

Spring 2008

# Taming the Mind: Current Mental Health Treatments and Obstacles to Expanding the Western-Model in a Tibetan Exile Community

Dylan Brock  
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# TAMING THE MIND:

Current Mental Health Treatments and Obstacles to  
Expanding the Western-Model in a Tibetan Exile Community

Dylan Brock  
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SIT: Tibetan/Himalayan Studies  
Spring 2007

Mental Health is more important than physical health. We must learn to tame our mind as it helps tame our body.  
–His Holiness the 14<sup>th</sup> Dalai Lama<sup>1</sup>

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<sup>1</sup> As quoted by Dr. Dorjee Dekhang 19 April 2007

# ACKNOWLEDGEMENTS

I would like to extend my sincere and lasting gratitude to everyone who helped me accomplish this research, especially:

Sonam Dekyi for her time and patience. I wish her much luck during her time studying in the States.

Reiko Makiuchi for introducing me to trans-cultural psychology. I wish her luck for her future here in Dharamsala.

Dr. Dorjee Dekhang for taking the time to sit down and introduce me to Tibetan Medicine and the subject of rlung.

Pema for offering her time to act as my translator.

I would also like to thank SIT, Tenzin Yudon, Hubert, Pam and of course His Lordship Manuel Antonio López Zafra López López for his continued love and support.

An additional thanks is also owed to the following people who helped make my time abroad an incredibly fulfilling one:

Nyima-la for her warm smile and sweet deserts.

The man, the legend, the true “dude,” Phuntsok Thondup. Thanks...dude.

Gill of Gill’s Cyberland.

And the whole community of Dharamsala for being the wonderful and welcoming community they are.

And mom and dad.

# ABSTRACT

Mental health issues such as anxiety and depressive disorders exist throughout all cultures but their respective treatments and meanings may vary widely across cultures (Raguram 2001). In cross-cultural studies of depression it has been found that in non-Western cultures the meaning, experience and behavior associated with depression is markedly different than that of the West (Weiss 1997). As such it is important to take these cultural differences into account when attempting to translate Western psychological diagnostic concepts into a non-Western community such as Dharamsala, where Western-style mental health services are still in the process of being established. Furthermore, a number of other local and cultural factors can often act as additional obstacles preventing the establishment of an extensive Western-model mental health program in non-Western contexts. This study will focus on the current available treatments (both traditional and Western Allopathic) for psychological disorders and explore how certain social factors act as obstacles to the further development of a Western mental health program. This study argues that an understanding of traditional treatments as well as these obstacles is relevant and necessary for developing a comprehensive, beneficial and sustainable treatment of mind for the local community of Dharamsala, India.

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For  
Nana  
and  
Kaity Garside

# INTRODUCTION

The Tibetan exile community located in Dharamsala, India was established in 1959 following the military occupation and subsequent annexation of Tibet by the People's Republic of China. It was in this year that His Holiness the Dalai Lama and thousands of Tibetans chose to flee the violence and turmoil in their homeland and enter exile. Nearly 50 years of persecution, political repression and restrictions on religious freedom have caused over 85,000 Tibetans, both children and adults, to seek refuge in India with more arriving every year (Tibet in Exile [Online]). Currently, the small mountainside community of Dharamsala provides refuge to thousands of these Tibetans. This study's primary focus will concern the mental health issues relevant for developing a mental health program within this Tibetan refugee community.

Mental health is generally taken to be a state of psychological and emotional well-being, but as the World Health Organization (WHO) notes, the concept is not so easily defined, especially across cultures:

Mental health has been defined variously by scholars from different cultures. Concepts of mental health include subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential, among others. From a cross-cultural perspective, it is nearly impossible to define mental health comprehensively. It is, however sometimes used as a broader definition, and professionals generally agree that mental health is broader than a lack of mental disorders. (World Health Report 2001 [Online])

Despite the difficulty associated developing a cross-cultural definition for mental health, mental health issues such as depression and anxiety disorders are faced on a global scale, confronting every culture and to less severe extent, every individual. The WHO estimated in its *World Health*

*Report 2001* that over 450 million people suffer worldwide from some form of mental or behavioral disorder (WHO [Online]). In fact, the report estimates that one in four people that visit a health professional suffer from some form of mental, neurological or behavioral disorder; depression alone is thought to be one of the most prevalent diseases globally, accounting for nearly one in every five visits to primary care doctors (WHO [Online], Kleinman 2004). Mental health problems are further magnified in poor and developing countries such as India where resources are often insufficient or absent altogether and where the population's mental health help-seeking behavior is often hindered by lack of awareness and increased social stigma attached to such illnesses (Desjarlais 1995, Sherer 2002). Additionally, refugee populations such as the Tibetan community in Dharamsala, as a group, are at a greater risk of developing common mental disorders such as depression and post-traumatic stress (PTSD) due to difficulties associated with adjusting to the new culture and leaving behind family members, in addition to the increased exposure to stressful and traumatic experiences both before and during escape (Silove 1997, 2004, Kinzie 1990). One study suggests that refugees are four to five times more likely to develop depression, anxiety and/or PTSD when compared to other migrant populations (Silove 2004). Taking this information into account, it is presumable that mental health issues such as depression, anxiety and PSTD pose a significant health threat to Dharamsala's Tibetan community. However, at present the extent to which this is true for this particular community is unknown as the available mental health resources and services in Dharamsala are quite limited.

The following will explore the existing mental health treatments offered in the community, paying particular attention to the Western-style counseling program, Traditional Tibetan Medicine and spiritual help. It will then discuss the obstacles that have heretofore inhibited and currently inhibit the further development of the limited counseling program. Often

these obstacles derive from the important observation that mental health and illness play a different role in different cultural contexts. It has been shown that in non-Western cultures the meaning, experience and behavior associated with psychological disorders is often much different than in Western cultures where the standard psychological diagnostic and therapeutic concepts first arose. This, of course, can in turn lead to significant problems when attempting to translate these concepts into a non-Western context. Additional obstacles to the development of a more extensive mental health program relate to religious beliefs, cultural values, customs and local ideas about mental illness and counseling. As such, the following study will argue that these obstacles prevented the mental health program from flourishing in the past and thus that a precise understanding of these obstacles is necessary before a more extensive mental health program can be established in the Tibetan Exile Community in Dharamsala, India. It should be noted that this study also has important implications for the other 51 Tibetan settlements in India who, at present, have no mental health program of their own.

# CURRENT TREATMENTS

Presently the Western-style mental health services available to the Tibetan Exile community in Dharamsala, India are quite limited. There are however, alternative treatments and services available to and frequently used by the Tibetan community. These include Traditional Tibetan Medicine offered by the Men-Tsee Khang (Tibetan Medical and Astrological Institute) and the spiritual advice and treatment available by the local Buddhist community. The combination of these three options represents the extent of the mental health services and treatments available to the community, each of which will be briefly explained in the following.

## WESTERN MENTAL HEALTH SERVICES

Western forms of mental health care aimed at treating psychological disturbances have their origins in the late nineteenth century and early twentieth century with the advent of psychoanalysis. Treatments and methods expanded greatly in the mid-twentieth century to include other forms of counseling and therapy, recently expanding to include psychopharmacology. Nowadays, the mental health field includes not only psychiatrists and psychoanalysts but also clinical psychologists and social workers. It is estimated that by 1990 at least one-third of the US population “had used psychotherapy at some point in their lives as an appropriate means for treating a broad array of physical, psychological, and behavioral problems and disorders” (Jansz 93). Current mental health counseling services for psychological disturbances stemming from depressive or anxiety disorders are often based around familiar “talk-therapy” models which attempt to change the client’s mind-set through investigating and developing an understanding of the cause and the individual’s reaction to the disturbance. For

this particular study, I will focus mainly on psychological disorders related to depression, stress and anxiety and avoid more serious and organic illnesses.

To this end, it is appropriate to provide a brief introduction and description of the relevant disorders. Depression is classified as a mood disorder characterized by a persistent depressed mood with associated symptoms such as low self-esteem, lack of appetite, insomnia and fatigue.<sup>2</sup>

Depression is often classified into two common types: Dysthymia and Major Depression.

Although both forms are described as being a form of chronic depression by the *Diagnostic and Statistical Manual of Mental Disorder (DSM-IV)*, the latter is characterized by its increased severity and the former by less-intense symptoms lasting “almost daily” for at least two years.

Anxiety disorders are characterized by symptoms of excessive anxiety or worry, sleeplessness, fatigue and increased irritability. It is important to note that although depressive and anxiety disorders have common and relatively minor psychosomatic symptoms such as fatigue, insomnia and loss of appetite, these disorders can manifest as more extensive physical symptoms including headaches and back, neck and/or chest pain. Post Traumatic Stress Disorders (PTSD) may occur after an individual has experienced or been exposed to extremely traumatic “events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others” and involved a reaction by the individual characterized by “intense fear, helplessness, or horror.” Symptoms of PTSD involve a persistent reexperiencing of the traumatic or stressful event in addition to increased arousal and avoidance of stimuli associated with the event. Adjustment Disorders is a class of disorders referring to a psychological disturbance caused by a stressor such as a family crisis, negative events or life-changes and is characterized by an individual experiencing a significantly difficult time adjusting. The symptoms are usually short term and are similar to those of depressive and anxiety disorders (DSM [Online]).

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<sup>2</sup> See Appendix D for the symptoms of and diagnostic criteria for the disorders discussed.

## Past Programs in Dharamsala

In 1996, the Tibetan Torture Survivors' Programme (TTSP) was established under the Department of Health with the help of two main organizations: Danish International Development Agency (DANIDA) and Trans-Cultural Psycho-social Organization (TPO). The original plan for TTSP was to provide an interdisciplinary approach, which integrated Traditional Tibetan Medicine and modern Allopathic Medicine to "care for and reduce the physical, psycho-social and psychological" trauma experienced by Tibetan victims of torture (TTSP [Pamphlet]). The approach consists of a team of Tibetan Traditional Medicine doctors, Allopathic doctors, psychologists and spiritual advisors who combine their efforts and methods in providing care for torture victims. Unfortunately, there is nobody left from the original staff and consequently there is not an extensive amount of knowledge about its founders, origins and findings. It is known that a Danish couple, Steven and Stella, thought to be psychologists from DANIDA, performed the initial needs assessment and took the first step to establish a mental health program for the Tibetan refugee community in Dharamsala (Kelsan Lhamo 1 May). The Tibetan DANIDA Project had a contract with the Department of Health to help fund and oversee activities at TTSP for a nine year period beginning in 1996 and expiring in December 2005. TPO also had a contract with TTSP to help create a mental health program, which expired in 2000 (Tsering 24 April). Psychiatrist Dr. Eva Ketzer and Italian psychotherapist Antonella Crescanzi of TPO were known to be intimately involved in the training of Tibetan mental health workers and counselors in the community, namely Tenzin Bhuti and Tsering Lhamo (Tsering 24 April). Currently, both of these counselors have left the Department of Health, Tenzin Bhuti retiring in 2005 and Tsering Lhamo<sup>3</sup> left in 2003 to work as a nurse for the Danish NGO Tibet Charity.

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<sup>3</sup> See Oral Sources for Tibetan names in proper script.

Although both supporting programs, DANIDA and TPO, have since left, the program is still in operation. However, as will be discussed shortly, the program no longer has a counselor or psychologist of its own and must refer torture survivors suffering from psycho-social and psychological disturbances to the counselor currently working for the Department of Health.

## Present Program

The mental health counseling services offered in the Tibetan exile community in Dharamsala are, at present, not very extensive; all of the former mental health workers, psychologists and psychiatrists from DANIDA and TPO or that were extensively trained by the programs have since left the community or are no longer employed by the Department of Health. Currently, there exists only one qualified Tibetan counselor to service the mental health needs of the entire Tibetan community in Dharamsala. In fact this counselor, Sonam Dekyi, has been the community's only mental health resource for all but a couple months of her two-year tenure at the Department of Health. Even the local Tibetan Delek Hospital, as Dr. Tsetan Dorjee, the senior staff physician informed me, does not have a trained psychiatrist on staff to treat or diagnose mental illness and psychological disorders (Dr. Tsetan 13 April). As such, psychosomatic symptoms of patients suffering from psychological disturbances must be properly identified and diagnosed by the general physicians on staff at Delek Hospital. This in turn means most patients suffering from psychological disorders either are referred to Sonam at the Department of Health or, if the case requires psychiatric evaluation, is referred to a nearby Indian hospital with a psychiatrist on staff. This situation has, however, recently begun to change since Reiko Makiuchi, a Japanese psychologist and social worker, began volunteering at the Delek Hospital three months ago.

Sonam Dekyi counsels clients once a week, on Tuesdays, at Delek Hospital's McLeod Ganj clinic. She informed me that she sees on average three to six clients each week, usually providing counseling to each for a five or six week period (Sonam 13 April). Of course, the amount of time spent counseling each client differs depending on the case and individual – Sonam noted that she has been seeing her oldest client for over a year now. She estimated that she receives a new client about every third week but that it depended entirely on the referral process. At present most of her clients are referred by Delek Hospital, where patients usually arrive complaining of physical symptoms, which are in turn determined to be psychosomatic. Once this determination is made and “the root cause is determined to be psychological” the patient is then advised to see Sonam the following Tuesday for counseling (Sonam 13 April). In general, most of Sonam's clients are new arrivals from Tibet who attend the Tibetan Transit School (TTS).<sup>4</sup> Most of these clients, Sonam informed me, suffer from some form of depressive or anxiety disorder caused by the increased stress and anxiety they experience as a result of difficulties adjusting to India, being separated from family, escaping from Tibet and resuming studies at school, among many other common problems. Among the many cases she sees, she mentioned that most of her clients suffer from depressive, anxiety or adjustment disorders. She noted that she has had clients in the past who suffered from PTSD and that these clients are usually referred by TTSP. Other problems that bring clients to Sonam include alcohol and substance abuse, domestic violence cases and behavioral disorders. When I asked Sonam whether all of the people that needed counseling were receiving it, she admitted to me that she believes “there are a lot of people that need help but do not know about counseling” (Sonam 13 April).

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<sup>4</sup> Alternatively referred to as Sogar or Sherub Gyatsel Lobling

## Looking Ahead

When looking towards the future of Dharamsala's counseling and mental health program, many people admitted that there was a lot of room for development and improvement. Sonam mentioned that she "really hope[s] that the mental health program can expand because mental health is *very* important...it effects everything including work, school, home," hinting that there was more that could be done to improve and expand the community's mental health services (Sonam 13 April). Additionally, Dr. Tsetan Dorjee informed me that although he hopes to expand the Delek Hospital's mental health program they must "take it one step at a time" and that now the program is facing a "salvage problem" (Dr. Tsetan 13 April). By this, Dr Tsetan was referring to the fact that until recently there was not a resident mental health professional to begin with. Complicating the issue of expanding and developing the current mental health program is fact that the program is facing a crucial and inevitable period of transition. This is because Sonam Dekyi is leaving in August on a Fulbright scholarship to receive a second masters in either counseling or psychology from Buffalo University. Presently, the Department of Health has no qualified Tibetan counselor lined up to replace Sonam on her departure. However, it is expected that Reiko Makiuchi will take over much of the counseling and mental health responsibilities at Tibetan Delek Hospital. Reiko has been volunteering at Delek Hospital for about three months and has begun counseling a handful of the hospital's inpatients, mostly for alcohol and substance abuse related problems. She has been studying Tibetan language in Dharamsala since November and is currently planning to stay (she quietly conceded) indefinitely (Makiuchi 18 April). Before there can be any expansion or development of the mental health services provided by the Department of Health and the Tibetan Delek Hospital, there must be a successful transition of counseling responsibilities from Sonam to Reiko. Much of the rest of this

study will research the factors that have kept the past and current Western mental health services, just discussed, from developing further and will in turn focus on the obstacles that must be overcome in the future.

## **TRADITIONAL TIBETAN MEDICINE**

While many systems of medicine such as the Tibetan are traditional and ancient, their importance in contributing substantially towards medical sciences particularly in the field of psychosomatic and non-infectious diseases should not be ignored. –The 14<sup>th</sup> Dalai Lama (Clifford xi)

Traditional Tibetan Medicine has its origins in the seventh century A.D. after Tibet opened its doors to religious and cultural influence from India –allowing both Buddhism and Indian Ayurvedic medicine to disseminate into Tibet (Clifford 3). Tibetan Medicine is intimately connected with Buddhist religion and philosophy; in fact, it is believed to have been taught by the Buddha, who emanated the Medicine Buddha (Dr. Dorjee 25 April). There are three types of Tibetan Medicine as outlined in *Tibetan Medicine and Psychiatry*: Dharmic, Tantric and Somatic (Clifford 131). Dharma plays largely a preventative role in Tibetan psychiatry as it enables one to “build a strong mind that cannot be overpowered by emotional strains, intellectual pressures, or evil spirits” (Clifford 132). Tantra, in the case of mental health, is used primarily used to provide description, explanation, and treatment of madness and evil spirits (Dr. Dorjee 19 April). The following will focus primarily on the somatic form of Tibetan medicine and its applications to and treatments of mental and psychological disturbances.

The concept of mental health in Tibetan Medicine is based largely on the Buddhist idea of the mind as a “constellation of wholesome, afflictive and neutral mental factors of perceptual,

cognitive and affective qualities...afflictive factors: hatred, envy, greed, pride, lack of insight are seen as underlying causes of both physical and mental diseases” (Epstein 67). As such, mental health is defined with respect to the extent to which the mind is freed from the influence and an imbalance of these afflictive mental factors and emotions. All of the afflictive mental factors can be consolidated into three destructive emotions commonly referred to as Buddhism’s the three poisons (*Nyan-mongs*<sup>5</sup>): ignorance/delusion (*gTi-mug*), hatred/aversion (*Zhe-dsang*) and attachment (*Dod-Chags*). These three poisons cause the three bodily humors (*nyes-pa*) of Tibetan Medicine to arise. The somatic form of Tibetan Medicine is concerned with maintaining a balance of the three humors, literally the “three defective energies”: *rlung*, *tripa*, *beken* (wind, bile, phlegm) (Dr. Dorjee 19 April). Dr. Dorjee Dekhang, a Tibetan Medicine Doctor at the local Men-Tsee Khang, described that the term “humor” is misleading and that it is more accurate to think of them as defective energies since an imbalance leads to physical and mental disturbances.<sup>6</sup> He described the relationship between the three bodily humors to the three poisons as analogous to a bird and its shadow. He explained that there are proximate causes (the bodily humors) and distant causes (the three poisons) of disease; the proximate cause is analogous to the bird itself while the distant cause is like the bird’s shadow insofar as it is inseparably linked but not physically linked to the bird (Dr. Dorjee 19 April). It is in this sense that Buddhism’s three poisons are believed to cause imbalances in the three humors which in turn cause physical and mental disturbances.

Of the three humors, an understanding of the nature, properties, and functions of *rlung* is necessary in order to understand mental illness and psychological disturbances from the Tibetan

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<sup>5</sup> See Glossary for Tibetan and Sanskrit terms in their proper script.

<sup>6</sup> Dr. Dorjee continued to use the term “humor” when speaking with me but wished to clarify the concept before continuing. For this reason I will continue to use the term “humor” in place of “defective energies” in order to be consistent with most English texts.

Medicine perspective. There are number of pranic energy currents in constant fluctuation that act as the basis of rlung. It is believed that the light, fluctuating nature of rlung is most similar to that of the mind and furthermore that the life-sustaining current (*sok-rlung*) which runs from the heart to the brain, “provides the physical basis for the mind” (Epstein 69). Since mind is believed to rest on the life-bearing current, a disturbance in that current leads to a respective disturbance in the mind. It is for this reason, as Dr. Dorjee informed me, that rlung is the main humor related to mental problems like depression, stress, anxiety and madness (Dr. Dorjee 19 April). Similarly, it notes in *Mind and Mental Health in Tibetan Medicine*, “most common anxieties, minor depression and uncontrollable surfacing of emotion are attributed to primary disturbances and aggravation of the balance of the life-bearing pranic current” (Epstein 69). A severe disturbance of the life-bearing current can result in psychosis.

A few nights before my last meeting with Dr. Dorjee I had spoken with a woman, Dawa,<sup>7</sup> who admitted that she had some emotional problems many years past due to debt and family problems. She informed me that during this period she was quite depressed because she had a “bad husband, lots of children and no money” (Dawa 21 April). She admitted that she had numerous arguments with her husband which often lead to her to develop symptoms and responses such as difficulty exhaling, fainting, back pain and chest pain. Because of these were recurrent problems she sought consultation from a lama who in turn advised her to go to the Men-Tsee Khang for treatment for her physical pain. It was at the Men-Tsee Khang that Dawa received treatment and was told she had sok-rlung, a disorder, she knew to “make people sad and even crazy” (Dawa 21 April). Knowing little about sok-rlung at the time I decided I would ask Dr. Dorjee what it meant to be diagnosed with such a problem. Without knowing anything

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<sup>7</sup> Name changed

further about Dawa's symptoms or experience Dr. Dorjee listed a number of symptoms and causes of sok-rlung:

Minor symptoms: back pain, chest pain and/or headaches

Major symptoms: loss of consciousness, trouble breathing – may occur after hearing bad or sad news that one cannot tolerate, often after severe argumentation. (Dr. Dorjee 25 April)

I found the similarity between Dawa's description and Dr. Dorjee's brief explanation of sok-rlung to be remarkable. When I expressed my surprise to Dr. Dorjee that his explanation described the exact symptoms and cause of Dawa's problem as she described it, he seemed to shrug it off as if there were never any doubt. It only appeared to reaffirm his prior assertion that "Tibetan medicine can stand strongly in disorders of rlung, while Western medicine is quite good at immediate relief" (Dr. Dorjee 19).

When attempting to diagnose which humor is disturbed, Dr. Dorjee informed me that he looks for the characteristics of each humor. Dr. Dorjee described the six characteristics of rlung as the following:

Rough: People become rough-edged and develop a rude nature. Rough skin.

Light: Like a feather, people cannot sit still in stationary position.

Cold: Loss of body heat, cannot stand cold, windy climate.

Subtle: Defined by the response to treatment involving oil application to the skin. Oil penetrates the subtle channels and gives quick relief.

Rigid: Such as rigidity in the limbs.

Mobile: Mind wanders quickly and often. (Dr. Dorjee 19 April)

When I asked him to explain how these characteristics related to depression and anxiety, Dr. Dorjee explained that "one who suffers from depression suffers from symptoms of being more

rough and rude than normal and cannot enjoy happiness and those suffering from anxiety and stress suffer from symptoms of being rough, mobile and light” (Dr. Dorjee 19 April).

Physiologically, a disturbance of rlung can manifest itself as “quicken heart beat, dizziness, insomnia, loss of appetite, lack of coordination and accident proneness” (Clifford 90).

Additionally, when diagnosing the patient, the doctor will examine the person’s pulse, eyes, tongue and urine, ask the patient numerous questions and finally examine their medical history.

Treatment of rlung disorders consists of four types: diet, behavior, medication, and accessory therapies. These four treatment methods are the same for all humoral imbalances. Dr. Dorjee stressed the importance of the order of these four treatment methods, noting that diet and behavior treatments must always come first and that “you cannot use accessory therapies in the first place.”<sup>8</sup> He also stressed the importance of diet and behavior as factors that support physical and mental health adding that combined the two are “50% of the supporting factor while medicine is the other 50%” (Dr. Dorjee 19 April). The diet prescribed for rlung disorders is different depending on the patient and disorder but generally consist high protein diets including “meat, soups from bones, hot milk, cooked dough of grains, seed oil, brown sugar, garlic and onion” (Epstein 70). Dr. Dorjee gave examples of a general diet that he might prescribe for Dawa which consisted of “warm or cooked food, Thukpa rather than momos, but momos soup is okay...no salads and sometimes wine or alcohol” (Dr. Dorjee 25 April). The warm foods, he explained to me, were to nullify the cold characteristic of rlung. He stressed that the specific foods and amounts of each would depend entirely on the patient’s specific situation. The behavior changes that he suggested as a remedy for Dawa’s previous condition involved, on a superficial level, “shunning away from argument” and on a deeper level involved, “looking into

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<sup>8</sup> At this point, Dr. Dorjee expressed his discontent with the Western method of prescribing drugs on first diagnosis of an illness

your own mind to see the problem from many perspectives: yours, your enemy's and the mediators point of view" (Dr. Dorjee 25 April). In this deeper method one is attempting to take fault and understand that the argument would have been less severe if he or she had been more calm or tolerant. In this sense, the rough characteristic of rlung is being nullified by calming or pacifying the mind. Dr. Dorjee mentioned that possible medication might involve sogzin-11, agar-35 or agar-8. As for accessory therapies, treatments may include meditation, massage, moxabustion<sup>9</sup>, or enemas.

Curious about what Dr. Dorjee believed the major strengths of Tibetan Medicine and alternatively, the major weaknesses of Western medicine were with respect to mental and psychological disorders, I decided to ask him to explain his opinion in our last meeting. As it turned out, Dr. Dorjee's major criticism of Western medicine and incidentally his primary praise of Tibetan Medicine with regard to the treatment of psychological disturbances, rested in their respective approaches. He noted that Tibetan medicine offers a holistic approach, that it "sees the whole person" and does not treat just physical symptoms but mental ones (Dr. Dorjee 25 April). He added that while Tibetan Medicine does not have specialists as does Western medicine, they are trained to treat all illnesses. Tibetan medicine doctors, he stressed, "approach the patient differently, they see, touch and ask questions in order to properly understand the cause (life, work, home, family)" (Dr. Dorjee 25 April). He criticized Western Allopathic methods for "neglecting simple things" because Western doctors do spend enough time with the patient to learn about and understand the problem; "they simply prescribe and send away" (Dr. Dorjee 25 April). That being said, he wished to let me know that all forms of medicine and spirituality had the same intention, to help the patient and reduce his or her suffering.

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<sup>9</sup> A treatment method that involves the burning of an herb directly on the skin.

## SPIRITUAL HELP

“Buddhism is my counselor”

It is not uncommon for Tibetans to seek consultation, advice or even treatment from the local Buddhist community. Often when one experiences any ailment, problem, or worry, they will seek out a Lama or Oracle. In fact, one woman, Pema<sup>10</sup>, told me that she last visited a Lama a few nights prior after she experienced an intense nightmare that caused her to wake up trembling (Pema 23 April). In Pema’s case the Lama told her not to worry about her nightmare and that it did not have any meaning or significance. Aside from general advice, Lamas will often perform divinations by throwing dice and reading the results to determine the severity of the situation and the best mode of action. When performing a divination, the Lama usually asks for the person’s birth year and sign and the specific problem they are facing. But every Lama has a different method. Janchup Phunstok a senior monk at Namgyal Monastery, told me that he once witnessed one Lama perform a divination by throwing up a sheep figurine and letting it fall to the ground. Depending on the roll of the dice or, in this case, the fall of the figurine the Lama will tell the individual his or her situation “looks promising, very bad or neutral” (Jangchup 2 May). Often the Lama will give the individual a series of practices to follow on his or her own. This may involve reciting a certain mantra or performing a certain ritual *puja* (chod-pa). Pujas can also be performed by the Lama or by number of monks (the more the better) from a local monastery. If Tibetan doctors have received initiation or “precious things” from a Lama the doctor may also be able to perform these healing rituals as a treatment for certain ailments (usually involving evil spirits). There are number of different healing pujas that can be given by the Lama, some are very general and others are for specific ailments. Unfortunately, I was unable

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<sup>10</sup> Name changed

to speak to a Lama about specific pujas given for psychological and emotional disturbances. However, Jangchup assured me that “most pujas would be good for relieving mental suffering” but that it is heavily dependent upon the individuals faith and the strength of the connection one has with the Lama (Jangchup 2 May).

Interestingly, when I surveyed the community’s ideas about mental health and where they sought help, many responded that they do not seek help from a specific individual but from Buddhism. One young man, Dorjee, explained that he does not need a counselor because “Buddhism is my counselor” (Dorjee 26 April). As it turns out, much of the community does not seek out help from any individual but instead attempts to solve his or her problems by returning to Buddhist philosophy and personal practice. Sonam Dekyi explained that most of the community, including herself, “find[s] solace in religious practice” (Sonam 13 April). She explained, “when I’m not happy, I go to temple and feel better,” noting that spiritual faith and practice, even a simple one such as visiting the temple “has a psychological effect” (Sonam 13 April).

Interested in learning more about how mental health relates to Buddhism, I asked Jangchup what he believed was, from his monastic perspective, the cause of emotional and psychological disturbances and how they could be treated. He explained that it is a common Buddhist premise that mental suffering is due to an unbalanced mind often considered to manifest itself as symptoms such as frustration, anger, anxiety and depression (Jangchup 2 May). Just as a physical health is often defined as being free of pain, a healthy and balanced mind is defined as being free of psychological distress. According to Buddhism, the intrinsic nature of mind is one of clear light, thought to be free of such imbalances. However, the common, unenlightened human does not have such a perfectly balanced mind free of all afflictions but

with skillful effort and practice, such imbalances *can* be remedied and a healthy mental state can be reached. He explained that at the gross level suffering, both physical and mental, is caused by karma, that is, it arises from your previous actions. Unfortunately, after you experience the effect of your karma “there is nothing you can really do except attempt to purify your mind” by generating regret and positive actions and intentions” (Jangchup 2 May). He explained this by making an analogy to seeds. You can purify seeds that have not yet sprouted or ripened by removing it from the earth or not planting it in the first place, however once the seed has sprouted there is nothing one can do; similarly, once you have experienced suffering from a manifested seed, you cannot undo it. You must attempt to purify the other un-ripened seeds and this will lead to a decrease in suffering and an increase in positive karma. On a more subtle level, Jangchup explained that mental suffering falls under the first of the Buddha’s Four Noble Truths (the Truth of Suffering) and that its cause is explained in the second of the four noble truths: the Truth of Origin. Here, suffering such as emotional disturbances, is believed to be a consequence of cyclical existence (*samsara*), caused by afflictive emotions (namely the three poisons) and in turn the action or karma created out of response to ignorance, attachment and aversion. Again, Jangchup informed me that once you experience mental suffering you can only work to purify seeds that have not ripened and suffer through the experience. In this sense he was advocating that one learn to accept his or her suffering. The Dalai Lama speaks to this end in *The Art of Happiness* by explaining, “if we can adopt an attitude towards suffering, adopt an attitude that allows us greater tolerance of it, then this can do much to help counteract feelings of mental unhappiness, dissatisfaction and discontent” (115). In fact, I spoke with one young lady, Palkyi at the Tibetan Women’s Association, who noted that depression was not a problem for her or her

family because Buddhism allows her to put her suffering in context and understand that her “suffering is so small compared to others, the rest of the world” (Palkyi 3 April).

## **MAINTAINING A DIALOGUE**

Combined, the Western counseling service, Traditional Tibetan Medicine and the spiritual community, act to exhaust the list of the mental health services and options available to the Tibetan exile community in Dharamsala, India. Presently, these three services are largely autonomous and interaction between the three is quite limited. This is despite the attempts to integrate these forms of treatment by the Tibetan Torture Survivors’ Program in the early 1990’s. Originally, the intention of TTSP and in particular its founding program, the Trans-cultural Psychosocial Organization (TPO), was to develop this kind of interdisciplinary mental health program for torture victims, however there appears to be some debate as to whether, a dozen years later, the program is still accomplishing this goal. In fact, I was unable to get any straight answers regarding how they were still attempting combine traditional and modern allopathic methods for an interdisciplinary mental health treatment. In this regard, Tsering Lhamo, a former counselor for the program, noted that she does not feel that the program is doing much to integrate methods any longer nor did she think that they were reaching out to the community (Tsering 24 April). There are also efforts are being made to integrate Tibetan Traditional Medicine at the Men-Tsee Khang and Western Allopathic at Delek Hospital but neither Sonam Dekyi nor Dr. Dorjee had any idea if there were any plans to integrate mental health treatments specifically. Aside from these attempts the only true cooperation between services appears to be when Lamas advise individuals to seek medical help from either the Men-Tsee Khang or Delek

Hospital. Additionally, patients often take a combination of treatments, usually taking advice from Lamas while seeking alternate treatments. Both the current counselor Sonam Dekyi and the past counselor Tsering Lhamo explained to that they advocate patients to continue taking this spiritual help in conjunction with counseling. Sonam believes that for many of her clients their faith is so strong that they can and often will benefit from seeking spiritual help (Sonam 13 April).

While the rest of this study will focus primarily on the obstacles to developing a Western-style mental health program in the community, it is important to develop an understanding of the current services available. In fact, I argue that to create a relevant and beneficial program for the community, there must be increased cooperation between the available services. Currently, there is not an extensive dialogue between the three services nor does there seem to be a great deal of understanding of the alternate options. However, from my research I found that progress in both of these regards may greatly improve the likelihood that a more extensive mental health program could be established. As I discovered, and it will be more evident in the following sections, the community is generally hesitant about seeking out counseling whereas they are more comfortable seeking help from Lamas or Tibetan Medicine. If the current mental health program made more steps to integrate and develop an understanding of traditional methods, the community may be less reluctant and ultimately more responsive to counseling. In fact, a summary of the TPO findings (published five years after the program's conclusion) observed, "subjects responded better when they realized that the counselors had an extensive knowledge of Buddhism and integrated Buddhist ideas and practices into therapy" (Mercer 2005). A number of community members I interviewed agreed that they would be more comfortable with a Buddhist counselor and a Western-model mental health service that was advocated by Lamas or Tibetan

Traditional Medicine (Dorjee 26 April, Dawa 21 April, Pema 21 April). In fact, two older women who had originally assured me that they would never go to a counselor conceded that if a Lama were to refer them to a counselor, they would oblige (Dawa 21 April, Pema 21 April).<sup>11</sup> Although, Lamas do advise individuals to seek medical treatment for physical ailments, it is not common for them to refer individuals to counselors. Both Tsering Lhamo and Sonam Dekyi agreed that Lamas are generally “open-minded” and would not have a problem educating the public about mental health issues (Tsering 24 April, Sonam 20 April). Dr. Tenzin Yashi, a physician at Upper TCV informed me that “spiritual leaders” including Lamas already come to give “health talks” to the students on the subjects of “substance abuse” and “peace” and that he sees no reason why they would not come to speak towards mental health issues like counseling, stress or depression. He added that students are more likely to listen to advice from spiritual leaders than a psychologist speaking on the subject of mental health (Dr. Tenzin 23 April). In general it appears that this uneasiness felt towards the Western-model counseling program could be, at least partially, dispelled if there were an increased cooperation and dialogue between the different services and options.

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<sup>11</sup> The reason for their hesitation was largely due to a mistrust of counselors ultimately built on an ill-informed notion that counseling sessions are not confidential. This will be better explained in the later sections.

# OBSTACLES

There is a general consensus among a number of community health workers I spoke with, that the mental health program in Dharamsala has much room for expansion. However, it is evident from my research that there are a number of obstacles that stand in the way of developing the current mental program. Before a Western-style mental health program can be fully established in the community, these obstacles must be understood and addressed. Because many of these obstacles relate to social and cultural issues, most of them have significant relevance to other Tibetan exile communities and thus have great implications for future attempts to develop mental health programs in these communities.

## TRANSLATING WESTERN CONCEPTS

Western psychological sciences have been criticized for certain presumptions: “that they are universally applicable and that all cultures should emulate Western psychology.” These criticisms rested on the observation that many of the foundations and theories of Western psychology including its academic emphasis on “individualism, objectivity, quantification, and mechanism” may be irrelevant and meaningless for non-Western people and their life contexts. The fear is that Western psychology, despite ultimately being local to Western contexts, assumes a dominant and universal role such that it is often projected onto foreign cultures where it can do nothing more than develop a “decontextualized vision” (Gergen 1996). This has led to the development of the fields of trans-cultural psychology and psychiatry which are founded on the idea that cultural differences should be taken into account because the Western model may not be appropriate for cultures that understand disorders differently and even experience them

differently. However, this observation that Western psychological concepts may have but superficial relevance to non-Western cultures subsequently implies that modern diagnostic concepts for psychological disorders (that were originally developed in and for Western cultures and contexts) may not have much application to other cultures and contexts. In fact, it is only after you understand the different meaning, experience and behavior attached to mental illness can you begin to translate Western diagnostic concepts into a non-western context. This was the inspiration for the development of the explanatory model interview catalogue (EMIC) which has as its aim, to examine “illness related experience, meaning and behavior in cultural epidemiology” (Weiss 1997).<sup>12</sup> The catalogue is based on an adaptable framework such that it can be used within a number of different cultural contexts. The authors argue that cultural beliefs and practices “affect nearly all aspects of psychiatry,” including assessment and diagnoses, illness behavior and help seeking, perceived quality of care, and “the design of culturally appropriate psychotherapies.” As such they note that it is opportune “to study the way in which cultural factors influence and shape the experience and expression of patterns of distress” and take this into account when assessing clinical needs. Among other things, the EMIC focuses on three general factors: patterns of distress, perceived cause and help seeking. In my research I chose to examine these factors and their role in the Tibetan exile community. Patterns of distress concerns the full range of problems associated with the “respondent’s condition, including symptoms...and stigma.” Generally, I attempted to explore what it is that troubles Tibetans most when they suffer from psychological and emotional disturbances. To determine the perceived causes of such disturbances I asked various health professionals and members of the community what the common perceptions were. Finally to determine the help seeking habits, I attempted to

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<sup>12</sup> Please see Appendix E for an explanation and example of the EMIC.

research where Tibetans most commonly sought treatment for mental and psychological disorders.

## Patterns of Distress

The most significant and interesting pattern of distress among Tibetans appears to be their insistence that they are suffering from a physical problem rather than a psychological or emotional problem. In fact, most Tibetans who are later found to suffer from psychological or emotional disturbances do not immediately seek help from counselor but usually end up at the hospital complaining of physical pain or discomfort. In the previous section I mentioned that most of Sonam's clients were referred from the Tibetan Delek Hospital. Most of these patients come to the hospital complaining of somatic symptoms and not with the intention of expressing or receiving treatment for the emotion or psychological problems they may be experiencing. Once the physicians at Delek Hospital recognize these physical symptoms to be psychosomatic in nature they refer the patient to Sonam for counseling. However, Sonam shared that most of her clients come to her thinking they are coming to see a physician or to "get an X-ray" (Sonam 13 April). In fact, after Sonam informs them that she is a psychologist and that they were sent to her to receive counseling, she said they often appear confused and respond defensively, "why should I go to counselor? I'm not psychotic!" adding, "I don't need this. I'm okay. I don't have a psychological problem, just this physical problem" (Sonam 20 April). She informed me that it takes more than one session for clients to admit that they do have some sort of emotional or psychological problem. For this reason Sonam always tells clients to come back for a second session and so far, she added, all have returned for a second session. She also mentioned that she

sees this reaction more extensively among newly arrived Tibetans who, she explains, “have never experienced this idea that someone will listen” (Sonam 20 April).

The somatic complaints that Sonam most often hears from new clients include lack of appetite, insomnia, inability to concentrate, lethargy, headache, dizziness, chest pain, epigastric pain and tightness or heaviness of the chest (Sonam 13 April). Of these she noted that the pain or heaviness in the chest was the most common complaint she has witnessed (Sonam 20 April). Additionally, Reiko Makiuchi noted that she sees more somatic symptoms than she did in the United States but added that, “Japanese clients in the US also complain of somatic symptoms” (Makiuchi 18 April). One particular symptom she found interesting was the prevalence of fainting among her female Tibetan clients. In her time in the US she noted that she saw only one or two cases in her entire career. Indian men, on the other hand, she has often seen complain of being physically weak (Makiuchi 18 April). Most of these psychosomatic symptoms presented by Tibetans suffering from depression or anxiety are not generally included as somatic symptoms of such disorders by the DSM-IV’s diagnostic criteria.<sup>13</sup> Although the DSM-IV recognizes that in some cultures depression may present with somatic complaints (such as headache, gastrointestinal disturbances, and unexplained pain), it still distinguishes these somatic complaints from somatic presentation of depressive illness (symptoms of which include loss of appetite, constipation, weight loss, loss of libido and insomnia) (Raguram 1996).

This process of expressing psychological or emotional problems in terms of physical symptoms is actually a well-studied phenomenon that appears to be a common occurrence in Asian cultures. In fact, this process by which psychological distress is experienced and communicated in the form of somatic symptoms has come to be termed somatization (Raguram 1996). Somatization of depression has been extensively studied in Asian cultures and has been

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<sup>13</sup> See Appendix D for DSM-IV diagnostic criteria

found to be a prevalent phenomenon of people from China, India, and Japan (Cheung 1981, Gada 1982, Raguram 1996, Raguram 2001). One particular study in Bangalore, South India noted that rates of somatization were extremely high among Indians suffering from depressive disorders, noting “patients spontaneously emphasized somatic symptoms when asked about the problems that brought them to seek help, but on further probing, they acknowledged feelings of depression and sadness, which they related to various social problems and interpersonal issues” (Raguram 2001). Additionally, somatization was found to be a prevalent phenomenon among Southeast Asian refugees, leading researchers to conclude, “somatization appears to be a common idiom for expressing depression and other psychological problems among refugee populations” (Nguyen 1982). Considering that Indian, Chinese and refugee populations have all shown this pattern of expressing somatic symptoms of depression, it is no surprise that somatization is common among Tibetan refugees.

The prevalence of this process of somatization of psychological and emotional disorders has led to the development of a variety of theories to explain its existence, origin and role. Among these theories there are two that may be relevant to Tibetan exile communities. The first is the idea of alexithymia, which postulates that sufferers (or cultures) lack the linguistic skills to correctly articulate or identify their emotional experience or related disturbances (Raguram 1996). However, this theory emphasizes cultural deficits (i.e. language) while other, often more preferred theories advocate cultural differences by arguing, “it is not just the inability to express sadness but a cultural shaping of experience” (Raguram 1996). The leading theory proposed by Raguram et. al. in their paper “Stigma, depression and somatization,” is that there is a socio-cultural stigma attached to the expression of emotional distress such that it affects the “experience and patterning of distress in somatic rather than psychological and social idioms.”

This may or may not be true for the Tibetan exile community as it is proposed to be for Indian populations however it presents an interesting explanation. The idea and role of alexithymia and stigma will be discussed further in later sections.

It is important to remember that while somatization is treated as a cultural expression or presentation of depression and even anxiety disorders, it is a very real experience for the sufferers. Sonam Dekyi informed me that often her clients are sincerely worried about their health when they go to seek help from a doctor. In fact, those who suffer from tightness of heaviness of the chest often believe they have some sort of serious heart condition (Sonam 20 April). It is not as if somatization implies that sufferers are projecting these somatic symptoms in order to avoid a powerful social stigma attached to emotional distress, they are real part of the individual's experience. (Dr. Tenzin 23 April). One of the two resident doctors at Upper TCV<sup>14</sup> stressed that the students "don't perceive it as a mental disorder, as depression or anxiety. They perceive it as an organic disorder, as physical --part of their body-- not mental" (Dr. Tenzin 23 April). That being said, Dr. Tenzin noted that some female students tended to faint and make abnormal movements or "pretend to have epileptic seizures as a way of making it seem like an internal disease problem rather than mental stress, depression or anxiety" (Dr. Tenzin 23 April). In contrast, Dr. Tenzin observed that male students conceal their emotional stress and let it out through aggressive behavior, a phenomenon that was familiar to Reiko Makiuchi in her experience with Western males.

Somatization, the severity of somatic symptoms, and the masking of psychological disturbances, all present significant reason to gain a thorough understanding of cultural patterning of distress. Having such an understanding allows one to more easily and efficiently translate standard Western diagnostic concepts into a non-Western context relevant for Tibetan

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<sup>14</sup> Upper Dharamsala Tibetan Children's Village

communities. This is especially relevant for physicians in the community who are often the first to see and diagnose these patterns of distress. Tenzin Norsang, a final year Tibetan medical student, shared that the “mental health problems are often missed by the physician because of lack of time” (Tenzin 26 April). He went on to point out that the psychosomatic complaints expressed by patients (both Indians and Tibetans) are at first treated as purely physical ailments and in turn the physician tends to think these aches and pains are “caused by problems with the endocrine system<sup>15</sup>” (Tenzin 26 April). The problem, Tenzin stressed, is that the physician is often too busy to devote enough time to diagnose psychological problems properly. However, if the physician (especially and primarily Western physicians volunteering in non-Western cultures<sup>16</sup>) is well informed on these distress patterns it may make identifying and diagnosing such disorders much easier.

## Perceived Cause

After speaking with health professionals and many community members I was unable to find a consensus and thus determine what the most common perceived cause of mental, psychological or emotional disturbances.<sup>17</sup> I mention all three (mental, psychological and emotional) because I quickly found out that my use of language when asking these questions often determined the response that I received. Often when I used the terms ‘mental’ or ‘psychological’ most uninformed community members immediately jumped to the conclusion

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<sup>15</sup> The endocrine system is a bodily control system consisting of glands that secrete hormones into the blood stream to affect target organs throughout the body. The system functions to regulate growth, metabolism and sexual development.

<sup>16</sup> This is quite common at Tibetan Delek Hospital where Western volunteers often make up the majority of the physicians on staff.

<sup>17</sup> The EMIC was originally developed for the sufferers of psychological disorders and not for the general community. However, since I am unable (ethically) to interview patients directly I have chosen to get a sense of perceived cause from the community instead.

that I was asking about psychotic people. I found that the term ‘emotional’ carried with it the least amount of stigma, but at the same time it also carried with it the least amount of preconceptions. That is, when I asked what they believed to be the cause of ‘emotional problems’ such as depression (often pairing this term with ‘severe sadness’ and ‘hopelessness’) or anxiety (often describing it as ‘stressed,’ ‘anxious’ and ‘worried’) they tended not have any real thought as to what might cause such a problem. For instance, Dawa, the woman who suffered from sok-rlung, had no idea what might cause mental problems or sok-rlung (Dawa 21 April). Furthermore, Sonam Dekyi also informed me that most of her patients do not usually have a “preconceived notion of cause” before they come to her (Sonam 20 April). This is, however, to be expected in a community where these concepts are quite new.<sup>18</sup>

Despite the general lack of preconception concerning the cause of psychological problems there is a sense in the community that any illness, be it mental or physical, is caused by karma. In fact, a 1996 dissertation focused on the “health-seeking behaviour” of Tibetans found that “fate/karma and part of the natural cycle of life and death” showed most support for being the major causes for various illnesses, second only to poor nutrition (Wangdu 1996). Although this finding does not differentiate between the perceived cause of psychological and somatic illnesses, it does act to illustrate that karma plays a major role in the community’s perception of the general cause of illness. In my research, karma was not often spontaneously volunteered as a cause but after further questioning it was common for individuals to return to karma as a general, if not default, explanation. Most of these individuals explained that people might suffer from these problems if they had performed actions in previous lives that lead them to generate negative karma for which mental suffering is the consequence in this lifetime. Sonam Dekyi did

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<sup>18</sup> Similarly, expecting a definite or relevant answer to the question, “Why are people depressed?” may be equally as fruitless in the US.

not think most of her patients believed karma was the cause of their problem but, she added, that most of her clients come from TTS and that the perception that karma as a cause is more common among older generations. She explained that she knew of one client who was told to enter a monastery by his parents because they believed “karma made him sick” (Sonam 13 April). The majority of other community members appeared to agree with Sonam’s assessment that this belief (that karma is the primary cause of psychological disturbances) was more prevalent among the older, more “superstitious,” generation (Tenzin 26 April).

Other causes volunteered by the community were debt/money problems, family problems, “feeling displaced” and evil spirits (Pema 23 April). A number of people interviewed noted that debt/money problems (including but not limited to unemployment) were common in the community and lead to a lot of worry and distress among Tibetans. Additionally, a couple women admitted that a “bad husband...who drinks and gambles and doesn’t take care of the family” may cause a woman to become depressed. Interestingly, I found that many Tibetans associate “feeling displaced” or “not having freedom” with emotional problems. In fact, one woman informed me that when she sees Chinese propaganda on television or sees Indian policemen mistreating Tibetans she develops a heaviness in her chest and headaches and often cannot sleep that night. She believed that this kind of distress may lead other Tibetans to develop the kind of emotional and psychological disturbances I was asking about. Lastly, I discovered that the perceived cause of serious mental illness such as psychosis are not “considered a medical problem but one caused by evil spirits” (Tenzin 26 April).

## Help Seeking Behavior

In 1996, Jurme Wangdu researched the community's health seeking habits for his dissertation entitled "Health Seeking Behaviour of Tibetan Refugee Community in Dharamsala, India." Jurme found that families sought Traditional Tibetan Medicine (TTM) first for medical treatment while individuals were split between TTM and Western Allopathic (WA) when seeking help for themselves. This may be due to influence from the older generation within a family who may be more likely to advise that a member go to TTM before WA. However, Tibetans indicated that the first place they sought consultation was from the spiritual community. There is a major age disparity in health seeking behavior, those between the ages of 15 and 25 sought WA half the time and TTM just under a third. Tibetans between the ages of 36 and 60 indicated that TTM was the most commonly sought (72.3% of those surveyed) and WA by just under a fifth (19.6%) of the population. Additionally, for depression, anxiety and psychosis, the majority of Tibetans surveyed (56.5%, 57.2% and 56.5% respectively) reported they would seek help first from "Spiritual Healers" (Wangdu 1996) and These findings are fairly consistent with my research in which most people agreed that the last place they would seek help from was from a psychologist or counselor whereas the first place was from the spiritual community. This was especially prevalent among the older generation where there exists a general distrust and misconception of counselors. The only time that the community seemed to seek out help from a counselor was after health talks. Both Tsering Lhamo and Sonam Dekyi informed me that after every mental health talk they have given, two or three girls often come up to them expressing a wish to talk about their problems. This serves to lend credence to the idea that increased education and awareness would in turn lead to a greater demand for counseling within the community. This subject will be further discussed in the next section.

## A NEW CONCEPT, A NUMBER OF MISCONCEPTIONS

There exist a number of misconceptions about mental health issues among the Tibetan community, largely due the fact that counseling and the concepts of depression and anxiety are relatively new to many members of the community. These misconceptions are obstacles insofar as they represent the need to be dispelled through education and awareness. Together they lower the community demand for counseling services and increase the stigma attached to psychological and emotional distress, which is ultimately counterproductive to any attempt to establish a sustainable mental health program. It is for this reason that an understanding of the level of knowledge and misconceptions regarding mental health is necessary for the future mental health programs in both Dharamsala and other Tibetan settlements.

In the West, counseling has been available for nearly a century and the concepts of depression and psychological disorders are well established such that those suffering from these problems are well aware of the help available and can utilize it if necessary. This is not the case for non-Western cultures and developing countries. In fact, the report, *Neurological, Psychiatric, and Developmental Disorders: Meeting the Challenge in the Developing World*, notes that "diagnoses of mental disorders, including depression, have no conceptual equivalent in many languages" (IOM 2001). This appears to be the case for Tibetans and the Tibetan language. In fact, one young man I interviewed who arrived to India a decade ago informed me that he did not have a proper understanding of what the English term "depression" meant when he first arrived. He noted that even today he couldn't think of a proper Tibetan translation of the term and turned to two other young Tibetans in the coffee shop to ask them if they could think of one. The three of them agreed that the best Tibetan term they could think of was *Sempa-Kyo-Wa*, which they explained to me simply meant sadness or feeling low but did not have the correct connotations to

act as a proper Tibetan equivalent to “depression” (Dorjee 26 April). Dawa Tashi of Gu Chu Sum Center for Ex-Political Prisoners gave me another Tibetan term, *Kha-bhug-Dhog-Pa*, which he described as meaning “someone who is sad because he could not share his feelings,” which assured me was the proper Tibetan translation for “depression” (Dawa 27 April). However, I was unable find any lay person in the community who could give me a definition of this term. While looking through an English-Tibetan dictionary I found that the definition of mental/emotional depression to be *yid-smug*. Although most Tibetans understand this term and agree retrospectively that it means depression, I was told it was not part of their spoken vernacular. Whether any Tibetan term exists that correctly captures the connotations of “depression,” it is telling that there is a general lack of consensus in the first place.

The primary and most common misconception in the community regarding the nature of counseling and psychological disturbances involves the belief that only “psychos” or “psychotic people” need counseling consequently that anyone who goes to a counselor is therefore psychotic. This misconception was alluded to earlier during the discussion of patterns of distress, in which new clients of Sonam’s tended to reject the notion that they had a emotional problem or needed to see a counselor because they were not psychotic (Sonam 13 April). In this misconception, psychiatrists and counselors are intimately linked to and inseparable from psychotic patients, and the phrase “psychological disturbance” becomes a tautology for psychosis. In fact, this misconception was so strong that I often found myself speaking of “emotional” disturbances instead of “mental” or “psychological” disturbances because any mention of the latter two terms lead immediately to belief that I was speaking about “psychotic people.” As I mentioned before, my language had to therefore be careful and precise depending upon the education of the individual I was interviewing at the time. This misconception, of

course, is a consequence of the relative youth of mental health concepts and could be reconciled through mental health education.

Another misinformed notion of mental health concerns the idea that mental health problems cannot be cured (Sonam 12 April). Sonam informed me that there was an old conception that there “are not cures” for mental health problems and that in some settlements this meant “many people suffering from mental illnesses were just left like that” (Sonam 13 April). But Sonam assured me that this was, in fact, an old conception and that people are beginning to understand that these problems are curable.

Finally, there is a last, grave misunderstanding of the nature and foundation of counseling. To begin with, there is a general distrust of counselors due to an ill-informed notion that whatever is told during counseling may somehow escape the privacy of the room and spread throughout the community. Although, counseling is always by nature, confidential, two older women alluded to their fear that their problems would not stay confidential if they told them to a psychologist because this psychologist might in turn tell her sister who then would spread these private feelings like gossip or news (Dawa 21 April, Pema 23 April). Pema explained to me two different sayings Tibetans had that often kept her from telling her problems. The first says, “every hole, at night, has eyes and ears. During the day, every mountain has eyes and ears” (Pema 23 April). The second Tibetan saying explains that water in a glass will stay in the glass whereas talking has no container and therefore leaks. Taken together, these two sayings represent Pema’s reasons for being fearful of sharing her feelings and problems with a counselor. She added, however, that she can trust a Lama with her problems and that one of the only reasons she may seek help from a counselor would be if a Lama advised her to do so. In addition to this distrust of counselors based on a misconception about counseling’s fundamental rule of confidentiality,

there exists a second misconception that seems to confuse counseling in the Western sense with counseling as performed by Lamas. Reiko Makiuchi noted that many of her initial clients did not understand that the point of counseling was not to receive advice or guidance but that it was based on a “talk-therapy” model in which they are supposed to share their feelings with someone who will listen (Makiuchi 12 April). Reiko believed this misconception might be because people associate the idea of counseling with “seeking and receiving advice from a Lama” (Makiuchi 12 April).

Although this does not represent an exhaustive list of misconceptions it serves to illustrate the common ones that must be addressed before a further developing the mental health program. Both Sonam Dekyi and Tsering Lhamo stressed to me that the first thing they must do when they approach a new patient is to educate them and dispel misconceptions by informing them as to what counseling is (“that it is just talking”) and what it means to suffer from psychological and emotional disturbances (Sonam 13 April). Only, after doing this can they begin to counsel the patient (Sonam 13 April, Tsering 24 April). Similarly, only after these misconceptions are dispelled on a community-wide level can there be a well established and ultimately beneficial mental health program.

## **SOCIAL STIGMA**

In the past psychological disorders used to be universally moralized, that is, it was believed to be a personal or character weakness of the sufferer. This has been changing in the West and as such there is less stigma attached to these disorders. However, Reiko informed me that she believes that many Tibetans know of depression but think of it as a personal or moral weakness or deficit (Makiuchi 18 April). This stigma, she continued, is necessary to remove

before counseling can continue. She informed me that when she first confronts a client suffering from depression she tells them it is “just like a cold, nothing to be ashamed of. It is a clinical/treatable illness.” She assures them that depression is not to be thought of a personality disorder, it is episodic, and it comes and goes (Makiuchi 18 April). Sonam also admitted that some Tibetans do view people who suffer from mental or psychological problems as having a weaker personality, or not being able to handle the stress of life’s pressures (Sonam 20 April). This is also related to the misconception just mentioned in which people who seek help from counselors are often assumed to be psychotic. This misunderstanding about counseling taken with the moralization of psychological and emotional disturbances has created a severe social stigma surrounding the expression of distress and seeking help from a counselor or psychologist. This in turn may make it socially disadvantageous to express one’s emotional distress. Consequently, individuals tend to suppress their problems. This is particularly worrisome because “these type of emotional problems tend to grow and must be caught early before they develop into a major problem and its too late” (Makiuchi 18 April). Allowing the problem to grow may offer, as Sonam mentioned, an explanation for why somatization is common among Tibetans. She explained that Tibetans “may wait until their emotional problem grows and develops into a physical problem” (Sonam 20 April).

This increased stigma that still exists in non-Western cultures has led many experts to question its role in somatization in these same cultures. One study that focused on this issue in particular found that in southern India stigma was “positively related to depressive symptoms and negatively related to somatoform symptoms” leading to the conclusion that depression was being re-constructed through somatization to be a less stigmatizing and therefore more tolerable condition personally and socially (Raguram 1996). Under this theory, the stigma attached to the

expression of emotional distress affects the patterning this distress and the experience of psychological disorders through physical symptoms rather than psychological ones. When I confronted Sonam Dekyi with this finding she noted that it is true among Tibetans that “you are not judged when you are [physically] sick.” She added that it may explain why her clients often come complaining of physical problems that they are not afraid to talk about or communicate (Sonam 20 April). Tenzin Norsang also agreed that he sees a stigma that directs people to physicians for their psychosomatic ailments rather than to a psychiatrist, noting “going to the physician is absolutely acceptable while Tibetans are embarrassed to go to a psychiatrist” (Tenzin 26 April). In this sense, physical symptoms are less socially stigmatizing because they approximate experiences that everyone gets from time to time.

This social stigma that appears to exist within the Tibetan community and which may explain the somatization of emotional problems acts as substantial obstacle for which the mental health services must overcome. This stigma makes it largely socially unacceptable to seek help from a psychologist and in turn suppresses the outward demand for mental health services in the community. Even if more extensive counseling services were offered and public awareness grew, it does not guarantee that the Tibetan community would seek the services out. The fear would be that people would continue to suppress their emotions and problems out of fear of the social stigma attached distress.

## **TIBETANS: INTERNAL AND INEXPRESSIVE**

One significant cultural obstacle that stands to inhibit the establishment of a fully developed mental health program in Dharamsala, is the generally inexpressive nature of Tibetans and their subsequent tendency to internalize their feelings and problems. Regarding this subject, Tsering Lhamo stressed, “it is not in our culture to speak about these problems or feelings. People hide it. People don’t talk about it. Our culture is very closed in this sense” (Tsering 24 April). Similarly, Sonam noted, “in a Tibetan family there is no tendency to sit down and talk about problems” (Sonam 20 April). This statement was generally seconded by everyone I spoke with. In fact, one woman seemed surprised when I asked her why she chose not to share her problems with others, responding simply, “why *would* I share my problems” (Pema 21 April). It is not as though Tibetans never share their problems with family, most people I spoke with agreed that they trusted their brothers or sisters enough to discuss their feelings with them but that in general they did not discuss these matters with friends. Pema explained to me that there is an expression among Tibetans that goes as follows: “If you have a problem and you tell your friend, they will be sad but if you have a problem and you tell your enemy they will be happy” (Pema 21 April). In this sense, discussing your problems with friends is generally perceived as placing a burden on them. It is largely for this reason that Tibetans prefer not to burden their friends by sharing their problems but wish instead to “sit down and deal with their problems themselves” (Sonam 20 April).

In addition to general cultural reasons for not expressing personal feelings or seeking outside solutions, there appear to be a number of religious reasons. To begin with, karma appears to play a role in the community such that it acts as a mechanism for taking personal responsibility for one’s own problems. In this sense, karma allows the sufferer to view his or her

problem or illness as a consequence and manifestation of previous negative action, intention, speech or thought such that it is a personal problem that should be dealt with by the sufferer. As such, the problem becomes personalized and there is no use in sharing. Additionally, Buddhism places emphasis on patience and actively not having afflictive mental states such as anger, hatred, envy pride, doubt and self-pity, which Reiko believes prevents many Buddhists from seeking immediately or fixating on their negative emotions (Makiuchi 18 April). This emphasis on patience, which Reiko admitted, does not exist in the West –citing as an example, the proportion of commercials that advertise faster and more powerful cars and painkillers—causes Buddhists to wait before seeking a solution for their problems. “Westerners,” she added, “want a quick fix but Buddhists and Asians,” specifically the Japanese patients Reiko has worked with, “are much more patient when a problem arises” (Makiuchi 18 April). This is because there is a conception that patience and enduring a minor amount of suffering builds character strength. As such, when the Japanese get a headache, they don’t take a pain killer but choose instead to lie down and suffer through it (Makiuchi 18 April).

Additionally, many Tibetans find it genuinely difficult to communicate their feelings and emotions openly. One young man commented, “since [Tibetans] are not very expressive as a culture, we find it difficult to communicate emotions or feelings. It is a major problem for me.” He hinted that some of this difficulty was related to a kind of embarrassment he felt in talking about emotions in addition to a difficulty describing or identifying how he felt (Dorjee 26 April). Similarly, Sonam noted that communicating emotions “is a difficult thing [for Tibetans] –if you are not used to talking about emotions then how can you just go and talk about it?” She described that this was a problem for Tibetans and that it also relates to why they generally “tend to keep it inside” (Sonam 20 April).

This tendency of Tibetans to internalize their feelings and problems and subsequently deal with them on their own may complicate efforts to expand a mental health program based on the notion that the community will willingly seek out someone with whom they can openly express and share their feelings. This creates an obvious disparity between the willingness of the community to share and express their distress and the required willingness necessary to establish a beneficial and well-utilized mental health service.

## **MAKING MENTAL HEALTH A PRIORITY**

Generally, it appears that mental health issues are not perceived as a priority within the Tibetan exile community. Furthermore, because there is no current, quantifiable data to show how prevalent mental health issues, the general community perception rules as the accepted barometer of the prevalence of such issues. The problem is of course that such a perception is counter to developing an extensive mental health program; if there is not an internal motivating factor contributing to the development of the program then it is quite unlikely that such a program will ever be achieved or sustained. The Trans-cultural Psychosocial Organization concluded in their report summary:

Although most interviewees did feel mental health was a concern, there was disagreement as to how big a problem it was, how best to treat it, and what priority should be given to it compared with other health issues. Many of those who were remote from the work of the project (the officials) felt that mental health problems were not a major concern.

Additionally, they concluded that the continuing debate about the priority of mental health issues and the future of the program suggests that there is an importance of developing a sense of need and priority among “all local stakeholders [...] from the outset of such projects” (Mercer 2004).

This seems to hint that the program leaders felt there was not enough priority placed on mental health from the government officials as well as the community to keep the program self-sustainable. The situation at present appears to be quite similar. Sonam Dekyi was unable to give me a precise idea about where mental health issues stood under the Department of Health's list of priorities but did concede that mental health issues were not "seen as a pressing need" and as such they were not given the "topmost priority" (Sonam 1 May). Thus, as in the past, it becomes necessary to show a need and explain why there exists the perception that mental health problems are not a major issue or concern.

Changing the common perception and making mental health issues a priority presented a major obstacle for TPO when it first began its study of Dharamsala. In fact, the report noted, "the higher level said that they have no problem. So we said 'OK, if you think you have no problem why not just [let us] prove it? Let's do an epidemiological survey.'" They did so and found results illustrating that PTSD and anxiety were much more prevalent than in average populations.<sup>19</sup> However, according to their accounts, there was a reluctance to accept these findings, prompting one researcher to claim, "No, this [the results] was never accepted. I mean, I can say it wasn't ever accepted. The Director of Health and Information at that time said that we should start a clinic but only because they had just started a human rights division" (Mercer 2004). Despite showing that there was a need for a mental health program, the report notes that the results were not accepted and the program was never given priority.

If developing a sustainable and extensive mental health program requires there to be a perception that it is in fact needed, then it becomes necessary to understand why mental health

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<sup>19</sup> The original TPO report could not be located by the Department of Health. The report that I was able to find represents only a summary of the program and its findings published five years after the program's conclusion. It is for this reason that there is no precise or quantifiable data but only the remark that these problems were, in fact, relatively common.

issues are *not* perceived to be prevalent or a major concern. Such an understanding will subsequently allow programs to focus on how to make these issues a priority. There are a number of reasons for this perception that mental health issues are not prevalent and thus do not deserve to be a high priority. These reasons, interestingly enough, seem to be independent of the actual need.

Many of the community members I spoke with noted that they did not think that psychological or emotional problems were common. The explanation I often heard was that Tibetans are generally “jolly and relaxed because of our religion” or that “Tibetans institute religious principles” and that as such they did not suffer from these depressive and anxiety disorders (Palkyi 30 April, Dorjee 26 April). It was a general consensus that because “Buddhism is all about calming the mind” or “purifying and taming the mind,” depression and anxiety were not common among Tibetan Buddhists (Sonam 13 April, Dr. Dorjee 19 April). But this turned out to be much more of an assumption than anything else. When I asked why they generally did not think these problems were common they commented that they did not see them often so they must not be common. However, as I have illustrated, Tibetans are generally inexpressive and tend to hide their distress such that it is no surprise that these problems are not perceived to be common. It could be that psychological and emotional disturbances are in fact much more prevalent than they appear on to be on the surface. This would, of course, mean that there are a number of Tibetans suffering from these problems that are hiding it and consequently suppressing the perceived prevalence within the community. This possibility sparked me to question community members as to whether they agreed that this could be the cause of this general perception that mental health issues are uncommon. Interestingly, most people I interviewed agreed that this was a likely possibility. One woman remarked that yes, it is “very

possible that this issue may be bigger than it appears on the surface” (Palkyi 30 April). Sonam Dekyi also agreed that this could be why depression and anxiety do not seem to be major problems facing the community (Sonam 12 April).

After gaining an understanding as to why the community feels that mental health issues are not common and subsequently do not deserve to be a high priority, it becomes important to show the mental health needs of the community. On Reiko Makiuchi’s request I performed an informal mental health needs assessment by visiting a number of non-governmental organizations, schools, institutions and government agencies and interviewing community members as to what they believed the community’s needs involved. From what I could gather, the community members in most distress and in need of mental health services are generally the new arrivals, more precisely students of TTS. This fit with Sonam’s assessment that they are the demographic that suffers from emotional and psychological trauma. She explained that they carry much more pressure and stress than the rest of the community; these individuals have escaped Tibet, put themselves in physical danger, left their family and loved ones behind in order to come to India where they must adjust to a new culture, start studying again and find a job. (Sonam 25 April). I was able to speak with an English teacher at TTS who said that depression and anxiety were “major problems at TTS because students are having a difficult time adjusting. They are homesick, missing their family. And they have difficult time starting to study again, lots of stress and anxiety related to school.” He added that one female student committed suicide last year. For this reason he believed that the problem is very serious and that “it will only get worse in the future” because there is “no single place where students go to receive counseling.” He commented that the problem is heightened because students come separately and have a “difficult time finding people they can trust enough to talk to or share their feelings with.”

Currently there is no counselor available at TTS to tend to the mental health needs of the students and as such they must be driven up to Delek Hospital's McLeod clinic on Tuesdays, to receive counseling from Sonam.<sup>20</sup> It is for this reason that the TTS teacher believed, "TTS as whole would greatly benefit from improved counseling services" (Tashi 27 April).

When I spoke with the Director of the Reception Center he noted that he did not see very many cases of emotional disturbances among the new arrivals and therefore did not see any need for counseling at the Reception Center. In fact, he informed me that most of the new arrivals were very excited to be in India and to be in the audience of His Holiness. (Dorjee 23 April). At first I found this quite interesting because, as it was, new arrivals made up most of Sonam's clientele and it was becoming obvious that new arrivals and students at TTS were the demographic most severely plagued by mental health issues. However, Reiko informed me that this pattern experienced by new arrivals consisting of an initial honeymoon period followed by a crisis stage consisting of emotional lows is consistent with the "w-curve" hypothesis. The w-curve hypothesis aims to model the cross-cultural adjustment stages of individuals immigrating to a new culture (Makiuchi 27 April). In this model there are two dips, the first is a culture shock that occurs after the immediate positive/honeymoon stage and the second represents a more difficult depressed stage marked by cultural "value conflict." After this second dip in emotions, there is a general rise in optimism when individuals begin to integrate with the culture anywhere from 2-5 years after first arriving (Gullahorn 1963). Reiko and I both agreed that, although there may not be an immediate need for counseling at the Reception Center, it would be a great place to create awareness about mental health issues because they are the demographic that is likely to fall under this w-curve model.

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<sup>20</sup> It should be noted that TTS is located in lower Dharamsala about a half hour drive (or a Rs. 300 cab ride) from the McLeod clinic located in Upper Dharamsala.

There are a number of additional general community needs concerning mental health issues that do not necessarily involve new arrivals. For instance, I spoke with a woman from the Tibetan Women's Association who mentioned that family and marriage problems including domestic abuse were not uncommon in the community and that there may be a need for counseling aimed at these problems (Palkyi 30 April). Alcohol and substance abuse also were seen as major issues facing the community. Although these problems are not strictly mental health problems they are intimately related and ultimately a factor that contributes to mental health problems. Reiko shared that she believes that alcohol might be a problem because Tibetans feel displaced and are "drinking away their sorrows" (Makiuchi 18 April). Currently, there are two programs aimed at treating these kinds of problems: Alcoholics Anonymous and Kunphen Center for Substance Dependence / HIV/AIDS. Despite these two programs there is a general consensus that more could be done to alleviate these problems and decrease their frequency.

Unfortunately, there has not been an epidemiological study performed on the subject of mental health since the small one done by volunteers from TPO over a decade ago. Without this quantifiable data it is difficult to illustrate that mental health issues such as depression, anxiety and PTSD are commonly experienced and therefore represent a major problem in the community. As such, until one of these studies is performed, it may not be possible to convince the community that mental health should be a priority and that there is a need for a more extensive mental health program. However, as was discovered by volunteers from TPO, there must develop a sense, within the community, that mental health issues are a priority before a sustainable and extensive program can be successfully established.

# CONCLUSION

The purpose of this study has been to explore the mental health services available to the Tibetan exile community in Dharamsala, India in addition to examining the obstacles that a Western-model counseling program may face as it attempts to develop and expand. I argue that a precise and thorough understanding of the alternate treatments and these obstacles is necessary before an extensive, beneficial and sustainable mental health program can be established in the community. Proceeding without such an understanding may lead the program to fall victim to the same or similar failures that lead to the fragmentation and dissolution of the previous counseling program. A number of these shortcomings and failures of the previous program, as established by TPO and Danida, are self-consciously included in a report summary from the TPO project. This report alluded to the project directors' doubts that the program would last and ultimately be successful due to their inability to convince the community and officials that mental health issues are a major concern and should be a priority. Additionally, the report noted the need for increased mental health education and awareness in the community (Mercer 2004). Now, five years after the program's conclusion this need still has not been satisfied. As such it exists not only as a major obstacle but also, and primarily, as a solution.

Creating awareness and educating the public is virtually unanimously agreed to be the community's primary mental health need. Both Sonam Dekyi and Reiko Makiuchi agreed that the number one need involved creating awareness within the community. Tsering Lhamo was especially adamant about this issue, she stressed, "these kinds of issues are not in our culture and that is why we must educate the public, especially the lay people." She cited that "somebody that comes into [her] clinic thinks depression means psychotic," adding that this is why "education and awareness is the number one, most important, need" (Tsering 24 April). It is true, there are a

number of misconceptions that have been discussed which can and will only be dispelled through some type of mental health education and awareness campaign. However, educating the public with the obstacles previously discussed in mind would not only begin to dispel these common misconceptions within the community (including that “depression means psychotic,” that psychological disorders are incurable and that counseling is not confidential) but will act to reduce the stigma and increase the likelihood that the public would utilize the services. To this end, Sonam noted there are “a lot of people that need help that do not know about mental health” but that if they are educated and made “aware of the problems then they will come to you and the problem will begin to reduce” (Sonam 13 April). Simply familiarizing the general public with the concepts of counseling and psychological disorders may be enough to reduce the social stigma attached to these concepts in addition to generating the sense that there are available options and treatments for those who need them. Currently, the public at large is virtually unaware that there is a counselor in Dharamsala and furthermore those that do know are usually mistaken as to where counseling is available. In fact, there were a handful of people that believed that TTS and TCV had a counselor, when in fact they do not. Others thought that Gu Chu Sum and the Reception Center had counseling services, which they do not. But the majority of the people I spoke with had no idea that there was a counselor at the Department of Health that was available to anyone who needed her services. If nothing else, generating an awareness that counseling services exist and are available would dramatically increase the likelihood that people would find the help they needed which would in turn increase the internal demand for a well-established mental health program. Ultimately, the first step to establishing a mental health program begins and ends with a community wide mental health awareness and education campaign. I spoke with nearly a dozen NGO’s and government agencies and all agreed that if

they were kept informed about the mental health services they would not only advocate their use but would even help to create awareness by passing out pamphlets or flyers. However, Dr. Tsetan Dorjee expressed his worry that Delek Hospital did not have the resources or facilities at present, to accommodate the public's need if awareness grew too rapidly (Dr. Tsetan 13 April). When I shared this worry with Tsering Lhamo she responded forcefully that "the more education there is, the more people will come find counseling. If it is not available here then they can go to Indian psychiatrists." Tsering expressed that she hopes Dharamsala will expand its mental health program in the future but noted that right now there is a desperate need for education –believing that education will ultimately lead people to seek the help they require which will in turn naturally lead to the establishment of a more extensive mental health program (Tsering 24 April).

## **APPENDIX A: RESEARCH METHODS**

This study was extremely interview intensive and as such most of the information presented in the following was attained through long conversations with some 20 community members including counselors, doctors, government employees, students and the general public. This includes my three key informants whom I met with three to four times each over a four-week period. Sonam Dicki, currently the only Tibetan mental health counselor in Dharamsala, acted as my primary informant for gaining insight into the community experience of psychological disturbances from a Western psychological perspective. Reiko Makiuchi, a volunteer psychologist at the Tibetan Delek Hospital, was my main informant concerning cross-cultural counseling; she provided me with much useful information regarding how the local community conceives and experiences mental health issues differently than communities in the West. Finally, Dr. Tsering Dorjee, a traditional Tibetan Medicine doctor, provided much information regarding the Tibetan medicine treatment and perspective of mental health. My interviews with community members were usually guided by a list of questions but did not strictly adhere to this list. The rest of the research was performed through a literature review of relevant materials from medicine, psychology and anthropology journals.

## **APPENDIX B: BIOGRAPHIES** OF KEY INFORMANTS

### Sonam Dekyi Contact:

Born and raised in India, Sonam was educated through class 12 at Tibetan Children's Village Schools in Ladakh and Upper Dharamsala. After graduating 12<sup>th</sup> standard in 1999, Sonam attended Madras Christian College in Chennai, South India where she graduated three years later with a Bachelors in Philosophy. She attained Masters in Clinical Psychology at Jamia Millia Islamia University in New Delhi in 2004 and a year later completed a postgraduate study in counseling psychology at the same university. She joined the Department of Health in 2005 as a mental health counselor and was put in charge of health education. Presently, she performs counseling at Delek Hospital's McLeod clinic every Tuesday. In August she will leave to get a second masters at Buffalo University.

### Reiko Makiuchi

Ms. Makiuchi was raised in Japan before moving to New York City in 1998 where she joined the Columbia School of Social Work. She currently holds a Masters in Social Work (MSW) and is a liscensed Clinical Social Worker in New York state. In addition to holding a private practice in New York City for 11 years she was a guest lecturer at Teachers College from 1996-2000 on Theories and Practices of Cross-cultural Counseling. She is also a trainer and consultant in global business and cross-cultural management. She moved to India in November of 2006 and has been volunteering at Delek Hospital since February. She is currently planning to stay in Dharamsala forever.

### Dr. Tsering Dorjee Dekhang

Dr. Dorjee Tsering Dekhang was born in Tibet in 1969 but was raised in India after he and his family escaped to exile in 1974. He was educated at TCV in Dharamsala, India until 12<sup>th</sup> standard. In 1992 he was awarded the Kachupa Degree in Tibetan Medicine. In 1995 he began working in the research wing of the Men-Tsee Khang. Dr. Dorjee was awarded the Menrampa Chungwa Degree (MD) in 2004. He is currently a practicing Traditional Tibetan Medicine Doctor and has given a number of speeches on Tibetan Medicine to Western audiences.

# **APPENDIX C: PHOTOS**

# APPENDIX D: DIAGNOSTIC CRITERIA

## MAJOR DEPRESSION

DSM-IV Diagnostic Criteria for Major Depressive Disorder (*DSM-IV [Online]*)

- A. At least one of the following three abnormal moods which significantly interfered with the person's life:
  1. Abnormal depressed mood most of the day, nearly every day, for at least 2 weeks.
  2. Abnormal loss of all interest and pleasure most of the day, nearly every day, for at least 2 weeks.
  3. If 18 or younger, abnormal irritable mood most of the day, nearly every day, for at least 2 weeks.
- B. At least five of the following symptoms have been present during the same 2 week depressed period.
  1. Abnormal depressed mood (or irritable mood if a child or adolescent) [as defined in criterion A].
  2. Abnormal loss of all interest and pleasure [as defined in criterion A2].
  3. Appetite or weight disturbance, either:
    - Abnormal weight loss (when not dieting) or decrease in appetite.
    - Abnormal weight gain or increase in appetite.
  4. Sleep disturbance, either abnormal insomnia or abnormal hypersomnia.
  5. Activity disturbance, either abnormal agitation or abnormal slowing (observable by others).
  6. Abnormal fatigue or loss of energy.
  7. Abnormal self-reproach or inappropriate guilt.
  8. Abnormal poor concentration or indecisiveness.
  9. Abnormal morbid thoughts of death (not just fear of dying) or suicide.
- C. The symptoms are *not* due to a mood-incongruent psychosis.
- D. There has *never* been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.
- E. The symptoms are *not* due to physical illness, alcohol, medication, or street drugs.
- F. The symptoms are *not* due to normal bereavement.

### Essential Features

By definition, Major Depressive Disorder cannot be due to:

- Physical illness, alcohol, medication, or street drug use.
- Normal bereavement.
- Bipolar Disorder
- Mood-incongruent psychosis (e.g., Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified).

Major Depressive Disorder causes the following mood symptoms:

- **Abnormal depressed mood:**
  - Sadness is usually a normal reaction to loss. However, in Major Depressive Disorder, sadness is abnormal because it:
    - Persists continuously for at least 2 weeks.
    - Causes marked functional impairment.
    - Causes disabling physical symptoms (e.g., disturbances in sleep, appetite, weight, energy, and psychomotor activity).
    - Causes disabling psychological symptoms (e.g., apathy, morbid preoccupation with worthlessness, suicidal ideation, or psychotic symptoms).

- The sadness in this disorder is often described as a depressed, hopeless, discouraged, "down in the dumps," "blah," or empty. This sadness may be denied at first. Many complain of bodily aches and pains, rather than admitting to their true feelings of sadness.
- **Abnormal loss of interest and pleasure mood:**
  - The loss of interest and pleasure in this disorder is a reduced capacity to experience pleasure which in its most extreme form is called anhedonia.
  - The resulting lack of motivation can be quite crippling.
- **Abnormal irritable mood:**
  - This disorder may present primarily with irritable, rather than depressed or apathetic mood. This is not officially recognized yet for adults, but it is recognized for children and adolescents.
  - Unfortunately, irritable depressed individuals often alienate their loved ones with their cranky mood and constant criticisms.

Major Depressive Disorder causes the following physical symptoms:

- **Abnormal appetite:**
  - Most depressed patients experience loss of appetite and weight loss. The opposite, excessive eating and weight gain, occurs in a minority of depressed patients. Changes in weight can be significant.
- **Abnormal sleep:**
  - Most depressed patients experience difficulty falling asleep, frequent awakenings during the night or very early morning awakening. The opposite, excessive sleeping, occurs in a minority of depressed patients.
- **Fatigue or loss of energy:**
  - Profound fatigue and lack of energy usually is very prominent and disabling.
- **Agitation or slowing:**
  - Psychomotor retardation (an actual physical slowing of speech, movement and thinking) or psychomotor agitation (observable pacing and physical restlessness) often are present in severe Major Depressive Disorder.

Major Depressive Disorder causes the following cognitive symptoms:

- **Abnormal self-reproach or inappropriate guilt:**
  - This disorder usually causes a marked lowering of self-esteem and self-confidence with increased thoughts of pessimism, hopelessness, and helplessness. In the extreme, the person may feel excessively and unreasonably guilty.
  - The "negative thinking" caused by depression can become extremely dangerous as it can eventually lead to extremely self-defeating or suicidal behavior.
- **Abnormal poor concentration or indecisiveness:**
  - Poor concentration is often an early symptom of this disorder. The depressed person quickly becomes mentally fatigued when asked to read, study, or solve complicated problems.
  - Marked forgetfulness often accompanies this disorder. As it worsens, this memory loss can be easily mistaken for early senility (dementia).
- **Abnormal morbid thoughts of death (not just fear of dying) or suicide:**
  - The symptom most highly correlated with suicidal behavior in depression is hopelessness.

## Evaluation

1. **History:** If depressive symptoms are present, determine:
  - Time course and severity.
  - Any prior episodes and level of recovery.
  - Any history of manic or hypomanic episodes.
  - If other major psychiatric disorders are present. Any suicidal ideation, plan, or intent.

May use Beck Inventory, or Geriatric Depression Scale to screen for high-risk patients.

2. **Examination:** Evaluate for possible related medical conditions: anemia, hypothyroidism, chronic infection, substance abuse, or medication side effects (oral contraceptives, antihypertensives, etc.).
3. **Lab tests:** Screen for medical causes of depression (if suspected by history or physical examination). Lab tests may include complete blood count with differential, electrolytes, renal and liver functions, thyroid studies, etc.

## Treatment

1. **Hospitalization:** Indicated if serious suicidal ideation is present (with a plan and access to the means), patient is dangerous to self or others, there is a complicating medical condition, or there is a lack of support system at home.
2. **Medication:** Most antidepressants believed to be equally effective in equivalent therapeutic doses. Expect a 2- to 6- week latent period before the full effect is seen at therapeutic doses. To prevent relapse, continue medication for at least 4 to 9 months after patient becomes asymptomatic. For recurrent depression, consider chronic prophylactic therapy.
  - a. **Tricyclic Antidepressants (TCAs):** A rational method for selecting a TCA is to narrow the choice to a dimethylated TCA (such as imipramine) and a monomethylated TCA (such as nortriptyline). Choose between them based on patient's sedation requirements and ability to tolerate orthostatic hypotension, weight gain, and anticholinergic adverse effects. TCAs are usually given QHS to take advantage of sedating effects. All TCAs may cause slowing of cardiac conduction. May be fatal in overdoses around 2000 mg or more in adults. A therapeutic trial usually is considered >100 mg/day of amitriptyline or its equivalent for at least 3 weeks. Note: Nortriptyline (Pamelor) has a "therapeutic window" plasma level of 50 to 150 ng/ml for optimal efficacy. It has the lowest risk for orthostatic hypotension of all TCAs making it a safe choice in the geriatric patients.
  - b. **Second-generation Antidepressants:**
    - **Selective Serotonin Reuptake Inhibitors (SSRIs):** Much safer in overdose than TCAs. Expensive in contrast to generic TCAs. Initial dose often an effective dose. May need to start at lower doses in the elderly or others sensitive to side effects. Side effects vary and may include nausea, anorexia, insomnia or mild sedation, sweating, headache, tremor, sexual dysfunction, and nervousness. Fluoxetine (Prozac) may have a slower onset of action than other SSRIs. Safety in patients with cardiovascular disease not well studied. Fluvoxamine (Luvox) is contraindicated with astemizole and terfenadine. All SSRIs

contraindicated with MAOIs. If switching from a SSRI to a MAOI, need a drug-free period of 14 days for paroxetine (Paxil), sertraline (Zoloft) or fluvoxamine (Luvox) or 5 weeks for fluoxetine (Prozac).

- **Bupropion (Wellbutrin):** Safer in overdose than TCAs. Safer choice in patients with history of cardiac disease. Very low incidence of sexual dysfunction compared to SSRIs, TCAs, and MAOIs. T1D schedule and 150 mg maximum single dose to minimize the risk of seizures (0.4%). Contraindicated in patients with seizure disorder, bulimia, or anorexia nervosa.
  - **Venlafaxine (Effexor):** Monitor for blood pressure elevation.
  - **Trazodone (Desyrel):** Patients with cardiac disease should be closely monitored. Used as monotherapy or adjunct to certain antidepressants for sedation at bedtime. Risk of priapism 1:6000.
  - **Nefazodone (Serzone):** A newer treatment option for patients experiencing either poor response or intolerable side effects from other antidepressants. Contraindicated with astemizole and terfenadine.
  - **Mirtazapine (Remeron):** A newer option for patients with a poor response or an inability to tolerate other antidepressants.
- c. **Monoamine Oxidase Inhibitors (MAOIs):** Sometimes used in depression refractory to the other treatments. Consider consulting psychiatrist before starting because of the serious adverse effect potential.
3. **Psychotherapy:** Supportive therapy is always part of depression treatment. Other types of psychotherapy may be helpful in mild to moderate depression, alone or with medication.
4. **Electroconvulsive Therapy:** Highly controversial treatment and the jury is still out. No explanation or theory for its sometimes surprising efficacy has yet been produced. However, ECT is sometimes the most effective, rapid method of treating severe major depressive disorder (MDD). Indicated for patients with poor response to medications, poor tolerance of usual antidepressants, severe vegetative symptoms, or psychotic features. The decision to administer ECT should be made by a psychiatrist.

### Associated Features and Comorbidity

- **Anxiety:**
  - 80 to 90% of individuals with Major Depressive Disorder also have anxiety symptoms (e.g., anxiety, obsessive preoccupations, panic attacks, phobias, and excessive health concerns).
  - Separation anxiety may be prominent in children.
  - About one third of individuals with Major Depressive Disorder also have a full-blown anxiety disorder (usually either Panic Disorder, Obsessive-Compulsive Disorder, or Social Phobia).
  - Anxiety in a person with major depression leads to a poorer response to treatment, poorer social and work function, greater likelihood of chronicity and an increased risk of suicidal behavior.
- **Eating Disorders:**
  - Individuals with Anorexia Nervosa and Bulimia Nervosa often develop Major Depressive Disorder.
- **Psychosis:**

- Mood congruent delusions or hallucinations may accompany severe Major Depressive Disorder.
- **Substance Abuse:**
  - The combination of Major Depressive Disorder and substance abuse is common (especially Alcohol and Cocaine).
  - Alcohol or street drugs are often mistakenly used as a remedy for depression. However, this abuse of alcohol or street drugs actually worsens Major Depressive Disorder.
  - Depression may also be a consequence of drug or alcohol withdrawal and is commonly seen after cocaine and amphetamine use.
- **Medical Illness:**
  - 25% of individuals with severe, chronic medical illness (e.g., diabetes, myocardial infarction, carcinomas, stroke) develop depression.
  - About 5% of individuals initially diagnosed as having Major Depressive Disorder subsequently are found to have another medical illness which was the cause of their depression.
  - Medical conditions often causing depression are:
    - Endocrine disorders: hypothyroidism, hyperparathyroidism, Cushing's disease, and diabetes mellitus.
    - Neurological disorders: multiple sclerosis, Parkinson's disease, migraine, various forms of epilepsy, encephalitis, brain tumors.
    - Medications: many medications can cause depression, especially antihypertensive agents such as calcium channel blockers, beta blockers, analgesics and some anti-migraine medications.

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**Mortality:** Up to 15% of patients with severe Major Depressive Disorder die by suicide. Over age 55, there is a fourfold increase in death rate.

**Premorbid History:** 10-25% of patients with Major Depressive Disorder have preexisting Dysthymic Disorder. These "double depressions" (i.e., Dysthymia + Major Depressive Disorder) have a poorer prognosis.

**Gender:** Males and females are equally affected by Major Depressive Disorder prior to puberty. After puberty, this disorder is twice as common in females as in males. The highest rates for this disorder are in the 25- to 44-year-old age group.

**Prevalence:** The lifetime risk for Major Depressive Disorder is 10% to 25% for women and from 5% to 12% for men. At any point in time, 5% to 9% of women and 2% to 3% of men suffer from this disorder. Prevalence is unrelated to ethnicity, education, income, or marital status.

**Onset:** Average age at onset is 25, but this disorder may begin at any age.

**Psychological stress:** Stress appears to play a prominent role in triggering the first 1-2 episodes of this disorder, but not in subsequent episodes.

**Duration:** An average episode lasts about 9 months.

**Duration:**

**Course:** Course is variable. Some people have isolated episodes that are separated by many years, whereas others have clusters of episodes, and still others have increasingly frequent episodes as they grow older.

About 20% of individuals with this disorder have a chronic course.

**Recurrence:** The risk of recurrence is about 70% at 5 year follow up and at least 80% at 8 year follow-up.

After the first episode of Major Depressive Disorder, there is a 50%-60% chance of having a second episode, and a 5-10% chance of having a Manic Episode (i.e., developing Bipolar I Disorder). After the second episode, there is a 70% chance of having a third. After the third episode, there a 90% chance of having a fourth.

The greater number of previous episodes is an important risk factor for recurrence.

**Recovery:** For patients with severe Major Depressive Disorder, 76% on antidepressant therapy recover, whereas only 18% on placebo recover. For these severely depressed patients, significantly more recover on antidepressant therapy than on interpersonal psychotherapy. For these same patients, cognitive therapy has been shown to be no more effective than placebo.

New research shows that a medication/psychotherapy combination - preferably Cognitive Behavior Therapy - seems to be most effective.

**Poor Outcome:** Poor outcome or chronicity in Major Depressive Disorder is associated with the following:

- Inadequate treatment
- Severe initial symptoms
- Early age of onset
- Greater number of previous episodes
- Only partial recovery after one year
- Having another severe mental disorder (i.e. Alcohol Dependency, Cocaine Dependency)
- Severe chronic medical illness
- Family dysfunction

**Familial Pattern And Genetics:** There is strong evidence that major depression is, in part, a genetic disorder:

- Individuals who have parents or siblings with Major Depressive Disorder have a 1.5-3 times higher risk of developing this disorder.

- The concordance for major depression in monozygotic twins is substantially higher than it is in dizygotic twins. However, the concordance in monozygotic twins is in the order of about 50%, suggesting that factors other than genetic factors are also involved.
- Children adopted away at birth from biological parents who have a depressive illness carry the same high risk as a child not adopted away, even if they are raised in a family where no depressive illness exists.
- Interestingly, families having Major Depressive Disorder have an increased risk of developing Alcoholism and AttentionDeficit/Hyperactivity Disorder.

## Differential Diagnosis

Some disorders display similar or sometimes even the same symptoms. The clinician, therefore, in his diagnostic attempt has to differentiate against the following disorders which he needs to rule out to establish a precise diagnosis.

1. Exclude depressions due to physical illness, medications, or street drug use:
  - If due to physical illness, diagnose: Mood Disorder Due to a General Medical Condition.
  - If due to alcohol, diagnose: Alcohol-Induced Mood Disorder.
  - If due to other substance use, diagnose: Other Substance-Induced Mood Disorder.

### **Organic Causes Of Severe Depression:**

**Illnesses:** Organic Mood Syndromes caused by: Acquired Immune Deficiency Syndrome (AIDS), Adrenal (Cushing's or Addison's Diseases), Cancer (especially pancreatic and other GI), Cardiopulmonary disease, Dementias (including Alzheimer's Disease); Epilepsy, Fahr's Syndrome, Huntington's Disease, Hydrocephalus, Hyperaldosteronism, Infections (including HIV and neurosyphilis), Migraines, Mononucleosis, Multiple Sclerosis, Narcolepsy, Neoplasms, Parathyroid Disorders (hyper- and hypo-), Parkinson's Disease, Pneumonia (viral and bacterial), Porphyria, Postpartum, Premenstrual Syndrome, Progressive Supranuclear Palsy, Rheumatoid Arthritis, Sjogren's Arteritis, Sleep Apnea, Stroke, Systemic Lupus Erythematosus, Temporal Arteritis, Trauma, Thyroid Disorders (hypothyroid and "apathetic" hyperthyroidism), Tuberculosis, Uremia (and other renal diseases), Vitamin Deficiencies (B12, C, folate, niacin, thiamine), Wilson's Disease.

**Drugs:** Acetazolamine, Amphetamine, Amantadine, Amphetamines, Ampicillin, Azathioprine (AZT), 6-Azauridine, Baclofen, Beta Blockers, Bethanidine, Bleomycin, Bromocriptine, C-Asparaginase, Carbamazepine, Choline, Cimetidine, Clonidine, Cycloserin, Cocaine, Corticosteroids (including ACTH), Cyproheptadine, Danazol, Digitalis, Diphenoxylate, Disulfiram, Ethionamide, Fenfluramine, Griseofulvin, Guanethidine, Hydralazine, Ibuprofen, Indomethacin, Lidocaine, Levodopa, Methoserpidine, Methysergide, Metronidazole, Nalidixic Acid, Neuroleptics (butyrophenones, phenothiazines, oxyindoles), Nitrofurantoin, Opiates, Oral Contraceptives, Phenacetin, Phenytoin, Prazosin, Prednisone, Procainamide, Procyclidine, Quinabenzacetate, Rescinnamine, Reserpine, Sedative/Hypnotics (barbiturates, benzodiazepines, chloral hydrate), Streptomycin, Sulfamethoxazole, Sulfonamides, Tetrabenazine, Tetracycline, Triamcinolone, Trimethoprim, Veratrum, Vincristine.

1. Exclude depressions having a previous history of elevated, expansive, or euphoric mood:
  - If previous history of a Manic Episode, diagnose: Bipolar I Disorder.

- o If previous history of recurrent Major Depressive Episodes and at least one Hypomanic Episode, diagnose: Bipolar II Disorder.
  - o If previous history of recurrent Hypomanic Episodes and brief, mild depressive episodes (milder than Major Depressive Episodes), diagnose: Cyclothymic Disorder.
2. Exclude depressions that merely represent normal bereavement, instead diagnose: **Uncomplicated Bereavement**.
  3. Exclude depressions associated with mood-incongruent psychosis:
    - o If previous history of at least 2 weeks of delusions or hallucinations occurring in the absence of prominent mood symptoms, diagnose either: Schizoaffective Disorder, Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

APPENDIX II

CHECK LIST OF SYMPTOMS OF DEPRESSIVE STATES

Item No.	Range of Scores	Symptom	Item No.	Range of Scores	Symptom
1	0-4	<i>Depressed Mood</i> Gloomy attitude, pessimism about the future Feeling of sadness Tendency to weep Sadness, etc ..... 1 Occasional weeping .. 2 Frequent weeping ..... 3 Extreme symptoms .... 4	10	0-4	<i>Anxiety, psychic</i> Tension and irritability Worrying about minor matters Apprehensive attitude Fears
2	0-4	<i>Guilt</i> Self-reproach, feels he has let people down Ideas of guilt Present illness is a punishment Delusions of guilt Hallucinations of guilt	11	0	<i>Anxiety, somatic</i> Gastrointestinal, wind, indigestion Cardiovascular, palpitations, headaches Respiratory, genito-urinary, etc.
3	0-4	<i>Suicide</i> Feels life is not worth living Wishes he were dead Suicidal ideas Attempts at suicide	12	0-2	<i>Somatic Symptoms, Gastrointestinal</i> Loss of appetite Heavy feelings in abdomen Constipation
4	0-2	<i>Insomnia, initial</i> Difficulty in falling asleep	13	0-2	<i>Somatic Symptoms, General</i> Heaviness in limbs, back, or head Diffuse backache Loss of energy and fatiguability
5	0-2	<i>Insomnia, middle</i> Patient restless and disturbed during the night Waking during the night	14	0-2	<i>Genital Symptoms</i> Loss of libido Menstrual disturbances
6	0-2	<i>Insomnia, delayed</i> Waking in early hours of the morning and unable to fall asleep again	15	0-4	<i>Hypochondriasis</i> Self-absorption (bodily) Preoccupation with health Querulous attitude Hypochondriacal delusions
7	0-4	<i>Work and Interests</i> Feelings of incapacity Listlessness, indecision and vacillation Loss of interest in hobbies Decreased social activities Productivity decreased Unable to work Stopped working because of present illness only ..... 4 (Absence from work after treatment or recovery may rate a lower score.)	16	0-2	<i>Loss of Weight</i>
8	0-4	<i>Retardation</i> Slowness of thought, speech, and activity Apathy Stupor Slight retardation at interview .. 1 Obvious retardation at interview 2 Interview difficult ..... 3 Complete stupor ..... 4	17	2-0	<i>Insight</i> Loss of insight ..... 2 Partial or doubtful loss ..... 1 No loss ..... 0 (Insight must be interpreted in terms of patient's understanding and background.)
9	0-2	<i>Agitation</i> Restlessness associated with anxiety	18	0-2	<i>Diurnal Variation</i> Symptoms worse in morning or evening. Note which it is.
			19	0-4	<i>Depersonalization and Derealization</i> Feelings of unreality } Specify Nihilistic ideas }
			20	0-4	<i>Paranoid Symptoms</i> Suspicious Ideas of reference } Not with a depressive quality Delusions of reference and persecution }
			21	0-2	<i>Obsessional Symptoms</i> Obsessive thoughts and compulsions against which the patient struggles

# GENERALIZED ANXIETY DISORDER

DSM-IV Criteria (DSM-IV [Online])

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) is a guide to the diagnosis of mental disorders in the United States. The following are a list of the criteria for Generalized Anxiety Disorder. Please note: although these criteria are designed to provide a guideline to diagnosis they *cannot* substitute a visit to a doctor or mental health practitioner. These guidelines are provided for information purposes only.

## DIAGNOSTIC CRITERIA FOR GENERALIZED ANXIETY DISORDER

### Diagnostic Criteria

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months).

**Note:** Only one item is required in children.

- 1. restlessness or feeling keyed up or on edge
  - 2. being easily fatigued
  - 3. difficulty concentrating or mind going blank
  - 4. irritability
  - 5. muscle tension
  - 6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
  - E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
  - F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder

## DIAGNOSTIC FEATURES

The essential feature of Generalized Anxiety Disorder is excessive anxiety and worry (apprehensive expectation), occurring more days than not for a period of at least 6 months, about a number of events or activities (Criterion A). The individual finds it difficult to control the worry (Criterion B). The anxiety and worry are accompanied by at least three additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, and disturbed sleep (only one additional symptom is required in children) (Criterion C). The focus of the anxiety and worry is not confined to features of another Axis I disorder such as having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder (Criterion D). Although individuals with Generalized Anxiety Disorder may not always identify the worries as "excessive," they report subjective distress due to constant worry, have difficulty controlling the worry, or experience related impairment in social, occupational, or other important areas of functioning (Criterion E). The disturbance is not due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure) or a general medical condition and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder (Criterion F).

The intensity, duration, or frequency of the anxiety and worry is far out of proportion to the actual likelihood or impact of the feared event. The person finds it difficult to keep worrisome thoughts from interfering with attention to tasks at hand and has difficulty stopping the worry. Adults with Generalized Anxiety Disorder often worry about everyday, routine life circumstances such as possible job responsibilities, finances, the health of family members, misfortune to their children, or minor matters (such as household chores, car repairs, or being late for appointments). Children with Generalized Anxiety Disorder tend to worry excessively about their competence or the quality of their performance. During the course of the disorder, the focus of worry may shift from one concern to another.

## PREVALENCE

In a community sample, the 1-year prevalence rate for Generalized Anxiety Disorder was approximately 3% and the lifetime prevalence rate was 5%. In anxiety disorder clinics, approximately 12% of the individuals present with Generalized Anxiety Disorder.

## COURSE

Many individuals with Generalized Anxiety Disorder report that they have felt anxious and nervous all of their lives. Although over half of those presenting for treatment report onset in childhood or adolescence, onset occurring after age 20 years is not uncommon. The course is chronic but fluctuating and often worsens during times of stress.

# POSTTRAUMATIC STRESS DISORDER

DSM-IV Criteria (DSM-IV [Online])

A. The person has been exposed to a traumatic event in which both of the following have been present:

(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

(1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

(2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.

(3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.

(4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

(5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

(1) efforts to avoid thoughts, feelings, or conversations associated with the trauma

(2) efforts to avoid activities, places, or people that arouse recollections of the trauma

(3) inability to recall an important aspect of the trauma

(4) markedly diminished interest or participation in significant activities

(5) feeling of detachment or estrangement from others

(6) restricted range of affect (e.g., unable to have loving feelings)

(7) sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) difficulty falling or staying asleep
- (2) irritability or outbursts of anger
- (3) difficulty concentrating
- (4) hypervigilance
- (5) exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

*Specify if:*

**Acute:** if duration of symptoms is less than 3 months

**Chronic:** if duration of symptoms is 3 months or more

*Specify if:*

**With Delayed Onset:** if onset of symptoms is at least 6 months after the stressor

### ***Diagnostic Features***

The essential feature of Posttraumatic Stress Disorder is the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (Criterion A1). The person's response to the event must involve intense fear, helplessness, or horror (or in children, the response must involve disorganized or agitated behavior) (Criterion A2). The characteristic symptoms resulting from the exposure to the extreme trauma include persistent reexperiencing of the traumatic event (Criterion B), persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (Criterion C), and persistent symptoms of increased arousal (Criterion D). The full symptom picture must be present for more than 1 month (Criterion E), and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (Criterion F).

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disasters, severe automobile accidents, or being diagnosed with a life-threatening illness. For children, sexually traumatic events may include developmentally inappropriate sexual experiences without threatened or actual violence or injury. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or a close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease. The disorder may be especially severe or long lasting when the stressor is of human design (e.g., torture, rape). The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increase.

The traumatic event can be reexperienced in various ways. Commonly the person has recurrent and intrusive recollections of the event (Criterion B1) or recurrent distressing dreams during which the event is replayed

(Criterion B2). In rare instances, the person experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relived and the person behaves as though experiencing the event at that moment (Criterion B3). Intense psychological distress (Criterion B4) or physiological reactivity (Criterion B5) often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g. anniversaries of the traumatic event; cold, snowy weather or uniformed guards for survivors of death camps in cold climates; hot, humid weather for combat veterans of the South Pacific; entering an elevator for a woman who was raped in an elevator).

Stimuli associated with the trauma are persistently avoided. The person commonly makes deliberate efforts to avoid thoughts, feelings, or conversations about the traumatic event (Criterion C1) and to avoid activities, situation, or people who arouse recollections of it (Criterion C2). This avoidance of reminders may include amnesia for an important aspect of the traumatic event (Criterion C3). Diminished responsiveness to the external world, referred to as "psychic numbing" or "emotional anesthesia," usually begins soon after the traumatic event. The individual may complain of having markedly diminished interest or participation in previously enjoyed activities (Criterion C4), of feeling detached or estranged from other people (Criterion C5), or of having markedly reduced ability to feel emotions (especially those associated with intimacy, tenderness, and sexuality) (Criterion C6). The individual may have a sense of a foreshortened future (e.g., not expecting to have a career, marriage, children, or a normal life span) (Criterion C7).

The individual has persistent symptoms of anxiety or increased arousal that were not present before the trauma. These symptoms may include difficulty falling or staying asleep that may be due to recurrent nightmares during which the traumatic event is relived (Criterion D1), hypervigilance (Criterion D4), and exaggerated startle response (Criterion D5). Some individuals report irritability or outbursts of anger (Criterion D2) or difficulty concentrating or completing tasks (Criterion D3).

### *Specifiers*

The following specifiers may be used to specify onset and duration of the symptoms of Posttraumatic Stress Disorder:

**Acute.** This specifier should be used when the duration of symptoms is less than 3 months.

**Chronic.** This specifier should be used when the symptoms last 3 months or longer.

**With Delayed Onset.** This specifier indicates that at least 6 months have passed between the traumatic event and the onset of the symptoms.

### *Associated Features and Disorders*

**Associated descriptive features and mental disorders.** Individuals with Posttraumatic Stress Disorder may describe painful guilt feelings about surviving when others did not survive or about the things they had to do to survive. Phobic avoidance of situations or activities that resemble or symbolize the original trauma may interfere with interpersonal relationships and lead to marital conflict, divorce, or loss of job. The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs, hostility; social withdrawal; feeling constantly threatened; impaired relationships with others; or a change from the individual's previous personality characteristics.

There may be increased risk of Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Social Phobia, Specific Phobia, Major Depressive Disorder, Somatization Disorder, and Substance-Related Disorders. It is not known to what extent these disorders precede or follow the onset of Posttraumatic Stress Disorder.

**Associated laboratory findings.** Increased arousal may be measured through studies of autonomic functioning (e.g., heart rate, electromyography, sweat gland activity).

**Associated physical examination findings and general medical conditions.** General medical conditions may occur as a consequence of the trauma (e.g., head injury, burns).

### *Specific Culture and Age Features*

Individuals who have recently emigrated from areas of considerable social unrest and civil conflict may have elevated rates of Posttraumatic Stress Disorder. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigrant status. Specific assessments of traumatic experiences and concomitant symptoms are needed for such individuals.

In younger children, distressing dreams of the event may, within several weeks, change into generalized nightmares of monsters, of rescuing others, or of threats to self or others. Young children usually do not have the sense that they are reliving the past; rather, the reliving of the trauma may occur through repetitive play (e.g., a child who was involved in a serious automobile accident repeatedly reenacts car crashes with toy cars). Because it may be difficult for children to report diminished interest in significant activities and constriction of affect, these symptoms should be carefully evaluated with reports from parents, teachers, and other observers. In children, the sense of a foreshortened future may be evidenced by the belief that life will be too short to include becoming an adult. There may also be "omen formation" - that is, belief in an ability to foresee future untoward events. Children may also exhibit various physical symptoms such as stomachaches and headaches.

### *Prevalence*

Community-based studies reveal a lifetime prevalence for Posttraumatic Stress Disorder ranging from 1% to 14%, with the variability related to methods of ascertainment and the population sampled. Studies of at-risk individuals (e.g., combat veterans, victims of volcanic eruptions or criminal violence) have yielded prevalence rates ranging from 3% to 58%.

### *Course*

Posttraumatic Stress Disorder can occur at any age, including childhood. Symptoms usually begin within the first 3 months after the trauma, although there may be a delay of months, or even years, before symptoms appear. Frequently, the disturbance initially meets criteria for Acute Stress Disorder (see p. 429) in the immediate aftermath of the trauma. The symptoms of the disorder and the relative predominance of reexperiencing, avoidance, and hyperarousal symptoms may vary over time. Duration of the symptoms varies, with complete recovery occurring within 3 months in approximately half of cases, with many others having persisting symptoms for longer than 12 months after the trauma.

The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors affecting the likelihood of developing this disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental disorders may influence the development of Posttraumatic Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

### *Differential Diagnosis*

In Posttraumatic Stress Disorder, the stressor must be of an extreme (i.e., life-threatening) nature. In contrast, in **Adjustment Disorder**, the stressor can be of any severity. The diagnosis of Adjustment Disorder is appropriate both for situations in which the response to an extreme stressor does not meet the criteria for Posttraumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Posttraumatic Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).

Not all psychopathology that occurs in individuals exposed to an extreme stressor should necessarily be attributed to Posttraumatic Stress Disorder. **Symptoms of avoidance, numbing, and increased arousal that are present before**

**exposure to the stressor** do not meet criteria for the diagnosis of Posttraumatic Stress Disorder and require consideration of other diagnoses (e.g., Brief Psychotic Disorder, Conversion Disorder, Major Depressive Disorder), these diagnoses should be given instead of, or in addition to, Posttraumatic Stress Disorder.

**Acute Stress Disorder** is distinguished from Posttraumatic Stress Disorder because the symptom pattern in Acute Stress Disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist for more than 1 month and meet criteria for Posttraumatic Stress Disorder, the diagnosis is changed from Acute Stress Disorder to Posttraumatic Stress Disorder

In **Obsessive-Compulsive Disorder**, there are recurrent intrusive thoughts, but these are experienced as inappropriate and are not related to an experienced traumatic event. Flashbacks in Posttraumatic Stress Disorder must be distinguished from illusions, hallucinations, and other perceptual disturbances that may occur in **Schizophrenia, other Psychotic Disorders, Mood Disorder With Psychotic Features, a delirium, Substance-Induced Disorders, and Psychotic Disorders Due to a General Medical Condition.**

**Malingering** should be ruled out in those situations in which financial remuneration, benefit eligibility, and forensic determinations play a role.

# APPENDIX E: EMIC

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## **Patterns of distress**

- Illness-related problems and concerns
- Name of illness, symptoms, anticipated outcome
- Psychological, social, and economic impact
- Stigma, disclosure, and self-esteem
- Marriage prospects and marital relations

## **Perceived causes**

- Foods
- Psychological factors, psychosocial stressors and victimization
- Sanitation, hygiene, contamination, and health habits
- Infection, prior illness, constitutional factors
- Humoral imbalance
- Magico-religious forces
- Heredity
- Sexual experience, retribution for previous deeds

## **Help seeking and treatment**

- Family support and home remedies
- Private practitioners and public clinics
- Western-styled health professionals, para-professionals, and specialists
- Traditional healers of various types
- Past experience and current preferences

## **General illness beliefs**

- Explanatory models of illnesses other than current problem
- Focus on illnesses with a range of cultural meanings
- Relationship between mind and body

## **Disease-specific queries**

- Ideas about the illness affecting the subject, but distinct from personal experience of presenting problems

Figure 1. Operational formulation of illness explanatory model for EMIC interviews.

## WEISS: EXPLANATORY MODEL INTERVIEW CATALOGUE (EMIC)

**Empowering introduction**

- Explain the nature of the queries that follow and assure the respondent that responses will not be a source of humiliation.

**Open-ended queries**

- By imposing minimal structure, enable the respondent to refer to what is most prominent in personal experience.

**Screening queries focused on categories of interest**

- A relatively more structured section of the inquiry minimizes errors of omission. Respondents may not mention important aspects of illness experience in response to open-ended queries for various reasons. Without inquiring about specific categories of interest, one cannot assume that failure to mention a particular aspect of distress, perceived cause, or help-seeking experience means that these play no role in this person's experience.

**Summary judgment comparing multiple responses**

- Since multiple responses are common, it is useful to weigh their relative significance, asking the respondent to identify which among them is most important, first in time (i.e. first symptom, first perceived cause, first help seeking), and how aspects of the explanatory model have changed over time.

**Prose elaboration**

- Most questions in EMIC interviews elicit responses in the context of a narrative account of illness experience. This prose elaboration of various aspects of illness experience may be the principal interest for qualitative analysis of thematic content, or it may be consulted to clarify the meaning of coded categories. In either case, qualitative data constitutes an integral component of the data set.

Figure 2. Structure of EMIC interviews

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# GLOSSARY

## of Tibetan and Sanskrit Terms

<i>Bad-Kan:</i>	Phlegm
<i>Ded-chags:</i>	attachment
<i>gTi-mug:</i>	delusion
<i>Gu Chu Sum:</i>	Center for Expolitical Prisoners (Tib. numbers: 9 10 3)
<i>Gyun-bZhi:</i>	Four Tantras/Treatises of Tibetan Medical Practice
<i>Karma:</i>	Action
<i>Kha-bhug-Dhog-Pa:</i>	(exact meaning undefined) “Someone who is sad because he cannot share his feelings”
<i>Kunphen:</i>	Beneficial to others
<i>Kyen:</i>	Secondary cause of disease
<i>Kyu:</i>	Primary cause of disease
<i>Men Tsee Khang:</i>	Traditional Tibetan Medicine Hospital
<i>mKris-pa:</i>	Bile
<i>Nyan-mongs:</i>	Afflictive emotions/mentatl factors
<i>Nyes-pa:</i> Three	Three humors that form the basis of TM
<i>rLung:</i>	Wind
<i>Sempa-kyo-wa:</i>	Sadness
<i>Sok-rlunh:</i>	rLung disorder maked by the seizing of the life-bearing channel
<i>Zhe-dsang:</i>	hatred
<i>Yid-smug:</i>	mental/emotional depression

# SUGGESTIONS FOR FUTURE RESEARCH

There are number of possible extensions of this research that could be performed in the future. To begin with, there are a number of shortcomings in my research that could be rectified in future projects. One of the primary shortcomings in this project is its lack of quantifiable evidence. Presently, there exists no current, clear or quantifiable data to support that disorders such as depression, anxiety or PTSD are prevalent in the community. For this reason, it would be extremely useful and quite interesting to find a qualified psychologist in the community with whom a true mental health epidemiological survey could be performed. Additionally, a mental health survey could be given out to the community to find out the extent of the community's mental health knowledge, how they think about it, what they would do if they suffered from symptoms of depression or anxiety, etc. Although my research addressed these issues I was only able to speak with about twenty community members, most of whom were under 35 years of age and well-educated. Exploring the older and less-educated members of the community may prove to give more depth to the picture. It may also prove interesting to interview more government officials, school directors and teachers to gain more insight to where mental health stands on their list of priorities. Additionally, I would explore these issues in other settlements where there are no Tibetan mental health facilities or counselors. Specifically, it may be interesting to visit the Suja school in Biir which predominately consists of new arrival students and, as I was told, has quite a number of students who suffer from depression and anxiety. Lastly, because the mental health services in Dharamsala are in a crucial period of transition (as Sonam Dekyi leaves for her masters and Reiko Makiuchi takes over) and thus it could prove interesting to keep an eye on how the program evolves and how the community responds.