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# From Sadness to Madness: Tibetan Perspectives on the Causation and Treatment of Psychiatric Illness

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**Abstract:** Buddhist-derived "mindfulness" practices are currently enjoying popularity amongst both the lay population and health professionals in the West, especially in the treatment of psychiatric conditions such as depression. This popularity leads to questions regarding how people in diverse Buddhist communities might conceptualise psychiatric illness and healing. This paper explores perspectives on psychiatric illness within a Tibetan Buddhist community in North India, focusing on the role of "emotions" in causation and treatment which was frequently discussed by informants. Comparisons between biomedical perspectives on emotional "disturbance" as a symptom of psychiatric illness and Tibetan conceptions of emotions as causal or contributory factors in a number of psychiatric illnesses are discussed. Three case studies are described to illustrate some of these common perspectives, examine how they are reflected in health-seeking behavior, and consider comparisons between the two systems.

**Keywords:** Tibet; psychiatry; madness; Buddhism

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## 1. Introduction

Buddhist-derived mindfulness-based practices such as mindfulness-based cognitive therapy (MBCT) and mindfulness-based stress reduction (MBSR) are enjoying popularity in contemporary psychology and psychiatry in the West. Williams and Kabat-Zinn note the significant growth in the field of what they term "mindfulness-based applications" during the late 1990s ([1], p. 2), with MBSR having been founded in 1979 ([1], p. 3) (See Jon Kabat-Zinn (2011) for a description of the evolution of the MBSR [2].) The roots of this however, lie in the growing interest in Buddhist (and other

Eastern) meditative practices in the West during the 1960s and 1970s ([3], p. 20). More recently, MBCT has been recommended by the UK's National Institute for Health and Clinical Excellence (NICE) for the prevention of relapse in patients who have experienced three or more episodes of depression for a number of years ([4], p. 35), and in the UK MBCT is often available through the government-funded National Health System (NHS). In addition, research has also examined the efficacy of MBCT in the treatment or management of certain psychotic disorders [5]. This leads to the question of whether these practices—described as "central to Buddhist practice" by Dreyfus ([6], p. 41)—reflect broader perspectives on psychiatric illnesses and their treatment found in divergent Buddhist communities. In fact, what *is* "mindfulness"? In the Western context, Dreyfus notes, "mindfulness" is often understood as a "non-elaborative and non-judgmental present-centred awareness" ([6], p. 42), and Batchelor has noted the similarity between MBCT and the "Four Great Efforts" taught by the Buddha ([7], pp. 159–60). Bhikkhu Bodhi tells us that "mindfulness" lies "[a]t the heart of all classical systems of Buddhist meditation", with "right mindfulness" (Pali: *sammā sati*, Tib.: *dran pa*) the seventh factor of the "Noble Eightfold Path", the fourth of the Four Noble Truths: the way leading to the cessation of suffering ([4], p. 20). The Pali term "*sati*" was first translated into English as "mindfulness" by the founder of the Pali Text Society, the translator T. W. Rhys Davids ([3], p. 23), although Bodhi notes that the term is actually used in multiple ways in the Pali texts [3]. However, perhaps significantly, Western appropriations of "mindfulness" have not always been well-received by Buddhists ([3], p. 35; [6]) and Dreyfus notes that the understanding of "mindfulness" as "non-elaborative and non-judgmental present-centred awareness" is only a "partial understanding" of the Buddhist concept ([6], p. 52), and disagreements remain over definitions of the term ([8], p. 219; [9]). Nevertheless, whilst Western mindfulness-based practices primarily derive from the Theravadin Buddhist context, if, as Batchelor and Bodhi suggest, such a concept is tightly related to fundamental Buddhist notions such as the Four Noble Truths and Four Great Efforts, then we might expect to some see parallels with these concepts in all Buddhist traditions.

This paper focuses on a specific area of causation and treatment which arose during research within a Tibetan Buddhist community in India: the role of emotions in "psychiatric illness" [10]. In the biomedical context, concepts of psychiatric illness often include "inappropriate emotion" amongst symptoms. Kring, for example, has discussed the ubiquity of "emotion disturbances" listed across the fourth edition of the biomedical *Diagnostic and Statistical Manual of Mental Disorders Text Revision* (DSM-IV TR) [11], including symptoms related to the excess, deficiency, or regulation of emotions [12]. In contrast, for Tibetan Buddhists, the idea of "controlling of the mind"—which is often used to mean controlling one's emotions—is sometimes discussed as an effective treatment. Enterprises such as the Mind and Life Institute in Dharamsala, India [13], have attempted to bring together a number of Tibetan Buddhist and Western scientific perspectives through dialogues between Tibetan religious experts and Western scientists. Some of these dialogues have included discussions on this issue, and have been published under titles such as *Healing Emotions* [14] and *Destructive Emotions* [15].

This paper will explore some Tibetan perspectives on the causation and treatment of a number of conditions categorised as "psychiatric" or "mind" illnesses in either Tibetan or biomedical terms, focusing on the role of cognitions and emotions. I will describe three case studies from fieldwork conducted within a Tibetan community in Darjeeling, North East India [16] to illustrate some of these

concepts in more detail, and examine how these perceptions of illness are reflected in health-seeking behaviour for example, in ideas of "controlling of the mind".

## 2. The Tibetan *rGyud bZhi* Medical Text and Biomedical Comparisons

Whilst there are a number of Tibetan medical and Tantric texts which cover conditions which might be termed "psychiatric", it is the the *rGyud bZhi* ("Gyu Shi": "Four Tantras") that is the "single core text" which forms the syllabus of the Tibetan government-in-exile affiliated Men-Tsee-Khang (MTK) Tibetan Medical and Astrological Institute in Dharamsala [17], and it is therefore the text which I will focus on here. Parts of the *rGyud bZhi* pertaining to "illnesses of the mind" (Tib.: *sems nad*) were translated during the 1980s by Terry Clifford in her book *Tibetan Buddhist Medicine and Psychiatry* [18]. Examining Tibetan textual descriptions of illness, she drew comparisons between some of the Tibetan classifications and certain biomedical diagnostic categories, using the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) [19]. [Writing at this time, she would have been referencing the third edition of the DSM (DSM-III), published in 1980 [20]. Other works—by both Tibetan and Western authors—followed, and more recently, ethnographic research has started to illustrate how some of these *rGyud bZhi* concepts are used in Tibetan doctors' practice in both Chinese-controlled Tibet and exile Tibet, as well as in the West.

In the *rGyud bZhi*, conditions which are described in Tibetan as "*sems nad*" ("sem né": "illness of the mind"), and those which would be regarded by contemporary biomedicine as "psychiatric illnesses" are covered in two sections of the Third Tantra (also known as the "Explanatory Tantra"): under the general category of *rlung* (wind: one of the three bodily "humours" or "faults") illnesses in Chapter 2; and under the category of "*smyo nad*" ("*nyö né*": "madness caused by spirits") in Chapter 78. Accompanied by commentaries, the *rGyud bZhi* covers the epistemological framework of medicine, medical theory, terminology and diagnostic and treatment methods ([17], p. 16). The text is thought to date from the twelfth century, and includes influences from multiple sources including Ayurvedic, Persian and Chinese texts, as well as original Tibetan medical concepts [21]. The Tibetan term "*sems nad*" is used in the *rGyud bZhi* to denote any kind of psychiatric illness, with the term "*smyo nad*" generally translated as "madness" or "insanity" [22]. Comparisons have been drawn between certain Tibetan textual diagnoses and biomedical diagnoses from the DSM and the WHO's *International Classification of Disease* (ICD), such as Colin Millard's relation of biomedical "neurotic" states with various Tibetan terms conveying depression or anxiety, and "psychotic" states (such as "schizophrenia" and "bipolar disorder") with *smyo nad* [22].

In Darjeeling, the term "*sems nad*" was mostly used to denote problems that we might liken to depression or anxiety, and "*smyo nad*" was often described with similar symptomatology to psychosis. Nonetheless, translations sometimes proved problematic, with one Tibetan term being translated into several different English terms and vice versa; and many terms had no direct or satisfactory translations. Moreover, there were also significant divergences between Tibetan and biomedical perspectives—often in terms of differences in cross-cultural norms of behaviour. Of course, "norms" can diverge not only across cultures, but also across time: see, for example, some of the current discussions of the recently-published fifth edition of the DSM (DSM-5) [23], including comments on the "reclassification" of grief into "Major Depressive Disorder" and changes to the boundaries between

"normal" anxiety and "Generalised Anxiety Disorder" which Frances has commented on in an online article [24]. Furthermore, in Darjeeling, divergences between biomedical and Tibetan approaches were especially evident in terms of perceptions of *causation* of psychiatric illnesses, where psychological factors and emotions such as sadness or anger were often discussed.

In the West, Tyrer and Steinberg delineate five models through which the causation of mental disorders is approached: disease; psychodynamic; cognitive-behavioural; social and integrated [25]. In reality however, both patients and doctors often understand both causation and treatment to be multifactorial; and in addition, religious and/or spiritual concepts are prevalent in many patients' explanatory frameworks [26].

The World Health Organization defines "mental health" as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" [27]. In comparison, in their paper *Mind and Mental Disorders in Tibetan Medicine*, Epstein and Topgay explain that from a Tibetan Buddhist perspective, "[m]ental health is defined as a mind freed from the influence of the afflictive mental factors [Tib.: *nyon mongs*, Skt.: *klesha*]" ([28], p. 68). Consequently, these "afflictive mental factors" or *nyon mongs* ("nyön mong") are also implicated in physical and mental *ill*-health: "Of the three types of mental factors, the afflictive factors (such as greed, hatred, pride, envy, lack of insight, *etc.*) are seen as the ultimate underlying causes of both physical and mental diseases" ([28], p. 68). In addition, they explain how the three root *nyon mongs* of desire, hatred, and ignorance are fundamentally involved in health, in that they are said to give rise to the three *nyes pa* (bodily "humours" or "faults") of *rlung* ("loong": wind), *mkhris pa* ("tri pa": bile), and *bad gan* (bé ken": phlegm), disturbances in which lead to illness:

> The three nyes-pa owe their arising to the three afflictive mental factors that serve as the roots of all unwholesome states of mind and that in Buddhist theory serve as the basis for birth in cyclic existence... Tibetan medicine ultimately attributes imbalances in any of the three nyes-pa to psychological causes ([28], p. 71).

We can read here an interesting relationship between these "mental factors" and illness—with certain factors causing disturbance in any of the three humours, and this disturbance then, manifesting as mental illness. Clifford summarises: "Emotional imbalance produces humoral imbalance that is manifested as a psychiatric disturbance" ([18], p. 139).

These "*nyon mongs*" are sometimes translated into English as "destructive emotions" or "negative emotions", and some researchers have discussed their role in mental health from a more Western perspective. For example, Goleman defines "destructive emotions" as those emotions which "cause harm to ourselves or others" ([15], p. xx). However, this is slightly problematic, not least due to the very different Western and Tibetan conceptions of what might constitute "harm" in this context. Ricard, for example, describes the Western perception of a "destructive emotion" as a state which results in obvious harm, contrasting with a Tibetan understanding of a more subtle harm in the form of distorting our perception of reality ([15], p. 75). Moreover, in terms of the nature of "emotions" themselves, there are also significant divergences between Western and Tibetan concepts. Ricard explains the Buddhist perception of an emotion as "something that conditions the mind and makes it adopt a certain perspective or vision of things" ([15], p. 75). On the other hand, Western theories such

as Lazarus's [29] emphasise the primacy of cognitive appraisal in the formation of emotions, while somatic theories centralise physiological components. In the absence of a consensus of what might constitute an "emotion" as opposed to say, a "thought", or a "feeling", and bearing in mind the variant ways in which the term "emotion" is used both in ordinary and professional contexts in the West, I shall follow Ekman's 1999 definition here, which encompasses 17 states including anger, contentment, fear, pride, sadness, and sensory pleasure [30]—some of which are particularly relevant in this context.

Furthermore, there are also some quite divergent perspectives in Western and Tibetan approaches to *specific* emotions. If we take "anger" for example, Shweder *et al.*, use a comparison of Western and Tibetan approaches to this emotion to emphasise some of these different perspectives. The Tibetan term "*rlung langs*" ("loong lang") is similar in conception to the English term "anger", and translates literally as "rising wind"—referencing one of the three *nyes pa* [31]. They note the significant difference between Tibetans' appraisal of *rlung langs* as "morally bad", assimilating it with the *nyon mongs* "hatred"; and Americans' views of anger as morally ambivalent, a neutral process, which can even have some positive aspects [31].

In Darjeeling a number informants described *rlung langs* as responsible for causing a type of illness often called "*srog rlung*" ("sok loong", literally "life-sustaining wind", referencing both one of the many energetic *rlung* currents in the body and the condition caused by a disturbance in it). Indeed, of the three *nyes pa*, *rlung* (wind) is the one which is most commonly associated with illnesses related to the mind. Epstein and Topgay describe how "much of Tibetan psychiatry and medicine is concerned with the manifestations and treatments of the disruptions or blocks in the flow of prana [wind]" ([28], p. 68); and the *rGyud bZhi* lists psychological symptoms which can result from disruptions to *rlung*, including "mental instability" ([32], p. 36), "impairment of the sense organs", "depression", and "confusion in perception"—perhaps hallucinations or delusions ([33], pp. 222–24).What about the other stated cause of "madness" in the Tibetan *rGyud bZhi*: how have Western authors understood madness caused by "spirits" in the Tibetan tradition? Some have also suggested an "emotional" or mental component here. Chapters 77–81 of the Third Tantra of the *rGyud bZhi* list eighteen classes of spirits (Tib.: *gdon*, "dön"), including "madness-causing spirits" ("*smyo byed kyi gdon*"), and Clifford, for example, has explained the spirits in terms of psychological or emotional states, characterising them as "primarily a psychological phenomenon" ([18], p. 149). She explains that, to Tibetans, ""demon" is a symbolic term. It represents a wide range of forces and emotions which are normally beyond conscious control" ([18], p. 148). However, I would suggest that perhaps this characterisation of "spirits" as "psychological" or "emotional" states sits more comfortably with many Western readers than viewing them as actual entities. This interpretation is also perhaps reflective of some of the psychoanalytic theories of the mind which focus on the unconscious mind and its role in the causation of mental illness which were more popular in Western psychiatry prior to the 1980s, before a return to biological explanations of mental illness was in evidence in the DSM. It is important to reiterate that for many Tibetan doctors and lay Tibetans, *gdon* are perceived as entities in their own right. Indeed all of my Tibetan informants described spirits in very real terms (often with a visible form), who had the ability to cause harm in the form of psychiatric or other illnesses or misfortune in humans quite directly. For example, one interviewee related a story about his father encountering a spirit coming towards him on the road one day, describing clearly what it had looked like. Others discussed how offence of different kinds of spirits can lead to illness—from skin rashes to full-blown madness (this

will be discussed further in one of the case studies, below). Causal explanations such as these seem to be more clearly aligned with what might be termed "folk-religious" practices and concepts, but they have been fully incorporated into Tibetan Buddhism, as Samuel notes:

> [M]ost of the basic Tibetan ideas about health, illness and fate are not really Buddhist, but derive from pre-Buddhist material re-worked to some extent in Buddhist terms. They include a range of concepts [...] all referring to various kinds of energy, vitality, life-force, or good fortune, and another range of concepts [...] referring to obstacles, spirit affliction, and the like ([21], p. 250).

Moreover, for Tibetans themselves, any such distinction is not a concern. This is reflected in health-seeking behaviour, which often finds Tibetan doctors—as well as, or instead of, monastic or spirit-medium practitioners—consulted in cases of spirit-affliction.

## 3. Psychiatric Illness in Darjeeling

Due to its diverse population, Darjeeling is an area of immense medical pluralism. Medical facilities include biomedical clinics and hospitals (both private and government), Indian Ayurvedic medicine clinics, two Traditional Tibetan Medicine clinics, and at least one homeopathic clinic [34]. There are also religious healing options of various kinds, including the local Nepali spirit-medium tradition of *jhakri* and *mataji*, and Tibetan Buddhist monastic rituals. The largest monastery in the area is the Kagyupa Buddhist *Drug Sangak Choling Gonpa*, just outside the town, and I spoke to a number of people who had commissioned monks to perform rituals either at the monastery itself or at their home, to deal with different kinds of illness or misfortune.

In terms of biomedical psychiatric services, when I initially arrived in Darjeeling in February 2011, the local Government hospital psychiatric department had been out of action for some time due to a lack of staff. A psychiatrist arrived in the winter of 2011, but had only two beds available to him in the psychiatric department. From Calcutta, he was unfamiliar with the local area, and used translators to interact with any Tibetan patients (at that time that he had one Tibetan inpatient with schizophrenia). With very few medicines available at the hospital, he described how many of his patients take his prescriptions and buy their medicines from pharmacies in town. He would have liked to be able to offer psychotherapy to patients, but unfortunately this was not possible due to time constraints, as he was the sole psychiatrist there and was struggling to manage the workload alone. Two private psychiatrists visited (from Gangtok and Siliguri—both around 3–4 hours' drive away) once a fortnight to see patients in rooms at local pharmacies.

More comprehensive biomedical psychiatric services were available outside Darjeeling. The STNM Government hospital in Gangtok—about 3–4 hours' drive away in the adjoining state of Sikkim—included a psychiatric department. Patients from Darjeeling could be admitted there but would have to pay (there were no charges for Sikkimese inpatients). In addition, larger Indian cities generally have a number of private and government psychiatric clinics, hospitals, and specialist psychiatric units.

Several informants in Darjeeling reported that they had taken biomedicines for psychiatric conditions with varying levels of success. All of them had also consulted religious practitioners concurrently with any biomedical treatment(s). Generally speaking, the concept of the humoural

involvement in *sems nad* was commonly held by the majority of Tibetan interviewees—especially regarding *rlung.* As mentioned above, *rlung* is the humour that is most commonly associated with psychiatric illness, and in Darjeeling explanations of others' depressive or anxiety states through the concept of *rlung* was common, with the term "*rlung*" frequently used to denote numerous emotional states, such as grief, sadness, or anger. For example, in the days following a major earthquake in the area in September 2011, some of the elderly ladies at the Refugee Centre were not in the workshop as usual, and it was explained by those present that they had "*rlung*", and they described how they had been especially upset and afraid as a result of the earthquake. Furthermore, previous researchers have found the term "*srog rlung*" used to describe a number of different mental illnesses related to disturbance in the "life-supporting wind" in the body: it has been equated variously with biomedical classifications of depression, bipolar disorder, and schizophrenia [22]; and this was also the case in Darjeeling. Some informants described *srog rlung* as a state that biomedicine would classify as clinical depression, whereas others described it as "stress" or an illness both caused by, and manifesting as, uncontrolled anger. Others still described it as a more serious condition.

However, sometimes mental and emotional factors were also seemingly described as direct causes of *sems nad* or *smyo nad*, with little or no mention of *rlung*. A significant number of interviewees explained that various emotions such as sadness or anger can directly cause what might be viewed as "psychiatric" problems, describing an explicit causal relationship between the two. And in addition, several interviewees described cases of *sems nad* and *smyo nad* caused by *behaviours* which were motivated by particular emotions, such as greed or sadness. For example, many interviewees held the view that *sems nad* in the form of "depression" (perhaps precipitated by worry), if left unchecked or untreated, could lead to madness (Tib.: *smyo nad*). Others explained that *sems nad* and *smyo nad* are caused by an individual's inability to "control" their mind, concentrating all the time on things that they cannot have (for example, more money, or a bigger house), or an inability to deal with life events effectively. In the same way, a person's inability to deal with their anger—holding it in rather than expressing it—could lead to *srog rlung*. Some of these ideas were summed up succinctly by one informant, Tsering (59), who explained, "If you can't control your mind, you'll become mad. If you can control your mind, you'll never become mad". The impression was that "controlling the mind" often referred to being in control of one's *emotions*. In the next section I will describe three case studies which illustrate some of these concepts in more detail.

### *3.1. Jigme*

The first case study is that of Jigme, a man in his 40s who I was told had been "*smyo nad*" for around 20–25 years. He lived alone in a small room, was not in a very good state, and when I met him, he was lying on the remnants of a broken bed on the floor of his room, fidgeting with a repetitive motion of his hands and talking quietly to himself. Jigme was given meals every day, but apart from that, was largely left alone. Neighbours reported that in the past he had been quite aggressive and even violent towards other people, but these days he was generally calm. Many years ago he had received biomedical treatment: a local nurse, Lhamo, recalled helping the local biomedical doctor administer pills and a monthly injection. Others remembered vaguely that his family had initially conducted *pujas* for him and he had received blessings from a lama, but these activities had not helped significantly. As

far as they were aware, there had been no "official" diagnosis given by Tibetan medical or religious specialists. Lhamo could not recall exactly what the medication had been, but she remembered that it used to calm Jigme down for a few days each time. However, after Jigme's father had become elderly and infirm, without his instigation and practical help, this treatment had ceased.

The most common explanation for Jigme's illness given by neighbours and members of the community was that his father had taken some religious artefacts from a monastery many years ago, in order to save them during the destruction and looting of monasteries in Tibet during the Cultural Revolution. Since then, his father should rightly have "returned" the artefacts to one of the re-formed Tibetan Buddhist monasteries in India. However, the objects were said to be worth a lot of money, and people explained that Jigme's father had not wanted to let them go, and it was this "greed" or "attachment" to the valuable objects that had caused his son's illness. Jigme would subsequently continue to be "mad" until his father returned the artefacts. Unfortunately, as a few people explained, this was unlikely to happen, due to his elderly father's frail health. There was therefore unlikely to be any resolution to this situation.

It is important to note that the Tibetan doctor at a local Tibetan medicine clinic regarded this explanation as nonsense, saying that karma cannot pass from one person to another. However, many of the lay Tibetans I spoke to did view this as a possibility, even if they were not aware of this particular case. Furthermore, another explanation for Jigme's condition was given by Tsering, a neighbour and senior member of the community. He thought that Jigme had most likely conducted some Buddhist Tantric practice incorrectly, thereby offending local spirits, whose subsequent anger had caused his *smyo nad*.

### *3.2. Wangmo*

Another case I came across was that of one interviewee's mother. Lhamo (45) related how around 25 years ago, her mother Wangmo had suddenly gone "totally mad", as she described it in English. She described how her mother had been talking nonsense, hallucinating, saying strange things, unable to sleep, and not recognising her family for more than two weeks. Lhamo thought that her mother's sadness and loneliness had caused this illness, as at that time she—an only daughter—had only recently left home, having got married and moved away to Sikkim, several hours away.

Lhamo and her father took Wangmo to a local biomedical hospital, where she was prescribed Diazepam to no effect. She returned home, where her symptoms continued for several days, until she suddenly asked to visit a particular Tibetan monastic practitioner that the family knew. Lhamo described how, on journeying to see him, her mother became immediately calmer on approaching the monastery; finally recovering completely after several days of receiving blessings from the practitioner. Interestingly in this case, whilst Wangmo's madness was perceived to have been caused by her emotions—her sadness—it was cured by religious practices.

A similar story of madness caused by "sadness" was told by another informant, Phurpu (50): He described a Tibetan woman was often seen in town, talking to herself and sometimes shouting at passersby. He explained that her *smyo nad* was thought to have been caused by her sadness and frustration over her husband's affairs with other women.

### *3.3. Tenzin*

Lastly, an interesting case I came across was that of a local family—and one family member in particular, Tenzin—who were said to be experiencing "madness" as a result of a particular Buddhist practice related to the deity Dorje Shugden. Several people in the community described a woman and two of her sons as "*smyo nad*", with a third son addicted to drugs—all as a result of this practice.

There is heated debate within the Tibetan Buddhist tradition over this particular deity, particularly regarding his status and nature, with his followers claiming him to be an enlightened deity, and his opponents asserting that he is in fact a *rgyal po* ("gyel po"), a particular kind of Tibetan worldly deity, characterised by arrogance and pride. If Shugden's status *is* that of a worldly deity rather than an enlightened one, this would obviously deem him an inappropriate object of worship or refuge for Buddhists ([35], p. 281). Generally, Tibetans tend to be quite cautious in their dealings with *rgyal po*, due to their rather volatile nature, and ability to cause harm to humans. Some interviewees described how worldly deities such as these can be inadvertently offended if regular honouring of them is forgotten, or if other deities are honoured in their place, and the deities' anger or jealousy can lead to harm for those who have caused the offence. One interviewee, Tsering (53), described how, due to Chinese restrictions on religious activities in Tibet (especially during the Cultural Revolution), many younger Tibetans had not learnt from their parents how to conduct these practices related to local deities correctly, leading to problems for them. He explained that in cases such as this, the madness would most likely initially come and go—with afflicted individuals talking to themselves or shouting abuse at others—but if not treated, the condition would escalate. The only treatments in these cases, he told me, were either to consult a Tibetan monastic practitioner who is able to subdue the deity through Buddhist ritual, or to ask the deity for forgiveness, and to resume making offerings to him.

Feelings amongst Tibetans on the issue of Dorje Shugden run high. The Dalai Lama initially expressed concern over this practice in the 1970s, finally issuing a ban on the practice in 1996. His line on this is evidenced by signs such as the one outside the small temple beneath the Darjeeling Tibetan Settlement Office, politely requesting followers of Shugden not to enter. There are most likely similar signs in other Tibetan government offices across India. In 1997 the debate spilled over into violence and the death of three Tibetans in Dharamsala, and the stigma and social isolation attached to followers of Dorje Shugden is significant.

It is important to point out that there are other issues at work here too, related to Tibetan Buddhist politics [35], but for lay Tibetans the fear and stigma around this topic are palpable. The *Samten Choling* monastery just outside Darjeeling was usually referred to by local Tibetans as a "Shugden monastery", where its fifty or so monks were known to honour the deity. Informants explained that—other than unwitting tourists—the only people who visit the monastery are those who conduct this practice; to opponents of this practice it is a place to be avoided completely, and local Tibetans advised me not to visit. Several Tibetan friends told me that it would be alright to visit in order to ask questions there for my research, but that I should refuse any tea or food offered and I should be very careful not to be seen by any Tibetans walking past, who might then assume that I was a follower of Shugden. Such is the suspicion and stigma around this topic that one informant later told me that he had actually been very worried that if anyone had seen me visit the monastery and then come to visit him (as I was often visiting his house to see him and his family), then they "might also suspect" him.

One neighbour of the afflicted family, Urgen (39) explained:

> "If you go to Samten Choling, and salute to the Shugden statue, I don't think you will immediately become crazy... But if you go and worship, and then out of carelessness, you go to a *gonpa* [monastery] Shugden doesn't like, for example Nechung's [the monastery of one of the main protector deities of the Dalai Lama], then Shugden will get jealous and will harm you, or [cause you to] get crazy—I've seen this many times... If you have no relations with him he has no power to harm you, he has no strength to do it. If you have relation with him he can."

Another informant, Penpa (40), explained that the deity can cause various kinds of misfortune as well as illness, saying, "I have seen this many times... Not diseases but [Shugden practitioners] have accidents and stroke... fatalities—travelling [car] accidents".

Several people in the community talked about this particular family who were affected by this. Sonam (21) described how the man and his family are "totally ruined", because of their Shugden practice, describing the woman and two of her sons as "psycho-type—mad... *smyon nad*", and explaining that "Sometimes they [Shugden practitioners] get really bad diseases, sometimes they get *smyo nad*". He told me that most people in the community would not talk to or socialise with the family because of this. Unfortunately I was not able to meet anyone from this family—neighbours raised the topic with me and expressed their opinions on the family's illnesses, but, having done so, were then unsurprisingly, not keen to introduce me to them.This case is particularly interesting in that there seem to be two factors here: the supposed motivations of the practitioner; and also those of the deity himself. Several interviewees explained that Shugden is one of a class of deities who can grant his followers worldly goods, such as money, or a nice car. Gyaltsen (28) explained: "Actually, if you worship him, he'll give you anything you want, but he is a worldly god—if he gets slightly angry, he'll kill you... You'll get sick—like vomiting blood, and then die." Abandoning practices related to Shugden were thought to be particularly risky in terms of the likelihood of causing offence, with one monk, Dawa (51), explaining that this would likely make Shugden angry and thus cause him to harm the practitioner.

The assumption here then was that the deity had been inadvertently offended—most likely through the neglecting of regular offerings. With worldly deities such as this, as long as individuals maintain their offerings to the deity, they are protected, but if such offerings are neglected (perhaps because the individual now has what he desires), they may arouse the deity's anger or jealousy, leading him to cause them harm. Interactions with enlightened deities (who, in contrast, are not concerned with the granting of worldly goods, and are not subject to worldly emotions such as anger and jealousy) of course, will not be subject to these issues.

The explicit suggestion here then, is that the afflicted individual has played a role in the causation of their illness through their desire or greed in respect to material goods. Obviously this is not how the practitioners themselves view this, but from the outsiders' perspectives, these emotions had led the individuals to this practice, which had consequently left them at the mercy of the deity's emotions: his anger; jealousy; pride or vengefulness. Cases such as this are interesting in that there is often a significant amount of blame, stigma, and social isolation surrounding these supposed followers of the

tradition. We might surmise that even if this practice itself did not cause mental health problems, these social issues are certainly not likely to help them.

## 4. Health-Seeking Behaviour

So how are these perceptions of the causes of *sems nad*, *smyo nad* and conditions related to *rlung* reflected in health-seeking behaviour in the Tibetan context? For cases understood to be related to *rlung*—mostly those described as *sems nad*, "depression", "worry", "anxiety" or *srog rlung*—Tibetan medicines, and sometimes also biomedicines, were often discussed by informants. In relation to *smyo nad*, Tibetan doctors I interviewed stated (as does the *rGyud bZhi*) that treatment for *smyo nad* can include herbal medicines, especially those for reducing *rlung* (or any of the other humours involved). However, few Tibetan informants in Darjeeling discussed this as an option, generally suggesting religious practices instead.

In cases where there was felt to be a certain amount of responsibility for the illness held by either the individuals themselves, or someone in their family, the "cure" was often also felt to be in their hands, or in those of their family members. "Treatment" was often viewed as accessible through the rectification of the causal circumstances. For example, several people who knew Jigme explained that in his case, if his father would only overcome his "greed" and return the objects he stole from the monastery, he would recover completely. In the case of Shugden practice, informants explained that if those affected could give up their desire for worldly goods and follow the Dalai Lama's instructions to carefully cease the practice, then "everything will return to normal". Illness caused by offending local deities could be cured by either repenting for the offence caused and appeasing the deity's anger through offerings, or through the subjugation of the deity by Tibetan Buddhist monastic ritual. In many cases people would conduct both of these activities concurrently. In other cases, a possible cure was perceived as accessible through specific Buddhist practices. For example, the reciting of particular Buddhist prayers or conducting of a particular Tantric practice known as "*gcod*" practice by a monastic practitioner on behalf of the afflicted individual was said to cure any kind of madness, regardless of the cause. In addition, blessings from high Tibetan Buddhist monastic practitioners and the making of offerings at monasteries were felt to be generally helpful. For example, as described above, Lhamo related how her mother's madness (which had been caused by sadness and loneliness) was cured by the blessings of a high level Buddhist monk known to the family.

More generally, a number of informants in Darjeeling suggested more individual ways to deal with these kinds of illnesses. Metok (63), for example, explained that the way to treat *rlung* or depression was to "go for a walk, don't go into depression, think positive, don't be worrying, take it easy, relax… Be positive, think positive... If you can't, then you become *smyo nad*". This view was expressed by many informants, such as Nyima (35), who explained that as *srog rlung* is caused by an inability to control one's anger, a calm mind will cure it; and several interviewees stated that a "calm mind" will also cure *sems nad* or *srog rlung*.

## 5. Conclusions

As we can see, from a Tibetan perspective, certain "emotions" are often implicated in the causation of various types of "illnesses of the mind", from those similar to biomedical classifications of

depression to madness. These perceptions are often reflected in health-seeking behaviour, and in perspectives on the prevention of such conditions. This is especially the case around perceptions of "controlling the mind". If, as suggested by Tsering, as mentioned above, "controlling the mind" prevents psychiatric illness, and an inability to do so can precipitate madness or depression, then *regaining* control of the mind might also be an effective treatment, as suggested by Metok and Nyima, above. Again, we find that "controlling the mind" often seems to refer to being "in control" of one's *emotions*, and this was emphasised by the suggestions that the way to help a depressed person is to "distract" them away from their sadness or grief, or relate to them a story of someone in a far worse situation than them, the comparison with which will serve to make them feel better. Gyaltsen summed up many interviewees' comments when he stated emphatically, that such illnesses "caused by the mind, can only be cured by the mind".

These perspectives on "controlling the mind" reflect both Tibetan cultural and Buddhist concepts, highlighting the interrelationship between Tibetan cultural and religious perspectives on the world. For example, as we saw above, in Buddhist philosophy the "afflictive factors" (such as greed, hatred, pride and envy) are viewed as the "ultimate underlying causes of both physical and mental diseases" ([28], p. 68). Furthermore, Epstein and Topgay tell us that "afflictive mental factors" are the "roots of all unwholesome states of mind", and that they "serve as the basis for birth in cyclic existence" ([28], p. 71). In more everyday terms, Tibetans discussed the need not to dwell on sadness or grief, but instead to "think positive" and not worry, as described above. And, despite the DSM's perspective of excessive or deficient emotional expressions as *symptoms* of a psychiatric illness, it seems that this Tibetan understanding that a lack of control over the emotions can contribute to psychological distress, is shared by many in the West. The MBCT UK website explains that, "sustaining recovery from… depression depends on learning how to keep mild states of depression from spiraling out of control… Mindfulness helps to halt the escalation of... negative thoughts and teaches us to focus on the present moment... teaching us to shift gears" [36]. It is telling us to "control" the way we manage our emotions, in much the same way that Metok suggested in Darjeeling. Perhaps then, Tsering is correct in his assertion that "If you can't control your mind, you'll become mad. If you can control your mind, you'll never become mad"; or even, as Gyaltsen told us, that illnesses "caused by the mind, can only be cured by the mind".

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**Abbreviations**

DSM: Diagnostic and Statistical Manual of Mental Disorders;
ICD: International Classification of Disease;
MBCT: Mindfulness-based Cognitive Therapy;
MBSR: Mindfulness-based Stress Reduction;
NHS: National Health Service;
NICE: National Institute of Health and Clinical Evidence;
WHO: World Health Organization.

## Conflicts of Interest

The author declares no conflict of interest.

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