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Understanding Tibetan Women's Distress: Rlung and the Circumstances of Everyday Life

Andrea Qian Lei

Shanghai High School International Division, Shanghai, China
andrealhop@outlook.com

Abstract. The social context of suffering is just as influential in shaping disease as medical conceptions of the body and mind. In Tibetan contexts, rlung ("wind") provides a conceptual framework for understanding social conditions underlying bodily discomfort and emotional distress that Western biomedical psychiatry may not fully recognize. This study explores how Tibetan medical notions of "rlung" make sense of women's distress, and how gendered responsibilities and social positions inform their responses and treatment-seeking. It draws on an interpretive analysis of scholarly literature on Tibetan medical texts, as well as thematic analysis of seven semi-structured interviews with Tibetan women conducted between 2025 and 2026. Interviews show that household labor and care responsibilities shape women's educational and work choices, and their resources to pursue care. Language barriers, transportation, trust in medical providers and access to social media platforms also influence where women seek out medical information. This study argues that the distress of Tibetan women cannot be explained by individual psychological or bodily conditions alone, and analyzes medical interpretations in conjunction with women's social responsibilities and access to resources. Rather, it must be situated in the social relations and material conditions through which suffering and access to care are structured.

Keywords: rlung, Tibetan women, gender, embodied distress, medical pluralism

1. Introduction

The body is the locus of illness, yet its causes are not always confined to bodily processes. Routine tasks, caregiving, problems in relationships, and repeated social pressures can all cause physical and emotional pain. Western biomedical practice does assess symptoms in an effort to inform treatment, but patients' social circumstances may be less considered in medical explanations. Key concerns raised by the World Health Organization and the United Nations have been the focus on biomedical approaches and the lack of attention to social determinants in mental health systems [1].

Tibetan medicine takes a view of this relationship in rlung ("wind"), a central idea in Sowa Rigpa, the Tibetan "science of healing." Tibetan medical literature has suggested that social factors (e.g., long-standing anxiety, family difficulties, taxing work and physical fatigue) have been associated with rlung problems [2]. These understandings put everyday experiences into explanations of illness. But the two approaches do raise questions about the incorporation of social

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circumstances into medical interpretations of suffering. This is not to say that Western biomedicine ignores social factors.

This article will explore how social conditions impact Tibetan women's physical and emotional distress, healthcare-seeking behavior, and what the Tibetan concept of "rlung" exposes about these connections. It includes a review of the literature on Tibetan medicine and thematic analysis of seven semi-structured interviews with Tibetan women aged 20-40 from May 2025 to August 2026.

2. Literature review and conceptual background

2.1. Rlung and the relationship between bodily and emotional distress

In Sowa Rigpa, "rlung" (wind) is one of the three nyes pa described in the Four Tantras. "Rlung" is associated with bodily movement and mental activity and provides a framework for understanding how emotional disturbance may be associated with physical illness [2]. *The Oral Instruction Tantra* mentions that strenuous activity may cause disturbed wind and fear, depression and unpleasant social experiences may aggravate symptoms [3, 4]. These accounts suggest that illness can be understood in terms of everyday experience, not simply bodily symptoms.

Current ethnographic research shows this explanatory potential. Deane mentions cases where family problems and work stress are considered as factors contributing to wind disorders [5]. But Prost warns against the assumption that rlung explanations always include patients' broader social circumstances. Her research shows that people may give explanations in terms of immediate bodily conditions and not develop a wider social interpretation [6]. In this way, "rlung" provides a paradigm for the linking of suffering with social life, although the extent to which this link is forged varies between patients and practitioners.

2.2. Gendered responsibilities and the social production of distress

Another perspective on the connection between bodily suffering and social inequity comes from medical anthropology. The concept of the "mindful body" by Scheper-Hughes and Lock links bodily experience to social relations and political arrangements [7], and Farmer's theory of structural violence accounts for how unequal social conditions restrict people's lives and lead to suffering [8]. These perspectives are particularly pertinent to women whose responsibilities for domestic labor and care may lead to exhaustion, while at the same time limiting their opportunities to obtain help.

Studies of Tibetan communities show the effect of gender on such responsibilities. Research by Dala Duo on elder care in Qinghai shows that women can shoulder a big part of caring work, and men are less involved [9]. Palden Trinley's writing on women's disorders also notes the gender discrimination in Tibetan society [10] and Adams looks at how women's experiences of suffering interact with collective and political circumstances [11]. Taken together, these studies suggest that women's distress is inextricably linked to the distribution of household responsibilities, social expectations, and resources available.

2.3. Healthcare access and the conditions of recovery

Recognizing social causes does not necessarily guarantee that women can access appropriate care. Deane [5] describes responses to rlung disorders that include emotional support, changes to the living environment, and medical treatment. But advice that requires rest or reduced workloads may be difficult to follow for women with substantial caregiving responsibilities. Research on maternal

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healthcare in Tibet also shows that safety perceptions, emotional support and family relationships influence experiences of and choices about healthcare [12, 13].

Thaddeus and Maine's three-delay model includes delays in deciding to seek care, reaching a facility, and receiving adequate treatment [14]. This framework highlights that access is influenced by transportation, household duties and social support, in addition to the availability of medical services. Medical pluralism complicates treatment-seeking even further: Janes explores the institutional and market conditions that shape Tibetan medicine [15]; Craig points to the social relationships through which healing becomes meaningful [16]. Kleinman's concept of explanatory models [17] and Nichter's idioms of distress [18] also shed light on how people make sense of and express suffering. Meanwhile, the research of depression narrative on Douyin identifies digital media as another potential source of health information [19]. Collectively, these perspectives suggest that Tibetan women's distress should be analyzed in terms of the social conditions underlying illness as well as the practical circumstances shaping their access to care.

3. Methodology

This research integrates Tibetan medical scholarship and seven semi-structured interviews to explore how women' s social positions shape their experiences of distress and access to health care. Medical texts and ethnographic research offer a way of understanding "rlung", the Tibetan medical principle often translated as "wind" (rlung) that links emotional strain to bodily discomfort. The interviews examined the influence of everyday responsibilities on worry, the resources available to women, and the challenges they faced in seeking help.

Interviews were conducted by telephone or online call from May 2025 to August 2026. Participants were recruited through snowball sampling and included seven women in their twenties to forties with diverse educational and occupational backgrounds, including small-business ownership, domestic caregiving, and student life. Some had had little formal schooling, others had been to university. Many had links with country areas, but their living and working conditions were not the same. Interview transcripts were analyzed through close reading and cross-case comparisons. The analysis accounted for the way household responsibilities constrained options for some women, while family support afforded others more independence. The interpretation of these accounts was informed by Tibetan medical scholarship on "rlung", keeping attention on the circumstances surrounding distress rather than to treat the interviews as evidence for medical diagnosis. Participants are coded as A-G based upon the date they completed their interview: A - May 30, 2025; B - June 6, 2025; C - June 25, 2025; D - June 26, 2025; E - May 3, 2026; F - July 30, 2026; G - Aug. 29, 2026.

4. Results& discussion

4.1. Everyday responsibilities and the recognition of distress

The interviews suggest a close link between women's distress and household responsibilities, family relationships and opportunities for personal development. Participant B had wanted to pursue further education but was at home because her family had extensive livestock-care responsibilities and limited alternative support. Her choice was a manifestation of her educational desires and her commitments to family members (Interview, Participant B, 6 June 2025). Conversely, Participant C described how leaving her home community and working in Lhasa gave her more control over her

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future, including marriage (Interview with Participant C, 25 June 2025). These stories show how education and mobility can widen women's choices but also how family obligations can limit them.

Such experiences are relevant for understanding "rlung", since worry and physical discomfort occur within specific social relations. Deane found that concerns about family and work-related stress were correlated with disturbances in the wind [5]. Duo also shows that higher negotiating power through education and employment does not necessarily reduce women's caregiving responsibilities [9]. Attention to women's burdens alone is therefore not enough to understand distress; attention to the relationships and resources through which those burdens are managed is also necessary, the interviews suggest.

There was variation in how well participants understood emotional distress. Participant F linked experiences described as depression with a wind condition, and thought Tibetan medicine could be one treatment. Some women may have limited education, making it hard for them to recognize persistent low mood and language accessible services may help them seek assistance (Participant F, interview, 30 July 2026). However, participant G was not sure that depression, anxiety or irritability could be explained in terms of wind illness. She suggested talking to the person concerned, not thinking too much and taking medicine when necessary, and also saw Douyin as a possible source of advice (Interview with Participant G, 29 August 2026). These differences suggest that the prominence of "rlung" in Tibetan medical scholarship does not necessarily mean that all women use such a framework to interpret distress.

Another concern was the ability to communicate health issues. Participants F and G were embarrassed to talk about menstrual pain, discharge and bleeding even in hospitals. Participant G wanted the doctor to be a woman who would talk to her in private and be patient with her, recalling a time when a practitioner moved on to the next patient before she had finished asking her question (Interviews with Participant F, 30 July 2026, and Participant G, 29 August 2026). These accounts do not identify reproductive complaints as disorders of the wind. Instead, they show how privacy, communication and quality of interpersonal care affect whether women can explain their concerns.

4.2. Everyday work and the practical possibility of care

Medical care was available, but it was not always available to women. Participants F and G described free screening for breast and cervical cancer, but said some women would prefer to collect caterpillar fungus, an important source of seasonal income, or feel uncomfortable attending screening with men (Interviews with Participant F, 30 July 2026, and Participant G, 29 August 2026). But removing fees did not remove the opportunity costs of going to services or the privacy concerns.

Distance also played a role in access. Participant G mentioned that it takes two to three hours to reach a medical facility from a pastoral household by horse or motorcycle. Women may have to leave the pasture early, in preparation for birth, and stay closer to medical services. Participant B reported difficulties in receiving medicine deliveries at mobile grazing sites, though overall obtaining medicine had become easier. Participant E mentioned access to nearby services and the option of calling an ambulance in serious cases (Interviews with Participant B, 6 June 2025; Participant E, 3 May 2026 and Participant G, 29 August 2026). These different experiences point to access being a question of specific living and working conditions, not simply the presence of services. This is in line with the difference between deciding to seek care and actually obtaining it [14].

Access to menstrual products was also dependent on location and livelihood. As Participant F described, her mother bought supplies on trips to the county as these supplies could not be bought in

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her pastoral home. Participant G was able to purchase products in her village but depended on her sister to supply her and provide pain medicine when her menstruation started while she was working in the mountains (Interviews with Participant F, 30 July 2026, and Participant G, 29 August 2026). Family support may have been sufficient to meet immediate needs, but women's ability to cope with discomfort still depended on where they worked and what facilities were available.

4.3. Relationships through which assistance becomes usable

Family relationships might be a cause of concern and also of practical support. Participant E had to take care of her young child, household chores and a clothing business while worrying about her old parents. She set up regular medical checks for them, showing that family concern could also be demonstrated by action. Healthcare experience was further shaped by language and access to information. Participant C stressed the need for explanations in spoken Tibetan for those with little schooling or command of Mandarin. Participant F also appreciated patient explanations in Tibetan and noted that biomedical doctors in her home area were also able to speak Tibetan (Interviews with Participant C, 25 June 2025, and Participant F, 30 July 2026). Douyin was mentioned by participants C, D, F and G as a source of general and health information. However, Participant B mentioned unreliable connectivity and lack of electricity at grazing sites and Participant F associated the ability to search for information about emotional distress with educational experience (Interviews with Participant B, 6 June 2025, Participant F, 30 July 2026).

Participants also described experiences in various healing settings. Participant D had surgery for a knee fracture at a Tibetan medical hospital and then used Tibetan medicines. Participant F described families using biomedicine and traditional Tibetan remedies, emphasizing the fact that healthcare may be a product of multiple traditions and social relationships [15, 16]. Participant D also described feeling physically and emotionally relieved at a temple after experiencing little relief from a hospital (Interview with Participant D, 26 June 2025). Participant F explained that prayer could give people confidence in their medical treatment, but she noted that divination could discourage people from going to the hospital. Participant G also mentioned prayer and individuals who opted for religious practices instead of medical treatment as they did not anticipate much gain from the treatment (Interviews with Participants F and G). These stories indicate that spiritual practices may promote or discourage people from engaging in medical care, depending on the circumstances and expectations.

5. Conclusion

When assessment is a matter of classifying symptoms, the responsibilities underlying women' s worry and exhaustion may be less attended to. "Rlung" provides a means to understand distress through daily life and to consider if the help offered is congruent with the circumstances of women. For example, advice to rest may not be feasible without family support or alternative care. This article uses seven interviews to explore how social responsibilities shape women' s "rlung" experiences and access to relief. The small, diverse sample cannot estimate prevalence or demonstrate that participants' health concerns are due only to wind disturbances. Instead, it shows how social circumstances may either impede or facilitate help-seeking. Further research might track women undergoing "rlung" treatment longitudinally, examine the impact of changing family and employment circumstances on explanatory models, and explore the role of social concerns in diagnosis and treatment. A comparison of the experiences of women in Tibetan medicine and Western biomedicine may also shed light on whether everyday concerns remain central as they

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move between practitioners. Such research would clarify how the explanatory power of "rlung" relates to the social relations and health care systems in which healing takes place.

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