

**The Interplay of Amchi Medicine and Ritual Treatments in
Zangskar: A Case of Wind Disorder**

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**“Rlung is common today because of the many changes in society and ways of life.”
—Lhasa physician, cited in Janes (1999a: 402)**

This essay analyzes the idiom of wind disorders (*rlung*) in Zangskar in order to understand how illness offers a window into the cultural production of meaning. A study of wind offers insight into the ways that healing practices mirror and refract wider cultural and social practices. The practice of amchi medicine in Zangskar are produced as much by individual decisions that emerge out of the chain of events surrounding an illness episode as much as the authoritative prescriptions and diagnostic tools of Tibetan medicine and Buddhist ritual. We consider how patients and healers—in both the medical and ritual realms—negotiate an illness episode from varying perspectives as they pursue a common goal of health.

Our analysis of intersecting practices of amchi medicine and Buddhist ritual specialists helps illuminate the slippery concepts of healing and cure in Zangskar. Every illness episode offers a series of moments in which patients and healers choose to make meaning out of ambiguous circumstances (Kleinman, 1980, Obeyesekere 1985). This local struggle for meaning can elucidate the unique and overlapping ways in which medical and ritual discourses are mobilized for therapeutic purposes. Additionally, the individual and pragmatic search for a cure illustrates the fluid boundaries between the medical and cultural realms.

Indeed, wind disorders are particularly susceptible to the blurring of the medical, the cultural, and the social, because *rlung* is such a common but multivalent ailment that can arise out of a conflux of psychological, behavioral, and social factors. This is partly due to the fact that wind is associated with the mind, which as two notable Tibetan doctors have explained, “is the architect of all our sufferings and happiness.”¹ If mind is the architect of human suffering, the idiom of wind offers a unique insight into the situational or contextual nature of that suffering. As this essay makes clear, wind disorders are defined and treated in a manner that has as much to do with its medical etiology as with the modernizing society out of which they arise.

This is true for both Zangskar and Ladakh as much as for the Tibetans in the Tibetan Autonomous Region (TAR) and among the Tibetan diaspora. Previous authors have noted that wind disorders represent a common but complex diagnosis that arises out of the conflux of modernization, increased expectations, and unique disenfranchisement that ethnic Tibetans face relative to their Han Chinese counterparts (Adams 1998, Janes 1999a, 1999b). Janes (1999a) however, is careful not to read *rlung* disorders as a “medical weapon of the weak” manifested primarily by those with the least social or economic power. Instead, he finds that *rlung* tends to afflict those individuals who are frustrated in their attempts to be upwardly mobile and who are denied the social and economic justice they

¹ Dr. Yeshe Donden and Mr. Gyatso Tshering are cited in Tom Dummer (1994 : 36).

expect. Both Janes (1999) and Adams (1998) identify a broader discourse surrounding *rlung* that makes frequent reference to social or political oppression, which extends far beyond the epidemiology of *rlung*.

Rlung in Zangskar differs from that in the TAR in a number of ways. Most significantly, it is not explicitly linked to a broader discourse of social or political oppression. It can, however, be an expression of the frustrated desire for social and economic mobility as our clinical case below will indicate. While both Zangskar and the TAR are remote regions subject to state manipulation and development schemes that only benefit a small sector of elites, their respective amchi industries could not be more different. Tibetan herbal medicines in the TAR constituted a 2.5 billion dollar industry by 2001.² By contrast, most of the *amchi* medicines in Zangskar are bartered or sold for a pittance. In other words, Tibetan medicines produced in the TAR and Dharmasala have become increasingly global commodities relying on international markets and consumers, while Zangskari medicines are produced mostly for local consumption. Yet the rising costs of production and ingredients purchased on the Indian plains have affected both Ladakhi and Zangskari amch. While the Ladakhi *amchi* have adapted by limiting their production or reselling Tibetan medicines in Ladakh, the Zangskari *amchi* face an economic crisis unless they begin to sell their medicines commensurate with the costs of producing them from raw materials.

These political and social differences between Tibet and Zangskar affect the etiology and treatment of wind disorder in salient ways. In Tibet, treatments for *rlung* consist primarily of herbal, dietary, and behavioral proscriptions that can be broadly subsumed under the term medicine. However, the treatment of *rlung* disorders in Zangskar often involves both medical and ritual and practices as our case below illustrates. This distinction reflects underlying social and cultural differences between Tibet and Zangskar. Significantly, the practice of *amchi* medicine in Zangskar has neither been secularized nor forcibly adapted to biomedical demands as has happened in the TAR (Adams 2001). The amchi in Zangskar have been adapting to modernity and changing social conditions; however, their reliance on Buddhist rituals has neither been suppressed nor discredited as it has in the TAR or Mongolia (Janes 2008).

As described below, *amchi* in Zangskar and Ladakh are part of a continuum of healers that include a wide array of ritual experts, including monks, nuns, oracles, exorcists, and astrologers (Pordie 2007).³ Indeed, Zangskari ritual healers

² The net worth of the Tibetan herbal industry was reported in the China Business Times in early 2001 and cited from Janes (2008 : 19). The commodification of the Tibetan medicine industry in the TAR is also described by Craig (2006).

³ I find Dollfus' (1989 : 36, 39) term for this array of ritual specialists---secular religious specialists---to be misleading as it is premised on the oxymoron (religious but secular figures) that does little justice to the fluidity of the secular and the religious within Ladakhi society. Dollfus and Pordie (2007 : 97) describe amchi and other ritual specialists as secular merely because they do not wear monastic robes. A better term would be non-

like oracles and monks thrive precisely because of the growing rather than shrinking need for their services. As I have argued elsewhere (Gutschow 2004, 2006), Buddhist and shamanic rituals are adapting to the growing economic and social uncertainties people face in Zangskar and Ladakh. Just as diaspora Tibetans have reinvented rituals for the new demands of their exile situation in urban India, Buddhist ritual specialists in Zangskar have adapted their practices to encompass the failures of modernity and its accompanying expectations.

A Clinical Case From Zangskar

Ngawang was the youngest of three brothers from a remote village in Zangskar, a Himalayan region located in the eastern half of Indian Jammu and Kashmir.⁴ His eldest brother had inherited the family estate and his second brother had become a monk as is often the case. Yet Ngawang's future prospects were uncertain. Unmarried and largely unschooled, he wondered how he could secure enough income to move out of his brother's house and establish a family of his own. He began to work as a horseman, ferrying tourists and their supplies along a popular north-south trekking route that ran directly through his village. Despite its location in India's conflict ridden state of Jammu & Kashmir, Zangskar has seen a small but steady influx of tourists since the early 1980's.⁵

In the summer of 1991, Ngawang earned 150 Rupees per day for every horse he hired out, a modest income in Zangskar where many government servants earned between less than five thousand Rupees a month. He had saved nearly earned six thousand Rupees by the end of the season, when this fortune was stolen from his hotel room in Manali. Located south of Zangskar, in northern Himachal Pradesh, the expanding hill town of Manali was teeming with Indian merchants, government contractors, urban investors from the plains, Tibetan refugees, and a sizeable number of long-term foreign residents and tourists.

The loss of an entire summer's earnings precipitated Ngawang's deep depression during the ensuing winter. After Ngawang seemed very listless for a few months, his family called several local doctors or amchi from nearby villages to

monastic or lay ritual specialists, as most (but not all) amchi are laypeople, but almost all would self-identify themselves as Buddhist and thereby religious.

⁴ Zangskar is presently incarnated as a subdistrict within Jammu and Kashmir, in the northwestern Indian Himalaya. Although now politically part of India, historically it was a separate kingdom that lay under the sovereignty of its immediate neighbors including Tibet and the kingdom of Jammu and Kashmir.

⁵ The rise of separatist movements in the Kashmir Valley after 1989 and the Maoist guerrillas in rural Nepal in the 1990's shifted some of the Himalayan trekking economy to Zangskar and Ladakh. Zangskar's trekking industry has been featured in the travel sections of London's *Financial Times* (4/21/01) the *Boston Globe* (6/25/00), and *Outside* magazine (2001). The number of tourists dipped during the Kargil war in 1999 but has risen steadily since then.

examine Ngawang. Both offered similar diagnoses of a generic wind disorder, which they treated with milder herbal treatments. The second also visited on several astrologically specified days to apply moxibustion – placing burning herbs on his skull and upper vertebrae. When his condition showed no sign of improvement, a more senior *amchi* was summoned from the distant village of Bya. This *amchi* diagnosed Ngawang's pulse and urine as a disorder of wind (*rlung*) complicated by phlegm (*bad kan*) – an imbalance of two of the three bodily humors in Tibetan medicine. He also treated Ngawang with herbal remedies before resorting to another course of moxibustion. By May, Ngawang's condition had improved somewhat.

Most of the villagers and doctors who had treated Ngawang agreed that his condition worsened during the following summer as he developed what is colloquially referred to as madness (*smyo ba*). When Ngawang returned to work as a horseman he secured a job as a guide on a three-week traverse of Zangskar. By the time that Ngawang returned to Zangskar's central village of Padum, there were abundant rumors about a series of mysterious thefts he had committed along the route. Ngawang had filched small items from the Zangskari homes where he had stayed; and some said that that Ngawang had stolen over a thousand Rupees from his client in Lamayuru. In most cases, the thefts were only discovered after Ngawang had moved on. After losing two horses on a subsequent trek out of Padum, informants reported that he became deranged (*smyo ba gyur song*). His eccentric behaviors ran the gamut from overt hostility towards close friends to delusions of grandeur. He was seen shouting epithets and throwing stones at friends as well as blessing strangers with his rosary as if he were a high monk.

When Ngawang finally made it back to his natal home, he was suffering from a mental disturbance that the Bya *amchi* now interpreted as demonic attack (*gdon*). He became increasingly violent and irrational. One night he broke most of the windows in his village – windows that had been shipped at considerable expense by truck to Padum and by horse to his distant village. In frustration, the local headman called a village-wide meeting where it was determined that Ngawang should be locked up. Having participated in the democratic decision, Ngawang's family agreed to secure him in their household storeroom for a few weeks. By offering Ngawang just enough food and Tibetan medicine during this period of solitary confinement, the family tried to sap the strength of the demons or desire that had precipitated his mental disorder. Yet Ngawang became manic soon after being released from his month-long confinement. His family then decided to invite a renowned Tibetan reincarnate monk to perform an exorcism.

When Dragom Rinpoche arrived in Ngawang's village in late September, he was riding a white horse and accompanied by roughly a dozen monks from Phugthal monastery. As the Rinpoche dismounted directly in front of Ngawang's house, the assembled villagers bowed in greeting. Ngawang usurped this reception somewhat by dodging in front of the faithful and blessing them himself. Yet the Rinpoche ignored him and strode purposefully into house wearing a blue motor cycle helmet – a protection against falls from his horse as much as the low Zangskari doorways, I was told. Once inside, the Rinpoche climbed onto a low

throne covered with the finest rugs where he was served a feast of delicacies I'd seen only during festivals or weddings such as fresh fruit, stewed apricots in clarified butter, fancy biscuits, fried noodles, and meat dishes. The Rinpoche began a set of Tantric meditations (*sadhana*) to invoke the Tantric protectors he would call on during the exorcism. After performing a brief divination ceremony (*mo*) and consulting his astrological texts, he announced that the spirits possessing Ngawang were a pair of male and female demons (*dri pho* and *dri mo*) and dictated the nature of the exorcism that was to follow.

Following this ritual diagnosis, the crew of monks began to prepare a small universe of effigies. After mixing barley flour and water into dough, the monks molded a set of effigies (*glud*). A pair of grimacing figures, one black and one white, depicted the male and female demons currently occupying Ngawang's consciousness (*mam shes*). Further set of effigies representing the demonic entourage (*'khor lo*) included 120 tiny figurines placed on four boards for each of the cardinal directions. Each board contained thirty figures set in three rows – ten dogs, then ten yaks, and finally ten humans – dusted with a colored powder according to the direction in which it would be tossed. Ngawang observed the preparations, occasionally intervening by lifting the effigies to his chest or jumping up wildly. In these moments, his motions became jerky, his voice changed to a high pitched and strangled whine, and his eyes often rolled wildly. He appeared to be rapidly alternating between dissociation and ordinary consciousness throughout the afternoon, while the monks watched in stupefaction or amusement.

When the effigies had been brought into the Rinpoche's chambers, Ngawang was called in as well. The Rinpoche summoned the Tantric protectors once more and commanded the demons to leave Ngawang's body and enter the central effigies.⁶ The efficacy of the ritual depended upon the Rinpoche's prowess in calling on his Tantric protectors to coerce the demons into doing his bidding. Ngawang showed a surprising deference at this time, prostrating fervently in front of the Rinpoche and eagerly accepting a protective amulet. The audience of villagers took Ngawang's subordination as proof that the demons possessing him were inferior and hence subject to the authority of the Tantric protectors.⁷ At dusk – when demons are believed to prowl – four volunteers each took a board of the tiny effigies roughly hundred paces from the house in the four directions. The smaller effigies were cast into the will grasses at the edges of the fields, for it was

⁶ Beyer (1978: 100-108; 324-355) details the generation and empowerment of ritual effigies in Tantric Buddhism while Ortner (1978) describes a Sherpa exorcism (*rgya bzhi*) that is quite similar to Ngawang's exorcism. Clifford (1984: 136-45) explicitly relates exorcisms to mental illness and Nebesky-Wojkowitz (1975), Day (1989), and Kaplanian (1981) offer symbolic analyses of Tibetan exorcism rites.

⁷ The Rinpoche, a reincarnation of the famous 9th century Tibetan monk, *Lha lung dPal gyi rDo rJe*, called on numerous Tantric protectors (*chos skyong*). These protectors or otherworldly gods (*'jigs rten las das pa'i lha*) have transcended the worldly cycle of rebirth, unlike demons and other lesser gods (*'jigs rten pa'i lha*) who remain trapped in the six spheres of existence.

inauspicious to toss effigies directly into cultivated fields. The larger effigies were tossed into the streambed at the bottom of the village, well below the points where the irrigation channels branched off from the streambed.

After completing the exorcism, the Rinpoche blessed each village house by tossing barley seeds and distributing blessed medicinal balls (*sbyin rlabs*). As the monks readied their horses for departure, Ngawang grabbed the Rinpoche's horse and proceeded to dash headlong out of the village with the monks in full flight. While the monks managed to wrestle the horse back from Ngawang, he continued his antics, blessing the villagers and their houses. As the Rinpoche and his procession rode off down the valley, Ngawang ran alongside trying, unsuccessfully, to grab the horse's bit from the villager assigned to guard the Rinpoche. When Ngawang returned from the village's last chorten, the ritual spectacle had dissipated. Ngawang wandered moodily about in the eerie silence, jumping and shouting mantras as he circumambulated his house. I noticed that he had tied a rope around his waist, dragging a cushion behind him while braying loudly like a donkey. His condition seemed to have gone from bad to worse.

Earlier that day, an oracle from Lingshed who was part of the Rinpoche's entourage had been briefly possessed by two spirits, *Kha che dmar po* and *rDo rje Shug Idan*. He prophesied that Ngawang's situation would only improve after the winter. The villagers did not view the Rinpoche's treatment a failure, as much as an indication that the illness had a deeper karmic causality that would take further ritual intervention before it healed if at all. The villagers were well aware that certain kinds of wind disorder, such as demonic attack, require both ritual intervention and merit making. Thus, the Rinpoche's ritual intervention may be perceived as first step towards a cure, and Ngawang's activities during the coming winter, which included textual study and other merit making actions, helped complete or further the cure.

When Ngawang's condition did not improve during the subsequent month, he was taken to the neighboring region of Ladakh, for further treatment by Ladakhi and Tibetan doctors. During an audience with the Rinpoche in Leh, Ladakh, Ngawang explained his wish to become a monk. He was advised to wait and spend the winter studying religious texts. He began to train as an oracle, seeking out a teacher from among the numerous oracles in Leh, many of whom begin their apprenticeship with similar possession experiences.⁸ His initial tutelage involved lengthy séances in which his teacher and other senior oracles would interrogate Ngawang to identify and authenticate the spirits haunting him. These rites also enabled his teachers to banish the remaining demonic influences. His initiation as an oracle concluded with the critical 'separation rite' (*lha 'dre phye byes*) in which the spirits inhabiting his consciousness were named and bound by oath to work for

⁸ Gutschow (2005) relates the rise of oracles to the social circumstances modern Ladakh, while earlier studies by Day (1990, 1989) describe the practices and training of oracles in Ladakh.

broader Mahayana aims, most notably the welfare of all sentient being.⁹

The following summer, Ngawang returned to Zangskar where he was summoned by Dragom Rinpoche to be ordained as a monk. Arriving far later than the time specified by the Rinpoche – an insult had he not been an oracle – Ngawang was ordained as a monk by the slightly annoyed Rinpoche. He was possessed in the Rinpoche's presence and the senior officiating monks, both of whom verified the deities inhabiting Ngawang's consciousness. Ngawang's fame spread throughout Zangskar and soon afterward, Ngawang was named resident caretaker (*gnyer pa*) of the Rinpoche's palace (*pho drang*) in Zangskar's capital, the town of Padum. Ngawang's thefts were forgiven and forgotten after he became an assistant to the highly respected Rinpoche who had rescued him from his ordeals.

The Diagnosis and Treatment of Wind Disorders in Zangskar

What can Ngawang's case tell us about the complex diagnosis and treatment of wind disorder in Zangskar? The methods of diagnosis and the basic course of treatment used by *amchi* in Zangskar run parallel to those described in Tibetan medical texts. However, the classification and the ritual and religious treatment of wind disorders differs or extends that which is found in the *Rgyud Bzhi*. The *Rgyud Bzhi*, which is the major and most often memorized text an *amchi* in Zangskar will study, lists the main forms of patient diagnosis as follows: pulse diagnosis, urine analysis, and verbal or visual examination of the patient. In Zangskar, the analysis of pulse and urine are considered advanced techniques that reflect the experience of the *amchi* and the type of training they had. In other words, it is not uncommon to have a slightly conflicting diagnosis between a senior and junior *amchi* or even two senior *amchi* who may have had different apprenticeships and teachers.

Many Zangskari *amchi* begin by taking the patient's pulse before moving to the verbal and visual examination of the patient. The *amchi* lays three middle fingers across each of the patient's wrists to read the pulse, taking up to several minutes on each wrist. Each half of the *amchi*'s digits reads a separate set of organs for a total of 12 organs.¹⁰ The pulse is a more figurative and subjective pulse than that measured by an electrocardiogram in biomedicine. The Tibetan

⁹ Day (1990, 1989) and Schenk (1994) describe the separation rite (*lha 'dre phye byes*) that is held during an oracle's initiation in Ladakh. The initiate's ability to distinguish good spirits from the bad may be tested by a game of dice with the officiant, calling to mind the famous dice games in the Tibetan Gesar epic and the Indian Mahabharat. Lopez (1998) describes the controversy surrounding the Tibetan deity, *rDo rje Shugs Idan*, who was one of the main deities possessing Ngawang.

¹⁰ Tibetan pulse diagnosis is described in Finkh (1980), Meyer (1981), and Khangkar (1982a). It draws on the pulse diagnosis used in Traditional Chinese Medicine (TCM) that is detailed in Liu (1988).

medical literature interprets the pulses using a rich metaphorical language. In one text, the pulse of a person suffering a wind disorder is described as adrift, empty, and discontinuous, “like a melon floating on water, push it down and it pops up.”¹¹

Most of the Zangskari *amchi* I have observed in the last decade follow a pattern that seems to privilege pulse and verbal/visual diagnosis over urinalysis. In the medical literature and in my *amchi* interviews, urine analysis consisted of measuring the color, cloudiness, odor, steam, sediments, and surface bubbles or scum of the urine.¹² In Zangskar, many *amchis* may diagnose and treat simple cases without ever using urine analysis. One of the *amchis* I interviewed, Meme Palchung from Bagartse, stressed the importance of urinalysis in his practice. He noted that urine analysis was particularly helpful for wind disturbances caused by spirit attack (*gdon*). In such cases, his analysis of a wind disorder might use divination and other astrological techniques to sort out the spirits responsible. He described in great detail how he would superimpose a virtual grid of nine squares (*me ba dgu*) used in many astrological calculations onto the surface of a cup of urine. He might then divine the source of the ailment depending on where the bubbles are rise and their relative duration.¹³ In his estimation, urine analysis was also helpful for ailments that proved most impervious to other kinds of diagnosis or treatment.

Along with the pulse and perhaps a urine reading, the *amchi* will undertake a visual and verbal examination of the patient, although not necessarily in that order. The visual examination covers the patient's tongue, complexion, and any other parts of the body as necessary. An oral interview of the patient (and other relatives, as necessary) will address the patient's diet, behavior, and other events which may have contributed to the illness. By talking to a patient's family, the *amchi* can solicit and cross-check significant details within the patient's illness narrative. In Ngawang's case, the *amchi* gained insight into many of the events leading up to his breakdown which Ngawang himself neglected to report. For example, Ngawang did not report his theft, but stressed the loss in Manali and his bad luck in recent trekking ventures. Because many wind disorders have some psychological or emotional causes, particular attention is paid to the patient's family and personal relations.

Yet the contextual richness of the *amchi*'s diagnosis in rural Zangskar has thinned somewhat in the urban clinics of Leh, where *amchi* may have little

¹¹ Cited from Clifford (1984: 101).

¹² Rabgyay (1985b) describes the pathological urine for a wind disorder as: bluish, watery, and transparent, with large bubbles that remain some time. In contrast, the urine for a combined wind-bile disorder is yellowish, light, and clear, with small to moderate bubbles that instantly disappear. There are urine patterns for specific diseases such as flu, meningitis, intestinal colic, dyspepsia, enteritis, worms, pneumonia, asthma, arthritis, etc.

¹³ Cornu's (1997) succinct account of Tibetan astrology explains the origin of Tibetan divination tools such as the grid of nine squares in Chinese astrology (*nag rtsis*), but does not comment on its medical use.

opportunity to meet the patient's extended family. These *amchi* also forfeit the chance to observe the patient on a daily basis as rural *amchi* often do. Most Zangskari *amchi* make daily or at least weekly visits on foot or horseback to their serious patients, if distance permits. By the end of the century, at least three fourths of Zangskar's 100 hamlets had a resident *amchi*, who was almost always male. When the first two *amchi* who treated Ngawang were unsatisfactory, a more renowned doctor was called from a distant village. It is not unusual for families to consult several *amchi* simultaneously in difficult cases. Most *amchi* operate on a collegial basis, sharing their diagnoses and treatment plans. If a succession of diagnoses and treatments fail, the patient may call further specialists such as monks, astrologers, exorcists, oracles, or allopathic practitioners such as the government employed medical assistants and pharmacists.

Many Zangskari *amchi* offer therapy in four stages, depending on the severity and course of the disease. The first stage of treatment involves diet and behavior modification, which is adapted to the disorder, the patient's bodily nature, and the season or place in which the illness occurred. Tibetan medical literature includes an elaborate dietology that draws on Indian Ayurveda, in which foods are classed according to their climate, taste (*rasa*), and the bodily humor (*dosa*) they nourish.¹⁴ Individuals, seasons, days, and times of the day can be described by a dominant humor,¹⁵ Indeed, Zangskari *amchi* prescribe or proscribe foods and behaviors according to a complex calculus that includes the individual's constitution, the season, and other circumstances surrounding the ailment. In general, wind disorders are fueled by the consumption of coarse, bitter, sour, spicy or astringent foods, as well as plants or animals that grow in high or dry climates. Commonly avoided foods include chillies, honey, ginger soup, goat's milk, soybeans, alcohol, and pork. By contrast, foods used to treat a wind disorder include meat stew, medicinal butters, clarified butter, and barley or pea flour gruel (*thug pa*) with meat or dried yak cheese.

Most *amchi* I observed and interviewed are quick to offer dietary and behavioral advice as well as some general suggestions about lifestyle, relationships, and other personal issues. Yet they are mostly reticent when it

¹⁴ Zimmermann (1987: 8, 1) describes how Indian āyurveda views the "the universe is a kitchen" while the Chain of Being is a "sequence of foods." His analysis (*ibid.*: viii, 9) notes that āyurveda "presupposes a cosmic physiology: the world seen as a sequence of foods and a sequence of cooking operations or digestions at the end of which nourishing essences from the soil are exhaled in the medicinal aroma or meats....[in sum] the nature of what is eaten is rendered appropriate to the nature of one who eats is."

¹⁵ Rechung (1976: 50, 46) states that "... [Wind disorders] accumulate during the late spring, break out during the summer, and subside during the autumn...Those persons born under the influence of Air [wind] have crooked bodies and are thin and bluish in complexion. Their joints produce a cracking sound during movement." Parfionovitch *et al.* (1992: I, 165) translates the *Blue Beryl Treatise* which describes the act of dressing, sleeping, and exercising appropriate to each hour and season as living "on the borderline between sun and shade."

comes to analytic or cognitive therapies and other forms of personal counselling. Ngawang's initial behavioural treatment – enforced confinement – was radical but not unheard of in Zangskar. More than one *amchi* mentioned its use in other cases where it was believed that patients might harm themselves or others. One of these cases involved a young man who was considered suicidal after he was fired from the army and dropped out of school. He was eventually cured with electroshock therapy in Jammu, an example of how *amchi* and ritual treatments may also intersect with allopathic treatments more commonly used in urban areas outside of Ladakh.

The second stage of treatment involves medicinal pills or powders taken with hot water or decocted. Although doctors in Leh usually administer herbs in the form of hardened pills produced locally or in Dharamsala, most Zangskari *amchi* remain unable to afford such ready-made pills. Many Zangskari *amchi* still produce their own medicinal mixtures at the bedside from powdered herbs. Yet due to the rising cost of ingredients and the lack of standardized prices for medicines or *amchi* services, the locally produced medicines suffer from a limited range of mostly local ingredients. In some cases, the *amchi* may prescribe an herbal mixture to “draw out” the illness so as to sharpen his diagnosis. The chosen herbs may actually exacerbate the illness until it peaks, at which point a new set of medications is prescribed. If the herbal treatment has little noticeable effect after a few weeks, the *amchi* may opt for third stage of therapy. This stage includes massage, enemas, purgatives, or moxibustion – in which the *amchi* applies the burning tip of the rolled up gerbera root, or a golden needle to specific points on the skull, vertebrae, or elsewhere on the body. The major points for moxa or acupuncture are charted in Sangyas Gyamto's famous medical thangkas, and may only be given on specific days of the month, according to astrological calculations.¹⁶

When a patient's illness stubbornly persists after any of the first three stages of therapy, the *amchi* may resort to ritual diagnosis and treatment. In some cases, ritual and merit making activities may be prescribed simultaneously to increase the benefit of the herbal and dietary treatments. Ritual cures are considered the most effective in ailments caused by spirits or those primarily due to prior karma. The *amchi* and other experts use a range of methods including divination, astrology, and oracular consultation to interpret the spiritual or karmic forces causing a certain ailment. Many *amchi* are trained to do basic divinations and astrological

¹⁶ Parfionovitch *et al.* (1992: I, 157-8) offers an illustration of the bodily points where moxa is given and, along with Khangkar (1986: 15-16) describes the method of determining when moxibustion can occur determination of moxibustion. Out of the 72 points on the body available for moxibustion, 6 major ones are used for most wind disorders. Moxa is not given on certain days of the week or the month in order to avoid offending the planetary deities (*gza'*) who rule over these days, while the days of the month most auspicious for moxa are calculated by tracking the soul's (*bla*) monthly journey through the body. In Ngawang's case, the *amchi* from Bya administered moxibustion on the 6th and 7th day of the 11th month.

calculations so that they can recommend appropriate rituals or merit making practices for their patients.

Zangskari *amchi* also work closely with a range of other local healers – astrologers (*rtsis pa*), monks, oracles, exorcists (*dbon po*), and allopathic doctors, – in the course of their therapeutic practice.¹⁷ All but the last of these healers draw on shared idioms of karma and responsibility, although their emphases may differ. While all but the allopathic doctors recognize the primacy of the law of karma, each healer focuses on slightly different paradigm of secondary or contributing causes (*rkyen*). While the *amchi* emphasizes on diet and behavior, the oracle will emphasize spirit possession and attack, and the astrologer look for planetary and other astrologically determined sources of disharmony. As *Amchi* medicine widens its focus to include a broader range of non-medical phenomena, it also sacrifices the sharpness or rigor of biomedicine.¹⁸

The Classification and Etiology of Mental Disturbances in Text and Practice

Zangskari *amchi* do not always separate psychic or mental disturbances from other somatic disorders. Yet they tend to use two dominant idioms for mental disorders: wind disorder (*rlung gi nad pa*) or broader mental disturbance (*smyo ba*) which may or may not have a wind component. Wind (*rlung*), bile (*mkhris pa*), and phlegm (*bad kan*) comprise the three bodily humors, upon which health depends in both Tibetan medicine and Indian Ayurveda. The body is healthy when these humors are in homeostatic balance, but unhealthy when they are unbalanced. The humors are known as ‘faults’ (*nyes pa* in Tibetan, *dosa* in Sanskrit) because each is related to one of three mental poisons (*dug gsum*). While wind arises from desire (*'dod chags*), hatred (*zhe sdang*) gives rise to bile and ignorance (*gti mug*) to phlegm.

The *Rgyud Bzhi* lists five different types of wind: life-sustaining, ascending, pervasive, metabolic, and descending, each of which sustain a wide variety of bodily functions.¹⁹ Put another way, wind affects not only the beating of the heart,

¹⁷ For comparison, see how Pordié (2003) describes the conscious interpenetration of religious and medical practices used by Ladakhi *amchi*. In contrast, Adams (2001) and Janes (1995, 1999) depict the *amchi* in the Tibet Autonomous Region as having sanitized their medical discourse by abandoning religious or ritual practices.

¹⁸ Lock (1987: 35-7) provides an excellent discussion of the difference between biomedicine and Asian medicines using the metaphor of photography apertures. She theorizes that biomedicine captures its object with a wide aperture, focusing on the object while leaving a blurry background, while Asian medicines close the aperture, placing foreground and background in equal focus.

¹⁹ In Tibetan and Sanskrit, the five types of wind are: *srog 'dzin*, *gyen rgyu*, *khyab byed*, *me mnyam*, and *thur sel*, or *prana*, *udana*, *vyana*, *samana*, and *apana*. Khangkar (1986), Tsarong (1981), and Epstein and Rabgyay (1982) describe their functions as follows: (1)

but also the rate of digestion in the stomach and intestines and the way that the bladder and colon produce elimination. Yet wind exists on a different plane than the other two humors. While bile and phlegm are simple contraries that cancel each other out, wind is pivotal humor that has the power to decrease or increase either bile or phlegm. This primacy and omnipresence of wind are as apparent in Tibetan medicine as in the discourses of Indian Ayurveda and Traditional Chinese Medicine.²⁰ Tibetan medicine emphasizes wind because it is the vehicle for consciousness. This theory is often visualized using the metaphor of wind as a horse upon which consciousness goes rides into the world. Without a stable wind, the mind literally will fly away. As one Tibetan doctor aptly stated: "It is like a tree supporting a bird. If there is no tree, where will the bird stay?"²¹

The *Rgyud bzhi* does not have a separate category for mental or psychiatric disorders, but subsumes them under three categories: 'wind disorder' (*rlung gyi nad*), demonic attack (*gdon*), or 'channel disorder' (*rtsa dkar*).²² While most cases of demonic attack or channel disorders exhibit some psychiatric symptoms, many wind disorders do not manifest as psychiatric disturbances. Indeed, as discussed earlier wind disorders can induce a wide range of somatic effects including restlessness, frequent sighing, vertigo, tremors, erratic or diffuse pain, lassitude,

Life-sustaining wind enables swallowing, spitting, sneezing, respiration, concentration, and sensory as well as mental clarity. (2) Ascending wind enables speech, breathing, salivation, complexion, body bulk, memory, and diligence. (3) Pervasive wind enables muscular movement, physical growth, lifting, walking, stretching, opening and closing mouth and eyes, etc. (4) Metabolic wind enables digestion and metabolism. (5) Descending wind enables defecation, urination, discharging semen and menstrual blood, uterine contractions and childbirth.

²⁰ Khangkar (1986: 29) analyzes the superior status of wind by noting: "*rlung* is more powerful than phlegm or bile, because *rlung* makes contact with bile and phlegm. *Rlung* goes to both. Suppose we blow a fire, we cause more heat to arise." In āyurveda, bile and phlegm symbolize the eternal oppositions of fire and water, sun (Agni) and moon (Soma), lack and plethora, or dry lands (*jangal*) and wet lands (*anupa*). Even here, wind has a superior status *vis-à-vis* the other two humors as Zimmermann (1987: 146-7) notes; "wind is then introduced into this fight between fire and water, where it remains in an alternating and dominant position. The primacy and ubiquity of wind are mentioned repeatedly in the texts." Compare Kuriyama's (1994) description of the shifting manner in which inner and outer wind (*qi* and *feng*) embodies pervasive change, uncertainty, and disorder in Chinese medical discourse.

²¹ Doctor Pema Dorje is cited in Clifford (1984:136). Khangkar (1986: 22, 23) states: "*Rlung* serves as the medium for consciousness enabling it to move from one object to another, just as a horse serves as a mount for a rider to journey from one place to another." She also (Khangkar 1982b, 1982c) explains how wind assists the mind's perceptive functions.

²² Wind disorders are classified in Chapter 12 of the *Explanatory Tantra* as well in commentaries such as the *Ambrosia Heart Tantra*, translated by Donden and Kelsang (1977). Demonic attack is described in six chapters (73, 77-81) of the *Oral Secret Tantra* three of which are translated by Clifford (1984). Chapter 60 of the *Oral Secret Tantra* deals with a category of central nervous system ailments known as *rtsa dkar*.

insomnia, fright on awakening, protruded eyes, frequent moaning, delirium, and anger. However, the category of wind disorders includes clearly mental and psychiatric ailments such as amnesia, mania, catatonia, depression, dysphasia, dyslalia, and hyperactivity.²³ The *rGyud bzhi* classifies wind disorders into 63 types; 48 general disorders and 15 specific wind disorders otherwise known as mental disturbance (*smyo ba*). The 48 general types of wind disorder are subdivided into 28 primary types grouped according to the bodily system they affect – the skin, muscle, adipose, vascular, or lymphatic system, and 20 secondary types grouped according to their bodily effects (muscular rigidity, muscle wasting, swelling, contraction, deformity, delirium, coma, and pain).²⁴

Epstein and Rabgyay (1982) have classified mental disturbances into seven categories, according to the underlying cause. The first three types involve a disturbance of wind caused by an underlying imbalance of one of the three bodily humors. The fourth type of mental disturbance involves all three humors simultaneously. The fifth, sixth and seventh group of mental disturbances arise from depression, toxins, and harmful spirits, respectively. Additionally, Epstein and Rabgyay note that excessive fasting, sex, sleep, or forceful retention of excreta can all exacerbate wind disturbances. By comparison, Clifford (1984) groups the major causes of mental disturbance as follows: karma, humoral imbalance, grief-worry, toxins, and evil spirits. Both Clifford and Epstein and Rabgyay, define toxins as poisons administered by others or the accidental but toxic combination of certain foods. Clifford's category of grief-worry is similar to Epstein and Rabgyay's category of depression although Clifford emphasizes compulsive thoughts over lost love, status, or possessions. In Epstein and Rabgyay's (1982: 80ff) account, depressive mental disturbances are caused not only by loss, but also by excessive self-absorption, self-criticism, antipathy, or anger.

Clifford (1984: 138-9) clarifies the psychological factors that compound the three major types of humoral mental disorders. In his schema, an excess of lust, mental strain, emotional attachment, or grief may cause a wind type of mental illness. Likewise, too much anger or aggression may lead to a bile type of mental disorder. Finally, confusion, ignorance, sloth, or social withdrawal may cause the mental disorders associated with phlegm. Epstein and Rabgyay have similar analyses of the three types of mental disorders. The wind type of mental disturbance manifests as excitability, sadness, constant crying, abrupt anger, or an inability to concentrate and remember. Patients suffering from a bile type of mental disorder may exhibit varying degrees of gluttony, self-destructiveness, violence, or obsessive grudges. Finally, those patients suffering from a phlegm type of mental disturbance may be withdrawn, silent, introverted, or drowsy.

²³ Rabgay (1985a, 1985b), Epstein and Rabgay (1982), and Donden and Kelsang (1977) discuss the classification and etiology of wind disorders.

²⁴ Rabgyay (1985a: 51) analyzes the 48 general and 15 specific types of wind disorder. The general types of wind disorder are classified as primary if the wind remains in its main bodily channel and secondary if it has spilled over into the two other bodily channels.

Clifford singles out karma as a specific cause, while Epstein and Rabgyay note that all illness is ultimately due to karma and secondarily due to a precipitating cause. As one notable Tibetan doctor explains, if karma is the root cause of an illness, one can expect that herbal treatments alone will be less effective than merit making or ritual treatments.²⁵ Both Clifford and Epstein and Rabgyay describe the idiom of demonic attack (*gdon*) in varying fashion. They combine Buddhist and psychoanalytic approaches to describe demons as embodied emotional affect or projections.²⁶ Like Epstein, and Rabgyay, Clifford describes demons as the projection of intense fear, anger, or grief. Clifford betrays his psychoanalytic leanings by depicting demons as unconscious or subconscious fantasies. However, he tempers this western analytic with a classic Buddhist interpretation when he cites the 12th century Tibetan *yogini* Macig Labdron, who said that demons are anything that obstructs Buddhist practice. An even earlier and authoritative source, the Abhidharma, classifies demons among the 84,000 obstructions (*bgegs*) that hinder Buddhist practice.

While Zangskari amchi recognize that all ailments are ultimately due to karma, they are primarily interested in the secondary or conditioning causes that are more susceptible to treatment. However, when they encounter ailments that remain impervious to medical diagnosis or treatment, they often fall back on the idioms of karma. This was the case with the Rinpoche's less than successful exorcism. The villagers accepted the Rinpoche's explanation that Ngawang's ailment was due to the burden of past karma (*ngan ma'i las*), and would be cured through individual merit making.

In Zangskari idiom, humans and demons (*'dre*) occupy separate but related realms within the wheel of life (*srid pa'i 'khor lo*). Many of the demons believed to commonly attack people like ghosts (*srin 'dre*, *ro langs*), king spirits (*rgyal po*), and rock spirits (*btsan*) are classified together with a more benign set of spirits called hungry ghosts (*yi dvags*).²⁷ As co-inhabitants of this multivalent realm of existence, demons and people come into conflict and must negotiate their

²⁵ Donden (1990: 18) notes, "When that Karma ripens and a disease manifests in the present lifetime, it is very powerful and thus is generally fatal. In Tibet, people with this type of disease would often renounce all worldly activities and engage in spiritual practices; however, few survive this type of disorder because the disease is a ripening of a powerful action that has been committed in the past".

²⁶ Guenther (1969: 36-7), notes that: "All that which is not and cannot be clearly understood as it rises out of the depth of the psychic life of man, and which not only disturbs but also frequently dominates him, has been concretely formulated as 'demons'." Clifford's (1984: 149) psychoanalytic analysis depicts demons "in the role of the Id trying to obstruct the Super-ego's higher promptings."

²⁷ In Zangskari and Ladakhi belief, demonic spirits (*gdon*) are firmly located in the cycle of birth and rebirth, as detailed by Riaboff (1997), Day (1989), and Kaplanian (1981). Oddly, Ortnier's (1978: 100) analysis of Sherpa culture places demons outside the transmigratory realm of existence, yet her provocative analysis defines demons as psychic projections of social hierarchy.

differences. In recommending or performing divinatory or propitiatory rites, the *amchi* accepts the provisional reality of these undesirable spirits. Both healer and patient understand demons as beings that can be offended and appeased. Healing rituals such as that performed by the Rinpoche one instance of such a negotiation.

One Zangskari *amchi* classified six types of mental disturbance (*smyo ba*) arising from non-humoral causes: (1) excessive desire or ambition, (2) problematic family relations, (3) misfortune or disaster, (4) improper Tantric study, (5) witchcraft, and (6) spirit attack. The first four kinds of mental disturbance in this Zangskari schema are related largely to the patient's inner social or psychic dynamic while the latter two arise from external causes. According to the same Zangskari *amchi*, medicine alone is helpful in treating disorders arising from the first three causes. By contrast, disorders caused by Tantric study, witchcraft, or spirit attack will require ritual intervention and/or merit making as part of the cure.

At first glance, the Zangskari classification of mental disturbance appears to neglect wind disorders caused by poison. Yet in fact, the category of witchcraft-induced disorders subsumes those caused by poison, which are administered by witches in Zangskari belief. Witchcraft in Zangskar is understood as a set of negative actions which are directed against the patient causing illness or other harm. Because women are believed to be more jealous and thus capable of directing negative energy against others, most witches in Zangskar are believed to be female. An *Amchi*, an oracle, or an exorcist (*dbon po*) may be called to identify a witch. The healer will attempt to channel the voice of the witch by grabbing the patient's fourth finger. If the patient yields the name of the witch, rites are held to destroy the witch's negative influence by burning a piece of the witch's clothing or a piece of paper with her name on it.

Conclusions

Ultimately, the Zangskari discourse about mental disturbances offers a productive site for both meaning and agency. Both patients and healers use illness narratives to draw the boundaries between order and disorder, between the desirable and the attainable. Patients and healers have considerable agency in deciphering the causes and consequences of their ailments as they blur the boundaries between medical and ritual treatments. The interactions between *amchi* and patients are pragmatic, flexible, contextual, and improvisational.²⁸ The intertwined and overlapping nature of healing discourses encourages an experimental approach by patients and doctors. Patients are relatively free to call a variety of specialists to find their cure, because the healers tend to operate in collaboration with one another.

²⁸ Kleinman (1980) analyzes the social and cultural construction of illness in terms of a number of vectors – including its pragmatism, flexibility, systemic nature, and ability to adapt to local contexts. Yet this earlier emphasis on systems is repudiated in his later work on experience and social suffering (Kleinman and Kleinman, 1995).

This logic of negotiating between human and spirit worlds parallels the broader social context in which the Zangskari amchi operates. Amchi medicine in Zangskar remains premised upon a profound knowledge of the local and the specific. Individual diagnoses and treatments of wind disorder require a set of transactions with human and non-human actors that are implicated in the disharmony afflicting the patient and his surrounding society. Amchi medicine has become increasingly professionalized, globalized, and thus separated from its local village and Buddhist context in the TAR, Nepal, and Ladakh (Craig, 2005, Janes 1999a). Janes (1999a) describes a highly rationalized medical bureaucracy in Lhasa, where amchi have so little time with their patients that they tend to trivialize or medicalize problems rather than explore their social or political origins.

Moreover, while it is often noted that Tibetan medicine is deeply imbued with a Buddhist ethos, the actual evidence from the TAR suggest a more strategic use of Buddhism (see Gyatso 2004, Janes 1999a). As Janes (1999a) notes, "Beyond the Western gaze, young Tibetans may be just as likely to articulate desires for landcruisers, cellular telephones, and nights filled with karaoke as they are to speak of dharma, freedom of religion, and the Dalai Lama." Both Janes and Adams (1996) have shown that Tibetans are using Buddhism strategically to further a connection with their western interlocutors. In Zangskar, while amchi may be using Buddhism in similar fashion vis-à-vis their western supporters, there is far less stigma associated and less political valence attached to Buddhism than in the TAR.

Zangskar offers a venue in which to study the more 'traditional' mediatory roles that amchi may have held in relation to their clients, their society, and Buddhist monasticism. While many modern amchi in Ladakh, Dharmasala, or Lhasa practice at least partly in urban contexts where they don't know their clients family or kin networks (Janes 1995), most Zangskari amchi still practice within a limited geographic area. For this reason, they can operate as village mediators between family, village, and the monastery. Although not always paragons of morality, many of the elder amchi embody the traditional mores of reciprocity, respect, and hierarchy.

The ritual discourse surrounding mental disturbances in Zangskar emphasizes the logic of social closure and appeasement. Therapeutic rites for mental disorders focus on healing the patient and their interpersonal relations, as well as appeasing any individuals or spirits that have been wronged. Both spirit attack and witchcraft are instructive in this regard. Because it is assumed that human witches or demonic spirits are operating involuntarily or unintentionally, neither spirits and to a lesser extent witches are punished. Instead they are appeased, albeit in rather different manners. In fact, it is rare for a witch to face social sanctions except in proven cases of poisoning. By the same logic, spirits are rarely destroyed in propitiary or exorcistic rites, but are either subdued or banished from the site. The Buddhist rites of ransom offerings (*be le*), subdual (*'dul ba*, *sri gnon*), and exorcisms (*rgya bzhi*) offer temporary cures that subtly continue the ongoing negotiations between the human and spirit realms.

The emphasis on attributing causes to local spirits offers individuals the chance to participate in their own cure through a variety of ritual and merit making acts. This logic dictates that a demon or human may need to be appeased and social or spiritual obstacles removed before any healing can take place. In addition to pragmatic rites of ablution, purification, and subdual noted above, a wide variety of merit making activities can further healing. Circumambulation, saying prayers, attending initiations, fasting, and making donations (*sbyin pa*) to the monastic assembly are available to any individual regardless of literacy or ritual training. The performance of these mechanical forms of merit making can produce a placebo effect in the individual, regardless of how they affect the physical symptoms of wind disorder that have been diagnosed. The efficacy of the placebo effect has been widely studied, albeit primarily in a biomedical context (Harrington 1997).

For patients, efficacy is measured in both bodily improvement and in moral meaning. The efficacy of treatment depends on repairing the patient's inner bodily state and on overcoming an apparent transgression of physical, psychic, or social boundaries. Because mental illness can signify both physiological and social pathology, the *amchi* alone may not be sufficient to heal the patient. While some patients may be told to propitiate demons, others will be required to perform compensatory actions within their village to repair ruptured social bonds. Additionally, the efficacy of the healer is measured in terms of moral and social status, regardless of individual cases of success or failure. As I have argued elsewhere in describing the monastic order, the more senior, meritorious, or successful the *amchi*, the more in demand and richly rewarded their services (Gutschow 2004, Pordieu 2007). The intertwined economies of merit and status reproduce and legitimate the extant social hierarchies within which *amchi* and monk practice.

For both *amchi* and monks, the practice of healing produces meaning out of individual misfortune. The monks and *amchi* who perform ritual and medical mediations by removing misfortune in exchange for material compensation are enacting and authorizing a highly interested relationship. They benefit from their engagement with individual misfortune and have an unfalsifiable alibi---karma---in case their ritual or medical treatment does not produce its desired effect. Karma offers an ultimately indeterminate source of causality and meaning for everyone---both patients and healers. Because karma is unknowable, the patients have accepted a system in which the reason and the cure of their ailment is internally generated, in the end. As patients cycle back and forth between health and illness following the directives of *amchi*, monks, and other ritual specialists, each of these professions is valorized, despite the increasing pressures of modernity.

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