International Journal of Psychological Studies; Vol. 16, No. 3; 2024
ISSN 1918-7211 E-ISSN 1918-722X
Published by Canadian Center of Science and Education

A Review of Mental Health Services in Tibetan Society: The Symbiosis of Tibetan Buddhism and Western Psychology Approaches

Qiaochu Ou[1]

[1] Shenzhen College of International Education, Mailing Address: 3 Antuoshan 6th Rd, Futian, Shenzhen, 518043, China

Correspondence: Qiaochu Ou, Shenzhen College of International Education, Mailing Address: 3 Antuoshan 6th Rd, Futian, Shenzhen, 518043, China. E-mail: ouqiaochu0526@outlook.com

Received: July 19, 2024 Accepted: August 18, 2024 Online Published: August 29, 2024

doi:10.5539/ijps.v16n3p95 URL: https://doi.org/10.5539/ijps.v16n3p95

Abstract

This paper first explores the prevalence of mood disorders, specifically depression and anxiety, within the Tibetan Plateau. It highlights the risk factors contributing to these conditions and assesses the current mental health services available, noting their interplay with Tibetan Buddhism within local populations. Additionally, it provides an overview of Tibetan traditional medicine, rooted in Buddhist principles, and compares it with Western psychiatric practices, revealing both differences and potential compatibility between the two approaches. Finally, the paper discusses existing treatments that integrate both approaches and proposes future directions for their combined use. This synergized strategy holds the potential to significantly advance global mental health and offer substantial benefits to mental health care in the Tibetan community.

Keywords: Tibetan Buddhism, mood disorders, Western psychiatry, mental health services, integrative treatments

1. Introduction

The Tibetan people, ranked as China's ninth largest minority group, primarily reside in the Tibet Autonomous Region (TAR) and neighboring countries like India, Nepal, and Bhutan (Hao, 2000). With an estimated population of around 6 million, they are renowned for their unique cultural and religious practices, especially Tibetan Buddhism (Wangmo & Teaster, 2009; Michael, 2019). This paper thoroughly examines the mental health landscape among Tibetans, focusing on the availability and effectiveness of mental health services. It also delves into the mental health risks and challenges unique to this population. In particular, it examines the integration of Tibetan Buddhism and Western psychological therapies. By exploring the symbiotic fusion of traditional Tibetan practices and modern Western psychological therapies, the aim is to illuminate how this cross-cultural integration can lead to a better understanding and treatment of mental health issues within the current Tibetan culture.

2. Prevalence of Mental Health Conditions among the Tibetan People

Studies have shown that there is a high prevalence of depressive symptoms and depression among the Tibetan population, with factors such as high altitude, alcohol consumption, socioeconomic status (SES), level of education, and traumatic experiences possibly responsible for the increased rates. This section will be focused on the specific mental health statistics, and the risk factors will be discussed more extensively in the section 3.

Wang et al. (2019) conducted a study in the Qinghai Plateau, showing that 52.3% and 28.6% of the Tibetan participants showed depressive symptoms and depression, respectively (Wang et al., 2019). The measure they used was the 10-item Chinese version of the Center for Epidemiologic Studies Depression Scale. The questionnaire was adapted to an oral version because the Tibetan participants' levels of education are low. One limitation is the risk of inaccuracy in self-evaluation questionnaires. Nevertheless, evidence from the study suggests that the depression rate is more prevalent in the Plateau (28.6%) compared to rates among the general Chinese population (5.3% to 23.8%; Wang et al., 2019). In a cross-sectional study, Eli et al. (2021) measured self-reported depression in children and adolescents aged 10–17 living in the Qinghai Plateau. The prevalence of depression was 29.2%, a higher rate than that of Chinese children and adolescents (19.8%–24.3%; Eli et al., 2021).

Mills et al. (2005) conducted an extensive systematic literature review investigating mental illnesses among Tibetan refugees in North India. They analyzed 10 online databases while locating both published and unpublished studies by contacting the Tibetan government-in-exile. To ensure the quality of the studies, they assessed the validation, interview administration, and translation. However, the literature search may have excluded inaccessible non-governmental organization reports, which may hinder the representativeness of the interpreted conclusion. That said, the existing results indicated that refugees who survived political torture had a statistically higher prevalence of elevated anxiety (54.3%) compared to non-tortured refugees (28.6%; Holtz, 1998). Some 18.9% of children from the Tibetan Children's Village School were diagnosed and met the full criteria for major depression when assessed psychiatrically with a DSM-IV diagnosis (Servan-Schreiber, 1998). Moreover, Terheggen et al. (2001) also found a correlation ($r = 0.67$) between traumatic events and mental health diagnoses among students at a North India refugee camp.

The empirical evidence above suggested that elevated depression and anxiety rates are present for both Tibetan inhabitants in TAR and special sample groups like refugees in exile. The next section will focus on the specific risk factors associated with the demographics and geography of each case.

3. Risk Factors

The risk factors for mood disorders in Tibetans are influenced by geography, demographics, and trauma. Specifically, living in high-altitude environments of over 3,000 meters may cause chronic hypoxia, a state where insufficient oxygen is present to maintain homeostasis. This condition can potentially affect neuropsychological functions, leading to unstable activities of dopamine and serotonin—two monoamine neurotransmitters that play important roles in the pathophysiology of depression (Arregui et al., 1994; Gerard et al., 2000; Lucca et al., 2009). The harsh climate, intense wind, and ultraviolet radiation characteristic of high-altitude environments may also cause symptoms of mood disorders and long-term adverse stress (Chen & Huang, 2000; Li et al., 2000).

SES and education levels influence the occurrence of mood disorders. According to the 2014 Health Survey of Tibetans, individuals with higher SES were linked to better health-related quality of life, highlighting health disparities among Tibetan respondents. Income was identified as the primary factor driving this inequality (JieAnNaMu et al., 2020). Yet simultaneously, societal stigmas and the undervaluation of higher education in Chinese rural regions, such as the Tibetan Qinghai Plateau, can create significant pressure and contribute to negative emotional symptoms, acting as stressors for anxiety and major depression (Wang et al., 2019).

Tibetan refugees in exile who have faced trauma from torture and violence are at an even greater risk of developing mood disorders. Common methods of torture include the use of "electric cattle prods on genitals and oral cavities," forced blood draws, and witnessing the murders of relatives and friends (Mills et al., 2005). These traumatic experiences result in chronic physical pain and difficulty adjusting to new environments away from their homeland which ultimately lead to heightened rates of depression and anxiety (Williams & Merwe, 2013). Furthermore, refugees hesitate to reveal their traumatic pasts because of feelings of shame and survivor's guilt. Coupled with a lack of financial and social support and cultural isolation, this exacerbates their distress (Porter & Haslam, 2005).

The magnitudinous impact of these risk factors highlights the importance of investigating potential treatments for the associated conditions. Additionally, the distinct and unique nature of these risk factors in TAR suggests that treatments should be specifically designed for the Tibetan community.

4. Current Mental Health Service in TAR

Because of a revamped public health program and socioeconomic development, mental health services in China have advanced rapidly within the past few decades. The number of psychiatric hospitals increased from 583 in 2002 to 1,026 in 2016 nationwide. The number of licensed psychiatrists and psychiatric registrars in psychiatric hospitals increased from 1.27 per 100,000 in 2002 to 2.15 per 100,000 in 2016 (Que et al., 2019). However, this rapid development did not occur in the Tibetan Plateau region. There is a significant shortage of mental health resources in the Tibetan Plateau. For example, Lhasa, the capital of TAR, only opened its first outpatient mental health clinic in 2004. A single psychiatrist ran the clinic, and when the psychiatrist moved away in 2008, it had to close (Cyranoski, 2010). In a 2019 nationwide study evaluating mental health services across Chinese provinces, Tibet was not included due to the absence of provincial tertiary psychiatric hospitals at the time of the survey (Xia et al., 2021). This lack of data reveals that the Tibetan Plateau region has been overlooked and underserved in terms of mental health services despite the nationwide progress in mental health care. Also, those afflicted with mental health conditions in Tibetan society typically do not approach health care experts for

assistance. Instead, they often turn to living Buddhas in monasteries for guidance and support (Xiang & Zhang, 2022).

Hence, despite nationwide advancements in mental health services in China, the Tibetan Plateau region remains significantly underserved. The lack of mental health resources and data highlights the disparity and neglect in this area.

5. Challenges in Establishing Mental Health Services in Tibet

Two major obstacles may impede the process of introducing mental health services into Tibet: language barriers and misconceptions regarding the nature of psychological disturbances and therapy.

First, many psychological terms do not have an exact equivalent in the Tibetan language, which makes the translation of psychological information for Tibetan people more difficult and prone to inaccuracy (Deane, 2014). Many terms could be translated into multiple different Tibetan words, each with a different nuance. For example, sems nad is the Tibetan term most equivalent to the psychological perception of anxiety or depression; yet the word (and several other alternative words like sems rnyog khra and sems skyon nad rigs) denotes "madness," which is not sufficient to directly define a mental condition with specific symptoms (Deane, 2014).

Second, there exists a fundamental difference between the Tibetan Buddhist framework and the modern Western approach to psychology. This results in differing definitions of mental health and the causation of psychological disorders. According to Epstein and Topgay, mental wellness is defined as minds that are freed from the influence of the three mental afflictive factors (nyon mongs): delusion (Tib. gti mug), attachment ('dod chags), and aversion (zhe sdang). The field of Tibetan medicine states that afflictive factors, such as hatred, pride, envy, and greed, are the most underlying causes of mental disorder from the Tibetan perspective (Deane, 2014). In comparison, the World Health Organization (WHO) defines mental health as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and can make a contribution to his or her community" (WHO, 2024). Rather than focusing on an individual's intrinsic state like in the Tibetan perspective, modern Western psychology highlights the interaction between genetics and the environment. Inherited vulnerability may amplify an individual's chance of being mentally ill, while environmental factors like childhood abuse, social and economic hardships, and war may catalyze a disorder (Mayo Clinic, 2022; WHO, 2024). Because Tibetan Buddhism is profoundly influential in the TAR and other regions like India and Nepal, people are less likely to gain a comprehensive understanding of the modern medical model and are hence hesitant to seek help from medical professionals.

To address these challenges and initiate the process of increasing mental health resources, a more comprehensive understanding of Tibetan Buddhism and its psychological perspective need to be examined. Only through this understanding can one begin to integrate these insights into contemporary mental health practices. The subsequent section will introduce the foundational principles and practices of Tibetan Buddhism.

6. Tibetan Buddhist View of Mental Disorders

6.1 Interpretation of Mental Well-Being and Disorder

According to Tibetan Buddhism, the cause of all mental disorders is the attachment to one's self-centered ego. The opposite is the Bodhisattva ideal—the aspiration to increase happiness while reducing suffering for all sentient beings. This is conceptualized through the afflictive mental factors consolidated into three "poisons" (ignorance, attachment, and aversion), and people who adopt and are dominated by these attitudes toward society and their lives will have emotional imbalances, leading to confusion in the mind (Deane, 2014). The disturbances caused by the three poisons subsequently cause an imbalance in the three defective energies (also called "humors"): wind (rlung), bile (tripa), and phlegm (beken; Deane, 2014). It is important to note that the Buddhist perspectives of the wind, bile, and phlegm are far beyond their literal physiological meanings but rather are a complex process that connects the mind, body, and maintenance of Buddhist values (Samuel, 2019). They serve as labels that illustrate the consequences caused by the afflictive mental factors (Samuel, 2019).

The imbalance of wind can be used as a specific example. The word rlung corresponds to prāna in the Buddhist Tantra (Deane, 2019). The word prāna translates in English as "breath." It refers not only to biological respiration but also to subtle inner "flows" in the body, where the continuity of the flow may be interrupted by the "poison" of desire or attachment. The concept of "wind" imbalance is closely linked to the mental poison of desire ('dod chags). American medical anthropologist Craig Janes interviewed local Tibetan physicians who follow the practice of traditional Tibetan medicine (TTM) about chain effects that lead to disturbances in rlung (Deane, 2019). The physicians emphasize that there is a gap between an individual's personal or societal aspiration and realistic capabilities, and this causes toxic desire to accumulate. For example, not everyone may

be able to achieve goals such as improved living conditions or healthy relationships. Consequently, these unfulfilled desires create mental agitation, ultimately leading to rlung imbalance (Deane, 2019).

6.2 Approaches and Treatments

Lasting for over 2,500 years, TTM is considered one of the oldest surviving medical traditions, and it has a holistic combination of logical, spiritual, and mystical healing practices with a temporal consideration of prevention, cure, and recovery (Begley, 1994). TTM is closely connected to Buddhist philosophy and practices because it is believed to be the approach taught by the Buddha. TTM can be split into three types, dharmic, tantric, and somatic, where each addresses different aspects of maintaining and manifesting overall health and well-being (Brock, 2008).

A dharmic approach emphasizes the spiritual and moral dimensions of health and illness, such as compassion, mindfulness, and interconnectedness, to address mental and physical well-being (Flynt, 2015). Its therapies aim to make the patient grasp the nature of the mind and control their emotions. This is achieved through practicing mindfulness, one of the fundamental qualities the Buddha advocates, bringing attention to one's mind and its connection with the physical body through meditations (Flynt, 2015). Engaging in dharmic practices can develop a resilient mind capable of withstanding emotional pressures, intellectual challenges, and negative spiritual influences. (Clifford, 1994). Its effectiveness may be displayed in playing the preventative role in decreasing the vulnerability for mental illnesses like the rlung condition (interpreted as depression in Western models), which happens because of an imbalance in and instability of the emotionally disturbed mind.

A tantric approach involves utilizing techniques and practices derived from Tantra to address mental and physical health issues. It provides explanations that primarily focus on evil spirits and madness (Brock, 2008). This may include practices involving the subtle energy channels (nadis) and centers (chakras), visualization exercise, mantra recitation, and rituals. Tantric principles are employed to harmonize the body, mind, and spirit. A tantric approach aims to alleviate suffering and promote holistic well-being (Brock, 2008).

The term "somatic" pertains to the body and physical experiences. In the context of the book "Tibetan Medicine and Psychiatry" by Clifford, a somatic approach involves recognizing the interconnectedness of the mind and body and addressing mental health issues through physical interventions and practices (Brock, 2008). Techniques might include Tibetan massage, acupuncture, herbal remedies, dietary changes, and exercises like yoga and tai chi (Brock, 2008). These somatic therapies work to relieve psychological distress by focusing on physical imbalances, enhancing relaxation, improving circulation, and promoting overall bodily health (Brock, 2008).

Hence, similar to the distinct perceptions and perspectives on mental disorders, the corresponding approaches to treating the symptoms vary from the Western approach to treatments. The TTM approach prioritizes restoring balance through spiritual practices and lifestyle modifications, whereas Western methods mainly deal with symptom management with psychotherapy and medications. This divergence, however, does not imply they are mutually exclusive within a treatment plan. Despite their varying approaches, the possibility of integrating these methods may offer comprehensive treatment options for mental disorders.

7. Existing Integration of Tibet Buddhism Practices and Western Psychology

Precisely because of the different focuses in TTM and Western psychology, the combination of the two may result in more holistic treatment options with a wider psychological breadth covered. This section will examine existing examples of this integration in treating mood and personality disorders.

7.1 Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy

The adaptation of mindfulness from Buddhism principles into the Western therapeutic process has received considerable validation. This is because a mindful state could catalyze the patient's acceptance of incurable symptoms (Kabat-Zinn & Hanh, 2009). For example, mindfulness-based stress reduction (MBSR) is a group program where participants are guided through structured mindfulness exercises, developing an accepting and nonjudgmental attitude toward physical discomfort and challenging emotions (Kabat-Zinn & Hanh, 2009). Fjorback et al. (2011) showed that MBSR improves mental health-related quality of life by reducing symptoms of stress, depression, and anxiety. Furthermore, mindfulness-based cognitive therapy (MBCT), developed by Zindel Segal, Mark Williams and John Teasdale, was created by combining cognitive behavioral therapy for depression and MBSR (Kabat-Zinn & Hanh, 2009; Mackenzie & Kocovski, 2016). Studies have shown that MBCT was particularly effective at preventing recurrences of depressive symptoms in patients with chronic depression. Its effectiveness for depression is comparable to antidepressant medication (Riemann et al., 2016).

According to the National Institute for Health and Care Excellence (2009) and American Psychiatry Association (2019), MBCT is recommended for treating adult depression.

7.2 Dialectical Behavioral Therapy

Dialectical behavioral therapy (DBT) is a form of cognitive and behavioral therapy applicable to individuals experiencing intense emotions and suicidality. DBT is a response to the inappropriateness of traditional behavioral therapy for high-risk individuals. Instead of a problem-solving approach, DBT focuses on developing skills that help patients tolerate distress and negative thinking. This intended focus led to researchers linking contemplative practices from Zen Buddhism to therapy. However, many patients who typically avoided inner feelings considered practicing meditation odd, intimidating, and inaccessible. Researchers, therefore, stripped the Zen practices of their spiritual and religious dressings and transformed them into teachable skills for clients and therapists (Linehan & Wilks, 2018). By integrating the framework of Buddhist philosophy and behaviorism, DBT has proven decisive in treating various mood and personality disorders. For example, research has shown that after 1 year of treatment with DBT, up to 77% of individuals no longer met the diagnostic criteria for borderline personality disorder (Stiglmayr et al., 2014). DBT has proven more effective than traditional cognitive restructuring therapy in severe clinical cases, suggesting that cognitive psychology may benefit from balancing absolute rationality with Zen and Buddhist elements, offering patients greater emotional outlet and spiritual support.

7.3 Mandala Drawings

Mandala originated as a Sanskrit word meaning “circle.” In Buddhist tradition, it is a geometric design that represents the universe, wisdom, impermanence, and the Five Buddhas (Grey, 2001). Tibetan Buddhists often use it in practice as an aid to meditation and tantric approaches. Stemming from meditation, Carl Jung later developed mandala drawing and proposed it could be integrated into psychotherapies to enhance psychological harmony and preserve personality integrity. Jung believed mandalas represented the Self and that drawing a mandala provided a sacred space for a person to meet that Self (Jung, 2012). Following Jung’s perspective, research has explored how Buddhist practices, such as mandala training, can not only reduce negative attachments like depression and anxiety but also maintain overall well-being through positive psychology (Jung, 2012).

Liu et al. (2020) explored how cooperative and individual mandala drawing exercises influence mindfulness, spirituality, and subjective well-being. Their findings indicated that both forms of drawing yield positive outcomes, though in different manners. Individual mandala drawing was linked to heightened mindfulness and personal well-being, whereas cooperative drawing was more closely tied to increased spiritual awareness. This implies that the social environment of the activity can shape its psychological benefits. The study underscores the potential of mandala drawing as a therapeutic practice, with its benefits varying based on whether the activity is conducted alone or with others (Liu et al., 2020). Their research design structured the drawing process as art therapy: (1) introduce mandala drawing with psychological education, (2) create mandalas using a given introspective prompt “How am I now?” and (3) discuss and share with others the coloring experience. This specific framework and its significant outcomes for psychological well-being demonstrates the advantage of combining Western treatments with TTM (Liu et al., 2020).

8. Discussion

First, the risk factors distinctive to the Tibetan population—high altitudes, socioeconomic circumstances, and traumatic experiences—were explored. Within these factors, high altitudes may be the more significant of the risk factors because the influence of geographical location affects all inhabitants in the area. Societal, financial, or traumatic reasons, however, may not apply to all age groups or locations. Nevertheless, the rates of mood disorders indicate a pressing need for mental health services in the Tibetan population. Future research should be directed toward gathering data on local preferences for mental health services and actively seeking constructive feedback from the Tibetan people regarding the provided services rather than passively imposing psychiatric infrastructures. These in-depth needs assessments will provide evidence that exhibits the necessity for relevant governmental funding and implementation.

Furthermore, the comparison between the traditional Tibetan and modern Western psychology approaches to mental health care yields notable outcomes. The Tibetan approach focuses on the interconnectedness of body, spirit, and mind, emphasizing the holistic balance between an individual and their environment. In contrast, the Western approach focuses on identifying and treating specific symptoms using evidence-based intervention. Despite these noticeable variations in theories and application, it is possible that integrations like MBCT could

be fostered between the two approaches by extracting the strengths of both practices to create more comprehensive treatments and preventions.

Elements of TTM could be integrated into the Western psychiatric model. The three Tibetan approaches, dharmic, tantric, and somatic, considerably highlight the overall spiritual practices, diets, and lifestyle in their diagnosis. This could supplement the Western medical model, which primarily focuses on observable clinical symptoms and genetic factors. Notably, Tibetan elements could also contribute to the prevention process because its focus is on improving daily conduct. Specifically, targeted practices like meditation and dietary changes could be incorporated into Western interventions. Essentially, modern clinical treatment could harness those aspects of Tibetan practices that support its definition of mental wellness.

Furthermore, elements in Western psychiatry's evidenced-based practices could offer valuable support to TTM practitioners. For instance, Cognitive Behavioral Therapy and DBT quantify clients' behavioral changes using daily tracking records of antecedents, thoughts, behaviors, and consequences. Clear and objective goals are also set to measure the treatments' effectiveness. Implementing these measures into the Tibetan approaches can enhance their reliability and validity. Ultimately, the ability to diagnose and treat mental illness will be more systematic and agile. Furthermore, Western medication could, tentatively at first, be introduced in addition to Tibetan approaches. Antidepressants, such as selective serotonin reuptake inhibitors, that treat depression or depressants, such as benzodiazepines, that treat anxiety may serve as valuable complements to TTM. As well, the integration process should also be culturally sensitive and still cater to the unique needs of the Tibetan community.

It is worth noting that when comparing the two types of integration, the latter—incorporating Western psychology into TTM—is considerably less developed in all societies alike. The dominance of Western psychiatric models in contemporary mental health care, coupled with the limited exposure of many Tibetan practitioners to Western psychological concepts and practices, has posed significant challenges to developing mental health services in the Tibet region. Future research should focus on designing a Tibetan version of structured interventions. This could be achieved by adapting current MBCT or MBSR programs and redesigning therapeutic components to the benefit of and suitability for Tibetans and their practitioners. For example, incorporating religious elements into therapy could help the deeply religious locals feel more aligned with the treatment process. This alignment to cultural relevance can enhance their engagement with and trust in the therapy, potentially making it more effective.

From a temporal lens, recent advancement and trends in clinical psychology have increasingly turned to positive psychology, promoting well-being and virtue development rather than only reducing the symptoms of disorders (Jankowski et al., 2020). Interestingly, this development in Western psychology aligns with the practices of TTM that aim at promoting holistic well-being through daily rituals and lifestyles. By integrating these emerging complementary approaches, practitioners can develop more effective interventions that not only address psychological symptoms but also foster sustained personal growth and resilience, ultimately bridging the gap between symptom reduction and the cultivation of a fulfilling life.

9. Conclusion

In essence, this paper examined the unique cultural and societal context of mental health care in the Tibetan community, offering directives for future research and practice. It revealed the potential for integrating TTM and Western psychological approaches, combining the holistic focus of Tibetan practices with the evidence-based methods of Western psychiatry. Integrated treatment holds promise for enhanced mental health care, particularly in the Tibetan region, if sustained attention is given to cross-cultural dialogue. This synergy could improve the reliability and validity of Tibetan methods and enrich Western practices with a focus on body, spirit, and mind. That being said, the task of translating and remodeling Western psychological interventions to fit within the Tibetan context is a complex undertaking. Hence, adequate deliberation and resources need to be directed to the development of an integrative plan. Moreover, collaboration is a key step within this plan. By being more communicative and interactive with the locals during investigations, a more synergistically comprehensive understanding and better mental health outcomes for the Tibetan community may be stimulated.

10. Glossary

Table 1.

Term	Definition
Bodhisattva ideal	In Mahayana Buddhism, the aspiration to attain enlightenment for the benefit of all sentient beings. A Bodhisattva prioritizes helping others achieve liberation from suffering, often delaying their own enlightenment to do so. These ideal stresses compassion, selflessness, and wisdom.
The three poisons	In Buddhism, these are the root causes of suffering and the cycle of rebirth, consisting of ignorance, attachment, and aversion.
The three humors	In Tibetan medicine, these are the three primary elements that govern bodily functions, consisting of wind, bile, and phlegm.
Dharmic	Pertaining to dharma, a key concept in Tibetan Buddhism, including cosmic law and moral duties guiding individual behavior and practices.
Tantric	Pertaining to the Tantra, an esoteric tradition in Tibetan Buddhism that involves rituals, meditation, and yoga to achieve spiritual enlightenment and transformation.
Somatic	Pertaining to the body in Tibetan Buddhism, encompassing physical sensations and practices integral to spiritual development and meditation.

References

American Psychological Association. (2019, August). *Depression treatments for adults*. Retrieved from https://www.apa.org/depression-guideline/adults

Arregui, A., Hollingsworth, Z., Penney, J. B., & Young, A. B. (1994). Autoradiographic evidence for increased dopamine uptake sites in striatum of hypoxic mice. *Neuroscience Letters, 167*(1-2), 195-197. https://doi.org/10.1016/0304-3940(94)91060-X

Begley, S. S. (1994). Tibetan Buddhist medicine. *Journal of Holistic Nursing, 12*(3), 323-342. https://doi.org/10.1177/089801019401200309

Brock, D. (2008). *Taming the mind: Current mental health treatments and obstacles to expanding the western-model in a Tibetan exile community*.

Chen, J., & Huang, H. (2013). Stress induced depression and monoaminergic system homeostasis. *J. Biol, 30*(1), 78-81.

Clifford, T. (1994). *Tibetan Buddhist medicine and psychiatry: The diamond healing*. Motilal Banarsidass Publ.

Cyranoski, D. (2010). China tackles surge in mental illness. *Nature, 468*(7321), 145. https://doi.org/10.1038/468145a

Deane, S. (2014). From sadness to madness: Tibetan perspectives on the causation and treatment of psychiatric illness. *Religions, 5*(2), 444-458. https://doi.org/10.3390/rel5020444

Deane, S. (2019). rLung, Mind, and Mental Health: The Notion of "Wind" in Tibetan Conceptions of Mind and Mental Illness. *Journal of Religion and Health, 58*(3), 708-724. https://doi.org/10.1007/s10943-019-00775-0

Eli, B., Zhou, Y., Liang, Y., Cheng, J., Wang, J., Huang, C., Xuan, X., & Liu, Z. (2021). Depression in children and adolescents on the Qinghai-Tibet Plateau: Associations with resilience and prosocial behavior. *International Journal of Environmental Research and Public Health, 18*(2), 440. https://doi.org/10.3390/ijerph18020440

Flynt, R. (2015). Mind within the body: The presence and importance of mental health within traditional Tibetan medicine. *Independent Study Project (ISP) Collection*. https://digitalcollections.sit.edu/isp_collection/2094

Fjorback, L. O., Arendt, M., Ørnbøl, E., Fink, P., & Walach, H. (2011). Mindfulness-based stress reduction and mindfulness-based cognitive therapy: A systematic review of randomized controlled trials. *Acta Psychiatrica Scandinavica, 124*(2), 102-119. https://doi.org/10.1111/j.1600-0447.2011.01704.x

Gerard, A. B., McElroy, M. K., Taylor, M. J., Grant, I., Powell, F. L., Holverda, S., Sentse, N., & West, J. B. (2000). Six percent oxygen enrichment of room air at simulated 5000 m altitude improves neuropsychological function. *High Altitude Medicine & Biology, 1*(1), 51-61. https://doi.org/10.1089/152702900320685

Grey, M. (2001). Encountering the mandala: The mental and political architectures of dependency. *Culture Mandala, 4*(1), 5840.

Hao, Y. (2000). Tibetan population in China: Myths and facts re-examined. *Asian Ethnicity, 1*(1), 11-36. https://doi.org/10.1080/146313600115054

Holtz, T. H. (1998). Refugee trauma versus torture trauma: A retrospective controlled cohort study of Tibetan refugees. *Journal of Nervous and Mental Disease, 186*(1), 24-34. https://doi.org/10.1097/00005053-199801000-00005

Jankowski, P. J., Sandage, S. J., Bell, C. A., Davis, D. E., Porter, E., Jessen, M., Motzny, C. L., Ross, K. V., & Owen, J. (2020). Virtue, flourishing, and positive psychology in psychotherapy: An overview and research prospectus. *Psychotherapy, 57*(3). https://doi.org/10.1037/pst0000285

JieAnNaMu, Xu, X., You, H., Gu, H., Gu, J., Li, X., Cui, N., & Kou, Y. (2020). Inequalities in health-related quality of life and the contribution from socioeconomic status: evidence from Tibet, China. *BMC Public Health, 20*(1). https://doi.org/10.1186/s12889-020-08790-7

Jung, C. G. (2012). *The red book: A reader's edition*. New York, NY: WW Norton & Company.

Kabat-Zinn, J., & Hanh, T. N. (2009). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. Random House Publishing Group.

Li, X. Y., Wu, X. Y., Fu, C., Shen, X. F., Wu, Y. H., & Wang, T. (2000). Effects of acute mild and moderate hypoxia on human mood state. *Space Med. Med. Eng, 13*(1), 1-5.

Linehan, M. M., & Wilks, C. R. (2018). The course and evolution of dialectical behavior therapy. *American Journal of Psychotherapy, 69*(2), 97-110. https://doi.org/10.1176/appi.psychotherapy.2015.69.2.97

Liu, C., Chen, H., Liu, C. Y., Lin, R. T., & Chiou, W. K. (2020). Cooperative and individual mandala drawing have different effects on mindfulness, spirituality, and subjective well-being. *Frontiers in Psychology, 11*, 564430. https://doi.org/10.3389/fpsyg.2020.564430

Lucca, G., Comim, C. M., Valvassori, S. S., Réus, G. Z., Vuolo, F., Petronilho, F., Gavioli, E. C., Dal-Pizzol, F., & Quevedo, J. (2009). Increased oxidative stress in submitochondrial particles into the brain of rats submitted to the chronic mild stress paradigm. *Journal of Psychiatric Research, 43*(10), 864-869. https://doi.org/10.1016/j.jpsychires.2008.11.002

Mackenzie, M. B., & Kocovski, N. L. (2016). Mindfulness-based cognitive therapy for depression: Trends and developments. *Psychology Research and Behavior Management*. https://doi.org/10.2147/PRBM.S63949

Mayo Clinic. (2022, December 13). Mental illness - symptoms and causes. *Mayo Clinic*. Retrieved from https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968

Michael, F. (2019). *Rule by incarnation*. Routledge. https://doi.org/10.4324/9780429304989

Mills, E. J., Singh, S., Holtz, T. H., Chase, R. M., Dolma, S., Santa-Barbara, J., & Orbinski, J. J. (2005). Prevalence of mental disorders and torture among Tibetan refugees: A systematic review. *BMC International Health and Human Rights, 5*(1), 7. https://doi.org/10.1186/1472-698X-5-7

National Institute of Health and Care Excellence [NICE]. (2009). *Depression: The treatment and management of depression in adults* (update). London: Author. Retrieved from https://www.nice.org.uk/guidance/CG90

Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: A meta-analysis. *JAMA, 294*(5), 602-612. https://doi.org/10.1001/jama.294.5.602

Que, J., Shi, L., Liu, J., Sun, Y., Bao, Y., & Lu, L. (2019). The development of mental hospitals in China from 2002 to 2016. *Chinese Journal of Psychiatry, 52*(2), 139-144. https://doi.org/10.3760/cma.j.issn.1006-7884.2019.02.007

Riemann, D., Hertenstein, E., & Schramm, E. (2016). Mindfulness-based cognitive therapy for depression. *The Lancet, 387*(10023), 1054. https://doi.org/10.1016/S0140-6736(16)00660-7

Samuel, G. (2019). Unbalanced flows in the subtle body: Tibetan understandings of psychiatric illness and how to deal with it. *Journal of Religion and Health, 58*(2), 770-794. https://doi.org/10.1007/s10943-019-00774-1

Servan-Schreiber, D., Le Lin, B., & Birmaher, B. (1998). Prevalence of posttraumatic stress disorder and major depressive disorder in Tibetan refugee children. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*(8), 874-879. https://doi.org/10.1097/00004583-199808000-00018

Stiglmayr, C., Stecher-Mohr, J., Wagner, T., Meißner, J., Spretz, D., Steffens, C., Roepke, S., Fydrich, T., Salbach-Andrae, H., Schulze, J., & Renneberg, B. (2014). Effectiveness of dialectic behavioral therapy in routine outpatient care: The Berlin Borderline Study. *Borderline Personality Disorder and Emotion Dysregulation, 1*(1), 20. https://doi.org/10.1186/2051-6673-1-20

Terheggen, M. A., Stroebe, M. S., & Kleber, R. J. (2001). Western conceptualizations and eastern experience: A cross-cultural study of traumatic stress reactions among Tibetan refugees in India. *Journal of Traumatic Stress, 14*(3), 391-403. https://doi.org/10.1023/A:1011177204593

Wang, J., Zhou, Y., Liang, Y., & Liu, Z. (2019). A large sample survey of Tibetan people on the Qinghai-Tibet Plateau: Current situation of depression and risk factors. *International Journal of Environmental Research and Public Health, 17*(1), 289. https://doi.org/10.3390/ijerph17010289

Wangmo, T., & Teaster, P. B. (2009). The bridge from then to now: Tibetan elders living in diaspora. *Journal of Applied Gerontology, 29*(4), 434-454. https://doi.org/10.1177/0733464809341468

Williams, A. C., & Merwe, J. V. (2013). The psychological impact of torture. *British Journal of Pain, 7*(2), 101-106. https://doi.org/10.1177/2049463713483596

World Health Organization. (2024). *Health and well-being*. Retrieved from https://www.who.int/data/gho/data/major-themes/health-and-well-being#:~:text=Mental

Xia, L., Jiang, F., Rakofsky, J., Zhang, Y., Shi, Y., Zhang, K., Liu, T., Liu, Y., Liu, H., & Tang, Y. (2021). Resources and workforce in top-tier psychiatric hospitals in China: A nationwide survey. *Frontiers in Psychiatry, 12*. https://doi.org/10.3389/fpsyt.2021.573333

Xiang, Y., & Zhang, Q. (2022). Mental health services on the roof of the world. *World Psychiatry, 21*(1), 157-158. https://doi.org/10.1002/wps.20797