Role of Tibetan Healing Practices in Psychological Well-Being among Tibetan Communities in India: A Scoping Review (2000–2025)

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Abstract

Tibetan refugees in India have experienced prolonged displacement, political persecution, and intergenerational trauma. Their understanding of psychological distress is shaped by Buddhist philosophy, indigenous medical systems such as Sowa Rigpa, and collective religious life. Conventional Western psychiatric frameworks often fail to fully capture these culturally embedded experiences of suffering. This scoping review examines how Tibetan healing traditions conceptualise mental distress, trauma, and resilience among Tibetan communities in India. It also explores how these frameworks intersect with contemporary psychological approaches to care. This review was conducted in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines. A search was conducted across PubMed, Scopus, and Google Scholar for peer-reviewed English-language articles published between 2000 and 2025. Studies were included if they focused on Tibetan refugees or Tibetan communities in India and addressed Tibetan medicine, Buddhist psychology, ritual healing practices, or other indigenous explanatory models in relation to mental health outcomes. After screening and duplicate removal, eligible studies were synthesised thematically. The literature highlights culturally specific idioms of distress, particularly *rlung* and *srog-rlung* disturbances, strong links between trauma and religious disruption, and the central role of Buddhist mind-training practices, ritual healing, and monastic institutions in fostering resilience. Several studies also identify conceptual parallels between Tibetan healing systems and contemporary trauma-informed psychological approaches. Indigenous Tibetan healing traditions provide culturally meaningful frameworks for understanding and responding to trauma among Tibetan communities in exile. Integrative mental health approaches that respect these traditions alongside evidence-based psychological care may offer more culturally responsive models for refugee mental health services.

***Keywords*:** Tibetan medicine, Sowa Rigpa, Tibetan refugees, Mental health, Resilience

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Tibetan refugees have faced decades of displacement, political marginalisation, and cultural disruption. Many have been exposed to imprisonment, torture, and sustained religious persecution, experiences closely associated with psychological distress (Benedict et al., 2009; Sachs et al., 2008). Tibetan communities show a distinctive form of resilience shaped by Buddhist philosophy, communal support, and ethical practice (Lewis, 2013). The idea is not to avoid suffering but to engage with it actively, treating adversity as an experience that can build inner strength. Spiritual teachings on impermanence and mind training (*lojong*) encourage individuals to reframe hardship and maintain psychological stability (Lewis, 2018a). At the community level, shared identity, cultural continuity, and mutual aid ensure that suffering is rarely faced alone (Lewis, 2021a). Resilience, in this context, is understood as an ongoing process through which trauma becomes a source of personal and collective growth (Lewis, 2018b, 2021b).

Mental distress among Tibetan refugees is rarely understood as a purely medical condition. Studies in cross-cultural psychiatry show that suffering is often framed through moral, spiritual, and bodily explanations rather than diagnostic categories such as depression or PTSD (Tidwell, 2025). Idioms such as *rlung* imbalance or karmic disturbance provide culturally legitimate accounts of anxiety, agitation, and intrusive thoughts, while avoiding the stigma associated with psychiatric labels (Samuel, 2019).

Over the last two decades, scholars have examined Tibetan indigenous healing systems including Sowa Rigpa, Buddhist psychology, ritual healing, and monastic care. These systems are not limited to cultural belief but operate as structured approaches to understanding emotion, suffering, and recovery. The literature has identified parallels between Tibetan healing practices

and contemporary psychological frameworks, particularly in relation to emotional regulation, meaning-making, and mind–body integration (Benedict et al., 2009; Lewis, 2021b). As a result, there is growing interest in integrative mental health frameworks that bridge indigenous Tibetan healing practices with evidence-based psychological interventions.

Methods

Objective

The objective of this scoping review was to examine how Tibetan refugees in India conceptualise mental health and how indigenous healing systems shape responses to trauma and resilience.

Review Approach

A scoping review was conducted to examine peer-reviewed literature addressing Tibetan indigenous healing practices and mental health among Tibetan refugees in India. This review was conducted and reported in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines (Tricco et al., 2018).

Search Strategy

Searches were conducted in PubMed, Scopus, and Google Scholar using combinations of the terms *Tibetan medicine*, *Sowa Rigpa*, *mental health*, *trauma*, *resilience*, *Tibetan refugees*, and *India*. Searches were limited to English-language journal articles published between 2000 and 2025. The search strings used are presented below:

PubMed (n = 71):

(("Tibetan Medicine"[MeSH] OR "Sowa Rigpa") AND ("mental health" OR "resilience") AND ("Tibetan refugees" OR "Tibetans") AND "India") Filters: Publication date 2000–2025; English

Scopus (n = 4):

TITLE-ABS-KEY (("Tibetan medicine" OR "Sowa Rigpa") AND ("mental health" OR resilience) AND ("Tibetan refugees" OR Tibetans) AND India) AND PUBYEAR > 1999 AND PUBYEAR < 2026 AND LANGUAGE (english)

Google Scholar (n = 453):

"Tibetan medicine" OR "Sowa Rigpa" AND "mental health" OR resilience AND "Tibetan refugees" OR Tibetans AND India (2000–2025)

Inclusion Criteria

Studies were included if they: (1) focused on Tibetan refugees or Tibetan communities residing in India; (2) examined Tibetan healing traditions, including Tibetan medicine, Buddhist psychological perspectives, ritual healing practices, or other indigenous explanatory models of distress; (3) explored mental health-related outcomes such as trauma, anxiety, emotional distress, coping processes, or resilience; and (4) were published as peer-reviewed empirical studies or review articles.

Exclusion Criteria

Books, book chapters, dissertations, reports, conference abstracts, non-English publications, studies conducted outside India, and biomedical studies without cultural analysis were excluded.

Study Selection

Across databases, 528 records were identified in total. After removal of duplicates, 202 articles remained for title and abstract screening. Full-text assessment of eligible records was then conducted, resulting in 18 included studies. The selection process is summarised in the PRISMA-ScR flow diagram below (Figure 1).

Figure 1

PRISMA-ScR Flow Diagram of Study Selection

Identification	
Records identified through database searching: PubMed (n = 71), Scopus (n = 4), Google Scholar (n = 453) Total = 528	Additional records identified through other sources (n = 0)
Screening	
Records after duplicates removed (n = 202)	Records excluded on title/abstract screening (n = 171)
Eligibility	
Full-text articles assessed for eligibility (n = 31)	Full-text articles excluded, with reasons (n = 13) • Not focused on Tibetan communities in India • No cultural/healing practice analysis • Book chapters/dissertations/reports

Included

Studies included in final synthesis (n = 18)

Data Extraction

Data were charted using a standardised extraction form covering: study context and population, indigenous healing practice examined, mental health or well-being focus, key findings relevant to the review objective, and implications for integrative mental health care. The first author conducted data extraction, with verification by the second author. Discrepancies were resolved through discussion.

Results

The studies included span a 25-year period and are largely qualitative or conceptual in nature, with a smaller number using mixed methods. Across the literature, mental distress is consistently described as relational, morally meaningful, and embedded in religious and communal life. Table 1 provides a summary of included studies.

Table 1.

Tibetan Indigenous Healing Practices and Mental Health among Tibetan Refugees in India (2000–2025)

Author(s) & Year	Study Context / Population	Indigenous Tibetan Healing Practice	Mental Health / Well-being Focus	Key Findings Relevant to Objective	Implications for Integrative Mental Health Care
Benedict et al. (2009)	Tibetan refugee monks receiving care in exile	*srog-rlung (life-wind), ritual healing, monastic support*	PTSD, trauma, religious impairment	Trauma symptoms overlapped with srog-rlung imbalance.	Trauma treatment must address religious impairment

				Inability to meditate was experienced as a core form of suffering. Religious persecution intensified distress.	and integrate Buddhist healing with psychiatric care.
Sachs et al. (2008)	Tibetan refugees exposed to political violence	Karma, moral causality, spiritual loss	Trauma, fear, meaning-making	Religious persecution and destruction of symbols were reported as more distressing than physical torture. Karma functioned as an anxiety-buffer.	Mental health interventions should respect moral and spiritual interpretations of trauma.
Samuel (2019)	Tibetan medical and religious traditions	*rlung system, mind-body balance*	Anxiety, agitation, trauma-related somatic distress	*rlung disturbances closely resemble autonomic nervous system dysregulation seen in trauma.*	Provides a conceptual bridge between Tibetan medicine and psychosomatic trauma models.
Lewis (2018b)	Tibetan Buddhist contemplative traditions	*Sems pa chen po (Big Mind), equanimity*	Psychological resilience	Well-being does not require constant happiness; spaciousness of mind allows suffering without collapse.	Challenges symptom-elimination models; supports resilience-oriented care.

Lewis (2021b)	Tibetan refugees in exile	*Lojong (mind training), compassion*	Trauma, agency	Tibetans avoid 'survivor' identity, reframing suffering as universal within samsara.	Promotes agency and reduces victimhood narratives in trauma recovery.
Deane (2014b)	Tibetan religious healing	Spirit affliction, ritual intervention	Severe mental disturbance	Certain mental illnesses are framed as karmic or spirit-related rather than pathological.	Calls for cultural humility in diagnosis and treatment planning.
Daniel (n.d.)	Tibetan cosmology and illness	Karmic imprints, moral disorder	Madness, distress	Mental suffering is morally meaningful, not random pathology.	Reinforces need for culturally sensitive assessment tools.
Roberti di Sarsina et al. (2011)	Traditional medical systems	Sowa Rigpa principles, humoral balance	Holistic health	Tibetan medicine is person-centred and constitution-based.	Offers a model for personalised mental health care.
Tidwell et al. (2023)	Tibetan ritual medicine	Exorcism, name-change rituals	Psychological distress	Rituals symbolically sever ties between patient and affliction.	Comparable to narrative and symbolic therapies in psychology.
Nagaoka (2022)	Tibetan communities in India	*Jinden pills, ritual healing*	Coping, distress	Patients actively negotiate healing with doctors and deities.	Emphasises patient agency and cultural legitimacy in care.
Craig et al. (2020)	Medical camps and monasteries	Monastic care, blessing pills	Community mental health	Monasteries function as informal	Highlights role of community-

psychosocial care centres.	based mental health systems.

Sowa Rigpa (Traditional Medicine)

Sowa Rigpa is an individualised, person-centred system in which the physician assesses the patient's humoral constitution (*nyespa*) and identifies imbalances caused by behaviour, diet, or spirits (Roberti di Sarsina et al., 2011; Tidwell et al., 2023).

Ritual Healing

Exorcisms and name-change ceremonies are used to sever the karmic connection between the patient and the affliction (Tidwell et al., 2023).

Monastic Support Structures

Monasteries act as centres for ritualised healthcare, where monks provide blessing pills and spiritual guidance to alleviate clinically significant religious impairment (Benedict et al., 2009; Nagaoka, 2022).

Insights into Modern Frameworks

Mindfulness and MBCT

While Western Mindfulness-Based Cognitive Therapy (MBCT) is used for stress reduction, traditional practitioners view it as a path to enlightenment and the total cessation of suffering (Deane, 2014b).

Trauma-Informed Care

Research suggests that standard trauma instruments such as the Harvard Trauma Questionnaire may fail to capture the somatic expressions of distress unique to Tibetans, such as *rlung* sensations (Sachs et al., 2008).

Integrative Models

Success is often found in complementary approaches, where non-invasive methods (e.g., singing bowl therapy, yoga) address the mental fogginess that prevents monks from meditating effectively (Benedict et al., 2009).

Discussion

The findings reveal a coherent and internally consistent system of healing that integrates philosophical, somatic, and communal dimensions of wellbeing. Rather than mapping straightforwardly onto biomedical or psychological categories, Tibetan healing practices offer a distinctive but not incompatible framework for understanding and addressing psychological suffering.

Framing Distress: Cultural Categories and Their Psychological Significance

A central finding of this review is that Tibetan communities articulate mental distress through culturally specific categories that do not correspond directly with Western psychiatric diagnoses. The concept of *rlung*, which can be understood as wind energy governing the nervous system and the mind–body interface, is frequently described by practitioners and patients as the primary vehicle of psychological disturbance (Samuel, 2019). Conditions such as *srog-rlung*, or life-wind imbalance, present with symptoms that overlap substantially with those of post-traumatic stress disorder (PTSD), including anxiety, sleep disruption, intrusive thoughts, and somatic complaints (Benedict et al., 2009). However, the explanatory frameworks differ significantly. Where biomedicine locates distress in neurological or psychological dysfunction, Tibetan medicine situates it within a dynamic interplay between internal energetic states, spiritual condition, and environmental forces.

Deane (2014a) observed that lay Tibetans in North India frequently attributed psychiatric illness to disturbances in emotional regulation and to disruptions of the boundary between self and environment, including interactions with deities, spirits, and external moral forces. The category of *don* (afflictive external influences) described by Tidwell et al. (2023) further illustrates how Tibetan medicine integrates biological, psychological, social, and cosmological factors into a unified aetiological framework. These illness categories reflect an understanding of mental health that is fundamentally relational and embedded in a broader moral and spiritual order, a perspective that departs considerably from the individualistic focus of mainstream Western psychiatry.

These differences in framing have direct implications for help-seeking behaviour and treatment. Sachs et al. (2008) found that among 769 Tibetan refugees arriving in Dharamsala, levels of psychological distress were significantly low despite high rates of traumatic exposure. Religious coping and the subjective reappraisal of trauma severity were significant mediating factors, suggesting that cultural frameworks actively shape how distress is experienced and expressed. This finding challenges the assumption that trauma produces universal psychological responses and underscores the need for culturally sensitive assessment tools in refugee mental health contexts.

Healing Practices and Mechanisms of Psychological Recovery

Tibetan healing practices operate across multiple registers simultaneously: somatic, cognitive, spiritual, and communal. This integrative character is a distinctive feature of the system. At the individual level, mind-training practices (*lojong*) are described as a primary means of cultivating psychological resilience. Lewis (2013, 2018b, 2021b) documents extensively how *lojong* teachings encourage practitioners to develop a spacious and flexible mind (*sems pa chen*

po), reducing the hold of negative emotions and reframing adversity as workable rather than catastrophic. This orientation is explicitly directed toward recovery from political violence and displacement and is understood as an active, disciplined practice of cognitive and emotional transformation.

The mechanisms underlying *lojong* practice share important parallels with evidence-based psychological interventions, including cognitive reappraisal as used in cognitive-behavioural therapy (CBT) and the cultivation of equanimity central to compassion-focused therapy and mindfulness-based stress reduction (MBSR). Lewis (2021b) argues that reducing *lojong* to a clinical technique misrepresents its nature: it is embedded in a broader ethical and soteriological framework concerned with the cultivation of compassion and the development of moral character. This distinction is important for understanding why Tibetan practitioners may resist the medicalisation of their coping practices even as those practices produce measurable psychological benefits.

At the somatic level, Tibetan medical treatments for *rlung* disturbance, herbal medicines, dietary regulation, massage, and ritual practices address the physical substrate of psychological distress. *Rlung* theory constitutes a sophisticated account of the mind–body relationship that corresponds in important ways with Western understandings of autonomic nervous system (ANS) dysregulation, which is recognised as central to trauma-related conditions such as PTSD (Samuel, 2019). This convergence suggests that the two systems may be targeting overlapping physiological processes through different conceptual and therapeutic means. The integration of somatic and psychological approaches in Tibetan medicine anticipates, in some respects, the growing attention to body-based interventions in contemporary trauma therapy.

Ritual and spiritual dimensions of healing are also significant. Deane (2014b) showed how belief and relational connection including connection to protective deities constitute active therapeutic forces within Tibetan healing encounters. Nagaoka (2022) similarly documents how blessing pills (*jinden*) function as materialised expressions of compassion and religious authority, facilitating care through the negotiation of social, spiritual, and hierarchical relationships. These practices are not peripheral to healing but central to it, operating through mechanisms of meaning-making, community cohesion, and the restoration of moral and cosmological order.

A particularly compelling account concerns how Tibetan Buddhist engagement with death and dying functions as a cultural resource for wellbeing. Meditative practices centred on impermanence and the preparation for death are understood to cultivate adaptive psychological orientations, equanimity, compassion, and reduced attachment to self that support resilience across the life course (Namdul, 2021; Namdul et al., 2025). The *tukdam* phenomenon, in which advanced practitioners are understood to remain in a meditative state following clinical death, represents an extreme expression of this cultivation and has attracted interdisciplinary scientific attention (Namdul, 2025; Tidwell, 2025). More broadly, the normalisation of death as a subject of contemplative engagement within Tibetan communities may contribute to a collective psychological robustness that differs markedly from the avoidance of mortality characteristic of many Western cultural contexts.

Resilience as Practice and Agency

A recurring theme across the reviewed literature is the understanding of resilience not as a fixed psychological trait but as an active, cultivated practice. Lewis (2018b, 2021b) is particularly precise on this point, arguing that Tibetan resilience is better understood as a form of moral agency

than as a clinical outcome. The capacity to face adversity without being defined by it is developed through sustained engagement with Buddhist teachings, community practices, and the everyday application of mind-training disciplines. This framing challenges trauma-resilience models that locate resilience within individuals and treat cultural and spiritual practices as secondary or supplementary resources.

The role of community and shared identity in sustaining resilience is equally important. The Tibetan exile settlements in India have developed around monasteries, cultural institutions, and shared political aspirations that provide a social infrastructure mediating the effects of displacement and political violence. Craig et al. (2020) showed how Sowa Rigpa medical camps in India and Nepal function not only as healthcare delivery mechanisms but also as expressions of a distinctively Buddhist humanitarianism grounded in compassion and moral community. The provision of care within these settings reinforces collective identity and social solidarity, which are themselves protective factors against the psychological consequences of exile.

The reviewed literature also highlights the potential risks of over-pathologising Tibetan refugees. Several studies note that many Tibetans actively resist or reframe trauma narratives, preferring frameworks of agency, spiritual significance, and communal solidarity over those of victimhood and disorder (Lewis, 2018b; Sachs et al., 2008). This resistance is a culturally coherent response that deserves recognition within mental health policy and practice. Denis (2024) similarly emphasises the importance of spatial and communal belonging in generating resilience among Tibetan settlement communities, drawing attention to the structural and environmental conditions that support or undermine psychological wellbeing.

Points of Convergence and Divergence with Modern Psychology

This review does not position Tibetan healing systems as incompatible with modern psychology. Several authors identify overlaps between *rlung* disturbance and autonomic nervous system dysregulation, and draw parallels between Buddhist mind training and cognitive or compassion-based therapies (Benedict et al., 2009; Samuel, 2019). The growing integration of mindfulness and compassion practices into mainstream clinical psychology reflects, in part, an appropriation of techniques derived from Buddhist traditions, though this appropriation is often decontextualised from the broader ethical and philosophical systems from which they originate.

Points of divergence are, however, substantive. Tibetan medicine's integration of spiritual causation, cosmological relationships, and ritual healing within its explanatory framework is difficult to accommodate within the secular, evidence-based paradigm of Western psychiatry. The concept of *don* (affliction by external spiritual forces) represents a diagnostic and therapeutic category with no direct equivalent in biomedical nosology. Similarly, the *tukdam* phenomenon challenges fundamental biomedical assumptions about consciousness and the boundaries of life. These divergences reflect different ontological commitments about the nature of mind, person, and world that have direct implications for how healing is conceptualised and practised.

Benedict et al. (2009) offer a productive model for bridging these systems in their discussion of Tibetan refugee monks presenting with a dual diagnosis of PTSD and *srog-rlung*. Their proposed integrated treatment approach respects the integrity of both frameworks rather than reducing one to the other, incorporating spiritually oriented interventions alongside conventional trauma therapy. Such approaches suggest that meaningful dialogue between Tibetan and Western systems is possible and potentially beneficial, provided it proceeds from genuine respect for the coherence and validity of traditional knowledge systems.

Implications for Mental Health Policy and Practice

The findings of this review carry several implications for mental health services serving Tibetan communities in India. First, assessment frameworks should incorporate culturally valid illness categories and idioms of distress including *rlung*-related presentations and spirit affliction narratives rather than mapping all presentations onto Western diagnostic criteria. Second, treatment pathways should recognise the legitimacy and efficacy of traditional healing practices, including Sowa Rigpa medicine, religious rituals, and community-based *lojong* practices, as primary or complementary components of care rather than barriers to treatment engagement.

Third, mental health professionals working with the Tibetan community should be trained to understand the community's specific historical and political context, including the experience of exile, cultural loss, and ongoing concern for Tibet as constitutive of individual psychological presentations. The Tibetan concept of resilience as communal and morally oriented rather than purely individual should inform the design of group-based and community-level interventions. Finally, research initiatives such as the LAMAS study (Namdul et al., 2025), which uses community-based participatory research methods to investigate health and ageing among Tibetan monks, offer a model for conducting culturally sensitive research that builds trust, incorporates indigenous concepts, and generates knowledge that is meaningful and usable within the community itself.

Limitations

The scoping methodology is appropriate for mapping a broad and heterogeneous literature but does not allow for systematic quality assessment of individual studies. The reviewed sources vary considerably in methodology ranging from ethnographic fieldwork and clinical case studies

to theoretical and philosophical analysis which limits the comparability of findings. The predominant focus on communities in Dharamsala and southern India may not fully capture the diversity of Tibetan refugee experiences across different settlement contexts.

As searches were restricted to English-language publications, studies in Tibetan, Hindi, or other regional languages may have been excluded, introducing the possibility of language bias. The possibility of publication bias also cannot be discounted: studies reporting positive outcomes or well-functioning community practices may be more likely to have been published than those documenting limitations or failures of traditional healing systems. Additionally, the literature on Tibetan mental health remains relatively sparse in terms of quantitative epidemiological data, which makes it difficult to assess the prevalence of specific conditions or the efficacy of particular interventions at a population level. Future research would benefit from mixed-methods approaches that combine ethnographic depth with larger-scale epidemiological data.

Conclusion

Tibetan healing practices operate across somatic, cognitive, spiritual, and communal dimensions simultaneously. Concepts such as *rlung* disturbance, *lojong* mind training, and the transformative engagement with death and impermanence represent distinct and sophisticated frameworks for understanding the relationship between mind, body, community, and the moral order. These frameworks shape how distress is experienced, expressed, and resolved, and the evidence reviewed here suggests they do so with considerable effectiveness, even under conditions of severe political violence and prolonged displacement.

A key contribution of this review is the documentation of resilience as a practised and communally sustained form of moral agency rather than an innate individual trait. The Tibetan

exile experience in India demonstrates that psychological wellbeing under adversity is inseparable from cultural continuity, shared identity, spiritual practice, and social solidarity. This understanding has direct relevance for how resilience is theorised and supported in refugee mental health contexts more broadly, where dominant frameworks continue to privilege individual psychological factors over structural and cultural ones. Tibetan healing traditions offer a rich and rational response to suffering that challenges the universality of Western psychiatric frameworks and demonstrates the depth of resources available within non-biomedical systems of care. Recognising and supporting these traditions is not only a matter of cultural respect but of sound and equitable mental health practice.

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