of history. Overcoming such an eschatological model requires the over-state and over-nation premised on forms of national consciousness that are not steeped in nationalism (last man values). The new human being, of whom Fanon wrote, after abandoning the fetishizing of Europe, is actually a new humanity, a relational humanity that takes on the global project of freedom at concrete levels of social interaction.

Like Sigmund Freud, then, Fanon raises the question of a healthy society in which social investments could be properly channeled into institutions, and thereby utilized for the betterment of that society's constituents.

Fanon as a Psychologist/Psychiatrist

Fanon never accepted positivist clinical psychiatry and psychology. Though not, as his former intern Alice Cherki (2006) insists in her portrait of his life and thought, a formally trained psychoanalyst, Fanon worked at psychoanalysis in ways similar to how Freud developed his own. Who, after all, was Freud's analyst but the founder himself? The error is to read Fanon as a disciple of Freud or any other psychoanalyst instead of the founder of his own approach to psychoanalysis, which we could call Fanonian psychoanalysis.

In his inaugural work, Fanon was, however, particularly concerned with the impact of structuralism on the psychoanalytical thinking of the day, which, in his time, was Lacanian psychoanalysis. We cannot address the details of structuralism here. Its basic premise, in short, is, as Peter Caws (1988) has argued in *Structuralism*, the rejection of an essential subject acquiring experience but instead the formation of

subjectivity through rules and relations, such as systems of signs and language, of produced meanings. Fanon's critique of Jacques Lacan's semiological psychoanalysis, which was heavily invested in linguistic rewriting of the signs and symbols of Freudian concepts, was that it worked only to the extent to which one ignores colonialism and race—in short, Lacanian psychoanalysis is rooted in the historical reality in which its theoretical assumptions were formed, namely, the Euromodern world. Making sex ontologically basic (and by extension the nuclear bourgeois family), the problem of sexual difference should make the authoritative voice of language male, but Fanon showed that even black men drew legitimacy from specifically *white* male testimony. Black men and women should not converge as logically the same if the Lacanian semiological model of the legitimating force of words were universal. The only way to account for the divergence was that the colonial and racial schemas intervened.

Change, then, requires addressing colonial and racial factors. Fanon's classic study, *L'an V de la révolution algerienne* ('Year V of the Algerian Revolution'; Fanon (1959/1972)), brings his point to the fore. Active participation in changing social conditions establishes new relations through which altered symbols produce new forms of people. Revolutionary action is, in other words, a healthy activity because it reinvigorates agency. In *Black Skin, White Masks*, Fanon had argued, for instance, that colonial and racist systems lack coherent notions of what it means to be a black *adult*. The persistent infantilization of the black subject in colonial and Western psychiatric systems was a racially paternalistic tendency that Fanon's therapeutic and theoretical interventions sought to remedy. Adulthood requires responsibility and hence agency. Seizing responsibility for one's existence—freedom—is, then, a fundamental feature of Fanonian psychology.

Among the many approaches to unleashing his patients' potential for action, Fanon held high regard for psychoanalysis and 'institutional therapy.' Psychoanalysis, as Fanon saw it, worked at subterranean levels of a patient's relationship to failure or, more specifically, not measuring up. The patient becomes inactive where there is no sense in which the self could pose as a standard of value. Thus, the patient works at an a priori level or presumption of falling short *before* action. Here, the measure

becomes the formulation of self-justified value, which, in white supremacist societies, is white. Here, a paradox emerges. The black patient not only fails at being white but also fails at properly failing to attempt being white. In other words, the black *should* fail at being white if blacks were to see value in blackness, but to do so requires rejecting the *attempt* to be white in the first place. The failure is, then, a double failure. Such mounting layers of failure result in inaction. Movement towards black consciousness and unmediated, positive agency requires being released from the project of whiteness, but that goal isn't as easy as it may at first appear. Where reactive, the effort would subtextually center whiteness as the norm *from which to go*. What the patient must see, psychoanalytically, is responsibility for her or his existence. Taking responsibility for living as Black in the world requires moving from a negative reaction (black) to a positive assertion of Blackness as an open instead of closed subject. That is why Fanon concluded *Black Skin, White Masks* with the prayer to the self to become a question—in other words, possibility. One of his early, explicit reflections on psychoanalysis in that text makes that goal clear:

As a psychoanalyst, I should help my client to become conscious of his [or her] unconscious, to no longer attempt a hallucinatory lactification but rather to act in the direction of a change in social structures.

In other words, the Black should no longer face the dilemma: become white or disappear. [He or she] must instead be made aware of the possibility of existing [as Black]…. My goal, once the patient's motives are made clear, is to enable him [or her] to choose action (or passivity) with respects to the true source of conflict—that is, with regard to social structures (Fanon 1952, pp. 80–81).

The French word *client* is translated as 'patient' in the various English editions. Fanon, however, is very precise in his language. He chose the word 'client' because he understood that an upset or troubled person is not necessarily sick. The Black's maladjustment to antiblack racism could, in other words, be a sign of health. Drapetomania, the supposed mental illness of an enslaved black attempting to escape slavery, was, for instance, an official disease for which psychiatrists attempted to develop 'treatments.' Fanon was acknowledging that the person who came to him might be upset for legitimate reasons that could be addressed through a clarified relationship to the source of the problems.

When Fanon refers to patients or the sick, he uses the French words *les patient* and *les malades*. The latter could also be ostentatiously translated as 'the maledicted,' but the ordinary expression 'the sick' suffices.

Fanon understood that no human being is a god. Thus, the resolve to action, though a mentally healthy development, faces immediate obstacles under materialized social conditions of limits. Institutional therapy, as Fanon saw it, is the methodical expansion of social access and meaningful choice. Participation in an expanded social world is, in his view, a process of re-humanization on a path to mature continued humanizing practices, where reach is the ability to affect the social world. In today's parlance, therapy, for Fanon, is a process of empowerment.

Here Fanon's existential phenomenological view of mental health is quite clear. He insists that psychic wellness is predicated upon a fundamental phenomenological apprehension (realized consciousness) of one's intrinsic freedom, which may only be grasped within and through the realm of lived experience. His designation of madness as a 'pathology of liberty' and his rejection of long-term hospitalization together reflect his overriding preoccupation with the potential of all human beings to actualize their freedom on all levels: psychological, social, and material. This freedom, for Fanon, must be actualized in the intersubjective realm of social relations, so that the patient's 'field of action' would not be circumscribed as it would in the institutional setting where the patient may only think of freedom in the magical realm of 'fantasies' and delusions.

Collectively, Fanon's psychiatric, psychological, and political writings comprise an oeuvre in which his decolonial therapy and political psychiatric practice of empowerment are enacted and articulated in three related aspects of his emancipatory praxis: Fanon's multidisciplinary psychiatric treatments, his ethno-psychiatric articles, and his revolutionary political texts.

Fanon's corpus consistently and systematically verifies that the European occupier's violent seizure of colonial territories necessitated a similar inhabitation of the colonized class' psyche. This physical and psychic occupation, as a matter of course, also entailed the colonizer's exploitation of the labor and consciousness of the colonized. These intersubjective dimensions of colonial relations—on the socio-political,

historical, and cultural levels—became the thematic framework for Fanon's discursive productions that condemn hegemonic colonial practices and their attendant manifestations of racism on the international stage. Within this context, Fanon's strivings and his entire corpus delineate his foundational decolonial therapy, which, as we have seen, blends elements of psychoanalysis, sociodiagnosis, and, through his discussion of lived reality, existential phenomenology. The ultimate goal of this transdisciplinary method was to move Fanon's colonial patients from the captivity of self-alienation to the freedom of their innate human agency (Desai 2014; Gordon 2015).

Negritude

In *Black Skin, White Masks*, Fanon illustrated the attempt to seek self-recognition in the form of Negritude, an affirmed black existence. Sartre, however, showed that such an attempt must ultimately struggle with a universal reality principle, which, he argued, was supposedly the proletariat. Fanon's response was he didn't need to know *that*, which robbed him of his 'last chance' at an articulated independent self. What was his immediate and more visceral response? He wept. The weeping cleansed him of delusion so he could face reality: The society offered no coherent notion of what it means to be a black woman and a black man. Further, he examined how racism positioned blacks in a 'zone of nonbeing', where they stand neither as selves or others. The black, in other words, looks at white others with the realization of seemingly ontological asymmetry: For the white, there is no other or self-invested in blackness. The black, then, is a category beneath other. Fanon closed that text with the call for embodied interrogatives. As a question, one is a possibility. His critique of Sartre, then, is that the latter invoked a *closed dialectic* upon what required an understanding of an open, critical relationship with reality. 'Applied' dialectics is not, in other words, dialectical. In *Year V of the Algerian Revolution*, he returned to Negritude with this observation: It was the white who created *le nègre*, but it was *le nègre* who created Negritude. The latter, even where misguided, is an act of agency and, thus, an expression of freedom.

Emergence of Black Consciousness

Fanon's thought negotiates the dialectics of black self-perception and its transition to Black understanding, making Fanonian methods conducive for mental health. Apprehension of a negative black imago is an experience identified not only by Fanon, but also W. E. B. Du Bois (1903) half a century earlier in *The Souls of Black Folk* as double consciousness. In 'L'Experience vecue de l'homme noir' (The Lived-Experience of the Black) in *Peau noire, masques blancs* (Black Skin, White Masks), Fanon (1952) writes of the realization of his having moved through the world with the presumption of that negative image—*le nègre* (and *le noir*)—was not he but some other (non- or subhuman) creature. The famous incident in which he was identified by a frightened white boy as '*le nègre*' split or exploded his consciousness into two: The presumed legitimate world of the white normative standpoint and his lived experience as a negative term in, as he put it, 'the zone of nonbeing.' As a negative term, black consciousness is a lived reality of existence without being. To exist is to stand out, but, as he learned, doing such as illegitimate meant a violation of being. Reality, in other words, is presumed legitimate where the black is absent. Black consciousness in this form is, then, a constant realization of self-illegitimacy. The world remains 'right,' in other words, where the black is presumed guilty and *does nothing*.

Fanon identifies here a special phenomenon, which he distinguishes from the German psychiatrist and philosopher Karl Jaspers's notions of legal, moral, political, and metaphysical guilt, for the black is guilty whether the black's crime is not only, in a word, *existence* but also, more bizarre, the very possibility of being. The black, in short, is what *must or ought not be*. This pathological situation of preordained culpability and inaction has traumatic effects, ranging from self-deprecation to an inability to articulate the public self as otherwise, which Fanon outlines in *Black Skin, White Masks* and his subsequent essays on race, racialization, and madness. Despite attempts to do otherwise, the black *secretes* blackness in a world premised on black exclusion. Fanon, however, rejected the legitimacy of such a standpoint. Its sustenance, he argued, was drawn from a posited fixed or "over-determined" society committed to the contradictory practice of reciprocal nonrelations. The *aim* of such a world is to block interaction, connectedness, or relations. The

immediate problem, beyond its racist logic, is its patently anti-*social* one. It is an appeal to modes of being-in-themselves, hermetically sealed, from which the social, because it is intersubjective, could not emerge. Black consciousness, then, is the lived realization of the *anti-social reality of colonialism and racism*.

Fanon, like Du Bois, thus makes a dialectical movement to a critical Black consciousness. This kind of consciousness identifies the societal elements at work in the production of degraded subjects. Realizing the systemic role in the production of negative self-perception, Black consciousness becomes a search for human agency. In Fanon's thought, such an effort, because it demands systemic change, is nothing short of revolutionary. Achieving changed conditions require, however, a both-and approach. On one hand, there is political praxis ranging from Black liberation struggles to tactical work at transforming institutions of power. On the other hand, there is the suffering client who needs to realize that her or his condition is not independent of societal and political conditions. Indeed, this is the possibility of politics, as the South African revolutionary Steve Bantu Biko later argued in his formulation of Black consciousness, since being 'non-political' for Fanon would be, in effect, a form of surrender to the condition of bondage as the happy slave. Fanonian psychology, then, had to work at levels collective and individual. Thus Fanon reads the phenomenon of black consciousness in at least two ways. The first is as a negative system of values constructed by whites (that is, black consciousness). The second is the realization of the particularity of whites, their non-universality, which makes Black consciousness a form of overcoming of reductionistic values of white superiority. It's not a propped up Blackness. Instead, it's the realization of a need to be what Fanon calls 'actional,' agents of history who create both the symbolic and material means of individual and collective self-determination.

Conclusion

Fanon's analysis of the movement from black consciousness to Black consciousness offers an important understanding of maturation and freedom. Though both the black and the Black are indigenous to the

Euromodern world, it is only the Black who has a healthy response to it. The former emerges in a world to which the black is indigenous and does not belong. The counsel of disappearance not being a viable action leaves recourse only into melancholia and despair. In psychoanalysis, melancholia is a form of loss constitutive of a subject. Our adulthood, for instance, is a function of our lost childhood. Our individuality requires an embraced separation from our parents. The difference, however, is that the resulting adult *belongs* to the world of adults. Whites are afforded such a transition from white child to white adult. Antiblack racism forestalls the legitimacy of 'black adult,' for the black in that formulation faces erasure. Fanon's capitalized Black is a refusal to disappear through an affirmation of a right to exist as a non-degraded subject. The practice of maturing, Fanon showed, requires systemic transformation. The Black, then, is also a revolutionary subject. The Black embraces social change with an understanding of possibility through which just as the movement from the black to the Black emerged, so, too, could another come forth from the courage to question and the resolve to fight.

Note

1. All translations are ours and references are to the original French.

References

Bulhan, H. A. (1985). *Frantz Fanon and the psychology of oppression*. New York: Plenum.

Caws, P. (1988). *Structuralism: The art of the intelligible*. Atlantic Highlands, NJ: Humanities International Press.

Cherki, A. (2006). *Frantz Fanon: A portrait* (N. Benhabid, Trans.). Ithaca, NY: Cornell University Press.

Desai, M. (2014). Psychology, the psychological, and critical praxis: A phenomenologist reads Frantz Fanon. *Theory and Psychology, 24*(1), 62–63.

Du Bois, W. E. B. (1903). *The souls of black folk: Essays and sketches*. Chicago: A.C. McClurg & Co.

Fanon, F. (1952). *Peau noire, masques blancs*. Paris: Éditions du Seuil.
Fanon, F. (1959/1972). *Sociologie d'une révolution: (L'an V de la révolution algérienne)* (2me ed.). Paris: François Maspero. Retrieved March 3, 2018, from http://classiques.uqac.ca/classiques/fanon_franz/sociologie_revolution/socio_revolution_algerie.pdf.
Fanon, F. (1961/1991). *Les Damnés de la terre*. Préface, de J.-P. Sartre. Paris: François Maspero éditeur S.A.R.L.; Éditions Gallimard.
Fanon, F. (1967a). *Black skin white masks* (C. L. Markmann, Trans.). New York: Grove Press.
Fanon, F. (1967b). *Toward the African revolution (political essays)* (H. Chevalier, Trans.). New York: Grove Press.
Fanon, F. (1967c). *The wretched of the Earth* (C. Farrington, Trans.). Harmondsworth: Penguin Books.
Fanon, F. (1979). *Pour la revolution africaine: écrits politiques*. Paris: François Maspero.
Fanon, F. (2016). *Frantz Fanon: Écrits sur l'aliénation et la liberté* (J. Khalfa & R. Young, Eds.). Paris: Éditions la découverte.
Gibson, N. C., & Beneduce, R. (2017). *Frantz Fanon, psychiatry, and politics*. London: Rowman & Littlefield International.
Gordon, L. R. (2015). *What Fanon said: A philosophical introduction to his life and thought*. New York: Fordham University Press.
Parris, L. (2015). *Being apart: Theoretical and existential resistance in Africana literature*. Charlottesville, VA: University of Virginia Press.
Tosquelles, F. (2012). Frantz Fanon à Saint-Alban. In La Fondation Frantz-Fanon (Ed.), *Frantz Fanon: Par lestextes de l'époque* (pp. 75–89). Paris: Les Petit Matins.

14

Gandhian Philosophy for Living in the Modern World: Lessons from the Psychology of *Satyagraha*

Vinod K. Kool and Rita Agrawal

Mohandas Karamchand Gandhi, through his nonviolent technique, popularly known as *Satyagraha*, attempted to shape human behavior. His approach included moral inclusion, utmost self-control and learning to monitor nonviolent behavior in the face of oppression and aggression by the adversaries. While the significance of these notions have been noted only recently in the field of Western psychology (for example, Kool 2008; Kool and Agrawal 2011; Hoffman et al. 2014; Opotow et al. 2010), Gandhi had long back put them in the forefront of his philosophy of life for human beings the world over, on the basis of what he called his 'experiments with truth' (Gandhi 1927, *The story of my experiments with truth*). There is much to learn from his life and philosophy which can enrich the content of modern psychology in general

V. K. Kool (✉)
SUNY Polytechnic Institute, Utica, NY, USA

R. Agrawal
Harish Chandra Post Graduate College, Varanasi, India

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_14

and well-being in particular. In this chapter, we focus, briefly, on a few selected concepts to highlight the usefulness of his work in promoting our understanding of human behavior and its relevance for the world of today.

According to Gregg (1941), lessons from Gandhi's life and work, especially in the context of morality, constitute a moral jiujitsu. While a Utopia would be hard to arrive at, Gandhi offered, not only, a philosophy but also delineated a specific methodology for overcoming many of the social and personal ills pervading our lives using the systematic use of truth and nonviolence, about which he writes: 'I have nothing new to teach the world. Truth and nonviolence are as old as the hills' (Kripalani 2011, p. 1). It is clear that we have simply thrown them into the back yard. Even scientists such as Nobel Laureate Paul Krutzen agree with the Gandhian model for solving present day problems in that there is enough for man's need but not for his greed and that 'what is happening on Earth is strongly determined by what humans do. Humans like you and me are shaping our home planet to a greater degree than other natural processes. That is a huge responsibility' (interview of Krutzen by Schwagerl 2013, p. 1). And, it was in the context of this responsibility which rests upon us humans that Gandhi developed the concept of *Satyagraha*.

Basic Tenets of *Satyragraha*

The word *Satyagraha* comes from two words, '*sat*' meaning truth and '*agraha*' meaning firmness. However, inculcating these two characteristics (if we could call them that) have never been easy and the inherent difficulties were obvious to Gandhi, who wrote: 'we are helpless mortals caught in the configuration of *himsa* (violence). Man cannot live for a moment without causing or unconsciously committing outward *himsa*' (Gandhi 1927, p. 205). Yet, thousands followed him voluntarily, in the adherence to the principles of nonviolence and *Satyagraha* in India and elsewhere, providing ample proof for the efficacy of the phenomenon.

Choosing Between Violence and Nonviolence

Nonviolence involves an active choice made by the person. As Gandhi had emphasized, the nonviolent person is not a coward, nor is nonviolence an act of weakness but the choice made between violence and nonviolence is an active choice made by the person/persons concerned. This is evident from the fact that both violence and nonviolence have been preserved through phylogenetic evolution and, therefore, both must serve some adaptive purpose. Based on observations on animal behavior in the natural setting, ethologist Lorenz (1966) contended that aggression is necessary for the survival of the species; yet, time and again, animals from a variety of species have preferred cooperative to competitive behavior. One cogent reason is that there is biological evidence to prove that organisms are indeed hard-wired for cooperative behavior and its many ramifications including empathy and altruism (for details, see Kool and Agrawal 2011). A second reason is that choices made may decide the survival of the species. In their article, 'Born to Choose', Leotti et al. (2010) discuss ways in which organisms including humans make choices and that this ability (to make choices) determines mastery over the environment.

When we consider the behavior-choice people make in terms of whether it is violent or nonviolent, it is mandatory to examine the relationship between the two types of behavior. Both theory and empirical research suggest that the two can be thought of neither as two ends of a single continuum nor as flip sides of the same coin. Rather, they can be viewed as two areas of behavior overlapping to a certain extent (Kool 2008, p. 11; Fig. 1). This overlap is the gray area in the midst of which men and women vacillate, choosing violence at times and

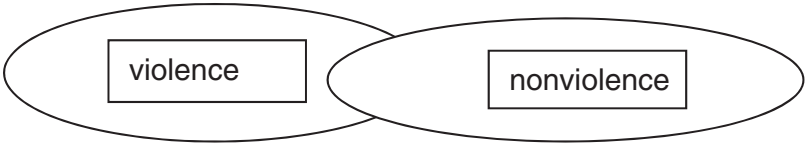


Fig. 14.1 Violence and nonviolence and the overlapping area between the two

nonviolence at others (see Fig. 14.1). Gandhi chose nonviolence, going against all odds and even evolutionary purpose sacrificing personal goals for the good of the community at large.

An American researcher, Milgram (1974), conducted an ingeniously devised experiment in which he invited ordinary citizens of USA to 'give' electric shocks to an 'erring learner'. In reality, no actual shocks were administered and the participants were only made to believe that they were doing so whenever the learner made mistakes. Most participating subjects administered (what they thought were) lethal levels of shocks simply to promote learning. Gandhi and his followers who practiced nonviolence, were much like the *few subjects* (in Milgram's experiment) who chose *not* to comply with the instructions to be violent, and, instead, manifested self-control of the highest order. While Milgram explained the majority behavior in terms of the extent to which people show compliance and obedience to authority; Kool wondered why a few refused to administer shocks at all or left the experiment early after delivering lower levels of shocks. From this position, Kool went on to develop a three dimensional model of nonviolence which is, in principle, inspired by Gandhian thought and action, the latter in particular emanating from *Satyagraha*. The model consists of three components to understand nonviolence: capacity to control aggression, use of moral judgment and sharing of power (Kool 2008).

Self-Control and the Role of Vows

The first tenet of *Satyagraha* is self-control. While the role of self-control, that is, the ability to resist temptation and ward off impulses, can hardly be doubted, it is only in recent times that Western psychology has begun investigating this phenomenon in terms of its implications for life and success (for example, Hoffman et al. 2014; Baumeister and Tierney 2011). Yet, more than half a century ago, the first thing that Gandhi demanded from his fellow *satyagrahis* was utmost self-control.

Realizing the worth of self-control, Gandhi practiced it stringently not only in his own life but also advocated it to all his fellow *satyagrahis*. However, unlike psychologist Skinner who used schedules of external

reinforcement (namely, rewards and punishments) to build self-control or some politicians (Hitler, being an extreme example) resorted to coercion, Gandhi let people decide for themselves. He asked them to listen to their heart, hear their inner calling and do what seemed right according to their conscience. This was more difficult because obeying someone is always easier while listening to one's heart takes longer. Gandhi writes:

> The satyagrahi general has to obey his inner voice, for over and above the situation outside he examines himself constantly and listens to the dictates of the inner self…. (Tendulkar 1954, p. 152)

In fact, Gandhi was far too advanced for his times in that he envisioned the ideal person as one who at the core was a profound individualist, practicing self-control but using it for collectivist ventures in working for the social good (Sanghvi 2006). Thus, in Gandhi, Erikson (1969) saw a unique blend of individual identity being formed through his social affiliations to the extent that Gandhi recognized that the 'realization of Truth is impossible without a complete merging of oneself in and identification with this limitless ocean of life' (Gandhi, cf. Joseph 2012, p. 416), leading to the establishment of a super identity with moral inclusion of the highest order, which included not only humans but all things sentient in nature. Gandhi's 'experiments in truth' showed him the way and he was soon to understand that self-control cannot be achieved without firm resolutions, '*vrata*' or vows, that is, making promises to oneself, which, in fact, has been advocated by a number of religions and sects, ranging from the Stoics to the Buddhists and has always been recognized as being mandatory for social living. It was these stringent vows that helped not only Gandhi but also his *satyagrahis* to achieve self-control: 'the vow was a sure shield against temptation' (Gandhi 1927, p. 256).

According to Gandhi, the term 'vow' is actually a misnomer, used only because of the lack of a better term in English for the Sanskrit '*Vrata*' which implies a promise made to oneself: a personal resolve, yet stronger than resolutions made to oneself. Gandhi emphasized that each vow must be based on the inner calling of the person: vows had to be internally determined, helping us make appropriate choices.

The virtues of such Gandhian vows are more than apparent. We have already mentioned that individuals are often caught at the crossroad of making choices between the use of violent versus nonviolent means. Vows help us to not only avoid short sighted decision that we may repent later, but also to attain self-discipline and strong will power. Commenting further on vows, Gandhi (1927) wrote, 'acts which are not possible by ordinary self-denial become possible with the aid of vows which require extraordinary self-denial' (p. 400) and 'a vow serves the same purpose as a lighthouse does. If we keep our eyes fixed on it, we shall come safe through any storm' (p. 142). Realizing that long term vows would be difficult to practice, Gandhi highlighted the value of *anuvrat*, a concept highlighting a small step towards self rationing, so crucial for the social good of the community.

Western psychology has only very recently understood the psychological underpinnings of the nexus between vows and self-control. Kirby (2014) through his experiments using the Ainslie–Rachlin delay discounting theory of impulsivity (according to which a higher reward available in the future has a much lower value for us than a smaller reward today, Ainslie 2001), has shown how people with a higher level of delay discounting manifest higher impulsivity. Vows help in controlling such impulsivity. At the same time, those who place a higher value on future rewards also show higher self-control than their counterparts who do not. It is clear that Gandhi was a practical psychologist and used principles only to be realized much later by modern psychologists. Gandhi didn't order his fellow men to adopt the vows. Rather, he made conditions conducive for people to understand the relevance of vows and adopt them. He used what cognitive psychologists, such as Kahneman (2011), call scripts and schemas.

Scripts and Schemas for Nonviolence

Think of actors in a play. Each one is provided with a script or behavioral guidelines which must be rehearsed extremely well in order to play the role exactly as the director wants it. Each actor is also encouraged to build and is also provided with examples of images of the role that she

has to play to help her imagine the character. One does much the same in daily life, too. Normally, such scripts and images are provided by the culture and help us to adhere to social norms. One is often explicitly reminded about expected behavior while at other times, exemplars set the way. Thus, over a period of time, certain behaviors become more ingrained in us, or, we can say that we develop certain habitual ways of reacting. The more we react in these ways, the more their mental images become pronounced and script well rehearsed. It is akin to an actor who becomes ever more perfect in his role with each rehearsal. It is these mental images that Nobel Laureate Kahneman refers to as schemas and behavioral guidelines as scripts. According to him, such schemas and scripts not only lead to socially approved behaviors but also to behavioral parsimony. One starts behaving according to them almost automatically (Kahneman 2011).

The above clarifies why despite its apparent utility from both the individual and the humanitarian perspective, it has always been more difficult to resist the temptation to be violent than to aggress and, despite being reminded of ethical and exemplary behavior from various sources, 'our nonaggressive ideals aren't always fully in mind' (Berkowitz 1993, p. 12). Also, in our daily life, violence is generally more salient than nonviolence, involving as it does, issues of survival. This greater salience leads, in turn, to the formation of well prepared scripts or behavioral guidelines and schemas pertaining to it. As a result, when faced by a situation that could be handled with either violence or with nonviolence, it is the schema and the script for the former that is the uppermost in the minds of people, making them react with violence. However, schemas and scripts can be developed for nonviolence, too. Gandhi used several of these to guide the satyagrahis and help them behave in nonviolent ways even amidst extreme exigencies, some examples of which are given below (see also, Kool and Agrawal 2014).

Because of Gandhi, the schema (mental image) that people had of the British was different from that for the acts of the British. Gandhi was able to create this difference in the minds of people by insisting that, we should not hate the British but hate only their acts.

Each *satyagrahi* would rehearse a set of action plans (or scripts) consisting of keeping a firm posture of fearlessness while being beaten

by the police, restraining from showing anger or retaliation, keeping on chanting the slogans and remaining on fast even after arrest (Bondurant 1965).

Anasakti, Aparigriha and Moral Inclusion

The second basic tenet of Gandhian *Satyagraha* is moral inclusion, the role of which has also been clarified by Kool (1993, 2008) in his three dimensional model of nonviolence. Gandhi propelled people to high levels of moral inclusion through *anasakti* or detachment, a concept drawn from the ancient Hindu scripture, the *Bhagwada Gita*. *Anasakti* and its opposite, *asakti* may, in fact, be seen as two ends of a bipolar personality dimension, with individuals showing varying levels of both and leading to the ambivalence between violence and nonviolence mentioned earlier. A person high on the *asakti* aspect would be naturally propelled by self-interest, obtained through any means. At the other end of the continuum would be the person who enjoys everything but does not have the desire to possess and who therefore develops an inner freedom from want (*anasakti*). However, *anasakti* does not mean the negation of love or other human emotions and nor does it preclude that the person becomes a recluse.

Gandhi's strong belief in *anasakti,* is brought to the fore by his statement on hating the acts of the British, but not the British. For the majority, it is the ends, which are important, reached as they may be by any means. This is also a major cause of violence. However, Gandhi writes, 'for me it is enough to know the means. Means and ends are convertible terms in my philosophy of life. We have control over the means but not over the end. I feel that our progress towards the goal will be in exact proportion to the purity of our means' (Iyer 1983, p. 362). Convinced as he was that if one used the right means, the efforts would automatically bear fruit, he focused on the idea that the only way to reach the goal was the path of truth and nonviolence, that of *Satyagraha*. Any attempt towards creating a nonviolent society must, of necessity, start by increasing these limits of moral inclusion and one way shown by Gandhi is *anasakti*.

In fact, an analysis of certain events during Gandhi's stay in South Africa reveals that Gandhi incorporated within himself all the three criteria considered important for moral inclusion, namely, fairness towards others, sharing of resources that foster well-being and the willingness to act with generosity (Opotow 2014) and this is what he expected from his followers. Moreover, Gandhi insisted that *anasakti* can be practiced by ordinary men and women, referring to the ability to love without discrimination with the highest degree of moral inclusion based on the Indian philosophy of *Vasudeva Kutumbkam* (Nature is my family).

The concept of *anasakti* can well be used to develop a comprehensive model of mental health (Bhushan 1996). At the heart of mental problems and a major causative factor as far as stress is concerned, lies the concept of frustration, that is, the actual or perceived thwarting of one's interests by other people or situations (Agrawal 2001).

Gandhi, with his faith in the *Bhagavad Gita* which propounds that one should focus on one's *karma* (actions) that is, on the means and not the ends, was also a true believer in the concept of *aparigriha* (non-possession), negating parigriha, whether it be related to power, position, wealth or material belongings. *Aparigriha*, per se, helps one to move away from self-interest, often seen as the dividing line between violent and nonviolent behavior. While *parigriha*, more often than not, leads to frustration and thereby to anxiety, depression, fear and insecurity, *aparigriha* would lead to mental peace and consequently mental health. The emphasis on non-possession would also help one to resolve cognitive dissonance and draw away from self-serving biases and inequities which have violence as the end result. Unfettered by self-interest measured through success and failure or by the trials and tribulations of life, it is but natural that such a person would find it easier to maintain an even keel.

However, for the above, total discipline was required. Gandhi did not believe in the use of coercion. Rather, for him, a focus on community work and community living was seen as the key to greater discipline and for promoting the practice of nonviolent methods and *Satyagraha*. A good analysis of the role of discipline and physical

work in the lives of nonviolent activists can be found in the book, *A Discipline for Nonviolence* (Gregg 1941).

Role of Discipline and Physical Work in Promoting *Satyagraha*

Commenting on the need for discipline among nonviolent activists, Gregg writes, '….so the believer in non-violence undertakes manual labour for the sake of the discipline even though he acknowledges the quantity of production to be thereby curtailed' (Gregg 1941, p. 4).

At the same time, just any physical work would not suffice: it had to produce something useful for the community, it must further the self respect of the workers and it had to entail interdependence and cooperation among the workers. Gandhi laid emphasis on the need for a sound program such that people felt that they are working for a cause. Such a well defined program would have far reaching effects, both for the individual, and, for the group. According to Gregg,

> Though to many it may at first seem incredible, careful and objective analysis shows that the same valuable benefits derived from military discipline — that is, habits of obedience, self-respect and self-reliance, self-control and self-sacrifice, tenacity of will, sense of unity with others, endurance of common hardships, sense of order and cooperation, energy, courage, equanimity and poise, practice in handling moral equivalents of weapons— are developed by wide-spread, habitual, understood hand work. (Gregg, ibid., p. 9)

Gandhi therefore focused on community spinning and *sarvdharma* (all-prayer) meetings through which he was able to promote *sarvodaya* (compassion for all) and founded several communities (for example, Phoenix, Tolstoy Farm and Sabarmati Ashram). This focus on community living and working made it easier for Gandhi's *satyagrahis* to follow the principles of *aparigriha* and *anasakti.* Many such communities and self-help groups flourish even today revealing the efficacy of his principles despite the perils of illiteracy and poverty (Bhatt 2015). In fact, it

was Gandhi's way of practicing occupational therapy, so often advocated and used by psychiatric wards to overcome depression and anxiety as also to enhance self-respect and courage.

Beyond Maslow to Ripening

Maslow (1954) claimed that among the very few people who can be said to have attained self-actualization, seen as the zenith of human strivings, are people like Gandhi, Desmond Tutu and Mother Teresa. What was Gandhi's formula for self-actualization? Through his 'experiments with truth' he has shown that truth is the only path to the realizing of one's potential, and the evolution of the self is possible through continuous self-examination and self-purification (*Tapas* or self-suffering). A true exemplar of such constant evolution of the self is Gandhi himself (Sanghvi 2016, Personal communication).

The practice of *Satyagraha* and nonviolence was not, therefore, 'a quality to be displayed to order, but an inward growth depending for sustenance upon intense individual effort and it can be effectively taught only by living. It is not a mere passive quality but the mightiest force man is endowed with' (Iyer 1983, pp. 195–196) and 'the end of a satyagraha campaign can be described as worthy only when it leaves the satyagrahi stronger and more spirited than they were at the beginning' (Gandhi 1927, p. 534).

Thus, Gandhi went a step ahead of self-actualization, providing *satyagrahis* the ways and means for personal growth and ripeness (Coleman 1997) thereby leading people to the successful resolution of life's final crisis of generativity versus despair (Erikson 1968)—that is, remain happy even during the last phase of life.

Satyagraha reveals the human capacity for being able to rise above adversity, for hardiness and resiliency, known as the ordinary magic of nonviolent individuals (Masten 2001), qualities recognized by modern psychology to be the very ingredients for coping with stress and well-being. In more ways than one, *Satyagraha* was an embodiment of the basic tenets of modern day positive psychology, with its focus on positive emotions such as forgiveness, gratitude, love and flow giving the

person internal strength. For, according to Gandhi, 'The weak can never forgive. Forgiveness is the attribute of the strong' (Prabhu and Rao 1966, p. 421) and in reply to a British official, he said, 'the people are not by nature violent but peaceful' (Gandhi 1927, p. 566).

Conclusions

It is contended here that the practice of nonviolence is arduous, involves sustained effort and could cause burnout and other mental health issues. While modern Western psychology is ready to benefit from Gandhi's lessons from nonviolence; can modern clinical psychology explain the sound mental health of the satyagrahis despite all the suffering and trauma they went through? How about Milgram's subjects? Those who gave shocks suffered from nightmares, but those who refused to shock did not report any conflict. Can clinical psychology explain that? Noted psychologists, too, have voiced their pessimism with traditional psychology. Cognitive psychologist, George Miller, is quoted in *The Washington Post* (Langer 2012): 'I was also taught… psychology was a sin…. So it took me a long time to look at psychology, but when I did, I came to it with a view that perhaps the mind really does have power to influence things'.

It has been stated that American psychology needs to become less American, mainly because it is based on a predominantly American population which is a mere five percent of the total world population (Arnett 2008). Gandhian principles would help Western psychology expand and it would be useful to absorb and utilize Gandhian concepts such as *anasakti, aparigriha* and *sarvodaya* to solve the multifarious mental health issues springing out of human weaknesses in particular and plaguing our nations and communities in general. 'Since the solutions he found for them were based on eternal verities, his influence and his relevance is also timeless and universal' (Gangrade 2004, p. 131). Indeed, one needs only to recall the title of Stricker's paper: *The scientist-practitioner model: Gandhi was right again* (Stricker 2000), to understand the lessons from and challenges of Gandhi's 'experiments with truth'. In fact, what Gandhi advocated once (Stricker 2000)—that these lessons should be tested in the Western world—is true even today.

References

Agrawal, R. (2001). *Stress in life and at work*. New Delhi: Sage-Response.

Ainslie, G. (2001). *Breakdown of will*. New York: Cambridge University Press.

Arnett, J. J. (2008). The neglected 95%: Why American psychology needs to become less American. *American Psychologist, 63*(7), 602–614. Retrieved September 6, 2017, from http://www.jeffreyarnett.com/neglected95arnett-tap2008.pdf.

Baumeister, R. F., & Tierney, J. (2011). *Willpower: Rediscovering the greatest human strength*. New York: Penguin Press.

Berkowitz, L. (1993). *Aggression: Its causes, control and consequences*. New York: McGraw Hill.

Bhatt, E. R. (2015). *Anubandh*. Ahmedabad: Navjivan Publishing House.

Bhushan, L. I. (1996). Asakti-Anasakti: A model of mental health. *Yoga.* Retrieved September 6, 2017, from http://www.yogamag.net/archives/1996/ajan96/menhelth.shtml.

Bondurant, J. V. (1965). *Conquest of nonviolence: The Gandhian philosophy of conflict*. Berkeley: University of California Press.

Coleman, P. T. (1997). Redefining ripeness: A social psychological perspective. *Peace and Conflict: Journal of Peace Psychology, 3,* 81–103.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.

Erikson, E. H. (1969). *Gandhi's truth*. New York: Norton.

Gandhi, M. K. (1927). *An autobiography or the story of my experiments with truth*. Ahmedabad: Navajivan Mudralaya.

Gangrade, K. D. (2004). *Moral lessons from Gandhi's autobiography and other essays*. New Delhi: Concept Publishing.

Gregg, R. B. (1941). *A discipline for nonviolence*. Ahmedabad: Navjivan.

Hofmann, W., Luhmann, M., Fisher, R. R., et al. (2014). Yes, but are they happy? Effects of trait self-control on affective well-being and life satisfaction. *Journal of Personality, 82,* 265–277.

Iyer, R. (1983). *Moral and political thought of Mahatma Gandhi*. New York: Concord Grove Press.

Joseph, S. (2012). Gandhi, religion and multiculturalism: An appraisal. *Gandhi Marg, 33*(4), 409–425.

Kahneman, D. (2011). *Thinking, fast and slow*. New York: Farrar, Straus and Giroux.

Kirby, K. N. (2014). Gandhi, vows, and the psychology of self control. *Gandhi Marg, 35*(4), 519–540.

Kool, V. K. (Ed.). (1993). *Nonviolence: Social and psychological issues*. Lanham, MD: University Press of America.

Kool, V. K. (2008). *The Psychology of nonviolence and aggression*. New York: Palgrave.

Kool, V. K., & Agrawal, R. (2011). From empathy to Altruism: Is there an evolutionary basis of nonkilling. In D. Christie & J. Pim (Eds.), *Nonkilling psychology*. Honolulu: Center for Global Nonkilling.

Kool, V. K., & Agrawal, R. (2014). Whither Skinner's science of behavior, his assessment of Gandhi, and its aftermath? *Gandhi Marg, 35*(4), 487–518.

Kripalani, K. (2011). *All men are brothers*. New York: Continuum.

Langer, E. (2012, August 1). George A. Miller dies at 92: Psychologist helped lead cognitive science revolution. *The Washington Post*. Retrieved September 6, 2017, from https://www.washingtonpost.com/national/health-science/george-a-miller-dies-at-92-psychologist-helped-lead-cognitive-science-revolution/2012/08/01/gJQALGHJQX_story.html?utm_term=.701d76cee773.

Leotti, L. A., Iyengar, S. S., & Ochsner, K. N. (2010). Born to choose: The origins and value of the need for control. *Trends in Cognitive Science, 14*(10), 457–463.

Lorenz, K. (1966). *On aggression*. New York: Hartcourt, Bruce, & World.

Maslow, A. H. (1954). *Motivation and personality*. New York: Harper.

Masten, A. S. (2001). Ordinary magic: Resilience processes in development. *American Psychologist, 56,* 227–238.

Milgram, S. (1974). *Obedience to authority*. New York: Harper.

Opotow, S. (2014). Gandhi's inclusionary trajectory in South Africa. *Gandhi Marg, 35*(4), 541–560.

Opotow, S., Gerson, J., & Woodside, S. (2010). From moral exclusion to moral inclusion: Theory for teaching peace. *Theory Into Practice, 44*(4), 303–318. Retrieved September 6, 2017, from http://dx.doi.org/10.1207/s15430421tip.

Prabhu, R. K., & Rao, U. R. (1966). *The mind of Mahatma Gandhi*. Ahmedabad: Navjiwan Press.

Sanghvi, N. (2006). *The agony of arrival, Gandhi, the South African years*. New Delhi: Rupa.

Sanghvi, N. (2016). Personal communication, Mumbai.

Schwagerl, C. (2013). 'A huge variety of possibilities': Interview with Nobel Laureate Paul Crutzen on his life, his career in research, and his views on the Anthropocene idea. *Environment & Society Portal.* Retrieved November 10, 2017, from http://www.environmentandsociety.org/exhibitions/anthropocene/huge-variety-possibilities-interview-nobel-laureate-paul-crutzen-his-life.

Stricker, G. (2000). The scientist practitioner model: Gandhi was right again. *American Psychologist, 55,* 202–254.

Tendulkar, D. G. (1954). *Mahatma: Life of Mohandas Karamchand Gandhi* (Vol. 5). Delhi: Publication Division, Ministry of Information and Broadcasting, Govt. of India.

15

The Black Consciousness Psychology of Steve Biko

Saths Cooper and Kopano Ratele

Apart from Nelson Mandela, nobody symbolised the struggle against apartheid more than Steve Biko. (Millward 2016)

Introduction

The psyche of Black South Africa (SA), more than two decades after the demise of apartheid, remains blighted by the mental subjugation of *white* as the aspirational standard connoting excellence, superiority and the epitome of desirability. The subordination of *black* in all spheres of SA life despite their majority demographic, and the insidious resurrection of *non-white* as the patently inferior appellation intended to diminish, to inferiorise, to render effete and ineffectual as a coterminous appendage of white,[1] has struck at the core of the emerging black

S. Cooper (✉)
Pan-African Psychology Union, Johannesburg, South Africa

K. Ratele
University of South Africa, Pretoria, South Africa

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_15

intelligentsia, as evidenced by the nationwide student protest movement starting with 'Rhodes Must Fall' in March 2015 and culminating in the 'Fees Must Fall' campaigns of 2016. Biko's ideas of psychological liberation as an essential precondition to physical freedom and unashamed assertion of black[2] humanity, pride and selfhood have become as alluring today as they were when igniting youth activism and ferment in the 1970s at the height of apartheid oppression.

The quest for true humanity through the seminal ideas of Steve Biko's Black Consciousness (BC) has continued to inspire generations—especially those youth born after May 1994 when Nelson Mandela became SA's founding democratic president—and will be concisely explored in this chapter, located at the interstice between the source and the power of psychology in SA as both regressive and assimilative and progressive and liberating. Historically, successive SA education systems aimed at creating a compliant dependent individual, bereft of any sense of autonomy and efficacy, initially German[3] and then American imported forms of psychological combat have entrapped black personality development, awareness and understanding as a subordinate condition within the dominant white culture and sociopolitical-economic order that continues to personify SA. As a body of theory and praxis, there is little evidence that psychological science has bothered to study majority world[4] behaviour and experiences, let alone that of black people, grounded in black or African cultural and philosophical antecedents. Certainly, successive accounts—colonialism, apartheid, imperialism and globalisation—resonate the voices and thoughts that have developed elsewhere, as any casual reading of SA's history shows.

Steve Biko's History and Thought

Stephen Bantu Biko was the third child and second son of Matthew Mzingaye Biko and Alice Nokuzola 'MamCethe' Duna on 18 December 1946 in the village of Tylden (SBF 2017; Biko 2004), in what is now the Chris Hani District Municipality in the Eastern Cape, one of SA's nine provinces. Translated from the Xhosa language,

Mzingaye means 'home because of him' (Qekema 2014); the name given to his firstborn *Khaya* means 'home' (ibid.); *Bantu* means "people". If the quintessential act of naming a child has any meaning and significance, then the Biko mantle from home to the nation as a whole (ibid.) was ineluctably laid. At the time of his death in 1950, his father was studying law through the distance-learning University of SA (SA History Online 2017), as Biko did when he was killed in police custody in 1977.

Biko was brought up by his mother in the segregated black African township of Ginsburg, King Williams Town, Eastern Cape, which was the hotbed of opposition to the apartheid state. The Pan-Africanist Congress (PAC) of Azania—the alternative name for SA—called on black Africans to leave their apartheid passes (permitting them to be in urban SA) at home and present themselves for arrest at the nearest police stations on 21 March 1960. Police shot and killed scores of mainly women, children and elderly men, many in the back. Subsequently on 8 April 1960, Prime Minister Verwoerd banned the ANC and PAC. A hiatus in black political activity ensued during the sixties, which the apartheid state replaced with palpable fear and brutality.

Variously described as naughty and bright, Biko attended Charles Morgan Primary School and Forbes Grant Secondary School where he excelled in mathematics and English (SA History online 2017). He joined his older brother Khaya at Lovedale College, and was arrested in early 1963 together with Khaya, who was charged and convicted for PAC activities. After Khaya's arrest, Biko was expelled from Lovedale after being there for only three months. His political immersion had begun[5] and he developed a 'strong resentment toward White authority' (SA History Online 2017). At Khaya's behest, he was admitted to St Francis College, Durban, Natal (now KwaZulu/Natal province) in 1964, where he was elected Vice-Chair of the Literary and Debating Society (SA History). He was enrolled in the Medical School at the University of Natal (now University of KwaZulu-Natal) Non-European (UNNE) section in 1966. Elected to the Student Representative Council (SRC) in his first year, Biko's trajectory as a student and political leader was set.

The white-led National Union of SA Students (NUSAS) dominated English and black university politics; Afrikaans campuses were influenced by the apartheid-supporting *Afrikaner Studente Bond*. The SRC at UNNE was affiliated to NUSAS. Biko became a de facto member, but was sceptical about the prevailing white values, which whilst opposed to apartheid nevertheless eschewed blacks as fully equal. This was to reveal itself when the annual conference held in July 1967 at Rhodes University in Grahamstown pandered to apartheid by accommodating Biko and fellow black African students in a township church building. 'So appalling were the conditions that it showed the blacks just how valued they were in the organisation' (SASO-BPC Trial 1976). The next day Biko delivered the UNNE report in Xhosa to 'drive home the point about black students' alienation from the NUSAS agenda' (SA History Online 2017). Biko proposed that the conference be suspended as the organisers had already known that they were going to perpetuate apartheid segregation and indifference. After a lengthy debate, the proposal was defeated by the huge white majority. Biko and other black students walked out (SA History Online 2017).

Thereafter Biko visited every black university and higher education campus in SA to canvass support for creating a black student organisation that represented their interests without fear, favour, or prejudice. A year later, representatives from various campuses mandated Biko to form the black South African Students Organisation (SASO), which was done from 1 to 3 December 1968 at his former High School. At the founding SASO meeting held in July 1969 (SA History) at the University of the North, Turfloop (now University of Limpopo), Biko was elected President. At the 1st General Students Council in July 1970, Biko became Publications Chair[6] (SA History Online 2017). Biko began writing his 'I write what I like' articles under the pseudonym 'Frank Talk' until his banning by the apartheid state in February 1973.

The wealth of Biko's writing can be traced to when he was 23–27 years of age and reveal a perspicacity and timeless relevance that finds meaning in contemporary SA. His *tour de force* was the testimony he gave at Pretoria's Palace of Justice in May 1976 as the main defence witness in the marathon SASO/BPC (Black People's Convention) Trial[7]

where nine BC leaders faced charges under the notorious Terrorism Act.[8] Although banned, Biko's testimony—as was the testimony of other witnesses and accused[9] who were banned—was widely reported by the local print media as this was supposedly an open court process, unwittingly enabling Biko's BC ideas to gain a national audience from 31 January 1975—when the accused were first brought to court—till 21 December 1976, when sentencing occurred.

His philosophy was essentially humanist, albeit located in the abject conditions prevailing, especially for the black African majority at the height of apartheid oppression. Delving into the black psyche confronting constant assault, diminution and reification[10] within a virulently racist and hostile environment, Biko defined BC as 'not a matter of pigmentation' but a 'reflection of a mental attitude', and that authentic blacks 'are those who can manage to hold their heads high in defiance rather than willingly surrender their souls to the white man' (Biko 2004, p. 52). Importantly, being truly black was a process on the 'road to emancipation' (ibid.), and 'the most potent weapon in the hands of the oppressor is the mind of the oppressed' (Wilson 2012).

Key Elements of Black Conscious Psychology

Biko and BC relied on psychological underpinnings to interpret the subjective inner world of the black oppressed majority as well as the objective conditions that the apartheid political system created in the socioeconomic environment that was—in many ways still is—SA. Accordingly, the concise treatment here will refrain from forcing BC into a procrustean bed to neatly package it in psychological terminology or rubrics, which we believe the reader will appreciate.

Besides the apartheid ideology, BC was the only SA grown theory and praxis. Biko was the latter's foremost proponent, posing a direct threat to the sustainability of the former, accounting for BC to be significantly erased from history and easily supplanted by neo-liberal shibboleths passing muster as freedom and democracy for the people, while rampant corruption and cronyism prevail. BC was influenced, inter alia, by certain ideas emanating from Negritude, Pan-Africanism and the

civil rights movement in the United States. Despite most of their works being banned, Aime Cesaire, W. E. B. DuBois, Frantz Fanon, Kwame Ture and Malcom X were widely read in BC circles in the late 1960s and early 1970s.

What we prefer to call black conscious[11] psychology enables black people to emancipate themselves from any constriction of historic or other determinism that in any manner or form, subtly or otherwise, construes them to be appendages of anybody else but themselves, freeing them to live meaningful lives complete in themselves. It recognises that many of the psychological health, social and economic problems in black people's lives in the SA context were produced by colonialism, apartheid and white racism. It places black lives at the centre of its field of vision, without in any way diminishing the other, even if the other were the source of their erstwhile psychological or physical inferiorisation and diminution. It positively reframes the misnomer that black is an aberration from normalcy, where white tends to be the accepted standard. Once the wrongly attributed deviance has been breached, equity is achieved, reducing dissonance for self and the other, making society safer for all. Black value conflict and identity dissonance occur throughout the lifespan, where 'a certain state of alienation' has been internalised and self-rejection occurs 'because he attaches the meaning white to all that is good,' equating 'good with white' which 'arises out of his development from childhood' (Woods 1978, p. 124).

BC desires 'to infuse the black community with a new-found pride in themselves, their efforts, their value systems, their culture, their religion and their outlook to life' (Biko 2004, p. 53). Biko emphases the 'interrelationship between the consciousness of the self and the emancipatory[12] programme,' eschewing reforming the system 'because so doing implies acceptance of the major points around which the system[13] revolves' (ibid.) which would be inimical to the sought-after egalitarian society. Liberation was 'of paramount importance' in BC as 'we cannot remain conscious of ourselves and yet remain in bondage' (Biko 2004, p. 53). For Biko and BC attaining such an 'envisioned self' indelibly meant that it was a 'free self' (ibid.). Political liberation therefore entails both physical and psychological liberation from the imprisonment of the mind occasioned by internalising physical and socio-economic

oppression and subjugating oneself to sustained inferiorisation. Biko and BC emphasised psychological liberation as an essential precondition to attaining any political liberation. A primary objective was to counteract the unremitting assault of the black psyche through a complexity of overt and subtle denigration and inferiorisation that was the abiding apartheid ethic.

Biko and BC maintained that at the rendezvous of victory no society can afford to have half human beings who took external points of reference and yet claim to be free, let alone being transformed. Almost autonomous reliance on allowing ourselves to be called a negative of another, such as the pejorative ascription 'non-white' is narcissism gone awry. If we remove 'white' from the term 'non-white' we remain with a lack of, a negative of, an absence of something/another, akin to being inhuman, a non-person, *nihil*.[14] BC maintains that to call others 'non-black' would be equally offensive and degrading and posits a positive affirmation of self by anybody without demeaning reference to anyone else. Viewed in this way, BC affirms a positive denouement to deeply racially cleaved societies like SA and the United States.

A key insight from BC is that 'black' would be the (not so new) normal. Under colonial and racist oppression, black family, black intelligence, black beliefs, black coping styles, black achievement, black interests, and in almost all facets of life black is apparently considered inferior, deficient and at best just not white enough. The main problem blacks face in a world of white hegemony is that the norm is unashamedly white. Black people are per definition abnormal in a white world, trapped mentally and consequently physically. Having awareness without consciousness (Chissano 2015) does not meet the necessary and sufficient conditions for attaining psychological emancipation.

It is noteworthy that Biko and BC seem to have 'unconsciously' anticipated community psychology, with a focus on engagement with people in their lived experiences, with renowned self-reliance programmes.[15] From this viewpoint, what we term black conscious psychology incorporates community well-being and vibrancy. At the same time, black conscious psychology stresses work on the self, suggesting that self-psychology and group identity are essential. Another key insight, already referred to, relates to this dual focus on the black self

and group is that black conscious psychology is a liberatory psychology. It seeks to liberate the self and the group. A liberatory psychology cannot use methods that oppress people. Black conscious psychology thus needs emancipatory methods that take what the people know seriously. Black conscious psychologists therefore co-create knowledge with the people.

There is an element of BC thought that is even more intriguing, if that is possible. Biko and BC envisage an element of therapy, which some might wish to read as a version of positive psychology. Both these interpretations are enabled by Biko's observation that BC is a process through which blacks have to go inside themselves, face their humiliation, deal with the 'whitened' yearnings, and restore their dignity. He clinically describes the subjugated person as 'a shell, a shadow of man, completely defeated, drowning in his own misery, a slave, an ox bearing the yoke of oppression with sheepish timidity' (Biko 2004, p. 31). 'Reduced to an obliging shell' and 'defeated person' (ibid., p. 30) aptly conveys the emptiness, the abjectness, the overwhelming nature of surrendering to racist oppression. A 'man only in form' (ibid., p. 30) who's fundamental 'content'—his integrity—has succumbed to the depth of profundity where 'dehumanisation has advanced' (ibid., p. 30). Such a people have 'lost their personality' and need to change to reconnect with their indelible humanity. The first step in such a change process to restore selfhood and wholeness is 'to pump back life into his empty shell; to infuse him with pride and dignity, to remind him of his complicity in the crime of allowing himself to be misused and therefore letting evil reign supreme in the country of his birth' (Biko 2004, p. 31). Biko terms this 'an inward-looking process' (ibid.) where dehumanisation may be staunched.

It is no coincidence that Biko drew from Frantz Fanon who closely studied blackness in varied contexts, positionalities and dimensions, which are historically and geo-politically contingent. Blackness emerges out of the conditions in which people defined as black find themselves, shaped by all the extant forces in a particular society as well as what occurs elsewhere in the world. Thus what it means changes from one place to another, from one historical era to the next. At the same time, blackness itself is one of those forces that shape the world. As such,

whatever prevalent meaning is attached to blackness is likely to change as the world changes and will not remain constant.

It would appear that it will be totally inadequate to regard black conscious psychology as a sub discipline of psychology. Black conscious psychology is a whole orientation towards psychology. Rather, it is a reorientation of psychology. It situates black people and the black condition at the centre of psychology and places psychology at the service of black people and all of humanity.

Evolution and Development of a Relevant Psychology in SA

We may well ask: Why is there no flourishing black psychology in SA? Why, after apparent independence from white colonial and apartheid rule, is psychology still dominated by frameworks, concepts and values from the former colonial powers? Although a country such as post-apartheid SA has had a black majority national government since 1994, one of the striking features of psychology in the country[16] is that the discipline continues to be discursively white and Western-centric. In our view, a white and Euro—or Western—centred psychology is one which puts the ideology—and hence psychology—of whiteness and white emotions, cognitions, behaviour, experiences, values, and relationships at the heart of the study of psychology and its applications, especially therapeutic and other applications. Even more significantly, white expertise remains at the helm of the discipline[17] effectively gatekeeping entry into the profession.

We wish to situate blacks as psychologists and subjects of study at the centre of the discipline of psychology. Our argument is simple, almost linear: SA's interest in BC was abruptly truncated, even denounced as retrogressive in the desire for race reconciliation and a so-called rainbow nation. Since the advent of democracy in SA, there has been an unravelling of interest in a positive intrinsic black identity and public attempt to embrace a civic nationalism, accompanied by a deep-seated thrust to reshape the compliance and pliability that the apartheid system created. This retreat has been countered by an apparent spontaneous clamour

from youth and students for a resurgence of BC free of sectarian political narrowness. This requires us to re-imagine a radical praxis. In doing so, we envisage civil society, the state, and universities as three conceivable terrains for the construction of a black conscious psychology. We suggest that the discipline has become a terrain for the distortion of our conceptualisation of the locations and possibilities for radical meaningful change that will undergird social certainty and economic security, which have perennially evaded SA.

Since critical reflection is fundamental to the task at hand, we believe there needs to be a meaningful deconstruction of the idea of 'Western psychology' as it evolved in SA and the often awkward but crucial role that BC scholars played in the development of the body of ideas we call black psychology must be interrogated. As a critical backdrop, we must engage with the importance of radical praxis as it developed during the 2015 and 2016 student revolts and how this has sparked new momentum towards our understanding of black psychology and re-thinking psychology in present day SA. This has to be part of the effort to contribute to a global more accessible and representative psychology that especially speaks to the neglected majority[18] world.

A challenge to be borne in mind and which has to be addressed is the sense of failure over the persistence of uncritically adopting Euro-American psychology in SA specifically and Africa and the majority world generally. Our desire is to realise a psychology that centres the psychological health and well-being needs of the majority of people in SA, instead of the self-limiting continuing focus on a small privileged white and emerging black elite, as well as more broadly the efforts towards attracting, educating and training critical and engaged black psychologists to more accurately reflect and engage the demographic reality in SA.

It should be meaningful to contribute towards global psychology and psychological health and well-being by presenting a version of black psychology we accentuate as black conscious psychology. While this is a somewhat awkward formulation, it should become clear why this is necessary. The ideas about BC articulated most famously by Biko are central in how we conceive of black psychology. It is crucial to note that Biko's ideas upon which we base our exhortation arose out of BC that started in 1969. Probably even more significant is that the emancipatory

struggle pursued by Biko and BC was thoroughly psychological as much as it was deeply political. This makes the task of building a consciously black psychology relatively easy.

Given that African American psychologists have already developed a black psychology, why is there a need for a black conscious psychology? In part, this is because until quite recently there were very few black psychologists in SA, and even fewer psychologists who identify as critical. But it is also precisely because South Africans have considered black psychology as an American exercise that only a limited number of psychologists have sought to explicate and theorise black psychology *qua* black psychology.

Stevens (2015) asserts that:

> the fundamental premise of black psychology is the recognition and assertion that Western, Euro-American models of psychology have serious challenges around their applicability to understanding the experiences of black people, given their location and immersion in a normative culture of whiteness. (p. 182)

What many scholars have not been bold to do is *own* black psychology. There is, hence, a need for a SA black conscious psychology because: (a) Black American psychology cannot dwell on SA conditions, and (b) it is not necessarily black conscious in the way we define it. There is also no denying that black psychology within the global context has a strong made-in the United States imprint while for others it is the psychology of Africans and the African diaspora around the world (for example, see Baldwin 1986; Karenga 1995; Nobles 2013). Extensive work is warranted to develop a black psychology that is centred in the liberatory politics and ethics around black experiences in other countries.

It is intriguing however that black psychologists in SA, the only country outside of the United States with a significant number of black psychologists, never took to black psychology. This is striking because, beginning in the 1980s, a number of young black psychologists began publically questioning the white European- and US-centredness of global psychology as well as the domination of SA psychology by whites. Some wrote under pseudonyms (see Anonymous 1986) for fear

of reprisals. Even more crucially perhaps, Manganyi (1973, 1977) published his work on the psychology of black experience in the 1970s, planting a seed for a black psychology that still needs nourishment. BC appears to have offered an opportunity for Manganyi to try and produce work, as a scholar and clinician, that is meaningful to black people, applicable to their economic, political and cultural realities, and tied to emancipatory projects for black psychologists in SA and internationally. Such work is not plentiful in Western-centred psychology. While it is evident in the US among some black psychologists, for instance in periodicals like the *Journal of Black Psychology*, there is no profusion of black-centric in SA. Both Biko and Manganyi are important in our thinking and efforts in trying to develop a black psychology reflective of and responsive to SA. What may be worthwhile is for emerging scholars, particularly psychologists, to explicate what a black conscious psychology in SA might look like with a view to contributing to (re)generating an interest in the area and its development for the world.

Conclusion

Mandela aptly said of Biko 'They had to kill him to prolong the life of apartheid' (Mandela 2002). If Biko had not been killed in police custody[19] during his attempt to unite the anti-apartheid liberation movements, the course of SA's chequered history may have been qualitatively different. Perhaps, a progressive nation where ethnicity, racism and corruption would have paled into the insignificance that BC espoused, to be proudly replaced by equity, fairness and equality that unfortunately still evades SA. 'We know today that when in the life of a nation the time comes for an idea, nothing, not even murder, can kill that idea' (ibid.). This 'spark that lit a veld fire across South Africa' (ibid.) requires psychology to rely on BC's nascent contributions to create a vibrant coalescing of Biko's notions to start afresh a journey of self-discovery where all of us, black and white, male and female, in SA and elsewhere, can emancipate ourselves from the shackles of biology, history and circumstance so that we regain our humanity, without rancour or bitterness. Psychology can then truly serve all of humanity.

Notes

1. A key architect of apartheid's horrors, psychologist HF Verwoerd, stated clearly 'There is no place for him [black] in the European community above the level of certain forms of labour' (Verwoerd 1954). 'White' soon replaced the European ascription, but the goal of ensuring that blacks would not aspire beyond the prescribed framework determined by white interests has prevailed. Most often, the black majority tends to know its place; intriguingly, the black voice in psychology may have suffered a similar fate.
2. We define Black, *pace* Biko, as a subjective identification with a greater objective reality where commonality of purpose and vision rise above narrow constructs of biology—specifically melanin pigmentation and hair texture—and other aspects of ascribed culture, such as language and ethnicity. The SASO Policy Manifesto (Biko 2004, p. 52) defined blacks as "those who are by law or tradition politically, economically, and socially discriminated against as a group in the South African society and identifying themselves as a unit in the struggle towards the realisation of their aspirations."
3. R. W. Wilcocks fresh from a Ph.D. obtained in Leipzig, headed the first Psychology Department in SA in 1917, soon after Stellenbosch University was established. H. F. Verwoerd, his protégé, studied in Britain, Germany and the USA, becoming a brutal Prime Minister who is widely regarded as the architect of the apartheid crime against humanity.
4. Former European colonial countries and the United States are a minority in the world.
5. According to Khaya Biko "Steve was expelled for absolutely no reason at all. But in retrospect I welcome the South African government's gesture of exposing a really good politician. I had unsuccessfully tried to get Steve interested in politics. The police were able to do in one day what had eluded me for years. This time the great giant was awakened" (SA History).
6. Biko courted Barney Pityana for the position of SASO President.
7. The accused—officers of SASO and BPC—were Saths Cooper, Muntu kaMyeza, Mosioua Lekota, Pandelani Nefolovhodwe, Nkwenkwe Nkomo, Kaborone Sedibe, Zithulele Cindi, and Strini Moodley. Biko's testimony was ably portrayed by Denzel Washington in Richard Attenborough's movie 'Cry Freedom'.

8. Act No. 83 of 1967.
9. Defence witnesses Rick Turner (a political scientist, who was assassinated by the secret police) and sociologist Fatima Meer and accused Saths Cooper, Aubrey Mokoape and Strini Moodley were banned.
10. Treating of *the other* as a thing or commodity, from the Latin *reus*.
11. *Pace* Biko and BC.
12. In the 1980s, Hussein Bulhan coined the term "Emancipatory Psychology" popularised by Isaac Prilleltensky.
13. In BC parlance "system" could mean many things, viz., the status quo, or apartheid agents especially the notorious Security Police.
14. Latin for nothing.
15. Examples include Black Community Programmes and Zanempilo Clinic where Mamphela Ramphele practiced medicine.
16. As it is in other countries in Africa where psychology is taught and practiced.
17. White females constitute a clear majority in psychology; whites comprise <8.12% of the total population of 55.65m (StatsSA 2016).
18. Former European colonial countries and the United States are a minority in the world.
19. On 12 September 1977 in Pretoria Prison, where the nine SASO/BPC officers were detained from October 1974 till December 1976.

References

Anonymous. (1986). Some thoughts on a more relevant or indigenous counselling psychology in South Africa: Discovering the socio-political context of the oppressed. *Psychology in Society (PINS), 5,* 81–89.

Baldwin, J. A. (1986). African (Black) psychology: Issues and synthesis. *Journal of Black Studies, 16*(3), 235–249.

Biko, S. (2004). *I write what I like: Steve Biko: A selection of his writings* (A. Stubbs, Ed.). Johannesburg: Picador Africa.

Chissano, J. A. (2015, November 12). *16th Steve Biko memorial lecture.* Pretoria: University of South Australia. Retrieved November 10, 2017, from http://www.decodehosting.co.za/biko/index.php/2015/11/30/16th-annual-steve-biko-memorial-lecture-by-his-excellency-joaquim-alberto-chissano/ and on youtube from https://www.youtube.com/watch?v=08fCoZLlSbk.

Karenga, M. (1995). Black psychology. In K. P. Monteiro (Ed.), *Ethnicity and psychology: African-, Asian-, Latino- and Native-American psychologies* (pp. 21–39). Dubuque, IA: Kendall/Hunt.

Mandela, N. (2002). *Tribute to Biko*. https://en.wikipedia.org/wiki/Steve_Biko.

Manganyi, N. C. (1973). *Being black in the world*. Johannesburg: SPRO-CAS/Ravan. Retrieved March 3, 2018, from http://www.sahistory.org.za/sites/default/files/Being_Black_in_the_World_by_Mangayi_0.pdf.

Manganyi, N. C. (1977). *Alienation and the body in racist society: A study of the society that invented Soweto*. New York, NY: NOK.

Millward, D. (2016, December 18). Who was Steve Biko and why is he so important to South Africa? *The Telegraph*. Retrieved November 10, 2017, from http://www.telegraph.co.uk/technology/0/steve-biko-important-south-africa/ and https://www.youtube.com/watch?v=_wjQNuBSTjo.

Nobles, W. W. (2013). Shattered consciousness, fractured identity: Black psychology and the restoration of the African psyche. *Journal of Black Psychology, 39*(3), 232–242.

Qekema, N. (2014). *A talk delivered by Nelvis Qekema at Steve Biko commemoration service organised by Azapo in Atteridgeville on 13 September 2014*. Retrieved November 10, 2017, from http://azapo.org.za/talk-delivered-nelvis-qekema-steve-biko-commemoration-service-organised-azapo-atteridgeville-13-september-2014/.

SA History Online. (2017). *The life of Steve Biko*. Retrieved March 3, 2018, from http://www.sahistory.org.za/archive/ii-life-steve-biko.

SASO-BPC Trial. (1976). *The State vs. Cooper and others*. SA Law Report, 1976(2) 875. Cape Town: Juta. Retrieved from south-african-law-reports-1947-to-date-the-online/.

SBF (Steve Biko Foundation). (2017). Steve Biko Foundation. Retrieved November 10, 2017, from http://www.sbf.org.za/biko/index.php/steve-biko/Johannesburg.

StatsSA. (2016). *Community survey 2016, statistical release P03011 July 2016*. Pretoria: Statistics South Africa. Retrieved November 10, 2017, from http://cs2016.statssa.gov.za/wp-content/uploads/2016/07/NT-30-06-2016-RELEASE-for-CS-2016-_Statistical-releas_1-July-2016.pdf.

Stevens, G. (2015). Black psychology: Resistance, reclamation, and redefinition. In I. Parker (Ed.), *Handbook of critical psychology* (pp. 182–190). London: Routledge.

Verwoerd, H. F. (1954). Minister of Native Affairs, introducing the *Bantu Education Act (No. 47 of 1953)* in Parliament. Cape Town: Republic of South Africa.

Wilson, L. (2012). *Steve Biko*. Athens, OH: Ohio University Press.

Woods, D. (1978). *Biko*. New York and London: Paddington Press.

Part IV

Contemporary Movements

The chapters in this section explore some current movements in the Global South which are basically indigenous but also innovative in being developed in situ and arising usually from community work and outside influences (whether during colonialism or post-colonial), and linking with Western psychiatry and psychology. The systems described in this part of the book indicate ways in which different psychologies may move towards amalgamation, with fusion of Western models with indigenous models leading to health care practices that derive from both Western and non-Western sources.

16

Indigenous Psychologies and Approaches to Well-Being in East Asia

Boon-Ooi Lee

Introduction

The disciplines of psychology and psychiatry (including various schools of psychotherapy) were introduced to East Asia along with Western cultural influences and colonization from nineteenth to twentieth centuries (Bhugra et al. 2015; Hohenshil et al. 2013; Lee 2013; Li 1994; Sato and Sato 2005). The sociopolitical power of biomedicine and psychopharmaceuticals (see Rose 2007) enables psychiatry to secure large public and private funds (see Liu et al. 2011; Roh et al. 2016) to expand its influence by shaping the social discourse of (psychological) 'normality' and 'abnormality' in East Asian societies. The dominance of biomedicine and psychiatry has also marginalized traditional healing practices and beliefs that have long existed in these societies. For example, traditional Chinese medicine (TCM), which once represented the most influential healing tradition in East Asia, has been ironically relegated

B.-O. Lee (✉)
National Institute of Education, Nanyang Technological University, Singapore, Singapore

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_16

to the status of complementary and alternative medicine while the imported Western biomedicine has become the mainstream medical system. In China, due to the shrinking government subsidies, traditional Chinese medical hospitals have to provide Western medical treatments to increase their revenues (Shen et al. 2011).

Although there is an increasing interest in traditional healing practices in East Asia, Western mental health models still occupy the center stage. For example, when examining the effectiveness of acupuncture for depressive-like symptoms (see Chan et al. 2015 for a review), researchers usually defined the symptoms according to the Western diagnostic category of 'major depressive disorder' instead of the TCM concept of '*yu*' (鬱 or constraint; see Ng et al. 2006, 2012; Scheid 2013) by treating the former as a 'real' disease that can be objectively studied in clinical trials whereas the latter as a cultural concept of distress even though both 'major depressive disorder' and '*yu*' are socioculturally constructed. The TCM concepts of meridian system, *qi*, and *yin-yang* underlying the acupunctural treatments have also been reinterpreted from a neurobiological perspective (see Bai and Lao 2013). However, in every form of healing systems (including psychiatry), therapeutic methods are the enactments of their rationales or cultural myths (Frank and Frank 1991), thereby making little sense to study the therapeutic methods (for example, acupuncture) without situating them in their cultural myths (for example, *yin-yang*, *qi*). It is more fruitful to retain the indigenous healing concepts and practices in clinical and research settings because these concepts and practices provide invaluable insights into the ways that ethnocultural groups understand life predicaments, explain and express illness experiences, and cope with adversities.

The aim of this chapter is to explore the contemporary movement for developing indigenous approaches to mental health and well-being in East Asia. This indigenization is an integral part of the movement of indigenous psychologies (IPs), which is currently evident in some parts of East Asia. The movement of IPs might have been propelled by nationalism, anti-colonialism, critical reactions to the cultural generalizability of Western psychological concepts and methodologies, and dissatisfaction with the applications of Western psychology for addressing local problems including mental health issues (Allwood and Berry 2006). By definition, IPs are

> a set of approaches to understanding human behavior within the cultural contexts in which they have developed and are currently displayed. They can also be seen as attempts to root psychological research in the conceptual systems that are indigenous to a culture, including the philosophical, theological, and scientific ideas that are parts of the historical and contemporary lives of people and their institutions. (Berry 2015, p. 59)

Clearly, Western psychology can be conceived as one form of IP because it is embedded in Western worldviews (Yang 2009). The American indigenous psychology is the most influential one as it has influenced the theories and methodologies of psychological and mental health research in other parts of the world including East Asia.

Geopolitically, East Asian countries comprise the Greater China Region (Mainland China, Hong Kong, Macau, and Taiwan), Japan, Republic of Korea (South Korea), Democratic People's Republic of Korea (North Korea), and Mongolia (United Nations 2017). Because research information for IPs and indigenous approaches is only available for some countries, this chapter focuses on China, Taiwan, Japan, and South Korea. To understand the movements of IPs and indigenous approaches to well-being in East Asia, it is important to understand how East Asian people conceptualize well-being.

East Asian Explanatory Models of Well-Being

There are cultural differences in the ways in which people understand, describe and express their illness experiences (Kleinman 1980). *Hwabyung* (火病 or fire-illness), for example, is a Korean idiom of distress characterized by chest pain, suffocating feelings, anger, and fatigue (Lee et al. 2014). *Shenjing shuairuo* (神經衰弱 or weakness of the nervous system) is an idiom of distress among the Chinese people. Common presenting narratives include weakness, fatigue, *fan-nao* (煩惱 or worry) and insomnia (Chang et al. 2005; Kleinman 1982). Rather than seeing these experiences as symptoms of mental illness, it is more useful to place them in a larger context to understand their sociocultural meanings (see Fernando 2002). The high rates of *Hwabyung* in women may

suggest that it is a culturally legitimate channel for women to express emotional distress and resentment in a male-domineering society in South Korea (Suh 2013). Far from being a psychosomatic disorder, the idiom of *shenjing shuairuo* may be an embodiment of the sociopolitical and economic predicaments in Chinese communities (Lee 1998). Nevertheless, more and more Chinese psychiatrists have preferred to use Western psychiatric diagnoses to *shenjing shuairuo* to represent Chinese emotional distress since 1995. This trend reflects the global power of Western psychiatric nosology and its failure to engage cultures in the local system of mental health practices (Lee and Kleinman 2007).

The cultural meanings of *hwabyung* or *shenjing shuairuo* reflect the East Asian indigenous conceptualization of well-being. Both idioms of distress are embedded in the philosophy of TCM, the main East Asian traditional medical system, which views mind and body as mutually constituted.[1] Health condition is the outcome of interplay between various modes of emotion (joy, thinking, anxiety/sorrow, fear, anger, shock) and their respective metaphorical organs (heart, spleen, lungs, kidneys, liver, gallbladder), which are not anatomically compatible with Western biomedicine. Illness experiences (for example, *hwabyung*, *shenjing shuairuo*) arise from the imbalance of processes such as *yin-yang*, the five-ways (metal, wood, water, fire and earth), and *qi*. TCM does not aim to eradicate pathology but to regulate and achieve the homeostasis of these processes. Neither is the excessiveness or the deficiency in *yin-yang* considered desirable. Because mind and body are mutually constituted, they are not separately treated. That is why, unlike biomedicine, there is no specialty or sub-discipline (for example, psychiatry) in the theoretical system of TCM.

Mind and body are also parts of a larger whole consisting of physical and sociocultural environments. Movements and changes in nature (e.g., seasons, weather, and geographic locations) can directly or indirectly influence human mind and body (Wang and Yang 2013). *Qi* occurs in both the internal body and the external environment. Wind, which is a form of negative *qi*, can affect the body and cause illnesses (Lee 2002a). Two approaches can be used to regulate the body and environmental interaction. While acupuncture is used to adjust the flow of *qi* in the internal body, the Chinese geomantic method of *feng-shui* (風水;

Lee 2002b) is used to regulate the flow of *qi* in the external environments such as homes, buildings, and open areas.

Taken together, the East Asian explanatory model of well-being perceives mind and body as mutually constituted, which are in turn parts of a larger whole consisting of physical and sociocultural environments. This holistic approach reflects an implicit model of relational self in East Asian culture, in which the self is *inseparable* from other people, spirits, animals, nonhuman agencies, physical environments, and the cosmic order (see Kirmayer 2007; Markus and Kitayama 1991). The following sections detail how this relational self is reflected in the everyday life experiences of East Asian people, and in their indigenous approaches to well-being.

The East Asian Concept of Relational Self

Yee (2009) observes that even though psychiatric-like concepts were documented in East Asian medical texts, there has been no attempt to classify emotional distress similar to the Western psychiatric nosology. It is not that East Asian people ignore or downplay the importance of emotional well-being, but they mainly address it in the social and ethical relationship rather than in the medical domain per se. For them, well-being is not simply the matter of mind and body but also about cultivating a noble character based on Confucian ethics, maintaining harmonious social relationships, following social expectations, and controlling negative emotions (Lu et al. 2015). In terms of emotional control, East Asian medicine perceives emotional excessiveness or inhibition, rather than emotional expressiveness per se, as pathological. Not only can emotional excessiveness (for example, anger) be harmful to the mind and body, but it can also hurt interpersonal relationships (Lee 2002a).

Since emotional well-being is intertwined with social relationships, East Asian people associate emotional suffering with character and relational deficiency represented in everyday life language, for example, resentment, greed, fear, pride, hatred, jealousy, attachment, or *xin-bing* (心病, heart problems). *Xin-bing* arises when people are too independent

and are not being integrated into social groups (Kolstad and Gjesvik 2014). However, the need for establishing harmonious relationships may heighten the East Asians' sensitivity to interpersonal relationships, and as a result, they may become more prone to social anxiety and interpersonal conflicts (Norasakkunkit and Kalick 2002). For example, Japanese people may develop *taijin kyofusho* (対人恐怖症), stemming from the fear of offending and embarrassing others. Common presenting narratives include the anxieties of blushing, maintaining eye contact, having deformed body, and having foul bodily odor (Suzuki et al. 2003). Because it is a cultural form of social anxiety, people who are orientated toward interdependent self-construal are more likely to develop *taijin kyofusho* (Zhou et al. 2014).

Since emotional suffering is not construed as an illness but as a relational issue, it can be regulated through personal cultivation and the maintenance of harmonious relationships based on the Confucian principles of *ren* (仁, benevolence), *yi* (義, righteousness), and *li* (禮, propriety) (Sun 2012). The essence of this relationship is similar to the way of treating internal illnesses through balance and moderation. As mentioned earlier, emotional control and moderation is not only important for a balanced mind and body but it is also essential for a harmonious social relationship.

In summary, the East Asian view of relational self is centered on the interplays of well-being, social relationships, and the environments. This notion of relational self is embedded in several indigenous approaches based on Confucianism, Buddhism, and Taoism.

East Asian Indigenous Approaches to Well-Being

Although not solely based on ancient Confucian principles, a therapeutic approach that focuses on the East Asian relational self has been developed in Taiwan (Lee 2007; Yee 2009). This approach, which is called ethical care (倫理治療), 'emphasizes people's suffering in their interpersonal predicaments and, therefore, finding ways to *re-order* the interpersonal constellations in which the suffering ones are situated' (Lee 2007, p. 48; emphasis added). The term 'ethical' does not mean the normative

ethics that define right and wrong behaviors in a social process, for example, the Confucian principle of Five Cardinal Relationships (see Sun 2012). Paradoxically, such normative ethics may indeed give rise to interpersonal conflicts that prompt people to look for other avenues to indirectly reorder their interpersonal relationships. Reordering of interpersonal relationships is fundamental to human ethics, as well as an essential focus in ethical care. When facing interpersonal conflicts, rather than confrontation, East Asian people may choose to avoid the conflicts by refocusing on personal cultivation, or by seeking help from another person or a psychotherapist (Lee 2007). The healing process does not focus on psychopathology or internal psychological attributes but on the interpersonal contexts in which the person lives in. The therapist–client encounter is an essential part of the client's interpersonal context, which may either facilitate or prohibit his or her healing experience. Clients learn to reorder their dysfunctional relationships through their encounters with their therapists. However, W. L. Lee (2007) is not clear on how this "reordering of interpersonal relationships" is exactly carried out in therapy. It may be a cultural enactment of transference or countertransference situated in a Confucian ethical context.

Ethical care, as an indigenous approach, may be germane to contemporary East Asian societies in which social relationships that have been previously regulated by Confucian principles are disrupted due to changes in traditional values.[2] However, in circumstances where interpersonal conflicts are beyond reconciliation, East Asian people may choose to liberalize themselves from the relational impasse. They may pursue the state of detachment and transcendence by resorting to Buddhist, Taoist or Shinto teaching, similar to existential approaches in Western psychotherapy (Yee 2009). For example, they may view their current interpersonal conflicts as unresolved issues carried over from previous lives. Instead of dwelling on the conflicts or confronting the opponents, they may accept the conflicting situations to cease the affinity, for any further confrontation would only continue and reinforce the negative *karma*.

Similar to Confucianism, Buddhism has shaped the East Asian ways of healing. One of the branches of Buddhism, *Chan* or *Zen* (禪宗), has influenced the development of Korean *Onmeum* counseling (온마음상담), and the Japanese *Morita* (森田療法) and *Naikan* (内觀療法) therapies.

Onmeum counseling proposes that people develop problems in life because they are stuck in their past beliefs (Lee and Yang 2013). This approach aims to help people to become more aware of how their perceptions of themselves, other people, and life events are related to their current problems. By learning to let go of these attachments and illusory realities, adopting alternative perspectives, and focusing on the here-and-now experiences, they can discover their true selves and then move on in life.

In *Morita* therapy (Tanaka-Matsumi 2004), clients are taught to follow a natural life path, and to immerse themselves in current life experiences consistent with the present-focus in Buddhism. This form of therapy consists of four stages. At stage one, clients stay in bed over a few days to control their negative thoughts and feelings. At stage two, they focus on physical actions by engaging in simple activities. At stage three, they increase their activity levels by doing house chores, and develop personal interests. At the final stage, with the inner awareness and positive mind-set they have cultivated from previous stages, they embark on more complex activities to prepare them for returning to actual life environments.

In *Naikan* therapy, clients reflect on their relationships with significant others (Tanaka-Matsumi 2004). This self-reflection takes the form of repentance about how much people have taken for granted the love and care from their significant others. Although they are unable to change their past relationships, they can change their views about their past. However, the approach of *Naikan* is more than the cognitive restructuring of cognitive-behavioral therapy. *Naikan* therapy aims to help clients to cultivate a relational self in terms of character development, penance, expressing one's guilt, and reshaping one's relationship with others. Clients learn to confess their social misdeeds to their therapists, peer groups, and significant others.

Philosophical Taoism is another East Asian tradition that has inspired the development of indigenous approaches. Unlike Confucianism, Taoism does not define the self in terms of social relationships, but as an extension of the cosmos, leading ultimately to a sense of selflessness (Ho 1998). Thus, Taoism rejects the Confucian principles of social propriety and hierarchical relationism. The only way to attain happiness

is by leading a simple life in harmony with Nature, and by liberalizing oneself from the pursuit of fame and fortune (Sun 2012). However, the epistemological difference between Confucianism and Taoism does not result in cognitive dissonance in ordinary East Asian people who have embraced both philosophical teachings. They follow the Confucian principles to guide their day-to-day social relationships but employ Taoist ideas for coping with life issues (Zhang and Young 1997).

The philosophy of Taoism has influenced the development of Chinese Taoist Cognitive Psychotherapy (CTCP) in China, and Tao Psychotherapy in South Korea. CTCP consists of five stages: identifying stressors, evaluating beliefs and value systems, examining the conflicts and coping styles, teaching of doctrines, and evaluating and maintaining the therapeutic effects (Cao et al. 2018). These stages resemble cognitive therapy but are infused with East Asian cultural values whereby the clients are taught the Taoist doctrines to cope with emotional distress.

The aim of Tao Psychotherapy is to focus on the therapist's personal cultivation; to foster a therapeutic relationship based on *metta* (loving kindness), *karuna* (compassion), *mudita* (joyous sympathy), and *upekkha* (equanimity); to elicit the client's 'nuclear feeling' (a psychological resource originating in childhood); and to approach client's issues with compassion and genuineness rather than with intellectual interpretations (Craig 2007). The theory of Tao Psychotherapy is derived from a combination of the Western depth psychotherapy, and Taoist and Buddhist teaching. The Taoist and Buddhist teaching is used to evoke experience and awareness leading to liberation from psychological suffering.

In summary, these East Asian indigenous approaches propose that, when working with Asian clients, the focus of therapy should move from psychological disorders to social dis-orders or transcendent liberation based on Confucian, Taoist, and Buddhist philosophies.

Conclusions

The East Asian IPs have been developed in reaction to the dominance of Western psychology and psychiatry. The movement has led to many fruitful research and ideas about the cultural aspects of psychology and

mental health. Despite these achievements, there are some limitations and challenges in the indigenization of psychology and mental health approaches in East Asia. First, Yee (2009) argues that the main reason for developing indigenous approaches is the incompatibility between the Western psychotherapeutic concepts and the everyday life experiences of East Asian people. However, he did not support his observation with empirical data. Since very few clinical trials have been conducted with East Asian clients in East Asian countries, it remains unknown whether or not Western psychotherapy is applicable to East Asian clients.

Whether those indigenous approaches presented here are effective with East Asian clients also remains unknown due to the paucity of empirical data. To date, only a few studies have been conducted to evaluate the efficacy of CTCP (Cao et al. 2018), *Morita* therapy and *Naikan* therapy (Liao et al. 2016; Zhang et al. 2014). Furthermore, not all contemporary East Asian people are receptive to traditional philosophical ideas, and not all ideas in traditional philosophies are relevant to contemporary societies due to globalization, Westernization, and multiculturalism. In China, younger people, particularly women, have become more financially independent. This change in social roles has redefined the patriarchal authority as a resource allocator in traditional Confucian society, thereby enhancing the women's social positions (Sun 2012). Richey (2015, p. 182) questions how, over time, Confucian ideology would be suited to 'an East Asia defined less by robes of state and more by Paris and Hollywood couture… In the postmodern era, it still is possible to be "traditional", but participation in tradition has, paradoxically, become a personal choice rather than an ancestral mandate, as it generally was in premodern times.' Thus, approaches that are embedded in Confucianism may not be acceptable by all East Asian people. Similarly, East Asian people who subscribe to Christianity and Islam may not be receptive to approaches that are based on Buddhist or Taoist doctrines. Thus, any attempts in indigenizing psychotherapeutic approaches must take into consideration the impacts of multiculturalism and globalization. Hence, more research should be conducted on the effectiveness and efficacy of Western and indigenous approaches with East Asian clients.

In conclusion, the movement of indigenous approaches to well-being has reflected how local people have become more aware of their cultural identities and strengths. Smith (2006) proposes that all personal strengths are culturally based because individual psychology cannot be divorced from its sociocultural and historical contexts. The cultural strengths lie in traditional value systems, social institutions, and indigenous healing systems that have existed long before the import of Western mental health practices. East Asian people draw on these cultural strengths to guide their behaviors and to cope with life adversities. Hence, it is germane to incorporate these cultural strengths into the mental health care.

Notes

1. Since the Japanese and South Korean traditional medicines originated from TCM, they all share a similar theoretical framework (Park et al. 2012; Yu et al. 2017). The subsequent discussion on TCM is therefore also applicable to these East Asian traditional medicines to some extent.
2. Traditional social and value systems have been essential resources for social supports in East Asia. However, rapid economic developments and urbanization have diluted the collectivistic value system, including the value of filial piety and extended family systems (Cheng et al. 2015; Grabosky et al. 2013; Lim and Lim 2013).

References

Allwood, C. M., & Berry, J. (2006). Origins and development of indigenous psychologies: An international analysis. *International Journal of Psychology, 41,* 243–268.

Bai, L., & Lao, L. (2013). Neurobiological foundations of acupuncture: The relevance and future prospect based on neuroimaging evidence. *Evidence-Based Complementary and Alternative Medicine: eCAM*, *2013*, 812568. http://doi.org/10.1155/2013/812568. Retrieved March 2, 2018, from https://www.hindawi.com/journals/ecam/2013/812568/.

Berry, J. W. (2015). Global psychology: Implications for cross-cultural research and management. *Cross Cultural Management, 22*(3), 342–355.

Bhugra, D., Tse, S., Ng, R., & Takei, N. (Eds.). (2015). *Routledge handbook of psychiatry in Asia*. Abingdon: Routledge Handbooks Online.

Cao, Y. P., Zeng, J., & Zhang, Y. L. (2018). Chinese Taoist cognitive psychotherapy. In R. Moodley, T. Lo, & N. Zhu (Eds.), *Asian healing traditions in counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Chan, Y., Lo, W., Yang, S., Chen, Y., & Lin, J. (2015, May 1). The benefit of combined acupuncture and antidepressant medication for depression: A systematic review and meta-analysis. *Journal of Affective Disorders, 176*, 106–117.

Chang, D., Myers, H., Yeung, A., Zhang, Y., Zhao, J., & Yu, S. (2005). Shenjing Shuairuo and the DSM-IV: Diagnosis, distress, and disability in a Chinese primary care setting. *Transcultural Psychiatry, 42*(2), 204–218.

Cheng, K. D., Lin, Y. C., Chen, C. C., & Shen, W. W. (2015). The care of the mentally ill in Taiwan. In D. Bhugra, S. Tse, R. Ng, & N. Takei (Eds.), *Routledge handbook of psychiatry in Asia*. London: Routledge.

Craig, E. (2007). Tao psychotherapy: Introducing a new approach to humanistic practice. *The Humanistic Psychologist, 35*(2), 109–133.

Fernando, S. (2002). *Mental health, race and culture* (2nd ed.). Basingstoke and New York: Palgrave.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: John Hopkins University.

Grabosky, T. K., Ishii, H., & Mase, S. (2013). Counseling in Japan. In T. H. Hohenshil, N. E. Amundson, & S. G. Niles (Eds.), *Counseling around the world: An international handbook*. Alexandria: American Counseling Association.

Ho, D. F. (1998). Indigenous psychologies: Asian perspectives. *Journal of Cross-Cultural Psychology, 29*(1), 88–103.

Hohenshil, T. H., Amundson, N. E., & Niles, S. G. (2013). *Counseling around the world: An international handbook*. Alexandria: American Counseling Association.

Kirmayer, L. J. (2007). Psychotherapy and the cultural concept of the person. *Transcultural Psychiatry, 44*(2), 232–257.

Kleinman, A. (1980). *Patients and healers in the context of culture*. Los Angeles: University of California Press.

Kleinman, A. (1982). Neurasthenia and depression: A study of somatization and culture in China. *Culture, Medicine and Psychiatry, 6*(2), 117–190.

Kolstad, A., & Gjesvik, N. (2014). Collectivism, individualism, and pragmatism in China: Implications for perceptions of mental health. *Transcultural Psychiatry, 51*(2), 264–285.

Lee, B. O. (2002a). Psychotherapy in Chinese medicine: A theoretical review. In A. G. Tan & M. Goh (Eds.), *Psychology in Singapore: Issue of an emerging discipline*. Singapore: McGraw-Hill.

Lee, B. O. (2002b). Chinese indigenous psychotherapies in Singapore. *Counseling and Psychotherapy Research, 2*(1), 2–10.

Lee, J., Wachholtz, A., & Choi, K. H. (2014). A review of the Korean cultural syndrome Hwa-Byung: Suggestions for theory and intervention. *Journal of Asia Pacific Counseling, 4*(1), 49–64.

Lee, S. (1998). Estranged bodies, simulated harmony, and misplaced cultures: Neurasthenia in contemporary Chinese society. *Psychosomatic Medicine, 60*(4), 448–457.

Lee, S., & Kleinman, A. (2007). Are somatoform disorders changing with time? The case of neurasthenia in China. *Psychosomatic Medicine, 69*(9), 846–849.

Lee, S. M., & Yang, E. (2013). Counseling in South Korea. In T. H. Hohenshil, N. E. Amundson, & S. G. Niles (Eds.), *Counseling around the world: An international handbook*. Alexandria: American Counseling Association.

Lee, W. L. (2007). Contacting and enacting "self for being ethical": A model for psychotherapy practiced in Taiwan. In C. F. Cheung & C. C. Yu (Eds.), *Phenomenology 2005, vol. I: Selected essays from Asia*. Bucharest: Zeta Books.

Lee, Y. (2013). Psychology in Korea: Historical development, current status, and future prospects. In E. Witruk & A. Wilcke (Eds.), *Historical and cross-cultural aspects of psychology*. Frankfurt am Main: Peter Lang.

Li, M. (1994). Psychology in China: A brief historical review. *Journal of Psychology, 128*(3), 281–287.

Liao, L., Zhu, M., Shen, X., Zhang, L., Li, W., Tang, L., et al. (2016). An open trial of modified Naikan therapy to patients with schizophrenia. *Chinese Journal of Clinical Psychology, 24,* 182–184.

Lim, B. K., & Lim, S. L. (2013). Counseling in China. In T. H. Hohenshil, N. E. Amundson, & S. G. Niles (Eds.), *Counseling around the world: An international handbook*. Alexandria: American Counseling Association.

Liu, J., Ma, H., He, Y. L., Xie, B., Xu, Y. F., Tang, H. Y., et al. (2011). Mental health system in China: History, recent service reform and future challenges. *World Psychiatry, 10,* 210–216.

Lu, X., Chauhan, A., & Campbell, C. (2015). Representations of mental health among middle-aged urban Chinese men. *Journal of Community & Applied Social Psychology, 25*(5), 384–399.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review, 98,* 224–253.

Ng, S., Chan, C., Ho, D., Wong, Y., & Ho, R. (2006). Stagnation as a distinct clinical syndrome: Comparing 'yu' (stagnation) in traditional Chinese medicine with depression. *British Journal of Social Work, 36*(3), 467–484.

Ng, S., Fong, T., Wang, X., & Wang, Y. (2012). Confirmatory factor analysis of the stagnation scale—A traditional Chinese medicine construct operationalized for mental health practice. *International Journal of Behavioral Medicine, 19*(2), 228–233.

Norasakkunkit, V., & Kalick, S. M. (2002). Culture, ethnicity, and emotional distress measures: The role of self-construal and self-enhancement. *Journal of Cross-Cultural Psychology, 33*(1), 56–70.

Park, H. L., Lee, H. S., Shin, B. C., Liu, J. P., Shang, Q. H., Yamashita, H., et al. (2012). Traditional medicine in China, Korea, and Japan: A brief introduction and comparison. *Evidence-Based Complementary & Alternative Medicine: eCAM, 2012,* 1–9. https://doi.org/10.1155/2012/429103.

Richey, J. L. (2015). Society and culture: Confucianism in East Asia today. In A. Prescott (Ed.), *East Asia in the world*. New York: Routledge.

Roh, S., Lee, S. U., Soh, M., Ryu, V., Kim, H., Jang, J. W., et al. (2016). Mental health services and R&D in South Korea. *International Journal of Mental Health Systems, 10,* 45. https://doi.org/10.1186/s13033-016-0077-3.

Rose, N. (2007). *The politics of life itself: Biomedicine, power, and subjectivity in the twenty-first century*. Princeton, NJ: Princeton University Press.

Sato, T., & Sato, T. (2005). The early 20th century: Shaping the discipline of psychology in Japan. *Japanese Psychological Research, 47*(2), 52–62.

Scheid, V. (2013). Depression, constraint, and the liver: (Dis)assembling the treatment of emotion-related disorders in Chinese medicine. *Culture, Medicine and Psychiatry, 37*(1), 30–58.

Shen, J., Wang, Y., Lin, F., Lu, J., Moseley, C. B., Sun, M., et al. (2011). Trends of increase in western medical services in traditional medicine hospitals in China. *BMS Health Services Research, 11,* 212.

Smith, E. J. (2006). The strength-based counselling model. *The Counseling Psychologist, 34,* 13–79.

Suh, S. (2013). Stories to be told: Korean doctors between hwa-byung (fire-illness) and depression, 1970–2011. *Culture, Medicine and Psychiatry, 37*(1), 81–104.

Sun, C. T. L. (2012). *Themes in Chinese psychology* (2nd ed.). Singapore: Cengage Learning.

Suzuki, K., Takei, N., Kawai, M., Minabe, Y., & Mori, N. (2003). Is taijin kyofusho a culture-bound syndrome? *The American Journal of Psychiatry, 160*(7), 1358. Retrieved January 7, 2018, from https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.160.7.1358.

Tanaka-Matsumi, J. (2004). Japanese forms of psychotherapy: Naikan therapy and morita therapy. In U. P. Gielen, J. M. Fish, & J. G. Draguns (Eds.), *Handbook of culture, therapy, and healing*. Mahwah, NJ: Lawrence Erlbaum Associates.

United Nations. (2017). *World population prospects: The 2017 revision* [online]. Retrieved January 7, 2018, from https://esa.un.org/unpd/wpp/publications/Files/WPP2017_DataBooklet.pdf.

Wang, K. Q., & Yang, Q. L. (2013). *Fundaments of traditional Chinese medicine psychology*. Beijing: People's Publisher.

Yang, K. S. (2009). The purpose and development of indigenous psychologies. In K. S. Yang, K. K. Hwang, & C. F. Yang (Eds.), *Chinese indigenized psychology*. Taipei: Yuan Liu.

Yee, D. H. (2009). Indigenized psychotherapy. In K. S. Yang, K. K. Hwang, & C. F. Yang (Eds.), *Chinese indigenized psychology*. Taipei: Yuan Liu.

Yu, W., Ma, M., Chen, X., Min, J., Li, L., Zheng, Y., et al. (2017). Traditional Chinese medicine and constitutional medicine in China, Japan and Korea: A comparative study. *American Journal of Chinese Medicine, 45*(1), 1–12.

Zhang, Y., & Young, D. (1997). Lao-Zhuang's philosophy and modern cognitive psychotherapy. *Medicine and Philosophy* (Suppl.), 103–105.

Zhang, Q., Yuan, Y., Ren, Q., & Lu, Y. (2014). A randomized single-blind controlled trial of combination of Naikan and Morita therapy (NMT) in patients with generalized anxiety. *Chinese Mental Health Journal, 28*(9), 651–656.

Zhou, B., Lacroix, F., Sasaki, J., Peng, Y., Wang, X., & Ryder, A. (2014). Unpacking cultural variations in social anxiety and the offensive-type of Taijin Kyofusho through the indirect effects of intolerance of uncertainty and self-construals. *Journal of Cross-Cultural Psychology, 45*(10), 1561–1578.

17

From Denial to Collaboration: Reflections on Shamanism and Psychiatry Based on a Case Study in Chile

Ana Maria Oyarce

> Illness in general and mental disturbances in particular must be understood as a product of the complex set of social determinations to which individuals are subjected according to the different levels of identity and social belonging that correspond to them according to the position they occupy in the social system. (Madariaga 2018, p. 20)

Background of the Mapuche People

The Mapuche people constitute one of the most numerous indigenous populations of the continent; being distributed in regions VIII, IX, X, XI, XII and metropolitan in Chile, as well as in the provinces of Neuquén, Río Negro, Tierra del Fuego, Chubut, Santa Cruz, La Pampa and Buenos Aires in Argentina (Cuyul 2008). They form a human group with common definable characteristics derived from a

A. M. Oyarce (✉)
University of Chile, Santiago, Chile

© The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_17

cultural substratum that is its own, with cumulative knowledge transmitted orally, and forming a social unit of biological, social and cultural transmission. The configuration as an indigenous people is born and is evidenced historically influenced by the Spanish invasion and then co-existing with Chilean and Argentinean societies.

In Chile, the Mapuche population is nearly 4% of the national population and about 87.7% of the total indigenous population of Chile. In the Araucanía, the Mapuche population constitutes 39.6% out of the total. Currently, the Mapuche communities are more or less extensive territorial units, which have a multiple network of ties of kinship, neighborhood, and friendship. These relationships define a series of mutual economic and social obligations between families and individuals (Cuyul 2008). There is an integral conception of the social and cultural, material and immaterial bonds that are based on the *mapu* (earth), being in this material and symbolic space of sociocultural reproduction, where the collective identity emerges and is based. This Mapuche identity, despite the territorial differences and the characteristics of each settlement, is based on an ethical norm of behavior and customs called *Az Mapu* (Cuyul 2008; Quidel 2001).

New Perspectives on Shamanism and Mental Health

Shamanism is a term which is often used loosely to refer to many different phenomena, some of which bear little relationship to one another or to any original derivation. Most writers state, however, that shamanism refers to a range of specialist religious activity and various forms of ecstatic behavior existing within many different religious and cultural contexts (Bowie 2000). A broader definition states that shamanism is not a simple, unified religion but a cross-cultural form of religious sensibility and practice (Vitebesky 2001).

Central to any definitions of shamanism is the ability to control the spirits, which inhabit the seen and unseen worlds; and which affect the life, health, and fertility of the world. Healing cannot take place until

the shaman has managed to domesticate a number of spirit helpers. The shaman's healing role is both preventive and curative, and depends on a view of the world, which holds that spirits are responsible for much of the good and bad fortune, which can happen to individuals and society (Lewis 1989).

Shamanism has been widely studied from different theoretical perspectives, which have followed three main philosophical positions: scientism, psychoanalysis, and Marxism (Glazier 1997). One common theme emphasized among the different theoretical perspectives is the fact that shamans and shamanic practices are interpreted in terms of (Western) psychiatric psychopathology (Kroeber 1952; Deveraux 1963). Other writers, using a scientific positivist model have suggested that shamans are mentally ill because of presumed 'delusions', namely their belief in seeing and dealing with spirits (Silverman 1967).

The literature on shamanism and spirit possession has changed directions in the past twenty years; the concern for behavioral and psychological rationalization has shifted to issues of local contexts, cultural logics, human imagination, and creativity. According to Boddy (1994) rationalist reduction was a humanizing enterprise, and attempt to render familiar what has seemed to be strange. However, this theorizing is insufficient to take into account the complexity and cultural specificity in shamanism phenomena.

In the last two decades there has been a gradual inclusion of shamanism, possession and trance into broader spheres of human endeavor, such as issues of selfhood and identity, challenging global political and economic domination, and articulating aesthetic of human relationship to the world (Boddy 1994). Studies that follow this perspective have shown that shamanism and possession are expressions not only of religion, but also of morality, kinship, ethnicity, history, and social memory (Boddy 1994). In these studies, shamanism, morality, and resistance are interlinked as expression of personal agency within contexts of ethnic revitalization and nationalistic political struggles (Lambeck 1989; among others).

From this stance, studies which explore the association between shamanism, religion, and mental illness have taken a more fruitful perspective emphasizing that shamanism and spirit possession can be

understood as a successful adaptive response by ¨normal¨ individuals to particular stressful situations (Crapanzano 1973, 1980; Crapanzano and Garrison 1977). These studies reflect a decline of disease-oriented interpretations of shamanism and a shift towards more context-oriented accounts. These writers do not limit possession to a form of religious behavior and refuse to use Western category at all. For them, what is important is to understand the multiple significance of possession within the particular contexts in which occurs. For Crapanzano, possession is an idiom of communication, in this sense, the key issue is to consider how the idiom is constructed and used in specific societies. Moreover, possession as an idiom requires acknowledgment of the existence of spirits in the believer's world and asserts that possession is about meaning.

Obeyesekere (1981) studies Sri Lankan ascetics possessed by ghost and deities in the Hindu Buddhist pantheon. He shows that—through the spirit idiom—subordinate women have capacity to enable personal growth by using cultural symbols. Obeyesekere's sensible analysis to local concerns demonstrates the potential congruity of psychoanalytic and religious interpretations. The approach taken by Crapanzano (1973) and Obeyesekere (1981) to the study of spirit possession allows the discipline of anthropology to move beyond positivists' approaches (like functionalism and structuralism) toward cultural interpretation. Both Crapanzano and Obeyesekere focus on those who are clearly troubled. A special point in their studies is the question about the ethnopsychological validity of notions such as the presumed bounded of the self.

In a similar vein, Lambeck (1989) critiques the literature on possession which decontextualizes possession and attempts to correlate it with mental illness. According to Lambeck, spirit possession is a whole social complex from which we cannot isolate trance without risk of naturalizing and reifying it. He proposes that both possession and trance should be considered in an open-ended discourse, which operates in the personal, interpersonal, and public domains, constructing multiple and overlapping meanings. More than being an idiom to communicate personal experience, Lambeck suggests that possession and trance provide means and procedures that contributes

to an ongoing, historically located process constituting the self and subjectivity. Using this framework, he regards Mayotee possession as a complex semi-independent cultural domain that lacks direct equivalent in the Euro American West and one that should not be reduced to naturalized Western forms such as religion or psychopathology. In Mayotte, possession raises issues of power and morality. Interestingly, Lambeck—following Crapanzano—argues that spirits are social beings who interact with their host's families not just during public ceremonies, but in everyday domestic life as well. Moreover, they enrich and modulate human relationships in numerous cultural domains including medicine and religion, but are themselves reducible to none.

Regarding possession and mental illness, Lambeck argues that possession is often spoken of in a medical idiom, but it cannot be assumed that trance or possession are more or less direct manifestation of disease or illness. In these medical-centered approaches, spirit possession becomes the social label or theory of the illness and/or the mode of therapy. He argues that writers who follow the (Western) psychiatric approach are often not able to distinguish clearly which elements of the 'cult' are manifestation of illness and which are forms of therapy. Moreover, the underlying assumption is that illness is a necessary condition for participation in the activity. He points out that it is true that in many instances trance may be linked to illness and that it may be an idiom through which illness is expressed or resolved, but the relation between trance and illness is by no means necessary or straightforward. In Mayotee people illness is not the only thing expressed in trance, and according to him, illness and trance inform rather than determine each other.

Lambeck suggests that possession and trance must be considered as social and human activities that are culturally constructed. This approach allows an understanding of what is valuable about any particular case and about the diversity of trance phenomena between and with particular societies, synchronically or diachronically. Within this framework, there is analytical room for a degree of freedom and the individual is not only a victim of natural forces, neither possession is a purely instrumental and individual strategy.

Shamanism, Psychiatry and Individuals

Most of the anthropological literature on shamanism has focused on shamans as religious specialists and/or political leaders. These studies have emphasized the social or collective dimension of the shaman role, ignoring how the individuals concerned experience and live their roles and culture. In addition, some studies have portrayed 'successful' shamanic activity without taking into account individual variation or unsuccessful careers. According to the literature, no anyone can be a shaman because it involves the difficult task and ability to control the spirits. Not all those seeking spirit help would finally succeed in becoming shamans. However, this is not the full story. The only two cases described in the literature regarding unsuccessful shaman role (Wolf 1990; Bacigaluppo 1994) reveal the complex dilemmas between shamans and spirits, tradition and modernity, collective constraints and personal agency, local communities, and global forces.

As an anthropologist working in the health sector, the author has been concerned to observe that a significant number of Mapuche women hospitalized in psychiatric services refer to their illnesses as spirits that they cannot domesticate and control because of lack of economic and social support, and ethnic conflicts. As a result there has developed an interest in bridging Western and non-Western approaches to shamanism and possession-trance phenomenon on the one hand, with a broad conceptual framework on the other, in order to understand the personal suffering of individuals, especially with regard to shaman or novice suffering. The aim is to use this knowledge to inform physicians who have been trained in the scientific and naturalistic Cartesian biomedical paradigm—and these are the people who have the political and social power to deal with human suffering. Thus, as a result of working in the field of health care and having a background in anthropology, the author has developed a system of viewing shaman's experiences and behavior through a phenomenological perspective—a framework that is useful for understanding people who don't want to be shamans or people who abandon the role.

Case-Study[1]

Ana (not the real name) is a forty-five-year-old indigenous Mapuche rural woman, who grew up in a rural community, and is married to a non-indigenous man. She has two children and lives in a small community in the Ninth Region of Chile. The author met her in 1997 when a psychiatrist referred her to an anthropologist because he thought that Ana's cultural background was a key issue in her 'disease'. As in other case studies, the author tried to gain a deeper understanding by working with a Mapuche health worker. Ana's life story was gathered in 1997 through interviews in the native language conducted by the Mapuche health worker and the author in the psychiatric service section of the regional hospital (Hospital de Temuco). Ana was in full agreement to work together with the author and health worker in order to alleviate her suffering. Also, she agreed that her story may be communicated to psychiatrists and others so that they could learn to understand her problems more fully. More recently, the Mapuche health worker has been to visit Ana at her home in the community and talked with her in her native language. The author worked with the psychiatrist reviewing the clinical record, and the summary of this data is presented in Table 17.1.

Table 17.1 Mapuche culture and psychiatric nosology

Mapuche culture	Psychiatric nosology
Machi kutran, more than an illness	Neurosis
It's a religious vocation sign	Psychosis maniac depressive Bipolar disorder
Delivery spirit's message and prayer	Over talkative
Sadness and suffering	Crepuscular state
'They hurt me because my spirit is very strong'	Paranoid
'I have to set up my rewe' (sacred three)	Maniac
'I have to be shaman'	Delusions
'I felt something like burning in my back'	Sensory hallucinations
'I have to play my kultrung (drum)'	Delirious
'I have to save Mapuche people'	
'I have been chosen by god'	

Ana Story (Obtained in 1997 Through Personal Interviews with the Author)

During childhood, Ana was exceptionally close to her *pelom* (a diviner) grandaunt, who lived in a special place with plenty of sacred plants used in rituals and healing (*Foye*, *triwe* and *maki*). Also living in this place were spirits and forces, which adopted human and non-human forms. When Ana was nine years old, her grandaunt predicted that she would be a shaman, despite her father who did not like Mapuche traditions. Ana was a shepherd on her grandaunt's sacred place land. When she was twelve years old, her father—against tradition and pushed by poverty—burned down the vegetation on this land in order to cultivate food crops and keep domestic animals in this space. One day, when Ana was taking care of the pigs, she felt a burning sensation in her back, with a great deal of pain and heat. Although she had no physical sign on her back, the burning sensation was intense, and she went to a *machi* (shaman), who was her father's cousin. According to this shaman, the feeling and pain that Ana suffered from were signs of the Mapuche illness *machi kutran*, which is caused by spirits trying to make her shamanic vocation known. She was treated with special plants, which helped her recover for a while.

However, Ana did not want to become a *machi*. Rejecting her calling, she went to the capital city Santiago, far away from her native land. In Santiago, she felt that she did not want to be Mapuche; she cut her traditional long hair, wore make-up and dressed as a 'Chilean woman' might do. Also, she stopped speaking in her native language. After working for a few months as a maid, Ana became sick with headaches, stomach-aches, and convulsions ('attacks'). And, being unable to work, she came back to the community. As her illness was getting worse, Ana went to the hospital in Temuco (the regional capital city). She had treatment there but her sickness continued, and she had problems eating, sleeping, and working. When Ana was in her twenties, she decided to see a second shaman.

The second shaman too diagnosed Ana's suffering and illness as indicating clear signs of a shamanic calling. Ana then agreed to be trained as a shaman. She started dressing in the traditional clothing

known as *kupam* and *ikilla*. She was poor and economically dependent on her brothers, although they had agreed that she should become a shaman, they did not have the money to support her training. When Ana had to leave the shaman's house, she brought with her some herbal medicine, which she took at home. She felt suspicious about this medicine, but drank it and 'became crazy'—anxious, shaking, and running in an uncontrolled fashion. She told the author that four people had to constrain her, and to take her to the hospital. When she felt a little better, she went to a third shaman who told her that the second shaman had been poisoning her because she felt envious that Ana had a more powerful spirit than she had.

Feeling better, Ana went to Temuco to work, but she felt sick again with stomach-aches, dizziness, and headache. Finally, when she had convulsions ('attack') and lost consciousness, her boss took her to the hospital. She went back to her community, and sought a male shaman who agreed with the previous traditional diagnoses of *machi kutran* (shamanic power). Again, Ana could not undergo training for lack of money. Ana said that her aunt *machi* (father's cousin) had a *machi pewma* (shamanic dream) in which she saw a sacred tree burning, and from the flames of the fire, a bull coming out with its back burned. The shaman said that Ana has *kawa kawa*-the power of the bull. Ana remembered that she had become 'sicker and sicker' from about the age of twenty-one, with great anxiety, distress, and loss of energy, head and stomachaches, attacks, convulsions, and period of unconsciousness. In her thirties, she became engaged to a Chilean man, a 'huaso' (traditional non indigenous farmer). She went to live with him in his land, and after her second child was born, she married the man.

In the five years before the author met her, Ana had suffered from headaches, stomachaches, anxiety, attacks, and loss of consciousness related to spirit possession. Ana felt that her life was miserable and that she was unable to work and take care of the children. In October 1997, she fell sick again, with sleep disturbances, loss of appetite, loss of energy, headaches; when the bull spirit possessed her, her husband took her to the hospital. She said that her illness gets worse during spring because the sacred plants are just coming up at that time and the *kopiwe*—a Mapuche sacred flower—is in bloom. In addition,

Ana told us that since she was married, she faced marital problems because not only did her husband reject all the Mapuche beliefs, but also he had been involved with another Chilean women. Ana told us that they separated for two years, during this time she lived with her mother and she acknowledged that she felt much better. But the husband convinced her to come back to him, which made Ana's mother and brother become upset with her.

During the interview in 1997, Ana said that her illness existed because she has *machi* power. She thought that the hospital treatment was good as a temporary relief, but she knows that she will become sick again. She said that the only cure was to become a *machi* and have her own sacred space to cure people—a *rewe*. But her husband denied this and Ana was economically dependent on him. Also, she noted that a shamanic vocation requires a great deal of effort, and she did not have social support from her original community. In addition since her children are young, she said she was waiting for a while before pursuing her vocation.

The Mapuche Point of View

According to the Mapuche health worker who works as cultural broker in cross-cultural health programs ('Programa de Salud con Población Mapuche. Servicio de Salud Araucanía Sur') Ana's patrilineal lineage is extremely powerful, the power being expressed through two relatives, namely her father's aunt who is a *pelom*, and her father's cousin, a *machi*. Inherited power explains much of Ana's symptoms in a kind of differential diagnosis for Mapuche people. Ana's power is caused by *kawa kawa* (bull's spirit), which is the most powerful shaman's force.

The health worker agreed with traditional healers' diagnoses of *machi kutran*. In his view, Ana never performed her *machiluwun* (the legitimating ritual), and she is unable to control and use her shamanic power. Even worse was Ana's incapacity to 'deliver' the spirit´s message because her husband (who is Chilean) makes the spirits turns against her, causing her illness to worsen. According to the health worker, Ana lacked the support and guidance from her husband,

relatives, and community—factors that the health worker interpreted as signs of loss of Mapuche values and influence of the modern world. He recommended that Ana must be trained by a shaman who has equally strong power. It should be noted that the disorder labeled as *machi kutran*, is caused by a spirit, which cannot be properly welcomed, controlled, delivered, and used. Ana's *machi kutran* illness is a sign and symptom of personal and familiar power and a symptom and sign of transgression against the shamanic cultural script.

The Psychiatric Interpretation

A detailed analysis of psychiatric ideologies and diagnostic processes are beyond the scope of this paper, but a brief analysis (Table 17.1) reveals how (Western) medical physicians rework the patient's suffering into disease-diagnosis and -treatment in line with the biomedical ideology (Kleinman and Kleinman 1991). Biomedicine has limited value in a Mapuche cultural setting because it is an ethnomedical system, historically and culturally situated, that transforms suffering into dichotomous and contradictory disease categories derived in a very different cultural setting.

The biomedical model (for 'mental' and psychological problems) is rooted in Western epistemology extending as far back as Aristotle's biological view, Hippocrates' rational clinical practice and Descartes' dualism between rational mind and natural body (Scheper-Hughes and Lock 1987). Its fundamental ideology of divisions between spirit and matter, mind and body, real and unreal, natural and supernatural, leads to a radically materialist thinking, which has produced a mechanistic conception of the body and its function, and a failure to conceptualize a 'mindful' causation of somatic states (Scheper-Hughes 1990). This tendency allows one to categorize and treat human affliction as if they were either wholly organic of wholly psychological in origin (Scheper-Hughes and Lock 1987). In (Western) medicine, the distinction between physical and mental health reveals the irresolvable contradictions between mind and body, rational and mental, and objective and subjective. Contradictorily, even in mental health, the majority

of psychiatrists working with suffering assume a biological paradigm following the disease-centered approach reflected in the Diagnostic and Statistical Manual of Mental Disorder (DSM).

The psychiatric categorizing system is based almost exclusively on the subjective evaluation of cluster of signs, symptoms, and manners of patients. And since the meaning of symptoms differ across cultures, the universality of psychiatric disease categories should be questioned (Kleinman 1988). In addition, classification in the area of psychopathology has consistently emphasized negative aspects of social functioning. This has commonly resulted in the stigmatization of the affected population or person, victim blaming, and exoneration of the forces responsible for the problem (Rothblum et al. 1986). The Western bias and methodological limitation of this classificatory system is clear in this case study.

In a similar vein (to the arguments in the previous paragraph), Lock (1993) and Low (1994) point out that if suffering is collapsed in disease categories, suffering is reduced to a personalized text where the individual is held responsible for his/her own distress. In addition, if the range of factors that might have contributed to Ana suffering are reduced to a single syndrome, attention is diverted from the social issues involved, reducing healing to the elimination of symptoms. In this case, individualization and medicalization deny the social and political implications of Ana's suffering. Moreover, medicalization may reduce the possibility of people discovering new ways to deal with suffering. By categorizing Ana suffering as a psychiatric entity, physicians dehistoricize and dehumanize the lived experience of Ana. The clinical record summarized in Table 17.1 shows the continuous process to naming Ana's suffering and fit it into a recognizable and 'real' disease entity. By doing this, the psychiatrists fail to take into account culture and cosmology and they cannot understand Ana suffering (Kleinman and Kleinman 1991). In Table 17.1, it is possible to observe how Western-trained physicians, lacking an understanding about Mapuche culture, religion and worldview, decoded all these vague and unusual somatic complains giving primacy to mind.

During the eight years prior to October 1997, five different psychiatrists, all Chilean men, had treated Ana. According to the latest physician, Ana's bipolar disorder is characterized by mood changes from

depression to exaltation. The depressive period is characterized by sadness, pessimism, and lack of energy. On the contrary, during the exaltation period, Ana shows overtalkative behavior, hyperactivity, happiness, and ideas such as being chosen by God to save Mapuche people. In the clinical record, the psychiatrist wrote that she has psychotic episodes in which she alludes to her condition of religious leader and her frustration: 'I wanted to be a *machi*, but (somebody) rejected it'. The psychiatrist noted that the 'maniac phase' is expressed in dancing and songs. In addition, he commented that when Ana talked about her shamanic calling, she showed a 'complete symptomatic relief, behaving in an appropriate way and maintain her reality judgment'. The psychiatrist remarked that the bipolar disorder was getting worse because Ana was refusing to take medicine, and he concluded that she presented only brief periods of normality. Broadly speaking, the psychiatrist failed to take into account what Ana's bodily idiom is trying to communicate, because they focus in particular symptoms as universal entities.

As Sharp (1994) notes that physicians are unable to comprehend or accept their patients' experiences, a disjunction exacerbated by their acceptance of a cognitive model based on Western conceptions. As in other cases, physicians do not recognize possession as a valid category of experience but see it as a form or symptoms of madness. In the same vein, they do not accept Mapuche religion as a valid religion but see shamanism as a form of psychopathology. Also by interpreting Ana's suffering as a disease, they not only medicalized her but delegitimized her personal, marital, familiar, ethnic, social, economic, religious, and political distress. In addition, they trivialized her suffering and distorted their significance. Finally, they also rendered the suffering more difficult to work through by converting human suffering into inhuman disease (Kleinman and Kleinman 1991).

Shamanism, Individuals, and Modernity

Through all her life Ana experienced the contradiction between the Indigenous and Western world. On one hand, she felt tremendous pressure to identify with Mapuche culture from her patrilineal

grandaunt and aunt. But at the same time, her own father pushed her to leave traditions. Her individual body reacted through feeling of burning, pain, and anxiety to her father's social transgression (burning the sacred place). Also, her alignment was a sign of shamanic calling, which always bore the religious and political meaning of maintaining indigenous tradition and worldview. In this context, Ana's body was resisting the breakdown of Mapuche traditional values. In this situation, she saws only one solution: displacement to another land, to change her body, and her ethnic identity (she cut her hair, dressed like Chilean, spoke Spanish). In this life-choice, it is possible to see resistance against Mapuche destiny and personal agency to manage shamanic calling. But in the city, like many other Mapuche women, Ana can only be marginal and disempowered. The conflict appears through illness, headache, stomachache, and attack, which push her to return to her community.

When Ana was in her twenties, she faced a distressful situation: she had inherited a non-desired power, she was unable to become a Chilean to move away from this, and she had no social support and resources from her family to be trained as shaman and so fulfill this shamanic calling. Ana's dilemma was expressed through the idiom of poisoning and major bodily symptoms: convulsion, attack, and uncontrollable physical force. Ana's individual body resonated with the contradictions and struggle between her powerful (male) spirit and her disempowered position, as a subordinate woman to brothers in a patrilineal and impoverished society. At age of thirty when she displaced to urban cities, Ana married an extremely traditional Chilean man—'huaso'—who embodied all non-indigenous values. Ana had been socialized with the notion of shaman's husband collaborating closely with her partner by assuming the role of *Dungunmachife*. At one level, Ana's marriage can be seen as personal agency, a second life movement to escape to shaman destiny.

Ana's wedding was an attempt to control 'the bull spirit' by giving 'her individual physical body' to a Chilean man, who belonged to social, economic, and political higher strata. But on other hand, she was reproducing the male and Chilean dominance in her everyday life. In this period of Ana's life, she was again resisting Mapuche tradition.

After her marriage, Ana's health got worse and she came back to Mapuche values, resisting biomedicine and modern Western style of life—for example, while in hospital she refused treatment and also did not watch television nor talk with other Chilean patients.

Ana's illness was a bodily response to disintegration and breakdown within Mapuche community, and other personal and marital situations, which reproduces the subordinate role in the Chilean society at large. Ana's suffering embodied the contradiction between belonging to a political dominant group as a marginal Chilean: a maid or a mental patient; or belonging to Mapuche community as a legitimate shaman. Despite her desire and decision, poverty, conflict within families, and lack of social support from the extended community makes a shaman role extremely difficult for Ana to undertake. In addition, following the argument made by Wolf (1990), Ana she did not became a *machi* because of her marginal position in the community (she lived most of her life in Santiago or in her husband's community and married a Chilean 'huaso' in opposition to her family's desire). In total, Ana's sickness resonates with disrupted social and political disharmony in the larger social context of Mapuche contemporary life.

Machikutran: A Multidimensional Idiom

Mapuche people categorize Ana's spirit possession as *machi kutran*. This is expression of multivocal idioms in the clinical context. Her traumatic experiences are symptoms and signs of a social role, spiritual power and religious calling. However, she needs to acknowledge a source of power over which she has no ownership. The power belongs to her people and is to be used to heal, but she is not given support to enable her to become a healer: her husband is a Chilean man, her family is poor and she wanted to leave tradition behind to seek a new identity in the city.

At the present, Mapuche people are experiencing a lack of a 'sense of community' and a decrease of collective rituals. Many sacred places have been neglected and the power of the spirits is thought to be out of control and dangerous. As a consequence of modernization, not all

the people experiencing signs of spirits become a shaman during youth, a period of social, ethnic, and spiritual vulnerability.

Ana's *machi kutran* is central to her moral identity as a Mapuche. Her illness is a reminder of who she is which cannot be erased by medications. Her insistence that *machi kutran* is an 'inherited power given by God' is a religious act, her body is a site of communicating with God and her symptoms a punishment and a reminder that she must do 'the right thing' regardless of what she desires as a mortal. In addition, Ana's bodily complaints express the fear, anger, and sadness to be unable to control this inherited spirit/power. Her somatic response expresses the conflict and dilemma between an individual self (leave the community and became a Chilean, married to a Chilean) and a collective self (follow the tradition and became a shaman, deliver the spirit's message). Also, Ana embodied suffering that cannot be separated from identity and landscapes, as Mapuche religious power and identity are linked with rural communities and scared landscape; on the contrary Chilean identity is closely associated with urban cities, boss house, and hospital. Her marriage, family, community, and the larger Mapuche society are crosscut by transforming and conflictive displacement between indigenous and Western places. Thus, *machi kutran* is not only an idiom of ethnicity but also an idiom of religious and ethnic distress.

Finally, Ana's illness can be understood as idiom of gender distress because, in a strict patrilineal society, women are in a subordinate position to men (fathers, brothers, and husbands). All the male members of her family—for different reason—failed to support Ana. Also, she felt an alliance between her husband and the physicians: '*the doctor always talks with my husband. They do not believe me*'. In total, Ana's bodily symptoms can be seen as an idiom of moral, religious, ethnic, and gender distress interlinked with contradictions caused by transformation of physical, social and political scenes.

Ana's *Perimontun* and *kuymun* are embodied suffering to a contradictory and changing world in which transforming physical and social landscape leave religious power and spiritual forces out of control on the body, self, place, and local and national spheres as well. Ana's narrative illuminates social and personal meanings of shaman

calling, spirit possession, and trance as an embodied suffering of conflict, transgression, and contradiction between individuals/collective self, male/female dominance, community/capitalist mentality, traditional/Western landscapes, religious/biomedical power, and Mapuche/Chilean identity.

In conclusion, Ana's embodied suffering is a sign and symptom of personal ethnic dilemma, interethnic marriage, difficulties in the family, changes in physical and social landscape, and contradictory medical systems, all of them consequences of the political transformation in Mapuche and Chilean society. By examining Ana's shaman calling in terms of its meaning in Mapuche culture, the discussion in this chapter has moved beyond dichotomous categories of shamanism and psychopathology to show that Ana's embodied suffering is an extreme case of tension between physical body, self, social, and political contexts. Also, this discussion has explored how the underlying larger problem—Mapuche and Chilean conflictive and contradictory relationships in the context of modernization and growing capitalism—is embodied and lived through by a particular individual in everyday life.

Conclusion

This chapter proposes a comprehensive approach to mental health that goes beyond the dichotomous mind–body training of health professionals, thereby contextualizing both biomedicine and traditional medicine. This is a key avoiding medicalization of lived experiences such as Ana *machi* 'calling' and to understanding the human experience in a phenomenological perspective. It argues that living out the role of a *machi* is not merely a matter of individual desire since it is framed and reframed by the socio-political and cultural context of the Mapuche families, communities, and society as a whole; taking into account the impact of Western style of life.

Psychiatrists (trained in Western medicine) tend to categorize the signs of *machi* vocation as representing mental illnesses and so fail to understand the true meaning of the shaman experience. But Mapuche medicine is different. It is not only spiritual with symbolic

elements (like all medical systems), but it is a complex socio-spiritual and physical medical system. Yet, traditional therapists use most of the elements that are used in Western psychiatry—for example, those addressed in integrative psychotherapy (Pérez-Sales 2004), family intervention techniques (although not the same as that of the Western psychotherapy) and other social therapeutic techniques; as well as contextualization of problems, prescription of new behaviors, reinforcement of the family and community support, the resignification of the person role and the provision of a structured social environment which restructures family and community ties through the ritual (Oyarce 1995; Pérez-Sales 2004). Thus, Mapuche healing offers a broad field for collaboration with psychiatry. The point here is that by re-conceptualizing Mapuche medicine as social and spiritual it offers a common ontological, epistemological and therapeutic field to be able to develop collaborative relationships between Mapuche shamans and psychiatrists in a more integrative approach to human suffering and experiences.

Healers, possession and trance are parts of a complex system that integrates spirit and matter, force and power, and bodily reality into a cosmos where the boundaries between an individual and his social group are permeable and negotiable. Changing from the hegemonic biomedical basis of institutionalized psychiatry to a more holistic, ecological, and participatory approach of community psychiatry could reinforce cultural rights and diversity through the recognition of the human rights of the mentally ill, strengthening the rights of indigenous peoples and indigenous medicines.

Note

1. This case was registered in 1997 by Ana Maria Oyarce (Universidad de la Frontera), Dr. Claudio Espejo (Psychiatrist, Hospital Regional Temuco, and Jose Ñanco (Cross cultural broker of the Mapuche Health Program) Servicio de Salud Araucanía. MINSAL. At this time Ana gave consent for her story to be shared with the health team and to be used for academic study.

References

Bacigalupo, M. (1994). Machi Fresia, the Mapuche woman who abandoned shamanhood? *UCLA Anthropology Journal, 21,* 15–33.

Boddy, J. (1994). Spirit possession revised: Beyond instrumentality. *Annual Review of Anthropology, 23,* 407–434.

Bowie, F. (2000). *The anthropology religion. An introduction*. Oxford: Blackwell.

Crapanzano, V. (1973). *The Hamadsha: A study in Moroccan ethnopsychiatry*. Berkeley: University of California Press.

Crapanzano, V. (1980). *Tuhami: Portrait of a Moroccan*. Chicago: Chicago University Press.

Crapanzano, V., & Garrison V. (1977). *Case studies in spirit possession*. New York: Wiley.

Cuyul, Andrés. (2008). *Prácticas culturales familiares y colectivas que protejen las salud en comunidades Mapuche en Chile y Argentina.* Thesis, Maestria de Salud Pública UBA.

Deveraux, G. (1963). Primitive psychiatric diagnosis: A theory of the diagnostic process. In I. Gladstone (Ed.), *Man's image in medicine and anthropology*. New York: International Universities Press.

Glazier, S. (1997). *Anthropology of religion: A handbook*. Westport, CT and London: Greenwood Press.

Kleinman, A. (1988). *Rethinking psychiatry. From cultural category to personal experience*. New York: The Free Press.

Kleinman, A., & Kleinman, J. (1991, September). Suffering and its professional transformation: Toward an ethnography of interpersonal experience. *Culture Medicine and Psychiatry, 15*(3), 275–301.

Kroeber, A. (1952). *Psychosis or social function. The nature of culture* (pp. 310–319). Chicago: University of Chicago Press.

Lambeck, M. (1989). From disease to discourse: Remarks on the conceptualization of trance and spirit possession. In C. A. Ward (Ed.), *Altered states of consciousness and mental health. A cross cultural perspective* (pp. 36–61). Newbury Park, CA: Sage.

Lewis, I. M. (1989). *Ecstatic religion: A study of shamanism and spirit possession* (2nd ed.). London and New York: Routledge.

Lock, M. (1993). Cultivating the body: Anthropological and epistemology of bodily practice and knowledge. *Annual Review of Anthropology, 22,* 133–155.

Low, S. (1994). Embodied metaphors: Nerves as lived experience. In T. Csordas (Ed.), *Embodiment and experience: The existential ground for culture and self* (pp. 139–162). New York: Cambridge University Press.

Madariaga, C. (2018). *Clínica psiquiátrica y ciudadanía: de la crisis del paradigma biomédico a la Salud Mental Colectiva*. Conference January 25th XV Summer International School. Faculty of Medicine, University of Chile. Unpublished, 21 pages.

Obeyesekere, G. (1981). *Medusa's hair. An essay on personal symbols and religious experience*. Chicago: University of Chicago Press.

Oyarce, A. M. (1995). Video: Vida entre dos mundos. Cooperación Italiana-Video Sur.

Pérez-Sales, P. (2004). *Psicología y Psiquiatría Transcultural: Bases prácticas para la acción. Bilbao, España: Desclee de Brower* [Transcultural psychology and psychiatry—Practical basis for action. Bilbao: Desclee de Brower (Text in Spanish)] Bilbao: Desclee de Brower. Retrieved March 3, 2018, from http://www.pauperez.cat/en/thematic/books/7-psicologia-y-psiquiatria-transcultural-bases-practicas-para-la-accion/file.

Quidel, J. (2001). Cosmovisión mapuche y etiología mapuche de la salud. Promoción de la medicina y terapias indígenas en la atención primaria de salud. El caso de los mapuche de Makewe-Pelale de Chile; serie Salud de los Pueblos Indígenas, N° 16; Washington, DC, OPS-OMS.

Rothblum, E. D., Solomon, L. J., & Albee, G. W. (1986). A sociopolitical perspective of DSM-III. In T. Millon & G. L. Klerman (Eds.), *Contemporary directions in psychopathology: Toward the DSM-IV* (pp. 167–189). New York: Guilford Press.

Scheper-Hughes, N. (1990). The subversive body: Illness and the micropolitics of resistance. In D. M. Thomas (Ed.), *The white hotel* (pp. 43–70). New York: Viking Press.

Scheper-Hughes, N., & Lock. M. (1987). The mindful body: A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly, 1*(1), 6–41. Retrieved December 19, 2017, from http://anthropology.msu.edu/anp204-us14/files/2012/06/The-Mindful-Body.pdf.

Sharp, L. (1994). Exorcists, psychiatrists, and the problem of possession in Northwest Madagascar. *Social Science and Medicine, 38*(4), 522–542.

Silverman, J. (1967). Shamans and acute schizophrenia. *American Anthropologist, 69*(1), 21–31. Retrieved December 19, 2017, from http://onlinelibrary.wiley.com/doi/10.1525/aa.1967.69.1.02a00030/pdf.

Vitebsky, P. (2001). *Shamanism*. Norman: University of Oklahoma Press.

Wolf, M. (1990). The woman who didn't become a shaman. *American Ethnologist, 17*(3), 419–430.

18

Contemporary Applications of Confucian Healing

Kwang-kuo Hwang

Any success depends upon previous preparations, and unpreparedness spells failure. (*The Doctrine of the Mean*/Zongyong attributed to Zisi/Kong Ji)

Morita Therapy

In the 1920s, Japanese therapist Shoma Morita (1874–1938) first tried to use the traditional Zen practice to help the client alleviate the anxiety-based disorder *shinkeishitsu* and to take constructive action in social situations.

The goals of Morita therapy are the recognition of facts, obedience to nature, focus on the present, the increase of spontaneous activities, the decrease of self-focused preoccupation, the elimination of indulgence in

The author was supported by a grant from Ministry of Science and Technology, Republic of China, 106-2410-H-037-004-MY2.

K. Hwang (✉)
Kaohsiung Medical University, Kaohsiung, Taiwan

© The Author(s) 2018

S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0_18

moods and emotions (*kibun honi*), the withholding of value judgments, the reduction of intellectualizing, the cessation of escape into a sick role, and the cultivation of a humble (*sunao*) mind (Iwai and Abe 1975). Morita was interested in eliminating contradiction in ideas and fostering acceptance of facts in a state of *arugamama*, which means accepting things as they are. Morita postulated that this would be made possible by teaching clients in complete social isolation.

The prototypical form of Morita therapy is an inpatient treatment involving four stages: (a) isolation—rest therapy, (b) light occupational therapy, (c) heavy occupational therapy, and (d) complicated activity therapy in preparation for actual life. In the first stage, the therapist gives detailed explanations of the functions of anxiety symptoms, which cannot be treated by intellect.

Naikan Therapy

Naikan is a Japanese word meaning inside looking or introspection. A more poetic translation is seeing oneself with the mind's eye. It is a structured method of self-reflection that helps people to understand themselves, their relationships, and the fundamental nature of human existence. According to Naikan therapy, an individual's psychological problems are rooted in distorted interpersonal relationships with significant others (Kimura 1972).

Naikan therapy is concerned with procedures of directed client self-examination. Clients are given sets of individual instructions. The three crucial instructions are: (a) Recall and examine your memories on care and benevolence you have received from a particular person, (b) recollect and examine your memories on what you have returned to that person, and (c) recollect and examine trouble and worries you have given to that person (Murase and Johnson 1974). Regardless of the clients' particular presenting problems, the instructions are entirely concerned with specific interpersonal relationships.

The first subject of Naikan therapy is usually clients' relationships with their mothers. The therapist instructs clients to recall and examine

specific detailed life events that involved them and their mothers, from when they were in elementary school chronologically to the present.

Based on the three questions of what the client has received, given, and the difficulties caused for others, Naikan therapy provides a foundation for reflecting on relationships with others. In each case, the clinician and the client search for a more realistic view of conduct and of the give-and-take that has occurred in relationships.

Constructive Living Therapy

David Reynolds (1976, 1980, 1983) studied Naikan and Morita therapies in Japan in the 1960s, conducted fieldwork in these methods for his doctoral dissertation, and began to integrate common value of these two methods. He called the result constructive living therapy.

Constructive living therapy assumes that with the uncontrollability of feelings and emotional states, a client's energy should be logically redirected toward behavior and action. This redirection helps to ground the client in the reality of life, rather than remaining absorbed in life's emotional overtones. The three elements of constructive living are "accept reality, know your purpose, and do what needs to be done" (Reynolds 1995, p. 21).

In the cognitive realm, Reynolds (1980) spoke explicitly of the importance of being "reality-centered" (Reynolds 1990, p. 110). Struggling with immutable aspects of life is seen as self-defeating.

Reynolds (1987) maintained that social and moral errors play as much a role in neurosis as ordinarily conceived psychological problems. He believed that many neurotic problems can be ameliorated by correcting "sloppy and thoughtless acts" (p. 21). Furthermore, an ideal outcome will result in behavioral attempts to repay the debt for what one has received from significant others and from society. These attempts can provide a new meaning to and a constructive sense of purpose in one's life. Reynolds (1989) commented, "When the focus of attention shifts from personal misery to making steps toward repaying others, much neurotic suffering evaporates as constructive purpose enters a life. I've never met a neurotic person filled with gratitude" (p. 7).

Constructive living can be viewed as the Westernized version of Naikan therapy. According to Reynolds (1995), the focus of autonomy, expression, and satisfaction of the individual in Western therapies can stand in the way of clients learning the satisfaction of serving others: "One of the goals of Constructive Living is to shake the foundations of clinical psychology and psychiatry in the West" (p. 5).

Taoist Healing for Authentic Self

Confucian and Taoist philosophies are best seen as complementary opposites of Chinese ethical healing. In contrast to the interpersonal disturbance that a relational self may experience, Taoism proposes several mental and physical exercises that may help an individual to eliminate all spiritual and psychological contamination, including *qigong* (a traditional Chinese therapy of physical movement aimed to enhance one's inner strength by exercising and controlling one's own muscle and breathing; Cohen, 1997), *taiqichuan* (shadow boxing), and Taoist meditation (Lu 1964; Ni 1992). By practicing these methods of self-cultivation, an individual may return to the state of authentic self in which that person moves with the rhythm of the universe, similar to a fetus moving in a mother's womb.

The Application of Daode Jing

Even before the practices of *taiqichuan* and *qigong* gained their popularity in Western world, Carl Jung (1875–1961), Swiss psychiatrist and psychoanalyst, was the first scholar to incorporate many ideas of Daoism into his theory of psychotherapy. He wrote the foreword for the German translation of *I Ching* (Wilhelm 1960) and collaborated with Richard Wilhelm in translating *The Secret of the Golden Flower*, a classic of Taoism, into German (Lu 1962).

The applied research of Ron Kurtz, who developed the Hakomi method of body-centered psychotherapy, and Greg Johanson, senior trainer at the Hakomi Institute, should be discussed here to illustrate

the connection between the ancient principles of the Lao Tzu's Daode Jing and modern psychotherapy. Written for both therapists and clients, Johanson and Kurtz's (1991) case study, anecdotal materials, and literature review addressed issues of nonviolence, the use of the body in therapy, the importance of mindfulness, and the interrelatedness of all things. The introduction suggested that the reader approach the book in a meditative way by openly acknowledging any sensation and using self-inquiry into the experience (Johanson and Kurtz 1991). Each chapter quotes various translations of the Daode Jing. Case examples are given to show a way of practicing therapy that is congruent with the principles of the Daode Jing and emphasize how Lao Tzu's wisdom can provide a foundation and framework for inventing whatever technique is useful in a particular moment.

Chinese Taoist Cognitive Psychotherapy

Although various forms of Taoist self-cultivation have been widely practiced in China for hundreds of years, it is a recent event that there are a group of Chinese psychologists who have tried to develop it as a method of psychotherapy and to study its effects by the scientific method of Western psychology (Zhang et al. 2002). The Chinese Taoist cognitive psychotherapy (CTCP) combines elements of cognitive therapy and Taoist philosophy for contemporary Chinese clients to learn coping skills with their current work and social reality.

CTCP involves a total of 15 1-hour sessions administered over 6 months. The CTCP model of intervention contains five sequential stages, which are sequentially conducted at 5 or more sessions of 1 hour each, depending on the client's need to repeat Stages D and E (Zhang et al. 2002). A careful assessment of the client's level of stress, hierarchy of needs, and conflict and coping styles is conducted from Stages A to C. After the first cycle of all five stages is completed, for the most part, Stages D and E are repeated.

In Stage A, the clinician assists clients in identifying and analyzing actual stressors based mostly on subjective experiences connected to their illness, rather than on an objective number of stressful events.

In Stage B, clients are instructed to share their self-prioritized needs according to personal opinion instead of suiting mainstream societal norms on moral behavior. In Stage C, the relative effectiveness of the client's coping strategies is evaluated based on the client's indicated degree of use in the event of psychological conflict (Zhang 1993). After a careful assessment of the client's level of stress, hierarchy of needs, and conflict and coping styles, the therapeutic core of CTCP in Stage D explains the complementary roles of Taoism and Confucianism prior to a discussion of the 32-character Taoist formula within the same Stage D.

The results indicated that BDZ treatment rapidly reduced symptoms of GAD from the 1st to the 6th month, with CTCP significantly taking effect at 6 months of treatment to maintain client reduction of GAD symptoms. Combined treatment led to acute as well as enduring symptom reduction. Unlike BDZ treatment, CTCP reduced Type A behavior, improved coping style, and decreased neuroticism. It was concluded that CTCP with or without BDZ treatment is a more effective, although slower, method for the treatment of GAD than BDZ for GAD patients in urban China.

Conclusions

The term self-cultivation is used in this article to integrate various culture-sensitive psychotherapies derived from Confucianism and Taoism. In all of these cultural traditions, the teaching role is important in maintaining the living tradition passed down for generations by words of mouth. In terms of ethical healing, this teaching role may be partially undertaken by a clinician. In addition, the students, or in this case the clients, should actually try and live their lives according to these principles rather than solely gaining a cognitive understanding of them (Watts 1961).

Those methods of ethical healing are essentially different from those of Western counseling psychology, which uses the core technique of confession derived from the tradition of Christianity (Foucault 1978–1985). A client needs to confess or disclose to the counselor his or her desires, misdeeds, guilt feelings, and psychological disturbances. To change or give up some undesirable aspects of oneself, one first has to face one's "real" self.

For people living in East Asian societies, the traditional one-on-one model of Western counseling is an unnatural way of communicating and conveying matters of mutual concern (Gerstein and Ægisdóttir 2005). If an individual confesses or discloses desires, misdeeds, guilt, or psychological disturbances to others in a collectivist or relational society, that individual risks psychosocial imbalance by losing face. On the contrary, once the master learns that the client is suffering from a particular problem, the master may provide guidelines or instructions to the client for self-cultivation. These guidelines may be teachings or proverbs derived from a religious doctrine. The process might well be described by a popular saying in Chinese societies: The master can only guide you to acquire fundamental principles of a doctrine; to practice them to any extent of expertise is your own business.

The goals of self-cultivation are also completely different from that of Western psychotherapy. Instead of using an analytic approach to search for the client's real self, the Asian models encourage the client to find ways for one's relational social self and authentic self. A careful examination over the sociocultural contexts for the development of various methods of psychotherapy reported in this article, namely, Morita therapy for anxiety-based disorders in pre-war Japan, Naikan therapy for the arrangement of interpersonal relationships in Japanese society after World War II, CTCP in contemporary China, and constructive living in America, it is obvious that the method of cultural adoption may assist a counseling psychologist to develop various techniques of psychotherapy intended to be most appropriate for clients from a particular sociocultural context.

References

Foucault, M. (1978–1985). *The history of sexuality* (vols. 1–2) (R. Hurley, Trans.). New York: Vintage. (Original work published 1976–1984).

Gerstein, L. H., & Ægisdóttir, S. (2005). A trip around the world: A counseling travelogue. *Journal of Mental Health Counseling, 27,* 95–103.

Iwai, H., & Abe, T. (1975). *Morita ryoho no riron to jissai* [Theory and practice of Morita therapy]. Tokyo : Kongo Shuppan.

Johanson, G., & Kurtz, R. (1991). *Grace unfolding: Psychotherapy in the spirit of the Tao-te Ching*. New York: Bell Tower.
Kimura, B. (1972). *Hito to Hito tono Aida* [Interpersonal space]. Tokyo: Kobundo.
Lu, K. Y. (1964). *The secrets of Chinese meditation*. London: Rider.
Lu, T. P. (1962). *The secret of the golden flower: A Chinese book of life* (R. Wilhelm, Trans.). New York: Harcourt, Brace World.
Murase, T., & Johnson, F. A. (1974). Naikan, Morita, and Western psychotherapy: A comparison. *Archives of General Psychiatry, 31,* 121–128.
Ni, H. C. (1992). *Internal alchemy: The natural way to immortality*. Santa Monica, CA: College of Tao and Traditional Chinese Healing.
Reynolds, D. K. (1976). *Morita psychotherapy*. Berkeley: University of California Press.
Reynolds, D. K. (1980). *The quiet therapies*. Honolulu: University of Hawaii Press.
Reynolds, D. K. (1983). *Naikan psychotherapy*. Chicago: University of Chicago Press.
Reynolds, D. K. (1987). *Water bears no scars*. New York: William Morrow.
Reynolds, D. K. (1989). Meaningful life therapy. *Culture, Medicine and Psychiatry, 13,* 457–463.
Reynolds, D. K. (1990). *A thousand waves*. New York: William Morrow.
Reynolds, D. K. (1995). *A handbook for constructive living*. Honolulu: University Press of Hawaii.
Watts, A. (1961). *Psychotherapy East and West*. New York: New American Library.
Wilhelm, R. (1960). *The I Ching or book of changes* (C. F. Baynes, Trans.). London: Routledge and Kegan Paul.
Zhang, Y. L. (1993). Comparison of coping styles after stress between patients with mental disorders and normal controls. *Chinese Journal of Clinical Psychology, 1,* 36–39.
Zhang, Y., Young, D., Lee, S., Li, L., Zhang, H., Xiao, Z., et al. (2002). Chinese Taoist cognitive psychotherapy in the treatment of generalized anxiety disorder in contemporary China. *Transcultural Psychiatry, 39,* 115–130.

Author Index

A

Aakster, C.W. 44
Abe, T. 302
Abimbola, W. 30
Abu Bakr Rabi 138
Abu Zayd Hunayn 138
Adeofe, L. 31
Adeponle, A.B. 5, 31
Adyashanti 114
Ægisdóttir, S. 307
Agrawal, R. 11, 229, 231, 235, 237
Ainslie, G. 234
Al-Balkhi 138
Al Farabi 138
Al-Ghazali, A.M. 137, 138, 142, 146, 148
Ali, Abdulla Yusuf 140
Ali Ibn Abbas Al Majusi 138
Al Kindi 138
Alleyne, M.C. 62, 69
Allwood, C.M. 3, 264
Al-Razi 138
Al Tabari 138
Al-Yaman, F. 165
Amundson, N.E. 263
Anderson, I. 165
Angelique, H. 91
Appiah, K.A. 29
Aranya, Swami H. 115
Arnett, J.J. 240
Asante, K.W. 44
Asante, M.K. 44, 45
Ashoka 120, 121
Atherton, K. 83, 87, 92, 94
Awanbar, D. 67

B

Bacigaluppo, M. 284
Bai, I. 264
Baldwin, J.A. 255
Balsekar, R. 114

© The Editor(s) (if applicable) and The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0

Barlet, H. 92
Baskin, C. 166
Bastien, B. 185
Bauman, Z. 33
Baumeister, R.F. 232
Bedoe, L. 166
Bemme, D. 1
Berkowitz, L. 235
Bernal, M. 42
Berry, J.W. 3, 85, 264, 265
Bhaktivedanta, Swami 115
Bharati, A. 29
Bhatt, E.R. 238
Bhattacharya, R.S. 115
Bhugra, D. 2, 69, 263
Bhui, K. 2, 14, 69
Bhushan, L.I. 237
Biko, Steve 10, 11, 226, 246–252, 254, 256
Bjertness, E. 165
Boccara, G. 204
Boddy, J. 281
Bodibe, R.C. 79
Bohm, D. 53
Bojuwoye, O. 7, 31, 66, 79, 80, 82, 83, 92, 93
Bondurant, J.V. 236
Botha, K. 86, 91
Boulton, A. 169
Bowie, F. 280
Bray, A. 173
Brideson, T. 177
Bronfenbrenner, U. 77
Bryant, E. 115

C
Cajete, G. 166
Calma, T. 177
Campbell, C. 267
Campbell, J. 65
Cao, Y.P. 271, 272
Capra, F. 13, 48, 52, 53
Carruthers, J.H. 45
Cartwright, D.E. 78
Castillo, R.J. 78
Caws, P. 220
Cesaire, A. 250
Chan,Y. 264
Chauhan, A. 267
Chen, C.P. 69
Cherki, A. 220
Cherrington, L. 170
Chevannes, B. 63
Chireau, P.Y. 63
Chissano, J.A. 251
Choi, K.H. 265
Choi, S.C. 29
Choi, S.H. 29
Church, A.T. 29
Citarella, L. 206, 207
Clarke, J.H. 45, 46
Clilverd, A. 92
Coleman, P.T. 239
Collins, S. 133
Comarroff, J. 92
Combs, G. 78
Comer, J. 218
Confucius 152
Connolly, M. 165
Conze, E. 188
Cooke, W. 193
Cookson-Cox, C. 170
Coward, H. 116
Cox, C. 132
Crafford, D. 79, 81

Craig, E. 271
Crapanzano, V. 282, 283
Cubillo, C. 173
Curhan, K.B. 26
Cuyul, A. 204

D
Dalal, F. 4
Das, A. 1
Dasen, P.R 78, 85
Dasgupta, S. 115
Davidson, R.J. 133
Davis, R.H. 115
Dayal, H. 133
Dechaume, J. 216
Descartes, R. 42
Deutsch, E. 115
Deveraux, D. 281
Dewar, J. 187, 191, 193
Diop, C.A. 42, 44, 46
Dong Zhong Shu 155
Doniger, W. 116
Dow, J. 70
Dryden, W. 87
D'souza, N. 1
Du Bois W.E.B. 25, 225, 226
Dudgeon, P. 9, 163, 172–174, 177
Durie, M. 171
Dylan, Bob 14

E
Edgerton, F. 115
Edwards, D.J.A. 84
Edwards, S.D. 85, 92
Elder, G.R. 132
Eliade, M. 115
Elkin, A.P. 176, 177
Embuldeniya, D. 187
Emery, T. 170
Engel, G.L. 52
Epp, L.R. 91, 92
Erikson, E.H. 233, 239
Eze, M.O. 30

F
Fanon, F. 3, 10, 11, 25, 164, 165, 215–227, 250, 252
Fernandez-Olmos, M. 63, 69
Fernando, S. 2, 4, 6, 10, 14, 39, 42, 43, 265
Finkler, K. 70
Fletcher, C. 30
Flint, K.E. 59
Fort, A.O. 115
Foucault, M. 4, 218, 306
Frank, J.B. 264
Frank, J.D. 264
Freedman, J. 78
Freire, P. 10
Fromm, E. 54
Frydman, M. 116

G
Gaines, A.D. 4
Gandhi, M.K. 3, 10, 11, 229–240
Gangaji 114
Gangrade, K.D. 240
Garfield, S.L. 2, 92
Garrison, V. 282
Gerstein, L.H. 307
Gethin, R.M.L. 124
Gibson, B.G. 69

Gifford, H. 169
Gilligan, S.G. 87
Glazier, S. 281
Goble, A.E. 132
Godman, D. 116
Gombrich, R.F. 132
Graham, H. 41, 48, 53
Grant, S. 131
Grebe, M.E. 207
Gregg, R.B. 230, 238
Grieves, V. 176
Gumede, M.V. 81
Gyatso, J. 132
Gyekye, K. 80

H
Hall, S. 2, 39
Handler, J. 68
Haque, A. 8, 138, 143, 149
Harley, D.A. 82
Haswell, M. 174, 175
Hayes, G. 89, 91
Heine, S.J. 21, 27
Heinrich, J. 21
Hilliard, A.G. 45
Hiriyanna, M. 115
Ho, D.F. 270
Ho, D.Y.F. 3
Hoffman, W. 229, 232
Hoge, E. 131
Hohenshil, T.H. 263
Hohmann, A.A. 67
Holland, C. 177
Howitt, D. 80, 82
Hsu, J. 69
Huang, A. 151
Hwang, K.-K. 3, 8, 12, 65, 69, 71, 153

I
Ibacache, B.J. 203
Ibn Bajjah 138
Ibn Khaldun 140
Ibn Sina 138
Ibn Tufail 138
Ishaq bin Imran 138
Isherwood, C. 42
Iwai, H. 302
Iyengar, S.S. 231
Iyer, R. 236, 239

J
Jacoby, J. 68
Jacques, M. 13
Jahoda, G. 3
Jaspers, K. 225
Jayatilleke, K.N. 50
Jayawardena, K. 10
Jeanson, F. 217
Johanson, G. 304, 305
Johnson, F.A. 302
Joseph, S. 233
Jung, C.G. 4, 116, 304

K
Kabat-Zinn, J. 133
Kahneman, D. 234, 235
Kakar, S. 40, 44, 54
Kalick, S.M. 268
Karasawa, M. 26

Karenga, M. 44, 46, 47, 255
Kashima, Y. 78
Kim, U. 3
Kimura, B. 302
King, A. 165
Kirby, K.N. 234
Kirmayer, L.J. 5, 23, 24, 30, 32, 33, 267
Kitayama, S. 26, 27, 29, 267
Kleinman, A. 265, 266, 289–291
Kleinman, J. 289–291
Kleinman, K. 83
Kool, V.K. 11, 229, 231, 232, 235, 236
Koss-Chioino, J.D. 70, 71
Koss, J.D. 70
Kpanake, L. 31
Kripalani, K. 230
Krishnamurti, J. 99, 114, 116
Kroeber, A. 281
Kurtz, R. 304, 305
Kuznetsova, I. 116
Kyle, K. 91

L
Lacan, J. 221
Lama, Dalai (Tenzin Gyatzo) 132, 133
Lambeck, M. 281–283
Lambo, A. 44
Lancaster, B.L. 62
Langer, E. 240
Lao, L. 264
Laozi 151, 152
Larson, G.J. 115
Laungani, P. 2
Lawson, E.T. 45, 47
Lawson-Te Aho, K. 170
Lazarus, N. 24
Lazlo, E. 51
Lee, B.O. 12, 266, 267
Lee, G. 193
Lee, W.L. 266, 268, 269
Lee, Y. 263, 270
Legge, J. 159, 160
Leotti, L.A. 231
Leventhal, G.S. 154
Levers, L.L. 83
Levin, J. 62
Lewis, I.M. 281
Liao, L. 272
Li, M. 263
Lipsedge, M. 2
Li Ren 158
Little Bear, L. 186
Littlewood, R. 2
Liu, J. 263
Liu, J.H. 32
Lock, M. 289, 290
Looking Horse, A. 191
Loomba, A. 26
Lorenz, K. 231
Lo, T. 63, 65
Louw, D.A. 84
Low, S. 290
Loy, D. 116
Lu, K.Y. 304
Lu, T.P. 304
Lu, X. 267
Lucas, J.O. 45
Lucca, N. 29

M
Macfarlane, S. 169
Madariaga, C. 279
Madden, R. 165
Makgoba, M.W. 79

Malcom X. 250
Mandela, N. 246, 256
Manganyi, N.C. 256
Mariach, L. 78
Marileo, A. 203, 206
Markus, H.R. 26, 27, 267
Marmot, M. 166
Marshall, G. 190, 197
Marshall, R. 68
Martin-Baró, I. 10
Maslow, A.H. 239
Masten, A.S. 239
Mauss, M. 24
Mbiti, J.S. 30, 46, 79–82
McBride II, R.D. 132
McCabe, G.H. 70
McCormick, R.M. 189
McGovern, C. 195
Milgram, S. 232, 240
Miller, B.S. 115
Mills, C. 2, 14
Millward, D. 245
Moghaddam, F.M. 32
Mohamedbbai, G. 77
Mohamed, Y. 140, 143, 145
Moletsane, M. 7, 84
Moodley, R. 2, 3, 6, 39, 63, 65, 68–70
Mooji 114
Moore, K. 189
Morita, Shoma 301–303
Mpofu, E. 83, 89
Murase, T. 302

N
Nanajivako, Bikkhu 50
Napper, E. 50
Nasr, S.H. 47, 51
Needham, J. 152
Ng, S. 264
Ngubane, H. 81
Ni, H.C. 304
Nicolas, G. 67
Nikora, L.W. 168
Niles, S.G. 263
Nobles, W.W. 46, 255
Nolan, G. 4
Norasakkunkit, V. 268
Norenzayan, A. 21
Nyanatusita, Bhikkhu 133
Nyasani, J.M. 79, 80

O
Obata, K. 172
Obeyesekere, G. 282
Ocampo, M. 39
Ochsner, K.N. 231
Odendaal, N. 83
Oishi, S. 28
Okazaki, S. 24
Olajide, D. 14
Olivelle, P. 116
Opotow, S. 229, 237
Owusu-Bempah, J. 80
Oyarce, A.M. 9, 12, 204, 208, 296

P
Palmer, S. 2
Pandey, S. 3
Park, H. 29
Parrott, C. 92
Paul Krutzen, P. 230
Payne-Jackson, A. 62, 69

Pedersen, P. 59, 61
Peltzer, K. 83
Pérez-Sales, P. 207, 210, 296
Perrett, R.W. 116
Petras, J. 1
Pihama, L. 166, 168
Pitama, S.G. 170, 171
Pomeranze, K. 3
Poortinga, Y.H. 78
Poussaint, A. 218
Prabhavnanda, Swami 42
Prabhu, R.K. 240
Prentiss, K.P. 116
Prophet Muhammad 137, 141
Pye, M. 133

Q
Qekema, N. 247
Quidel, J 207, 280
Quidel, L.J. 203

R
Raerino, N. 170
Rahula, Walpola 132
Rama, Swami 42
Ramstead, M.J. 23
Rao, M. 1
Rao, U.R. 240
Rao, V.A. 69
Raud, R. 33
Ray, C.B. 88
Reynolds, D.K. 303, 304
Richey, J.L. 272
Riley, R. 176
Rinpoche, S. 119
Robbins, J. 9, 185, 191, 197
Robson, B. 165
Rodrigues, H. 7, 8, 99, 114, 116, 119
Rogers, J.A. 46
Roh, S. 263
Rose, N. 263
Rosman, A. 68
Ross, E. 70
Rothblum, E.D. 290
Rubel, P.G. 68
Rudnick, H. 79
Ryff, C.D. 26
Ryle, G. 42

S
Safaya, R. 49–51
Sahih Al-Bukhari 144
Sampson, E.E. 30
Sanghvi, N. 233, 239
Sartre. J.P. 217, 224
Sato, T. 263
Scheid, V. 264
Scheper-Hughes, N. 289
Schwagerl, C. 230
Segal, M.H. 78
Senghor, L. 79
Sharp, L. 291
Shen, J. 264
Sheweder, R.A. 78
Shukla, A. 1
Shulman, H. 3, 10
Shutte, A. 79, 93
Silverman, J. 281
Smedley, A. 25
Smedley, B.D. 25
Smith, E.J. 273
Smith, F.M. 116
Soanes, C. 139

Solar, M.A. 201
Sones, R. 177
Sorbero, M.E. 131
Spinnelli, E. 80
Steele, C.M. 25
Stephenson, C.E. 4
Stevens, G. 255
Stevenson, A. 139
Stone, M.H. 60, 62
Straker, G. 85
Stricker, G. 240
Stubbs, A. 47
Suh, S. 266
Summerfield, D. 1
Sun, C.T.L. 66
Suzuki, D.T. 54
Suzuki, K. 268
Swartz, J. 114

T
Taitimu, M. 170
Tanahashi, K. 133
Tanaka-Matsumi, J. 270
Tatz, M. 133
Tendulkar, D.G. 233
Teng Wen Gong 156
Thrasher, M. 9, 185, 188–190, 193, 195–197
Tien-Lun Sun, C. 66
Tierney, J. 232
Tolle, E. 114
Tomlinson, B.R. 3
Tosquelles, F. 217
Triandis, H.C. 29
Tseng, W.S. 69
Tu, W.M. 29, 157
Tulku, T. 82
Ture, K. 250
Turia, T. 166
Tutu, D. 66, 239
Tynan, M. 165

V
Valentine, H. 169
Velimirovic, B. 189
Veltmeyer, H. 1
Vignoles, V.L. 28
Villareal, M.J. 29
Vitebsky, P. 280
Vontress, C.E. 2, 70, 79, 86, 91–93

W
wa Thiong'o, Ngũgĩ 25
Wachholtz, A. 265
Wagemakers-Schiff, J. 189
Waitoki, W. 163, 169
Waldron, I.R.G. 67
Walker, R. 163, 174, 177
Wang, K.Q. 266
Watkins, M. 3, 10
Watt, R. 30
Watts, A. 306
West, W. 3, 4, 69
Whicher, I. 107
White, D. 116
White, D.G. 115
Whitley, R. 31
Wilhelm, R. 151, 304
Wilkie, M. 167
Williams, J. 133
Wilmore, G.S. 47
Wilson, L. 249
Wimby, R. 45

Wolf, M. 284, 293
Woods, D. 250
Wujastyk, D. 116

Y
Yahya Ibn Massawayh 138
Yang, K.-S. 3, 265
Yang, Q.L. 266, 270
Yee, D.H. 267–269, 272
Young, D. 271

Z
Zhang, Q. 272
Zhang, Y. 271, 305
Zhao, D. 132
Zhou, B. 268
Zhu, N. 63, 65
Zimmermann, K.A. 78

Subject Index

A
Aboriginal Act of 1905 173
Accumulated memory of the unconscious 99
Acknowledgement to the Creator 194
Acupuncture 65, 69, 264, 266
African American 25, 63, 255
African cultural worldview 79, 80
African healers 83
African healing strategies 91
African indigenous health care 82, 83
African Indigenous Knowledge 7, 94
African personality theory 84
African religious ontology 81
African traditional healing 31, 78, 83, 91–95
Akhenaton 46
*Anasakt*i 237
*Anasakt*i, *aparigriha* and moral inclusion 236
Anatman 8, 111, 126, 128, 133
Anatta 50
Ancestors 3, 9, 29–31, 46, 66, 68, 81, 84, 85, 87, 88, 92, 170, 171, 197, 204
Ancestors as a source of power 47
Ancient Greeks 41
Animism 64, 79, 80
Anishinabi 9, 185, 188, 189, 191, 197
Antiblack racism are, in Fanon's language, *sociogenic* 217
Aotearoa 8, 40, 163–168, 178
Aparigriha 237, 238
Apartheid passes 247
Aql 141, 146, 147
Arabic equivalent of the term psychology 139
Araucanía 280, 288, 296
Asian 6, 12, 14, 15, 23, 27, 29, 40, 42, 43, 47, 50, 55, 64, 67, 116, 120, 263, 265–273, 307

© The Editor(s) (if applicable) and The Author(s) 2018
S. Fernando and R. Moodley (eds.), *Global Psychologies*,
https://doi.org/10.1057/978-1-349-95816-0

Australian 64, 164, 176
Australian Indigenous psychology 165, 173
Australian Science Media Centre 172

B
Balance 6, 8, 30, 39, 44, 46, 64, 65, 71, 81, 85–87, 125, 186, 189, 193, 194, 197, 203–205, 208, 210, 268
Balance and harmony 65
Basic concepts of Mapuche health 205
Benevolence (*ren*) 153–156
Bhagavad Gita 7, 42, 61, 107, 108, 112, 115, 116, 237
Biko, Steve
  Black Consciousness (BC) definition by 11
  Black Consciousness (BC) psychology in SA 11, 246
  history and thought 246
Biomedicine 289
Biopsychosocial model 52
Black as a disease of the body 217
Black Consciousness (BC) 11, 47, 219, 222, 225, 226, 253
Black conscious psychology 249, 251–256
Black experience 256
Black liberation struggles 226
Black People's Convention 248
Black Power 47
Black Skin, White Masks 11, 216–219, 221, 222, 224, 225
Black South Africa 245
Black Theology 47
Bodhisattva 129, 130, 133
Brahman 49, 108, 109, 111, 114
Brahmins 101, 111
Buddha 50, 120–125, 131, 132
Buddhi 49, 102–106
Buddhism 8, 48, 50, 54, 61, 100, 101, 111, 112, 119–126, 128, 129, 131–133, 158, 268–270
Buddhism, goal in 125
Buddhist principles 129

C
Calling to become a healer 78
Caribbean 45, 62–64, 68, 69
Cartesian body–mind dualism 66
Cartesian dualistic 61
Cartesian mind–body dichotomy 4
Cartesian-Newtonian 6, 42
Case-study 285
Cheong 29
Chile 9, 12, 202, 279, 280, 285
China 13, 14, 47, 48, 65, 69, 121, 132, 151, 152, 158, 264, 265, 271, 272, 301, 305–307
Chinese Cultural Healing 8
Chinese culture spirits 29
Citta 49, 102, 105, 106, 131
Cognitive therapy 131, 271, 305
Collective identity 46, 84, 280
Collectivism 7, 28, 30, 79, 80, 85
Colonialism 10, 14, 22, 24, 25, 33, 47, 67, 217, 221, 226, 246, 250, 264
Colonisation 3, 42, 164–166, 171, 172, 175, 177
Communitarianism 28
Community 9, 29–32, 44, 67, 68, 79, 80, 83–85, 91, 93, 121, 157, 164, 167, 169, 170, 174,

177, 186, 189–192, 197, 204, 205, 207, 209, 210, 232, 234, 237, 238, 250, 251, 257, 258, 285–289, 292–296
Concept of health 41, 44, 85, 174, 204
Confucian ethics 8, 153, 267
Confucian ethics for ordinary people 12, 153, 158
Confucian ideology of control 157
Confucianism 12, 65, 151, 155, 157–159, 268–272, 306
Confucian principle of Five Cardinal Relationships 269
Connectedness 29, 54, 66, 86, 225
Construals 22
Constructions of 'self' 129
Constructions of the self 5, 11, 24, 26, 33
Constructive living therapy 303
Constructivists culture 6, 22
Consumer capitalism 22
Contextualization (biomedicine and traditional medicine) 295
Control the spirits 280, 284
Cooperative Research Centre for Aboriginal Heath (CRCAH) 176
Core identity 128
Cosmocentric 30
Cosmologies 31, 65
Cosmology of Daoism 151, 152
Creolization 63
Critical literature 215
Cultural form of social anxiety 268
Culturally appropriate healing 164
Culture-specific emotions 29

D
Daode Jing 151, 152, 159, 304, 305
Daoism 12, 151, 157, 304
Daoists' contemplation 159
Darshana 101, 104, 105, 107, 111, 114, 123
Declaration on the Rights of Indigenous Peoples 168
Decolonial therapy 223, 224
Decolonizing psychology 32
Definitions of psychology 164
Dehumanization 217, 218
Demons 88
Department of Science and Technology (DST) 94
Depression and mania 78
Dharma 110, 112, 116, 124, 131
Dharma-chakra 124
Dichotomy between mind and body 42
Disconnection within the individual 89
Diversity of human experience 22
Doctrine of the Mean 153, 154, 160, 301
Domain of knowledge 187
Domain of psychiatry 60
Drapetomania 222
Dravidian cultures 101
Dravidians 100
Dreaming 176
Duhkha 123, 124

E
Earth 191
East Asia 12, 26, 263–265, 272, 273
East Asian concept of Relational Self 267
Eastern Mysticism 64
East-West difference 40
Ecocentric 30

Egypt 45, 46
Egyptian civilisation 45
Eightfold Path 8, 125
Eight limbs (*ashtanga*) of Yoga 105
Elders 121, 156, 177, 185–187, 196, 197
Embodied suffering 294, 295
Emergence of 'the black' in psychological study 215
Enlightenment 4, 47
Enlightenment (*bodhi*) 129
Epistemologies 2, 6, 23, 33, 59, 63, 65, 68, 174, 176
Espiritismo 63, 68
Ethical care 269
Ethical healing 12, 157, 304, 306
Ethics 31, 42, 46, 60, 155–157, 176, 203, 255, 269
Ethnocentric 2
Ethnopsychologies 22, 23, 28, 30
Euro-American models of psychology 255
Eurocentric 2, 131
Euromodern world 221, 227
European colonialism 24, 64, 71
European occupier's violent seizure of colonial territories 223
Evil Eye 8, 145
Existential and ontological concerns 64
Existential angst 123, 127
Experiments with truth 229, 239, 240
External causes of diseases 88

F
Facilitators of healing 193
Family intervention techniques 296
Fanon, F.
  approach 217
  black consciousness ways 226
  capitalized Black 227
  existential phenomenological view of mental health 223
Fanonian methods 225
Fanonian psychoanalysis 220
Fanonian psychology 221, 226
Fear of offending and embarrassing others 268
First outpatient psychiatric facility on the african continent 218
Fitrah 8, 139–145
Five Cardinal Ethics and Three Bonds 155
Forced removal of children 166, 167, 175
Forefathers and foremothers (teachings and kindness) 186
Forgiveness 240
Formal apology to Indigenous people 167
Four Noble Truths 8, 123, 124, 131

G
Gandhian model 230
Gandhian philosophy 11
Geo-political power dynamics 1, 3
Ghost in the machine (dogma) 42
Globalization 1, 23, 24, 33, 40, 42, 71, 94, 246, 272
Global psychology 5, 254, 255
Global South 3–6, 10, 12, 22, 59, 61, 64–71, 131
Greek civilisation 42, 46

Group 7, 24, 25, 27–29, 44, 45, 63–67, 78, 79, 85, 91–94, 99, 154, 177, 191, 238, 251, 252, 257, 279, 293, 296, 305
Group healing 83, 93, 94

H
Hakomi method of body-centered psychotherapy 304
Han dynasty 155, 158
Harmony with forces of nature 86
Healing of the mind 60
Healing practices 2, 6, 12, 24, 30, 31, 64, 68–70, 83, 132
Healthcare delivery 92, 94
Healthy skepticism 124
Heart (*al-qalb*) 139, 143
Heart Sutra 131, 133
Heart/mind (*manas*) 102, 105
Herbal infusion 83
Hexagram 152
Himsa (violence) 230
Hindu culture 7, 42
Hindu philosophies 100, 111, 113
Hindu philosophies of the Self 112
Hindu psychology 7, 50
Hinduism 48, 61, 100, 107, 109, 110, 112, 120
Hispanic 64
Historical and cultural contexts 6, 61
Historical trauma 165, 166, 167, 175
History of western psychology 6
Holism 6, 39, 44, 51–53, 65, 66, 68
Holistic approach 13, 53, 190, 267
Holistic concept of well-being 204
Holistic model of intervention 94
Humanistic 29, 30, 48, 115, 216
Human nature socially constructed 7, 80, 85, 94
Human nature
  view of 79, 80
Human rights 60, 94, 296
Humble approach 186

I
I Ching 8, 151–153, 304
Iconicity of images 60
Identity 11, 22, 24, 27, 46, 50, 54, 66, 79, 129, 146, 169, 170, 172, 202, 233, 251, 279–281, 292–295
Identity dissonance 250
Idioms of distress 266
Imbalance in our minds 190
Impermanence 50, 131
Independence and interdependence 28
Indian psychology 48–51, 61
Indian subcontinent 7, 100
Indigenizing psychotherapeutic approaches 272
Indigenous American 14, 64
Indigenous Australians 40, 163, 166, 168, 172, 173
Indigenous healing system 82
Indigenous health framework 171
Indigenous peoples 7, 24, 29, 30, 32, 164–168, 171, 172, 176, 178, 187, 189, 196, 296
Indigenous philosophy 186, 196
Indigenous psychological paradigms 165

Indigenous psychology (IPs) 3, 6, 8, 12, 23, 32, 149, 164, 165, 168–170, 178, 264, 265
Indigenous therapeutic knowledge 173
Indigenous traditional health and healing 190
Individual exists for the group 79
Individualism 8, 22, 27–30, 80
Individualistic 2, 163
Individuals 3, 10, 24, 26, 27, 29, 33, 50, 54, 60, 63, 65, 66, 68, 78, 80, 88, 92, 107, 166, 190, 206, 234, 236, 239, 279–282, 284, 291, 295
Innate nature 140
Institutional therapy 221, 223
Institutionalised racism 173
Intellect (*al-aql*) 139
Internalized stereotypes 25
Interpersonal process 21
Intersubjectivity 33
Iradah 141, 144
Islam 14, 47, 48, 51, 120, 139, 140, 272
Islamic culture 40
Islamic psychology 137, 139, 140, 143, 149
Itrofillmongen 205

J
Jainism 100, 101
Jamaican folk medicine 62
Jinn 8, 145

K
Kabbalistic thought 62
Karma 108–110, 113, 114, 116, 237, 269
Kaupapa 165, 168
Kaupapa Māori psychology 168
Kawa kawa 287, 288
Kemetic knowledge 46
Knowledge carrier 190, 193, 194
Knowledge production 4, 64
Krutzen 230
Kshatriyas 101
Küme 204, 206
Kümelkalen/Wezafelen rewe 204, 206
Kutran 206
Kuymun 203, 294

L
Lacanian psychoanalysis 220, 221
Lacanian semiological model 221
Language 9, 22, 25, 26, 45, 78, 132, 164, 165, 169, 172, 177, 205, 207, 218, 221, 222, 246, 257, 267, 285, 286
Lao Tzu's wisdom 305
Lawen 206
Law of *karma* 49, 51
Le nègre 218
Liberating spiritual teachings 123
Liberation 5, 9–11, 50, 51, 100, 107, 109–112, 129, 246, 250, 251, 256, 271
Liberation theology 10, 47
Liberatory psychology 252
Lived experience 219, 223, 225, 290
Lived-Experience of the Black 225
Lived reality of blackness 218
Lived realization 226
Lumbini 120, 132

M
Machi 203, 206–209, 286–288, 291, 293, 295
  diagnosing ability of an illness 207
Machi kutran 207, 208, 286–289, 293, 294
Machi pewma (shamanic dream) 287
Machi (shaman/traditional healer) 205, 207, 286
Machikutran:a multidimensional idiom 293
Machiluwun 203, 288
Madness 223
Mahayana 121, 125, 129, 131, 132
Maladjustment to antiblack racism 222
Manaakitanga 169
Manas 49, 102, 103, 106
Manichean binaries 219
Māori
  creation stories 170
  cultural foundation 169
  epistemologies 168
  identity 169
  practices 169
  therapists 170
  values and worldviews 168
Mapuche
  experience social/spiritual illness 208
  healing system 9
  health worker 285, 288
  logic 206
  medicine specialists 205
  notions of good and bad 206
  people 9, 12, 202–204, 206–208, 279, 288, 291, 293
  therapist 209
  traditional healers 207
  understanding of health and illness 203
Maya 48, 108, 109, 111
Mayotee 283
Means and ends are convertible terms 236
Medicalization 43, 290
Medicalization of lived experiences 295
Meditative practices 108, 122, 125, 130
Mediums 80
Meihana model 171
Mental disorders 24, 29, 139
Mental health 1–3, 6, 8, 9, 11, 12, 14, 23, 32, 33, 39, 52–54, 63, 68, 71, 78, 100, 120, 128, 129, 131, 133, 139, 145, 166, 167, 174, 176, 177, 186, 190, 194–197, 237, 240, 264–266, 272, 273, 289, 295
Mental well-being 189
Meridian system, *qi*, and *yin-yang* 264
Middle Way 125
Migration to Europe and North America 1
Mihimihi (ceremonial greetings) 169
Mind-body dualism 52
Mindfulness 8, 125, 126, 131, 133, 305
Mindfulness movement 130
Mino-bimaadzawin 189
Model for Self-Improvement 148
Models of wellbeing 265
Modern psychology 60, 229, 239

Modimo 84
Mongen 204, 206, 207
Monism 51, 53
Morita therapy 12, 65, 270, 272, 301, 302, 307
  anxiety-based disorders in pre-war Japan 307
Morphostasis 8
Movement for Global Mental Health 1
Multiculturalism 149, 272
Myanmar 121

N
NACCHO 167
Nafs 139, 142, 146–148
Naikan therapy 12, 65, 270, 272, 302–304
  for interpersonal relationships 307
National Aboriginal Health Strategy Working Party 174
National Union of SA Students (NUSAS) 248
Native American spirituality 64
Native Title Act of 1993 173
Natural law 186, 191, 193, 197
Nature of human soul 8
Negritude 224, 249
Negro 217, 279
Nêhiyaw 191
Nepal 120, 132
Nervios (nervousness) 208
Newtonian physics 42, 43
Ngenechen 202, 203
Ngenechen (the human being's creator) 202
Nietzschean notion of the last man and the overman 219
Nigeria 7
Nirvana 50, 120, 121, 124–126, 130, 132
Nkulunkulu 46
Noble Eightfold Path 124
Nondual Spirituality 100, 113, 114
Nonviolence 230–232, 234–236, 238–240, 305
North African Syndrome 217
Nuba in Kenya 46

O
Obeah 63
Objectivity 55
Office of the Auditor General 168
Oludumare 46
Omoluabi 30
Oneness of God (*Al-Tawhid*) 140, 143, 144
Onmeum counselling 12, 269, 270
Oral tradition 185–188
Oral transmission 187, 188
Orisha 68
Ovambo in Namibia 46

P
Parable of the poisoned arrow 121, 122
Patanjali 7, 104, 105
Pelom 203, 286, 288
People Culture Environment and One Generation Media Elkin 177
Perceptions 108, 126, 127, 270
Perimontun 202, 203, 294
Perimontun becomes *kuymun* 203
Personal growth 157, 239, 282

Personal self-image 127
Person exists because of other people 84
Personhood 22–33, 153
Pewma 203
Pewütun 205
Philosophy of *I Ching* 152
Physics 13, 43, 48, 53, 138
Placebo effect 52
Plant-based medicines 193, 195
Polynesians 41
Positive intrinsic black identity 253
Possession and trance 202, 281–283, 296
Power of biomedicine 12, 263
Power relations among cosmic entities 81
Prakrti 50
Pretoria's Palace of Justice 248
Propriety (*li*) 153–155
Psyche 4, 12, 21, 23, 41, 45, 50, 53, 125, 139, 223, 245, 249, 251
Psychiatric ideologies and diagnostic processes 289
Psychiatry 2–4, 12–14, 24, 42, 52, 53, 196, 215, 216, 219, 220, 263, 264, 266, 271, 284, 296, 304
Psychiatry in the sweat lodge 196
Psychoanalytical thinking 220
Psychological (*hinengaro*) 171
Purusha 50, 101, 102, 106–109, 111, 114

Q
Qalb 143, 146
Qigong 69, 304
Qur'an 137–146

R
Rab healing 67
Racial factors 221
Racialized identities 25
Racism 224
Reductionist idiom 52
Reductionist method 52
Relatedness 29, 87
Relevant Psychology in SA 253
Religion 4–6, 14, 25, 42, 45–48, 50, 51, 54, 60, 63–65, 67–69, 71, 78, 82, 116, 121, 129, 141, 203, 250, 280, 281, 283, 290, 291
Respect and Relationships 9
Respecting the superior 153, 154, 156
The Rest 2, 14, 39, 81, 87
Restoring Balance 193
Rhodes Must Fall 246
Rhodes University 248
Righteousness (*yi*) 153–156
Romans 41
Royal Commission on Aboriginal Peoples (RCAP) 189, 195
Ruh 146

S
SA History Online 247, 248
Saiwalo 61
Samadhi 106, 107, 126
Sangha 121, 122
Sankhya 8, 101–109, 111, 112, 114, 115
Sankhya *darshana* 101, 104, 105
Sankhya philosophical system 101
Santeria 63, 68
Sarvdharma (all-prayer) meetings 238

Sarvodaya (compassion for all) 238
SASO-BPC Trial 248
Satan (*Shaitaan*) 145
Satyagraha 11, 229, 230, 232, 236, 237, 239
  discipline and physical work 238
Satyagrahi general has to obey his inner voice 233
Schizophrenia 78, 138
Schools of Indian philosophy 100
Scientific paradigm 42, 43
Scientific psychology 139
Scuthorpe 176
Secret of the Golden Flower 304
Self 5–8, 11–13, 21–31, 33, 49, 50, 54, 61, 62, 65–67, 80, 82, 89, 94, 99–101, 103, 104, 106–111, 116, 119, 125–128, 130, 138, 139, 142–144, 146, 186, 197, 221, 222, 224, 225, 233, 234, 237–239, 250–252, 267, 268, 270, 282, 283, 294, 295, 304, 306, 307
Self-actualization 11, 239
Self-alienation 224
Self-construction 26, 66, 127
Self-construction process 129
Self-control 29, 229, 232–234, 238
Self-cultivation 12, 65, 157, 158, 304–307
Self-esteem 27, 93
Self-examination 239, 302
Selfhood for the colonized 25
Self-images 8, 111, 127, 128
Self in Hindu Philosophes of Liberation 7
Self-purification 239
Self-realization 42, 100, 104, 109, 110, 112–114, 120
Self-reliance 28, 125, 238, 251
Sense of self 23, 30, 128, 129
Shahwa 144
Shakyas 120
Shaman 12, 66, 70, 203, 207, 208, 281, 284, 286–289, 292–295
  healing role 281
  and psychiatrists 296
  Shamanic calling 286, 291, 292
  Shamanic power 203, 287, 288
Shamanism 12, 208, 280–282, 284, 291, 295
  mental health 280
  psychiatry and individuals 284
Shango 63, 68
Shankara 8, 108, 114, 115
Shinkeishitsu 301
Shudras 101, 111
Slavery 14, 24, 63, 68, 222
Social and Emotional Wellbeing model 9
Social construction 87
Social determinants of health 165
Social Health Reference Group (SHRG) 174, 175
Social justice 60
Social networks 31, 92
Sociodiagnosis 224
Sociogenic analysis 11
Soul 31, 46, 49, 50, 60–64, 66, 80, 82, 85, 89, 111, 122, 126–128, 130, 138, 139, 141–146
Soul (*al-nafs*) 139
South Africa 7, 10, 11, 45, 47, 237, 256
Spanish and Chilean domination 202
Spirit 4, 31, 43, 44, 46, 50, 61–64, 66–68, 70, 71, 80–83, 85, 87,

88, 92, 93, 129, 132, 139, 141, 143, 144, 146, 147, 171, 176, 186, 189, 190, 197, 281, 282, 284, 287–289, 292, 294, 296
Spirit (*al-ruh*) 139
Spirit possession 203, 281–283, 287, 293, 295
Spiritism 62, 66, 68
Spiritual (and sociopolitical) system 176
Spiritual Baptist 63
Spiritual enlightenment 120, 121
Spiritual healers 84, 146, 177
Spiritual healing 177
Spiritual liberation 100, 107, 110, 112, 113
Spiritual power 83, 293
Spiritualism 7, 79, 80, 82
Spirituality 4, 6, 9, 39, 43, 44, 54, 55, 71, 91, 143, 174, 176, 190
Spirituality (*wairua*) 171
Sri Lanka 121
Stereotypes 25
Steve Biko Foundation (SBF) 246
Structuralism 220, 282
Suffering (*duhkha*) 122
Sufism yoga 51
Sunao 302
Supreme God 46
Surveillance 173
Sweat lodge 9, 194–196
Systems theory 48, 53

T
taijin kyofusho 268
Taiqichuan 304
Taoism 48, 54, 65, 66, 158, 268, 270, 271, 304, 306
Taoist cognitive psychotherapy 12, 271, 305, 307
Taoist Cognitive therapy 65
Taoist healing for authentic self 304
Tao of Nature 66
Tao psychotherapy 12, 271
Ten things of righteousness (*yi*) 156
Ten Wings 151, 152
'*Te whare tapa wha*' (the four-sided house) 171
Thailand 121
Theory of the self 23
Therapeutic knowledges 172, 173
Theravada 121, 132, 133
Think therefore I am 66
Third World 2, 3, 10, 14
Thought (*citta*) 102, 105
Three dimensional model of nonviolence 232, 236
Tibet 119, 121, 132
Tibetan Buddhism 50, 188
Tikanga (ethics and moral codes) 169
The Times They Are A-Changing 14
Tino rangatiratanga 168
Torres Strait Islander people 167, 172, 177
Traditional Chinese Medicine (TCM) 65, 69, 263, 264, 266, 273
Traditional healer 194, 203
Traditional healing 82, 83, 176, 186, 187, 189, 191, 195–197
Traditional healing practices 3, 6, 64, 69–71, 92, 94, 177, 191, 263, 264

Trance 70, 85, 203, 205, 207, 281–284, 295, 296
Trance shaman 70, 203, 284, 295
Trance spirit possession 203, 295
Tranquil soul or *nafs al-mutmainnah"* 142
Treatment of the soul 60
Trishna 124
Turtle Island 9, 195, 196

U
Ubuntu 30, 66
Ukuthwasa 78
United Nations (UN) 164, 166, 168, 265
Universal truths 6, 21
Upanisads 49
Upanishads 61, 107

V
Vaishyas 101
Vasudeva Kutumbkam 237
Vedanta 101, 107–109, 111, 114–116
Vedanta *darshana* 107, 111
Vedanta systems 8
Vedic tradition 7
Violence 10, 11, 25, 111, 165, 166, 219, 231, 235–237
Voodoo 63, 68
Vows and self-control 232
Vrata 233

W
Waitangi Tribunal 168
Way of Heaven on the Way of Humanity 152
Well-being
  dynamic equilibrium 205
  Mapuche world 204
The West 2, 14, 39, 41–43, 48, 59–61, 68–71, 91, 100–104, 113, 115, 116, 304
Western academic psychology 22
Western Christianity 14, 47
Western psychology 3–7, 9, 15, 22, 24, 28, 32, 33, 50, 61, 71, 139, 149, 154, 156, 163, 165, 169, 170, 229, 232, 234, 240, 254, 264, 265, 271, 305
Whakawhanaungatanga 169
Whānau Ora 168, 169
Wheel of Life 127
Whiteness 25, 222, 253, 255
Whole-of-life view 174
Wisdom (*prajna*) 129
Wolof 45
World Health Organization (WHO) 82, 87, 166
Worldviews 13, 23, 32, 33, 41, 59, 65, 100, 101, 113, 114, 167–170, 178, 204, 265
Wounded healer 207

X
Xhosa 78, 246, 248
Xhosa-speaking communities 78

Y
Yang 44, 53, 65, 152, 153

Yin 44, 48, 53, 65, 152, 153
Yoga 8, 51, 100, 101, 104–107, 109, 111, 113, 115, 116
Yoga *darshana* 104, 105, 107
Yoruba 30, 31, 45, 46, 62, 68

Z
Zar healing 67
Zen 48, 116, 269, 301
Zen *Buddhism* 54
Zulu 45, 46, 66, 78

View publication stats