Causation as Strategy: Interpreting Humours among Tibetan Refugees

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The article focuses on the incidence of humoural wind (rlung) disorders among Tibetan exiles in India. It investigates the reasons behind the emergence of rlung as a significant problem among Tibetan exiles, and seeks to unpack some of the local meanings of this ‘epidemic’. Previous studies have generally described rlung disorders as symptomatic of political and moral concerns, highlighting the connections that Tibetans make between physical, moral and psychological states in the context of Buddhist practice and everyday life. This paper aims to further nuance these findings by showing that, while Tibetan exiles include complex causes linked to morality and psychosocial wellbeing in their explanations of rlung disorders, they also ‘cut’ into this explanatory network in strategic ways, sometimes bypassing religious or psychosocial interpretations of illness altogether. Drawing on this analysis, the article warns researchers against literal readings of general religious precepts when analysing people’s everyday negotiations of illness and wellbeing: the attribution of causation is always strategic, and religious observance should never be assumed to be uniform, or taken as a given.

Recent studies of Tibetan traditional medical practice in the Tibetan Autonomous Region (TAR) have highlighted the prevalence and political significance of wind disorders (rlung gi nad) among contemporary Tibetan communities (Adams 1998, 2002a, 2002b; Janes 1999, 2001; Samuel 2001). In this article, I aim to examine the extent to which rlung is perceived as a problem among Tibetan exiles in Dharamsala and Bir (H-P, India), and to outline some of its local meanings. I aim to show how narratives of causation relating to rlung, and, to a certain extent, karma, are employed by Tibetan exiles as contextual devices in illness narratives. This strategic use of rlung and karma, I argue, shows that the connection between the sacred morality of Buddhism and health is more complex than is often assumed. In this I seek to counter the recurrent essentialisation of Tibetans as full-time religious exegetes, continually investing the social world with...
abstracted religious meaning. Medical anthropologists who strive to demonstrate
that health can only be understood and planned for at the intersection of multiple
planes (biophysical, social, political, and economic) can find theoretical
inspiration in the religious emphasis on the interdependence of phenomena;
yet, just as Tibetan exiles only go back so far down the chain of disease causation
in their illness narratives, should we also, as Marilyn Strathern proposes, learn to
‘cut’ through the network and to restore causation as a strategic interpretation? In
short, should we stop ‘re-enchanting’ what our informants strive to disenchant?

The Significance of *rLung*: Findings from the Tibetan Autonomous Region

According to recent anthropological discussions, disorders pertaining to *rlung*
have arisen in the contemporary TAR as somatised manifestations of psychosocial
stress linked to political and social tensions. *rLung*, one of the three humours that
regulate the state of the body in traditional Tibetan medicine along with bile
(*mkhris pa*) and phlegm (*bad kan*), is said to arise through negative mental states
(melancholy and sadness), inadequate diet (lack of nutritious food or excess of
certain foods), and inadequate behaviour (sexual excess or intellectual over-
exertion). According to Tibetan medicine’s main treatise, the *rGyud bzhi* or four
tantras, there are 42 types of *rlung* disorders, both specific (relating to specific
organs in the body) and general, i.e. caused by a combination of *rlung*, *mkhris pa*
and *bad kan*. Although imbalances in all three humours can cause serious diseased
states, *rlung* plays an especially important role because it commands the body’s
general state: Adams has described how Tibetan doctors in Lhasa depict the three
humours as three fighter planes flying in unison, *rlung* being like ‘the lead pilot
who, when he detects small deviations in his flanking planes, moves towards them
rather than keeping them on course himself’ (Adams 2004, p. 12). *rLung* is seen
as the root cause of all disorders because of its influence on the regulation of heat
and cold in the body, a process seen as fundamental to health in Tibetan
medicine (Finckh 1978, p. 22). Another dimension of *rlung* is its close
relationship to the mind, and to perceptions of the environment: severe *rlung*
disorders both stem from, and give rise to, serious distortions in perception. The
traditional Tibetan saying that ‘the mind rides on *rlung* like a horseman on his
mount’, conveys the idea that *rlung* is largely responsible for carrying and
regulating states of mind. An imbalance in *rlung* therefore has serious
consequences for one’s mental health; equally, unhappy mental states can bring
about increases in *rlung*. In an ethnographic study of a women’s clinic in the
traditional Tibetan medical institute (*sman rsti khang*) in Lhasa, Adams (2001) has
shown that *rlung* is a local ‘idiom of distress’ through which discontents with
political oppression and the forced secularisation of life in TAR can be articulated.
Other ethnographic work by Connor (2001, p. 16) also supports this
interpretation: ‘Tibetan medicine provides a context in which people can express
their distress in their own cultural idioms as a vulnerable and disenfranchised
minority in the PRC [People’s Republic of China], subjected to forms of racism’.
The view from the TAR therefore suggests that the current *rlung* ‘crisis’ witnessed
in traditional clinics is an epidemic engineered by political, economic and religious inequities.

As previously mentioned, a common assumption underpins the studies described above, i.e. the notion that Tibetans view bodily states, morality and social suffering as interconnected. Janes (1999, p. 92), for example, proposes that ‘in Tibetan culture, the category of *rlung* encompasses the political as part of bodily suffering, and as expression of the social and moral connections between people. Its expression in ailing Tibetans thus reveals that they experience subjectivity as at least partially collective, based on notions of karma and an inseparation of body, mind and society.’ Adams shares this belief in a ‘collective’ Tibetan subjectivity: in her view, the boundaries between internal (bodily) and external (social and political) imbalance are artificially constructed by external discourses, and in fact misrepresent the Tibetan understanding of suffering and the body. Rather, the Tibetan model of health posits that morality is embodied, and that ‘people’s bodies are literally expressions of their accumulated virtue and non-virtue in relation to past sentient beings in past lives’, thus making the *ethical* constitutive of the *physical* (Adams 2004, p. 8).

However, the connections between moral imaginations and health are multifarious and context dependent. Can we state that Tibetan subjectivities are largely perceived as collective, and, if so, what are the implications of this? An investigation of the aetiologies of *rlung* among Tibetan refugees in India may help answer some of these questions.

*rlung* in Exile

*rlung* disorders have emerged as a significant problem among Tibetan refugees in India. In this section I examine some of the explanations given by exiles for this ‘epidemic’. The analyses proposed draw on eleven months of fieldwork in Dharamsala (2000–2002), and investigates the aetiologies of *rlung* in relation to other prevalent disorders for which Tibetans consulted at clinics, both traditional or biomedical. The following tables (Tables 1 and 2) show some of the results of a short survey with patients at the Men-Tsee-Khang (traditional) and Delek Hospital (biomedical) in Dharamsala, India. In these surveys, conducted twice (2000 and 2001), I asked about the types of health problems for which they presented to the clinics, and about their explanation for these.

In July 2001 I conducted further interviews with patients from the Men-Tsee-Khang and Delek Hospital (36 and 38 respectively) to try and identify the perceived causes for these prevalent disorders, and more specifically for *rlung* disorders (Table 3). The majority (63 out of 74) cited financial concerns as the main cause of *rlung*, and many said that worry, anxiety and sadness were also important (55 out of 74), as one elderly woman visiting her Men-Tsee-Khang doctor explained:

How does *rlung* arrive . . . *rlung* comes through sadness, yes, mostly sadness. I had a lot of *rlung* when I left Tibet, and now I still have a lot of *rlung*. Chos [dharma, or Buddhist religious practice] helps me with this, it stops me from becoming too agitated . . .
A young newcomer working in Men-Tsee-Khang explained why he thought his *rlung* had worsened in India:

I don’t know . . . I didn’t think it [exile] would be so difficult. I was told I had family here, but when I came to India I found out they have moved to Bylakuppe [South India]. So I don’t really have relatives here, I have never met them. I was lucky to find this job, that is true. But back in Tibet I was earning more and I had family, friends. People my age who were born in India all have their own friends, so I mostly stay with people from Lhasa.

Financial concerns reflect the high level of economic uncertainty in the exile communities, where unemployment is high and many Tibetans resort to asking...
foreign donors for sponsorship to make ends meet (de Voe 1981; Prost 2006). The
link between rlung and anxiety/sadness was most strikingly expressed in the high
prevalence of rlung disorders among recent (newcomer) refugees, for whom the
trauma of exile was especially fresh. Traditional Tibetan practitioners reported
symptomatically finding rlung recurrently among newcomers, so much so that they
would automatically take medicines for rlung afflictions when visiting camps where
recent refugees are hosted (see Prost 2006, forthcoming). A Men-Tsee-Khang doctor
who conducted bi-monthly clinics in one of these camps commented that rlung was
the first thing she would ‘pick up’ among newcomers: ‘They all have rlung, all of
them, it’s the first thing you feel in the pulse’.

In addition to psychosocial stress, there was an ‘environmental’ dimension to the
exile rlung crisis: refugees complained that living conditions in the Indian
settlements, in particular the heat and lack of ‘wind’ [sic] made them more
susceptible to rlung disorders and to health problems in general. Pollution, heat and
crowdedness were some of the main sources of discontent mentioned in interviews,
and conditions in India were recurrently contrasted with those in Tibet. Pema, a 16
year-old female student from the Tibetan Children’s Village said:

I think what most affects us here is that they are destroying the environment. Building
hotels everywhere, making roads that never get finished, really they are polluting. . . . In
Tibet it is not like that. If you look at pictures of Tibet, you know, the rural areas, the
sky is always deep blue, the mountains are very, you know, pure . . . . Here it’s like living
in Delhi, but on the mountain. But maybe Tibet has changed so much it is also very
polluted. I think the Chinese are polluting a lot.

rlung disorders arise primarily in the summer season and younger exiles told me that
they saw the Dalai Lama’s yearly monsoon teaching in Dharamsala as an opportunity
to cleanse themselves from the accumulation of rlung, quite literally, to ‘cool down’.
Exiles also regularly commented on the scarcity and poor nutritional quality of food
supplies in the settlement, which was understood to be a major contributing factor in
the rise of rlung disorders. At the level of ‘lay epidemiology’ therefore, the exile
context and its associated socio-economic pressures was seen as causing the
occurrence of rlung disorders.
Migmar’s Dream . . . Lobsang’s Ambitions

One of my first encounters with a rlung-related illness was through Migmar, a young Tibetan mother of two who had taken me to visit a local monastery in early 2001. As we came out of the monastery to catch the local bus back to lower Dharamsala, Migmar was seized with intense cramps and what she described as an underlying ‘heavy’ pain in her stomach. She then told me about a vision of the Buddha she had experienced the previous night. She had seen a white-bodied Buddha [Chenrezig\textsuperscript{10}] above her as she lay on her bed in a dream state (rmi nyams). In the dream, she could see herself sleeping, skinny (kham po) and pale: ‘I looked [as if] dead, my eyes and mouth were open’. She described the Buddha as smiling and looking down upon her and made the gesture of a flower opening as she recalled this.

The next morning, as we departed for the monastery she began suffering from stomach pains. Migmar thought she would faint before we could return to her home and so we made for the local biomedical hospital (Delek). She was seen by a young Tibetan practitioner and I sat in the consultation room as he examined her. Migmar lay on a bare examination table, languished. The doctor questioned her on the nature of the pain as he put his hands on various parts of her stomach and lower abdomen. She responded negatively to most questions (‘Did you eat any old foods? Have you missed your period?’). When the practitioner pressed on her lower abdomen with both hands, she jumped in pain. The doctor sighed and said he would give her an injection (khab) immediately and that she should come and see him again if she was not rid of the pain by the next day. He proceeded to turn Migmar over onto her stomach and gave her an injection of analgesics.

As we left the hospital Migmar rubbed her stomach, having wrapped a shawl around her waist in the manner of old Tibetan women. rMi lem diy la gyog po che nang byed kyi dug [after that dream, it was scary]. Nge sug po diy ’og la mthong pa yin [I saw my body down there]. Ani sang gyes gyi sku skar thong pa yin [and I saw the Buddha’s white body], she carried on, Diy la rlung red sha [this is certainly rlung]. The pain disappeared the next day, and Migmar attended to her busy schedule without any further mention of rlung or seeking further treatment. A few months later, she offered the post-hoc explanation that her stomach pains had been caused by unspecified ‘gynaecological problems’ and an accumulation of rlung. In her view, the rlung had helped ‘set in motion’ the gynaecological problems, which had then triggered the stomach pains. The underlying causes of rlung were not discussed and no attempt was made to link its emergence to broader moral or psychosocial factors. So while Migmar’s first explanation for the disorder engaged to some extent with psychomoral causes, using the religious imagery from her dream, her later explanations sidelined these in favour of a more ‘mechanistic’ interpretation.

The second case of rlung I witnessed was of a quite different nature. rLung afflicted Lobsang, a monk in his mid-thirties, who suffered from high blood pressure (khrag shed). He had entered monastic education at the age of nine and had had a particularly successful ascent in the religious hierarchy, completing the degree of Geshe (dge bshes)\textsuperscript{11} at a young age and travelling widely as a member of
the Dalai Lama’s private office. Geshe Lobsang’s concern with health took a
number of unexpected forms: he carried with him an imported American
sphygmomanometer and checked his blood pressure regularly. This apparatus had
earned him the nickname sku gzhogs deng dus (modern monk), a playful reprieve
for the monk’s fascination for Western gadgets. Lobsang pointed out to me on a
number of occasions that diseases caused by high blood pressure were very
common in the West among mi chen po, i.e. men in positions of power. This was
due, he explained, to their numerous commitments and unnatural levels of
activity. High blood pressure was therefore a disease of busy and important
people. For Geshe Lobsang, hypertension (khrag shed) had a certain cultural
cachet. He attempted to rein in his blood pressure by controlling his diet, but
despite his efforts, gained more weight and felt increasingly unwell. He finally
resolved to ask the advice of an elderly and experienced Tibetan doctor from the
Men-Tsee-Khang. The practitioner diagnosed a potentially very dangerous srog
rlung (life-sustaining wind) disorder, which could potentially lead to severe mental
illness. A urine examination by his personal Tibetan doctor revealed large bluish
looking bubbles, confirming the diagnosis.

Medical students from the local Men-Tsee-Khang had already explained to me
that such rlung illnesses are common in people involved in religious studies,
where intellectual overexertion is common. rLung imbalances therefore character-
istically affected monks and students of Buddhism, who, through their constant
preoccupation with abstract considerations, sometimes became hot-tempered,
nervous and irritable, as illustrated in the expression used for short-tempered
people, rlung tsha po, or literally ‘hot strong wind’. Geshe Lobsang’s illness arose
from the overwork of his mental faculties, engrossed with spiritual matters. Yet
even after the traditional doctor’s diagnosis, he referred to his disorder as a ‘BP’
(blood pressure) problem and resisted engaging with the traditional aetiology of
rlung, though he regularly took the Tibetan herbal pills prescribed by his
physician. Lobsang’s condition did not improve however, and his physician
offered a more radical form of treatment, which involved applying a long, heated
golden needle to the cranium. However Geshe Lobsang was repelled by the
invasive nature of this method and managed to persuade his physician to let him
continue with his herbal pill treatment, on the condition that he regularly went to
seek blood tests at the hospital to check for Diabetes.12 But Lobsang avoided the
local hospital where patients were prone to gossiping about monks’ illnesses;
Diabetes, especially, was viewed as a disease of indulgent and ‘rich’ monks. When
I asked him whether he believed this rlung illness might have been caused in some
way by over-exertion or karma Lobsang shrugged off the remark and said: ‘if that
is the case, then everything is caused by karma’. According to the traditional
Tibetan doctor who had treated him, Lobsang’s busy lifestyle, his diet and high
level of intellectual activity had caused the rlung increase. Yet despite his
adherence to Tibetan medicine, Lobsang actively refused to engage with the full
local aetiology of his disorder, preferring to view his problem as hypertension
rather than rlung. Even though he felt that rlung was probably implicated, he was
reluctant to delve into the psychosocial and moral factors linked to the disorder.
Causation as Strategy

Tibetan exiles are meaningfully selective in the way they attribute causation to illness. Some will relate the emergence of a particular illness episode to moral emotions or psychosocial causes, often through religious motives. Others, such as Geshe Lobsang, sideline humoural and karmic explanations in favour of more biophysical motives.13 Geshe Lobsang’s reluctance to adhere to a ‘traditional’ explanation and his readiness to segregate the biophysical from the social, are a reflection of his concern with social status: by switching between the labels of rlung and ‘BP’, he is able to shrug off social sanctions that judge his rapid social and financial ascent. The possibilities afforded by medical pluralism are an infinite strategic resource; not only can one shift between humoural and biomedical explanations, but also between different ‘levels’ of humoural causation. rlung can be seen as a restricted humoural category in a very biophysical sense, just as it can open the Pandora’s box of affect and karma. Causation is constituted as a post-hoc judgement to justify a therapeutic strategy that has already been acted upon.

The diversity of explanation modes presented by Tibetan exiles thus reveals their margin of agency in the search for causes: the spheres that Adams and Janes see as interrelated are only so in as far as exiles choose them to be, indeed insofar as their integration may legitimate or compromise social status and help make sense of personal narratives of exile. Related to this, rlung and karma are motives easily invoked to create order in otherwise piecemeal exile trajectories. Karma and rlung are cognitive and narrative vectors that help make sense of one’s life and instil significance in traumatic events. As such, recourse to them can be seen as a contextual ‘technique’ rather than as an ontological statement. Individual agency determines the recourse to humours and karma in selective strategies of presentations of the self and contextual negotiations of status.

As shown in the two short case studies presented in this article, the ‘suffering’ of exile is not experienced by all in the same manner, but internalised and expressed in ways that reflect individual experiences. There are, for example, stories that contradict the expected ‘exile as trauma’ scenario. Some older Tibetans described the feeling of relief and recaptured sense of wellbeing (including physical wellbeing) experienced in exile, especially after seeing the Dalai Lama. Young exiles would often confess that they did not want to move away from Dharamsala, where their friends and families were, not even for the West.

On the basis of the above arguments, it becomes clear that anthropologists have obscured the particularities of Tibetans’ understandings of health behind a gloss that extends the Buddhist outlook onto the whole of Tibetan life. This effectively participates in what Adams justly terms an ‘orientalism’: we often seek to depict Tibetans has having solely religious concerns.14 It is not my purpose to doubt that Buddhist practice frames and underpins sufferers’ notions of aetiology, and provides individuals with a meaningful prism through which to interpret health and illness. However, it is presumptuous to believe that Tibetans unilaterally regard suffering as a collective affliction caused by political and karmic activities. Rather, it is unavoidable to remark that their understanding of suffering operates
through a ranking of potential causes and that the politics of this ranking deserve attention. Causation, as a category invested with strategic social meaning, must be fixed, even if only temporarily, because it loses the power to legitimate suffering when diffused. The ‘interconnectedness of everything and everybody to this life and previously for uncountable eons’ (Janes 1999, p. 156) is a suitably appealing concept, but it remains critically important to understand how this interconnectedness is ‘cut’ at specific points—specific nodes of causation—in illness narratives and what the meaning of these cuts might be. In Lobsang’s case, the ‘cut’ of interpretation is of critical importance to understand his perspective on rlung illness.

The strain of interconnectedness that Janes refers to has much in common with Strathern’s (1996, p. 522) description of the ‘network’: ‘a concept which works indigenously as a metaphor for the endless extension and intermeshing of phenomena...an apt image for describing the way one can link or enumerate disparate entities without making assumptions about level or hierarchy’. However, Strathern sees the analytic incommensurability generated by the network as self-defeating: ‘one can always discover networks within networks...yet analysis, like interpretation, must have a point; it must be enacted at a stopping place’ (Strathern 1996, p. 523). The interpretation of causation in illness is such a stopping place. It is of course individuated, political and contextual in a way that displeases connection seekers, but connections are generally obscured for a reason.

The construction of Tibetan suffering as a manifestation of collective subjectivity owes to the overflow of Buddhist thought onto our understanding of lay realms. Social scientists influenced by Buddhist theory have not been careful enough in delineating the difference between elite and religious discourses on suffering. While the former places emphasis on a universalistic vision of the body and on the nature of suffering as both a result and cause of karma, that of the laity is assuredly equally concerned with the suffering of the individual body and the immediate benefits of therapeutic practices.

Baxi’s (1994) and Das’ (1995) writings on suffering are particularly pertinent to this argument: in their view, suffering has its own political economy, its modes of production and consumption which are linked to the production and consumption of discourses about suffering. Law and medicine both require the construction of ascertainable, authentic narratives of pain and suffering to produce ‘objective’, ‘scientific’ accounts that legitimate the position of actors within competing versions of the truth. In this case, the voices of Tibetan refugees may simply be lost if we only speak of their suffering as collective and inter-subjective. Where one stands for all, at the same time one also stands for none in particular. To silence the voice of the patient or the victim, says Baxi, is to appropriate his/her suffering in a ‘perfect crime’, where she is denied the means to prove harm. To dilute the ‘subject’ of suffering by denying it the possibility of objective quantification, the possibility of becoming ‘objectified’, is effectively to silence the victim. To create a further objectification of suffering by defining it as ‘collective’, describing its mode of expression as primarily somatic and religious, further robs individuals from the means of articulating individual suffering.
Conclusion

Tibetan exiles are meaningfully selective in the ways in which they present and legitimate the intervention of rlung in the course of an illness. Traditional disease aetiologies linked to the cosmology of Tibetan Buddhism do not have a homogenous configuration either in the TAR or in exile; individual strategies of self-presentation play a crucial role in shaping the form and content of illness explanations. As I have shown in the exile context, individuals actively pick out causation models—and corresponding treatments—which legitimise their social position and render illness intelligible in culturally significant ways. More generally, putting emphasis on the interconnectedness of factors shaping the production of health should not prevent us to attend to the ‘interpretive cuts’ performed by patients and sufferers when allocating a cause to illness. Researchers should also take great care when generalising about the extent and nature of religious influence on health-related practices.

Notes

[1] The principle of dependent arising stipulates that all mental and physical phenomena are conditioned and ultimately caused by ignorance, which is the fundamental misconception of reality as having inherent existence. The twelve links of dependent origination arise when ignorance gives rise to consciousness and karmic acts, which in turn make one enter the cycle of death and rebirth. Understanding the principles of dependent origination is fundamental to attaining enlightenment, as explained by Nagarjuna in the Madhyamika-karika 24, 40: ‘The one who sees Dependent Origination, sees this precisely as Suffering and the Source, precisely as Cessation [of suffering] and Path [to the cessation of suffering]’. There are competing interpretations of this principle: some see dependent origination as causing the rebirth of individual bodies, others understand it as a more generic principle guiding the emergence of all phenomena and beings as conditioned. For a detailed exposition of the Tibetan view, see Napper (1988). The Tibetan Gelugpa view of dependent origination is outlined extensively in Tsongkhapa’s 15th century Lam rim Chen mo or ‘Great Exposition of the Stages of the Path’.

[2] These are perceived to be ‘secondary’ factors in Tibetan medicine. The primary cause of illness according to the rGyud bZhi is ignorance (ma rig pa) and its associated three poisons (dug gsum), desire, hatred and delusion:‘dod chugs, zhe sdang and gti mug.

[3] Such modernistic metaphors are also common employed by exile doctors. For instance, MTK doctors often compare the tsa (pulse) to a telephone line, and the practitioner to the device that interprets the electric signal.

[4] For example, fainting or comatose states are referred to as rlung gis khyer te grong thangs yung byung [when the wind carries one off].

[5] See also Jacobson (2002) for an explanation of srog rlung as ‘panic attack’.

[6] Accounts of Tibetan ethnoanatomy, aetiological systems and ‘idioms of distress’ that may enlighten us on this relationship between Buddhism, medicine and the self ‘outside’ the conventional works on Tibetan medicine are scarce. They are mostly derived from historical inquiries (Tucci 1956; Snellgrove & Richardson 1968), or from more recent anthropological work on illness in the TAR and among Tibetan Sherpas of Nepal (Ortner 1978; Adams 1998; Desjarlais 1992) and biographical accounts of life in Tibet (Taring 1970; Norbu 1987).

[7] Some of the interviews were pre-scheduled and others were conducted on the premises. Many of the persons interviewed in the Men-Tsee-Khang were previously interviewed in December 2000 because they were regular patients there.

[8] Sems khrul byed pa, skyo ngal ba, sms sslug pa.
Tibetans who have arrived in India post-1980 are commonly referred to as newcomers (gsar byor ba). Here I refer specifically to the very recently arrived young refugees who are accommodated in the reception centre in Dharamsala and then later sent to ‘Transit schools’ to further their education. Torture survivors constitute a special group within the newcomer community and special facilities have been designed to accommodate them and facilitate their integration in the refugee community. For an account of the politics of a psychosocial care project for torture survivors in Dharamsala, see Mercer et al. (2005).

Chenrezig (Avalokiteshvara) is the protective deity of Tibet, a bodhisattva who has made the vow not to leave the world until all sentient beings have attained liberation. The Dalai Lama is seen as a manifestation of Chenrezig. Migmar’s dream vision incorporates this ubiquitous and highly significant religious figure and the sequence of the dream itself is culturally encoded: the metaphor of flowers opening is commonly used to describe Chenrezig’s compassionate care for sentient beings.

The equivalent of ‘Doctor of Philosophy’ in the monastic curriculum.

The diagnosis and rapid treatment of diabetes has become a public health priority in the Tibetan community, as diabetics are very prone to infections, particularly to tuberculosis.

This is of course not a new preoccupation for anthropologists. Geertz (1973, pp. 119–120) asserts: ‘the movement back and forth between the religious perspective and the common sense perspective is actually one of the more obvious empirical occurrences on the social scene… human beings move more or less easily, and very frequently, between radically contrasting ways of looking at the world, ways which are not continuous with one another but separated by cultural gaps for which Kierkegaardian leaps must be made in both directions’.

A powerful critique of the orientalism entrapping Tibetans is Donald Lopez’s (1998) ‘Prisoners of Shangri-La’.

The term ‘cutting’ is employed intentionally here for its highly significant use in Tibetan Buddhism. The practice of cutting (gcod), rooted in the teachings of the Prajñaparamita and set down by Padhampa Sangye and Machig Labdrön, consists of ritually ‘severing’ the ego, for example, by offering one’s body to a deity. Yet the term also means to define, restrict, and circumscribe.

What Veena Das (1995) has termed the ‘burden of proof’ in her analysis of the Bhopal crisis and has of course elsewhere been linked to the wrongful appropriation of victims’ suffering by Joan and Arthur Kleinman (1997).

References


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