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# Perspectives on Psychosis from Dharmashala's Tibetan Community in Exile

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# ‘POISON THE SPIRITS’

PERSPECTIVES ON PSYCHOSIS FROM  
DHARMASHALA’S TIBETAN COMMUNITY IN EXILE

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 and Himalayan Peoples, SIT Study Abroad, Spring 2023*

*Cover photo: A mural of the deity Vajrakīlaya (rdo rje gzhon nu, རོ་རྩེ་གཞོན་ནུ་) painted in the  
 Namdroling Monastery, Bylakuppe, Karnataka, India. Vajrakīlaya is a wrathful deity within  
 Tibetan Buddhism. He protects ritual spaces and destroys human and demonic enemies. He may  
 also dispel obstacles on the path to enlightenment. Vajrakīlaya is the deification of the ritual  
 dagger kīla, which can be used in Tibetan Buddhist rituals to subjugate demons.<sup>1</sup>*

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<sup>1</sup> "Vajrakīlaya." *The Princeton Dictionary of Buddhism*, edited by Robert E. Jr. Buswell, and Donald S. Jr. Lopez, Princeton University Press, 1st edition, 2013. *Credo Reference*.

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## Abstract

What is psychosis? The term itself is relatively recent. Yet clinicians and religious figures have tried to explain ‘psychosis’ from pathological and nonpathological perspectives for hundreds of years.<sup>2</sup> From an allopathic, medical standpoint, psychotic disorders are devastating diseases. Up to 3% of the world’s population struggle with hallucinations, delusions, and cognitive impairments that make it difficult or impossible to function in society.<sup>3</sup> Tibetan Buddhism does not have an exact analogue to the clinical term ‘psychotic disorders’. Nevertheless, Tibetan medicine understands some cases of psychosis as pathological. For instance, the Tibetan word *smyo nad* (སྨྱན་) roughly translates to madness.<sup>4</sup> Yet in Tibetan society psychosis is not inherently unhealthy. For example, people may purposefully become possessed for religious and ceremonial purposes.<sup>5</sup> Through this project, I hope to investigate Tibetan Buddhism as an alternative to allopathic medicine understandings of psychosis. Based on fieldwork in the Tibetan settlement of Dharamsala, India, I aim to explore Tibetan medicine’s and religion’s conception, and treatment, of psychosis. I will also explore the role of people with psychosis in the community. Finally, I will consider if, and how, Tibetan and allopathic understandings of psychosis can be reconciled.

## Acknowledgments

I am indebted to many people who assisted me in my fieldwork, without which this paper would not be possible. First, I would like to thank some of the incredibly kind members of the Dharamshala community who took the time to answer my questions. Thank you to Kelsang and Choetso, who so kindly introduced me to Men-Tsee-Khang and the world of Tibetan medicine. I am also very grateful to Dr. Dhonden for allowing me to shadow his practice and for some fascinating conversations. In addition, I am thankful to Ringzen, who helped show me around Dharamshala and made sure that I had a roof over my head.

Thank you to Nazneen and Professor Lambe for their invaluable feedback and suggestions.

Finally, I would like to thank my father. It all started with a ‘Free Tibet’ bumper sticker.

This paper is dedicated to Frederic Whitney “Eric” Wu, Brown University Class of 2022.

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<sup>2</sup> Harold G Koenig, "Schizophrenia or Possession? A Rejoinder to Irmak," *Journal of Religion and Health* (2023): 1.

<sup>3</sup> Consortium, W. T. C. C. & Psychosis Endophenotypes International Consortium, "A genome-wide association analysis of a broad psychosis phenotype identifies three loci for further investigation," *Biological Psychiatry* 75 (2014): 386.

<sup>4</sup> C. Millard, "Tibetan medicine and the classification and treatment of mental illness," *Soundings in Tibetan Medicine* 10 (2007): 247.

<sup>5</sup> Mark Epstein, *Mind and Mental Disorders in Tibetan Medicine* (New York: Potala Publications, 1982) 24.

## Preface

The following is based on first person interviews within the Tibetan community in exile. I spent two weeks in Dharamshala during late April and early May 2023. I talked to Tibetan nurses, allopathic doctors, monks, traditional Tibetan doctors, astrologers, and students. I had no formal process to find interviewees. I met some through friends (e.g., Ringzen) and some during Tibetan cultural events. I approached hospitals and clinics in-person to obtain most of my interviews with healthcare workers.

Some interviewees requested anonymity. I indicate with quotation marks when a pseudonym is used. Otherwise, reported names and positions are as written. A full list of interviewees, along with their name/pseudonym and a brief background, can be found at the end of the paper. Quotes are written verbatim as recorded. I did my best to accurately present interviewees' stories and perspectives. I take full responsibility for any errors or misinterpretations.

The main limitation of this project is that I did not talk to people who had experienced psychotic symptoms themselves. My lack of professional training, position as a foreigner, and limited time made it ethically and practically infeasible to approach those who were either currently undergoing, or had undergone, a psychotic episode. Lacking this crucial perspective limits my findings. While I can discuss how Tibetans in exile perceive psychosis, I cannot explore what the experience of psychosis *feels* like for Tibetans. I recommend the excellent collection *Our Most Troubling Madness* (University of California Press 2016) for those interested in accounts from people experiencing psychotic symptoms. The collection includes some essays on peoples in Northern India and discusses similar themes as this project.

All pictures are original photographs taken by the author.



*Maps of Dharamshala and the surrounding regions (left) and fieldwork sites in and around Dharamshala. Generated by Google Maps.*

## Introduction: A Primer on Psychosis

### *Tibetan Buddhist understandings of psychosis*

Tibetan medicine and its understanding of psychosis are inexorably tied to Tibetan Buddhism. Buddhist teachings hold that the mind underlies all phenomena, including illness and health.<sup>6</sup> The root cause of all diseases are afflictive factors such as greed, hatred, and ignorance.<sup>7</sup> This applies to both physical and mental disease. Tibetan Medicine does not separate psychiatry from other medical specialties.

Per Tibetan Medicine, three *nyes pa*<sup>8</sup> (ཉེས་པ་) are necessary for life. An imbalance of *nyes pa* results in disease. Of the three *nyes pa*, a disruption of *rLung* (རླུང་) is most associated with disturbances of the mind. *rLung* can be further divided into types of currents, including a “life-sustaining current.” The “life-sustaining current” provides the physical basis for the mind, visualized as “the horse on which [the] mind rides.”<sup>9</sup> Per Tibetan Medicine, such currents travel through literal channels in the body, some “as tiny as the width of hair in a horse’s tail.”<sup>10</sup>

Disturbing the flow of the life-bearing current can cause *rLung* disorders. Poor diet, improper behavior, poisons, and even suppressing a sneeze can disrupt the flow of *rLung*.<sup>11</sup> Tibetan Medicine also holds that negative actions from a past life can cause *rLung* disorders in the present. Practitioners treat *rLung* imbalances with herbal medicine, diet, behavior changes, and religious rituals.

Tibetan medicine does not have a perfect cognate for the allopathic concept of psychosis. The term *smyo nad* (སྤྱུ་ནད་) literally translates to ‘mad disease’. *Smyo nad* includes many of the symptoms associated with psychosis (e.g., hallucinations, delusions, strange behavior).<sup>12</sup> However, *smyo nad* is a broad category that could include intoxicated people and those with chronic psychotic disorders like schizophrenia.<sup>13</sup> Tibetan medicine often considers *smyo nad* to be a more severe form of *rLung* disorder.

Cosmology plays a major role in Tibetan Buddhist understandings of *smyo nad*. Buddhist cosmology is very complex. Cosmologies vary among Buddhist texts, and descriptions are often treated more metaphorically than literally. In general, Tibetan Buddhist texts describe an infinite universe with an infinite number of worlds.<sup>14,15</sup> Philosophers divide the universe into 31 realms inhabited by different beings. Some realms contain heavenly beings and purely pleasant feelings.

<sup>6</sup> Terry Clifford, *Tibetan Buddhist medicine and psychiatry: The diamond healing* (Motilal Banarsidass Publ., 1994)

<sup>7</sup> Epstein, 3.

<sup>8</sup> *Nyes pas* is often translated as “humors” but more means “defects” or “faults”, indicating the suffering inherent in all sentient life.

<sup>9</sup> Lobsang Rapgay, *Mind-Made Health: A Tibetan Perspective* (New York: Potala Publications, 1982) 50.

<sup>10</sup> Epstein, 22

<sup>11</sup> Epstein, 14

<sup>12</sup> Susannah Deane, “From sadness to madness: Tibetan perspectives on the causation and treatment of psychiatric illness,” *Religions* 5.2 (2014): 444.

<sup>13</sup> When I asked ‘Pema,’ a Tibetan nurse in Dharamshala, if she had ever seen patients with psychosis, she told me “I have seen some psychosis in a drunkard...they are like too much in a fantasy. The way they talk, the way they walk, everything is zig zag.”

<sup>14</sup> C. George Boeree, “Buddhist Cosmology,” online, George Boeree Homepage, Available at: <https://webpace.ship.edu/cgboer/buddhacosmo.html>

<sup>15</sup> The notion of a universe infinite in time and space follows from Hindu philosophies that preceded Buddhism

For instance, future Buddhas spend millions of years in the Tushita heaven before arriving in the human realm.<sup>16</sup> Other realms are hellish pits of destruction. The ancient *Abhidhamma* texts describe worlds of suffering dominated by hate and torment. Beings in these hells can only experience painful sensations. Humans occupy a middle realm between the heavens and hells, where we experience both pleasures and pains.

Beings from hells can cause *smyo nad* in humans. For instance, beings from the world of ‘famished spirits’ are motivated by the afflictive emotions of desire, hatred, and ignorance, just like humans. These ‘hungry ghosts’ are often depicted with long, thin necks and exaggerated, distended stomachs. They are constantly hungry but unable to consume food. ‘Hungry ghosts’ can be understood literally or as metaphors for suffering caused by greed.<sup>17</sup> Some ‘hungry ghosts’ target humans. They can enter the channels through which life-sustaining *rLung* normally travels. Their presence disrupts the working of the mind. Dr. Yoshe Donden, former personal physician to the Dalai Lama, described such an invasive spirit as impairing the mind like “two people forcefully living together in one room.”<sup>18</sup> The spirit--or some other energy--interrupts the life-bearing currents that flow through the body’s channels. Their presence disturbs the relationships between *rLung* and mind, resulting in psychosis. Practitioners may perform an exorcism to remove the spirit and alleviate the patient’s symptoms.

Tibetan Medicine does not regard all forms of possession as unhealthy. Some forms of possession are considered “healthy and functional,” such as when spirits speak through oracles.<sup>19</sup> A main aim of this paper is to dissect when such possessions, and psychosis in general, are considered ‘good’ or ‘bad’. In short, what role does psychosis play in Tibetan society?

### *Allopathic understandings of psychosis*

Tracing the history of allopathic understandings of psychosis can be tricky. On one hand, psychiatric language has changed dramatically since the 1800s. ‘Psychosis’ has meant many different things over the years. For instance, German physician Karl Friedrich Canstatt first introduced the concept ‘psychosis’ into the medical literature in 1841.<sup>20</sup> Canstatt used the term interchangeably with ‘psychic neurosis’. The term remained nonspecific: physicians used ‘psychosis’ as a synonym for general mental illness. Eugen Bleuler, a Swiss psychiatrist, introduced the more precise term schizophrenia in 1908. But Bleuler’s understanding of the psychotic disorder did not include hallucinations as a key symptom.<sup>21</sup> Emil Kraepelin’s ‘dementia praecox’ is a closer analog to the modern term schizophrenia. Kraepelin distinguished

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<sup>16</sup> *Mythology*, online, Encyclopedia, Britannica. Available: <https://www.britannica.com/topic/Buddhism/Celestial-buddhas-and-bodhisattvas#ref300591>

<sup>17</sup> Epstein, 24.

<sup>18</sup> Epstein, 23.

<sup>19</sup> Epstein, 24.

<sup>20</sup> M Bürgy, “The concept of psychosis: historical and phenomenological aspects,” *Schizophr Bull.* 2008 Nov;34(6):1200-10. doi: 10.1093/schbul/sbm136. Epub 2008 Jan 3. PMID: 18174608; PMCID: PMC2632489.

<sup>21</sup> Tanya M Luhrmann, “Introduction,” *Our most troubling madness: Case studies in schizophrenia across cultures*, Eds. Tanya M. Luhrmann and Jocelyn Marrow (University of California Press, 2019) 1.

‘dementia praecox’ from affective disorders like manic-depression and emphasized the disease’s degenerative course.

Today, clinical texts define psychosis as a ‘loss of contact with reality’ characterized by delusions, hallucinations, and disordered thought.<sup>22</sup> From an allopathic understanding, psychotic symptoms can result from a huge variety of causes. Anything from a tuberculosis infection to Alzheimer’s disease can trigger a disassociation with reality understood as ‘psychosis.’ However, these diverse etiologies can be manageably divided into primary and secondary psychoses. A secondary psychosis has an identifiable biological cause--say a tumor in the brain that triggers hallucinations. A primary psychosis (e.g., schizophrenia) lacks a clear biological cause; psychosis is a core part of the disease, not just a symptom.

Physicians have long understood primary psychosis—or psychosis spectrum disorders—through tangled medical and spiritual means. Exorcists, priests, psychologists, and physicians have struggled to define and treat ‘abnormal’ behavior. But beginning in the late 19th century, many mental health care workers begin to distance themselves from the field’s more ‘spiritual’ roots in order to assert scientific authority.<sup>23</sup> Psychiatry and neurology aligned in the early 20<sup>th</sup> century and defined many psychosis spectrum disorders as organic brain diseases. Freudian thought disrupted psychiatry by conceptualizing psychosis disorders as a reaction to social experience.<sup>24</sup> The conditions were seen as more subjective classifications of ‘unacceptable’ behavior than biological illnesses. Psychoanalysts often blamed overprotective mothers for schizophrenia. They maintained that children who grew up with intimacy issues became psychotic.<sup>25</sup>

In the 1980s, new antipsychotics shook psychiatry. Western doctors began to understand psychotic disorders as an imbalance of neurotransmitters.<sup>26</sup> Many conceptualized schizophrenia as a purely biological disease marked by specific changes in the brain. Yet the failure to find specific, predictive schizophrenia genes wounded ‘biomedical psychiatry.’<sup>27</sup> Elements of psychoanalytic thought have remained in psychiatry. For instance, clinicians still recognize the importance of social factors in developing psychosis.<sup>28</sup> Those from marginalized settings are more likely to develop psychosis spectrum disorders than the privileged.

Yet for all this evolution in understanding, psychiatrists struggle to treat primary psychosis. The most common psychosis spectrum disorders are bipolar disorder, schizophrenia, and schizoaffective disorders. Schizophrenia itself affects about 1% of the world’s population.<sup>29</sup>

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<sup>22</sup> Rudolf N. Cardinal and Edward T. Bullmore, *The Diagnosis of Psychosis* (Cambridge: Cambridge University Press 2011) xv.

<sup>23</sup> Jennifer Lambe, "In the shadow of the double: Psychiatry and spiritism in Cuba," *History of Psychology*, 2018, 21.3, 224.

<sup>24</sup> Luhrmann, 9.

<sup>25</sup> Luhrmann, 10.

<sup>26</sup> First schizophrenia was considered a ‘dopamine disorder’, although more recently scientists have focused on the importance of the neurotransmitter glutamate.

<sup>27</sup> T. R. Insel, “Rethinking schizophrenia,” *Nature*, 2010, 468(7321), 188.

<sup>28</sup> Luhrmann, 18

<sup>29</sup> W. T. C. C. Consortium & Psychosis Endophenotypes International Consortium, 386.

Yet allopathic doctors cannot agree on schizophrenia's cause. Treatment is generally ineffective; less than one fifth of diagnosed patients report a sustained recovery.<sup>30</sup> Even the diagnosis of schizophrenia is controversial: there is no biomarker or biological test for the disorder. Instead, doctors identify psychosis spectrum disorders by checking through lengthy lists of criteria. Guides like the DSM--the bible of modern psychiatry--layout descriptions of symptoms. Doctors choose symptoms from these lists and decide which disorder best aligns with the clinical presentation. Consequently, a diagnosis of schizophrenia can look very different from patient to patient. Some patients may present with schizophrenia dominated by hallucinations and paranoid delusions while others may demonstrate a quieter disease of disorganized thoughts and severe withdrawal. Most allopathic doctors agree that schizophrenia and psychotic spectrum disorders are biological diseases, but they are not understood as rigorously as ailments like diabetes or hypertension.

### *Reconciliation*

The symptoms that allopathic doctors most often attribute to schizophrenia hold a striking similarity to those that Tibetan Buddhists identify as caused by spiritual possession. Patients diagnosed with schizophrenia often describe a lack of control over their thoughts and actions.<sup>31</sup> They may see things that nobody else can see. Voices may 'talk' to patients and 'insert' thoughts into their head. Entities may interrupt a patient's thoughts or seem to remove them entirely. It is not surprising that many--including some allopathic doctors--understand the symptoms of schizophrenia as the work of demons possessing a patient's mind.<sup>32</sup>

Through this project, I will investigate how Tibetan and allopathic medicine can be reconciled. The DSM accepts that religion is an important factor in understanding psychosis; practitioners are advised not to pathologize hallucinations that occur in a religious context, like hearing a deity's voice while praying. On the other hand, do practitioners of religions like Tibetan Buddhism accept a role for psychiatry alongside spiritual treatment? Past studies of religious Buddhist societies have reported individuals seeking treatment from both spiritual healers and psychiatrists.<sup>33</sup> Can the same be said for Tibetan Buddhist communities? Can psychiatry and Tibetan Buddhism cooperate, or are they destined to conflict?

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<sup>30</sup> Insel, 187.

<sup>31</sup> K. Soares-Weiser, N. Maayan, H. Bergman, C. Davenport, AJ. Kirkham AJ, S. Grabowski CE. Adams, "First rank symptoms for schizophrenia," *Cochrane Database Syst Rev.* 25 (2015).

<sup>32</sup>M. Kemal Irmak, "Schizophrenia or possession?," *Journal of Religion and Health* 53 (2014): 773.

<sup>33</sup>Raveen Henwalla et al., "Religious beliefs, possession states, and spirits: Three case studies from Sri Lanka," *Case Reports in Psychiatry* (2012).

## Part 1: Ghost Stories



*Depictions of demons in the Tibetan Buddhist underworld from Namdroling Monastery in Karnataka, Bylakuppe, India*

To understand Tibetan views on psychosis, you must enter the world of ghosts. Dr. Dhonden told me his ghost story over tea and curry in the kitchen above his herbal clinic. The story began in the early 1970s, when Dhonden was 6 years old and living with his family outside Lhasa. Like many families in rural Tibet, Dhonden's family was polyandrous;<sup>34</sup> his mother married a pair of brothers. Dhonden never knew who his biological father was but referred to the elder brother as 'father.' The younger brother, Tashi, was 'uncle.'

One day Tashi herded the family's massive flock of sheep--over one thousand animals--up the slope of a mountain. The sheep fed until sunset, at which point a sinister feeling overtook Tashi. Dhonden explained that a feeling of something "very uncomfortable and hot...very acrid" began to enter Tashi, who instantly sensed danger. Although night was falling and he was over 30 km from home, Tashi decided to trek back to his family. Ill feelings plagued his journey. One side of his body became entirely numb, and walking was very difficult. Yet he struggled forward, one kilometer at a time. He sensed that if he did not make it home, a sinister force would kill him.

Around 10 pm Tashi finally made it home. One leg had become entirely numb and his whole body was in great pain. Then, Dhonden saw a *gDon*<sup>35</sup> (གཏོན, spirit) enter his Tashi: "[the] evil spirit had come to transform him. He was physically my Tashi, but his mind was transformed."

Dhonden's family knew that they must seek religious guidance. There was a high lama related to Dhonden's mother known to be skilled in rituals to ward off *gDon*. Yet the Cultural Revolution had gripped Tibet and expression of Tibetan Buddhism was severely restricted. The Chinese government had destroyed thousands of monasteries and killed many. Fear was everywhere: these were "very difficult times."

Yet without assistance, Dhonden's family feared that Tashi would die. The *gDon* had announced that it would kill Tashi by sunset tomorrow. The family enlisted four men to restrain Tashi and "quietly" snuck him to the lama's home. They hoped that the lama's "strong energy" would be enough to remove the *gDon*'s grip over Tashi's mind.

As they neared the lama's house, the *gDon* in Tashi sensed the threat and announced that he would defeat the lama. When the two met face to face, the *gDon* stated its terms. He would challenge the lama, and if he won, he would kill Tashi. If he lost, then he would leave Tashi's body--but only if provided with a needle, cloth, salt, and rice.

The lama accepted the challenge. The *gDon* mocked the lama: "I have the power. Nobody can challenge me. Do you even have any tantric energy? If not, I will kill Tashi." As a show of strength, the *gDon* lowered Tashi's hand into a pot of boiling water. Then he took one cup of the scalding water and poured it on his skin. Then he drank another. He did not even flinch.

The lama remained calm. He lit ceremonial butter lamps and began to meditate while repeating a mantra. Suddenly, he took off his shoes and began to beat Tashi about the head with "very powerful energy." The attack stunned Tashi and left him unconscious. He lay on the floor, unresponsive and drooling.

After ten or so minutes, Tashi awoke. The *gDon* was still in him, but it was chastened: "Lama, please don't torture me. Please release me. I will not kill Tashi, I promise. But I

<sup>34</sup> Fjeld, Heidi E. "The Return of Polyandry." *The Return of Polyandry: Kinship and Marriage in Central Tibet*, Berghahn Books, 2022, pp. 25–47. JSTOR, <https://doi.org/10.2307/j.ctv2vr8tr2.9>. Accessed 3 May 2023.

<sup>35</sup> Alternatively translated as 'harmful influence'. Pronounced 'duhn', *gDon* often target humans until they are sated with offerings.

absolutely need needle, thread, rice, and salt.” The lama refused to appease the *gDon*. He performed more mantras and demanded that the *gDon* promise to leave Tashi for his entire life. Only then would he release the *gDon*. Tashi prostrated himself before the lama and accepted the deal. The lama repeated more prayers and meditations, and Tashi again fell unconscious.

Then the lama lit a butter lamp and set it outside his house. He commanded Dhonden’s family to walk with him the 20 km back to their house without looking back. Meanwhile, another group would walk to the mountain where Tashi was possessed to light a butter lamp and place offerings. This, the lama promised, would ensure that the *gDon* did not return.

Around 6 am, Dhonden’s family returned home with the lama and an unconscious Tashi. They set Tashi down in bed, where he slept for hours and hours. When he awoke, he rubbed his eyes and yawned: “What are you doing here lama? I had a very late sleep.” Tashi did not remember any of the previous night’s episode, save for the feeling of great foreboding and numbness on the mountainside. The *gDon* never troubled him again, though for decades after people avoided the area on the mountain where Tashi became possessed.

## §

Can we say that Tashi had a psychotic episode? One could try to explain Tashi’s behavior using psychiatric terminology: the numbness in his body could be a ‘somatic symptom,’ the voice of the *gDon* could be ‘thought insertion’, the belief in the *gDon* a ‘delusion’. Yet it seems a fool’s errand to diagnose a DSM-V disorder based on a decades-old family legend. What is really interesting is how the story of Tashi reveals types of behavior sanctioned by Tibetan culture. In many countries, Tashi’s bizarre behavior would be stigmatized as a mental illness. Yet in Dr. Dhonden’s story, his uncle’s actions were accepted and treated within the local religious system. Tashi’s family did not view him as ‘mentally ill.’ Instead, he suffered from a temporary and curable condition.

Furthermore, the course of Tashi’s symptoms does not easily fit into the allopathic model of primary psychosis. Tashi recovered as quickly as he became ill, and as far as Dr. Dhonden reported, did not have a similar episode ever again. Tashi did not show the chronic symptoms and cognitive decline that mark diseases like schizophrenia. Tashi’s experience models an archetypical possession story; other Tibetans whom I talked to described similar events. A person would, out of the blue, start to act in a strange manner. Their symptoms would escalate until they received some sort of exorcism. Then the person would fall unconscious and awake without any memory of the possession.

For example, ‘Pema,’ a nurse in Dharamshala, described a possession that she witnessed as a child. ‘Pema’ went to a Tibetan school in India. There, one of Pema’s classmates often prayed to a “deity.” One day she stopped her prayers and “bad things [began to] happen.” Her classmate suddenly began to shake. Then, she began “shouting...[and] scratching on the tables. She scratched so much.” ‘Pema’s’ classmate made strange noises as if two voices were talking at once. One of the voices sounded deep, like a male voice. The speech was incomprehensible.

The teachers came and performed “so many rituals.” They burned incense to try and expel the spirit. Then, all the teachers came and held ‘Pema’s’ classmate’s hand. She was still screaming, but the teachers forced her to get into her bed: “After a few minutes, it was settled. She was sleepy.” Like Tashi, the classmate woke up with no memory of the paranormal experience. ‘Pema’s’ classmate was not possessed again.

A clinician could pathologize these types of possessions as a “non-affective acute remitting psychosis.”<sup>36</sup> The term emphasizes the sudden, yet transient, nature of psychotic symptoms. Nevertheless, neither Dr. Dhonden nor ‘Pema’s’ pathologize possession in their stories. For both, possession was an accepted part of life, a problem to be solved with religion, not with institutionalization or marginalization. The stories reveal how difficult it is to apply the label ‘psychosis’ to Tibetans in exile. What constitutes delusion and what constitutes religious belief?

Indeed, Dr. Dhonden described how he and other Tibetans believe in a huge variety of spiritual beings, “like so many beings in the ocean.” Different spirits have different relations with humans: “Some spirits protect people as a bodyguard...that watch over monks and Tibetan high officials.” Other spirits are indifferent towards humans but can still harm them. Dr. Dhonden described one entity that flies across the sky on certain auspicious days. If its shadow touches an unfortunate human, they will suffer fear, despair, or even epilepsy.

Another group of spirits actively targets humans. Māra is perhaps the most prominent of such ‘demons’. Māra is a powerful deity who acts as the “personification of evil in Buddhism.”<sup>37</sup> He resides in the realm *kāmadhātu* and aims to hinder humans in their quest for enlightenment. For example, Māra sent his minions to destroy Siddhārtha as he meditated under the Bodhi tree. Siddhārtha countered Māra by turning the attackers’ weapons into flower blossoms.

Some Tibetans actively channel spirits to become possessed. For instance, the Nechung Oracle is a highly esteemed figure among the Tibetan community in exile. Since 1544 AD, a line of mediums has become the Nechung Oracle.<sup>38</sup> When possessed, the oracles manifest the deity *Pehar* (པེ་ཧ་ར་), the king of the *gyalpo* (རྒྱལ་པོ་).<sup>39</sup> *Gyalpo* are also known as ‘arrogant king-like spirits’, and they typically interfere with human affairs. However, *Pehar* uses his leadership of *gyalpo* to protect the Dalai Lama and the Tibetan government.<sup>40</sup> Tibetan officials consult the Nechung Oracle to aid in tough decisions. For instance, the Nechung Oracle’s advice proved instrumental in spurring the Dalai Lama to flee Tibet following China’s 1959 invasion. To this day, the Dalai Lama consults *Pehar* via the Nechung Oracle.

During my second morning in Tibet, I witnessed a possession of the Nechung Oracle at Dharamshala’s Nechung Monastery. The Tibetan Women’s Association requested a public audience with the oracle. They, and many other Tibetans, gathered outside the monastery, eager to receive blessings from *Pehar*. The oracle entered his public audience composed and collected. He stood patiently as consorts dressed him in thick layers of ceremonial robes, belts, plates, sashes, and other gold-yellow adornments. He maintained a peaceful expression that suggested a controlled mind. The room erupted with horns, drums, and chants--yet the oracle remained still. As the minutes wore on the oracles’ assistants fidgeted and shuffled their feet. But from my vantage point, the oracle remained still as a statue, barely breathing.

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<sup>36</sup> Luhrmann, 23,

<sup>37</sup> “Māra.” The Princeton Dictionary of Buddhism, edited by Robert E. Jr. Buswell, and Donald S. Jr. Lopez, Princeton University Press, 1st edition, 2013. Credo Reference, <http://revproxy.brown.edu/login?url=https://search.credoreference.com/content/entry/prdb/mara/0?institutionId=1019>. Accessed 12 May 2023.

<sup>38</sup> IB Hoban, “Nechung: A Tibetan Oracle in Exile,” *The Tibet Journal*, 2008, 33(2), 49.

<sup>39</sup> *Pehar*, Rigpa Wiki, online, Rigpa Shedra. Available: <https://www.rigpawiki.org/index.php?title=Pehar>

<sup>40</sup> Christopher Bell, “Nechung: A Tibetan Buddhist Oracle,” *Oxford Research Encyclopedia of Religion*, 2022.

Then *Pehar* entered his body, and the Nechung Oracle transformed. He began to rock his head slightly back and forth. He opened and closed his lips as if muttering to himself. He lifted his heels off the throne and both legs began to shake. Sensing the change, the oracle's consorts secured a mighty crown on his head. The word crown seems insufficient, though. The object placed on the oracles' head was a massive work of art, a metal behemoth topped with puffy white plumage; draped with green, yellow and red sashes; decorated with an arc of dark green feathers; and complete with a golden visor featuring the heads of mythological beasts. The mantle weighs more than 30 pounds and seemed like it would break the elderly man's neck.<sup>41</sup> The visor slipped over his eyes and his face began to darken from exertion.



*The Nechung Oracle with his crown, while possessed by Pehar. Monks surround the oracle to help with his complicated adornments.*

Convulsions spread from his legs to his arms. Against the frantic background of horns' crescendo, the oracle shook his head back and forth. He effortlessly leaned his head forward until the tip of the crown approached his knees, and then righted himself again. Then, a wooden bow in one hand and ritual sword in another, the oracle shot to his feet. Unburdened by his massive crown, the oracle spun and hopped on his feet. He swayed his arms and bowed to onlookers. Then he threw his bow to the ground and sat upon his throne. His face was a grimacing mask, his lips quivering, baring his teeth.

This was not the same calm, elderly man who had entered the room thirty minutes earlier. Once resolutely still, his entire lower body now vibrated with energy. Once silent, he now gulped for air. His calm visage disappeared under frantic eyes and a deep frown. The man appeared tormented, wrestling with a powerful internal force. It does not seem far-fetched or heretical to claim that the Nechung Oracle had become detached from normal reality. In allopathic terms, he seemed to be undergoing a psychotic episode.

Still, the word psychosis carries a negative, pathologizing valence that does the Nechung Oracle an injustice. In the West, a cardinal feature of a psychotic

<sup>41</sup> "The Nechung Oracle (Kuten-la)", online, The Nechung Foundation, 2022. Available at: <http://nechungfoundation.org/oracle.html>

disorder like schizophrenia is disorganization. Those with schizophrenia often present garbled thoughts and a confusing ‘word salad’ of speech. They may neglect their hygiene and appear disheveled. Yet everything about the Nechung Oracle and his trance was meticulously planned. Monks coaxed the oracle with choruses of horns, rhythmic chanting, and smoking incense placed under the oracle’s nose. Even while in the throes of possession, the oracle handed ritual *nechung chagne*<sup>42</sup> to each among a long line of supplicants.

If the possession was a psychosis, it stretches the usual clinical understanding of the term. But the oracle’s behavior mirrored many characteristics of a patient with schizophrenia. As *Pehar* possessed his body, the oracle underwent dramatic changes and seemed to lose control over his thoughts and actions. Similarly, patients with schizophrenia will describe thoughts ‘broadcast’ into their minds as outside entities control their actions. Yet the oracle’s possession was planned; he underwent a ‘controlled’ psychosis. None would consider the Nechung Oracle to be *smyo nad*. Perhaps that is a key feature of Tibetan understandings of mental illness; there can be a mixture of madness and order, a ‘useful’ insanity. The crowd highly esteemed the Nechung Oracle and his possessed state. By 6:30 am, the square outside the Nechung monastery was packed with audience members. When the doors to the shrine opened, people threw aside their cups of *pu cha* (ཕུ་ཇ་, Tibetan butter tea) and sweet rice to claim a front-row seat. And when the oracle entered his trance, the whole room rose so quickly that monks had to form a human chain to corral the audience. The oracle’s psychosis, if I may use the term, is a prized treasure. But what about psychosis in less elite individuals? What about spiritual possession that is not so meticulously controlled?

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*The Nechung Oracle before (left) and after (right) possession by Pehar. In the left photo, monks help dress the Nechung Oracle in his ceremonial robes. His demeanor remains calm and composed. In the right photo, the Nechung Oracle takes on a fearful, distorted expression.*

<sup>42</sup>A dried red grain that, per members of the audience who preferred to remain anonymous, grants the owner luck in overcoming obstacles.

For some Tibetans whom I talked to, the line between psychosis and possession blurred when symptoms disrupted daily life. Many instances of possession were discrete episodes of odd behavior that ended as rapidly as they occurred. They followed the archetype demonstrated by Dr. Dhonden's uncle and 'Pema's' classmate. The victim tended to remember nothing of the event once the spirit retreated; these single episode possessions had happy endings. Chronic psychoses posed more issues. Tibetans with symptoms similar to psychosis spectrum disorders were less likely to be cured through religious means.

In between patients applying for TB screenings and consulting about treatment for Hepatitis B,<sup>43</sup> Dr. Namdon (མཁའ་ལྷན་) explained her experience with psychosis spectrum disorders. Dr. Namdon works at Delek Hospital, a small allopathic institution perched above the traditional Tibetan medical college Men-Tsee-Khang. Delek Hospital generally treats minor injuries and cares for chronically ill patients. More complicated cases are referred to larger urban centers. Dr. Namdon generally sees acutely psychotic patients, especially those under the influence of drugs and alcohol. She rarely treats patients with chronic psychosis spectrum disorders.

There have been exceptions. A few years ago, a family brought a woman in her 60s to Delek Hospital. The woman had fled from Tibet to Dharamshala when she was 20. She married and started a family. But after her husband died 15 years earlier, the woman became a nun. She gradually became more interested in Tibetan Buddhist rituals and increased her religious practice.

The family brought the woman to Delek Hospital because of unremitting abdominal pain. But further conversation revealed that the woman suffered from delusions and hallucinations. Three years before the appointment, the woman began to act strangely. She began to claim that a high lama had fathered a child with her and then "snatched away her kid" because the child was a reincarnation of the 'evil lama.' She became obsessed with the 'evil' high lama and his sins. The woman complained to her family that the lama tormented her. She "could see the lama, hear his voice" when nobody else was around. She could not sleep. At random times she would warn her family: "the lama is coming." Everything that went wrong in her life, including her abdominal pain, was the lama's fault. Her hate grew to the point that she demanded her family's help in making a video to call out the lama and shame him.

At first, the family blamed the woman's symptoms on a "local deity." But years of *pujas* failed to alleviate her symptoms. While talking to Dr. Namdon, the family became receptive to treating the woman's condition as a mental illness. They agreed to start a course of antipsychotics, which they secretly administered to the woman.<sup>44</sup> Her symptoms improved, but only partly.

Why was the woman's family more open to a psychiatric understanding of her symptoms? The most obvious explanation is that religious means had failed them, so they had no choice but to turn to alternatives. In addition, the woman's symptoms align very closely with DSM-V criteria of schizophrenia. She reported paranoia, auditory and visual hallucinations, and

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<sup>43</sup> TB has been a major health issue for Tibetans in exile, including those in Tibet. Many Tibetans live close together in small, poorly-ventilated households, increasing their risk for the disease. Healthcare workers in Dharamshala also struggle with high rates of drug-resistant TB. Some strains show resistance to more than eight different antibiotics. Dr. Namdon also reported high rates of stomach cancer among Tibetans living in Dharamshala. She was unsure why stomach cancer affected the community but hypothesized that a meat-rich diet and Tibetan genetics play important roles.

<sup>44</sup> In *Our Most Troubling Madness*, Amy June Sousa also describes a North Indian family sneaking a patient antipsychotics. The family cooked the patient's medicines into a *paratha*. The oily, heavily spiced disk masked the taste of the medicine.

irrefutable persecutory delusions. The symptoms were chronic and disrupted her relationship with her family. Allopathic methods were prepared to explain a condition that frustrated spiritual treatment.

Nevertheless, some accept spiritual explanations for disease even if religion does not offer a quick cure. Tibetan medicine associates many spirits with physical and mental illness. I witnessed one patient come into Dr. Dhonden's office with great purple discolorations on the back of her legs, arms, and neck. She told me that she had suffered from the ailment for the last 15 years. Allopathic doctors diagnosed it as psoriasis, but she was skeptical. Dr. Dhonden questioned the woman and discovered that she had frequent dreams of snakes and frogs. Furthermore, 35 years ago she and her family had cut down many trees while building their house. These observations and the type of skin ailment indicated that a *lu* (ལུ) was responsible for the woman's suffering. *Lu* are half snake, half human guardian nature spirits that seek revenge on humans who desecrate their land. In order to appease the *lu*, Dr. Dhonden ordered the woman to take herbal medicine and provide offerings every full moon. He also stamped the affected parts of the woman with a mandala imprint encompassing many prayers and holy words. Then he touched the woman's head with a prayer scroll wrapped in silk, offered her three *nechung chagne*, and declared that her symptoms would alleviate within a year and a half. The woman left satisfied and hopeful. After fifteen years of suffering, another one-and-a-half-year wait did not seem unreasonable.

Some patients also prefer spiritual treatment for disorders familiar to psychiatry. Dr. Dhonden recalled one female patient who came to him due to obsessive cleaning habits. She could barely sit still for 15 minutes before rushing to the washroom to clean her hands and face: "she feels [that her body] is always dirty". The woman's symptoms neatly fit within the allopathic criteria for obsessive-compulsive disorder.<sup>45</sup> Yet the patient turned to spiritual treatment: Dr. Dhonden recognized this 'cleaning spirit' as a *jungpo* (རྟུང་པོ་), an elemental spirit that can invade the human psyche.<sup>46</sup> He prescribed the appropriate herbal medication. The patient did not return for a follow-up. Even when allopathic methods can explain psychosis, some prefer a spiritual understanding.

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<sup>45</sup> Substance Abuse and Mental Health Services Administration. Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health [Internet]. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2016 Jun. Table 3.13, DSM-IV to DSM-5 Obsessive-Compulsive Disorder Comparison. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK519704/table/ch3.t13/>

<sup>46</sup> Rigpa Wiki.

## Part 2: Karma and Freud



*A thangka painting from the Men-Tsee-Khang College featuring the Medicine Buddha*

Not all Tibetans whom I talked to believed that spirits can trigger psychosis. For instance, ‘Pema’, who works at a TB clinic in Dharamshala, laughed at the idea. ‘Pema’ believes that the older Tibetan population is more “superstitious” and open to spirits. But she is skeptical: “I do not believe much.” Even among religious Tibetan Buddhists, the role of spirits in psychosis is controversial.

‘Dawa’, a religious Buddhist and nurse, was also dismissive: “I do not believe in demons. Thoughts are demons.” ‘Dawa’ understands spirits as a manifestation of painful emotions. Similarly, Yeshe Gyaltsen, a Buddhist monk and scholar, described spirits as “discursive thoughts.” Both understand malevolent spirits metaphorically.

Similarly, some traditions discuss four emanations of the arch-demon Māra.<sup>47</sup> One emanation is ‘The Mara of Disturbing Emotions and Attitudes’ (*nyon mongs kyi bdud*, རྣམ་མཁེལ་གྱི་བདུད་). This mara encompasses emotions that hinder one’s path toward enlightenment, such as desire, anger, delusion, and pride. Such thoughts can cause great distress. In addition, the renowned Tibetan Buddhist lama Sogyal Rinpoche described ‘hungry ghosts’ as a psychological state that exists “wherever people, though immensely rich, are never satisfied.”<sup>48</sup> Different spirits can serve as metaphors for different mental afflictions. As ‘Dawa’ suggested, they act like ‘demons’ that disrupt one’s psyche. ‘Dawa’ and Yeshe Gyaltsen focus on Buddhist cognitive teachings that offer alternative explanations for possession-induced psychosis.

Choetso<sup>49</sup> takes a similar approach. Choetso is a religious Tibetan Buddhist. She has attended weekly classes on Buddhism since 2009. She wakes up every morning at 4:30 am to pray that all human beings are saved from suffering. She has worked as a nurse for the last 25 years and peppered our conversation with both medical terms and pleas for compassion. Choetso builds her identity around Tibetan Buddhism. Like ‘Dawa’ and ‘Pema,’ she is firm in her attitude towards spirits: “I do not believe in demons.”

Choetso discussed her views on psychosis as we sat in her office overlooking Dharamshala. Red-roofed buildings dotted pine forests that stretched off into the horizon. The branch clinic was quiet; no patients interrupted us during our hour or so of conversation. Choetso sat at her desk, which was cluttered with both allopathic literature and treatises on Tibetan medicine. An examination table occupied one half of the small office, while a bookshelf stuffed with nursing texts, Tibetan literature, and equipment to monitor vitals took over one wall.

Religion colors Choetso’s understanding of psychosis spectrum disorders. I asked if Choetso was familiar with schizophrenia, and she rapidly shook her



Choetso in her office at the Delek Hospital Branch Clinic, McLeod Ganj

<sup>47</sup> Alexander Berzin, *Demonic Forces: The Four Maras*, online, Studybuddhism.com. Available: <http://studybuddhism.com/en/advanced-studies/lam-rim/samsara-nirvana/demonic-forces-the-four-maras>

<sup>48</sup> Sogyal Rinpoche, *The Tibetan Book of Living and Dying* (San Francisco: Harper 2002) 113.

<sup>49</sup> Choetso requested that I only include her first name, which is as written.

head: “Yes yes yes.”<sup>50</sup> Her clinic mostly treats minor illnesses and monitors blood pressure, but she has seen the occasional patient presenting with psychosis. Choetso recalls some patients hearing voices and seeing things that “were not there.” Choetso hopes that such patients will receive help from Tibetan and allopathic doctors. She believes that religious pujas can work in conjunction with antipsychotic drugs to stabilize the mind.

Choetso does not believe that psychosis spectrum disorders are fundamentally different from other mental afflictions: “Whether you have depression or schizophrenia, the bottom line is that you are not happy.” Choetso dismisses the painstaking categorization that defines modern psychiatry. In her view, the fundamental cause of different mental illnesses is the same; they simply manifest in different ways.

Other Tibetans whom I talked to held similar views. Yeshe Gyaltzen classified all mental illnesses on the same spectrum. The difference between, say, psychosis and depression, was the degree of “hope.” Losing some hope could lead to a “mental instability” like psychosis. But losing all hope was very dangerous and could lead to suicide. ‘Dawa’ held a slightly different formulation: “If you cannot handle [your thoughts], that will cause depression, and if you can’t handle [depression]...then psychosis.” As Choetso had analyzed, the root of all mental illness was unhappiness. Most of whom I talked to did not subscribe to the insistent categorization of psychiatry.

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This line of thinking reminded me of Freud. None of the Tibetans I talked to linked psychosis to sexual frustrations. But just as Freud explained hysteria as a response to suppressed sexual feelings,<sup>51</sup> Choetso and others understand psychosis as a response to buried unhappiness. In both systems of thought, psychosis is a reaction to some deeper, uncovered thought. Furthermore, Freud thought that behaviors as diverse as obsessions and phobias could be explained by suppressed sexual thought.<sup>52</sup> Many of the Tibetans I talked to also took a unitary approach. They grouped psychosis, depression, and other mental illnesses on the same spectrum. Though different mental illnesses may manifest differently, they are all fundamentally cognitive.

The Tibetans I interviewed approached mental illness with a sort of ‘diagnostic neutrality’ that is found among different cultural groups in Northern India.<sup>53</sup> Medical practitioners do not focus on labels for disease, emphasizing individual factors. For instance, I consulted a traditional doctor at Men-Tsee-Khang about descriptions of patients with different psychosis spectrum disorders. I presented one patient with hallmark symptoms of bipolar disorder and asked for her possible diagnoses:

*A person who suddenly becomes very energetic, cheerful, and talkative. This behavior is unusual for them. They are very arrogant and believe that they are more important or powerful than they really are. For instance, they may think that they are an important politician or businessperson when they are not. They may spend lots of money or take many risks. This period of high energy may be followed by a period of low energy and*

<sup>50</sup> Shaking one’s head from side to side indicates agreement throughout much of India.

<sup>51</sup> Storr, Anthony. Freud: A very short introduction. OUP Oxford, 2001. 20.

<sup>52</sup> Storr, 22.

<sup>53</sup> Amy Sousa, “Diagnostic Neutrality in Psychiatric Treatment in North India,” *Our most troubling madness: Case studies in schizophrenia across cultures*, Eds. Tanya M. Luhrmann and Jocelyn Marrow (University of California Press, 2019) 42.

*depression.*

To my surprise, the doctor replied that she did not have nearly enough information about the patient to guess what disease they could have. She still needed to learn more about the patient's individual history, their "personality." Her focus was on underlying cognitive issues, not specific constellations of symptoms.

In general, Tibetan practitioners deemphasized labels. For instance, one teacher at Men-Tsee-Khang told me that "when it comes to numbering the spirits, we have different traditions saying different things." He downplayed the importance of specific classifications of spirits for treating mental illness. Again, focusing on an individual's inner thinking was more important than finding a precise label for their syndrome.

On the other hand, part of the discomfort with psychiatric classification may have stemmed from translation issues. I found it difficult to convey the nuances of psychiatric classification. The closest Tibetan equivalent to psychosis—*smyo nad*—was still a general term for 'madness.' During my conversation with Yeshe Gyaltsen, the monk began to refer to people with psychosis as "psychos." Was this just a convenient shorthand, or was Yeshe Gyaltsen referring to generally 'crazy' people? Did 'psycho' hold the same pejorative connotations for Yeshe Gyaltsen as it did for me? During another conversation with Dr. Dhonden, I asked if he had ever seen a patient with catatonia. I tried to explain the symptoms, but Dr. Dhonden seemed to think that I was asking him about paralysis. He talked about people with frozen facial expressions like "Stephen Hawking." Ultimately, I could only be sure that I was discussing what I considered to be psychosis by asking for specific stories. I could parse through descriptions to identify possible hallucinations or delusions. Language limitations steered me to discuss patients with the same 'diagnostic neutrality' that I recognized within Tibetan treatments of mental illness.

The Tibetan Buddhist conception of mental illness that my interviewees subscribed to lends itself to cognitive solutions. Choetso believes that those suffering from diseases like schizophrenia can be their own savior:

*When you [do not] have [an] attack of schizophrenia and you are a little bit normal, then you can think, you can analyze... Why are other people not having this problem? This is a good chance to practice patience or to just pray for other people... And then [realize] maybe I did something bad or whatever in the past. Now I am having this problem.*

Choetso's then continued with an unequivocal claim: "It is all because of karma."

Dawa agreed. Because one's "present life is connected with [the] past," an illness like schizophrenia can be tied to one's karma. Pema furthered that for all misfortunes, "...not only schizophrenia. Whatever bad things happen in our life, we consider past actions...because we believe in karma".

Karma (*las*, ལས་) can be a tricky concept for non-Buddhists to understand. I entered Nepal familiar with the Western, vernacular use of the word. If I cut someone in line at the grocery

store and got home to find mold on my Pepperidge Farm? That was karma. Of course, the Buddhist understanding of karma is not so trite. Karma literally translates to “action.” Per karma, every action has consequences; it can be thought of as the law of cause and effect.

Metaphorically, karma manifests the same way that planting a mango tree will lead to mango fruit. The same logic applies to human activities: “wholesome actions result in eventual happiness for oneself and others; on the other hand, unwholesome actions result in suffering for oneself and others.”<sup>54</sup>

Furthermore, Tibetan Buddhist belief in reincarnation means that actions in a past life can ripen in one’s current existence. Tibetan Buddhist philosopher, author, and monk Matthieu Ricard describes “the transmission of consciousness...from one existence to the next” as a bit like a radio wave traveling through space. A consciousness impaired by negative afflictions in one life can carry impairments onto the next one, predisposing one towards mental illness. This understanding of karma justifies Choetso’s belief that someone with schizophrenia should reflect on their past actions in order to understand their current suffering.

At first, the karmic explanation of mental disorders troubled me. From my Western perspective, Choetso’s understanding of schizophrenia carries a whiff of stigma. Psychiatric understandings of schizophrenia put the blame on genetics, early life injuries, and other uncontrollable factors. Yet if one blames karma for one mental illness, they assert that the disease is a result of our own actions. It is less an illness than a punishment. It is hard to avoid the implication that schizophrenia is the sufferer’s ‘fault’--or at least the fault of their past self.

I brought up my concerns to Dr. Namdon. She disagreed with my interpretation that believing in karma ‘blames’ those who have mental illness: “That’s not how we think about it.” Dr. Namdon explained that karma is “a good thing and a bad thing also. Because that’s how you cope with situations, you know. For example, if someone is diagnosed with cancer we would believe [that] maybe he has done some bad things in the past or in the present...so most of the time for the person maybe it’s better in accepting that...it’s because of the past deeds that I might have done...It’s more easy to accept the condition. And that’s in a good way... Less angry, and more accepting.”

Part of the acceptance of karma gives those suffering from illness hope. If one has accumulated ‘bad’ karma, one can carry out positive actions to balance the scales. From this perspective, karma is empowering and allows the mentally ill to take control over their ‘condition.’ Indeed, Men-Tsee-Khang’s *Fundamentals of Tibetan Medicine* recommends that those afflicted by “evil spirits...save the lives of animals, help the poor and needy, etc., to build up virtuous actions.”<sup>55</sup> These tasks are far more achievable than, say, fixing one’s neurobiology.



*Butter lamp offerings at the Dalai Lama Temple*

<sup>54</sup> Nanako Sakai, "Ancestors Are the Storytellers: The Realm of the Hungry Ghost and Hell in Buddhism," *Religious Education* 117.5 (2022): 414-425.

<sup>55</sup> Lobsang Tsultrim Tsona and Tenzin DAKPA, *Fundamentals of Tibetan Medicine* (Dharamshala: Men-Tsee-Khang Publications 2001) 46.

## Part 3: “Poison the spirits”



*The sun shines through clouds, viewed from a Triund hill station overlooking Dharamshala*

Over lunch one afternoon, I asked Dr. Dhonden about antipsychotics. I expected him to be skeptical. Many Tibetans whom I talked to, especially those involved with traditional medicine, were wary of pharmaceuticals. Some pointed out that ‘Western’ drugs failed to treat the root cause of disease. Others felt that they carried more side effects than traditional Tibetan medicine. Yet Dr. Dhonden enthusiastically endorsed psychiatric medication: he believes that such drugs can be very effective in people with psychosis because they “mix with the blood” and “poison the spirit”. This makes the “evil spirit want to move outside the body.” Pharmaceuticals can be thought of as exorcisms in a pill bottle.

I asked Dr. Dhonden about electroconvulsive therapy. Zapping a patient with over 100 volts of electricity might not seem as benign as prescribing them pills. Yet Dr. Dhonden also thought that this treatment could be “very effective” for one possessed by evil spirits. He drew parallels to Golden Needle Therapy. In Golden Needle Therapy, Dr. Dhonden explained that a Tibetan doctor will heat a needle to very high temperatures. They will then pierce the patient’s skull at carefully chosen locations to assist *rLung* flow. Granted, Men-Tsee-Khang texts describe golden needle therapy as a “drastic” measure. Yet electroconvulsive therapy is similarly used as a last resort for patients with schizophrenia.<sup>56,57</sup> Dr. Dhonden suggested that both therapies use large amounts of energy--one in the form of heat and puncturing, the other in the form of electricity--to treat diseases of the brain.

I probably should not have been surprised that Dr. Dhonden was open to psychiatric practices. His entire practice integrates allopathy. Most of the patients that I saw Dr. Dhonden treat came to the clinic with bulky folders of X-ray photographs, ultrasound scans, or lab values. Dr. Dhonden would use the clinical information to guide his treatments. If a scan showed a tumor in the left lung, he would take special care in applying *mandala* stamps on points connected to that part of the body. He could monitor the effectiveness of his herbal medication for kidney disease through lab values on the organs’ function. Dr. Dhonden explained that most Men-Tsee-Khang doctors learn to interpret allopathic data through university courses or as they worked with more experienced Tibetan doctors.

Dr. Dhonden is not the only Tibetan healthcare worker open to collaboration with allopathic doctors. In Bylakuppe, a Tibetan colony in south India, the monastery runs a clinic where allopathic and traditional Tibetan doctors work side by side.<sup>58</sup> Choetso thinks that practitioners of traditional Tibetan medicine should work “together” with psychiatrists. ‘Dawa’ agreed and will recommend that some patients consult a psychiatrist for sleep issues. Dr. Namlha of Men-Tsee-Khang has seen patients taking just Western medicine, just traditional Tibetan medicine, or a combination of both to treat mental illness. She also concluded that “integration is what all of us need.”



The outside of Dr. Dhonden's clinic

<sup>56</sup> Grover S, Sahoo S, Rabha A, Koirala R. ECT in schizophrenia: a review of the evidence. *Acta Neuropsychiatr.* 2019 Jun;31(3):115-127. doi: 10.1017/neu.2018.32. Epub 2018 Dec 3. PMID: 30501675.

<sup>57</sup> Tsona, 61.

<sup>58</sup> This pluralistic model is also standard in Bhutan.

His Holiness the Dalai Lama would likely agree. He argues that Tibetan and Western medicine should reconcile their practices:<sup>59</sup>

*Tibetan medicine is far more advanced in the understanding of the nature of mind than Western medicine. In matters of understanding the physical functioning of the human body, Tibetan medicine...is less advanced than the Western medicine. Without mixing the two approaches, and without saying one is better than the other, both schools should work together in order to find ways of understanding each other and thus boost the effectiveness of the two healing techniques.*

Both allopathic and traditional Tibetan medicine are frustrated by chronic mental illness. Within Tibetan medicine, pujas often fail to rid people of the symptoms of possession. Other techniques, like herbal medicine and astrology, can be similarly thwarted. Allopathic medicine has used advanced neuroscience and precision science to make great strides in treating psychosis spectrum disorders. But for many, diseases like schizophrenia are crippling.<sup>60</sup> Perhaps the two systems can work together to improve outcomes.

There may be more common points for dialogue than meet the eye. I asked Dr. Namlha how she would approach a patient showing signs of psychosis. Her investigation relies partly on urine analysis and pulse reading, arts unfamiliar to most Western doctors. But her proposed interrogation covers much of the same ground that a psychiatrist might explore. She emphasized the importance of “previous karmic imprints, their parent’s actions, nature of sperm and eggs of patients, diet and lifestyle mother has taken during pregnancy, environmental factors they have [been] exposed to after being born.”

Of course, Western psychiatrists would almost certainly not consider the role of karma. Dr. Namlha also emphasized “one unique aspect of Tibetan understanding...some mental disorders arise from [the] influence of evil spirits.” Nevertheless, despite the seemingly incompatible theories of spirits, karma, and neurobiology, Tibetan and allopathic medicine agree on many of the same concepts surrounding psychosis spectrum disorders. The real difference is in their language and proposed mechanisms. For instance, both systems recognize diseases like schizophrenia as heritable. Allopathic medicine deduces that risk factors for schizophrenia can be carried from parents to offspring via genes. On the other hand, Dr. Namlha explained that defective energies (e.g., *rLung*) in sperm and eggs transmit risk for the disease. If the word ‘defective energies’ was replaced by DNA, the concepts would be virtually identical.

Similarly, Tibetan medicine pinpoints fetal development as a critical risk period for the development of mental illness. Stress to the mother, poor diet, and emaciation can all increase the odds that a child will develop mental disorders. Allopathic medicine also links fetal damage to the development of schizophrenia.<sup>61</sup> Like allopathic medicine, Tibetan medicine links upbringing “parents’ actions” and “environmental factors” to mental illness. And as in psychiatry, Dr. Dhonden observed that adolescence is a particularly vulnerable time for the development of psychosis spectrum disorders.

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<sup>59</sup> Tsona, back cover.

<sup>60</sup> Insel, 187.

<sup>61</sup> E. Lipner, S.K. Murphy, and L.M. Ellman, “Prenatal Maternal Stress and the Cascade of Risk to Schizophrenia Spectrum Disorders in Offspring,” *Curr Psychiatry Rep* 21, 99 (2019), <https://doi.org/10.1007/s11920-019-1085-1>

Tibetan astrology<sup>62</sup> and psychiatry could also benefit from increased dialogue. Tenzin Loden, a seasoned astrologer at Men-Tsee-Khang, argues that diseases like schizophrenia have so “many layers” that perspectives from many different fields are needed to increase the “scope of helping.” Tenzin Loden counts astrology as one way to assist those suffering from psychosis spectrum disorders.

During our conversation, Tenzin Loden carefully referred to himself as an ‘astroscientist,’ not an astrologer. He recognizes that many Western people, especially Western scientists, are skeptical of anything astrological. The field conjures images of pop-horoscopes offering dating advice or fashion advice.

Granted, like such pop horoscopes, Tenzin Loden puts great importance on date of birth and one’s zodiac sign. He argues that time of birth can provide useful information about one’s temperament. He acknowledges that some astroscientists hold more “extreme” views that planets physically determine events on Earth. These astroscientists believe that the position of the planets “makes the world go around.” Tenzin Loden takes a more nuanced approach. He believes that the position of the planets provides important data: “From the experiences that we have gathered over many years...we do see [that] certain positioning of certain planets really gives us a signal.”

Tenzin Loden recalls the words of one of his astroscience mentors: “Look around, everything is a sign.” Events in the natural world can correlate with human well-being and actions. For Tenzin Loden, the positions of the planets are particularly strong natural signs.

Looking to the planets to explain mental illness may seem far-fetched to many scientists. But Western clinicians have repeatedly linked natural events to human illness. For instance, rigorous scientific studies of more than 100,000 patients have tied the risk for schizophrenia to season of birth in many Northern and Southern hemisphere locations.<sup>63</sup> Scientists struggle to explain the phenomenon but hypothesize roles for seasonal illnesses or differences in sunlight. People born in certain years, say during the Dutch Hunger Winter following World War 2, also show higher rates of schizophrenia.<sup>64</sup> On a smaller scale, two years ago Tenzin Loden helped conduct a study of over 100 Men-Tsee-Khang patients that connected mental illness to year of



*The entrance to the main Men-Tsee-Khang building*

<sup>62</sup> Tibetan astrologers draw on traditional knowledge about the elements, magic square numbers, and horoscopes. They provide advice on birth, marriage, death, illness, and difficult decisions. Astrologers use the position of the planets and charts to predict the future. For instance, they may construct a birth chart to determine if a newborn is predisposed to illness. Astrologers can also create protective amulets to help people overcome obstacles.

<sup>63</sup> Geoffrey Davies, BMedSc, Joy Welham, MAPs, David Chant, Ph.D., E. Fuller Torrey, M.D., John McGrath, M.D., Ph.D., A Systematic Review and Meta-analysis of Northern Hemisphere Season of Birth Studies in Schizophrenia, *Schizophrenia Bulletin*, Volume 29, Issue 3, 2003, Pages 587–593, <https://doi.org/10.1093/oxfordjournals.schbul.a007030>.

<sup>64</sup> Hoek, H., Brown, A. & Susser, E. The Dutch Famine and schizophrenia spectrum disorders. *Soc Psychiatry Psychiatr Epidemiol* 33, 373–379 (1998). <https://doi.org/10.1007/s001270050068>.

birth. Tenzin Loden acknowledges that his predictions cannot be certain. They may work “75-80%” of the time for a given patient. Furthermore, his astrological predictions are not linked to specific events or explanations. But the concept that variations in nature can correlate with mental health should not be strange to Western science. It should not be absurd to consider the patterns that Tibetan astrosciences have observed over hundreds of years of practice.

Allopathic psychiatry might benefit from other longstanding observations of Tibetan medicine. In recent years, scientists have linked mental illnesses ranging from depression to schizophrenia to the microbiome and diet.<sup>65</sup> Some scientists believe that impaired glucose metabolism could explain schizophrenia; they point to data linking a ketogenic diet to reduced symptoms of schizophrenia in both animal models and some humans.<sup>66</sup> These findings would not be surprising to practitioners of traditional Tibetan medicine. Tibetan medical texts emphasize the crucial role of diet in health. For instance, Dr. Namlha explained that all foods have properties linked to the basic energies of *rLung*, phlegm, and bile. Consuming more food with one of the six properties<sup>67</sup> of *rLung* can contribute to mental distress. Perhaps a collaboration between Western scientists and traditional Tibetan doctors could link the findings of the two fields.

### §

Traditional Tibetan religious and medical figures operate with very different philosophies than most psychiatrists. It does not make sense for one to replace the other, as they address different aspects of the human experience. But there is plenty of room for Tibetan doctors and psychiatrists to work together. For instance, some patients come to Dr. Dhonden so that he can treat the side effects that they are experiencing from chemotherapy. A similar model could work for those dealing with the side effects of antipsychotics. Dr. Namlha has helped treat such patients who complain of drowsiness and loss of concentration associated with their medication. She maintains that “integrating both [Tibetan and allopathic] medicines together works better.”

The relationship between Tibetan medicine and psychiatry could also be thought of as that between a therapist and a psychiatrist. Indeed, as Yeshe Gyaltzen explained, Tibetan Buddhist practices focus on the “cognitive” aspects of mental disorders. Consultations with a lama could be thought of as similar to Cognitive Behavioral Therapy. Both practices work to identify and break down destructive thought patterns.

On the other hand, Tenzin Loden felt that his work was similar to that of a “psychotherapist.” His main goal is to build a trusting relationship with his patients--similar to the ‘therapeutic alliance’ of psychotherapy.<sup>68</sup> His techniques differ from most Western models of therapy. For instance, Tenzin Loden tries to impress patients with his predictions about the nature of their lives. He gained one patient’s trust by using astrological procedures to guess that their depression began when they were 27 and was brought on by multiple stressful events. Such techniques may make Western mental health workers squirm. Tenzin Loden’s style harkens back

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<sup>65</sup> Rogers, G. B., et al. "From gut dysbiosis to altered brain function and mental illness: mechanisms and pathways." *Molecular psychiatry* 21.6 (2016): 738-748.

<sup>66</sup> Sarnyai, Zoltána,b; Kraeuter, Ann-Katrina,b; Palmer, Christopher M.c. Ketogenic diet for schizophrenia: clinical implication. *Current Opinion in Psychiatry* 32(5):p 394-401, September 2019. | DOI: 10.1097/YCO.0000000000000535

<sup>67</sup> The six properties of *rLung* are rough, cold, light, subtle, hard, and mobile.

<sup>68</sup> Ardito RB, Rabellino D. Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Front Psychol.* 2011 Oct 18;2:270. doi: 10.3389/fpsyg.2011.00270. PMID: 22028698; PMCID: PMC3198542.

to the mysterious, showy performances of Mesmerists, whose theatrical techniques convinced patients that Mesmerists could control their ‘animal magnetism.’<sup>69</sup>

But as Tenzin Loden explained, “When you feel like nothing is working, belief and faith play a very important role.” Tenzin Loden has treated many patients with chronic mental illness that they thought was incurable. His main goal is to give patients hope: “Once hope is gone nothing really remains.” Loden’s formulation mirrors Yeshe Gyaltsen’s analysis that a lack of hope underlies all mental illnesses, including schizophrenia. For many Tibetan Buddhists, culturally relevant figures like astrologers and lamas are much better positioned to instill hope for the future than an allopathic doctor.

Comparing hope to a door, Tenzin Loden then predicted: “if the outer door is open, then the medicines tend to work more” Combining psychotherapy and psychiatry often leads to better outcomes for the patient.<sup>70</sup> For some patients with psychosis spectrum disorders, the same could be true for combining traditional Tibetan practices and psychiatry. When I asked Tenzin if psychiatrists could work with lamas, she worried that psychiatrists would not be receptive “that depends on the culture...” Many Tibetan Buddhist understandings of psychosis, from the role of spirits to karma, fall outside mainstream psychiatry. But an openness to collaborating with people from different world systems could allow patients to access the benefits from both fields.

On the other hand, some differences between psychiatry and traditional Tibetan practice seem irreconcilable. Psychiatrists should be careful to respect views that may seem bizarre from an allopathic point of view. Take the story of ‘Lhamo,’ a Tibetan from a Himalayan village in northern Nepal. She currently studies social work in Kathmandu and is supportive of psychiatric models of mental illness. But she also believes in spiritual occurrences that escape allopathic understandings.

‘Lhamo’ told me that when she was a young girl, a witch possessed her mother. Lhamo’s mother first began to act strange as the two of them were at a wedding. She began feeling cold. Warm jackets did not help, and Lhamo’s mother insisted on going home. Yet she could barely walk. She would sit in random locations: in the street, in front of other people’s houses. She began to recall memories of her day that had plainly not occurred.

Observant villagers realized that Lhamo’s mother must be possessed. There was a woman in the village who held witch-like powers. She had been known to possess people in the past. Even more damning, Lhamo’s mother recalled events--such as going to the market that morning--that villagers had seen the witch woman do. It seemed that Lhamo’s mother was recalling the woman’s memories.

Lhamo’s aunt helped bring her mother home. They performed a *puja* to help dispel the spirit. Then, Lhamo’s aunt took a leather belt and began to beat her mother. ‘Lhamo’ was horrified. She tried to stop her aunt but was pushed back. Her aunt explained that she had to beat out the spirit--but that Lhamo’s mother would not be physically hurt. Lhamo watched the beating with misery. But sure enough, after the beating Lhamo’s mother began to recover. And when ‘Lhamo’ later checked the area where she had been beaten, there were no lash marks to be seen. Local legend held that one could beat someone possessed by a spirit and the spirit would absorb

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<sup>69</sup> Jessica Riskin, *Franz Anton Mesmer*, online, Stanford Libraries. Available: <https://exhibits.stanford.edu/super-e/feature/franz-anton-mesmer-1734-1815>

<sup>70</sup> Kamenov K, Twomey C, Cabello M, Prina AM, Ayuso-Mateos JL. The efficacy of psychotherapy, pharmacotherapy and their combination on functioning and quality of life in depression: a meta-analysis. *Psychol Med*. 2017 Feb;47(3):414-425. doi: 10.1017/S0033291716002774. Epub 2016 Oct 26. PMID: 27780478; PMCID: PMC5244449.

all of the physical damage. One could even behead a possessed person and they could live once the spirit left their body.

None of the Tibetans whom I talked to in Dharamshala subscribed to this particular lore about spirits. They certainly did not endorse beating the possessed. But they did not dismiss the story of possession. ‘Lhamo’ knows that ‘Western’ science would dismiss her. She realizes that she does not have solid proof that her mother was really possessed. But she believes anyway. Biological disorders can cause psychosis--but ‘Lhamo’ and many other Tibetans in exile believes that sometimes, spirits can as well. Allopathic psychiatrists cannot fully gain the trust of many Tibetan Buddhists without respecting these views.

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‘Pema’ worries about Dharamshala’s younger generation. She sees more and more “youngsters” struggling with “mental issues.” Many teenagers “have a very unhappy life.” ‘Pema’ blames social media: “Nowadays people are not socializing much.” Similarly, many Western countries are facing a youth mental health crisis. Suicide ranks as the second leading cause of death among teenagers in the United States and Europe.<sup>71,72</sup> Echoing Pema, some researchers blame social media for deteriorating mental health among American adolescents.<sup>73</sup>

Faced with parallel crises, it seems especially appropriate for allopathic psychiatry and traditional Tibetan practices to work together. As the Dalai Lama pointed out, two systems as different as psychiatry and traditional Tibetan medicine cannot and should not replace each other. ‘Western’ psychiatry does not have to accept the world of ghosts and karma, just as traditional Tibetan medicine does not accept much of psychiatry’s biological determinism. But an exchange of knowledge could benefit both fields. At Men-Tsee-Khang, students of traditional Tibetan medicine learn

allopathic understandings of anatomy and brain function. What if allopathic psychiatrists became more fluent in discussing spiritual views of possession? What if they collaborated with lamas to counsel Tibetan Buddhist patients grappling with mental illness? Psychiatrists may seek long-term remission of symptoms in patients with schizophrenia. Traditional Tibetan practitioners may hope to protect patients from evil spirits. But both groups of experts could unite around a common goal: ensuring mental flourishing and happiness.



A classroom in Men-Tsee-Khang

<sup>71</sup> Alicia VanOrman and Beth Jarosz, “Suicide Replaces Homicide as Second-Leading Cause of Death Among U.S. Teenagers,” Online, Population Reference Bureau, June 9, 2016. Available: <https://www.prb.org/resources/suicide-replaces-homicide-as-second-leading-cause-of-death-among-u-s-teenagers/>

<sup>72</sup> UNICEF, “A worsening mental health situation for Europe’s children”, online, October 15 2021. Available: <https://www.unicef.org/eu/press-releases/worsening-mental-health-situation-europes-children>

<sup>73</sup> Jean M Twenge, "Increases in depression, self-harm, and suicide among US adolescents after 2012 and links to technology use: possible mechanisms," *Psychiatric Research and Clinical Practice* 2.1 (2020): 19-25.

## Appendix



*The author meeting the Dalai Lama during a public audience*

### **Project Advisor Profile**

Professor Jennifer Lambe is an Associate Professor of Latin American and Caribbean History at Brown University. She also teaches courses on the history of psychiatry. She has published books and articles on the history of mental illness and treatment in Cuba. Lambe is currently working on projects exploring the transnational history of psychiatric dehospitalization. She received her AB from Brown University and her PhD from Yale University.

### **Suggestions for Future Research and Contact Information**

As discussed in the preface, the main limitation of this project was my inability to contact individuals who had actually experienced psychotic symptoms. Researchers who are able to learn from such individuals could add crucial perspectives. My work was also limited by my poor knowledge of Tibetan. A more skilled speaker may learn perspectives that I could not access. Furthermore, research on more rural Tibetan communities may find different attitudes than I did in Dharamshala. Dharamshala is a tourist hotspot and has a lot of Western influence. These factors could bias what views I learned about during my fieldwork.

For those interested in non-psychiatric health issues, Delek Hospital does incredible work combatting tuberculosis in Dharamshala. The Tibetan in exile population suffers from very high rates of tuberculosis. Dr. Tsetan Dorji (CEO of Delek Hospital) has spearheaded a zero-TB campaign in the community. The TB clinic of the hospital does very important work and is staffed by wonderful, friendly healthcare workers. Furthermore, I learned from my conversation with Dr. Namdon that Tibetans in Dharamshala suffer from very high rates of stomach cancer. The reasons are unclear and could be very interesting to investigate.

Feel free to reach out to me at [donald\\_daniel@brown.edu](mailto:donald_daniel@brown.edu) or +1-703-408-1811.

## Interviews and Interviewee Profiles

Pseudonyms are in quote marks, while actual names are as written.

‘Lhamo,’ March 29, 2023. Interview conducted in Sermatang, Nepal.

*‘Lhamo’s’ father was born in the Utsang region of Tibetan while her mother is from Humla, a region on the border between Tibet and Nepal. ‘Lhamo’ strongly identifies with her Tibetan heritage. She is currently completing a Bachelor of Social Work in Kathmandu.*

Choetso, April 17, 2023. Interview conducted in the Delek Hospital Branch Clinic in McLeod Ganj, India.

*Choetso was born in India after her parents fled Tibet following the Chinese invasion. She trained as a nurse for 3 years in Delhi and has worked at Delek Hospital for 25 years. She has worked at the quieter branch clinic for a few months. She mostly treats colds, manages chronic illnesses like hypertension and diabetes, or gives basic first aid. Choetso identifies as a religious Buddhist.*

‘Dawa,’ April 18, 2023. Interview conducted in Dharamshala, India.

*‘Dawa’s’ parents fled from Tibet in 1960. She studied nursing at K. S. Hegde Medical Academy in Mangalore, India, and worked as a nurse in Delhi for 7 years. Dawa works at a clinic that mostly serves monks and nuns.*

‘Dorjee,’ April 18, 2023. Interview conducted at the Men-Tsee-Khang Museum in Dharamshala, India.

*‘Dorjee’ worked as a Tibetan herbal medicine dispenser at Men-Tsee-Khang for 15 years. She currently works in the Men-Tsee-Khang Museum. ‘Dorjee’ has lived in Dharamshala since childhood. Her parents were born in Tibet.*

Dr. Kelsang Dhonden, April 19-20, 2023. Interview conducted at the Sorig Herbal Clinic in McLeod Ganj, India.

*Dr. Kelsang Dhonden is a doctor of traditional Tibetan medicine. He owns and runs the Sorig Herbal Clinic in McLeod Ganj. He completed his training in traditional Tibetan medicine at Men-Tsee-Khang and studied allopathic medicine at Delek Hospital during his internship. Dr. Dhonden conducts traditional pulse readings and urine analysis. He also makes his own medicine. Dr. Kelsang was born in Tibet.*

Dr. Tenzin Namdon, April 21, 2023. Interview conducted at Delek Hospital in Dharamshala, India.

*Dr. Tenzin Namdon is a medical officer at Delek Hospital. She received her training from Dr. Rajendra Prasad Government Medical College in Kangra, India. Dr. Namdon started working at Delek Hospital in 2017. She was born in the Orrisa Tibetan settlement and grew up in Dharamshala.*

‘Pema,’ April 21, 2023. Interview conducted at Delek Hospital’s TB clinic in Dharamshala, India.

*‘Pema’ is a 35-year-old nurse working for the TB clinic affiliated with Delek Hospital. ‘Pema’ received her training in Bengaluru and has been a nurse for 8 years. She has worked at the TB clinic for 6 months. ‘Pema’ was born in Tibet and entered India when she was 5.*

Yeshe Gyaltzen, April 24, 2023. Translated from Tibetan to English by Ringzen Wangmo. Interview conducted in McLeod Ganj, India.

*Yeshe Gyaltzen is a Tibetan Buddhist monk. Gyaltzen joined the monkhood when he was 13 and living in the Kham region of Tibet. Gyaltzen entered India when he was 18. He has studied Buddhist philosophy for over 25 years.*

Dr. Tenzin Dhola, April 24, 2023. Interview conducted at Dr. Dhola’s Tibet Power Healing Centre in McLeod Ganj, India.

*Dr. Tenzin Dhola is a ‘power healer’ who practices traditional Tibetan medicine, reiki, sound healing, and other techniques. He received his training in traditional Tibetan medicine at Men-Tsee-Khang. Dr. Dhola was born in Tibet and fled to India in 1985.*

Dr. Namdol Lhamo, April 27, 2023. Interview conducted at Men-Tsee-Khang Medical College in Dharamshala, India.

*Dr. Lhamo is the Vice Principal of Men-Tsee-Khang Medical College and a member of the teaching faculty. She received her training in Tibetan Medicine at Men-Tsee-Khang and has taught at the college since 2012. Dr. Lhamo also worked in Men-Tsee-Khang’s branch clinic in Bangalore.*

Dr. Namgyal Lhamo and Tenzin Loden, May 1, 2023. Interview conducted at Men-Tsee-Khang in Dharamshala, India.

*Tenzin Loden is the head of Men-Tsee-Khang's Department of Astro-Science Outreach and Development. He trained in astroscience at Men-Tsee-Khang and teaches there as a lecturer. Loden also conducts research ranging from the effect of season of birth on mental illness and Thukdam, a phenomenon where a realized master's consciousness can remain in their body for days after physical death.*

*Dr. Lhamo trained as a doctor of traditional Tibetan Medicine at Men-Tsee-Khang, where she now works. She currently serves the research department of Men-Tsee-Khang. Dr. Lhamo has also worked with patients suffering from addiction at the Kunphen Rehab Center.*

### ***Additional Pictures from Dharamshala***







*A demonstration in support of His Holiness the Dalai Lama*

## Glossary of relevant Tibetan terms

Wylie transliteration given in italics.

*Bad kan* (བད་ཀན་): phlegm, one of the three bodily humors. Associated with earth and water. A heavy and viscous humor that can manifest in the brain, leading to dullness and depression.

*gDon* (གདོན་): roughly equivalent to ‘evil spirit’. Phonetically ‘duhn’.

*Lay nad* (ལཱ་ནད་): literally ‘brain disease’, a more modern term for mental illness.

*Lu* (ལུ): a half-human, half-serpent deity that protects nature. The deity will punish humans who desecrate nature with skin sores. Also called *naga*.

*mKhris pa* (མཁྲིས་པ་): bile, one of the three bodily humors. A hot humor associated with fire. *mKhris pa* can be found in the liver and gall bladder, where it increases body heat. *mKhris pa* is associated with anger.

*Pu cha* (ཕུ་ཇ་): Tibetan butter tea

*rLung* (རླུང་): one of the three bodily humors. *rLung* is associated with air. Elevated *rLung* is associated with anxiety and mania. Its main properties are rough, cold, light, subtle, hard, and mobile.

*Sems mi bte ba* (སེམས་མི་བདེ་བ་): ‘Mind is unwell,’ an inclusive category of mental illness that could include allopathic notions of depression alongside psychosis. Phonetically ‘sem mi de wa.’

*Sems skyon nad rigs* (སེམས་སྐྱོན་ནད་རིགས་): issues with the mind. Phonetically ‘sem kyon nad rik.’

*Snyom ba* (སྟོན་པ་): a ‘mad’ person. Phonetically ‘nyom ba.’

*Smyo* (སྟོ་ལྗོ་): any sort of insanity, including drunkenness. More akin to positive symptoms of psychosis (e.g., delusions and hallucinations) than negative symptoms (e.g., withdrawal, catatonia). Phonetically ‘nyo.’

*Smyo nad* (སྟོ་ནད་): literally ‘mad disease,’ any sort of insanity.

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