COVID-19 AND REFUGEE MENTAL HEALTH:
A HOLISTIC COMMUNITY-BASED PROGRAM FOR TIBETAN REFUGEES IN DHARAMSHALA

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ABSTRACT

Dharamshala serves as the largest settlement for Tibetan refugees living in India. Since the Chinese occupation of Tibet in 1950, thousands of Tibetans have fled due to oppression and violations of human rights. The journey from Tibet involves passing through Nepal, where the United Nations High Commissioner for Refugees facilitates safe passage into India. Tibetan refugees have experienced much adversity and trauma before arriving in Dharamshala, and post-resettlement challenges add additional mental health distress. With COVID-19 adding additional stressors, focus on mental health is crucial in a post-2020 context. This paper provides an overview of Tibetan refugee mental health and proposes a holistic community-based mental health program that aims to improve the quality of life and mental health of Tibetans living in Dharmshala.

BIOGRAPHICAL SKETCH

Vidhi Trivedi received her BA in Psychology from Florida Atlantic University and served as a middle-school teacher for students with disabilities at Score Academy in Boca Raton, Florida. As a teacher, Vidhi learned how to understand the specific needs of her students and how to compassionately and effectively deliver tailored instruction. It was during this time that Vidhi traveled to Dharamshala and taught English to Tibetan monks aspiring to preserve Buddhist texts in English. After some time, Vidhi pursued a Master's in Education in Urban School Counseling and worked in lower-income (Title I) schools to improve students' mental health and overall wellbeing. That experience served as the basis for Vidhi's interests and passion in providing mental health support to vulnerable populations. At Cornell, Vidhi works on the MBA admissions team. Alongside, she is pursuing her MPS in Global Development degree with a specialization in Non-Profit and NGO Management.

To my loving parents and husband who have always pushed me to dream bigger.

And to my grandmother, who taught me what activism and altruism mean.

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LIST OF ABBREVIATIONS

COVID-19 – Coronavirus disease 2019

CTA – Central Tibetan Administration

IAT-G – Group Integrative Adapt Therapy

INR – Indian Rupee

IPT – Interpersonal Therapy

MHPSS – Mental Health and Psychosocial Support Programming

MTSS – Multi-Tiered System of Support

PHR - Physicians for Human Rights

PTSD – Post-traumatic stress disorder

TRTC – Tibetan Refugee Transit Centre

TST-R – Trauma Systems Therapy for Refugees

UNHCR – United Nations High Commissioner for Refugees

Chapter 1

BACKGROUND

This paper studies the mental health issues suffered by Tibetan refugees living in India. There are more than 100,000 Tibetan refugees in India, mainly around Dharamshala. The paper is aimed at proposing possible solutions to the problems afflicting this populations, considering the unique circumstances which led them to their current situation.

Since the Chinese occupation of Tibet in 1950, thousands of Tibetans have fled to India through Nepal seeking cultural, political, and religious freedom. After almost a decade of failed negotiations, the Dalai Lama fled into exile to India in 1959 and the Tibetan Local Government was dissolved. Once there, the Dalai Lama established the Tibetan Government in Exile or the Central Tibetan Administration (CTA), in Dharamshala. After the occupation of Tibet, the

Chief among the factors that led to the exile of so many Tibetan people is the violence and significant suppression of their cultural identity and personal liberties by the Chinese authorities. Many Tibetans fleeing are Buddhist monks and nuns, as they are faced with persecution for practicing their religion by Chinese government. In Dharamshala, a strong community of Buddhist monks aims to preserve the cultural and religious identities of Tibetan people by documenting Tibetan Buddhist scriptures. Other refugees who are not monks flee to India to avoid persecution of other kinds and to save themselves from violence and oppression.

The United Nations High Commissioner for Refugees (UNHCR) estimates that around 5,000 Tibetans flee to Nepal yearly through treacherous terrain, although only half are successfully able to complete the journey due to death or captivity along the way (Dolma et al., 2006). For those that are able to arrive in Nepal, the UNHCR facilitates the safe passage of the

refugees into Tibetan settlements in India. As of January 2020, the UNHCR has received 108,005 Tibetans (UNHCR The UN Refugee Agency, India 2020 [Fact Sheet]). Upon arriving in Nepal, the refugees are received by the Tibetan Refugee Transit Centre (TRTC) and are provided medical care, food, and shelter, along with needed refugee status documentation (2006). While Nepal considers Tibetan refugees to be "persons of concern," they are considered still illegal immigrants. Therefore, the refugees must transit to India where they will be granted asylum and provided with services by the CTA and the Indian government (Subhash, 2018).

Figure 1. A map showing the geographic relationship between China, Tibet, and India. Tibetan refugees migrate to Nepal where the UNHCR facilitates safe passage into the Tibetan refugee settlement in Dharamshala, India. Reprinted from "Connecting Tibet's Exile Community via the Web," by Doug Beach, NPR, 2006.

The escape from Tibet into Nepal is extremely dangerous with difficult terrain and military challenges. The most common route is through the Himalayan mountains which can take anywhere from days to several months to complete. The physical challenges of the journey include suffering from extreme exhaustion, sleep deprivation, hunger, and injury along the way. Given the conditions in the Himalayan mountains, Tibetan refugees also endure altitude sickness and unforgiving weather that can result in hypothermia or frostbite. With limited rations of food that can be carried while traveling on foot, hunger and exhaustion are usually common throughout the journey as well. Aside from the physical challenges, refugees also risk getting captured by authorities (Dolma et al., 2006). The atrocities and torture reported by captured

refugees are supported by substantial evidence (Mercer et al. 2005; Mills et al. 2005). It is clear that Tibetan refugees experience traumatic events and mental health distress before arriving at the Dharamshala settlement.

The prevalence of anxiety, depression, mood disorders, and post-traumatic stress disorder (PTSD) has been noted across several refugee populations, especially for those that endured torture and other physical violence (Hollifield et al. 2002). Causes of trauma for Tibetans in exile include forced displacement, life-threatening experiences during the journey, and resettlement challenges. Even if the Tibetans seeking asylum in Dharamshala did not endure imprisonment or torture, several studies have found a significant relationship between psychological distress and post-migration factors (Crescenzi et al., 2002). Tibetan refugees migrating to India have experienced much trauma and the stressors of post-migration resettlement continue to add psychological distress to the community.

Another harrowing statistic for the Tibetan community involves self-immolation protests. Since 2009, 157 Tibetans have self-immolated in protest of the Chinese occupation and suppression of Tibetan human rights (International Campaign for Tibet, 2021). In the Tibetan community, self-immolation serves as an extreme form of political action. The prevalence of self-immolations in the past 15 years is a cause of significant trauma for the Tibetan community as a whole. The self-immolations represent a radical confrontation with Chinese authorities and the international community. While Tibetan self-immolations have resulted in an increased awareness within the intended audiences, these acts serve as a painful and continuous form of trauma for the collective Tibetan community (Kaku, 2020).

Despite the overwhelming evidence that the Tibet in exile community is experiencing much trauma and psychological distress, there is an alarming lack of mental health services

offered in the Dharamshala settlement. With the lack of services offered, additional factors inhibit the accessibility of these services. These factors include financial barriers, social stigma, cultural response to mental health, and Buddhist beliefs. The purpose of this literature review is to address the lack of mental health services available and to propose a mental health program for Tibetan refugees in Dharamshala.

While this paper serves to address the mental health distress of Tibetan refugees, it is important to acknowledge and appreciate the resiliency of this community. A study conducted by Keller et al. in 2006 found that Tibetan Buddhists exhibited the fewest symptoms of PTSD compared to refugees from other countries. Further studies have found exceptionally high resiliency with the Tibetans in exile community (Lewis, 2013; Lhewa et al. 2007; Ruwanpura et al. 2006; Sachs et al. 2008; Terheggen et al. 2001). With that said, it would be helpful to have additional mental health services and approaches for Tibetan refugees who would benefit from a variety of approaches to mental health healing.

Chapter 2

COVID-19 AND MENTAL HEALTH

Global effects of COVID-19 on mental health

The world has changed as we knew it since the onset of the coronavirus pandemic. While COVID-19 is a public health crisis, it has affected people in all aspects of their lives and caused significant mental health distress on a global level. Causes of mental health distress during COVID-19 include lockdown isolation, health concerns, financial struggles, and loss of employment, amongst many others. While research on the mental health impact of COVID-19 is still evolving, studies around the world have found similar results on the negative effects of the pandemic on overall mental wellbeing.

A Kaiser Family Foundation Health Tracking Poll from July 2020 found that 53% of US adults expressed that stress related to COVID-19 had a detrimental impact on their mental health (Hamel et al, 2020). The poll also reported that 36% of adults in the US were experiencing difficulty sleeping after the onset of the pandemic. Another 32% of adults reported challenges with appetite and there was a 12% increase in substance use and alcohol consumption. Unfortunately, the average amount of adults reporting characteristics of anxiety/depressive disorder in 2021 increased by 30% from 2019 as well. To address this sharp decline in public mental health, the US government implemented the Consolidated Appropriations Act that allocated $4.25 billion in funding toward services for improving mental health and substance use (Panchal et al., 2021).

In a large-scale national survey conducted in China to assess the mental health status of the public during COVID-19, the results found that 35% of participants experienced mental

health distress during the pandemic (Qiu et al., 2020). Higher rates of mental health distress and likeliness to develop PTSD were found with women participants. The highest rates of mental health distress were found with adults 18-30 years, as the authors proposed that this group used social media at a higher rate, and repeatedly reading stressful and triggering info was detrimental to their mental health. The findings also determined that there were three main events during COVID-19 that led to public panic: 1) releasing information relating to human-to-human transmission of COVID-19, 2) strict quarantine and confinement measures, and 3) a WHO statement released on January 30, 2020, that determined that COVID-19 had spread to 83 countries (World Health Organization, 2020). The authors of the articles urged increased attention to mental health and the effects COVID-19 may continue to have on psychological wellness.

Research by Fouad et al., (2021) explored the mental health impacts of COVID-19 on refugees in Lebanon. Lebanon has experienced significant economic and financial deterioration due to COVID-19, and as a result, the limited financial resources that are available are prioritized for obtaining medical supplies and services. With the lack of available financial resources, mental health is very low on the country's priority list. The article discusses the refugee's heavy reliance on non-profit and humanitarian organizations to provide aid, food, and shelter. With the economic interruptions from COVID-19, the support provided to these already vulnerable refugees was greatly diminished.

Refugee populations are already considered vulnerable groups, as they are more likely to experience psychological disorders, PTSD, depression, and mental health distress in response to the traumatic experiences of their past (and often present) circumstances (Kokou-Kpolou et al., 2020). In addition to existing causes of refugee vulnerability, COVID-19 has added a host of

challenges that cause further mental health distress. A study conducted by Pinzon-Espinosa et al. (2021) found that COVID-19 challenges have exacerbated refugee stressors involving eviction, discrimination, violence, along with living conditions and confinement measures.

UNHCR and mental health

In a May 2020 press release, the UNHCR issued a statement urging the prioritization of mental health for refugees during COVID-19. Psychiatrist Pieter Ventevogel (UNHCR, 2020) from the UNHCR was quoted saying, “Before the pandemic, refugee mental health was a severely overlooked and under-prioritized issue. Now it is a full-blown crisis.” The statement notes that one of the major concerns contributing to mental health distress is the loss of employment for refugees. The loss of income and livelihoods has a direct impact on daily life and mental health. The refugees already experience a lack of stability with the resettlement process and the additional instability caused by the pandemic can have a serious impact on mental health. During the pandemic, many resettlement organizations have experienced abrupt discontinuation of funding and consequently are unable to offer services to the refugees. In addition, social distancing guidelines have reduced the volume of refugees being served. Since refugees typically come from cultures that stigmatize seeking support for mental health and rely instead on social support, the lockdowns and socially restrictive measures have made matters worse.

In an October 2020 press release, the Commissioner of the UNHCR Filipo Grandi stated that there was an urgent need for further investment in refugee mental health and psychological support programs. He said that if the mental health of refugees during the pandemic was not addressed in a holistic approach, the impact could be “irreversible and last for generations”

(UNHCR, 2020). In response to the increased need for mental health services during COVID-19 the UNHCR has 1) provided remote tele-counseling services, 2) increased capacity in existing community support services, 3) trained staff and volunteers in Psychological First Aid, and 4) advocated that mental health services be considered "essential" by nations.

Tibetan refugee mental health and COVID-19

There is much evidence surrounding the prevalence of psychological distress, trauma, and mood disorders within refugee communities, like the Tibetan refugee community in Dharamshala. However, due to the lack of priority given to mental health, specific research on the mental health of Tibetan refugees is limited. Most refugee psychological studies are centered on refugees that migrate to Western countries. Despite this, scattered studies from various authors and information from the UNHCR and Central Tibetan Administration strongly suggest a need for additional mental health attention and services for Tibetan refugees. In several studies conducted to assess the psychological state of Tibetan refugees, including the Hopkins Symptom Checklist [Tibetan Version] (2002) (Lhewa et al., 2007), anxiety rates ranged between 25-70% while depression ranged from 14-57% (Crescenzi et al., 2002; Holtz, 1998; Keller et al., 1997; Terheggen, Stroebe, & Kleber, 2001).

A study conducted by Mills et al. (2005) utilized a systematic literature review to determine the prevalence of mental illness within the Tibetan refugee community. The review consolidated information from electronic databases, studies on Tibetan refugee psychology, and input from the Tibetan Government-in-exile in northern India. The results for that study found that 11-23% of Tibetan refugee participants had PTSD. Mills et al. (2005) also analyzed the

study conducted by the Physicians for Human Rights (PHR) (1997) and found that 21% of Tibetan refugees had experienced torture before arriving in the settlement in India.

Tibetan refugees were already experiencing significant mental health distress before the COVID-19 pandemic. Given that COVID-19 is a relatively new and currently evolving situation, there is little data on Tibetan refugee mental health. With that said, there is data from several studies that have assessed global mental health and the psychological state of certain refugee communities (World Health Organization, 2020; Panchal et al., 2021; Qiu et al., 2020; Fouad et al., 2021; Kokou-Kpolou et al., 2020). The elevated levels of mental health distress seen across emerging COVID-19 mental health research strongly indicate a similar increase in distress for the Tibetan refugee community.

Chapter 3

CONTRIBUTING FACTORS

Social stigma in the Tibetan refugee community

Mental distress and illness have been stigmatized around the world until very recently. While in Western cultures discussing mental health is more prevalent, it is less acceptable in Eastern cultures. Seeking support for mental health is still perceived as "weak" and "for crazy people." In many cultures, especially those from the East, mental illness is something that individuals and their families hide. Researchers studying stigma have found that "stigma occurs when an objective characteristic of the individual leads to a negatively valued social identity" (Crocker et al., 1998). Shannon et al. (2014) noted that mental health stigma continues to be the most prevalent reason why mental health services are inaccessible to refugees (Morris et al., 2009; Saechao et al., 2012.) The study explored the reasons behind the social stigma and why it is taboo to discuss mental health in South Asian and African refugee communities. The results found that there were seven main reasons why it was challenging for refugees to discuss mental health:

1) political suppression,
2) fear,
3) belief that speaking about distress is unhelpful,
4) lack of awareness,
5) ignoring symptoms,
6) shame and
7) cultural influences.

The reasons behind social stigma for seeking mental health are very similar for the Tibetan refugee community. In a study done by Brock (2008) in Dharamshala, he found that social stigma was a significant reason why Tibetans in exile did not seek support for mental

health distress. A Department of Health counselor was interviewed who stated that those who seek mental health support within the Tibetan refugee community are perceived as "having a weaker personality, or not being able to handle the stress of life's pressures." Unfortunately, stigma continues to keep individuals from reaching their full potential for overall wellbeing. Local authorities and community leaders should work to destigmatize seeking support for mental health.

Response to mental health distress

Seeking mental health support is not a practice well-embedded within the Tibetan refugee community. Instead, psychological support is usually introduced to refugees if they visit a health clinic for somatic responses to stress. In heath personnel interviews (Brock, 2008), findings showed that refugees would come to a hospital mistaking a panic attack for a health attack or interpreting a racing heartbeat at night for hypertension. Once the refugee is clinically evaluated for physiological issues and the results come back without any diagnoses, the prevalence of a mental health disorder or distress usually comes to light. In fact, somatization is prevalent across Chinese, Indian, Japanese, and Asian refugee communities. In these Asian populations, the somatization of depression can look like headaches or unexplained physiological pain, amongst other physical complaints (Raguram et al., 1996; Raguram et al., 2001). Tibetans experience symptoms of psychological distress in ways that differ from those in Western cultures. Therefore, it can sometimes be less evident that the distress they are experiencing is related to mental health.

Seeking spiritual support from experienced Lamas

Another reason that Tibetan refugees do not often seek mental health support from a practitioner is the lack of trust in the counselor. Brock (2008) conducted interviews with Tibetan refugees about their perceptions of speaking with a counselor. Some refugees mentioned that speaking with a counselor felt like gossiping. The counselor represents an outsider asking them to divulge their secrets. Untrusting and unfamiliar with the client-counselor relationship and the strictness of the confidentiality measures, they were afraid that others in the community would find out what they said in the sessions.

Additionally, a mental health provider is perceived as someone who serves those who are "crazy" or "psychotic." There is also a disconnect with western counseling models that are based on "talk-therapy." Due to these reasons, Tibetans in exile would instead consult with an experienced Lama. Lamas represent a credible and trusted entity that can provide advice for any issues they may be experiencing. Suppose the complaints are health-related (like fainting or shortness of breath). In that case, the Lama may refer the seeker to a Tibetan Traditional Medicine provide that would address the defective energies of "*rlung, tripa, beken* (wind, bile, phlegm)" (2008). While this cultural method may work for many, some people may respond better to western counseling and therapeutic approaches. Therefore, diverse approaches and holistic practices should be accessible to Tibetan refugees when addressing mental health.

Religious beliefs that inhibit seeking mental health support

While Tibetan Buddhism has had an overall positive effect on Tibetans' resiliency and mental health in exile, some Buddhist beliefs inhibit seeking mental health support. These beliefs primarily include the following: *fate*, *karma*, and *suffering*.

Fate in Buddhism usually refers to the idea that what is happening is in accordance with a pre-determined plan. It can also be understood as the result of a higher entity's will, like the universe. A dissertation by Wangdu (1996) explored factors surround "health-seeking behavior" in Tibetans. The author proposed that believing in fate was one of the reasons Tibetans did not seek mental health support. The study suggested that if one believed that their circumstances and experiences were pre-determined or the will of a higher entity, they were less likely to seek support. While believing that fate had a role in one's circumstances can lead to a sense of acceptance, it can also be disempowering.

Another significant belief in Buddhism is *karma*, or the belief that one's current circumstance, either positive or negative, is a direct result of past deeds (Smith, 2020). The past deeds can go beyond this lifetime and be actions from a past life, as reincarnation is another core belief in Buddhism. Essentially, if someone is experiencing an adverse circumstance, the experience serves as a punishment or consequence of past deeds. While believing in karma can provide a sense of control, it can be harmful to refugees that have undergone trauma and significant losses. Believing that they were to blame for their trauma is damaging because it causes further distress. It may also keep them from seeking support for their distress if they think they deserve it because of their past/past life actions.

A fundamental belief in Buddhism is that *suffering* is an inherent condition of being human. The first of the Buddha's Four Noble Truths is suffering, or *duhkha* (Brock, 2008). Buddhist teachings state that suffering will be a part of one's life as long as one is part of the life and reincarnation cycle. The suffering will cease only when someone reaches liberation, or *moksha*, by following the teachings of Buddha and becoming one with the universe. While this belief does offer a sense of universality and community between the Tibetan refugees,

believing that suffering is a part of life can normalize unhealthy mental coping mechanisms and trauma. Beliefs regarding suffering may also reduce the likelihood that Tibetan refugees will seek support for mental health distress.

Chapter 4

EXISTING APPROACHES AND SERVICES

There are some existing mental health services in Dharamshala that serve Tibetan refugees. Among them are services provided by the Central Tibetan Administration, private practitioners, religious/spiritual providers, and a social support system within the community.

Central Tibetan Administration (CTA)

In response to the widespread mental health distress during the COVID-19 pandemic, the Central Tibetan Administration established a tele-counseling service for all Tibetans in the Dharamshala area. This initiative aligned with the UNHCR's May 2020 recommendation for governments to increase their attention to refugee mental health and establish remote mental health services. Based on a flyer provided by the Mental Health Desk of the Department of Health, the tele-counseling service employs nine mental health care providers (Central Tibetan Administration, 2020). To tackle specific COVID-19 related issues, the CTA created the COVID-19 task force that reported weekly on the number of individuals who utilized the tele-counseling service. Based on reported numbers on the task force briefings (Central Tibetan Administration, 2020), less than 10 Tibetans have utilized that service per week since implementing the tele-counseling initiative in April 2020.

Given that the population of Tibetans in exile in Dharamshala is close to 94,000 (Press Trust of India, 2010), the tele-counseling service is underequipped to serve the population. Given the limited capacity of the service, Tibetan refugees are significantly underserved with this initiative. Additionally, the CTA has not provided information on whether this service will

continue after the pandemic. With that said, the CTA's endorsement of seeking mental health support is beneficial in breaking down stigma and encouraging similar services in the future.

An ongoing effort by the CTA in addressing mental health is training initiatives for healthcare workers. In a July 2015 press release, the CTA reported a training workshop for 27 healthcare workers that served the Tibetan refugee population. The training included ways to identify anxiety, depression, and other mood disorders and fundamental counseling skills to address these issues. Since most Tibetans experience psychological distress with somatization (Raguram et al., 1996; Raguram et al., 2001), this training was tailored specifically to the community's needs.

Private providers

There are a variety of private providers that offer mental health services in the Dharamshala area. Web searches of mental health providers in Dharamshala generally link the seeker to a psychiatrist or a hospital where clinical services are offered. The search results yield very few counseling-based services, though there are several eastern-approach providers in Dharamshala.

Eastern Approaches: Buddhist Providers

A common practice for Tibetans seeking mental health support is to obtain a consultation from a Lama. In Brock's (2008) study, an interviewee informed him that she consulted a Lama after experiencing nightmares that resulted in waking tremors. After listening to her concerns, the Lama counseled that her nightmares did not have any significance and that she should disregard them and worry less. Along with providing advice, Lamas also act as Oracles and

perform spiritual rituals to help the seeker. The Lamas' approach is not standardized, so each Lama may have a different method of performing divination. A Lama may utilize dice to determine the severity of the seeker's circumstance. Following the consultation, the seeker may be prescribed a series of rituals to perform at home to remedy their situation. Often Tibetans will turn to Buddhist practices even before the consultation. It is not uncommon for them to visit a temple in search of mental clarity and balance. One interviewee from Brock's study (2008) said, "Buddhism is my counselor."

Eastern Approaches: Tibetan Traditional Medicine

Tibetan Traditional Medicine is deeply rooted in Buddhism. It serves as a primary method for Tibetans seeking physical and mental health support. Tibetan refugees usually access Tibetan Traditional Medicine through the Men-Tsee Khang or the Tibetan Medical and Astrological Institute established by the Dalai Lama. In 1994, Terry Clifford published *The Diamond Healing: Tibetan Buddhist*, which explored Traditional Tibetan Medicine elements. The three types of Tibetan Medicine include 1) dharmic, 2) tantric, and 3) somatic.

In Buddhism, dharma usually refers to the order of the universe or the universal truth. It is also interpreted as following the teachings of Buddha. In Tibetan Medicine, dharma builds a sturdy mind that cannot be easily influenced by negativity or spirits (Clifford, 1994). Tantra serves to define the ailment by providing an explanation of the “insanity” or the evil energy causing the distress (Brock, 2008). Somatic refers to a more physiological understanding of the complaint and aligns more closely with Ayurveda (i.e., providing herbal medication for indigestion) (1994). Brock's (2008) study found that within the somatic type of Tibetan

Medicine, mental disorders and distress can be categorized further into "poisons" or "defective energies":

> All of the afflictive mental factors can be consolidated into three destructive emotions commonly referred to as Buddhism's the three poisons (*Nyan-mongs*): ignorance/delusion (*gTi-mug*), hatred/aversion (*Zhe-dsang*) and attachment (*Dod-Chags*). These three poisons cause the three bodily humors (*nyes-pa*) of Tibetan Medicine to arise. The somatic form of Tibetan Medicine is concerned with maintaining a balance of the three humors, literally the "three defective energies": *rlung, tripa, beken* (wind, bile, phlegm) (p. 45).

Eastern Approaches: Astrology

In 2000, Professor Jhampa Kalsang published the first English textbook on Tibetan medical astrology called *Tibetan Astro-Science* to bring eastern practices to western medicine. Dr. Kalsang has served as a consultant to western doctors in psychological support by introducing Buddhist philosophies (Mason, 2013). *Medical astrology* is a practice that is considered both a science and an art, as the interpreter must take several factors into account before making a diagnosis. In the Tibetan understanding of health, there are elemental factors that affect one's wellbeing, like fire and wood. To understand how the universal elements affect someone, a Tibetan astrologer would construct a chart that provides astrological information.

To construct a chart, the astrologer needs the date and time of birth, along with the place of birth. This information allows the practitioner to get a snapshot of the stars and planets at the time of birth. The astrologer then analyzes how those stars have since transitioned. Suppose the practitioner finds a "liver-pulse" in a patient (2013). In that case, they can infer that the wood element is affected and then consult the natal chart to see the interactions of planets in their horoscope. Regarding mental health, Tibetan astro-medicine practitioners believe that a combination of several factors, including the celestial bodies, affects one's wellbeing. Based on

the astrological diagnosis, the treatment for a mental health disorder can include rituals or wearing a specific gemstone to offset the effects of a negative planetary interaction.

Community Social Support

In addition to the aforementioned services, Tibetan refugees rely on one another for social and emotional support. With their shared experiences and background, the dialog between the community members is often helpful to many. Sharing experiences strengthens a community's unity and cohesiveness, and a strong social network is usually indicative of a healthy coping outlet (Hussain and Bhushan, 2011).

Chapter 5

INACCESSIBILITY OF CURRENT SERVICES

While there are various Eastern providers in the Dharamshala area, counseling-based services are not extensive. Despite existing services, there is a prevalence of anxiety, depression, PTSD, and other mood disorders within the Tibetan refugee community (Crescenzi et al., 2002; Holtz, 1998; Keller et al., 1997; Terheggen, Stroebe, & Kleber, 2001). With COVID-19 adding a host of additional challenges, mental distress has increased worldwide, especially for refugee populations (Fouad et al., 2021; Kokou-Kpolou et al., 2020; Pinzon-Espinosa et al., 2021; UNHCR, 2020). Accordingly, the UNHCR has issued several statements urging authorities to increase refugee mental health services. COVID-19 has reduced the reach of humanitarian organizations, and national funding has been relocated to address other priorities during the pandemic. Substantial mental health services are needed now more than ever in a post-2020 COVID-19 context. Unfortunately, the services the Tibetan refugees have in Dharamshala are mostly inaccessible or insufficient. Social stigma, financial barriers, lack of awareness, and a disconnect with Buddhist approaches account for the lack of accessibility with existing services. Therefore, a standardized and holistic mental health program needs to be established for Tibetan refugees to address their mental health needs.

As mentioned previously in this review, social stigma is a significant inhibitor in seeking mental health support. In interviews conducted with Tibetan refugees, many believed counseling-based mental health support was appropriate only for those with acute psychological conditions, like psychosis (Brock, 2008). Interviewees said that they believed mental health support was only for those that were “crazy.” Others were unfamiliar with (or untrusting of) the

counselor-client relationship and were afraid that their secrets would be disclosed to others in the community. Despite this, Central Tibetan Administration authorities, like President Sikyong, made a statement on World Mental Health Day in October 2020 that "a holistic approach is key." This encouraging statement was issued with a 40-minute mental health awareness video produced by the Department of Health (CTA, 2020). Accompanying that video was a statement from the Dalai Lama emphasizing the importance of self-care and addressing mental health concerns.

For those who would like to access counseling services despite the stigma, significant financial barriers render the services inaccessible. Tibetan refugees often hold employment that offers a working wage. With the closures and budget cuts of businesses all over India, Tibetan refugees' financial health is also significantly impacted during the COVID-19 pandemic. Given this new stressor, the need for mental health services is higher, but the cost to access counseling services increases inaccessibility. The average income of a Tibetan refugee dual-earner household is 80,000 INR per year (around 3,300 per adult per month) (Tibetan Innovation Challenge, 2017). Private counselors in the Dharamshala area typically charge between 100-1000 INR (500 INR was the most common cost) per session. Mental health counseling is a costly service averaging 500 INR per session. There is a need for a cost-effective alternative to local private providers.

Another barrier to the existing services is a lack of awareness. In Brock's (2008) interviews of Tibetan refugees, many participants were unfamiliar with the concept of speaking with a counselor whose occupation entails listening and assisting with mental health goals. The idea of "talk therapy" is distant to the community. Additionally, the intentionality behind "fixing" mental health distress is foreign, as a core Buddhist belief is that suffering is a normal

part of life, no matter the severity of the distress. It is helpful that Tibetan youth (Youth of Tibet [Facebook], 2019) and the CTA raise awareness of mental health distress and encourage seeking services for it.

Finally, while there are several Buddhist mental health providers in Dharamshala (Lamas, Tibetan Traditional Medicine providers, astrologers), many Tibetans feel disconnected from these services. Since practicing Tibetan Buddhism was persecuted before arriving in India, many Tibetans may not identify closely with Buddhism or relate to the services grounded in Buddhist philosophy. Therefore, alternate approaches to mental health services need to be accessible to Tibetan refugees.

Chapter 6

PROPOSED SOLUTION: A HOLISTIC MENTAL HEALTH SUPPORT PROGRAM

The Tibetan in exile community in India is already vulnerable to mental health challenges, and COVID-19 has exacerbated that vulnerability. It is imperative that a holistic approach utilizing community-based and Western practices be available to Tibetans in Dharamshala. The proposed solution entails a mental health intake program for Tibetan refugees that have recently entered India. The program's purpose is twofold: 1) to assess the level of mental health services needed and 2) to funnel the refugees into appropriate mental health services. Continuing services should also be offered, as it can often take time to process the effects of trauma and feel psychological distress after a negative experience.

The holistic mental health support program is based on the UNHCR's Mental Health and Psychosocial Support Programming (MHPSS) model (UNHCR, 2021). The proposed program's structure closely aligns with the UNHCR's *Operational guidance, mental health & psychosocial support programming for refugee operations* published in 2013. It also follows recommendations from the highly accredited Multi-Tiered System of Support (MTSS) and Trauma Systems Therapy for Refugees (TST-R) models. The program's overall goal is to promote a healthy transition into the Dharamshala settlement and provide ongoing accessible mental health resources to promote psychological wellbeing.

Anatomy of the Holistic Mental Health Support Program

The proposed program is tiered by the intensity and specialization of the services needed. Upon arriving, training mental health professionals will assess the degree and intensity of the

services needed. All newcomers would have access to the Universal tier (tier 1) upon arriving in Dharamshala. If more specialized services are needed, the mental health professionals will refer the Tibetans to the Selective/Specialized tier (tier 2). In severe cases, like torture survivors and political prisoners, refugees would be referred to the Intensive tier (tier 3). It is important to note that these services, while recommended for the refugees, would be optional. Imposing forced participation in the program would be insensitive and possibly detrimental to the refugees' mental health. Therefore, it is important that refugees understand that these services are there for them if/when they are ready.

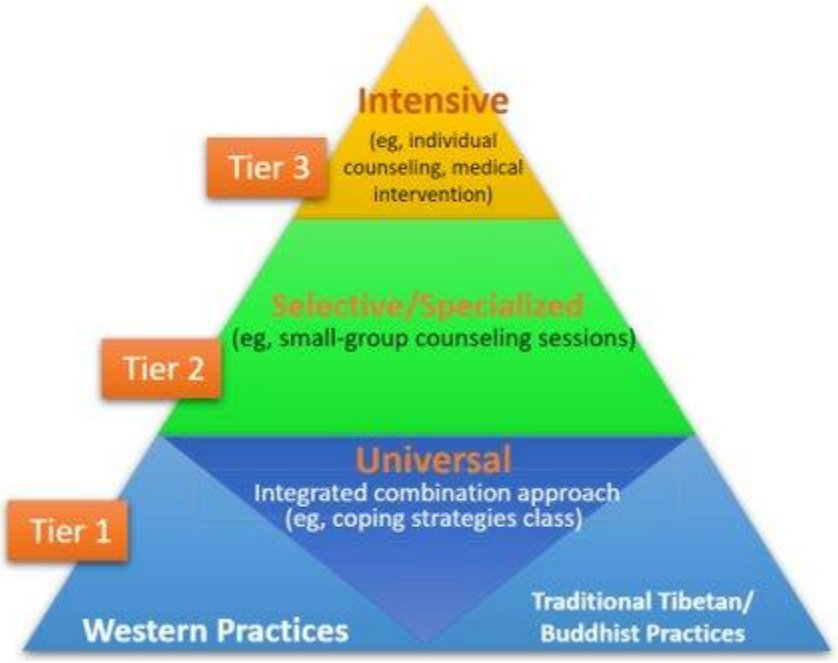

Figure 2: *Tiers of the proposed holistic community-based mental health support program.*

Tier 1: Universal

The Universal tier utilizes an integrated approach in a larger setting. An example of this is a coping strategies class that teaches Tibetan Buddhist meditation practices and cognitive reframing tactics. This tier, like the others, would integrate western practices with traditional

Tibetan Buddhist practices. *Universality* in mental health refers to the idea that others share one's experience and are not alone (Thomas, 2016). Along with teaching helpful mental health fundamentals, the purpose of this tier is to establish a sense of community between the newcomers and allow them to make social connections shortly after arriving in the settlement.

Along with discussing mental health, this tier will introduce the newcomers to the settlement and connect them with various services provided to refugees. Ideally, services in this tier will be led by community leaders, mental health professionals, and Lamas. Even if the newcomers do not return for continued mental health sessions, the services in this tier should allow them to gain exposure to mental health skills and other helpful resources. The recommended length of this intervention is three sessions.

Tier 2: Selective/Specialized

The interventions provided in tier two would be more selective or specialized. The mental health professional assessing the needs of the newcomer would determine if services in addition to those in the Universal tier are necessary. The services in this tier will include small-group counseling using the Group Integrative Adapt Therapy (IAT-G) model adopted by the UNHCR to "help refugees to develop resilience and capacities for managing maladaptive reactions to trauma and post-migration living difficulties" (Mahmuda et al., 2019). In small group counseling sessions, refugees would have the opportunity to share their experiences in a safe space with others with similar experiences. Candidates for the small group counseling would need to be appropriately screened, as the group's purpose is to aid in each other's mental health goals. Unlike refugees recommended for Universal services, those recommended for the Selective/Specialized tier would have a specific experience for which group counseling would be

helpful. An example of this is a group for refugees that have lost family members on the journey to Dharamshala.

For this tier, the screening process is fundamental. An effective group dynamic is established by careful screening. The screening process must ensure that individuals who would not be conducive to the group goals are referred for Intensive tier services instead (Smith and Impalli, 2007). An example of this could be someone with extreme social anxiety or someone prone to challenging a facilitator. Such individuals can distract the group trajectory and, in turn, be detrimental to group members. For groups to effectively realize their mental health goals, there must be a set of foundational rules that all group members adhere to. The non-negotiable rules must include confidentiality and respect for other group members. The recommended length for this tier is five to eight sessions (UNHCR, 2018).

Group facilitators for services in this tier would be a combination of community leaders, like Lamas, and mental health professionals. An integrative approach is key to a culturally sensitive service (James and Prilleltensky, 2002), so it would be helpful to have refugees with experience in the settlement aid in the small groups. It is also crucial for the group facilitators to be proficient in Tibetan and understand the political and social situation affecting the refugees.

Tier 3: Intensive

The Intensive tier would be designed to offer services for those with specialized mental health needs. Examples of those recommended for this tier would be torture victims or ex-prisoners. These individuals need specialized care and would not be good candidates for group counseling, given their extreme experiences. These individuals may need one-on-one counseling sessions with a Lama or mental health professional proficient in trauma care. These refugees

may also need to be referred for clinical services, like psychiatric or in-patient mental health care. The recommended length for this tier is 10-12 sessions. Given that these individuals have a higher chance of developing PTSD, anxiety, depression, and mood disorders (Mills et al., 2005), they must be assessed upon arriving in the settlement to provide them with the care they may need.

Community-Based Approach

Studies have found that strong refugee mental health programs integrate the community they serve (James and Prilleltensky, 2002). Integrative approaches ensure that the interventions are culturally sensitive and facilitate community investment in the program. Thus, the Tibetan refugee community must be well-integrated as facilitators of this program. Additionally, community health care workers and leaders need to be trained in Mental Health First-Aid to promote psychological wellbeing in various settings outside of the proposed program.

In response to the global increase in refugee mental health distress, the UNHCR partnered with Rohingya refugee camps and utilized the MHPSS model for training volunteers, mental health professionals, and community members in strategies for "healthy coping and maintaining psychosocial wellbeing" (UNHCR, 2013). The UNHCR trained 43 clinical psychologists, who in turn trained 500 community volunteers and healthcare workers. This strategy disseminated the training in a highly effective way and was implemented in refugee communities all over the world, including the Rohingya refugee camp (UNHCR, 2013; Tarannum et al., 2019)

Counseling Approaches

The proposed program will utilize a variety of counseling approaches, including the Integrated Adapt Therapy (IAT-G) (Mahmuda et al., 2019), Interpersonal Therapy (IPT) for Depression (WHO, 2020; Weissman et al., 2007; Wilfley et al., 2002), the Trauma Systems Therapy for Refugees (TST-R) model (Cardeli et al., 2020), and Buddhist counseling approaches (Mindfulness-based Psychotherapy and Contemplative Psychotherapy). The commonalities between the aforementioned counseling approaches are that they are recommended for refugee populations and have specific interventions and strategies for trauma.

Chapter 7

STAKEHOLDER INVOLVEMENT

Since the holistic mental health support program is intended to be a community-based approach, it is of primary importance to involve the Tibetan refugee community in Dharamshala. It is evident that the community understands their needs best, so it would be beneficial to conduct various focus groups before implementing a mental health program. Ideally, the program leaders would consist of community members, Lamas, mental health professionals, and Department of Health members.

Buddhist Lamas from local monasteries in Dharamshala are the primary method of obtaining advice and mental health guidance (Brock, 2008). Therefore, if a mental health program were established in Dharamshala, it would have to be with the support of the Lamas. They serve as community leaders, and the purpose of the proposed program is to work in conjunction with current services to enhance the availability of mental health offerings for Tibetan refugees.

The Central Tibetan Administration manages the intake of the Tibetan refugees from the UNHCR and is primarily responsible for the initial resettlement procedures. Given that the proposed mental health program is designed to work with newcomers to the Dharamshala settlement, involvement from the CTA would also be necessary.

Existing mental health providers in the Dharamshala area would be a great asset to the program, as they are familiar with the region and the local population. Additionally, many of them have already been integrated into the CTA's tele-counseling initiative, so an established relationship exists between local mental health providers and the Tibetan refugee community.

The UNHCR was highly effective in training mental health professionals in the MHPSS, who in turn trained hundreds of volunteers and para-counselors. Implementing that training approach would likely be effective in Dharamshala in expanding the reach of mental health care.

Chapter 8

ANTICIPATED CHALLENGES AND DESIRED OUTCOMES

While the importance of mental health in refugee communities is becoming more of a priority, there are still many challenges before mental health services can be widely available and easily accessible. The anticipated challenges with implementing a holistic mental health support program include 1) mental health prioritization, 2) social stigma, and 3) rejection of Western approaches.

There is significant global evidence stating that mental health distress is prevalent in refugee communities due to exposure to traumatic experiences. Unfortunately, given the lack of prioritization for Tibetan refugee mental health, there is little data to demonstrate how prevalent mental health issues are in the community. Given the scarcity of data, it has been challenging to justify why further mental health services are needed for the Tibetan refugee community. Despite this, the CTA is making active efforts to address mental health issues. Mental health was brought forward during the COVID-19 pandemic, and President Sikong of the CTA agreed that "a holistic approach is key" (CTA, 2020).

Social stigma may also pose a challenge. Even if mental health services are extensively offered, social stigma can inhibit their accessibility. Even though the perception of seeking mental health support is changing, much of the community still believes that mental health support is for "crazy people" (Brock, 2008). Globally, stigma is the most prevalent reason refugees do not access mental health support (Shannon et al., 2014).

Finally, the Western approach integrated into the proposed mental health program may be rejected. Given the Chinese oppression of Tibetan cultural identity, Tibetans are understandably

and rightfully protective of their culture. Introduction of foreign approaches to how they address their personal issues can be interpreted as a way of diluting or altering their culture. With that said, mental health concerns are growing in the Tibetan refugee community, including self-immolations, trauma, anxiety, and depression. A holistic and culturally sensitive mental health program that is voluntary gives Tibetans an alternate way of addressing their mental health needs

DESIRED OUTCOMES

First and foremost, the proposed holistic mental health support program's desired outcome is to improve the quality of life and mental well-being of Tibetan refugees living in the Dharamshala settlement. Tibetan refugees have experienced much trauma before arriving in Dharamshala, and the resettlement process is fraught with additional hardships that can be highly detrimental to mental health. With the added challenges of COVID-19, another desired outcome is prioritization and an increase in funding for mental health services. The proposed program would ideally integrate the Tibetan refugee community in its development/implementation and other community stakeholders, like Buddhist Lamas. Finally, long-term desired outcomes include an increased awareness of mental health distress and a breakdown of the stigma associated with seeking mental health support.

In addition, the proposed program can serve as a model for other efforts around the world. While the particular circumstances and cultural practices of the Tibetan refugees in Dharamshala dictate a program specifically tailored to their needs, the general problem of a lack of accessible and culturally appropriate mental health services is by no means confined to them. In fact, both stigmatization and cultural resistance to Western style approaches can fairly be

characterized as widespread among refugee populations around the globe. Indeed, it is almost inevitable that refugees will experience both trauma and a different cultural milieu when they are forced to flee their homes. Making sure that first, mental health services are readily available to refugees and second, that they are appropriate to the cultural practices of the target population need to be prioritized in the future.

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