Madness in a Tibetan context: A comparison of Tibetan textual and lay perceptions of 'smyo nad' (madness) among Tibetans living in North India

Susannah Deane[1]

Cardiff University

Ethnographic research on psychiatric illness in the Tibetan context – both in exile and in Chinese-controlled Tibet – has to date mainly focused on *rlung* ('wind') illnesses (i.e. those related to '*rlung*' – one of three bodily 'humours' of both Tibetan and Ayurvedic medical theory);[2] and those which would be classified in biomedicine as depressive or anxiety conditions or post-traumatic stress disorder (PTSD).[3] Further research has explored the politicisation of *rlung* ('wind') illness,[4] and Tibetans' health-seeking behaviour in medically pluralistic areas in both Tibet and

[1] Susannah Deane is a PhD candidate at Cardiff University. She completed a BA(Hons) in Psychology at the University of Wales, Bangor and an MA in Buddhist Studies at the University of Bristol. Many thanks to Dr. Tracey Loughran for comments and suggestions on this paper.

[2] See, for example, Eric Jacobson, 'Panic Attack in a Context of Comorbid Anxiety and Depression in a Tibetan Refugee', *Culture, Medicine and Psychiatry,* 26 (2) (2002), pp. 259-279; Eric Jacobson, 'Life-wind Illness in Tibetan Medicine: Depression, Generalised Anxiety, and Panic Attack', in *Soundings in Tibetan Medicine: Historical and anthropological perspectives (Proceedings of the Tenth Seminar of the International Association of Tibetan Studies (PIATS), Oxford 2003)*, ed. by Mona Schrempf (Leiden, Boston: Brill Academic Publishers, 2007), pp. 225-246.

[3] See: Dylan Brock, 'Taming the Mind: Current Mental Health Treatmentsand Obstacles to Expanding the Western-model in a Tibetan Exile Community', *Independent Study Project (ISP) Collection*, Paper 209 (2008); Audrey Prost, 'Causation as Strategy: Interpreting Humours among Tibetan Refugees', *Anthropology & Medicine* 13 (2) (2006), pp. 119-130; Audrey Prost, *Precious pills: medicine and social change among Tibetan refugees in India*. (Oxford and New York: Berghahn Books, 2008); Eshani Ruwanpura and others, 'Cultural and Spiritual Constructions of Mental Distress and Associated Coping Mechanisms of Tibetans in Exile: Implications for Western Interventions', *Journal of Refugee Studies* 19 (2) (2006), pp. 187-202; Emily Sachs and others, 'Entering Exile: Trauma, Mental Health, and Coping among Tibetan Refugees Arriving in Dharamsala, India', *Journal of Traumatic Stress* 21 (2) (2008), pp. 199-208.

[4] Vincanne Adams, 'Suffering the Winds of Lhasa: Politicized Bodies, Human Rights, Cultural Difference, and Humanism in Tibet', *Medical Anthropology Quarterly* 12 (1) (1998), pp. 74-102; Janes, Craig R., 'Imagined Lives, Suffering, and the Work of Culture: The Embodied Discourses of Conflict in Modern Tibet', *Medical Anthropology Quarterly* 13 (4) (1999), pp. 391-412; Audrey Prost, 'Exile, Social Change and Medicine among Tibetans in Dharamsala (Himachal Pradesh), India' (unpublished doctoral thesis, University College London, 2004); Prost (2006).

the Tibetan diaspora.[5] Such research has led to significant advances in our understanding of Tibetan medicine and Tibetan notions of health and illness. It has neverthless left conceptions of madness largely unexplored – especially in relation to lay perspectives. The Tibetan term '*smyo nad*' (also '*smyo pa*') is generally translated into the English words 'madness' or 'insanity', and its symptoms share similarities with Western understandings of 'psychosis'.[6] Jacobson notes the use of '*smyo pa*' as a 'generic term for conditions marked by obvious hallucinations, delusions, and disruptive speech and behaviour'.[7] However, this means that '*smyo nad*' could be used to refer to a number of divergent biomedical diagnostic categories which include episodes of psychosis (e.g. schizophrenia and its subtypes, manic depression or bi-polar disorder, etc.), and other researchers have found patients diagnosed by biomedical psychiatrists with 'schizophrenia' and 'bipolar disorder' diagnosed by a Tibetan doctor as having '*srog rlung*', rather than '*smyo nad*'. [8] Clearly then, direct Tibetan-English translations can be problematic, with one Tibetan term being translated into several different English terms, or being used to discuss what would be a number of different biomedical classifications. This is illustrated in the often widely divergent translations of many Tibetan terms, particularly in regard to Tibetan medical terms, which may have multiple meanings, and be understood quite differently by Tibetan doctors, lay Tibetans and Westerners, but with no ultimately direct or satisfactory translations. Furthermore, Gerke notes that differences in Tibetan doctors' translation of Tibetan medical terms can depend on multiple factors such as 'their exposure to patients using biomedicine (which has a palpable rural and urban divide), their involvement in research studies or clinical trials, their education, and also their personal interest in biomedicine', as well as

[5] Mona Schrempf, 'Between Mantra and Syringe: Healing and Health-seeking Behaviour in Contemporary Amdo', in *Medicine Between Science and Religion: Explorations on Tibetan Grounds*, ed. by Mona Schrempf and others (New York: Berghahn Books, 2011), pp. 157-184; Barbara Gerke, 2010. 'Tibetan Treatment Choices in the Context of Medical Pluralism in the Darjeeling Hills, India', in *Studies of Medical Pluralism in Tibetan History and Society. PIATS 2006: Proceedings of the 11th Seminar of the International Association of Tibetan Studies, Konigswinter 2006*, ed. by Mona Schrempf and others (Andiast, Switzerland: International Institute for Tibetan and Buddhist Studies GmbH, 2010), pp. 337-376.

[6] Colin Millard, 'Tibetan Medicine and the Classification and Treatment of Mental Illness', in *Soundings in Tibetan Medicine: Historical and anthropological perspectives (Proceedings of the Tenth Seminar of the International Association of Tibetan Studies (PIATS), Oxford 2003)*, ed. by Mona Schrempf (Leiden, Boston: Brill Academic Publishers, 2007), pp. 247-282.

[7] Jacobson (2002), p. 261.

[8] Millard, p. 257.

multiple other political and/or pragmatic factors.[9] In addition, the poetic meter of the Tibetan medical text, the *rGyud bZhi* – which aids memorisation (the traditional manner in which it is learnt) – creates difficulties for translation, with some words omitted or shortened to keep to the poetic structure, and 'partly encrypted' verses.[10]

In the absence of direct translations, we are left to grapple with Tibetan and Western conceptions of an illness or state of being which have some quite fundamental differences. How then do we navigate the 'no-man's land' between Tibetan and English concepts, and come up with acceptable translations? There is no easy answer to this question of course, only an awareness of its complexities, and a system of trial and error, which hopefully over time, will improve our understandings. Consequently here, I will use the Tibetan diagnosis of '*smyo nad*' and its most common translation of 'madness', as these were the terms used most frequently by Tibetan informants during fieldwork.

Some have suggested that Tibetan medicine's models, methods, and predictions differ so significantly from biomedical ones that they are 'completely incompatible' with biomedicine.[11] For example, the Tibetan medical text describes causes of madness such as spirit possession and 'imbalance' or 'disturbance' in the body, and lay Tibetans often have a broader understanding of causation, taking in both Tibetan religious concepts and what might be termed 'social' causes. Many of these concepts could be viewed as comments on social and religious norms, or judgements of 'appropriate' and 'inappropriate' behaviour in Tibetan society, and they are reflected in health-seeking behaviour.

This paper examines lay perceptions of *smyo nad* in a Tibetan settlement in Darjeeling, Northeast India, and therefore contributes to the body of knowledge on psychiatric illness in the Tibetan context. If Bhui and Bhugra are correct in their assertion that more work on understanding local explanatory models of illness and healing is required *before* attempts are made to map them onto 'biomedical

[9] Barbara Gerke, 'Correlating Biomedical and Tibetan Medical Terms in Amchi Medical Practice', in *Medicine Between Science and Religion: Explorations on Tibetan Grounds*, ed. by Vincanne Adams, Mona Schrempf and Sienna R. Craig (New York: Berhahn Books, 2011), pp. 127-152 (p. 145); see also Gerke (2012b).
[10] Barbara Gerke, *Long lives and untimely deaths: life-span concepts and longevity practices among Tibetans in the Darjeeling Hills, India* (Leiden: Brill Academic Publishers, 2012a), p. 18.
[11] Joseph J. Loizzo and others, 'Tibetan Medicine: A Complementary Science of Optimal Health', *Annals of the New York Academy of Sciences* 1172(1) (2009), pp. 218-230 (p. 224).

diagnostic categories and related care pathways',[12] then such research is not only crucial, but overdue. These findings therefore have significant implications for health policies and health planners working within Tibetan communities in North India. In addition, ethnographic work on local meanings of mental illness can contribute to debates over the cross-cultural validity and utility of Western models of psychiatric illness, which are often brushed aside in the 'Global Mental Health' agenda,, and may thereby illustrate the complexities facing researchers and health-planners working cross-culturally. [13]

Here I will describe a case study in order to illustrate some comparisons between textual and lay perceptions of 'madness' in the Tibetan context. Such cases can highlight the often divergent understandings of psychiatric illness and healing and their implications for health-seeking behaviour for lay Tibetans.

Methodology

This paper is based on two six-month periods of ethnographic fieldwork carried out within a Tibetan community in Darjeeling, Northeast India during 2011 and 2012.[14] Here, first, second and third generation Tibetan exiles reside at both the Tibetan Refugee Self-Help Centre (TRSHC) situated just outside the town, and within the town itself, amongst the majority Nepali population. Local medical and healing facilities included biomedical clinics and hospitals, Ayurvedic clinics, Tibetan medicine clinics, Tibetan Buddhist monasteries, local Tibetan Buddhist Tantric practitioners, and local Nepali spirit-mediums.[15] General interviews were conducted with lay Tibetans as well as with a number of religious and medical practitioners residing in and around the area.[16] In addition, I was able to interview Dr. Pema

[12] Kamaldeep Bhui and Dinesh Bhugra, 'Explanatory Models for Mental Distress: Implications for Clinical Practice and Research', *The British Journal of Psychiatry*, 181(1) (2002), pp. 6-7.
[13] See, for example, Summerfield's comments in: Richard Horton, 'Offline: Is Global Health Neocolonialist?' *The Lancet* 382(9906) (2013), p. 1690.
[14] This fieldwork was conducted as part of a PhD research project, and was part-funded by grants from Cardiff University School of History, Archaeology and Religion, Cardiff University Body, Health and Religion Research Group (BAHAR) and the Wellcome Trust.
[15] See Gerke (2010, 2012a) for an in-depth examination of medical pluralism in Northeast India.
[16] In total, I conducted interviews with 26 lay Tibetan informants (recruited through chain referral sampling), eight with Tibetan medicine doctors, three biomedical doctors (in Darjeeling, Gangtok (in the neighbouring state of Sikkim) and Dharamsala), and four local monastic practitioners as well as four local Nepali spirit-mediums. In addition, I included four more in-depth illness narratives, one of

Dorjee, a first generation Tibetan exile and well-known Tibetan doctor, at his house in Delhi; and Dr. Sonam Dolma (44), a second generation exile and at that time head of the Men-Tsee-Khang (MTK) Translation Department in Dharamsala, Northwest India, in her office. Both had trained at the MTK and worked in a number of MTK clinics across India prior to their current posts. Topics discussed with informants included illnesses and conditions which are classified as 'psychiatric' illness by biomedical classification (according to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV TR)[17] or *International Classification of Disease* (ICD-10),[18] or as *sem nad* ('illnesses of the mind') in Tibetan medical textual classification or in lay perceptions. In this way, it was possible to include a broad range of conditions, some classified as an 'illness' by only one or the other of these systems. It also enabled an examination of the boundaries of health and illness as perceived by Tibetan informants in a way which also makes sense from Western understandings of psychiatric health and illness.

Interviews with Tibetan medical and religious specialists were conducted in their place of work with only the two of us present. Interviews with lay informants were generally carried out wherever they suggested – often in the individual's house or place of work. In such cases, we tended to be alone for the duration of the interview, although interviews occasionally became more of a group or family endeavour. These interviews varied in length and depth depending on the individuals' time and willingness (although in they most cases, lasted approximately 1-1½ hours) and, whilst some of these informants were interviewed once only, a number of them became key informants, meeting me numerous times (often in a more social context), inviting me into their lives and homes, and endlessly discussing the topics they had learned that I was interested in.[19]

---

which is discussed here. This paper therefore, draws on material from a number of these interviews most pertinent to this topic. All names used, other than those of Dr. Pema Dorjee and Dr. Sonam Dolma, who were interviewed in their official capacity, are pseudonyms used to protect informants' anonymity.

[17] American Psychiatric Association, *Diagnostic and Statistical Manual of mental disorders: Fourth Edition Text Revision (DSM-IV-TR)* (Arlington, VA: American Psychiatric Association, 2000), now revised in its fifth edition, DSM-5 (2013).

[18] World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (Geneva: World Health Organization, 2005).

[19] I had been concerned that informants might be reticent to discuss topics related to psychiatric illness due to its often sensitive nature, but in actuality I rarely encountered an unwillingness to discuss this topic.

Apart from interviews with Nepali spirit-mediums – which were conducted entirely in Nepali with the aid of a translator – formal interviews and general conversations were conducted in English and/or Tibetan,[20] sometimes with the aid of a Tibetan friend, who translated when the conversation got too fast or technical for my Tibetan. However, I was aware that the presence of a 'translator' not only alters the dynamic of an interview, but also adds another layer of interpretation to the translation and thus the interview. Furthermore, the majority of the Tibetan doctors I interviewed (particularly those who had trained in Dharamsala, with its significant population of Westerners) were used to discussing Tibetan medicine with foreigners to a greater or lesser extent, and it is likely that Westerners' particular interests in, and preconceptions of, Tibetan medicine may result in interactions with Tibetan doctors significantly different from those between doctors and their Tibetan patients (whether consciously or unconsciously).

Jigme: a case study

One of the case studies from this research was Jigme, a Tibetan man and former monk in his mid-forties, and the neighbour of a friend, Nyima. Alone in a small room, with an overgrown beard, wild hair and dirty clothes, lying on the wooden floor with pieces of a broken bed strewn about him and talking quietly to himself, he appeared a stereotypical illustration 'madness'. Nyima spoke to him briefly – asking how he was, if he had eaten lunch, and introducing me. Jigme greeted us, mainly giving one-word answers to Nyima's questions. All the while he continued quietly talking to himself, and seemed unperturbed by our presence: calm and quite cheerful in his demeanour.

Jigme was described by many in the community either using the Tibetan term '*smyo nad*', or the English words 'mad' or 'crazy', and Nyima explained that Jigme has been '*smyo nad*' for around twenty years. Others in the community explained that in the past Jigme had often been aggressive or violent towards others; but these days he was calm and did not disturb anyone, so long as no-one aggravated him. Jigme was given three meals a day by the people who ran the kitchen; and a couple

[20] Many local Tibetans attend private English language schools in the area, and have a high level of English.

of the older women in the settlement told me that they helped him to change his clothes every few months, enticing him to be calm with sweets.

In the past Jigme had received treatment for his condition, at one time having regular monthly injections and daily administration of biomedical pills by a local biomedical doctor. Neighbours described how these had helped to some extent: at that time Jigme had often been violent or aggressive, and the injection had tended to calm him down for a while, the effect usually 'wearing off' near the end of the month when the next injection was due. However, neighbours reported that this treatment had often left Jigme incapacitated, serving only to keep him calm – he had not been able to work, marry, or take part in any other activities of 'normal' Tibetan life. Others remembered vaguely that his family had initially conducted a number of Tibetan Buddhist rituals for him and he had received blessings from a lama, but these activities had not helped significantly. Jigme no longer received any treatment, most likely related to the fact that his now elderly father, having become ill, was unable to help – it was explained that the administration of the injection and ingestion of medicine had required his practical help in physically restraining his son.

'Madness' in the Tibetan medical text

Whilst there are a number of Tibetan medical and Tantric texts which cover conditions which might be termed 'psychiatric', it is the the *rGyud bZhi* ('Four Treatises') which is considered to be the 'root' medical text used in teaching across the Tibetan plateau,[21] the 'single core text' which forms the syllabus of the Tibetan government-in-exile affiliated Men-Tsee-Khang (MTK) Tibetan Medical and Astrological Institute in Dharamsala,[22] and it is therefore the text which I will focus on here. Accompanied by commentaries, the *rGyud bZhi* covers anatomy and the nosological framework of medicine, as well as diagnostic and treatment methodology.[23] Thought to date from the twelfth century, the text is understood to be as a composite work influenced by multiple sources including Sanskrit and Chinese

[21] Yang Ga, 'The Sources for the Writing of the Rgyud bzhi, Tibetan Medical Classic' (unpublished doctoral thesis, Harvard University, 2010), pp. 1-2.
[22] Stephan Kloos, 'Tibetan Medicine in Exile: The Ethics, Politics and Science of Cultural Survival' (unpublished doctoral thesis, University of California, San Francisco with University of California, Berkeley, 2010).
[23] Yang Ga (2010).

texts, as well as original Tibetan medical concepts.[24] The *rGyud bZhi* describes the multiple factors which can be involved in the causation of *smyo nad*, including: karma; grief-worry; humoural imbalance; poison; evil spirits;[25] mental discomfort or exertion; a weak heart; poor diet; or certain behavioural patterns.[26] During fieldwork, the notions of *rlung* and spirit possession often predominated in discussions with lay Tibetans about *smyo nad* and its causation, and therefore I will focus on these factors here.

Tibetan medical theory – similarly to Ayurvedic medical theory – describes the three *nyes pa* (Sanskrit: *doṣa;* English*:* 'humour') of *rlung*, *mkhris pa* and *bad kan* (generally translated as 'wind', 'bile' and 'phlegm' respectively), 'disturbance' in any one of which can lead to illness. The English translations of these terms are problematic however, with Gyatso noting the questionable translation of *nyes pa* into the English term 'humour' (or 'humor').[27] Literally translated, *nyes pa* means 'fault' or 'weakness',[28] but has more recently been translated as 'defective energies' by MTK doctors.[29] Furthermore, Gerke notes that the Eurocentric nature of the English translations of the three *nyes pa* themselves means that the polysemous meaning of them is lost.[30] To avoid confusion, I will simply use the Tibetan terms here.

Whilst any of the three *nyes pa* can be implicated in psychiatric illness, it is *rlung* which is most closely related to consciousness, and therefore most commonly associated with mental ill-health. *sMyo nad* is thus included in the 'Third Treatise' (*Man Ngag rGyud*, 'Oral Instruction Treatise') of the *rGyud bZhi* under two sections: the general category of *rlung* disease, where it is discussed as the result of disturbance in the *rlung*; and the category of '*smyo byed kyi gdon*' ('madness caused by spirits'). I will examine these concepts in turn as a means of opening out some of the similarities and differences between Tibetan textual and biomedical delineations of madness, before examining lay perceptions of this below.

---

[24] *Ibid.*; see also Emmerick (1977); Yang Ga (2014); Gerke (2014) and Karmay (1998) and for in-depth examination of the *rGyud bZhi.*
[25] Terry Clifford, *Tibetan Buddhist Medicine and Psychiatry: The Diamond Healing* (Irthlingborough: Crucible, 1989), p. 137.
[26] Lobsang Rapgay, *Tibetan Medicine: A Holistic Approach to Better Health* (New Delhi: Sona Printers, 1985), p. 48.
[27] Yonten Gyatso, 'Nyes Pa: A Brief Review of its English Translation' *Tibet Journal* 30 & 31(4 & 1) (2005), 109-118 (pp. 109-110).
[28] Samuel (2001), p. 255.
[29] Kloos (2010), p. 17 [note 20].
[30] Gerke (2011), p. 129.

rLung flows through *rtsa* ('energetic' channels) which run throughout the body, said to number up to 360,000,[31] and disturbance to the *rlung* in any of these channels can result in multiple physiological and/or psychological symptoms. The *rGyud bZhi* lists psychological symptoms including mental instability,[32] impairment of the sense organs, depression, and confusion in perception.[33] Similarly in Dharamsala, Dr. Sonam Dolma explained,

> There's no denying of the fact that the principle *cause* of all mental problems is *rlung*. And then along with the *rlung* – with the dominating *rlung*, there could be other associating factors, like, there could also be *mkhris pa*, there could be *bad kan*.[34]

In addition, one particular *rlung* current, the '*srog rlung*' (usually translated as 'life-sustaining wind'), which resides in the centre of the body, is thought to be especially related to psychological conditions, with symptoms including confusion and visual hallucinations.[35]

Tibetan doctors I interviewed during my fieldwork with a good knowledge of English translated '*smyo nad*' as 'psychosis', 'madness' or 'insanity'. In addition, the term '*smyo nad*' was also often used in lay parlance in a similar way to the English words 'crazy' or 'mad' – to denote someone doing something odd or inexplicable.[36] Millard and others have drawn correlations between *smyo nad* and various biomedical diagnoses of divergent psychotic disorders (such as 'schizophrenia' and 'bipolar disorder') from the DSM-IV TR and ICD-10 classification systems.[37] For example, Clifford suggests that madness associated with the three *nyes pa* can be corresponds 'generally' with a number of biomedical classifications, and she draws comparisons between *bad kan*-caused madness and the DSM-IV TR's

[31] Tenzin Wangyal and Mark Dahlby, *Healing with Form, Energy and Light: The Five Elements in Tibetan Shamanism, Tantra, and Dzogchen* (Ithaca, NY and Boulder, CO: Snow Lion Publications, 2002), pp. 80-1.
[32] Barry Clark, *The Quintessence Tantras of Tibetan Medicine* (Ithaca, NY: Snow Lion Publications, 1995), p. 36.
[33] Drungtso, pp. 222-4.
[34] Interview with Dr. Sonam Dolma at her office at the MTK Translation Department, Dharamsala, November 2012.
[35] Ronit Yoeli-Tlalim, 'Tibetan 'Wind' and 'Wind' Illnesses: Towards a Multicultural Approach to Health and Illness', *Studies in History and Philosophy of Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences* 41(4) (2010), 318-324 (p. 320).
[36] In Tibet there is also a tradition of 'visionary' or high-level tantric practitioners who may appear '*smyo nad*', but are not 'mad' in this sense, instead understood to be operating at a level incomprehensible to less spiritually-advanced individuals.
[37] Millard, pp. 247-8.

'schizophrenia, catatonic type, excited', and *rlung*-caused madness and 'classical schizophrenia'.[38]

Nonetheless, as mentioned above, attempts at correlating two divergent medical classification systems are problematic, and in some cases, a single biomedical classification might fall under more than one Tibetan classification. For example, Millard noted in his research at a Tibetan Medicine clinic in Edinburgh (UK) that patients diagnosed by biomedical psychiatrists with 'schizophrenia' and 'bipolar disorder' were both diagnosed by the resident Tibetan doctor as having '*srog rlung*',[39] rather than '*smyo nad*'. Similarly, during my fieldwork, translations often proved ambiguous, with one informant describing his condition as '*rlung*', '*srog rlung*' and 'depression'; and another describing her mother's brief episode of something akin to psychosis variously as '*smyo nad*', '*sems nad*' and 'madness'.

In terms of Clifford's fifth suggested cause of insanity, 'spirit-caused madness', Chapters 77-81 of the 'Third Treatise' of the *rGyud bZhi* list eighteen classes of *gdon* ('spirits'). Some authors have explained these 'spirits' as 'symbolic' rather than real entities. Clifford, for example, has characterised these as 'primarily a psychological phenomenon',[40] where 'demon' is a 'symbolic term' for Tibetans.[41] Perhaps this explanation of 'spirits' as psychological states sits more comfortably with many Western readers than viewing them as actual entities. However, it overlooks the fact that for many Tibetans, such *gdon* are often clearly perceived as entities in their own right. Indeed, all of the Tibetans I spoke to during fieldwork described the spirits in very real terms (often with a visible form), with the ability to cause harm in the form of psychiatric or other illnesses and misfortune quite directly. This perception of spirits as real entities not only informs health-seeking behaviour but also expectations of treatment efficacy. Attempts to distance Tibetan medicine from such concepts undermine these factors, as well as Tibetan understandings of the environment and their relationship with it which underlie the ways in which lay Tibetans construct meaning in relation to health and illness.

[38] Clifford, p. 144.
[39] Millard, p. 257.
[40] Clifford, p. 149.
[41] *Ibid*., p. 148.

Lay Tibetan perceptions of madness

Conducting his research in Darjeeling in the 1990s, Jacobson found that whilst many lay Tibetans were illiterate in Classical Tibetan (which is significantly different from colloquial Tibetan), 'simplified cognates' of the *rGyud bZhi*'s terminology and theory were common in their discourse.[42] Similarly, during my fieldwork there, I found that lay Tibetan informants talked frequently of '*rlung*' (and, to a lesser degree, *mkhris pa* and *bad kan*), but were less familiar with some of the more complex concepts of the *rGyud bZhi.* However, I found lay understandings of the symptomatology of '*smyo nad*' mostly quite consistent amongst interviewees. A number of Tibetan informants translated it as 'craziness', 'madness', or 'insanity'; with most listing similar symptoms, such as: aggressive or violent behaviour towards others; strange behaviour inconsistent with the individuals' usual behaviour; a lack of inhibitions; laughter or anger for no apparent reason; or talking to oneself. Some of these were summed up by one informant, Phurpu's, description of a neighbour's 20-year old daughter who had apparently suddenly become *smyo nad* a few years ago: '*Gang byung mang byung byed pa red*' ('She would do just anything!').

Many of my Tibetan interviewees related stories of individuals with *smyo nad* who they either knew directly (usually family members or neighbours), or were aware of within their community; and all reported some or all of the symptoms listed above. Where they differed, however, was in their perceptions of the *causes* of *smyo nad*. Similarly to Jacobson's findings, some of these reflected concepts covered in the *rGyud bZhi*, whilst others either seemed to be common notions amongst lay informants (whilst not necessarily present in the medical text), or more idiosyncratic concepts of causation. In similar terms to Clifford's description of 'grief-worry' in the *rGyud bZhi*, many interviewees explained that various emotions such as sadness or anger could directly cause psychiatric problems, describing an explicit causal relationship between the two. In discussing *smyo nad* in Darjeeling, lay Tibetans often explained the condition via concrete links to activities and emotions in direct 'cause and effect' terms, such as one informant's description of her mother's 'madness' caused by the sadness of her only daughter moving far away from home. In addition, notions of 'correct' and 'incorrect' behaviour wove in and out of the

[42] Jacobson (2007), p. 232.

interviews during fieldwork – mainly in terms of religious practice, but also in terms of social behaviours. From stealing religious artefacts to 'spending too much time alone', 'too much study' (either monastic or scholastic study), or talking to oneself; the individuals I interviewed had clear ideas of what might lead someone to become *smyo nad*. These concepts were reflected in the local perceptions of Jigme's illness and its likely causes, and I will explore these next.

Within the Tibetan community, a common causal explanation of Jigme's illness was that it resulted from his father having 'stolen' a religious artefact. It was explained that his father had taken a religious object from a Buddhist monastery many years ago, in order to save it during the destruction and looting of monasteries in Tibet during the Cultural Revolution. Since then, his father should rightly have 'returned' the object to a monastery in exile. However, neighbours explained that the object was worth a lot of money, and consequently Jigme's father had kept it; his 'greed' or 'attachment' to the valuable object causing his son's illness. Informants explained that Jigme would subsequently continue to be *smyo nad* until his father returned the object, which was in fact most likely impossible due to the now elderly man's poor health. There was therefore, it was explained, most probably no resolution to this situation. I asked, Lhamo (45), a nurse who worked at a local biomedical clinic, and had previously been involved in Jigme's treatment many years before about this. She stated that – even after all these years – if his father could 'repent and ask forgiveness, it would bring things back to normal', explaining, 'It's true – if you take things like that from a monastery, it can haunt you'.

When I discussed this with a Tibetan doctor at a local MTK Tibetan medicine clinic, *Amchi* Nyima (30, a second-generation MTK-trained *amchi* – 'doctor'),[43] he disagreed, stating that it was not possible for such 'karma' to pass from one person to another like this. But many of the lay Tibetans I spoke to did view this as a possibility, even if they were not aware of this particular case. However, not everyone was convinced by such explanations; as Gyaltsen, a young man of 28, who had fled Tibet as a teenager, wryly commented, 'Taking things from the monastery can't be the cause – the Chinese took many things, and had no bad results!'.

[43] Interview at *Amchi* Nyinma's clinic, Darjeeling, May 2012.

Furthermore, others had alternative explanations. For example, one senior member of the community who had known Jigme for many years, Tsering (59, a first generation exile), explained that whilst such illness *can* result from the theft of religious artefacts, in this case he thought that Jigme's incorrect tantric practice had actually been the cause of his *smyo nad*. Whilst tantric Buddhist rituals often utilise particular human bones, Tsering explained that only highly accomplished tantric lamas should conduct these practices. Moreover, there are specific methods through which to 'purify' such objects. He explained that he thought that Jigme had not conducted this practice correctly, simply putting a human shin bone into a fire to try to clean and purify it. This incorrect practice had harmed nearby spirits, whose subsequent anger had caused his *smyo nad*. This causal explanation clearly references not only Tibetan Buddhist tantric practices, but also concepts of offending local spirits, and other neighbours also suggested the involvement of *gdon* (spirit) or *'dre* (ghost), suggesting the possibility of possession. Others thought that perhaps Jigme's state of mind had been negatively affected by too much monastic study, an inability to follow the rules of the monastery, or even some kind of past trauma.

Interestingly, concepts of causation and treatment did not always correspond. For example, whilst a number of people who knew Jigme explained that if his father would only overcome his greed and return the objects he stole, he would recover completely, others who agreed that the illness was caused directly by his father's actions suggested treatments unrelated to this. Sonam (21), a second generation exile now studying for a degree at a local college, followed this theory of causation, but explained that the best way to treat this kind of *smyo nad* was to consult a (biomedical) psychiatrist. Others stated that it was now too late to help him, asserting that such illnesses need to be treated early on, and too much time had passed.

So what does all this mean for Jigme and his father? Divergent perceptions of illness causation can bring with them a stigmatisation of the afflicted individual, or – as we see in this case – of one or more of their family members. For many in this community, the blame for Jigme's illness rested clearly with his father, seen to have caused this situation through his greed. Consequently, the 'cure' was also perceived by many to rest in his hands. In this way, whilst Jigme's father was stigmatised, Jigme himself was viewed as blameless. Neighbours felt sad for him, but essentially helpless, not viewing themselves as in a position to rectify his situation in any way.

With a general perception that it was 'too late' for any treatment to be effective for Jigme, no efforts were being made to treat him. In contrast, in Tsering's description of Jigme's incorrect tantric practice, or others' explanations of his condition as caused by too much monastic study or an inability to follow the monastic rules, Jigme's own behaviour was seen as causative, essentially stigmatising him as responsible for his condition. This is not to say that they did not feel compassion for him – indeed he was looked after by his community to a certain extent – simply that he was viewed by some as in some way responsible for his misfortune. It is also important to point out that in the absence of any treatment, Jigme also seemed to be in a better condition than he had been in the past. Whilst not able to take part in 'normal' society, he appeared to be generally calm, seemingly not in any pain or distress, and not in any way disturbing others. Bearing in mind the fact that his past treatments appeared to have provided only limited help, perhaps this is the best outcome one might hope for in this situation.

Other cases of *smyo nad* discussed by lay informants in Darjeeling shed light on varied perceptions of cause. Some of these were centred on Buddhist concepts such as karma, which was often mentioned as an underlying cause of anything from bad luck or misfortune to illness. For example Samten (42), a second generation exile, explained, 'All nasty diseases – bad diseases are karma'. A particularly devout Buddhist, she used most of our 45-minute interview to discuss the importance of Buddhism, and was not keen to discuss spirits or '*grib*' ('pollution'), which she derided as 'superstition'. In Delhi, Dr. Pema Dorjee explained that for the majority of his patients,

> When they get some problem, they'll say, "It's karma, you know, it means we have done something bad, and that's what you get... This is karma and then we have to bear it". And they call to God, and they pray, you know. So, this is psychologically what I see... they pray to the god, or accept [that] this is karma, so, this relaxes the mind very much... So definitely this has a strong influence in the mind of people.[44]

Karma can be viewed as one of the 'long term causes' of illness, as opposed to the 'short term' causes such as spirit or seasonal influences.[45] 'Short term' or

[44] Interview with Dr. Pema Dorjee at his house, Delhi, November 2012.
[45] Clifford, p. 97.

'immediate' causes of illness include those discussed in relation to Jigme's illness, such as incorrect religious practices. For example, many informants' perceptions of the cause of *smyo nad* involved significant 'wrongdoing' on the part of the individual who subsequently became afflicted: not only such misdemeanours as stealing religious artefacts, but factors such as a monk finding himself unable to follow monastic rules, or individuals commencing meditation before they are ready or without proper instruction. This last point is perhaps a reflection of such concepts in the *rGyud bZhi*, which discusses how a disorder of '*srog-rlung*' can be caused by improper meditation practice, more likely to occur in meditators who either do not receive proper instruction, or whose concentration is disturbed by negative states of mind.[46] Rapgay explains that this leads to the mind becoming restless, emotional, anxious, and 'insensitive to the guidance of teachers'.[47] This is recognised to be a problem for Westerners too: for example Gyaltsen (28) explained, 'They [foreigners new to Buddhism] jump suddenly into emptiness', but with little background knowledge or preparation, 'they go crazy'. Norbu (35), a second generation exile with fluent English, agreed, 'If Westerners grow up Christian, and try to become Buddhist – they go in deep and become *smyon pa*... They will be crazy forever I think'. In Dharamsala, Dr. Sonam Dolma agreed, noting that the manipulation of *rlung* can especially cause problems for Westerners:

> Many people in the West, they do Dzogchen [a particular type of practice from the Nyingma school of Tibetan Buddhism] practice without initiation... I know somebody in Germany who has this problem – [a] breakdown, because everybody wants to have instant Nirvana, and then they over-exert themself, and then, they are not able to, what do you say, adjust their inner [*rlung*] channel – the *srog rlung* is nothing but disturbance of the inner channel. This is possible – very possible.[48]

Furtrhermore, Tsering (40), a hereditary *amchi*, explained that incorrect meditation practice, or other practices such as yoga or t'ai chi which manipulate the *rlung* inside

[46] Rapgay (1985), p. 44.
[47] *Ibid*., p. 45.
[48] Interview with Dr. Sonam Dolma at her office at the MTK Translation Department, Dharamsala, November 2012.

the body can also cause *rlung* disturbance – leading to problems including *smyo nad*.[49]

In other discussions of *smyo nad* in Darjeeling, '*gdon*' ('spirits') were at the forefront, and lay informants described multiple ways in which spirits can cause illness. For example, a number of interviewees described how *smyo nad* can result from offending '*rgyal po*' (a particular category of Tibetan worldly deities, characterised by arrogance and pride), through inadvertently neglecting the ritual offerings made to them. Furthermore, there can be a multitude of different spirits involved in this highly ethnically pluralistic area of North India. Nyima (35), a second generation exile born in Darjeeling, related the story of a Tibetan neighbour of his who had become *smyo nad* and died as a direct result of offending local Nepali *Rai* ancestor spirits, describing how the afflicted woman had been taken to a biomedical doctor who, unaware of the spirit causing her illness, had been unable to help.

In addition to causal explanations of *smyo nad,* which span a number of Tibetan religious concepts, other explanatory notions of it were focused on cognitive and/or behavioural factors, and these perceptions will be explored next. Over the course of the fieldwork, lay Tibetans discussed various non-religious causes of *smyo nad* including such emotions as sadness or anger. For example, many interviewees held the view that factors such as worry or stress could lead to 'depression' or *rlung*. They further described how, if an individual's depression is not successfully treated, he could become *smyo nad*. I discussed this with Metok (63), a first generation exile and former nurse who had done her training many years ago in the UK. She explained that 'if [there is] no cure for *rlung*, then [the afflicted individual] can go into depression... If you don't look after yourself and control your mind then *rlung na tsha* ['*rlung* illness'] can lead to *smyo nad*'. Similarly, Tenzin (28, an MA student and first generation exile), stated that *smyo nad* comes 'mainly from depression'. In addition, mental actions such as 'thinking too much' or 'too much study' were often commonly held up as causes of *smyo nad*, and Norbu described a Tibetan neighbour who had become mad because of this.[50]

[49] Interview at *Amchi* Tsering's private clinic, Darjeeling, May 2012.
[50] This was also described by Prost in her research on Tibetans in Dharamsala, where she noted that '*rlung* illnesses are common in religious studies, resulting from 'intellectual overexertion' (2006, p. 125).

Finally, other causal explanations seemed to reference both Tibetan religious *and* non-religious concepts. Many interviewees explained that *smyo nad* can be caused by an individual's inability to 'control their mind', for example, concentrating too much on things that they cannot have (examples given included more money, a bigger house, an expensive car), or an inability to deal with life events effectively. Gyaltsen stated that *smyo nad* is caused by 'not keeping your mind clear, thinking about things like wanting to be a millionaire, always thinking about this. This kind of desire can cause hallucinations'. Phurpu (50, a first generation exile from Southeast Tibet), discussed a neighbour whose *smyo nad* was caused by her frustration and sadness at her husband's affair with another woman. Similarly, a person's inability to deal with their anger – holding it in and not expressing it – is thought to lead to *srog rlung* or *smyo nad*. Samten (42) explained, 'If you are very much unsatisfied by everything... If your mind is thinking too much... being angry, or asking again and again why something has happened, you'll become *smyo nad*'. Some of these ideas are summed up quite succinctly by one interviewee, Tsering (59), who explained, 'If you can't control your mind, you'll become mad. If you can control your mind, you'll never become mad'. Here, 'controlling the mind' appears to refer to being in control of one's emotions. These are not only Tibetan cultural concepts of course, but also Buddhist concepts of the mind, clearly highlighting the intermeshing of Tibetan cultural and religious understandings of the world.

Health-seeking behaviour

How then are these perceptions of the causation of madness reflected in health-seeking behaviour in Darjeeling? If incorrect religious practice can *cause* madness, then perhaps correct practice can *cure* madness – whether through the 'correction' of, or atonement for, specific wrong practice, or through the practice of religious behaviour which increases Buddhist merit. This kind of discourse was familiar in the majority of my informants' descriptions. In cases where there was felt to be a certain amount of responsibility for the illness held by either the individual or a family member, the 'cure' was often also felt to be in their hands. 'Treatment' was often viewed as accessible through the rectification of the causal circumstance(s), for

example through the appeasement or subjugation of the spirits which had been involved.

In contrast, the *rGyud bZhi* describes many herbal medicines for treating *smyo nad*, and Tibetan doctors I interviewed echoed this – especially in cases of *rlung* (or other *nyes pa*-related) disturbance. Indeed, the Men-Tsee-Khang's Tibetan Medicine Museum in Dharamsala displays many plants, precious stones and medical compounds labelled (in English) for use in the treatment of 'psychosis' and 'insanity'. However, few of my lay Tibetan informants discussed this as an option, favouring religious practices instead. Indeed, many of them echoed Gyaltsen's comment that *smyo nad* cannot be treated by biomedicine or Tibetan medicine: instead, 'it needs to be fixed from the mind's side'.

A number of interviewees discussed particular Buddhist practices which could heal individuals with *smyo nad*, and many related stories to illustrate this. For example, Nyima explained that the recitation of a particular Tibetan Buddhist prayer could cure any kind of madness, asserting that even reading it only once would help to some extent. Of course unfortunately, Jigme was entirely unable to make sense of or read anything or undertake such an activity. Other Buddhist practices were discussed too, and can sometimes be conducted on behalf of the patient by a qualified Buddhist practitioner. For example, Penpa (44), a first generation exile who had arrived in India aged 19, mentioned '*gcod*' practice, a particular form of tantric meditative practice involving the practitioner visualising the cutting up of his body and the invitation to spirits to feast on his corpse, often conducted in graveyards or charnel grounds. He explained that this practice is 'very effective', able to cure any kind of madness, no matter the cause, adding, 'I have seen this [be successful] – especially for mental illness and demons'. Similarly, Phurpu related the story of a neighbour who, a few years previously, at the age of thirty-five, 'all of a sudden became *smyo nad*'. His brothers took him to a local Tibetan diviner, who instructed them to read some particular prayers, and, 'in one week he was cured', with this never happening again. In addition, blessings from high lamas and the making of offerings at Buddhist monasteries were often felt to be generally helpful for illness. For example, Lhamo related how her mother's *smyo nad*, thought to have been caused by sadness and loneliness, had been cured by the blessings of a rinpoche (a high level Tibetan Buddhist practitioner).

In relation to *smyo nad* caused by 'emotional' factors such as sadness or loneliness, informants described some quite pragmatic suggestions for treatment or prevention against escalation of the condition. Metok explained that to prevent sadness or depression from becoming *smyo nad*, the person should, 'Go for a walk, don't go into depression, think positive, don't be worrying, take it easy, relax... be positive, think positive... If you can't, then you become *smyo nad*'. Again we find the concept that the patient has control over their illness through their own mental efforts, echoing Rapgay's explanation that, '[q]uite often voluntary regulation of internal states enables patients to alleviate the symptoms of their psychogenic disorder through their own effort'.[51] Gyaltsen summed up many interviewees' comments when he stated emphatically, that such illnesses 'caused by the mind, can only be cured by the mind'.

Conclusion

This paper has addressed some of the lacunae in the research on psychiatric illness in the Tibetan context by examining lay perspectives on the causation and treatment of '*smyo nad*' in a Tibetan community in Darjeeling, Northeast India, as well as through conducting interviews with MTK-trained *amchi* in Darjeeling, Dharamsala and Delhi. Here, it was evident that religious concepts often predominated in causal explanations of psychiatric illness, and this was reflected in the health-seeking behaviour of patients and their families. Tibetan religious and cultural explanations of illness and misfortune can come into play either in isolation or in conjunction with one another. This is likely the result of enduring Tibetan cultural and religious concepts of not only the person and the mind, but also about the environment and an individual's relationship to it – expressed, for example, in concepts of spirit-causation. This reflects the findings of previous research in the Tibetan context, such as that by Calkowski, Samuel and Wangda,[52] which has found similar explanations of non-psychiatric conditions encompassing Tibetan cultural and religious concepts. However, I would suggest that religious explanations may be more frequently employed in Tibetans' attempts to conceptualise *psychiatric* illnesses, especially

[51] Rapgay, p. 23.
[52] Calkowski (1985), Samuel (2009) and Wangda (1996).

smyo nad. This is perhaps a result of the nature of the condition, which may be inherently hard to conceptualise. I would therefore suggest that Jigme's case is fairly representative of Tibetan perceptions of *smyo nad* among contemporary Tibetans exiles living in Darjeeling, as well as some other diagnoses, such as *srog rlung*. However, more research is necessary to enable broader conclusions to be drawn.

As discussed above, ideally such research on non-Western explanatory models of illness and healing should be conducted *before* attempts are made to map these onto biomedical diagnostic categories and treatment pathways.[53] Jacobson suggests that it is possible to correlate Tibetan categories of mental illness with biomedical illness categories to some extent, which he does in his 2007 article, using DSM-IV categories.[54] However, I would suggest that whilst there *are* some similarities in terms of symptomatology, the drawing of such equivalences brushes aside these fundamental Tibetan understandings of mental health and ill-health that link together a number of medical and religious concepts of the mind and body and the wider environment, which underpin Tibetan notions of *smyo nad* and its causation and treatment, and which differ markedly from those of biomedicine. Furthermore, the assignment of causation in illness is a constructive process: a way of making sense of and finding meaning in a period of illness, and relating it to broader personal and social experiences (Bhui and Bhugra 2002; see also Prost 2006). I would suggest that this is particularly the case for mental illness, where culturally-constructed subjective judgements of 'normal' and 'abnormal' are inherent, and the personal – and social – experience is all. Thus the drawing of equivalences between uniquely Tibetan experiences and the supposedly 'universal' categories of the DSM or ICD, in challenging local understandings of illness, may also undermine traditional coping and healing mechanisms which encompass a number of these uniquely Tibetan religious and cultural perspectives and activities.

Such findings have implications for health policies which affect Tibetan communities in exile communities in Northeast India. Treatments which have arisen in the Western world including psychotherapeutic medications and Western-style counselling are rapidly becoming more widespread in Tibetan communities such as this one (as well as in numerous other non-Western societies), at the same time that

[53] Bhui and Bhugra, pp. 6-7.
[54] Jacobson (2007).

research demonstrates that the presence of biomedicine and attempts at 'integrative' health projects frequently lead to the decline of traditional healing methods.[55] Ethnographic research from communities such as this only illustrates some of the complexities of the 'Global Mental Health' agenda. It is unfortunately not within the scope of this research to investigate the utility or efficacy of Tibetan perceptions of illness and healing; and further research of this kind is urgently needed, as we struggle to keep up with the rapid changes in healthcare systems in divergent communities such as this one.

Bibliography

Adams, Vincanne, 'Suffering the Winds of Lhasa: Politicized Bodies, Human Rights, Cultural Difference, and Humanism in Tibet', *Medical Anthropology Quarterly* 12 (1) (1998), pp. 74-102

Adams, Vincanne and Fei-Fei Li, 'Integration or Erasure? Modernizing Medicine at Lhasa's Mentsikhang', in *Tibetan Medicine in the Contemporary World: Global Politics of Medical Knowledge and Practice*, ed. by Laurent Pordié, (London: Routledge, 2008), pp. 105-131

American Psychiatric Association, *Diagnostic and Statistical Manual of mental disorders: Fourth Edition Text Revision (DSM-IV-TR)*, (Arlington, VA: American Psychiatric Association, 2000)

Besch, Nils Florian, 'Tibetan Medicine off the Roads: Modernizing the Work of the Amchi in Spiti', (unpublished doctoral thesis, University of Heidelberg, 2006)

Bhui, Kamaldeep and Dinesh Bhugra, 'Explanatory Models for Mental Distress: Implications for Clinical Practice and Research', *The British Journal of Psychiatry*, 181(1) (2002), pp. 6-7

[55] See for example: Vincanne Adams and Fei-Fei Li, 'Integration or Erasure? Modernizing Medicine at Lhasa's Mentsikhang', in *Tibetan Medicine in the Contemporary World: Global Politics of Medical Knowledge and Practice*, ed. by Laurent Pordié, (London: Routledge, 2008), pp. 105-131; Nils Florian Besch, 'Tibetan Medicine off the Roads: Modernizing the Work of the Amchi in Spiti' (unpublished doctoral thesis, University of Heidelberg, 2006); Linda Connor, 'Ships of Fools and Vessels of the Divine: Mental Hospitals and Madness, a Case Study', *Social Science & Medicine* 16 (7) (1982), pp. 783-794; Laurence J. Kirmayer, 'Beyond the 'New Cross-cultural Psychiatry': Cultural Biology, Discursive Psychology and the Ironies of Globalization', *Transcultural Psychiatry* 43 (1) (2006), pp.126-144.

Brock, Dylan, ‘Taming the Mind: Current Mental Health Treatments and Obstacles to Expanding the Western-model in a Tibetan Exile Community’, *Independent Study Project (ISP) Collection*, Paper 209 (2008)

Calkowski, Marcia, ‘Power, charisma, and ritual curing in a Tibetan community in India’, (unpublished doctoral thesis, University of British Columbia, 1985)

Clark, Barry, *The Quintessence Tantras of Tibetan Medicine*, (Ithaca, NY: Snow Lion Publications, 1995)

Clifford, Terry, *Tibetan Buddhist Medicine and Psychiatry: The Diamond Healing*, (Irthlingborough: Crucible, 1989)

Connor, Linda, ‘Ships of Fools and Vessels of the Divine: Mental Hospitals and Madness, a Case Study’, *Social Science & Medicine* 16 (7) (1982), pp. 783-794

Drungtso, Tsering Thakchoe, *Tibetan Medicine: The Healing Science of Tibet*, (Dharamsala, HP: Drungtso Publications, 2004)

Emmerick, Ronald E., ‘Sources of the rGyud-bzhi’, *Zeitschrift der Deutschen Morgenländischen Gesellschaft sup 1*, III (2) (1977), pp. 1135–42

Ga, Yang, ‘The Sources for the Writing of the Rgyud bzhi, Tibetan Medical Classic’, (unpublished doctoral thesis, Harvard University, 2010)

Ga, Yang, ‘The Origin of the Four Tantras and an Account of its Author, Yuthog Yonten Gonpo’, in *Bodies in Balance: The Art of Tibetan Medicine*, ed. by Theresia. Höfer (Rubin Museum of Art, New York in association with University of Washington Press, Seattle and London, 2014)

Gerke, Barbara, ‘Tibetan Treatment Choices in the Context of Medical Pluralism in the Darjeeling Hills, India’, in *Studies of Medical Pluralism in Tibetan History and Society. PIATS 2006: Proceedings of the 11th Seminar of the International Association of Tibetan Studies, Konigswinter 2006*, ed. by Mona Schrempf, Sienna Craig, Frances Garrett and Mingji Cuomo (Andiast, Switzerland: International Institute for Tibetan and Buddhist Studies GmbH, 2010), pp. 337-376

Gerke, Barbara, ‘Correlating Biomedical and Tibetan Medical Terms in Amchi Medical Practice’, in *Medicine Between Science and Religion: Explorations on Tibetan Grounds*, ed. by Vincanne Adams, Mona Schrempf and Sienna R. Craig (New York: Berhahn Books, 2011), pp. 127-152

Gerke, Barbara, *Long Lives and Untimely Deaths: Life-span Concepts and Longevity Practices among Tibetans in the Darjeeling Hills, India*, (Leiden: Brill Academic Publishers, 2012a)

Gerke, Barbara, ‚Introduction: Challenges of Translating Tibetan Medical Texts and Medical Histories‘, in *Wurzeltantra und Tantra der Erklaerungen. aus "Die Vier Tantra der Tibetischen Medizin"*, ed by F. Ploberger (Schiedlberg, Austria: Bacopa Verlag, 2012b), pp. 17-29

Gerke, Barbara, ‘The Art of Tibetan Medical Practice’, in *Bodies in Balance: The Art of Tibetan Medicine*, ed. by Theresia Höfer (The Rubin Museum of Art, New York in association with University of Washington Press, Seattle and London, 2014)

Gyatso, Yonten, ‘Nyes Pa: A Brief Review of its English Translation’ *Tibet Journal*, 30 & 31 (4 & 1) (2005), pp. 109-118

Horton, Richard, ‘Offline: Is Global Health Neocolonialist?’ *The Lancet* 382 (9906) (2013), p. 1690.

Jacobson, Eric, ‘Panic Attack in a Context of Comorbid Anxiety and Depression in a Tibetan Refugee’, *Culture, Medicine and Psychiatry* 26 (2) (2002), pp. 259-279

Jacobson, Eric, ‘Life-wind Illness in Tibetan Medicine: Depression, Generalised Anxiety, and Panic Attack’, in *Soundings in Tibetan Medicine: Historical and anthropological perspectives (Proceedings of the Tenth Seminar of the International Association of Tibetan Studies (PIATS), Oxford 2003)*, ed. by Mona Schrempf (Leiden, Boston: Brill Academic Publishers, 2007), pp. 225-246

Janes, Craig R., ‘Imagined Lives, Suffering, and the Work of Culture: The Embodied Discourses of Conflict in Modern Tibet’, *Medical Anthropology Quarterly*, 13 (4) (1999), pp. 391-412

Karmay, Samten, ‘The Four Tibetan Medical Treatises and their Critics’, in *The Arrow and the Spindle*, (Kathmandu: Mandala Book Point, 1998)

Kirmayer, Laurence J., ‘Beyond the ‘New Cross-cultural Psychiatry’: Cultural Biology, Discursive Psychology and the Ironies of Globalization’, *Transcultural Psychiatry* 43 (1) (2006), pp. 126-144

Kloos, Stephan, ‘Tibetan Medicine in Exile: The Ethics, Politics and Science of Cultural Survival’, (unpublished doctoral thesis, University of California, San Francisco with University of California, Berkeley, 2010)

Loizzo, Joseph J., Leslie Blackhall and Lobsang Rapgay, ‘Tibetan Medicine: A Complementary Science of Optimal Health’, *Annals of the New York Academy of Sciences* 1172(1) (2009), pp. 218-230

Millard, Colin, ‘Tibetan Medicine and the Classification and Treatment of Mental Illness’, in *Soundings in Tibetan Medicine: Historical and anthropological perspectives (Proceedings of the Tenth Seminar of the International Association of Tibetan Studies (PIATS), Oxford 2003)*, ed. by Mona Schrempf (Leiden, Boston: Brill Academic Publishers, 2007), pp. 247-282

Prost, Audrey, ‘Exile, Social Change and Medicine among Tibetans in Dharamsala (Himachal Pradesh), India’ (unpublished doctoral thesis, University College London, 2004)

Prost, Audrey, ‘Causation as Strategy: Interpreting Humours among Tibetan Refugees’, *Anthropology & Medicine,* 13 (2) (2006), pp. 119-130

Rapgay, Lobsang, *Tibetan Medicine: A Holistic Approach to Better Health*, (New Delhi: Sona Printers, 1985)

Ruwanpura, Eshani, Stewart W. Mercer, Alistair Ager and Gerard Duveen, ‘Cultural and Spiritual Constructions of Mental Distress and Associated Coping

Mechanisms of Tibetans in Exile: Implications for Western Interventions', *Journal of Refugee Studies*, 19 (2) (2006), pp. 187-202

Sachs, Emily, Barry Rosenfeld, Dechen Lhewa, Andrew Rasmussen and Allen Keller, 'Entering Exile: Trauma, Mental Health, and Coping among Tibetan Refugees Arriving in Dharamsala, India', *Journal of Traumatic Stress,* 21 (2) (2008), pp. 199-208

Samuel, Geoffrey, 'Tibetan Medicine in Contemporary India: Theory and Practice', in *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Studies*, ed. by Geoffrey Samuel and Linda H. Connor (Westport, CT and London: Bergin & Garvey, 2001), pp. 247-268

Samuel, Geoffrey, 'Religion, health and suffering among contemporary Tibetans', in *Religion, Health and Suffering*, ed. by John R. Hinnells and Roy Porter (Abingdon and New York: Routledge, 2009), pp. 85-110.

Schrempf, Mona, 'Between Mantra and Syringe: Healing and Health-seeking Behaviour in Contemporary Amdo', in *Medicine Between Science and Religion: Explorations on Tibetan Grounds*, ed. by Mona Schrempf, Vincanne Adams and Sienna R. Craig (New York: Berghahn Books, 2011), pp. 157-184.

Wangda, Jurme, 'Health seeking behaviours of Tibetan refugee community in Dharamsala, India', (unpublished MSc thesis, Queen's University, Ontario, 1996).

Wangyal, Tenzin and Mark Dahlby, *Healing with Form, Energy and Light: The Five Elements in Tibetan Shamanism, Tantra, and Dzogchen*, (Ithaca, NY and Boulder, CO: Snow Lion Publications, 2002)

World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*, (Geneva: World Health Organization, 2005)

Yoeli-Tlalim, Ronit, 'Tibetan 'Wind' and 'Wind' Illnesses: Towards a Multicultural Approach to Health and Illness', *Studies in History and Philosophy of*

Science Part C: Studies in History and Philosophy of Biological and Biomedical Sciences 41 (4) (2010), pp. 318-324