Cultural and Spiritual Constructions of Mental Distress and Associated Coping Mechanisms of Tibetans in Exile: Implications for Western Interventions

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The Tibet-TPO project in Dharamsala, North India aims to provide culturally sensitive psychosocial support to Tibetan refugees. In this study we have examined the cultural and spiritual constructions of mental distress of Tibetan exiles from a secondary analysis of previously published data. Tibetans refugees' constructions of mental distress were intimately linked to cultural, religious and political factors. Family and religious support were regarded as key coping strategies, yet many new refugees lacked both family support and detailed knowledge and understanding of Tibetan Buddhism. Not all of those interviewed were positive about ‘western approaches’ to dealing with mental distress, but those using the service seemed to do so in a pragmatic and integrative way. We conclude that culturally sensitive psychosocial support can usefully ‘fill a gap’, especially for new refugees who lack both family support and access to, or understanding of, traditional religious coping mechanisms.

Keywords: Tibet, exiles, torture, mental health, culture, Buddhism, integration

Introduction

It is now commonly accepted that different cultures have different ways of understanding, coping with and treating mental health problems. According to Mulatu and Berry (2001), explanations underpinning mental distress are often fundamentally different in western and non-western cultures. Hence, mental health, illness and healing needs to be understood within the context of a society’s or community’s cultural and social system (Kleinman 1978).
Of the 50 million forced migrants worldwide, a significant portion are refugees. Many of them have been forced to migrate as a consequence of war, ethnic conflict, and/or political, racial and religious persecution (Westin 1999). The refugee discourse abounds with ‘evidence’ demonstrating that the experience of being a refugee is commonly associated with psychological distress (Mollica et al. 1998; Agger 1997). Several studies have revealed that most refugees meet the diagnostic criteria for a post-traumatic stress disorder (PTSD) and/or clinical depression according to western diagnosis (Servan-Schreiber et al. 1998; Shrestha et al. 1998; Herlihy et al. 2002). There is little doubt therefore, that the experience of being a refugee can be psychologically distressing and can have a significant effect on the overall wellbeing of the individual (Ager and Young 2001; Bracken 1998; Summerfield 1998). However, in the recent past, the psychological functioning of refugees and torture survivors has gained considerable significance in the humanitarian agenda, often to the point of being given more importance than meeting their basic needs. Consequently, there has been a proliferation of interventions that aim at providing psychosocial assistance to refugees (Bracken et al. 1995). Many of these interventions provide psychotherapy or counselling, often with an inadequate understanding of local cultural belief systems and their associated coping strategies for addressing psychological distress (Bracken 1998; Harrell-Bond 1999).

**The Situation of Tibetans in India**

The People’s Republic of China invaded Tibet in 1950. In 1959, when Tibet was annexed to China, the Dalai Lama escaped to India (Norbu 1998). Even though the total number of Tibetans who have fled Tibet to date and sought refuge in the neighbouring countries is not known, the most recent statistics claim it to be over 125,000 (International Campaign for Tibet 2003). The Tibetan government-in-exile was established in Dharamsala, in Himachal Pradesh, North India with assistance from the Indian government and various international humanitarian agencies (Bhatia et al. 2002a, 2002b).

It has been argued that the Tibetans are different from many other refugee groups, in that they have the advantage of being self-settled with a functional government-in-exile (Harrell-Bond 1999). Consequently, they have a well-established social and cultural support system (Holtz 1998; Rabgey 1998). In addition, it is thought that the knowledge that most Tibetan refugees have about Buddhism as well as the freedom they have to practise their cultural beliefs in India help them cope effectively with the stresses of life-in-exile (Brown 1997). However, there are only a few studies seeking to understand the wellbeing of Tibetan refugees, and most have concentrated on investigating the prevalence of psychological distress and mental illness using western diagnoses and perspectives. Quantitative studies conducted amongst tortured and non-tortured Tibetans have revealed higher levels of anxiety and symptoms of PTSD amongst Tibetans who have been imprisoned and tortured.
(Holtz 1998; Crescenzi et al. 2002; Ketzer and Crescenzi 2002). A qualitative study conducted by Mercer et al. (2005) indicates that even though mental health issues are of growing concern among Tibetans living in Dharamsala, many key community leaders feel that traditional coping strategies are adequate to cope with the distress experienced by refugees. In the present paper we explore in depth the different constructions of mental distress and the varying coping strategies that are common amongst the Tibetan community living in exile in Dharamsala.

Methods

This current investigation was based on a secondary analysis of 20 semi-structured individual interviews that were conducted with a range of refugees from the Tibetan community-in-exile, in Dharamsala, North India (Mercer et al. 2005). These interviews were conducted during a three week period in April and May 2001. In this analysis, we explore three themes that provide an insight into how Tibetans living-in-exile culturally construct mental illness and distress and the coping strategies they use for dealing with the same. The following three themes emerged in nearly all the interviews even though the ideas varied and were expressed differently according to the social standing of the individual. The three themes (posed here as our research questions) were:

1. How do Tibetans living-in-exile make sense of mental illness and distress?
2. What are the strategies used by Tibetan refugees to deal with mental illness and distress?
3. Are patients able to integrate traditional and western treatment approaches, and if so, how?

The interviewees were selected from three distinct groups of the hierarchy in the Tibetan community-in-exile. Individuals from these three groups were interviewed to gain a broader understanding of the perceptions surrounding mental illness/distress and local coping strategies. With the exception of the western psychologist and the western medical doctor, all interviewees were Tibetan. The interviewees were broadly categorized into the following three levels:

— Officials: members of the Tibetan government-in-exile, religious/community leaders, staff from different local organizations and Tibetan medical personnel.
— Patients: individuals who had used or were currently using services offered by a counselling programme.
— Employees: individuals employed in a counselling programme.

Further details of the sample and method of data collection can be found in Mercer et al. (2005).
Results

Tibetan Understandings of Mental Illness/Distress

The role of culture, religion and politics. The Tibetans interviewed understood mental illness or distress mainly in the context of their cultural and spiritual beliefs (two entities that were strongly inter-related). Most were of the opinion that mental distress related to ‘possession’ by spirits. For example, the words of a local social worker clearly articulated this.

I have never, actually I have not been very close with Tibetan physicians. But judging from my role, I have a feeling that most Tibetans see mental health as related to the spiritual, spiritualism or spirit. Epilepsy [for example] has always been [seen as] spiritual, possessed by spirits.

There was a general view that mental distress was often caused by spirits, either good or bad. For example, the western clinical psychologist recounted the case of a patient diagnosed with psychosis, who attributed her mental disturbance to a deity (spirit) from her hometown in Tibet.

And if you ask her, ‘What’s wrong with you?’ she says, ‘A Neppa [deity], it is a Neppa from the home’. The majority of the people will tell you about home, you know the native place of family—somebody there is disturbed. It is a general disturbance, not necessarily an extremely negative one. The deity is calling her back. Basically it means that people are missing the old country [Tibet].

Lay Tibetans frequently combined both religious and cultural beliefs in their understandings of mental distress whereas the monastics (Buddhist monks) who were interviewed seem to place a greater direct emphasis on Buddhism and karma. For example, an elderly monk who had been imprisoned for nearly 27 years and frequently subjected to torture explained how important Buddhism was in making sense of his experience.

I used to think that this [being tortured and the consequences] is because of my past karmic life. In one way I did something in a past life, which is why I am now suffering.

Some of the Tibetans interviewed saw mental distress more as a direct result of the ongoing Chinese occupation of Tibet. This was especially apparent amongst those who had been imprisoned.

So mental health will only be solved, the problem will only improve, if Tibet gets the justice or freedom and what we’ve been fighting for.

Interestingly, the western psychologist reported that the patients she treated who were vigorously involved in the cause of a free Tibet seem to be better able to cope with their emotional distress:

(...) but some of them, they are doing very well. Usually this is when they are more educated, when they are prepared, when they know that they are going to suffer but they have conviction to this big ideology, so these people understand better. They have less you could say clearly evident symptoms and in some way they are able to integrate the suffering [into their lives].
The other extreme of this was evident amongst the new arrivals in Dharamsala who had unrealistically high expectations. As such, they experienced much difficulty in adjusting to life in exile. The western psychologist explained this as follows;

Yeah, huge and they are missing, the most pain is from missing that [the Tibetan environment]. You can say that in some way [when they are in Tibet] you know they are one, they are all Tibetans, suffering for the same reason. They come here and I never know exactly how much they are already tortured but the majority of people come here with expectations, big expectations and they never find what they want because the situation of fighting with the real enemy and fighting with the enemy that is far away is completely different.

*Physical representations of mental illness/distress.* It was common for the Tibetans interviewed to equate ‘mental illness’ that required treatment by a doctor or therapist as being synonymous with psychosis or ‘being crazy’. Contrary to western psychological understanding, symptoms such as anxiety, fatigue, recurrent nightmares and depression were generally not recognized as ‘mental illness’ nor were they related (in a causal sense) to traumatic events within the person’s life. A Tibetan nurse/counsellor expressed it thus;

I’ve also been to the settlements. And there we have so many chronic psychotic individuals and because of our project I can help—most of them but not everybody (...). But in the settlements, they think mental health is only for the psychotic. Depression, anxiety, and these, they don’t care about. Traumatize. They don’t know. We can be traumatized and this will affect the mental health, this they don’t know.

Evidently, talking about psychological symptoms or problems is uncommon in Tibetan culture. From several accounts it seemed that expressions of somatic complaints were more common and these were understood as psychosomatic complaints by the western staff as can be clearly seen from the following excerpt:

(...) if you speak with a Tibetan, the first thing they will tell you is ‘I have a terrible headache’. This is an idiom for expressing pain, you know, everybody has a different way of communicating suffering. So you have to understand that in Tibetan, the opening of the door for a Tibetan is usually more somatic, is more collective, is more eastern. But if you slowly, slowly give them time and you help them through you can find out what is behind the complaint.

*Coping Strategies for Mental Distress*

*Family support.* Many of those interviewed stressed the importance of family support as a primary coping strategy in overcoming mental distress. The system of a large and extended family—the traditional norm in Tibet—is still in operation to a large extent amongst the old-comers and those who were born and have lived in Dharamsala all their lives or for many years. Giving
personal advice and support, taking the person to a well-respected Lama (Buddhist monk), and giving some financial assistance were some of the common local support mechanisms that were mentioned:

The first generation that came here went through a lot of terrible suffering. But the more stable second and third generations, anyway, there are a kind of family. It is a disrupted family because one is boarded in Dharamsala, one is making sweaters and selling them in Maharastra and the other one is working in the south. But I mean the feeling is that there is at least somebody, eh?

Advice giving, especially by older family members and collectively trying to help those who have experienced a negative life event also appeared to be a very common feature in Tibetan culture:

The other thing is Tibetans have this attitude, listening but I mean giving a lot of advice. People come and they tell you, ‘Kitchi mare, Kitchi mare, Kitchi mare’—‘Don’t worry, don’t worry, don’t worry’. I mean, you have lost your husband and you want to cry. Everybody says ‘Don’t cry, kitchi mare, kitchi mare’. But also, everybody gives a lot of advice.

The director of the school for Tibetan children explained the use of family/community support in coping with mental distress, partly necessitated—perhaps by the lack of specialized services in the Tibetan community.

There is no expert handling as far as (...) in our situation, we cannot provide that expert healing or expert care because it is not available and we cannot afford it you see. So there is a natural sort of support by the staff members, by the ‘house mother’ concerned and the teachers. We cannot go for special care. Unless it is determined that this is a mental case [a psychotic patient] that needs special attention, unless until it is really made distinct, we just go by the normal way.

All these excerpts illustrate a family- and community-based approach to coping with mental distress.

*Coping mechanisms based on religious and cultural beliefs.* It is difficult, if not impossible, to separate Tibetan practices into entities of ‘religion’ and ‘culture’. Religious practices and rituals usually require a Lama to perform pujas (prayers). Traditional rituals were clearly considered as an extremely important aspect of helping individuals who are mentally distressed.

Mostly when it is the personal life of the sick person, divine help is one of the most important help there is. So as soon as somebody has some little problem, normally they tend to go to a Lama first and then he decides what type of ‘medicine’ is good and what type of approach is best.

However, it was also apparent that most Tibetans would pursue a combination of strategies when coping with mental distress or other problems:

So, you go to a Lama. He will tell you it is this Neppa and you have to say this prayer. So basically you are offering to somebody, somebody is ‘metabolizing’ for you and solves the problem (...) and it is not an individual way of solving it (...) and then there is this more Buddhist meditation approach.
Those who had a good understanding of Buddhism stressed the importance of Tibetan Buddhism per se in preventing and healing mental illness:

(...) we organize some teaching [Buddhist] from the High Lama for these torture victims who have mental problems. This gives them a lot of encouragement and peace of mind. They have (...) with this way of protecting oneself and His Holiness' teaching can help them have a peaceful life and not have mental problems.

Two of the monks who were interviewed recounted coping strategies that they used in prison, in which specific practices of Buddhism played a key role.

To overcome the anxiety and stress of my own problem, I used to contemplate and realize that there are more people far worse off than I am. I started realising that and sometimes I pray for them. According to Buddhism, in this world it’s not only one person who is suffering, it’s other people too. So this kind of mental mind transformation helped me.

The other monk recounted using a Tibetan Buddhist practice of compassion, whilst in prison, in which he meditated on relieving his torturers of their mental suffering by visualizing their suffering in the form of black smoke, and visualizing the movement of this from them to himself, taking it into his own body. The monks interviewed commonly referred to the practical use of Buddhism in coping with distressing situations.

Buddhism was seen as an effective buffer against mental illness by all interviewees. The director of the Tibetan children’s school expressed it as follows:

In the first month the children don’t talk much and seem to be depressed. After that they begin to adapt. You see our Tibetan mentality makes them feel integrated and gives them self-confidence. I think we don’t need external mental health care. The young and teenage children find self-confidence in their Tibetan Buddhism, Tibetan Buddhist way of thinking, which prevents mental disease.

Others echoed similar sentiments. Buddhism, regardless of whether it is practised according to strict philosophy or in a more culturally adapted manner, was understood to be a profoundly effective coping strategy.

The role of traditional medicine. Similar to religious and cultural coping strategies, the use of traditional Tibetan medicine in treating mental distress was another coping mechanism mentioned by most of those interviewed. The Minister of Health, when questioned about the use and efficacy of traditional medicine, indicated that she felt traditional medicine was effective in treating mental distress and preferred by a majority of Tibetans.

Yes, I do, I do yes. Especially the elder ones, you know, those that come from Tibet, they believe more in this system of Tibetan tradition. The younger ones they like the western approach a little bit more but I think the majority they go for this Tibetan system of treatment. Yes.

Several of the patients who were interviewed endorsed the use of traditional medicine as one of the primary treatment methods.
Using organizational support and local services. Several ‘social services’ organizations have been set up in Dharamsala by the Tibetan government-in-exile to respond to the needs of new refugees coming from Tibet for reasons succinctly expressed by a Tibetan social worker.

So my feeling is that anyway the newcomer has a huge sense of isolation, you know, I mean more than the old-comer. So this is an important thing because they come here, they feel isolated not only from the local people, Indians, but also from the Tibetans. There is a big gap between newcomers and old-comers and from the beginning you can feel that they are two different populations. That is quite painful (…) obviously.

Various forms of organizational support are available, including some social support, for example at the reception centre in Dharamsala for new arrivals:

So we take care of them and, in that, what we do is we mainly try to rehabilitate them and that includes both social and health rehabilitation. And eh from the social aspect we provide guidance, provide housing (…) And then like we also try to find jobs for these people and train them in the local trades that they are interested in.

According to the director at the school for Tibetan children, his school too provides the support that children need. However, this support was again constructed as more social and collective rather than individual.

The environment here is the best thing. Particularly, I think the children themselves are the greatest cushioning factor. When they are here we have our traditional approach and outlook to life, you have to be kind to each other, you must help each other, not be aggressive, not be angry, you know.

Those who had made use of the support provided by the western psychotherapy clinic claimed its effectiveness, even though they found the approach quite alien. For example, one patient expressed the initial difficulties he had with this western approach.

At first I thought, I started realizing that it was more like a prison that I used to be in China. You know the authorities interrogate you and it was quite similar to that.

He was, however, able to prevail over his difficulties and spoke very highly of the services offered by the clinic. Almost all interviewees, even those who had not made use of the facility, commended the services offered by the clinic and the care and concern expressed by the two western volunteers.

Integrating Traditional and Western Treatment Approaches to Mental Distress

A pragmatic approach to treatment. Many of the interviewees, and especially the clients, mentioned that they used a range of different treatment approaches to alleviate their distress. Often, these approaches were fundamentally different to each other. Buddhist practices, religious and cultural rituals, traditional
Tibetan medicine, allopathic medicine and western psychotherapy were all combined with little or no evidence of ‘conflict’. For example, the Tibetan social worker, who personally believed in the prevention of illness through one’s *karma*, also advocated the use of western medicine. According to him, most Tibetans are very practical and would take western and Tibetan medication and use a range of strategies to treat and recover from mental distress. The following quotation by the health worker at the reception centre is indicative of how people try different combinations of treatment.

And eh, then also people like to access other help. They go to a Tibetan monk, they take Tibetan medicine, take western medicine and do *puja*. They often take a little from all these things. So, it’s a combination of things.

Others who work directly with Tibetan refugees, and who to a great extent give directions to the refugees on what approaches are available and are most suitable, were also of the opinion that a combination of methods is helpful in treating mental illness/distress. The director at the reception centre indicated that he too advocated a combination of approaches.

Whenever we have a newcomer here with a mental health problem our health workers take them to Eva [the counselling centre], the Delek hospital [western medicine hospital], and eh, we also take them to the TMI [Tibetan Medical Institute].

Similar to the opinions expressed by the employees and the officials in the community, patients too indicated how they have tried a range of different treatment approaches. Whilst some of them gave different reasons, many of them merely stressed that all approaches are useful and therefore they have used them. One patient simply said:

I used to take Tibetan medicine, take Western medicine, go to TPO [counselling centre], I think everything helps.

‘Failure’ of one approach facilitating the use of other methods. The failure or inadequacies of a particular approach were related to the length of time it took to produce results, the apparent ineffectiveness of that method in treating mental health problems or simply the lack of adequate resources to invest in treating mental illness/distress. All these were also mentioned as reasons for trying out different treatment approaches. A social worker at the clinic recalled how some individuals simply spend money on a Lama who is not qualified to carry out the *puja* and then get disheartened when no improvement is seen.

And those who have no real training or skill in divination, for example, are totally unqualified to do it and can’t do it. Instead of doing any good they do more harm [to the well-being of the people].

A religious leader, on the other hand, explained how the inefficiency of the system as a whole has resulted in people trying out different treatment approaches.
there is inefficiency in the health care systems that exist locally. For example, after spending a long period under the care of the Delek hospital [western medical hospital], TPO [counselling centre] or TMI [Tibetan Medical Institute], then they say they can’t treat the patient, and that he has to go to Chandigar [nearest major Indian Government Hospital] or Delhi. I feel this is really wasting a bit of a time.

Other interviewees also mentioned this perception of inefficiency. The majority of patients were of the opinion that counselling worked well for them especially because of the attitude of the two western employees.

I stayed at the Delek hospital a long time and at that time I didn’t feel like eating at all. And somehow, I don’t know, they just told me to meet Eva [counselling centre]. Now, because of the counselling I have been feeling much better.

One patient, however, expressed concerns about how ‘speaking therapy’, whilst being effective, may not be easily accepted by the majority of the Tibetan people. He explained why people might be reluctant to use this approach.

But sometimes I feel that when people ask a lot of questions, people will get tired of doing that, speaking therapy, because they don’t feel like talking. It’s kind of (…) odd, different. They [patients] will feel it’s different you know, like they put a lot of questions and you know (…) there are different people having different views about that [discussing your problem] so it might be a problem talking with them.

One western employee acknowledged that discussing a problem was not common in the Tibetan context. According to her, it was the lack of access to traditional healing strategies that has resulted in the Tibetans using non-traditional approaches and this is especially so with the newcomers. She explained how the newcomers do not have a family support structure, do not believe much in Lamas and are rather isolated and, therefore, use non-traditional approaches. The other western employee supported this view.

Everybody knows each other [for the old-comers]. I mean you know there is a structure. The newcomers don’t have it. So I think for them to come to the clinic [counselling], it was because of this possibility of being supported. They were missing a support system. And the clinic in some way was offering the possibility of being listened to by somebody eh, and eventually be helped.

Discussion

The issues that have emerged from the present analysis provide a valuable insight into the constructions of mental distress by Tibetan refugees, their views on its causation, and common coping strategies used. It is clear that the Tibetans interviewed constructed their understanding of mental distress mainly through their traditional religious and cultural beliefs. A belief in wider supernatural or ‘karmic’ causations of mental distress, rather than a simple, linear causal relationship between traumatic events and psychological problems was evident in many of the narratives. Similar findings have been
reported in several studies that have been conducted in non-western contexts (Kenny 1996; Lambek 1996; Shrestha et al. 1998). Pakaslahti (1998) argues that the community belief in spiritual possession is both less stigmatizing for the individual and decreases the burden of ‘responsibility’ for the mental illness from the individual to the family and wider community. Moreover, in Asia mental health is often seen as the existence of harmonious relations between the mind, the body and spirit (or the spiritual forces) (Marsella and Higginbotham 1984), a finding which also emerged in several interviews in the present study.

Given the various beliefs surrounding the causation of mental distress in non-western cultures, it should not be surprising that a range of coping strategies are commonly employed. In non-western contexts, healing mental illness is often achieved through a combination of several different approaches (MacLachlan 1997). For example, family support and resources, traditional medicines, ritual performances, divination, prayer and western therapy may all be used (Lefley 1984). However, the most common and frequently used healing strategies in many non-western cultures are the traditional rituals. These include religious rituals, dissociated states, ayurveda, tantra and bhuta-vidya (Prince 1984; Wagner et al. 1999; Raguram et al. 2002).

Ahearn et al. (1999) argue that countries with greater traditional and religious heritage are better at giving meaning to and making sense of distressing events. Amongst the Tibetans living-in-exile, their understanding of psychological wellbeing was strongly linked to their Buddhist belief system. This was especially evident amongst the monks. Their belief in karma—that one’s negative actions in the past (even those from a previous life) influence one’s present situation (Sastri 1956)—appeared to greatly help many of these monks make sense of and cope with their distress and suffering.

‘Body pain’ appeared to be another way to ‘make sense of distressing feelings’ in the present study. Western psychiatry interprets such expressions as psychosomatic complaints (MacLachlan 1997). However, what such interpretations do not take into consideration is the fact that the expression of suffering requires a language to make the suffering real and understood by others in the society (Antze 1996) and many Asian cultures do not have a language to express psychological distress (Marsella 1979). In Tibetan, loong and tip were the only commonly used terms that expressed some level of mental distress and neither of these two were directly perceived as mental ill health.

The strategies for coping with mental illness/distress mentioned by the interviewees were notably more varied than their perceptions on its causation. Nearly all interviewees elaborated on the importance of traditional and cultural coping strategies in alleviating mental distress. A traditional approach was mentioned as the first avenue of treatment that would be pursued by many Tibetans. Accordingly, many of them were able to provide detailed explanations of the cultural rituals and treatment procedures. We have previously reported that most patients interviewed had sought help from traditional spiritual and medical sources prior to being seen at the clinic, and indeed the staff at the clinic actively encouraged such a ‘combined approach’ (Mercer et al.
The preference for traditional coping strategies has also been reported in several other studies that have been conducted in Asian countries (Sharma and Van Ommeren 1998; Saeed et al. 2000; Das et al. 2002).

With coping strategies like family support, pujas, divination, prayers and Tibetan medicine, it can be seen that a range of rich local traditions are commonly practised within the Tibetan community-in-exile to alleviate mental health problems. Crescenzi et al. (2002), however, claim that in Dharamsala traditional coping strategies do not always reach tortured refugees or newcomers, a finding that was also supported in this study. Even though many of the officials interviewed were of the opinion that local coping strategies were adequate to treat mental distress and illness, several others expressed the view that western approaches were also helpful. Ager (1997) argues that in the absence of local coping strategies to deal with mental distress, the provision of culturally sensitive western support services is appropriate. As we have pointed out in our earlier analysis, it was not possible in the present study to delineate the reported benefits of the western support service into distinct components (Mercer et al. 2005); that is, we cannot specifically ascribe the benefits reported as being due to ‘talking therapy’ per se. Non-specific effects such as the perceived empathy, understanding, and ‘engagement’ of the staff are also likely to be of major importance.

An interesting finding that emerged from the interviews with the patients was the apparent ease with which they were able to use a combination of diverse coping strategies in treating mental illness or psychological distress. When the other interviewees were questioned about combining different treatment strategies, they too expressed the possibility of using a range of different approaches simultaneously. Whilst combining cultural and religious coping strategies such as pujas and prayers is not unusual, it is of interest to explore how Tibetan refugees use western counselling together with other traditional coping strategies with apparently very little conflict.

Notwithstanding the general belief that traditional coping strategies were more appropriate for addressing mental distress, the employees and the patients of the counselling and psychotherapy clinic were of the opinion that counselling was also an effective approach. This ability to combine coping strategies that have fundamentally different underpinnings has also been reported in other studies (Pakaslahti 1998; Wagner et al. 1999, 2000). Similar to Wagner et al. (1999, 2000), we suggest the notion of cognitive polyphasia to explain and understand how the Tibetans living-in-exile combine such fundamentally different coping strategies to deal with mental distress and illness. The present circumstances of life-in-exile in Dharamsala (including perhaps ‘globalization’ and engagement with certain forms of Western modernity) have necessitated or facilitated the adoption of different modes of thinking for treating psychological distress and mental illness. This is especially applicable to the newcomers who do not have complete access to traditional support structures that would help them cope with difficult circumstances. Moreover, it is a reasonable assumption that the primary concern of any
individual who is ill would be to recover from their ‘sickness’. Therefore, it has been argued that having faith in and utilizing a strategy that is largely alien, can also be understood in terms of the desperation the ‘sick’ person feels to achieve some relief and cure from the sickness (Pigg 1996).

**Implications**

It is evident from the interviews that Tibetans have a unique understanding of mental distress, psychological well-being and appropriate coping strategies. Even though these beliefs are largely based on Tibetan Buddhism and Tibetan culture, beliefs regarding coping strategies have additional dimensions. Tibetan patients and the employees of the counselling clinic supported the effectiveness of western-style counselling whereas many of the officials who were more distant from the project were of the opinion that western approaches were not necessary because local coping strategies were adequate to cope with mental illness/distress. These diverse representations of counselling as an alternative coping strategy can be understood in terms of the pragmatic context of different social groups (Bauer and Gaskell 1999). An important feature may well be the time and effort spent by the western staff who set up the counselling project in gaining cultural understanding of the Tibetan community in exile. Such an investment in time and energy may be a prerequisite for a successful integrative approach.

**Limitations of the Present Study**

As we have pointed out in our earlier analysis of this data (Mercer et al. 2005), this study had a number of limitations. The study was limited in size, particularly in terms of the views of the users and providers of the service. The sample size was limited to 20 interviewees and we therefore cannot be certain that data ‘saturation’ was reached in terms of views and themes of the three groups (officials, patients, staff). Furthermore, in the context of the present analysis, seeking the views of ‘everyday’ Tibetan refugees (both ‘newcomers’ and ‘old-comers’) in addition to the views of the ‘stakeholder’ groups that we did interview (who were either using or providing the counselling service or were ‘officials’ in the community) would have been extremely useful. However, this was not possible because of time constraints and the original focus of the study.

**Conclusions**

This study has explored the constructions of mental distress/illness, its causation and coping strategies amongst a group of Tibetan refugees living in Dharamsala, North India. Constructions of mental distress and the associated coping strategies of Tibetans in exile were intimately linked to cultural,
religious and political factors, principally relating to the philosophy and practice of Tibetan Buddhism.

Family support and religious advice and support were key cultural coping strategies. Almost every interviewee stressed the importance of traditional coping strategies in treating mental distress. The officials were especially firm in espousing this view. The belief that traditional coping strategies were more appropriate for treating mental distress, however, was put into question by the lack of real access to many of these coping strategies, especially for the newcomers. Many new refugees lack both family support and detailed knowledge and understanding of Buddhism (and thus have limited ‘access’ to the associated local spiritual support systems in Dharamsala), and the counselling service was seen to fill an important niche. Not all of those interviewed were positive about ‘western approaches’ to mental illness, but those using the service seemed to do so in a pragmatic and integrative way. In general, holding fundamentally different beliefs about causation but seeking a form of treatment which did not coincide with those beliefs did not seem to cause any problems for the Tibetans who were interviewed. This may in part be due to the cultural sensitivity of the staff involved with the project and the time and effort spent by the western staff, living in the Tibetan community in exile in Dharamsala, to better understand the Tibetan culture.

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Coping Mechanisms of Tibetans in Exile 201


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