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HINDU PSYCHOLOGISTS' PERCEPTIONS OF MENTAL ILLNESS

A Research Report by

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DECLARATION

I declare that this thesis is my own unaided work. It is submitted in partial fulfilment of the requirements for the degree Master of Arts in Psychology by Coursework and Research Report in the Department of Psychology, University of the Witwatersrand, Johannesburg. It has not been submitted for any other degree or examination at any other university or institution.

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Priyanka Padayachee

20 April 2011

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CHAPTER 1: LITERATURE REVIEW

Culture shapes the expression of mental illness (Matsumoto & Juang, 2004), as well as the perceptions of illness and pathways to health care (Komiti, Judd & Jackson, 2006; Saravanan Jacob, Deepak, Prince, David, & Bhugra, 2007). Furthermore, many non-Western cultures do not conform to the assumed universality of Western psychological theories (see Swartz, 1998). Thus, the application of Western ideas and understandings of mental illnesses without integrating the respective culture's beliefs and values will not result in an understanding of those afflicted (see Chong, Verma, Vaingankar, Chan, Wong & Heng, 2007). This in turn would deter more traditional communities from seeking the help of Western practitioners. Evidence for this is found in a study conducted by Campion and Bhugra (1997 cited in Campion & Bhugra, 1998) which observed that almost half of the patients interviewed in a Westernised psychiatric facility had been to see a religious healer prior to seeking help from a psychiatrist. Thus the way in which mental illnesses are expressed and perceived in different cultures needs to be incorporated into the therapeutic process as they may play a role in determining whether treatment is effective.

This study explores Hindu psychologist's perceptions of mental illness, and the role, if any, of religion on these perceptions. In the discussion that follows, mental illness is defined and explored in terms of its conceptualisation in various cultures and within the Hindu religion. Prominent beliefs held by Hindus regarding the origins of mental illnesses will then be discussed, followed by an elaboration on the treatment of mental illnesses in Hinduism.

1.1. Defining Mental Illness

The terms ‘mental illness’, ‘mental disorder’, and ‘psychological disorder’, are often used interchangeably. The British government, in their Draft Mental Health Bill (Department of Health, 2004, p.3 cited in Pilgram, 2005), define mental disorder as an “impairment of, or a disturbance in the functioning of the mind or brain, *resulting from* any disability or disorder of the mind or brain”.

In his study of public knowledge and beliefs about mental disorders, Jorm (2000) found that many members of the public could not correctly recognise mental disorders and do not understand the meanings of psychiatric terms. Instead, their beliefs about the causes of mental disorders and the most effective treatments thereof, differed from those of mental health experts. Thus clinicians may have difficulty in implementing effective mental health care if patients do not believe in the interventions offered. Jorm (2000) concluded that attitudes which hinder recognition and appropriate help-seeking are common. Even among mental health professionals, there are great disparities in the definitions of mental illness (Granello & Granello, 2000). Schinnar, Rothbard, Kanter and Jung (1990) reviewed literature on mental health in order to determine if consensus was present, and instead, found seventeen different definitions of mental illness between 1980 and 1990, and concluded that the conceptualisation of mental illness varies greatly and often according to the beliefs of one’s community.

There are several reasons why achieving professional consensus regarding the definition of mental illness, may be difficult. While definitions in Western models primarily focus on the individual, biological and intra-psychic causalities; mental health professionals may exhibit a wide range of their own opinions regarding the aetiology of a mental illness (Granello & Granello, 2000). Interpersonal definitions, however, view maladaptive social systems as a potential cause of mental illness. It is believed that such systems increase the individual’s susceptibility to stress and other predisposing factors, or may actually lead to the diagnosis of a patient as mentally ill (Granello & Granello, 2000). It is therefore difficult to define mental illness when even within the professional community there is a lack of agreement as to whether individuals or systems should be the primary focus.

Szasz (1974) argued that mental illness did not exist and was in fact a social construction used to control individuals who display behaviours that deviated from those accepted by society. This, together with the existence of vague definitions of what constitutes a mental illness in both mental health law and communities (as described above), give rise to the idea that the conceptualisation, perceived cause, and treatment methods for mental illnesses are specific to one's community, society, or culture. Indeed, in some non-Western cultures, supernatural phenomena, such as witchcraft and possession by evil spirits, are seen as important causes of mental illness (Jorm, 2000). However, these ideas are not recognised in Western conceptualisations of mental illnesses.

1.2. Culture and Mental Illness

Matsumoto and Juang (2004) define culture as a system of rules (implicit and explicit) established by a group so as to retain the survival of their attitudes, values, beliefs, norms, and behaviours. A more comprehensive definition of culture conceptualises it as the ways of life for an entire society; including arts, beliefs, manners, dress, language, religion, rituals, and norms of behaviour of a group that are passed down to future generations (Sue & Sue, 2003). Not only does culture influence the perceptions of illness and pathways to health care that its members follow (Saravanan et al., 2007), but it also shapes the expression of mental illnesses and plays a role in the emergence of culture-specific syndromes (Matsumoto & Juang, 2004), such as *amafufunyana* in African culture (Lund & Swartz, 1998), and *Taijin-Kyofu-Sho* in East Asia (Choy, Schneier, Heimberg, Oh & Liebowitz, 2008). This is further highlighted by Zaumseil (1998), who posits that mentally ill individuals understand their psychological experience from within their own cultural milieus. Therefore the issue of cultural perceptions of mental illness is of global importance as 80% of the world's population depends on traditional medicine for their primary health care (Aiken, 2003 cited in Ross, 2008). More locally, 84% of the South African population consult with indigenous healers over three times a year (Lambrecht, 1998 cited in Ivey & Myers). Moreover, culture influences how mental illness is experienced, interpreted and exhibited (Swartz, 1998).

Throughout the years there has been some debate in the field regarding the nature of the concept of culture. The debate centred on whether or not culture remained fixed, or was

subject to change over time and across contexts. While previous conceptions revealed culture to be fixed (Fernando, 1991), post 1980s research has shown an increasingly fluid understanding of culture (Lund & Swartz, 1998). This is particularly relevant in the South African context, where culture is not fixed or static, but is mutually influential. Thus in such dynamic contexts, it becomes difficult to posit an individual as being located purely within one culture and holding one view.

Adding to the complexity of the relationship between culture and mental illness is the fact that there is no one definition of mental illness that is accepted across all cultures, as definitions differ according to the point of view of the one who is defining it (Narendra, 1999). Cultural consideration is thus a vital component in understanding peoples' perceptions of mental illness. This frame of reference will also prove beneficial in providing appropriate treatment for the afflicted. It is important to note, however, that cultural belief and tradition for the Hindu, is *religious* belief and tradition – since religion and culture are one and the same thing for this group (Fowler, 1997). It becomes evident then that Hindus use a religious framework from which to understand psychological symptoms and mental illnesses alike. Religions of such traditional communities tend to advocate supernatural beliefs in their understanding of mental illnesses. It is believed that such supernatural forces influence the behaviour of a person in a manner that resembles that of a mentally ill individual (Ally & Laher, 2008). However, in understanding the perceptions of Hindus towards mental illness, one must have a basic understanding of the relationship between religion and mental illness.

1.3. Religion and Mental Illness

Religion, integral to culture, is defined by Hill et al. (2000 cited in Worthington & Aten, 2009, p. 124) as ”the adherence to a belief system and a set of practices associated with a tradition and a community in which there is general agreement about what is believed and practiced”. As such, Hinduism would be classified as a religion. It is also worth noting that, as mentioned previously with regard to culture, it is difficult to posit a static conceptualisation of a religion’s beliefs and practices. Indeed, not all Hindus practice Hinduism in the same way – if at all. Among those who do practice Hinduism, the degrees of observance among the different Hindu groups (Gujarati, Hindi, and Tamil respectively) in addition to the interaction within a multicultural South African context, make the category ‘Hindu’ very varied. Despite this, however, the researcher considered all Hindus as a homogenous group, for this study.

When exploring the relationship between religion and mental illness, a number of published empirical studies suggest that religious involvement is associated with better outcomes in physical and mental health (see Fallot, 2007; Huguelet, Mohr, & Borras, 2009; King, Weich, Nazroo, & Blizard, 2006; Rasic, Belik, Elias, Katz, Enns, & Sareen, 2009; Sullivan, 2009; and Taylor, 2001). This influence is considered to be beyond the effects of traditional measures of coping due to the added benefits of spiritual support (in addition to traditional social support), lower levels of loneliness, and greater life satisfaction (Pargament & Brant, 1998). However, attention has also been given to the potential for negative effects of religion on health. Historically, religion has sometimes been used to justify hatred, aggression, and prejudice (Lee & Newberg, 2005). It can be judgemental, alienating and exclusive. Moreover, although religious participation may foster beneficial social networks, social relations may also be a source of stress (Chatters, 2000). Failure to conform to community norms may evoke open criticism by other members (Williams & Sternthal, 2007). Feelings of religious guilt and the failure to meet religious expectations or to cope with religious fears contribute to illness (Trenholm, Trent & Compton, 1998). Certain types of religious coping may also adversely affect health. An extrinsic religious orientation and negative religious coping has been associated with elevated symptoms of depression (Smith, McCullough, & Poll, 2003), and negative interpersonal religious experiences and congregational criticism has been associated with increased risk of depression among adolescents (Williams & Sternthal, 2007).

With regards to religious conceptualisations of mental illness, research indicates that religious individuals tend to attribute explanations of mental illness in "strongly religious terms, and consider psychiatric disorders to reflect the will of God (or some other higher power)" (Schnittker, Freese, & Powell, 2000, p. 1104). The perceptions of mental illnesses held by such devout individuals may account for the success of religious coping in adverse conditions such as psychological disturbances. Furthermore, the way in which different religious groups conceptualise mental illness is important, as the beliefs held by people regarding the causes of mental illness may shape their views of help-seeking behaviour. For example, in Malaysia, belief by psychiatric patients in supernatural causes was associated with greater use of traditional healers and poorer compliance with medication (Jorm, 2000).

The differences in these beliefs across communities often cannot be explained by socioeconomic status or other confounding variables. Instead, they reflect cultural or ideological differences that are rooted within the historical and structural position of that particular group. Broman (1987 cited in Schnittker et al., 2000) for example, uses a comparison between black and white individuals to illustrate that collectivistic communities are less likely than Western communities to seek professional treatment for mental health problems. Evidence suggests that as a result of their stronger religious beliefs and higher levels of religious participation, collectivistic individuals tend to turn to prayer or consult religious leaders for help with personal and psychological problems; while Western individuals, however, tend to endorse the beliefs of mental health professionals in their conceptions of mental illness (Milstein, Guarnaccia, & Midlarsky, 1995 cited in Schnittker et al., 2000). For example, in Ethiopia, Alem et al. (1999 cited in Jorm, 2000) discovered that traditional sources of help, such as witchcraft, holy water and herbalists, were preferred over medical help for a range of mental health problems. The Hindu community may also be deemed collectivistic. As such, the pathways to treatment outlined above for such communities may also be followed by the Hindu individual. In order to fully comprehend the Hindu's view of mental illness and treatment thereof, a discussion on the relationship between Hinduism and mental illness is warranted.

1.4. Hinduism and Mental Illness

The Hindu view of mental health and illness includes magical, religious and naturalistic elements. Unlike the West, spiritual influences on health are strongly recognised in Hinduism. One common and recurrent theme in Western literature is the mind-body dichotomy. Narendra (1999) posits that Western thought appears to be preoccupied with thinking in terms of dichotomies, be it body or mind, good or evil, or nature or nurture. In contrast to this Western separatist world view, Hinduism reflects a holistic system of beliefs which views the aspects of human nature as being independent and integrated (Fowler, 1997). Therefore, Hindu concepts of mental health cannot be separated from beliefs about physical and spiritual health. Furthermore, Hinduism values mutual dependence and thus, community well-being is stressed above individual well-being (Juthani, 2001). The inter-relatedness between the nuclear family, the extended family, and the wider community is deemed necessary for the balance and harmony of the individual (Chekki, 1996). Hinduism shares with African culture the notion of illness as a manifestation of one's imbalance in the total world situation rather than as a predominantly physiological or psychological dysfunction (Holdstock, 1979). Evidence for this is found in a study by Mdleleni (1990 cited in Lund & Swartz, 1998), who interviewed Black psychiatric patients who perceived their condition as *amafufunyana*, or 'the calling'. Failure to heed this call would result in increased distress: spiritual, emotional, physical, and psychological.

Hinduism is both a theology and a philosophy. As a religion, it is one of the oldest, most diverse and complex religions known to mankind (Stroup, 1972). With no known beginning, no human founder, the religion predates recorded history (Juthani, 2001). The term Hinduism has come to represent a whole spectrum of beliefs and practices, and is as much a 'way of life' than a religion. Hinduism affects every aspect of life for Hindus, from birth throughout their lives (Mysorekar, 2006), and therefore forms an integral part of the cultural practices of its followers.

The philosophy of Hinduism has its basis in religious texts and epic scriptures from which Hindus have gained spiritual inspiration. Among these are the Upanishads, the Bhagwad Gita, and the Vedas; as well as the Ramayana and Mahabharata epics. These scriptures are all

written in Sanskrit and emphasise the importance of knowledge, active work, sacrifice and service to others, and culminate in renunciation (Chekki, 1996). The Vedas hold the title of the largest body of literature in Hinduism, and are among the oldest religious texts in recorded history. They originated as the sacred scriptures of the Aryans and are revered by Hindus as being of divine origin and authority. Juthani (2001) adds to this by observing that Hinduism has also been referred to as the Vedic religion. The Vedas are regarded as the "eternal truths" revealed by God to the *Rishis* (Saints) of India and are the ultimate source to which all religious knowledge may be traced (Naidoo, 1987). Thus, these scriptures give light to the fact that Hindu philosophy is rooted in the experience of many Rishis. These religious scriptures provide conceptualisations of mental and spiritual illnesses (defined and distinguished from mental illness at a later stage in this study), which resonate in widely accepted Hindu beliefs and practices.

The basic philosophical beliefs of Hindus comprise the concept of one Supreme force, the law of Karma, reincarnation, and a vested interest in the cosmos. Hindus believe that there is one supreme and absolute God, referred to in the Upanishad as *Atman* (the human soul) or *Brahma* (the creator). The juxtaposition of these terms highlights Hinduism's belief that God resides in every living creature. To illustrate, the Hindu greeting of Namaste is usually accompanied by the folding together of one's hands, which is believed to be symbolic of a humble salutation to the God within the other individual. Hindu devotion is directed towards various gods and goddesses (also referred to as deities), headed by a trinity comprising *Brahma* (the creator), *Vishnu* (the sustainer), and *Siva* (the destroyer) (Danielou, 1991). The Saivaits who worship Lord Siva, and the Vishnuites who worship Lord Vishnu, comprise the two dominant strains of Hinduism, each with their own unique sets of rituals and practices.

Astrology plays an integral role in the lives of Hindus. It is believed that the positions and movements of the planets have an effect on people's lives. Major life events are planned according to astrological predictions as certain dates are considered more auspicious than others in the lunar calendar. Hindus also believe that the soul has to be reincarnated through many cycles of birth and death until it is pure enough to attain communion with Brahma in a state of bliss or *nirvana* (heaven). Karma refers to the law of moral causality that is necessary in human affairs in order to control imperfection. Karma ensures that an individual will be

reborn into a life corresponding with his/her actions in a past life. In order to avoid bad Karma, the path of *Dharma* or righteousness should be followed. The highest Dharma of a Hindu is to practice *Ahisma* or non-violence (Juthani, 2001). The law of Karma (i.e. every action – good or bad - has a reaction), refers not only to actions undertaken by the body, but also those undertaken by the mind. As such, mental illness is often understood as resulting from the Karma of a past life (Juthani, 2001). For example, bad thoughts such as ill will, resentment or jealousy; an action which performed in the mind, produces bad karma as this conduct is not deemed righteous. As a consequence, in their next birth, the individual may experience a negative reaction, manifested as a mental illness.

It is interesting to note that the day-to-day practice of a Hindu may be carried out as tradition without understanding its meaning and purpose, although it may bring peace to that individual (Juthani, 2001). Indeed, "one striking feature of Hinduism is that practice takes precedence over belief" (Flood, 1996, p. 12). For example, despite the religious scriptures being venerated by Hindus, no Hindu need read them, and few do.

The religious beliefs of Hindus are considered supernatural, and encompass traditions, practices and rituals that enable their religious, and consequently their cultural, beliefs to be transmitted to generations to come. The next sections present a discussion of a few religious beliefs held by Hindus, which are largely seen as the causes behind mental illnesses. These are referred to as 'spiritual illnesses'. It is also important to note, however, that there is a thin line between mental and spiritual illnesses. While a spiritual illness may result in a mental illness, they may also exist in isolation. Additionally, at times a spiritual illness may be misconstrued as a mental illness, and mental illnesses may be misconstrued as spiritual illnesses. Witchcraft, the evil eye, and spirit possession are perceived as the most common spiritual illnesses, and are presented accordingly.

1.4.1. Witchcraft

The word ‘witch’ is derived from the old English ‘Wicca’, meaning a female magician (Joshi, Kaushal, Katewa & Devi, 2006). Witchcraft, then, may be defined as the deliberate use of magic or enchantment, typically with the intention to bring harm to another (Summers, 1945). The witch, or *Dakini*, is said to have become one at birth. As Dwyer (2003) notes, she is born at an inauspicious time, may have been possessed by a malevolent spirit in her youth, or possibly consumed impure substances during childhood, particularly faeces and urine. In addition, she may be further corrupted or made wicked because her body was never washed or because she enjoys wearing dirty clothes and sits in filthy places (Dwyer, 2003).

The witch is inherently malevolent, aggressive, bad tempered, mean, greedy, envious or jealous of those who prosper (Dwyer, 2003). The witch may cause illness or misfortune by way of direct or indirect methods (Roy, 1984 cited in Joshi et al., 2006). Ash from cremation grounds, poisonous herbs, chicken bones and mustard seeds, are ingredients commonly mixed with the victim’s food in the direct method of bewitchment. The indirect method on the other hand, would involve the invocation of occult powers through the chanting of spells. She is said to inflict ailments such as loss of appetite, vomiting, feelings of uneasiness or lethargy, and sicknesses in children such as constant crying (Dwyer, 2003; Joshi et al., 2006). Additionally, labour pains and miscarriage amongst women are also frequent (Dwyer, 2003). Lack of motivation, social withdrawal, intense agitation, terror, sleeplessness, feelings of helplessness and despair, and in some instances, trance-like states, are also believed to be common in victims of witchcraft (Dein, 2003).

According to Dwyer (2003), these events are thought to take place at night, when ghosts and other supernatural creatures are active. Another weapon that the witch is believed to utilise in her attack on victims, is *najar* (also referred to as *nazar* i.e. the ‘evil eye’). It is thought that the witch may cause someone to become sick and/or die, merely by glancing at the individual. Because she is inherently malevolent, she has no control of the evil power that constantly emanates from her eyes. As such, whatever she looks at is negatively affected by her gaze. It becomes evident then that witchcraft in Hinduism is closely linked to the concept of the evil eye.

1.4.2. The Evil Eye

The evil eye, or *najar*, is primarily the belief that someone can project harm or create adversity by means of a malign gaze (Dwyer, 2003). The evil eye belief is found in many societies across the world, though it is not universal (Maloney, 1976). This power is described as involuntary and is stimulated by negative emotions, especially jealousy or envy. Dwyer (2003) elaborates on this by suggesting that the evil eye is related to the concept of witchcraft, since "a person can unconsciously injure or harm another with either of these mystical forces" (p. 77). Furthermore, the malign gaze (*najar*) is claimed to be the main weapon used by witches to harm their victims (Dwyer, 2003). The difference, however, is that unlike witchcraft, no particular action or ritual is required for the evil eye to take effect. It can work simply by wishing harm on another.

Vulnerability to *najar* attack is highest amongst those who are in transition, whose status is uncertain. For example, "those who are newly married, pregnant, newly delivered women, or babies and young children" (Spiro, 2005, p. 72). Abu-Rabia (2005) adds to this by stating that the young, the wealthy and the beautiful, are also vulnerable to *najar* attack. The evil eye may result in bad luck, broken marriages, illness and even death. Characteristic symptoms of *najar*, are changes in appearance or character, uncontrollable shaking of the body, fatigue, convulsions, loss of appetite, incessant crying among children, and labour pains among pregnant women (Abu-Rabia, 2005; Spiro, 2005).

Preventative measures against *najar* are mainly stipulated for children and infants. Smudging the infants outer eye with *kajal*, which is made of *kohl* (soot from the burning of candles mixed inside a coconut shell with castor oil), is done to make the child look less attractive to envious people (Spiro, 2005). A tiny knife may also be pinned to the infants' clothing in order to protect the child by 'cutting' the evil. Routinely holding the child over smoke produced by the burning of charcoal and *sambrani* (popular Indian incense), is also considered a preventative measure as it is believed to cleanse the child from all evil (Hindu Guru, personal communication, 2010).

1.4.3. Spirit Possession

Belief in possession by an earth-bound spirit or *bhut* (ghost) (Betty, 2005) is an integral part of Hindu ideas of the soul and its karma. Spiro (2005) elaborates on this by stating that Hindu cosmology, premised on the idea of the soul transitioning from this world to its next birth, requires that attachments be relinquished and correct rituals be performed in order to achieve completeness or closure. Consequently, unfinished business or an untimely death may result in the spirit lingering as a *bhut*. Betty (2005, p. 14) defines an evil spirit as "more or less intelligent beings, insensible to us, with a will of their own who seem to bother or oppress us or, in rare cases, possess our bodies outright". MacNutt (1995 cited in Betty, 2005), who believes that many mentally ill people are oppressed by spirits, distinguishes between two types of spirits: those who are truly satanic, and the dead who are not so much evil as confused. He does, however, acknowledge that in their blind selfishness these earthbound-spirits can do serious, if unintended, harm (MacNutt, 1995 cited in Betty, 2005). In relation to us, therefore, they too are evil.

Bhuts are said to reside in a house, garden or tree (Spiro, 2005). As such, doorways – especially the back door leading to the garden – are considered dangerous. The dangers associated with the doorway are attributed to its conceptualisation as a threshold i.e. neither in nor out. Therefore, much like the victims of *najar* who are in a transitional period, the doorway's status is ambivalent and as such, one should not linger in them. Again, like *najar*, women and children are especially vulnerable to possession by a *bhut*. Dwyer (2003) addresses this by suggesting that this susceptibility is essentially a function of the beliefs and values of the culture. That being said, Hindu belief stipulates that women (including young girls) and children should not leave the house at twelve noon or night, nor should they play in gardens or stand near trees. These times of day are considered inauspicious as it is a time of 'bad winds', when spirits roam.

Victims of *bhut* possession sometimes show supernatural strength and agility, or behave self-destructively. Other signs include trance-like states, moans or shaking, and strange speech (Betty, 2005). Added to this are fainting, hallucinations and epilepsy (Dwyer, 2003); as well

as changes to the personality, physique and voice of the possessed. In such instances, the assistance of an exorcist is needed to expel the spirit from the afflicted.

It should be noted, however, that the trance-like state, or 'controlled possession' (Flood, 1996), brought about by the invocation of certain deities, is not equivalent to spirit possession, as it has been defined above. The biggest difference is that these controlled possessions do not occur as a result of an evil spirit. Instead, a devotee – through dance, prayer and ritual practices – would urge a particular deity (such as *Kali*, *Hanuman*, or *Siva*) to possess him or her (Flood, 1996). Much like those possessed by *bhuts*, the person is transformed physically and emotionally – but not in a menacing way. Rather, the person becomes an embodiment of the deity, mimicking their physical postures. In fact, these deities are only invoked out of devotion, especially in times of bad luck or misfortune, so that they may perform *aarti* (waving a tray of lights) and use *vibbuthi* (holy ash) to bless devotees and rid them of all obstacles to their prosperity. However, not all devotees are able to invoke this kind of holy possession. Those who are able to are said to be born with such capacities, yet are required to be at a certain spiritual level – one in which they can actively channel their spirituality – before they are able to successfully call upon a certain deity and invoke a trance-like state. As such, these spiritual individuals are usually older in age, although it is not uncommon for young children, thought to be more in touch with their spirituality, to engage in these types of possession states.

A Western mental health professional may be quick to point out that the symptoms of witchcraft, evil eye, and spirit possession identified above, bear a resemblance to certain psychological states and dysfunctions. Yet in many other (traditional) societies, these psychological symptoms are taken as evidence of supernatural forces and illnesses. Much of the Western secular world is suspicious of religion and can easily become rigid and intolerant. Indeed, "sections of the secular lobby have rejected Hinduism as irrational and unscientific" (Siddhartha, 2008, p. 36). This outlook leads many Western practitioners to be weary of 'the delusion of possession' (Betty, 2005), amongst other things. Furthermore, belief in witchcraft and the evil eye would not be widely accepted into the scientific and rational practice of Western psychology. It is for this reason that Hindus generally seek more traditional forms of treatment.

1.5. Treatment of Mental Illnesses in Hinduism

Due to their mode of cultural heritage, the majority of South African Hindus follow cultural practices taught and passed down by their ancestors, thus ensuring that links to their heritage in India have been maintained over the years. Hence, while literary and philosophical knowledge characteristic of Hindu culture is limited among South African Hindus, their practices are fairly similar. Due to the similarity in treatment methods (see Naidoo, 1985), and the shortage of locally-based literature, this section outlines the common treatment methods employed by Hindus from both the United Kingdom and Northern India.

Most Hindus perceive mental illness as having a supernatural aetiology. And since patients and carers often seek help from sources that match their own explanations of the illness, traditional healers are usually consulted when psychological symptoms (resembling depression, schizophrenia, or psychosis) are displayed by the individual (Dwyer, 2003; Betty, 2005). It has been highly misconceptualised that there exists a dichotomy in seeking indigenous healers between urban and rural populations, with the more urban and educated people (like South African Hindus) seeking Western based healing systems; whilst the more rural people (like Hindus in India) seek indigenous healing. Authors such as Swartz (1998) and Pretorius, De Klerk and van Rensburg (1991) highlight that even in metropolitan environments indigenous healers are still highly sought after.

As noted by Spiro (2005), the exorcising of *bhuts* requires positive energy in the form of *vidhya* (knowledge) which is derived from performing many mantras. The treatment process requires the afflicted individual to be brought to the healer (Guru, Baba, Pandeet) on temple grounds. The *bhut* within the individual becomes restless upon entering the holy ground, and takes full possession of the person once the healing ritual is underway. To remove the spirit, the Guru performs aarti in front of the afflicted; this agitates the *bhut* as it embodies the power of both the Guru, and of God (Betty, 2005). The body of the person may then fall into a lifeless trance, moan, shake, or gyrate bizarrely (Betty, 2005).

An alternative method of treatment that is often practised would be for the family to take the individual to a fellow devotee. One who is able to invoke the spirit of a particular deity. As mentioned previously, these individuals, whilst in their trance-like states, are able to draw

upon the knowledge and healing powers of the deity, in order to help the afflicted. These "spiritual healers", as referred to by some, commonly use *aarti*, *vibbuthi*, cloves, and lime in the treatment of 'sick' individuals. Various mantras, hymns (*bhajans*) and sacred phrases and words such as 'Om' and 'Shanti' are used to increase the healer's power. Through this process, the healer is either able to completely heal those affected by supernatural entities, particularly bewitchment and spirit possession, or denote certain rituals and practices that must be performed in order to heal the person. Interestingly, treatment of the evil eye does not require the assistance of a traditional healer, or a spiritual healer. Instead, mothers and female kin alike, are able to expel the 'evil' using either water in a *chumboo* (small brass vase), chillies, salt, alum, or limes; rotating these items three (or seven) times around the persons head; then discarding the substance without looking at it (Spiro, 2005).

It is important to note that a Hindu individual may also seek professional help for the treatment of psychological disturbances. However, there still remains the possibility that the individual may present in therapy, alternative beliefs which are fundamentally different from traditional Western worldview. As a result of this issue, there have been documented efforts to integrate Western scientific and traditional healing methods (see Bodibe & Naidoo, 1993).

This is important as according to Naidoo (1985), Indian clients, if and when they seek professional help, do so after first going to indigenous sources such as spiritual and traditional healers. Quite often, even while obtaining help from professionals trained largely within a Western framework, they are following treatments suggested by indigenous healers (Bodibe & Naidoo, 1993). This is supported by Watts (1980 cited in Naidoo, 1985), who found that 25% of a random sample of individuals who were in receipt of a treatment at a large general hospital in Chatsworth, Durban, had consulted an indigenous healer for either a physical or mental problem. Indeed, religion and spirituality play important roles in the lives of millions of Hindus and therefore Hindu professionals need to reconcile Western psychology with Hindu beliefs in order to respectfully acknowledge religious issues and address the spiritual needs of their patients (Chattopadhyay, 2008). This method would alleviate the person's concern that the psychologist does not understand their beliefs, and so, does not understand them. This would undoubtedly facilitate the bridging of gaps between traditional societies and Western psychology.

Despite this ideological approach, however, contemporary psychological ideas and practices are still deeply rooted in Western thought. This may prove problematic for those Hindu practitioners who adhere to the cultural values and religious practices of Hinduism, and so, may actually believe that the patient is affected by supernatural forces, yet is confined within a predominantly Western profession, with Western explanations, interpretations and treatments of psychological symptoms. These understandings are in line with the concept of cultural competence, which assumes that some individuals may be unwilling to seek assistance from those who do not share the dame religious or cultural beliefs. Wohl (1989), however, disagrees with this. He states that in cases of cultural similarity, the therapist may make assumptions about the patient that are not justified, or may ignore and fail to explore certain material because it seems self-evident. Thus even if differences are minimised, culture may still be an intrusive factor in treatment, as assumptions made by each party about the other on the basis of cultural similarity may be incorrect. Indeed, "there is always a difference in the understanding and internalisation of a culture" (Wohl, 1989, p. 344).

Therefore, this study sought to highlight the current situation of Hindu psychologists by investigating what their own perceptions of mental illnesses are, and what influence their religious beliefs play on these perceptions.

CHAPTER 2: METHODS

2.1. Aims

The aim of this study was to investigate the perceptions of mental illness amongst a group of Hindu psychologists in the Johannesburg area. It also aimed to establish the role of religion (Hinduism), if any, on these perceptions.

2.2. Rationale

South African psychology is at a stage where the need to be more accessible to the community it serves is being recognised as important. Mental illnesses are one of the most prominent factors affecting health in developing countries such as South Africa. The World Health Organisation (2001) estimates that 10% of the adult population suffers from some form of mental illness. Western psychology has addressed many of the aspects related to the explanation and manifestation of mental illnesses. However, in the more traditionally bound cultures, issues of relevance are plentiful. According to Chong et al. (2007), this is largely due to the attitudes and perceptions towards mental illness being coloured by one's cultural values and beliefs. Matsumoto and Juang (2004) add to this by positing that culture shapes the expression of psychological disorders and plays a role in the emergence of culture-specific syndromes. Given that South Africa is a multi-cultural society, there is a need to explore different cultural perceptions and the interaction of different cultural beliefs on issues such as mental illness. It is not adequate to exclusively focus on one philosophical system that is taken mainly from a Westen culture (Swartz, 1998).

Despite this awareness, Western psychology at large continues to undervalue the role of culture in perceptions of mental illness. While the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV-TR, 2004) may warn that unfamiliarity with the facets of an individual's cultural framework may result in an incorrect psychological diagnosis, cultural characteristics are still often overlooked. Furthermore, Western psychology stipulates that psychological disturbances must be considered a manifestation of a behavioural, psychological or biological dysfunction – regardless of its original (perceived) cause (DSM-IV-TR, 2004). This depicts a clear limitation in the field of psychology, as spiritual and

religious beliefs, pivotal in traditional cultures such as Hinduism, are not considered as influential factors in the origin of psychological symptoms. This is particularly problematic as "each culture influences the perceptions of illness and [the] pathways to health care that its members follow" (Saravanan et al., 2007, p. 231).

While modern (or Western) forms of treatment may be considered foreign and thus looked upon with doubt and uncertainty (Ross, 2008), the treatment provided by traditional healers is seen as holistic as it targets the mind, body, and soul of patients within their family, community and religious contexts (Muller & Steyn, 2002 cited in Ross, 2008). As a result of its perceived benefits and high prevalence, there appears to be increasing literature on indigenous understandings of mental illness (Ally & Laher, 2008; Mzimkulu & Simbayi, 2006; Yen & Wilbraham, 2003). However, there is a lack of research regarding the interface between the two healing systems. Indigenous healing and healers alike play an important role in the diagnosis and treatment of various health care needs such as mental illness (Pretorius, de Klerk, & van Rensburg, 2009). In fact, it is estimated that 8 out of every 10 South Africans consult with traditional healers in conjunction with, or in preference to, Western trained medical professionals (Cooks, 2002 cited in Ross, 2008). If people are seeking both healing systems, there is a need to understand how health care providers are addressing this situation. Therefore the main focus of this research was to gain an understanding of Hindu psychologists' perceptions of mental illness.

By interviewing Hindu psychologists, this study had a contribution to make, as Hindu psychologists were trained in a predominantly Western profession and are thus in a position to comment on both Western and Hindu understandings of mental illness. Furthermore, these Hindu psychologists were uniquely situated to provide information on whether or not these two positions can be reconciled. It should be noted that whether these psychologists are practicing Hindu's, or simply occupy a position in the Hindu community due to birth or ancestry, they are still more familiar with Hinduism as a religion and the Hindu culture than non-Hindu individuals, and were thus still able to provide a unique view of Hinduism and mental illness. These practitioners can also provide insight in terms of how Hinduism may or may not contribute to Western psychology.

Finally, this study by virtue of interviewing Hindu psychologists about mental illness contributes to the strengthening of the therapeutic alliance – which may not be the same across all areas of psychological practice. Thus it is essential that health professionals familiarise themselves with traditional systems of healing and models of illness which are used by various cultures (Dein, 2003), as this would serve to maximise the therapeutic alliance. Therefore some of the questions in the interview schedule centred on the way in which Hindu practitioners navigate between their profession and their religion.

2.3. Research Questions

1. What are the perceptions of mental illness amongst the Hindu psychologists in Johannesburg?
2. What influence, if any, does religion play on these perceptions of mental illness?

2.4. Sample

The sample comprised of six Hindu psychologists who practice within the Johannesburg area. This sample size was largely a result of the difficulty experienced in sourcing such participants. Access was initially obtained through both the researcher's supervisor, who was be able to put the researcher in contact with potential participants, as well through additional internet research. Following this initial access, additional sample members were obtained using a snowball method. Snowball sampling is a method used to target difficult to reach persons by selecting a few people and asking them to direct the researcher to others within the same group (Burton, 2000; Whitley, 2002). Therefore those participants who are interviewed were asked to identify additional members to be included in the sample, helping to direct the researcher to the next participant, until a target sample size of six participants was reached. This form of non-probability sampling was be used for its convenience.

The researcher was able to obtain a sample of psychologists from three areas of registration: Clinical, counselling, and educational psychology. Additionally, the participants ranged in their occupational practice. R1 was an Educational psychologist in private practice that was based at a hospital. R2 was an Educational psychologist in private practice, who worked at a

medical centre. R3 was a Counselling psychologist, who was also in private practice and worked at the same medical centre as R3. R4, R5, and R6 were Clinical psychologists. R4 worked in the corporate sector, while R5 and R6 were in private practice, both based in medical centres. Most participants consulted at multiple practices around Johannesburg. As such, all participants cited a diverse client base – ethnically, culturally, socioeconomically, and in terms of gender. Such a diverse client base also ensured that these psychologists encountered various psychological problems.

2.5. Measures

The method of data collection was qualitative in nature so as to obtain first-hand, subjective accounts of respondents' perceptions regarding mental illness, as well as the influence of religion on these perceptions. Qualitative research enables one to focus on understanding and interpretation of meanings and intentions that underlie human behaviour as opposed to focusing on quantitative research which seeks to uncover measurable aspects of human behaviour through generalisations (Weiss, 1994). The strengths of this approach are that it provides rich contextual information thus enabling the discovery of new phenomena not discovered by previous research. This in turn may help in the generation of new theories (Greenstein, 2003). A frequently mentioned shortcoming of qualitative research is that it has limited ability to generalise given its small sample size (Greenstein, 2003). However, it is important to note that generalisation may not necessarily always be the aim of a qualitative study and was in fact not the aim of this particular study.

Interviews are the most common technique utilised with qualitative research. The type of data collection instrument used in this research was qualitative semi-structured interviews. Semi-structured interviews are flexible in that the role of the researcher is to remain fairly unobtrusive so as to encourage respondents to freely express or share their thoughts on a particular issue. This method also has the advantage of allowing the researcher to build rapport with the interviewees and allows for effective interaction with them (Greenstein, 2003). Given the unstructured aspect of this method, respondents can feel free to develop their own train of thought. In addition, due to the flexibility of this approach, valuable insights that may not have been initially predicted may come to light. However, the

researcher ensured that the focus of the study was not lost, by using the interview schedule as a means of guiding the participants towards addressing all the issues relevant to the study. Semi-structured interviews enabled the researcher to explore complex individual beliefs and examine issues in greater depth and detail. In addition, elaboration of vague points and clarification of obscure details was achieved with this method through the use of probes and prompts, further highlighting the relevance of this method for the research at hand (Weiss, 1994).

The semi-structured interview schedule (Appendix D) was developed by the researcher based on appropriate literature reviewed (See Ally, 2008; Ally & Laher, 2008; Betty, 2005; Spiro, 2005). These studies examined similar constructs, using interview schedules with clearly defined sections. Following this method, the researcher constructed her own sections of interest to be examined by the study. These questions were piloted using two Hindu postgraduate students. The final interview schedule comprised of four sections, which is in line with what other interview schedules in the field have used. A total of twenty-four questions designed to ascertain the participant's perceptions of mental illness in general, as well as the influence they believed religion to have on these perceptions, were developed.

The first section consisted of questions designed to understand the context within which the psychologist consults. This was necessary as not all psychologists were in private practice. Some were in hospital settings, NGO's, corporate environments, and medical centres. The second section attempted to explore the psychologist's perception of mental illness based both within Western and religious conceptualisations of mental illnesses. It was noted that some participants may not practice Hinduism; however, the study found that such participants were still familiar with the Hindu religion. Question thirteen is a specific question on spiritual illnesses (which are as a result of supernatural forces), as spiritual illnesses are an important component of mental illness in Hinduism, and are not covered in Western models. Thus it was interesting to see what the participants' responses to this question were.

The third section looked at the treatment of mental illness, more specifically, the different forms of treatment as prescribed by Western psychology, and as indicated by Hinduism. In

this section it was important to look at other health care professionals, particularly those involved in traditional healing. Lastly, the fourth section was a more general section around being a Hindu practitioner who practices according to a Western psychology. This section looked at whether the two positions that Hindu psychologists occupy (i.e. being Hindu and being a psychologist) have lead to any personal conflicts, or if these positions can be reconciled.

2.6. Procedure

The researcher contacted the potential respondents telephonically, in order to request their participation in the study. The participant information sheet (Appendix A) was then emailed to them. Once they agreed to participate, a time and place that was convenient for the individual was arranged. The researcher met the participants on the day and the nature and procedure of the study was once again explained prior to conducting the interview. The researcher also reminded participants that participation in the study was voluntary and that they had the right to withdraw from the study, or refuse to answer particular questions at any point during the interview. The participants were then asked to sign a consent form formally requesting their participation in the study (Appendix B), as well as their permission to have the interviews recorded (Appendix C). The interviews were conducted as per the semi-structured interview schedule (Appendix D), participants were thanked for their participation, and the interviews were transcribed and analysed.

2.7. Self-reflexivity

Researchers are encouraged to be self-reflexive so that they may be aware of any preconceptions and expectations regarding their research. Reflexivity is also used by a wide range of scholars as a methodological tool to better represent, legitimize, or call into question their data (Pillow, 2003). It raises the issue of researcher subjectivity in the research process. This focus requires the researcher to be critically conscious of how the researcher's self-location (across for example, gender, race, class, sexuality, ethnicity, nationality), position, and interests influence all stages of the research process (Pillow, 2003). The researcher should also be conscious of the ways in which they may be perceived by others. Reflexivity

then “becomes a continuing mode of self-analysis and political awareness” (Callaway, 1992, p. 33 cited in Pillow, 2003, p. 178).

In the interest of self-reflexivity, the researcher acknowledged that this research was a study about Hindu perceptions, conducted by a Hindu researcher. Thus the researcher was made aware of her possible preconceptions and expectations about both the participants, and the nature of the data to be obtained. Likewise, the researcher attempted to view herself in the eyes of the participants, particularly with respect to the researcher’s own religious beliefs and perceptions of mental illness. The researcher observed that many participants sought confirmation in their responses due to the fact that they were not very indoctrinated in the faith. To circumvent this, the researcher constantly reminded participants of the study’s aims (i.e. to ascertain *their* perceptions) and reassured them that all information provided is useful. Furthermore, as a Hindu, the researcher in this study could be seen as having a vested interest in the chosen topic, and although this fact cannot be ignored, it should also be considered that as a researcher, the need to search for information and increase understanding plays an equally significant role. Additionally, the researcher was aware that some of the participants may not be practicing Hindus and was also aware of her opinion that even non-practicing Hindu’s will still have knowledge of the religion. Although the researcher aimed to avoid this bias by recognising that non-practicing Hindu participants may not be able to provide answers and elaborations to some questions, particularly those inquiring about Hinduism, it was found that even those participants who advocated that they were not religiously inclined, were still able to provide information on Hindu beliefs and practices.

2.8. Ethical Considerations

Ethics clearance was received from the Human Research Ethics Committee (Protocol number: MPSYC/10/003). Hindu psychologists’ participation in the study was completely voluntary. Prior to the interview, participants were reminded of the study’s aims and given the opportunity to withdraw at any time during the interview should they wish to do so. They were also reminded that they could stop the interview or refrain from answering any question at any time during the interview. Participants were further assured that despite the interview being taped, all tapes would be destroyed after the relevant information is obtained. Since the

researcher's supervisor was instrumental in putting the researcher in contact with potential participants, it was decided that only the researcher would have access to the tapes. Additionally, since it is such a small population, identification of participants may be possible, thus pseudonyms was used both in the transcripts and in the research project. Thus participants' confidentiality, anonymity, and right to privacy were preserved.

Another potential issue was that the psychologists may make references to confidential information about their clients. Due to this possibility, sections were added to both the participant information sheet and the consent form, asking the psychologists not to reveal and identifying information about their clients. Additionally, the researcher reminded the participants to preserve their clients' confidentiality in the interview, and undertook to exclude client-specific information when writing up. Upon agreement of these terms, participants were required to sign the consent forms. Participants were then provided with an informed consent form comprising two parts, requesting consent to participate in the interview, as well as consent to having the interview audio-recorded. Lastly, participants were informed that they may contact the researcher for feedback on the overall results of the study upon completion of the study. However, since no participants sought any feedback, no feedback sheet was developed. On completion of the study, the tapes and transcripts will be kept for a period of three years (for publishing purposes) in a locked cupboard, after which they will be destroyed.

2.9. Data Analysis

Once interviews were transcribed, the data was analysed using thematic content analysis. Thematic content analysis is a means of standardising and comparing the acquired data into coherent information, and highlights relevant issues (Henning, 2004). This analysis involves the identification of prominent or recurring themes in the text, and summarising the findings using thematic headings (Dixon-Woods, Agarwal, Jones, Young, & Sutton, 2005). Thematic content analysis facilitates researcher flexibility as it allows for the integration of qualitative and quantitative evidence (Dixon-Woods et al., 2005), and provides rich and detailed accounts of the data (Braun & Clarke, 2006). Some of its drawbacks, however, include the lack of transparency due to a failure to distinguish between its theory driven (evaluation of themes through interrogation of the literature) and data driven (driven by the themes identified in the data itself) approaches (Thomas & Harden, 2008). More generally though, Dixon-Woods et al. (2005) highlight the lack of clarity regarding what thematic analysis involves and the process by which it can be achieved. This is further highlighted by Braun and Clarke (2006, p. 78), who suggest that "a lack of concise guidelines around thematic analysis means that the 'anything goes' critique of qualitative research may well apply in some instances".

This study followed an inductive, or data driven, form of category development. The data was examined and categories were gradually deduced. These categories were revised, reduced to main categories, and their reliability checked (Mayring, 2000). The process of thematic content analysis that this study will use was derived from Braun and Clarke's (2006, p. 87) six phases of analysis, which is described in the Table 1 below.

Table 1. Six phases of thematic content analysis.

Phase	Description of the Process
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report:	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

It is important to note, however, that these phases are guidelines, not rules; and that analysis is not a *linear* process. Instead it is more *recursive*, where movement throughout the phases is back and forth as needed (Braun & Clarke, 2006).

Conclusion

This chapter presented a discussion on the methods and procedures utilised by this study. The next two chapters will present the study's findings and a discussion thereof.

CHAPTER 3: RESULTS

Six Hindu psychologists were interviewed around the Johannesburg area. Semi-structured interviews were conducted and transcribed. The interviews were analysed using thematic content analysis. Six themes emerged. These are: Identification in a Western Framework; Perceptions of Psychology in The Hindu Community; The Role of Religion, Conflict in Negotiating Identity; Cultural Competence; and A Unique Brand of Hindu Psychology. These themes, as well as their subthemes are discussed accordingly.

3.1. Identification in a Western Framework

Most participants, to varying degrees, drew on traditional or Western psychological concepts in their discussions around understandings, aetiologies and treatments of mental illnesses.

3.1.1. Definitions, Understandings and Aetiology

Five participants recalled the nature-nurture debate in their definitions and understandings of mental illnesses. These participants advocated an integrated perspective that viewed both biological predispositions and environmental factors as equal contributors. As R2 reported, *"Hereditary and all those things does have an impact on a person's wellbeing, but environment plays a major role"*. R3 reported, *"Biological or family problems, in relationships at work, all that"*. R5 reported, *"It could be biological, it could be situational factors involved"*. In addition to this, two participants advocated a more systemic approach. R1 reported, *"I'm talking from a systemic point of view where I find, yes, there is an interaction between all these different systems"*. R6 said, *"When I look at an individual, I look at an individual through systems, so the different systems operating in that individual's life"*. Thus therapists subscribed to Western understandings of mental illness, and so, define mental illness according to western concepts.

As with their understandings of mental illness, four participants alluded to the nature-nurture debate when discussing aetiological factors. Again, participants appeared to have an integrated perspective. As R1 stated, *"I would again relate that to the whole nature-nurture thing"*. R5 reported, *"I think most people are predisposed to some personality or mood issues, and situations or life experiences trigger them off and exacerbate certain of these*

underlying characteristics that we have". R6 advocated, *"I think it's a complex interface, I don't think there's any one definitive answer. Each individual is unique and complex, so one would have to look at the interplay between the biological, genetic, as well as the environment and history"*. Furthermore, all participants cited the impairment in functioning as a marker for distinguishing a mental illness from everyday problems. As R2 cited, *"It's more disruptive in terms of your everyday functioning"*. R5 reported, *"It's the level of debilitation that it causes in a person's life"*. R6 stated, *"It comes back to the issue of it being debilitating"*.

3.1.2. Treatment

Despite many (four) participants citing that they did not personally believe in spiritual illnesses, five recalled traditional (Western) psychological approaches to treatment, such as helping the client make sense of their own beliefs regarding the cause of their problems – regardless of what they may be. R1 stated, *"You cannot say that this is because I don't believe, you must not believe. You know, you go with what the client is saying and work with that"*. According to R2, *"As a psychologist, you have to go with what the client is thinking and feeling at that point. We're not there to say it's right or it's wrong"*. R4 reported, *"We cannot tell them that their beliefs are right or wrong, because it could be very real for them. So you have to work with their reality, not yours"*. R6 reported, *"I would definitely go with what they are saying. I think the important thing is for me not to impose my own judgment, it is to go with what the client brings"*. However, R5 warned that there is still a need for cultural sensitivity, reporting, *"I think it's basically taken as paranoia, or it's a type of psychosis or schizophrenia if someone believes that, and it's kind of just down to that from a Western point of view"*.

Furthermore, of those (three) participants who have encountered clients that believe their illnesses to be caused by spiritual or religious factors, all advocated that these clients were receptive to Western forms of treatment. R3 reported, *"I think it was useful because it was a very systemic approach, so looking at it in terms of the biological and in terms of the spiritual as well. So in that way, it made them more comfortable being in this process"*. R5 reported, *"I think for most of them, they've tried all the other options like rituals, but still needs help so*

they turn to therapy". R6 advocated, *"If they make the effort and attempt first of all to make an appointment and come through of their own free will, then they are receptive"*.

3.2. Perceptions of Psychology in The Hindu Community

Participants were able to offer insight into the current perceptions of psychology in the Hindu community. Various issues deemed characteristic of such a collectivist community were cited.

3.2.1. Lack of Understanding about Psychology and Confidentiality Issues

Three participants noted that the issue of confidentiality and the work that therapy entails is not well understood amongst the Hindu community. R1 reported, *"I'm a Hindu myself and I'm not getting clients, and maybe society plays a role. People don't trust, they don't understand our work. They don't understand that confidentiality is an important aspect...Knowing that I'm a Hindu, knowing that I'm in the society...especially if you're living amongst the community, people are very secretive...they don't want to be seen out with their shrink"*. R2 reported, *"For Hindu people, mental illness is if you're psycho...and when you say you're a psychologist, they just sort of look at you differently like you're reading their mind. They're not open to what psychology is*". R5 stated, *"At first they might be a bit apprehensive because they're not sure what it is – I mean, psychology in South Africa is not as mainstream as it probably is in America"*.

3.2.2. Stigma

Five participants noted that stigma was a problem in the mental health field, particularly amongst the Hindu community. R2 reported, *"There's a stigma around psychology, and if you're having problems then there's something wrong with you. If you're going to a psychologist there's something wrong with you"*. Additionally, R2 noted, *"We make ourselves sick just thinking about what the other one's thinking"*. R6 reported, *"I think the culture that I come from, historically there's been a lot of stigma...There's a sense that if you're seeing a therapist then there must be something wrong with you...you might be*

crazy...There is a lack of knowledge that translates into stigma". Interestingly, R4 cited, *"I think the issue of stigma is prevalent across the board...irrespective of the religion they come from, the idea of seeing a therapist...there's been a lot of shame, sense of guilt and secrecy, not wanting their families to know...it feels like there may be more universal beliefs about mental illness"*. Additionally, the importance of social standing was also mentioned. R5 reported, *"People are very scared of what others will think if they go to therapy. They'll be called crazy"*. R6 cited, *"They [Hindus] don't want to come for therapy because then the rest of the world will know that they have a problem, and not just a small one, it must be a big problem if you have to see a therapist. Then all your relatives will get to know and you'll be the talk of the town...that's the mindset"*.

3.3. The Role of Religion

Participants noted the important role that religion played not only in conceptualisations of mental illness, but also in their treatment. Additionally, opportunities for collaboration between religious and western modes of treatment were alluded to.

3.3.1. Therapists' understanding of the role of religion in mental illness.

Five participants emphasised the important role that religion plays in both defining and understanding mental illness. Specifically, the client's religious beliefs were perceived as influencing their understandings of mental illnesses. According to R1, *"If they are very religious and believe in all those spiritual things, then they are more likely to believe that it's a spiritual problem"*. R3, *"It can be defined differently because of your religious beliefs"*. R4 reported, *"I think it influences one's perceptions depending on how invested in it you are"*. R5 stated, *"It's the culture that you grow up and the experiences in that culture, because what might be normal for one person, might be extremely abnormal for another"*. Thus in contrast to their personal understandings of mental illnesses, participants appear to incorporate religious understandings, when faced with clients who believe as such.

Hindu conceptualisations of mental illness were frequently described in philosophical terms, even among those participants who were not practicing Hindus. R1 reported, *"It involves Karma, as you sow so shall you reap...It's astrologically based"*. R3 reported, *"Not feeling a*

sense of calm ore being at peace, so when there's an inner conflict, then I would say it would be defined in that way". R4 noted, *"Hinduism gets mixed up with cultural practice and societal discourse...culture and the discourse around mental illness dictates that, and then it almost gets fused with religion"*.

Participants varied in their opinions of whether the Hindu conceptualisation of mental illness is in accordance with other religious conceptualisations. Two participants were unsure if Hindu understandings were similar to that of other religions, yet all participants advocated that there was a distinct difference between the Hindu and other collectivistic communities, and the Western communities. R2 said, *"The White community is so much more, therapy is so much more prevalent because they realise that, you know, this is unhealthy. I'm having a problem, let me get help. I think there's a big difference between the two mindsets of the communities"*. Importantly, however, R2 also noted that *"Compared to the Hindus, Muslims are a lot more open to it [therapy]"*. R3 advocated, *"Depending on which cultures you're looking at, I think it would be similar with Muslim people. But I think from a Westernised perspective, it's very clinical, it's very structured and factual – we have books that we can look to. I think looking at it from a religious perspective, it's clouded by religious beliefs and practices, things you do, things you don't do, what is considered normal and what is not considered normal"*. R5 reported, *"I would say it's not very similar in terms of Christianity, they're not so into that frame of dealing with the paranormal or supernatural, but I think it's more the Black and Indian culture that have strong beliefs in that"*. The characteristics of this collectivist community, and their relationship with mental illness, are discussed in earlier, as well as subsequent themes.

Additionally, R1 and R4 noted that the various positions that individuals occupy are important to consider. R1 said, *"They [Hindus] are very indoctrinated with their faith, although they come in with their practical and logical reasoning, they would still go with what religion says and what religion does, and there's a lot of hypocracy and contradictions"*. R4 cited, *"I think a lot of people I interact with have multiple identities, so they might be religious and live in a Western world...there's a fusion of those identities"*.

Furthermore, a similarity in symptoms across spiritual (religious-based illnesses) and mental illnesses was noted by a few participants. R3 reported, *"Tamil people specifically, they get the trance...they define it as a spiritual state, and if you compare it to your mental illness...looking from a Western point of view on how Tamil people practice, you could view it as some form of mental illness like schizophrenia or delusions"*. R6 stated, *"I think that sometimes it can overlap, if they have a spiritual problem, a paranormal problem, or a mental illness, there are similarities in the symptoms that someone would have"*. However R5 was the only participant who believed that spiritual factors were the cause of mental illness, reporting, *"If I take a very stereotypical point of view...It's more along the lines of bad luck or someone doing something to you with negative intention, someone being jealous"*.

3.3.2. The Role of Religion in Treatment of Mental Illness

Four participants believed that religious background had a significant impact on choice of treatment. R2 again drew on the characteristics of individualist vs. collectivist communities, stating, *"The Black and Indian communities would first go to a traditional healer if they believed in them, or they feel it's just a phase, you'll get through it, or 'we grew up that way and we had no problems'. So they look at a no treatment sort of style. And the White community are more aware of it so they would say, you know what, there is a problem, I'm going to a psychologist"*. R3 reported, *"It depends on your religious background, what they've been brought up to believe. If they believe that it's a spiritual illness then they will most likely first seek out spiritual forms of treatment"*. R4 advocated, *"I think it's a function of your religion, your culture, the level of investment you have in it, how much exposure you've had to alternative thinking...the more exposure you have...you may see alternatives and you may be able to leverage off a range of different things, medical, psychological etcetera"*. R6 reported, *"It might influence them to seek advice from their communities that share their beliefs or even their religious institutions"*.

All participants noted the beneficial aspects of prayer in adverse circumstances such as mental illness. R1 reported, *"A lot of people believe that prayer can help, and that gives them some sort of peace and calm"*. R2 stated, *"if you've grown up in a home where prayers has*

been important, then when you're faced with a problem, mental or physical or whatever, then you would seek out prayer more...you would understand prayer to be healing". However, R2 warns, *"If you grew up in a home where prayer doesn't mean anything, no one ever prayed together and you're not sure what it actually means, then I think you would definitely feel differently about it because you wouldn't feel that prayer is a healing something"*. R3 advocated, *"I think it does have a benefit, performing more rituals and prayers helps focus your mind, it's helping you focus and channel all your energy into that specific challenge and you find solutions or try to look at things more positively"*. R4 reported, *"I'm not super religious but I do pray and I find that when I'm going through harder times, I would pray more. There's something about giving up the problem to a higher being that is freeing to some degree. It may not solve the problem, but I do think there's some level of comfort in it"*. R5 advocated, *"Prayer is always good – it's positive and gets the mind into a positive frame"*.

Interestingly, all participants had no qualms with referring their clients to reputable traditional and spiritual healers, if necessary. R1 reported, *"I cannot tell them what the right option is, but if that is what they want and what they believe, then I would tell them to get that help, but still insist that they remain in therapy"*. According to R2, *"If it comes to a point where they really believe that that's the only way, then I would definitely refer them to one if it will help change their mental perceptions, but it's not an alternative to therapy, I would do it simultaneously"*. R3 said, *"I would refer someone to them if they believed in it...some people need to take care of things on a spiritual side through rituals...whatever it takes for them to reach a place where they feel balanced, they feel better and they're able to cope better, then I think that that's the solution"*. R6 cited, *"If I were to refer anyone it would be to someone that I felt had integrity...But if someone came to me and they had already sourced their own spiritual healer, then I would function in a supportive role around that"*. However, R5 warned, *"You have to do a lot of screening and clinical observation and evaluation to make sure that if you're referring on that it's not something that the person is latching onto as an escape for dealing with their issues, rather that it is something that is presenting as a real problem"*.

It is therefore not surprising that all participants believed that a collaboration between Western and spiritual forms of treatment is possible. R2 reported, *"Definitely. Like I say, it's altering that mental perception, the way we understand things"*. R3 said, *"I think sometimes clients don't bring all of their beliefs and all of the religious stuff into therapy, I think they bring what they want you to hear...Intervening on a spiritual level as well as through a Western practice like psychology would be very beneficial for a person who is struggling with certain [spiritual] challenges in terms of making meaning"*. R4 cited, *"I think a collaboration is possible, but there needs to be a great deal of understanding. I also think it depends on the type of therapeutic philosophy one has"*. R5 stated, *"Definitely, I mean I've worked that way in the past and I definitely do think it works"*. R6 noted, *"If we could all work together, then clients would be able to get a more holistic treatment. I think those with strong cultural beliefs need something like that"*. According to R1, however, *"It depends on the client...you can open up their awareness, but it's there decision"*.

3.4. Conflict in Negotiating Identity

Most (five) participants demonstrated some degree of conflict between the various positions which they occupy. Two participants found it difficult to reconcile their personal beliefs regarding spiritual factors, with their knowledge of Hindu beliefs (in spiritual illness) and rituals. As R3 reported, *"I don't know, I don't personally believe in them because I see them as folktale and myths that are passed on to keep you in line – especially with Hindu people, but I suppose it could be real"*. R4 stated, *"I've grown up not necessarily believing in the more supernatural...You know, I have family and friends who are Hindu and they believe in these things, but it's not real for me"*. Three participants, however, demonstrated conflict in the therapeutic space between Western thought (i.e. the Western psychological profession with its own set of understandings and practices), and Hindu beliefs. R2 cited differing personal and occupational perspectives, reporting, *"I was brought up in a very staunch Hindu home, so part of me believes that, then at work I feel, no"*. R5, stated, *"I can't discount it...I do believe that these things may exist...but my beliefs are suspended in the therapy session"*. According to R6, *"You may believe that it's real, but you can't bring in your own religious beliefs in therapy"*. In contrast to this, R1 advocated, *"I don't believe in spiritual illness"*.

3.5. Cultural Competence

By describing Hindu specific problems, and the need for therapists' recognition of these issues, two participants alluded to the necessity for therapists to demonstrate cultural competence. The issue of problematic family dynamics was alluded to by two participants. These concerns were seen as being characteristic of the collectivistic Hindu community. R2 reported, *"The mother-in-law/daughter-in-law thing is a big problem among Hindu women, and if they went to say a normal Western [White] psychologist, they would just say 'Well why don't you say something or move out then?'. They don't get it"*. R4 stated, *"I truly believe that so many of the actual problems that Hindus face fall through the cracks when they go to therapy, because a non-Indian psychologist won't understand where this person is coming from and how their family relationships for example, influence in their lives"*.

Additionally, despite the aforementioned conflicts in identity, five participants felt that their status as a Hindu has helped them relate better to their Hindu clientele, yet has not impacted on their ability to assist those clients from other religious backgrounds. R2 cited, *"I think it has helped a lot, being a Hindu and working with a Hindu client, because you understand a lot more where they're coming from and why they're trying to hide certain things"*. R3 stated, *"Although I feel I'm not a traditional Hindu, I still think my religion has helped me relate better to Hindu clients, but it doesn't make me less effective when I'm relating to Muslim clients, or to people in the urban suburbs that have White people, Black people, Jewish people, you know"*. R5 reported, *"Being a Hindu has taught me to be a lot more tolerant in terms of other religions and other people because it's not so indoctrinated that this is it and this is how it has to be...the underlying teachings are basically the same"*. R6 said, *"I don't necessarily think of my religion and rituals and rules, I think of it as a lifestyle...a philosophy of life and a code of practice...that's how I translate my religion. So if your intentions are inherently good and you live by similar rules and values, then that fits in to my religion. But I don't necessarily sit in judgment of clients. I've always felt that in a therapeutic space, my religious beliefs are suspended to some degree"*. In contrast to this, R1 stated, *"I don't see religion, I don't even consider religion...my client is my client, a person and that's it"*.

Interestingly, even among those non-practicing Hindus, cultural competence was demonstrated, as four participants advocated working with the clients' beliefs and wishes in the therapeutic process. R2 reported, *"I would work with what the client brings in...If the client is a more modern sort of person, then I would use the more Western approach. But if they bring through a lot of culture, because I have that background, I am able to relate with them as well"*. R3 cited, *"I prefer a Western approach, but if a client feels that there's certain things they have to do or perform in terms of religion, it's never discouraged...I can understand the importance of rituals and beliefs"*. R4 noted, *"Some people are a lot more religious than others and rituals for them are a lot more sacred and play a big role...so I would see a person that was Hindu in the context of their religion, but not necessarily abandon the fact that I come from a particular training"*. R4 went on to highlight the importance of such an approach, as *"people will judge how people operate in their environment. So if you live at home till you're 25, it might seem odd in the purely Western environment and people may question whether that's a dependency or if it's a co-dependent relationship...you must look at where they're coming from, is it culturally appropriate"*. R1, however, advocated using a traditional psychological approach, stating, *"Definitely Western, like I said, I don't consider religion"*.

3.6. A Unique Brand of Hindu Psychology

Four participants felt that the development of a unique Hindu brand of psychology was not necessary. R1 advocated, *"The skills and techniques in normal psychology can be applied to all cases and religions"*. R3 said, *"No, I think psychology as it is, is accessible enough, because I think that we are so Westernised...I do feel that the Hindu society is progressing toward a more modern way of life, even though we perform rituals and keep up with traditions"*. R4 reported, *"I think there's a danger in wanting to create something like that because there's a risk of stereotyping...there are cultural trends but this is the case with any culture or religion...These would be useful for a therapist to know, but I don't know if it would need to be that exclusive or defined. Because I think that then boxes you in"*. According to R6, *"I don't think so...I've been managing just fine with my religious clients...they've been receptive to the [psychological] techniques"*.

In contrast, R5 believed that such a psychology can exist, but warned, *"It has to relevant to the people that you're working with. It doesn't necessarily mean that if someone's Hindu and you're preaching Hinduism to them and using psychology, that they're going to take to it... someone clients may feel comfortable knowing that you understand what their beliefs are"*. R2 advocated the need for a Hindu psychology, reporting, *"Definitely...psychology's not only for people who are really mentally and clinically disturbed, it's for everyone who's going through everyday life problems, such as financial or stress...I think there's so many issues with the Hindu community, the mother-in-law/ daughter-in-law thing...I think a lot of Indian women become depressed and you won't even hear about it because they won't say, they don't even know that they have a problem".*

When probed about how this brand of psychology will differ from traditional psychology, R5 reported, *"Hinduism's principles and philosophy, like the Bhagvad Gita, is an excellent example of living a perfect moral life. You can use this to help people develop this lifestyle"*. R2, however, reported, *"The principles and foundation would be the same but the type of problems would be different...the whole mother-in-law/ daughter-in-law thing...issues in the family relationships...The family dynamics as well as issues in the community, like worrying what everyone thinks of you, saving face"*.

Conclusion

These results seem to indicate that these Hindu psychologists do encounter some tensions between their personal beliefs and/or knowledge about the Hindu faith, and their Western occupational duties. Overall, these psychologists advocate that they are able to navigate between these two positions which they occupy i.e. being a Hindu and being a psychologist, in an efficient manner, adjusting therapeutic practices when necessary to suit the clients' religious needs, without imposing judgment. While some have noted that being a Hindu may help relate better to fellow Hindu clients, they are adamant that it is not a barrier in effectively treating clients from other faiths. This is partly due to the fact that Hinduism promotes principles for a better way of life, rather than strict rules and practices. Additionally, these psychologists are open to the idea of collaboration with spiritual and traditional healers, when assisting those who require a more holistic approach. Besides the

ability to relate and a greater awareness of important influences and characteristics of a collectivistic community (i.e. the importance of familial and societal relationships and the issue of stigma), these was no strong case made for the development of a unique brand of Hindu psychology. Instead the adjustment of Western therapeutic approaches and techniques are believed to be sufficient, appropriate and applicable to meet most clients' needs. The next chapter will discuss these themes that have emerged in greater depth.

CHAPTER 4: DISCUSSION

This chapter will offer a discussion on the six themes, as well as their subthemes, presented in the results section. These themes helped address the research questions outlined in this study, and shall be discussed accordingly. In an attempt to answer the first and second research questions, the following themes will be discussed in order to ascertain what the perceptions of mental illness amongst the Hindu psychologists in Johannesburg are, as well as what influence, if any, religion has on these perceptions of mental illness. These are: Identification in a Western Framework; Perceptions of Psychology in The Hindu Community; The Role of Religion, Conflict in Negotiating Identity; Cultural Competence; and A Unique Brand of Hindu Psychology. These themes, as well as their subthemes are discussed accordingly.

4.1. Identification in a Western Framework

This theme will discuss the use of Western concepts and approaches in the definition, understanding, aetiology, and treatment of mental illness.

4.1.1. Definitions, Understandings and Aetiology

Most participants conceptualised mental illness from a bio-psychosocial perspective i.e. they advocated an integrated perspective that viewed both biological predispositions and environmental factors as equal contributors. By prioritising both sides of this debate, these psychologists demonstrate that they favour a more holistic approach to understanding mental illness. Specifically, they take consideration of all aspects of their clients' problems – even spiritual. This approach may prove useful, for Schwartz (1998) has discussed at length the damage that rigid or one-sided positions have had in the past. However, Schwartz (1998) adds that there is still much benefit in examining our understandings of mental illnesses using the nature-nurture debate. Other psychological conceptualisations included the use of a systems approach to therapy, as well as the acknowledgment of debilitated functioning as a marker of mental illness. Among those who advocated a systemic approach, common practice was to consider the individual's circumstance through the various systems operating in their lives. This can be seen as an extension of the psychologists' holistic approach to understanding and assisting their clients. Again, such an approach is valuable as the issue of maladaptive social systems has been posited as potential causes of mental illnesses. This has been addressed by Granello and Granello (2000), who suggest that these systems can either

increase the individual's exposure to predisposing factors, or directly result in mental illness itself. Additionally, almost all participants cited the impairment in everyday functioning as the marker which separates an everyday problem from a mental illness. This idea of an impairment in functioning is also present in more mainstream definitions of mental illness, such as by the British Department of Health (2004, cited in Pilgram, 2005). Thus these Hindu psychologists' understandings of mental illness are reflective of traditional psychological conceptualisations, corresponding to the Diagnostic and Statistical Manual of Mental Disorders (DSM).

4.1.2. Treatment

If faced with a client who believed their illness to be caused by spiritual forces, the most common approach cited (regardless of the practitioners' personal beliefs) was going with what the client says, without imposing one's own judgment. This strategy is reflective of traditional psychotherapy. This illustrates that Hindu psychologists, despite their personal beliefs and religious backgrounds, are able to – and often prefer to –utilise traditional psychological approaches in treating clients who are more religiously inclined. In this manner, psychologists are able to curb any blatant conflict between their personal beliefs and occupational duties, as their beliefs and personal opinions are not given priority in the therapeutic space. Rather, their focus is on applying and adapting psychological techniques and methods to suit the client, regardless of the perceived causes of the problem. Additionally, one respondent claimed that the clients' choice to come to therapy was taken as evidence enough that, regardless of their religious beliefs and beliefs about their illness, they were receptive to Western forms of treatment. This was a rather interesting finding and is worth exploring further. Why, in instances where clients believe their illnesses to be caused by spiritual forces, would they seek out Western forms of treatment? Perhaps this occurrence is reflective of contemporary South African society, in which, as mentioned in previous chapters, individuals now occupy multiple identities. Through acculturation and socialisation with the Western world, traditional Hindus are now becoming more knowledgeable about mental illnesses, and so, are open to the idea of psychotherapy. Despite this, however, it is evident that the desire to hold on to their cultural beliefs and practices are reflected in some Hindu clients' beliefs about the causes of their illnesses.

4.2. Perceptions of Psychology in the Hindu Community

This theme discusses the following subthemes in conjunction with each other, in order to better understand how they relate: Lack of understanding about Psychology, Confidentiality Issues, and Stigma.

It was believed by some that ignorance, and perhaps the fact that the psychologists are Hindu themselves, perpetuated fear and distrust, as well as stigma around psychology – and in particular, psychotherapy. This in turn prevented the afflicted from seeking treatment. Hindus are thus perceived as being very concerned with the way in which they are viewed in the larger community i.e. afraid of the negative stigma that can often be associated with mental illness and the treatment thereof (Byrne, 2001). However, it was also noted that the issue of stigma is prevalent in all communities, for as Mason, Carlisle, Watkins, and Whitehead (2001) assert, people suffering from a mental illness are often perceived as straying from the social norms and are viewed as inferior to the group at large. Additionally, it was believed that due to their lack of understanding about the field, the issue of confidentiality and the work that therapy entails is not well understood by Hindu's. This concern is important, for as Winderowd, Montgomery, Stumblingbear, Harless, and Hicks (2008) note, some traditional Indian people who prefer traditional or cultural interventions may be hesitant or distrustful of health care providers, including counsellors and psychologists who are from the mainstream culture. It is worth noting that the issue of stigma was again cited, with the psychologist (rather than the client) being positioned as the stigmatised victim. Therefore it appears that it is not just those who suffer from mental illnesses who are stigmatised, as all those who are associated with the field of psychology, both practitioners and clients alike, are subject to stigmatisation. The issues around a lack of understanding, and particularly, stigma associated with mental illness and psychotherapy could be attributed to the nature of the collectivistic Hindu community. These considerations are important as it offers insight into the issues surrounding mental illness stigma in the Hindu community, and the need to circumvent it in order to allow those who are inflicted from seeking treatment.

4.3. The Role of Religion

The influential function of religion on conceptualisations and treatment of mental illness is discussed further under this theme.

4.3.1. Therapists' understanding of the role of religion in mental illness

Some conceptualisations of mental illness were in Hindu philosophical terms. Concepts such as Karma, life circumstances being astrologically determined, and the idea of mental illness resulting from an imbalance of the body, mind and soul, or an inner-conflict, were cited. Furthermore, it was proposed that Hinduism views a mental illness as something that one has no control over, and that is characterised by an absence of inner-peace. These ideas are in line with Juthani's (2001) description of the psychiatric treatment of Hindus. Religion's role in conceptualising mental illness was also cited as being dependent on the client's religious beliefs. It was believed that differential definitions and understandings of mental illness were a direct result of one's religious beliefs. In particular, those who are quite indoctrinated in the faith are more likely to believe in spiritual illnesses, which may resemble the symptoms of mental illnesses. This is in line with Kakar's (1988 cited in Campion & Bhugra, 1998) suggestion that models of illness are related to the socioeconomic status and religious castes of individuals. However, one participant noted that caution is needed when trying to equate a spiritual illness to a mental illness. An example used to illustrate this point, was the ritual of trance-like states that are invoked by certain devotees. Of concern was the way in which the 'spirit possession' is described, as it may be misconstrue as a mental illness, particularly schizophrenia. This likening was elaborated on by Campion and Bhugra (1998), who noted that previous authors (Varma, Srivastava, & Sahay, 1970 cited in Campion & Bhugra, 1998) in the field had classified possession states and trance as a hysterical condition (referred to by these authors as 'possession syndrome'. The construction of certain Hindu rituals as 'madness' is critiqued by Govindama (2006), who draws links between the unfolding of these rituals and its implications for Hindu behaviour and conduct. Specifically, he highlights how certain cultural practices may be used to assess and treat individuals. Therefore, the Hindu psychologists highlight the importance of taking cognisance of clients' religious backgrounds, and the impact on their understandings of mental illness thereof. In this way, the client's religious beliefs may be seen as influencing understandings, perceived aetiologies, as well as treatment preferences. Additionally, due to the similarity in symptoms, care must be taken not to reduce spiritual illnesses as mental illnesses. This may be

challenging, particularly for those who are not familiar with the religious beliefs of this group, as they may not be aware of the concept of spiritual illnesses, or the way in which mental illness is conceptualised in religious scriptures.

Interestingly however, despite the awareness by one participant to not reduce spiritual illnesses to mental ones, a link was indeed proposed between religious and cultural beliefs, and the aetiology of mental illnesses, such as witchcraft and the evil eye, and conceptualisations of mental illness. Though opinions on this matter appeared to vary drastically, even those who did not believe in spiritual illnesses would not negate their existence. Additionally, most of those who claimed that they did not actively practice Hinduism were still familiar with Hindu beliefs and practices. Specifically, it was suggested that mental illness is a result of bad luck or witchcraft due to another's jealousy or intention to harm. Judging from this viewpoint, it is clear that even some non-traditional Hindus consider spiritual illnesses to be cultural aetiologies or expressions of mental illnesses. This supports the assumption that even non-practicing Hindus are still familiar with the principles and beliefs of Hinduism. The concept of culture-specific beliefs regarding mental illness aetiology and treatment is supported by Wynaden, Chapman, Orb, McGowan, Zeeman, and Yeak (2005). In their study, Wynaden et al. (2005) assert that traditionally, many western health-care interventions have been based on the premise that illness is culturally neutral and, therefore, interventions were applicable to all clients. Nevertheless, research has demonstrated that health and illness are culturally constructed experiences (Manderson 1990 cited in Wynaden et al., 2005), which are manifested in different variations of illness. This assertion is supported by Masha (1995 cited in Wynaden et al., 2005) and Sheikh and Furnham (2000 cited in Wynaden et al., 2005) who stated that the way people conceptualize their level of mental health is related to their cultural beliefs. These findings are useful considerations, as not only do they support the dominant argument being made (i.e. that religious background influences understandings of mental illness), but also highlights that psychology should be cognisant of these cultural nuances, and tailor interventions and other psychological approaches accordingly, for the belief about the perceived cause of one's illness, will likely have an effect on treatment preferences.

A broader distinction was also made between Western communities and the more collectivistic communities, when similarities in mental illness conceptualisations were drawn between the Hindu community, and the Muslim and Black communities. According to Sheikh and Furnham (2000), the beliefs in more traditional cultures are deep-rooted and more structured than in many western societies with religion playing a significant role in understanding the cause and treatment of illness. However, despite their perceived similarities, it was stated that these collectivistic communities were not comparable in all aspects. Specifically, a few participants noted that while the Muslim community were similar to the Hindu community in terms of their understandings, the Muslim community were still more open to psychology than the Hindus (as mentioned previously). Perhaps this phenomenon is due to the long history that Muslim scholars have had with the field of psychology. Early Muslims wrote extensively about human nature and called it *Iil-al Nafsiat* or self-knowledge, and in many cases, their work seems to be the original ideas for many modern day psychological theories and practices (Haque, 2004). Findings by Sinha, Vohra, Singhal, Sinha, and Ushashree (2002), however, suggests that these findings are more complex in that they reflect a shift in dynamics between these groups as a result of the changing socioeconomic scenario. Specifically, it is noted that collectivist groups are increasingly cultivating individualist intentions, which are likely to get stronger, particularly in more affluent areas with better infrastructure. Nevertheless, the suggested incongruence between Western (Individual) and Hindu (Collectivistic) conceptualisations of mental illness was unanimous. Western frameworks are perceived as structured and factual, as opposed to the Hindu framework which prioritises religious practices and provides religious bases for what is considered, or not considered, normal. The need for the Western paradigm to be culturally sensitive was also advocated. Swartz (1998) also addressed the importance of cultural sensitivity, by positing that culture may influence how mental illness is experienced, interpreted, and exhibited. This supports the argument made earlier, that individuals' religious backgrounds are important as it influences their mental illness conceptualisations.

4.3.2. The role of religion in the treatment of mental illness

The general belief was that a client's religious and cultural beliefs may influence their perception of the illness and thus their pathways to treatment. Furthermore, the level of investment one has in their culture or religion, and the level of exposure one has had to alternative thinking also plays a part. The important role of culture and religion in determining pathways to treatment had also been taken up by Whitbeck (2006), who proposed that different ways of healing may be favoured based on the extent to which an individual identifies with their culture or religion. For example, traditional Indian people may prefer traditional or cultural interventions to address relevant physical, emotional and spiritual issues. Campion and Bhugra (1998) also highlight that, partly for transitional reasons and partly for financial reasons, people with mental illnesses and their carers continue to choose religious and indigenous medical practitioners, who may also tend to believe in supernatural explanations of mental illness, thereby making help-seeking from these sources more likely. To support the importance of culture in treatment choice, comparisons were once again drawn between the Black and Indian (collectivistic), and White (individual) communities. It was suggested that the Black and Indian communities favour traditional modes of treatment, while the white community were described as being more aware of mental illness and psychology, and so, being more receptive to it.

The belief in the benefit of prayer amongst those inflicted with mental illness was unanimous. It was assumed that religious clients prayed more in times of adversity, which was considered to be beneficial as it would provide a sense of peace, calm, and safety. Similarly, a study by Weisman de Mamani, Tuchman, and Duarte (2010), supports the view that incorporating adaptive religious and spiritual elements into treatment for patients with serious mental illness is beneficial, particularly among ethnic minority patients who do not exhibit severe psychotic symptoms. Findings from this study indicate that religion and spirituality can often be incorporated into treatment in a way that coalesces with patients' values and enhances treatment gains. The study also highlights the importance of addressing spiritual issues within minority populations (Weisman de Mamani et al., 2010). However, the benefits of prayer are dependent on the value that it has in the client's life. Indeed, for those who are not religiously inclined, the suggestion of increased prayer as a coping mechanism may lead them to feeling forced into it. Thus they would not perform prayer as a means of attaining solace, but rather,

as a means of treating or curing their illness. When the problem does not magically disappear, these individuals may either become increasingly anxious or despondent. Additionally, feelings of religious guilt and the failure to meet religious expectations or to cope with religious fears may further contribute to illness (Trenholm et al., 1998). Studies in the area support the contested nature of religion and its influences on mental illness treatment. While Huguelet et al. (2009) and Rasic et al. (2008) attest to the benefit of religion and spirituality in both the treatment of mental illnesses, as well as in the reduction of mental illness prevalence; Fallot (2007) highlights religion's role as both potentially supportive and burdensome. Additionally, findings in King et al.'s (2006) study warns that higher levels of religious involvement is only associated with better health for those who *have* a spiritual life view.

Again despite their personal beliefs on the topic, when it comes to traditional modes of treatment, psychologists believe in supporting the client. Furthermore, in the event that traditional psychotherapy alone is not benefiting the client, most psychologists had no qualms with referring a client to a reputable traditional or spiritual healer. However, such treatment methods are to be used in collaboration with therapy, rather than as an alternative. Though to varying degrees, the idea that Western and spiritual forms of treatment could work collaboratively, was cited. It appears then that that it may be useful for practitioners to familiarise themselves with traditional systems of healing and models of illness which are used by cultures (Dein, 2003). These views are in line with the large body of research around the potential benefits of adopting a collaborative approach in psychotherapy (see Hopa, Simbayi, & Du Toit, 1998; Ross, 2008 Yen & Wilbraham, 2003). It is believed that such collaboration will help provide clients with a more holistic, systematic if you will, approach to treatment. This would be particularly beneficial to those clients who are quite religious and whose beliefs influence their conceptualisations of mental illness.

4.4. Conflict in Negotiating Identity

Participants gave contradictory responses when discussing the notion of conflicting identities and beliefs. Specifically, despite being a Hindu in a Western profession, most participants refuted the idea of a conflict between their personal and occupational beliefs, as the flexibility of therapeutic practice allowed practitioners to adjust the principles of therapy to a manner that is comfortable for both the client, as well as themselves. Additionally, the use of an adaptive approach was seen as valuable, as certain culturally-appropriate phenomenon or events may be overlooked or appear unusual in the Western environment (see Wedel, 2009). Thus a context-specific approach was perceived as helping reduce the undervaluing of certain situations. This idea is supported by a study comparing traditional versus Western perceptions of mental illness conducted by Latzer (2003), which concluded that professionals treating traditional populations must avoid imposing Western standards, and consider the treatment in the context of cultural beliefs. As such, Hindu psychologists are better able to understand and assist their clients, due to their familiarity with their religious background and their understanding of the nuances of the collectivistic community. However, these claims contradict earlier responses given by some participants who cited tensions between both their personal beliefs and their knowledge of Hindu beliefs, as well as between their personal beliefs and their duty as a therapist. Thus not only is the assumption that even non-practicing Hindus are still aware of Hindu beliefs and principles supported, but an important conflict between Hindu psychologists' occupational duty and their religious understandings and/or beliefs is highlighted.

4.5. Cultural Competence

Cultural competence is defined as one's ability to work within a community or culture different to their own, but observe a respect and understanding for that community and their cultural beliefs and practices (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007). This concept is based on the premise that in order to provide culturally competent care, knowledge of cultural beliefs, values and practices is necessary to avoid ineffective management and poor compliance (Bhui et al., 2007; O'Hagan, 2001). Thus certain cultures create systems that define what is viewed as a psychological problem or what causes mental illness; therefore, it is helpful to either come from the same cultural background or have an understanding of the cultures' belief systems regarding mental illness (O'Hagan, 2001).

Specifically, within the Hindu community, the importance of relationships, both familial and social, and the negative psychological impact this has on individuals when they fall out of favour with family and community members, was highlighted. It is clear then that the nuclear family, the extended family, and the community are important components in the balance and harmony of the individual (Chekki, 1996). These findings add to the description of the Hindu group as collectivistic, for in collectivist cultures, people tend to define themselves in terms of their place in the larger collective (McAuliffe, Jetten, Hornsey, & Hogg, 2003). They place greater emphasis on maintaining group harmony, and are strongly guided by group norms (Triandis, 1989; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988 cited in McAuliffe et al., 2003). The need for cultural competence or the awareness of these culture-specific problems is needed in order to understand the dynamics of, and help, this community. Thus, most participants felt that being a Hindu themselves has helped them relate better to Hindu clients. Interestingly however, participants believed that this did not make them any less effective when dealing with clients from other religious backgrounds, as Hinduism's principles are seen as a way of life rather than a set of rules and rituals. In support of this, Tarakeshwar, Pargament, and Mahoney (2003) attest to the better psychological well-being that the application of Hinduism's principles may bring about. It is important to note, however, that despite these perceptions, participants had previously cited that Hindu clients were weary of seeking help from Hindu therapists. Such findings contradict literature on cultural competence, which generally suggest that people are not willing to engage in treatment that is foreign to their cultural upbringing, and so, would benefit from mental healthcare workers who understand where the individual is coming from as they may better help and engage with these clients (Sue & Sue, 2003). Thus the fear of stigma and negative social standing due to confidentiality concerns, are clearly prioritised by Hindu clients, rather than the value of cultural competence.

4.6. A Unique Brand of Hindu Psychology

Most Hindu psychologists believed that due to the adaptability of psychological techniques to suit individual clients, as well as the increasing Westernisation of South African Indians, the development of a unique Hindu brand of psychology was unwarranted. This is in contrast to the ever increasing development of Hindu psychology, seen globally (see Sinha, [D.] 1994 and Sinha [J.B.P.] 1987, 1997; 2001). According to Chakkarath (2005, p. 33), "one of the reasons why western psychology has not shown very much interest in indigenous psychological concepts may have to do with the assumption that those concepts are often integral parts of religious or other prescientific worldviews and, therefore, do not meet western scientific standards". Additionally, indigenous psychology has been defined as psychological understanding developed and historically rooted in a particular cultural context, thus being designed primarily for the people of that culture (Kim, 1990 cited in Chakkarath, 2005). As such, indigenous psychology appears to be 'merely' part of the general knowledge of a specific culture. This is relevant as it is assumed that western paradigms may pay little attention to methods or understandings that are relevant only to a small subset of people, without scope for widespread applicability.

Furthermore, while cultural trends may exist, it was believed that an exclusive brand of psychology runs the risk of equating these trends with stereotypes, thus categorising and defining people. However, it was mentioned that the principles of Hinduism as a way of life may be beneficial to some. This is supported by a comparative study by Jeste and Vahia (2008), who found several similarities between the *Bhagvad Gita* and modern scientific literature, such as rich knowledge about life, emotional regulation, insight, and a focus on common good (compassion). Apparent differences include an emphasis on control over desires and renunciation of materialistic pleasures. Importantly, the *Gita* suggests that at least certain components of wellness and wisdom can be taught and learned. Jeste and Vahia (2008) posit that these concepts outlined in the *Gita*, are relevant to modern psychiatry in helping develop psychotherapeutic interventions that could be more individualistic and more holistic than those commonly practiced today, and they aim at improving personal wellbeing rather than just psychiatric symptoms. Thus the use of such Hindu principles and concepts may prove beneficial in helping religious or spiritual clients, to overcome their problems in an attempt to develop a more balanced and moral lifestyle.

Additionally, of those who did advocate for a uniquely Hindu psychology, reasons were centred around using therapeutic techniques to address Hindu-specific problems, such as problematic family dynamics or financial stress, and not just the more serious clinical disorders. This may be a particularly useful tactic amongst Hindu women, who are likely to suffer from psychological problems due to the various stressful family dynamics and relationships, yet are unlikely to be aware of the psychological impact of these stressors, or to seek help. This is evidenced by Navsaria and Petersen (2007), who found that Indian women, seek mental health services at a lower rate than other populations, but not due to a lesser need. Indeed, in such instances incorporating components of Hinduism culture, value, and beliefs, as well as an understanding of the cultural ideals and gender roles, may prove beneficial in helping these clients. Additionally, such a psychology may allow clients to feel more comfortable knowing that the therapist understands their problems, however, this needs to be used at the practitioner's discretion as not all Hindus practice Hinduism, and so, may not be receptive to such a form of therapy. Thus both arguments presented by participants, regarding the benefits and concerns around developing a Hindu or Indian (i.e. collectivist-orientated) psychology are valid and may prove useful to current research in the area.

Conclusion

It appears that Hindu psychologists may hold conflicting beliefs regarding the dynamic relationship between personal beliefs, religious beliefs, and mental illness. However, the psychologists still believed that they were able to successfully navigate between the two positions which they occupy, namely, being a Hindu, and being a psychologist. This was attributed more to Hinduism being a way of life rather than a rigid set of rules, than with the psychologists being able to separate these two positions. These psychologists drew more on traditional psychological conceptualisations of mental illness, yet did not discount, discourage, or judge those who believe in spiritual illnesses or religious explanations for illnesses. Rather, there was a focus on *why* traditional and spiritual treatment is important to the individual (e.g. brings a sense of spiritual peace). The findings in this study contradict the assumptions of cultural competence, as participants felt that clients prioritised the effects of stigma and negative social standing, over the value of seeking help from a therapist that is culturally competent. Furthermore, even those clients who are indoctrinated in their faith and believe their illness to be caused by spiritual forces, are still perceived as being open to

Western modes of treatment, by virtue of them attending therapy. An interesting remark made that is perhaps worthy of further exploration, is the stigma attached to psychology *professionals*, rather than just their clients.

Overall the Hindu psychologists seem to advocate that religion plays a crucial role in defining and understanding the causes of, as well as pathways to treatment for, mental illnesses. This is especially true of the Hindu community due to the importance placed on religious and cultural beliefs, and traditions within this collectivistic community. Given that these psychologists are in a unique position to comment on the applicability of Western treatment with religious individuals, this distinction between the value systems and characteristics of individualist and collectivist communities, was commonly cited as a failure on Western psychology's part in making their approaches accessible and relevant to all groups of people. Specifically, the Hindu community tend to place a great deal of importance on familial and community relationships which, when negative, may be the source of psychological distress. As such, this study has highlighted a need to pay closer attention to such issues among clients from these backgrounds. A strategy that was reiterated was to avoid dismissing the value that clients place on their social standing and religious beliefs, for if addressed effectively, may assist in the treatment process.

Additionally, being a Hindu has helped these psychologists to relate better to their Hindu clientele in so far as they are able to better understand the importance of certain issues that would otherwise be overlooked by some Western professionals. This once again alludes to the importance of cultural competence, specifically, understanding the dynamics of collectivistic communities. Furthermore, while the psychologists advocate that the principles of Hinduism reflect a better way of life, the development of a unique brand of Hindu psychology was not recommend. Instead, it was suggested that practitioners focus more attention on understanding *all* aspects of their clients' lives i.e. adopt a more holistic approach. Thus a collaborative relationship with traditional and spiritual healers was advocated.

It appears, however, that these observations occur on a global level. Much like the findings in this study, the *National Mental Health Plan* (Australian Health Ministers 1992 cited in Wynaden et al., 2005) identified several problems with the provision of mental health care to migrant communities. These problems were related to: (i) beliefs about the causes and treatment of mental illness; (ii) distrust of psychiatric services; (iii) lack of familiarity with the health system; (iv) trying to cope with the problem within the family; (v) preference to use traditional health-care methods; (vi) communication difficulties; (vii) stigma and shame; and (viii) the perceived cultural incompetence of health-care providers (see Fann 1999; Lam & Kavanagh 1996; Shin 2002). Furthermore, the results of Wynaden et al.'s (2005) study confirmed existing documented problems regarding the delivery of mental health care to migrant communities. Specifically, the findings highlighted that people from minority communities are unwilling to access help from mainstream services because of their beliefs, and that stigma and shame are key factors that influence this reluctance. Concerns around stigma and shame are supported by this study; however, as mentioned earlier, this study contradicts general literature in the area which assumes that people refrain from seeking [psychological] help from those who do not share the same beliefs and cultural or religious background as them.

CHAPTER 5: LIMITATIONS AND RECOMMENDATIONS

This study explored mental illness perceptions among Hindu Psychologists in the Johannesburg area. Specifically, the study sought to determine the influence, if any, that religion had on these perceptions. While this study has contributed to the knowledge economy by adding to this growing body of literature, it has also yielded the following limitations and recommendations.

5.1. Conceptual and Methodological Limitations and Recommendations

This study attempted to understand the perceptions of mental illness from a Hindu perspective. While there may be a large amount of information available, the researcher struggled to obtain a sufficient quantity of this information. Additionally, there was scant literature available on Hindu understandings of mental illness within the South African context. Given the dynamic nature of this country, such information would help conceptualise the current state of Hinduism in South African, as well as its relationship with, and perceptions of, mental illness. Thus there may be gaps in understanding the role of Hinduism in perceiving mental illness. This in turn makes it difficult to substantiate claims made by participants, thus potentially limiting the impact and validity of any conclusions made. It is recommended that future studies adjust timelines and utilise additional resources, so as to circumvent this problem by allowing for more time in which to review literature.

Additionally, the nature of the sample indicates a potential bias in favour of women. Thus much of the perspectives provided were reflective of the female cohort of the Hindu psychological community. This is an important consideration as females are generally considered to be the ones who carry and teach a family's culture, traditions, and religious beliefs, to future generations. Thus despite many participants advocating that they were not practicing Hindu's, they were still knowledgeable of Hindu concepts and principles, presumably due to the teachings of elder females in the family (e.g. mothers, grandmothers, and mother-in-laws). However, since no male participants were obtained, it is unclear if gender differences exist. Thus it is recommended that future studies address this potential limitation. This will enable one to fully understand whether or not the perceptions and beliefs

provided by the Hindu female participants in this study are similar to, or different from, male psychologists.

Given the researcher's own status as a Hindu, some participants alluded to feeling tested, as they were not sure if their responses were 'correct'. Thus participants may have withheld certain responses so as not to feel judged. In order to overcome this, the researcher assured participants that all responses were valuable as the aim was to ascertain *their* perceptions. Another tactic used by the researcher, was to reiterate the confidentiality and anonymity of the study; however, the researcher cannot guarantee that these attempts successfully eased participants' anxieties. Nevertheless, future research should endevour to convey the same reassuring information to participants.

Moreover, the qualitative nature of the study yields various methodological limitations and concerns. This method is frequently criticized for its inability to generalize. However, it should be noted that this study did not aim to generalize its findings, but was exploratory in nature, and so, attempted to establish potential areas of interest in order to guide future research, as well as contribute to literature in the area. Also, the fact that qualitative methods of analyses are subject to researcher interpretations are seen as an advantage. However, the researcher in this study sees this as an advantage, as the absence of interpretation would result in a mere description of the data.

5.2. Further Recommendations for Future Research

Despite the aforementioned conceptual and methodological limitations of this study, its findings prove useful in directing future research in the area. Specifically, such research will help shed light on the issues surrounding Hindu psychologist's identities, as well as the psychological profession's effective treatment of clients from diverse religious and cultural backgrounds.

Studies exploring the perceptions of psychologists from other religious backgrounds may prove useful. Comparisons will help identify common issues and/or differences, and so, will help expand the literature base of related areas. Additionally, such information will help the psychological profession to flag areas of concern. By addressing these issues, practitioners will be able to improve their treatment methods for people from diverse backgrounds. Furthermore, it may also be helpful to expand this research to incorporate patients' and other community members' perceptions of mental illness and the role that religion, if any, has had on these perceptions. However, given the dynamic nature of the South African context, the effects of globalization in the 21st Century, and the occurrence of generational gaps, research in this area needs to be fluid and ongoing, rather than static.

Furthermore, the findings in this study highlight the need for mental health professionals to reassess their treatment approaches among their more religious clientele. Specifically, strategies designed to make psychologists more culturally competent, and so, more accessible to the diverse South African population, need to devised. Additionally, the ever-present issues of stigma and a lack of understanding need to be addressed. Moreover, tactics, directed at collectivistic communities need to be developed, in order to promote greater awareness of mental illness and the treatment methods available. By familiarizing people with mental illness and the work of psychologists, it is believed that they would be able to better distinguish mental illnesses from spiritual illnesses, and be more willing to seek the relevant treatment.

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Appendix A: Participant Information Sheet



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Dear Sir/ Madam

Hello,

My name is Priyanka Padayachee and I am a Master's student at the University of Witwatersrand. As part of my course I have to complete a research project. My research focuses on exploring the perceptions of mental illness among Hindu psychologists in the Johannesburg area. I would like to invite you to participate in this study.

Participation is completely voluntary and you may withdraw at any time and there will be no negative consequences. Your participation would consist of a one-on-one interview with me where you will be asked a range of questions dealing with the above-mentioned issues. Although it would be appreciated if you could answer all of the questions, you are free to omit questions if you wish. I assure you that all information gathered will be dealt with in a confidential manner. No identifiable information will be included in the research report. You will be referred to by a pseudonym (Respondent X, Respondent Y etc.) throughout the research. The interview tapes will not be seen by anyone other than myself. However, my supervisor may have access to the interview transcripts. In such instances, you will be referred to by a pseudonym and all identifiable information will be removed so that she is unable to identify you. The tapes and transcripts will be destroyed on completion of the research.

If required, feedback will be available approximately 6 months after the interview. Feedback will be in the form of a one-page summary of the study and its results. If you require any

further information or feedback, please feel free to contact me. My details appear in signature below. You may also contact my supervisor, Sumaya Laher.

Your participation in this study will be greatly appreciated.

Priyanka Padayachee

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Sumaya Laher

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Appendix B: Consent Form (Interview)

I, _____ consent to being interviewed by Priyanka Padayachee, for her study exploring the perceptions of mental illness among Hindu psychologists. I understand that:

- Participation in this study is voluntary.
- I may refrain from answering any questions.
- I may withdraw my participation from the study at any time.
- There are no risks or benefits associated with this study.
- All information provided will remain confidential, although I may be quoted in the research report.
- If I am quoted, a pseudonym (Respondent X, Respondent Y etc.) will be used.
- I should not reveal any confidential information about my clients.
- None of my identifiable information, or that of my clients, will be included in the research report.
- I am aware that the results of the study will be reported in the form of a research report for the partial completion of the degree, Master of Arts in Psychology (Research).
- The research may also be presented at a local/international conference and published in a journal and/or book chapter.

Signed:_____

Date: _____

Appendix C: Consent Form (Recording)

I, _____ give my consent for my interview with Priyanka Padayachee to be recorded for her study exploring the perceptions of mental illness among Hindu psychologists. I understand that:

- The tapes and transcripts will not be seen or heard by anyone other than the researcher and her supervisor.
- The tapes and transcripts will be kept in a safe place for the duration of the study and will be destroyed after the relevant information has been obtained from them.
- No identifying information will be used in the transcripts or the research report.
- Although direct quotes from my interview may be used in the research report, I will be referred to by a pseudonym (Respondent X, Respondent Y etc.)

Signed: _____

Date: _____

Appendix D: Interview Schedule

I would like to thank you for agreeing to participate in my study. Before beginning with the interview, I would like to assure you that everything you say during this interview will be kept confidential, and only my supervisor and I will have access to the tapes. The tapes and transcripts will be destroyed after the relevant information has been obtained. Although I know who you are, confidentiality will be maintained by not disclosing any information that is of a personal nature in the report. Assigning a pseudonym to your information in the report, for example, Respondent X or Respondent Y, will maintain confidentiality. Any information that you may reveal regarding your clients will also be kept confidential.

I would like to remind you that you maintain the right to withdraw from the study at any time during the interview. You also have the right to refrain from answering any question should you wish to do so. A feedback sheet in the form of a one to two page summary of the study and its findings will be provided to you upon request. The feedback will be available approximately 6 months after the collection of the data.

Before beginning the interview I will need you to read through and sign these two consent forms (See Appendix B & C).

Thank you. If you are ready we can begin the interview.

QUESTIONS

Section 1: Work Context

1. What kind of work do you do / are you involved in (if they're not in private practice)?
2. What kinds of clients do you consult with? Not only their problems/pathologies but also their demographic characteristics especially population group, gender, religious affiliation? (remind practitioner that they should not compromise their clients' confidentiality)
3. What are the more general/practical problems you encounter with these clients/with assisting these clients?
4. Do you feel that your university training adequately prepared you for this or are there additional aspects that in retrospect you feel could have been added? Elaborate

Section 2: Psychologist's perception of mental illness

5. Given both your training and practical experience, how would you define a mental illness?
6. According to you, what are the chief causes of mental illnesses?
7. In your opinion, how does a mental illness differ from everyday problems?
8. In your opinion, what role do you feel religion has in defining and understanding mental illness?
9. How does Hinduism conceptualise illness and mental illness?
10. Do you think this is similar to how mental illness is conceptualised in other religious cultures? Please elaborate.
11. How congruent is this with a Western understanding of mental illness?
12. Can it be said that there is a distinction between mental illness and spiritual illness? Please elaborate.
13. What are your personal beliefs regarding spiritual illness? (Prompt with: do they exist, what typically characterises spiritual illnesses like the evil eye/ witchcraft/ spirit possession? what experiences have you had with them, etc.)

Section 3: Treatment of mental illness

14. How do you counsel clients who believe their illnesses are caused by spiritual forces? (Prompt with: what do you say to them?)
15. Do you believe that one's religion or culture is a key factor in determining their choice of treatment for mental illness? Please elaborate.
16. How do you feel about other spiritual forms of mental illness treatment, i.e. by Guru's and traditional healers, etc? Would you refer someone who seeks your help to one of these professionals?
17. In your experience, have people who believed their illness to be caused by spiritual forces been open to seeking assistance from Western professionals? Or receiving Western forms of treatment? (Prompt with: what responses have these clients had with regard to Western forms of treatment? Did they find that it helped or didn't help?)
18. In your opinion, do you believe it is possible for Western and spiritual forms of treatment to work collaboratively? Please elaborate.
19. According to you, what influence do religious rituals and practices such as prayer, have on a person's illness? (Prompt with: to your knowledge, do you find that people

tend to perform more religious rituals and practices when faced with a mental illness?) Please elaborate.

Section 4: General section around being a Hindu psychologist in a Western psychology

20. How has being a Hindu affected your ability to work in this field? (Prompt with: has it lead to any conflict in beliefs, has it helped relate to clients, etc.)
21. Do you practice more of a religious approach to psychology on Hindu patients or do you prefer a western approach to psychology? Do you believe any one of them to be more/less effective than the other? Please elaborate.
22. Do you think there can be an Indian Psychology / Hindu Psychology? Please elaborate.
23. How would it differ from Western Psychology?
24. Do you have any further comments, or would you like to add any other information that you feel we have not discussed?

Thank you for your time and co-operation.