Doctoral thesis submitted to
the Faculty of Behavioural and Cultural Studies
Heidelberg University
in partial fulfillment of the requirements of the degree of
Doctor of Philosophy (Dr. phil.)
in Anthropology

Title of the thesis

Purifying Purges and Rejuvenating Massages
Ayurvedic Health Tourism in South India

presented by
Christoph Cyranski

year of submission
2016

Dean: Prof. Dr. Birgit Spinath
Advisor: Prof. William S. Sax, Ph.D.

Purifying Purges and Rejuvenating Massages

Ayurvedic Health Tourism in South India

Christoph Cyranski

To Jutta Cyranski,
in loving memory

Acknowledgments

This research has greatly benefited from numerous people's support, for which I would like to express my sincere thanks. Without the help of all the people I interacted with in Kerala, who in many ways co-created this work by sharing valuable ideas and time, the project would not have taken its final form. I am most grateful to all the practitioners, therapists, managers, owners and employees of Ayuresort and all other Ayurvedic resorts, centers, hospitals and clinics I visited for their interest in my work and overall support.

My largest debt is to Dr. Praveen, who let me see the realm of Ayurvedic resorts and the Ayurvedic world in general through his eyes. Interested in my study from our first meeting, he became not only the perfect conversation partner on all issues related to my research and many things beyond but also a friend. I was most impressed by his patience and 'stress-free' approach to my extended conversations and requests for clarifications following a seemingly infinite number of questions. I further want to thank Vasu, the general manager of Ayuresort, for his resourcefulness and for letting me stay to conduct my research at the resort. I graciously thank Dr. Sudhakaran as well for letting me stay at his hospital for one month and for introducing me to the world of clinical Ayurvedic practice.

This dissertation also owes a great deal to the guests at Ayuresort, who not only willingly and openly shared their thoughts and parts of their life with me but also provided great company on the otherwise lonely evenings within the resort compound.

Outside of Kerala, a number of people were instrumental at different stages of the project. First and foremost, I owe much to the careful supervision of William Sax. His guidance and constant support over the years contained the right amount of encouragement combined with a surplus of sharp comments from the time I first wrote my scholarship application for my doctoral program until the completion of this dissertation. I am also very grateful to my second supervisor Laurent Pordié for his insightful feedback and cheerful attitude. His generosity in sharing his time and thoughts in spirited exchanges reminded me how rigorous scholarship can be fun when you know how to appreciate what surrounds you. In addition, my sincere thanks to Eva Ambos, Friederike Faust and Sergio Mukherjee for their perceptive reading and critical feedback of earlier drafts of this dissertation. I am

also extremely grateful to Sergio for his thorough editing – and for his friendship.

I further want to thank my fellow doctoral candidates at Heidelberg University for all those engaging debates about our research and for social distraction when I needed a break from work during the last years: Eva Ambos, Sandra Bärnreuther, Hasan Ashraf, Ravi Baghel, Silke Bechler, Christoph Bergmann, Lisa Caviglia, Sophie Kotanyi, Matthias Liehr, Sridevi Padmanabhan, Antony Pattathu, Nike-Ann Schröder, Roman Sieler and Roberta Tontini. Inside the office (Room 503 at the South Asia Institute, and Room 014 at the Karl Jaspers Centre) I shared not only 'blood, sweat and tears,' but also great conversations with Eva Ambos, Sandra Bärnreuther, Sinjini Mukherjee and David Picherit.

I also want to thank Gabi Alex, Ananda Samir Chopra, Eva Jansen, Claudia Lang, Harilal Madhavan, Hari Kumar Bhaskaran Nair, Harish Naraindas, Karin Polit, Johannes Quack, Christian Strümpell and Constanze Weigl-Jäger for stimulating exchanges, fruitful feedback and helpful suggestions. Anne Scheuing and Annika Bohn helped me with the transcription of my audio-recorded material – a tiring job conducted by them tirelessly.

In addition to individuals, a set of institutions made this work possible. I am grateful for the academic and financial support of the Cluster of Excellence 'Asia and Europe in a Global Context' and the South Asia Institute, both at Heidelberg University. In India, my thanks to the Institut Français de Pondichéry for hosting me during my enriching research stays in Pondicherry.

Last but not least, I would like to thank Ben, Biggi, Peter, Sarah, Ulf, Fritzi, Julia and all *Fetzer und Spuler*, who accompanied me throughout the years – in the good and not so good moments –, as well as Claudia and Thomas Cyranski for their unconditional love and support.

Contents

Acknowledgments **vii**

List of Figures **xi**

1 Introduction: Transnational Ayurvedic Spaces **1**

2 Pragmatics of Imagination: Ayurveda Reconfigured **37**

2.1 Therapy – Illness Prevention – Recreation: Resort Visitors' Perceptions of and Reasons for Choosing Ayurveda 39

2.2 Imag(in)ing Ayurveda: Ayurvedic Experiences and Media Representations of Ayurvedic Treatment 52

2.3 Translating Imagination: Ayurvedic Practice at Ayuresort 73

Conclusion 105

3 The New *Śirodhārā*: A Panacea for Stressed Europeans **111**

3.1 Stress: A Largely Western Creation? 113

3.2 *Manasika Roga* Extended: The Incorporation of Stress in Ayurvedic Nosology 126

3.3 From Therapeutic Treatment to Relaxation Technique: The Transformation of *Śirodhārā* 138

Conclusion 155

4 Taking the Oils: *Ayurveda-Kur* and the Merging of Therapy, Wellness and Vacation **161**

4.1 Traveling for Health Care: Medical Tourism, Spas and the German *Kur* 164

4.2 The Familiar in the Foreign: The Practice of *Ayurveda-Kur* in India 181

Conclusion 197

5 Conclusion: Ayurveda's Multiple Authenticities **201**

References 217

Appendix 257

A Quoted Interlocutors 257

A.1 Ayurvedic Practitioners 257

A.2 Staff members at Ayuresort 257

A.3 Guests at Ayuresort 257

A.4 Other Interlocutors 261

B Treatment Plans Ayuresort 262

B.1 Christina 262

B.2 Barbara 263

B.3 Julie 264

C Treatment Plans Private Ayurvedic Hospital Ernakulam 265

C.1 Mohanan 265

C.2 Velu 266

D Clinical Questionnaire Ayuresort 267

E Price Sheet Single Applications Ayuresort 272

F Ayuresort's Green Leaf Certification 273

Erklärung gemäß § 8 Abs. (1) c) und d) der Promotionsordnung der Fakultät für Verhaltens- und Empirische Kulturwissenschaften 275

List of Figures

1.1 Billboard advertising Ayurvedic treatment in Varkala 2
1.2 Billboards of Ayurvedic centers on a road leading to Varkala 2
1.3 Varkala beach with cliff and Papanasam Beach 24
1.4 Walkway on the cliff in Varkala beach 25
1.5 Ayuresort complex 27
1.6 The Ayurvedic center at Ayuresort 28
1.7 Treatment room in Ayuresort's Ayurvedic center 29

2.1 Photo shoot of Ayurvedic treatment at Ayuresort 58
2.2 Picture of *śirodhārā*, produced during photo shoot at Ayuresort 60
2.3 Picture of *ki̱li*, produced during photo shoot at Ayuresort 60
2.4 Inner face of folder advertising Ayurvedic treatment at Ayuresort 63
2.5 Outer face of folder advertising Ayurvedic treatment at Ayuresort 64
2.6 Table display advertising Ayurvedic treatment at Ayuresort 65
2.7 Front side of leaflet produced by Ayurvedic center in Varkala beach 66
2.8 Back side of leaflet produced by Ayurvedic center in Varkala beach 67
2.9 Advertisement for Ayurvedic treatment by India's Ministry of Tourism 69
2.10 Explanation of *pañcakarma* by Dr. Praveen 82
2.11 Explanation of *saptadhātu* and *rasa* by Dr. Praveen 82
2.12 Explanation of general aspects of Ayurveda by Dr. Praveen 83
2.13 Recitation of *śāntiḥ* mantra during yoga class at Ayuresort 97

3.1 Guest receiving *śirodhārā* at Ayuresort I 140
3.2 Guest receiving *śirodhārā* at Ayuresort II 140
3.3 *Śirodhārā* vessel at Ayuresort 141
3.4 Sketch of *śirodhārā* vessel with string, coconut shell and piece of wood 141
3.5 Explanation of *śirodhārā* by Dr. Praveen I 146
3.6 Explanation of *śirodhārā* by Dr. Praveen II 147

4.1 Male ward in a governmental Ayurvedic hospital in Kerala 186
4.2 Open-air restaurant / common area at Ayuresort 187
4.3 Advertisement picture for Ayurveda by Kerala's Department of Tourism 190

1 Introduction: Transnational Ayurvedic Spaces

A young blonde woman is lying face-down, relaxed with eyes closed on a puce wooden treatment table with a white towel underneath her head and another one covering her lower back. Two white muslin pouches filled with herbal leaves are carefully placed on the woman's fair shoulder blades by two Indian female therapists standing on opposite sides of the treatment table, dressed in a cream-colored sari with golden borders and a dark green blouse. Not far from them, a picture of Dhanvantari, the tutelary deity of Ayurveda, is framed next to a yellow buttercup flower, three brass cannikins used in some Ayurvedic treatments and two lit brass oil lamps to produce a ritualistic ambiance.

The scene, representing the Ayurvedic treatment *kiḻi*[1] is showcased on a billboard advertising Ayurveda at an Ayurvedic center in the South Indian state of Kerala that offers Ayurvedic treatment for tourists (see Figure 1.1). The appealing treatment represented on the photo, together with the slogan "Health Assured, Naturally…!" printed in convoluted green letters above the picture are meant predominantly to attract international guests. It also places Ayurvedic practice at the junction of health care and leisure in an intercultural setting – the topic of this dissertation.

Driving north from Trivandrum International Airport in Kerala's capital Thiruvananthapuram along the coastline of the Arabian Sea to Varkala, one of the two main seaside holiday spots in Kerala, one is regularly confronted with such billboards. Many or even most portraying a white woman receiving Ayurvedic treatment from Indian female therapists in a pleasant ambiance, they punctuate the 50 km long road and indicate that one is on the way to one of the hubs of Ayurvedic treatment for foreigners in India (see Figure 1.2).

For the last three decades, an ever increasing number of foreigners have visited India for Ayurvedic treatment. Located at the south-western tip of the country, and bordered by the Arabian Sea to the west and the state of Tamil Nadu to the east, Kerala is the main destination in India for 'Ayurvedic health tourism.' Since the 1980s, and following the establishment of the first Ayurvedic centers targeted at an international clientele, this

[1] Transliterations of Malayalam and Sanskrit terms follow the Romanization system of the Library of Congress, except for those terms that are also used in English language and appear in common dictionaries such as Merriam-Webster or Oxford English Dictionary. Those words are written in their usual English spelling without the use of diacritics, as for instance in the case of Ayurveda (instead of *āyurveda*).

Figure 1.1: Billboard advertising Ayurvedic treatment in Varkala (photo by the author)

Figure 1.2: Billboards of Ayurvedic centers on a road leading to Varkala (photo by the author)

government-supported industry generates today about 40 percent of the state's total tourism revenues of almost US$ 4 billion (Department of Tourism, Government of Kerala 2015: 40 [Table 2.2.9]; Ramesh and Joseph 2012: 30). In the course of the tourism sector's rapid growth in Kerala, these Ayurvedic centers mushroomed in the 1990s and early 2000s. Today more than one hundred such centers have been officially accredited by the government of Kerala, in addition to an even higher number of non-recognized institutions (Department of Tourism, Government of Kerala 2013). Distributed over the whole state but concentrated in tourism areas, mainly in and around the two seaside towns of Varkala and Kovalam, these centers offer a combination of health care and holidays within pleasant natural surroundings, and one might be forgiven for thinking that they are more connected to the latter than the former.

Such centers represent a fairly new institution of Ayurvedic practice in Kerala compared to former times when Ayurvedic treatment was primarily located in private and governmental Ayurvedic clinics, hospitals and dispensaries. Still, in 2010, Kerala's Ayurvedic sector included approximately 120 Ayurvedic hospitals with 4,000 beds, 900 dispensaries and 16,000 registered practitioners (Ministry of AYUSH, Government of India 2010). Ayurvedic treatment in those clinical settings represents in most cases a remedial health care practice (see e.g. Alter 1999) that is generally utilized because of biomedical failure. While different authors list aspects such as the absence of side effects, naturalness, complete cure 'from the root,' and better outcome in the treatment of chronic diseases as perceived advantages of Ayurvedic treatment over biomedical treatment,[2] the primary reason for consulting an Ayurvedic practitioner in Kerala is dissatisfaction with biomedical treatment. The great majority of patients visit Ayurvedic clinics and hospitals only after having tried biomedical treatments. If biomedicine does not improve their condition, they are either referred to Ayurvedic clinics or hospitals by their biomedical doctor, or they opt for Ayurvedic treatment on their own initiative.[3]

---

[2] See Banerjee et al. 2013: 183f.; Cameron 2008: 95; Islam 2009: 137; Langford 2002: 56; Nisula 2006: 208; Tirodkar 2008: 233f. This is in accordance with my own research findings. Such reasons were given by patients of Ayurvedic clinics and hospitals in Kerala as well as mentioned by Ayurvedic practitioners when referring to advantages of Ayurvedic over biomedical treatment. As I will demonstrate below, they also play a major role in the perception of Ayurveda by foreigners receiving Ayurvedic treatment in Kerala.

[3] The status of Ayurvedic treatment as a second choice has been the subject of scholarly scrutiny. For example, in their large-scale quantitative study of health-seeking decisions by parents with sick children in Kerala, Rajamohanan Pillai et al. demonstrate that biomedicine is overwhelmingly the treatment of first choice (2003: 785). Other scholars present similar results. Nazrul Islam shows that 81 percent of the 75 patients interviewed in Ayurvedic clinics and hospitals in Kolkata had first tried biomedicine before undergoing Ayurvedic treatment (2009: 142 [Table 3]). Manasika Tirodkar noted similar trends in her study in Pune, where about 90 percent of the patients in her sample had consulted an Ayurvedic practitioner only after they had "exhausted all allopathic options" (2008: 237). Similar numbers are reported by Tapio Nisula, who claims that in Mysore, Ayurvedic services represent a "secondary health resort" (2006: 215, 212ff.). My research supports those findings. Since many Ayurvedic practitioners see their

The literature on patients' reasons for visiting Ayurvedic clinics and hospitals in South Asia confirms Joseph Alter's claim that clinical Ayurvedic practice today is mainly a "remedial quest for recovery" (Alter 1999: 58) with musculoskeletal complaints and gastrointestinal disorders being the most common ailments,[4] which is confirmed by my findings in different clinics and hospitals in Kerala. The majority of patients who see an Ayurvedic practitioner in India receive outpatient treatment, either in an Ayurvedic clinic, Ayurvedic dispensary or the outpatient department of an Ayurvedic hospital. In most of the cases, the treatment consists of the intake and application at home of Ayurvedic medicines in form of tablets, syrups, pastes, powders and decoctions. If patients are admitted to Ayurvedic hospitals, they usually receive *pañcakarma*[5] or local external applications in combination with internal medicines and a specific diet. The decision about the exact treatment is generally made after the initial diagnosis, usually based on general observation, interrogation and, if necessary, physical examination, and often combines Ayurvedic and biomedical elements such as *nāḍī parīkṣā* (pulse diagnosis) or *jihvā parīkṣā* (tongue diagnosis) with serological tests or radiography (see e.g. Banerjee et al. 2013: 154, 237f.; Frank 2004: 177f.; Tirodkar 2008: 228).

Biomedical influences also manifest in the use of biomedical nosologies, terminologies and concepts in English instead of Ayurvedic ones in Sanskrit.[6] I follow Harish Naraindas (2006: 2659; see also 2014b: 123) in suggesting that the predominance of biomedical terms and concepts results in part from the health-seeking pattern prevalent in the local population. Since the great majority of patients only resort to Ayurvedic treatment after biomedicine has failed, patients receive their diagnosis in biomedical terms. They often bring their X-ray and MRI scans to the Ayurvedic clinic, and these become the basis for further communication with the Ayurvedic practitioner.[7] Moreover biomedical disease categories, terms and concepts feature in the curriculum in Ayurvedic colleges, which includes biomedical physiology, anatomy, nosology and pharmacology. In addition, the patient's greater familiarity with biomedical terms and concepts certainly contributes to the

patients only after being treated by biomedical practitioners, several Ayurvedic doctors I talked to referred to them as "second-hand patients."

4 See Banerjee et al. 2013: 189 [Table 6.10]; Edwards 2009: 292; Islam 2008: 121 [Table 4.3], 2009: 141 [Table 2], citing Central Research Institute (Ayurveda), Government of India 2004: 70-73; Langford 2013: 274; Malhotra et al. 2001: 73 [Table 2], 74 [Table 3].

5 *Pañcakarma* is a major Ayurvedic in-patient treatment that usually takes about two weeks and includes internal and external application of medicated oil and evacuative measures. Further details about the treatment can be found in Section 2.3, where I analyze its vital role in the formation of Ayurvedic practice prevalent in Ayurvedic resorts.

6 See Das and Das 2006: 182; Edwards 2009: 291f.; Mallick 2013; Naraindas 2006: 2659, 2662; Nisula 2006: 220.

7 Naraindas nicely describes the dominance of biomedical nosology by demonstrating that in his study of the doctor-patient interaction in an Ayurvedic clinic in Chennai Ayurvedic re-diagnoses "[...] cannot in some measure escape the 'original' diagnosis even if they set out to prove it wrong [...]" (2006: 2668).

latter's prevalence in consultations. As my own research reveals, Ayurvedic knowledge is very basic or even nonexistent among most patients (see also Frank 2004: 186f.; Langford 2002: 268; Nichter 1980, 1989a),[8] whereas the language of biomedicine is well established due to the prevalence of biomedical health care facilities in India and the historical hegemony of biomedical practice and theory there.[9]

Biomedical influences on contemporary Ayurvedic practice are a manifestation of the mutability of health care practices in general and Ayurveda in particular. Over several centuries, Ayurvedic theory and practice – like all medical theory and practice – has been constantly modified through processes of adaptation in response to different scientific, political and economic developments. With the spread of Unani Tibb in India after the establishment of the first Islamic Sultanates in the thirteenth century and in the course of the expansion of the Mughal Empire in the sixteenth and seventeenth century, medicinal preparations of the Perso-Arabic medicine entered Ayurveda's *materia medica*.[10] In the sixteenth century the first influences of European medicine on Ayurveda were recorded, when drugs based on European plants began to enter Ayurvedic pharmacopeia. From the eighteenth century onward, disease patterns derived from European medicine appeared increasingly in Sanskrit medical texts, together with notions of European anatomy and physiology (Meulenbeld 1995: 8f.).

The nineteenth and twentieth century witnessed a 'decline' and subsequent 'revival' of Ayurveda in India, resulting in major transformations of Ayurvedic practice, theory and education. While initially supportive, the British colonial government ceased its support of Ayurvedic practice and education after educational reforms in 1835. As a response to the governmental promotion of biomedicine in the following decades and the increasingly restrictive policy against Ayurveda, proponents of Ayurveda began at the end of the nineteenth century to develop strategies to revive it as an indigenous medical tradition. This period of 'medical revivalism' – part of a larger nationalist, anti-colonial movement – lasted until the middle of the twentieth century and involved the 'biomedicalization' of Ayurveda. Leaders of the revivalist movement promoted Ayurveda as a distinctive Indian medical system in negotiations over what constitutes Indian identity. But at the same time, they adopted many of the structures and institutions of the European medical

[8] This was also claimed by several practitioners I talked to.

[9] For the dispersion and resulting hegemony of biomedicine in colonial and post-colonial India, see e.g. Arnold 1993; Bhattacharya et al. 2005; Ernst 2002b; Harrison 1994; Jeffery 1979, 1982, 1988; Kumar 1998; Leslie 1976b; Leslie and Young 1992a; Naraindas et al. 2014.

[10] Also the diagnostic tool of *nāḍī parīkṣa* found its way into Ayurvedic practice in the thirteenth and fourteenth century. While its appearance is associated with the spread of Unani Tibb by some scholars, its genesis remains unclear (Meulenbeld 1995: 6).

establishment in order to compete with the dominant biomedicine and its underlying natural science paradigms, which by then had become the gold standard in India (Kapila 2010; Prakash 1999). For several decades, a struggle between 'integrationists,' who advocated the incorporation of biomedical concepts and practices into Ayurvedic theory and practice, and 'purists,' who promoted 'pure Ayurveda' without biomedical influences, was fought. It eventually shaped a system of practice and education that comprised biomedical practices, ideas and institutional forms and entailed a 'professionalization' and 'standardization' of Ayurveda. Ultimately, through various government acts and regulations, Ayurveda has been solidified in this professionalized and standardized form after India's independence in 1947.[11]

In the wake of this revitalization, Ayurvedic publishing houses were founded that distribute Ayurvedic knowledge through professional journals, textbooks and popular tracts in vernacular languages (Abraham 2009: 70; Panikkar 1992: 299f.; Reddy 2002: 102), contributing to the increased adaptation of biomedical epistemologies in Ayurvedic theory (Chopra and Quack 2011; Ganesan 2010: 109; Leslie 1992: 179; Naraindas 2006: 2667). Professional associations and research institutions were founded that today apply standards of evidence-based Western medicine to the South Asian medical system (Langford 2002: 103; Manohar 2013; Shankar 2013; Sujatha 2011). In addition, Ayurvedic training moved from informal apprenticeship to formal college education. The *guru-śiṣya-paramparā* or teacher-student tradition, where the student lived and studied in the house of an experienced practitioner for many years, has been replaced by professional training in colleges that lasts five and a half years. Ayurvedic college training is based on a nationwide standardized syllabus which is structured similarly to the curriculum at medical schools and includes biomedical knowledge of anatomy, physiology and pharmacology and practices such as laboratory experiments (Langford 2002: 101-109, 113f.; Leslie 1992: 179; Welch 2008: 129f.; Wolfgram 2009: 66-104, 105f.).[12] The pharmaceuticalization of Ayurvedic medicines is another aspect of Ayurveda's reconfiguration in the twentieth century that is worth noting. In order to revive the indigenous system, proponents of Ayurveda founded pharmaceutical companies for the commercial production of Ayurvedic medicines. Not only did this influence Ayurvedic practice but also its epistemology by transforming Ayurvedic medicines from individualized remedies produced by the Ayurvedic practitioner into general

---

11 See Berger 2013a, 2013b; Brass 1972; Ganesan 2010; Langford 2002; Leslie 1973, 1976a, 1992; Panikkar 1992; Wolfgram 2009; Wujastyk 2008.

12 Although Ayurvedic practitioners without college degree exist (see e.g. Chopra and Quack 2011; Langford 2002; Menon and Spudich 2010; Yamashita and Manohar 2008a, 2008b), virtually all individuals who start their education as Ayurvedic practitioners in India today enroll in one of over 300 governmental and private Ayurvedic colleges in the country (Welch 2008: 129f.).

proprietary medicines[13] manufactured by pharmaceutical firms and addressing biomedically conceptualized disease patterns (Banerjee 2002, 2008, 2009; Bode 2002, 2006; Naraindas 2006: 2667; Wolfgram 2009: 182-225).

The institutionalization and standardization of Ayurveda also shifted Ayurvedic treatment from private practices to governmental and private clinics and hospitals modeled on biomedical institutions, where it underwent a '(re)invention' (Langford 2002: 2).[14] In the wake of this reinvention, biomedical concepts and technologies have been incorporated into clinical Ayurvedic practice. As mentioned above, clinical practice is generally "framed by the language of biomedicine" (Naraindas 2006: 2662), with regard to technical terms and disease patterns as well as their underlying concepts.[15] In these clinics and hospitals, diagnostic procedures are often brief and superficial. They concentrate on symptomatic problems and pre-existing diagnoses rather than a comprehensive investigation of the patient and his/her condition through an elaborate anamnesis. Such an elaborate anamnesis would include a systematic assessment of the patient's lifestyle, daily routine, sleep, digestion and diet, in addition to a comprehensive history and background of the ailment and other diagnostic tools such as pulse or tongue or analysis according to Ayurvedic theory (Langford 2002: 127f.; Mallick 2013; Tirodkar 2005: 168f.). For determining the therapeutic measures, the majority of Ayurvedic practitioners, however, tend to rely on biomedical examinations and laboratory techniques[16] that include radiography, computer tomography, blood tests and the use of biomedical paraphernalia such as stethoscopes or blood pressure monitors.[17] Those technologies, together with the underlying biomedical paradigms, are not only used for diagnosing ailments and establishing a therapy plan but also for assessing the efficacy of the therapy in the course of the treatment. Naraindas demonstrates this dominance of biomedical technologies and argues that their measurements are given more weight by practitioners in determining the health status of the patient than his/her subjective feeling of wellbeing (2006: 2662). Thus, biomedical technologies have a considerable impact on the way health and illness are communicated in clinical Ayurvedic settings.

---

[13] This term refers to medicines industrially produced by pharmaceutical companies on the basis of classic Ayurvedic (*śāstric*) formulas, which have been slightly modified by the companies through which they can claim them their 'property.'

[14] See also Durkin 1988; Langford 1995, 1999, 2002; Leslie 1976a, 1992; Naraindas 2006, 2014b; Nichter 1980; Nichter and Nordstrom 1989; Nisula 2006; Nordstrom 1989; Tirodkar 2005, 2008; Waxler-Morrison 1988; Wolfgram 2009.

[15] See e.g. Langford 2002: 127; Mallick 2013; Naraindas 2006: 2659, 2662, 2014b: 114-120; Nichter and Nordstrom 1989: 381; Tirodkar 2005: 169.

[16] See Chopra and Quack 2011: 19; Langford 2002: 128; Mallick 2013; Naraindas 2006: 2663, 2014b: 120; Tirodkar 2005: 168.

[17] See Chopra and Quack 2011: 19; Leslie 1992: 185; Naraindas 2006: 2662, 2014b: 119; Nichter 1980: 226; Tirodkar 2008: 228.

The superficial investigation of the patient and his/her ailment is also reflected in the treatment. In comparison to those practitioners who claim to practice Ayurveda in a more 'traditional way' that is closer to classic Ayurvedic theory (Tirodkar 2008: 227f.), secondary problems such as constipation, loss of appetite or hair loss[18] are neglected in hospitals and clinics, where treatment usually aims at the major ailment. This eventually results in a greater incidence of 'localized treatment' focusing on specific body parts than a 'generalized therapy' that takes the whole patient into account (Tirodkar 2005: 168, 170). The biomedical influence on Ayurvedic therapy is further visible in the treatment as the latter generally consists of the prescription of industrially produced proprietary medicines targeting biomedical disease categories (Langford 2002: 128; Mallick 2013; Tirodkar 2008: 228, 232). Various scholars have in addition observed that the treatment repertoire of Ayurvedic practitioners includes biomedical drugs such as antibiotics, analgesics, anti-inflammatory drugs or glucose powder.[19] While Naraindas even claims that most Ayurvedic practitioners in Bangalore in the mid 1990s prescribed biomedical medicines (see e.g. Naraindas 2014b: 120), I did not observe this during my research; all Ayurvedic practitioners I met prescribed Ayurvedic medicines exclusively. But even without the prescription of biomedical medicines, Ayurvedic treatment in India has approximated biomedical practice by centering around drug-based therapies instead of dietetics, regimens and *pañcakarma* treatments which, in clinical Ayurvedic practice, increasingly take a back seat to Ayurvedic proprietary drugs (Naraindas 2014b: 112 [Footnote 19]).

These instances of modification of Ayurvedic practice and theory result from processes of adaptation labeled 'syncretism' (Leslie 1992), 'mimesis' (Langford 2002) or 'creolization' (Naraindas 2014b).[20] They only represent a sample of Ayurveda's long history of smaller and larger transformations, which resulted in differences in Ayurvedic theory and practice at local, regional and global scales. For example, diagnosis may be done primarily through Ayurvedic techniques in one clinic, while another clinic in the same neighborhood might follow mainly biomedical technologies due to differences in the practitioners' educational backgrounds, professional experiences or personal preferences. Furthermore, the influence of other – non-biomedical – medical practices, such as various forms of local folk medicines,

---

18 Such problems represent symptoms of the concerned health problem.

19 See Durkin 1988: 493; Leslie 1992: 185; Naraindas 2006: 2663; Nichter 1980: 226; Van der Geest and Whyte 1989: 347.

20 This transformation is determined by processes of 'asymmetrical conversations' (Naraindas et al. 2014) between biomedicine and Ayurveda, with the latter representing the 'inferior system' due to the historically institutionally grown dominant position of the former in India and worldwide. See the edited volume by Naraindas et al. (2014) for theoretical discussions and ethnographic examples of such asymmetries between and within biomedicine, Ayurveda, psychiatry and ritual healing.

may shape Ayurvedic treatment variously in different regions (Nichter and Nordstrom 1989; Nisula 2006: 209f.; Sax and Bhaskar Nair 2014). Finally, regional differences due to distinct local histories of medical practice also result in specific regional forms of Ayurvedic practice.[21]

These instances point to Ayurveda's dynamic nature that includes "multifaceted approaches to healing [...] [that] develop to meet the constantly changing needs of the society and of illness patterns" (Nordstrom 1988: 479; addition by the author), unrestricted to the Indian subcontinent. Indeed, Ayurvedic practice and theory has also spread outside South Asia in the last three decades, resulting in the emergence of Ayurvedic treatment forms that differ from Ayurveda practiced in South Asian clinics and hospitals. Frederick Smith and Dagmar Wujastyk present three developments of a so-called "global Ayurveda" (Smith and Wujastyk 2008). The first one dates back to the sixteenth century, when Europeans became interested in Ayurvedic *materia medica* and Ayurvedic botanical and pharmaceutical knowledge was transferred to Europe as a result. The second occurred in the academic realm. In the early nineteenth century, Orientalist scholars started to become interested in Ayurvedic literature and in preserving and reviving Ayurvedic knowledge. Later Ayurveda became an object of research in academic disciplines such as Medical Anthropology (1970s) and Ethnopharmacology (1980s). The latest development is the spread of Ayurvedic practice in North America and Europe, which has resulted in a "globally popularized and acculturated Ayurveda" (Smith and Wujastyk 2008: 3, 2-4).

The global popularity of Ayurveda surged in the 1980s, when it was introduced to Europe and North America in the form of Maharishi Ayurveda.[22] This specific version of Ayurvedic practice and theory was developed in the mid-1980s by Maharishi Mahesh Yogi, the founder of the Transcendental Meditation movement. It is characterized by a 'holistic approach' that emphasizes consciousness as the basis of health and on the related practice of Transcendental Meditation. Through the foundation of local organizations and the establishment of Ayurvedic health centers in North America and Europe, Maharishi Mahesh Yogi spread Ayurvedic ideas and practices on both continents (Humes 2008; Jeannotat 2008; Koch 2005; Newcombe 2008; Schmädel 1993; Stollberg 2001).[23] In addition, popular writers like Deepak Chopra and David Frawley promoted Ayurveda in Europe and especially

[21] For instance, in Kerala the *materia medica* virtually lacks of mineral and metallic elements and includes many medicines prepared from local plants that are not mentioned in classic Ayurvedic texts (Abraham 2009: 69).

[22] Ayurvedic medicine has also been transferred to Europe through South Asian immigrants, especially to Great Britain (Bhopal 1986; Newcombe 2008: 258, quoting Mahomet 1997: 155-156, 169-171; Reed 2002; Stollberg 2001: 6-8).

[23] Today, Maharishi Ayurveda is one of the most popular forms, organizations, and trademarks of Ayurveda in the Euro-American world. For detailed presentations of Maharishi Ayurveda, see Humes 2008; Jeannotat 2008; Newcombe 2008; Sharma and Clark 1998; Skolnick 1991.

in the United States by founding schools and institutes for training and practice, giving public talks and publishing books on particular versions of Ayurveda they had developed and popularized as specific brands (Reddy 2002: 102; Warrier 2011: 87).

Ayurveda's increasing popularity in the Euro-American world occurred against the backdrop of a general increase in the use of complementary and alternative medicine in the last decades of the twentieth century.[24] The reasons for this growth are diverse. They include on the one hand a shift from a focus on therapeutic treatment to health maintenance and illness prevention along with the wish of 'balancing of body and mind,' and on the other hand a dissatisfaction with biomedical treatment, mainly with respect to the limits of its effectiveness, perceived side-effects, and concerns about the objectification of the patient (Cant and Sharma 1999: 192; Saks 2008: 31-35).[25]

People looking for alternatives found them especially in Asian medicines, which are regarded as 'holistic,' i.e. integrating body, mind and soul, and as linking health to the wider social and physical context instead of reducing it to biochemical processes (Saks 2008: 32). This resulted into the "CAMinisation" of Ayurveda (Bode 2013: 21). In the course of a "growing disillusionment with biomedicine" (Warrier 2011: 86), Ayurveda became a "holistic alternative to biomedical orthodoxy" (Reddy 2002: 97, 102) and an "alternative to the harshness of biomedicine" (Zimmermann 1992: 209) in various places outside South Asia (see e.g. Frank and Stollberg 2002: 227f.).

In spite of the growing popularity of Ayurveda in the Euro-American world, not many studies on Ayurvedic practice 'in the West' exist so far. Selected contributions to Wujastyk and Smith's edited volume *Modern and Global Ayurveda: Pluralism and Paradigms* (2008) address different aspects of Ayurveda as a global phenomenon, such as Ayurvedic education in the United States and the United Kingdom (Svoboda 2008; Welch 2008), the use of Ayurvedic *materia medica* and legal regulations of Ayurvedic practice in Great Britain (Newcombe 2008; Pole 2008) or the history of Maharishi Ayurveda in North America and Europe as well as Ayurveda's 'spiritualization' in the course of its transfer to the Euro-American world (Humes 2008; Jeannotat 2008; Newcombe 2008). While these and similar topics have also been investigated by other scholars,[26] ethnographic studies on Ayurvedic practice outside South Asia are rare and have been primarily conducted in the German context.

[24] See e.g. Barnes et al. 2004; Eisenberg et al. 1993; Joos et al. 2008; Sharma 1992.

[25] For the motivations of physicians for practicing non-biomedical medicines in Germany see Frank and Stollberg 2006; Stollberg 2010; Thanner 2010.

[26] See Chalmers 1990; Reddy 2002; Schmädel 1993; Skolnick 1991; Stollberg 2001; Warrier 2009, 2012, 2014; Wujastyk 2005; Zysk 2001.

Scholars have studied the reasons why patients seek clinical Ayurvedic treatment in Germany and how they experience and make sense of it (Chopra 2005a; Frank and Stollberg 2002, 2004b; Naraindas 2011a, 2011b), and why practitioners offer Ayurvedic treatment as well as how they adapt it to local legal and infrastructure conditions.[27] As in South Asia, dissatisfaction with biomedical treatment leads patients in many cases in Germany to seek Ayurvedic treatment (Frank and Stollberg 2002: 228f.). The disease patterns that draw patients to an Ayurvedic practitioner also resemble those in South Asia, with musculoskeletal disorders and skin diseases being common complaints, but also include other concerns such as stress-related fatigue, insomnia, allergies or obesity (Chopra 2005a: 40 [Table 1], 2008: 248 [Table 14.2]; Frank and Stollberg 2002: 227, 2004b: 85). Like patients seeking Ayurvedic treatment in South Asia, most German patients tried biomedical treatment first (Frank and Stollberg 2002: 227, 2004b: 85; Naraindas 2011a: 78). In many cases, patients' choice of Ayurvedic treatment was influenced by former positive experiences with other non-biomedical therapies such as Traditional Chinese Medicine or Homeopathy (Frank and Stollberg 2002: 228).

In the course of its transfer to Germany, Ayurvedic practice has been reconfigured. Complex therapeutic interventions like *pañcakarma* are carried out only by a few Ayurvedic practitioners in Germany since they involve great effort (Frank 2004: 211f.); and those *pañcakarma* therapies that are conducted[28] are divested of rigorous elements like emetics and purgatives (Frank 2004: 212f.; Frank and Stollberg 2002: 224, 241, 2004a: 82; Otten 1996). As a result, Ayurvedic treatments, stripped of their harsh elements, assume a shape of gentle and 'non-violent' features that focus on soothing massages and external oil applications (Stollberg 2005: 1), which has been metaphorically described as the "flower power of Āyurveda" by Francis Zimmermann (1992).

Another major characteristic of Ayurvedic treatment in the Euro-American world is the emphasis on nutritional regimens rather than the application of internal medicines. This is partly due to legal restrictions on the administration of Ayurvedic medicines, together with difficulties in their acquisition.[29] This results in a profound difference in Ayurvedic

[27] See Chopra 2005a, 2008; Frank 2004; Frank and Stollberg 2004a, 2006; Naraindas 2011a, 2011b; Otten 1996.

[28] According to Naraindas, *pañcakarma* represents the main in-patient Ayurvedic treatment in Germany (2014b: 112 [Footnote 19]). Also the German Ayurvedic physician and scholar Ananda Samir Chopra claims that *pañcakarma* is a primary treatment in his Ayurvedic hospital (Chopra 2005a: 40).

[29] See e.g. Chopra 2008: 246; Frank 2004: 208, 244-246; Frank and Stollberg 2004a: 82; Stollberg 2005: 1; Warrier 2009: 442f. For a brief description of the legal situation for the sale and promotion of Ayurvedic medicines in Britain see Newcombe 2008: 277f., citing Medicines Control Agency, Government of the United Kingdom 1996, 2001a, 2001b; Pole 2008; Stone and Matthews 1996. For the availability of Ayurvedic medicines in Germany, see Frank 2004: 209-211 and Frank and Stollberg 2004a: 82. And for recent developments in the European Union see Banerjee 2009.

therapy inside and outside South Asia. While in India the emphasis in Ayurvedic therapy is on the administration of medicines, with nutritional regimens playing only a minor role, in Germany and the United Kingdom this relationship is reversed. The practitioners interviewed by Robert Frank replaced herbs and vegetables from India with local ones, e.g. a specific type of basil with one that grows in Germany, or coriander with parsley (2004: 208f.). In this way, various "new" herbs and vegetables were, through their therapeutic usage, incorporated into the local Ayurvedic *materia medica*. In the United States, Ayurvedic dietary regimens also seem to take a prominent position in Ayurvedic practice (Reddy 2002: 107f.; Zysk 2001: 16, 20). Hence, the focus on nutritional regimens and the designing of a diet according to one's 'personal constitution' *prakṛti* (a basic Ayurvedic concept discussed in Chapter 2), absent in South Asian clinical contexts, seem to play a major role in Ayurvedic practice and theory in the Euro-American world.

In addition to its focus on dietetics, Ayurveda outside South Asia is partially characterized by 'spiritual elements.' While Ayurvedic treatment on the Indian Subcontinent today generally seems to be a "de-spiritualized" and 'de-ritualized' practice (Naraindas 2014b: 112 [Footnote 19]; though see Sax and Bhaskar Nair 2014),[30] the spread of Ayurveda in the Euro-American world through charismatic proponents such as Maharishi Mahesh Yogi, Deepak Chopra or David Frawley, who incorporate different 'spiritual' and religious elements in their teachings, resulted in an institutionalization of Ayurveda as an "esoteric and spiritualized practice" (Naraindas 2014b: 112 [Footnote 19]), especially in North America.[31] In many ways, the fertile soil for planting the Ayurvedic seed in America was prepared by the loose cluster of beliefs and practices labeled the 'New Age Movement,' characterized by ideas combining Asian philosophies and religions with Western science and human potential psychology to achieve personal transformation and empowerment (Reddy 2002: 100). These forms of Ayurveda have been subsumed under the 'New Age Ayurveda' label.[32] Situated "between medicine and metaphysics" (Reddy 2002: 99), the promoters of those forms of Ayurveda sell the content of classical Ayurvedic texts as 'authentic Ayurveda' and 'eternal knowledge' (Warrier 2011: 87; see also Baer 2003).

The multiplicity of Ayurvedic practice in Europe and North America is largely due to the lack of standardized education in Ayurveda and recognized licensing of Ayurvedic practice.

[30] Although no empirical data on the role of religious and spiritual elements in pre-colonial Ayurvedic practice exist, some authors claim that religious and ritual practices were part of Ayurveda until they were gradually and systematically eliminated in the course of Ayurveda's 'modernization' in the nineteenth and twentieth centuries (see e.g. Leslie 1976a: 360; Naraindas 2014b: 112 [Footnote 19]).

[31] While Anne Koch claims that also in Germany Ayurveda is often linked to spiritual aspects (Koch 2005, 2006), they seem to be less pronounced than in North America.

[32] See e.g. Chopra 2005a; Reddy 2002; Smith and Wujastyk 2008; Zysk 2001.

A massage therapist or Reiki practitioner in the United States may incorporate certain 'Ayurvedic massage techniques' in his/her repertoire or assess the client's 'constitution' *prakṛti* and eventually create a new form of Ayurvedic practice (Welch 2008: 136f.). Moreover, by characterizing Ayurveda as a religious healing system, licensing and regulation that are usually necessary for medical practices are circumvented (Reddy 2002: 102, 108).[33] A similar picture exists in the realm of Ayurvedic education in the United States. Due to the lack of national educational standards, institutions that offer Ayurvedic training have their own educational guidelines and programs (Reddy 2002: 102; Welch 2008: 133, 136), which eventually contributes to the existence of multiple forms of Ayurvedic practice.

A similar scenario prevails in most European countries, where standardized education in Ayurvedic medicine and recognized licensing of Ayurvedic practitioners or Ayurvedic treatment barely exist. However, in some countries there have in recent years been initiatives to change this. The British government for instance established minimum standards and regulations for practitioners of all alternative and complementary therapies, while the Ayurvedic Practitioners Association, founded in 2005 to become the most important Ayurvedic professional association in the United Kingdom, takes an active role in unifying the variously qualified Ayurvedic practitioners (Newcombe 2008: 276-278). However, as Maya Warrier shows, 'medical' and 'spiritual' versions of Ayurveda exist side by side in the United Kingdom (Warrier 2014). The lack of standardized Ayurvedic training in most European countries further contributes to the multiplicity of Ayurvedic practice on the continent. Here again, Great Britain seems to represent an exception where standardized education, based on a syllabus used in Ayurvedic colleges in India, has recently been introduced at the Ayurvedic University of Europe and the College of Ayurveda, both in London (Warrier 2009: 428f.).[34]

The largely unregulated realm of Ayurveda in the Euro-American world has not only resulted in the emergence of different forms of clinical Ayurvedic practice and self-help procedures like dietary regimens, but also to a shift of Ayurveda to the realm of day spas, massage salons and beauty parlors. On the way to my office at Heidelberg University, I pass by a massage and beauty parlor that offers "Beauty – Wellness – Massage," as the description

[33] By representing a metaphysically oriented alternative medicine, Ayurveda is grouped by most state provider practice laws under the statutory classification of 'nonmedical health professions,' which grants practitioners the status of legally defined religious healers with a legitimate focus on healing, counseling and advising – without being allowed to diagnose and treat patients through the prescription of medicines (Reddy 2002: 105f., quoting Cohen 1996).

[34] Another exception was the introduction of training as *Facharzt für Ayurvedische Medizin* (doctor of Ayurvedic medicine) at the Kerala Ayurveda Akademie in Castrop-Rauxel in Germany in 2004, a specialization program for medical school graduates jointly organized with the Universities of Witten-Herdecke, Münster und Bochum (Koch 2006: 170, 182 [endnote i]).

in the window reads, and promises "total recreation for body, mind and soul" (original in German)[35] in its brochure. This is said to be achieved through fruit acid exfoliation, aromatic oil massage, or different Ayurvedic applications like Ayurvedic reflexology or 'Ayurvedic head, face, neck, and décolleté treatment.' This parlor provides an example for the transformation of Ayurveda from a clinical practice into a beauty and wellness treatment with its therapeutic elements diminished in favor of providing a pleasurable experience (see also Stollberg 2005: 1). The dominance of wellness-related Ayurvedic practice in Germany is clear from the list of Ayurvedic practitioners registered in the European Professional Association of Ayurveda Practitioners and Therapists VEAT (n.d.), which contained 212 Ayurvedic practitioners in the category of "Ayurvedic wellbeing (health promotion, massage and wellness)" in November 2013, but only 35 in the field of "Ayurvedic medicine (diagnosis, medical consultation, panchakarma, clinical therapy)."

Ayurvedic treatment has found its way into the realm of wellness, massage and beauty parlors in other countries as well (see e.g. Jeannotat 2008: 285). In most European cities, Ayurvedic treatments offered in massage or beauty salons can be spotted, be it a "royal massage" represented by photos of *kiḻi* in a Thai massage parlor in Prague, an "Ayurvedic powder peeling" in a beauty parlor in Warsaw, or an "Ayurvedic acupressure massage" in a massage parlor in Vienna. In Switzerland for instance the prevalence of wellness-related Ayurveda is revealed by the small number (9) of Swiss practitioners registered with VEAT in the category 'Ayurvedic medicine' in contrast to the high number (97) in the category 'Ayurvedic wellbeing' (European Professional Association of Ayurveda Practitioners and Therapists n.d.).

Martha Ann Selby documents similar developments in the United States in her analysis of the modification of Ayurvedic ideas of woman's health in the course of Ayurveda's transfer to the United States. She illustrates that medical notions from classical Ayurvedic texts have been transformed into notions of beauty, with spa-based commodities in the American cosmetics and wellness industry being a manifestation of this transformation (Selby 2005).[36] Selby attributes a crucial role in the emergence of Ayurvedic cosmetics to regulations established by the United States Food and Drug Administration (FDA). The FDA includes warning letters, consumer advisories, and refusal reports for many Ayurvedic medicines produced in India on its website (Selby 2005: 122, citing the website of the FDA),

35 All written and oral quotations in German have been translated by the author.

36 Smith and Wujastyk also point to the prevalence of this new form of Ayurveda in both Europe and North America, which they describe as "[...] a new commercialized form of Ayurveda, emphasizing wellness and beauty as fundamental components of good health" (2008: 3).

and Selby concludes that it

> [...] is likely that this sort of constant watchdogging by the U.S. government has led to the import and/or the stateside manufacture of noninvasive, nonconsumable 'for external use only' items that would fall under the cosmetic category – soaps, shampoos, make-up, lotions, skin-care items, and so on (Selby 2005: 122).

While the strict regulations for Ayurvedic medicines may be one reason for the emergence of an Ayurvedic wellness and cosmetics industry in both the United States and Europe, an additional one might also be laissez-faire government politics when it comes to Ayurvedic education and practice. Due to the lack of recognized standards, the practitioner's range of practice is neither protected nor specified. And since Ayurveda is not a licensed health care procedure, massage therapists can incorporate the usage of 'Ayurvedic oils' and 'Ayurvedic massage strokes,' enabling Ayurveda to enter the stage of beauty and massage parlors. At the same time, the 'flower power of Ayurveda' – its transformation into a gentle treatment with a focus on soothing massages – might have also facilitated Ayurveda's transfer from clinical settings to the field of wellness, where it is adapted to the clients' search for pleasure and indulgence.

To summarize, with its transfer from South Asia to the Euro-American world, Ayurveda has been de- and re-contextualized. Multiple forms of Ayurvedic practice have evolved that are situated in the realm of alternative and complementary medicine centered around nutritional regimes, gentle external treatments and spiritual elements on the one hand, and on the other hand in the wellness and beauty industry through oil massages and cosmetic applications. They contribute to the global diversity of Ayurveda, that constitutes also in South Asia "a plural medical system in itself" (Nordstrom 1988: 480).

Here I should note that I do not regard particular forms of Ayurveda as less 'authentic' than others or even as 'diluted versions' of an 'authentic Ayurveda,' as does Koch who speaks of "German Ayurveda*s*" in the plural when referring to different forms of Ayurvedic practice and knowledge in Germany (Koch 2005; original in German, emphasis by the author). Instead, I see Ayurveda as a 'boundary object.' This concept was developed by Susan Star and James Griesemer in order to analyze the confluence and interaction between different communities or social worlds. Boundary objects are concrete or abstract items that are on the one hand characterized by local plasticity as they are defined and interpreted differently by different social groups. On the other hand, they include a firm and stable core that gives them a global identity and enables interaction between these groups (Star and Griesemer 1989). Star and Griesemer described boundary objects as

> [...] both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use,

> and become strongly structured in individual-site use. [...] They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation" (Star and Griesemer 1989: 393).

Boundary objects are thus characterized by coexisting homogeneity and heterogeneity. Their global coherence functions as a bridge between groups while their local plasticity promotes flexibilities in terms of interpretation and practice. They are adapted to the specific context and purpose, while allowing at the same time cooperation between different social worlds without necessarily requiring a consensus about the boundary object (Clarke and Star 2008: 121). The concept of boundary objects has been applied in various realms. Examples include: climate models (Shackley and Wynne 1996), organizations (Moore 1996), food labels (Eden 2011), or notions of resilience (Brand and Jax 2007) and competition (Langenohl 2008). Also Ayurveda can be conceptualized as a boundary object useful for understanding Ayurveda's global diversity and for regarding the different forms as distinct versions of Ayurvedic practice – i.e. no version being more 'diluted' or 'authentic' than another. It can explain the simultaneity of Ayurveda's local plasticity illustrated by the different practices of various groups and actors and Ayurveda's global coherence through common core elements, such as *tṛdoṣa* theory or oil applications. Hence, the conceptualization of Ayurveda as a boundary object that different groups and actors can attach dissimilar meanings, histories and practices while being considered Ayurvedic, circumvents an essentialist view on Ayurveda while emphasizing the tantamount nature of its multiple forms.

This global diversity of Ayurveda has been categorized in various ways by different authors. Smith and Wujastyk (2008) differentiate between 'modern ayurveda' and 'global ayurveda.' They describe 'modern ayurveda' as having emerged with the professionalization and institutionalization of Ayurveda in the Indian subcontinent. It is "characterized by a tendency toward the secularization of ayurvedic knowledge and its adaptation to biomedicine, and at the same time by attempts to formulate a unitary theory based on doctrines found in the classical ayurvedic texts" (Smith and Wujastyk 2008: 2). 'Global Ayurveda' by contrast is characterized by the diversity of Ayurveda outside of India resulting for example into what they refer to as "New Age Ayurveda" and Maharishi Ayurveda (Smith and Wujastyk 2008: 2, 11-17). Chopra likewise juxtaposes Ayurveda as "an independent professionalized medical system" and "a traditionally taught medical science" in India with Ayurveda as wellness practice and "New Age Ayurveda" in Europe and North America (2005a: 41; original in German). A similar categorization is provided by Tirodkar, who

categorizes the global prevalence of Ayurvedic practice into 'traditional,' 'modern,' 'self-help' and 'commercial' (2008: 227-230). By 'commercial ayurvedic practices,' Tirodkar means health spas and resorts in India, which primarily offer "health-promoting services" for mostly foreign clients, mainly in the form of 'stress-management' and 'rejuvenation packages,' other relaxation therapies, nutritional counseling and oil massages (2008: 228f.).

With the growing popularity of Ayurveda outside South Asia, the interest in receiving Ayurvedic treatment in its region of origin has also increased in the last years. Jean Langford provides a brief examination of the interaction between European and American patients and Indian practitioners in her analysis of "the modernization of Ayurveda" (2002: 1) in post-colonial India (2002: 56-60). Langford also describes an Ayurvedic doctor who offers treatments for foreigners at a resort hotel in a popular tourist destination in Kerala in order to explore how the interaction between the practitioner and the patients led the doctor to think of Ayurvedic treatment as a 'cultural commodity' for the 'imagined cultural emptiness' of his foreign clientele (2002: 3, 263-266, 269, 2013). But Langford offers only a limited glimpse of the actual practice, the intentions of the patients and their understanding of Ayurveda – critical gaps that this dissertation fills.

While Langford's research took place at a time – during the first half of the 1990s – when the institutions specializing in Ayurvedic treatment for foreigners were just emerging, today there are a multitude of such 'Ayurvedic resorts.'[37] They differ from clinical institutions not only due to their holiday resort-like facilities and picturesque environment, but also by virtue of their orientation towards a predominantly foreign clientele. Primarily located in Kerala, they represent a unique space, producing new forms of Ayurveda through the interaction between foreign guests, local practitioners and other human and non-human actors, as shown in later chapters.

While Ayurvedic resorts represent an integral component of the Keralan Ayurvedic landscape, ethnographic accounts of Ayurvedic resorts are rare. Most of the few existing

[37] Officially labeled 'Ayurveda Health Centers' by the Keralan government (see e.g. Department of Tourism, Government of Kerala 2013), various other names such as Ayurvedic (health) spas, Ayurvedic retreats or Ayurvedic (health) resorts circulate in public and academic discourse. Based on criteria such as size, setting, organization and treatments offered, Purba Rudra established a typology that includes 'Ayurvedic resorts,' which resemble holiday resorts in their set-up and ambiance but which "lay stress on Ayurvedic treatment," 'resorts/hotels with Ayurvedic centers,' where Ayurveda "is just another service that is offered," and 'small Ayurvedic massage centers,' which usually do not provide accommodation and whose scope of treatment is much smaller (Rudra 2011: 61f.). The most frequently used designation in public discourse during my research in Kerala for those institutions that provide Ayurvedic treatment and offer accommodation for their guests – thus differentiating themselves from "small Ayurvedic massage centers" – was 'Ayurvedic resorts' or 'Ayurveda resorts.' The majority of resort owners, managers, practitioners, therapists, employees of Kerala's tourism department and visitors used this term when referring to Ayurveda Health Centers – no matter if they were exclusively visited by guests for Ayurveda or also by other tourists who did not undergo any treatment. For this reason I will use the term 'Ayurvedic resort' in this work.

studies have been conducted in the fields of tourism (management) studies and economics and provide mostly quantitative data primarily on the embedding of Ayurvedic resorts in Kerala's tourism industry and their economic potential. Priyaa Ravikanth for example discusses the introduction of quality control standards and regulations of Ayurvedic practice by the Kerala tourism board and the state government (2008: 174f.). The author claims that foreign tourists "are deceived" by a "commercial product" that lacks of basic principles of Ayurveda (2008: 183, 194), concluding that "such commercialization and exploitation only harms this traditional science" (2008: 184). V. T. Bindu et al. investigated the satisfaction, motivations and sources of information of 88 guests at five Ayurvedic resorts in Kerala through a survey based on a structured questionnaire (2009: 68). They found that the major motivations for visits were "leisure," "health" and "nature," and correspondingly, the most popular treatments were 'rejuvenative and stress management,' 'anti-ageing,' 'detoxification,' 'slimming' and 'beauty care,' without further elaboration (Bindu et al. 2009: 69-71). Ramesh U and Kurian Joseph investigated the infrastructure and the market potential of "Ayurveda based wellness tourism" in Kerala (2011, 2012). Based on a survey conducted in 110 'wellness centers' and data collected in state tourism institutions, an Ayurvedic college and the Directorate of Indian Systems of Medicine, Ramesh and Joseph provide statistical data of resort guests including their age (the majority being over 40 years old), origin (the majority coming from England, followed by Germany) and the length of the tourists' stay in Kerala (the majority staying between 16 and 20 days) (2011: 216-219), as well as on the resorts: for example their location, the qualification of the practitioners, number of staff and visitors and methods of price fixation (2012: 32-35). Ramesh and Joseph also claim that treatment decisions are made jointly between the doctor and the patient in most cases (70 percent), and that the majority of visitors have "adequate knowledge" of Ayurveda before their arrival at the resort (77 percent of the interviewed doctors stated that) (2012: 35f.). The authors define the practice at the resorts as "[w]ellness holiday [...] [that represents a] [...] rejuvenation and clean up process on all levels – physical, mental and emotional" (Ramesh and Joseph 2012: 29), without providing more details on specific practices. Similarly, Rudra regards the treatment in Ayurvedic resorts as 'wellness practice' under which she subsumes "all de-stress, de-toxification, relaxation, and other preventive care therapies," (2011: 63). While she claims that the resorts offer services "for people ranging from those in need of serious treatment to casual experimenters who just want to get an introduction to Ayurvedic healing," the majority of visitors came for unspecified "wellness/rejuvenation therapies" (Rudra 2011: 61, 63).

Tirodkar's study into Ayurvedic resort practice as part of her research on contemporary Ayurvedic practice in Maharashtra represents one of the few existing ethnographic accounts of Ayurvedic resorts (2005: Chapter 6, Part III, 2008). Her study took place at a resort in a mountainous region near Pune during a month-long visit, as well as at five Ayurvedic resorts and day spas in Maharashtra, Kerala and Bangalore. The resorts were attended by upper-middle or upper class Indians from nearby cities and by foreign guests, primarily for "a relaxation and rejuvenation vacation break" (Tirodkar 2008: 233).[38] Those "feel-good treatments" (Tirodkar 2005: 188) involve hardly any diagnosis or medical prescription, and *pañcakarma* applications like *vamana* (vomitus), *virecana* (purgation), and *raktamokṣaṇa* (bloodletting) are not administered at all as they are perceived as being too 'violent' (Tirodkar 2005: 84, 2008: 229). The emphasis of Ayurvedic practice in those resorts and day spas has, according to Tirodkar, "shifted away from illness prevention and treatment and lies more on rejuvenation" (2008: 229).

An additional anthropological study is provided by Islam, who studied a 'holistic health village' near Kolkata (Islam 2008, 2012). This resort is indeed a 'village' spreading over 120 acres with privately-owned housing units that are owned by affluent Indians looking for "a traditional Vedic way of life" and "body-mind-sprit [*sic*] holism" (ibid 2008: 211), and rented out to Indian and foreign tourists. A major focus of the 'health village' lies in Ayurvedic treatment, which is promoted as a "holistic healing and wellness treatment programme," enriched by New Age elements like daily prayers and yoga sessions (ibid 2008: 213, 214). Islam considers Ayurveda at the village to be "an alternative healing for rejuvenation, and [...] an attractive New Age health product," which has been shaped by Ayurvedic practice prevalent in the Euro-American world (2012: 230). He concludes from his findings that Ayurveda at the village represents mostly a "consumer product," which is rather perceived by the guests as "relaxation therapy" than as medical treatment (Islam 2008: 230, 2012: 227).

In her study on 'Ayurvedic tourism in Kerala,' Denise Spitzer, supporting Langford's and Islam's findings, describes Ayurveda as a "tonic of the East [that] is offered as a balm for those infected by the stressful lifestyle of the West" (2009: 149). On the base of visits to different Ayurvedic resorts and interviews with various stakeholders of Kerala's tourism industry, Spitzer investigated how Ayurveda is deployed as "an identity marker of the Indian nation-state" (ibid: 139). By selling Ayurveda as a living heritage, 'Ayurvedic tourism' in Kerala is considered as a means to foster economic growth in the private sector

[38] The term 'rejuvenation' is a buzzword in the Ayurvedic resort industry, as I will discuss below.

and on the state level (ibid: 142f.). Indicating the success of this marketing, the tourists Spitzer interviewed considered Ayurveda as grounded in Indian or, more specifically, Hindu heritage (ibid: 146, 149). This applied particularly to visitors with Keralan roots living abroad who sought treatment connected to their native place and to 'Keralan culture' (ibid: 147, 148). While non-resident Indians and North Indians usually came for treating chronic health problems after having previously tried other treatments, Spitzer found that foreigners, including visitors from North America and Europe, primarily wanted to "recharge their batteries" (ibid: 143). Though Spitzer mentions that resort operators, clients and doctors collaboratively reconfigure Ayurveda (ibid: 148, 149), she does not elaborate on this point, and in fact does not investigate how Ayurveda is practiced at these resorts.

While Ayurvedic resorts represent a new development in the Indian Ayurvedic landscape, they are also part and parcel of a global Ayurvedic sphere that is constantly created and re-created through transnational encounters and entanglements to produce a global multiplicity of Ayurvedic practices, knowledge and institutions. This transnational Ayurvedic space represents an Ayurvedic 'medicoscape' – a term coined and defined by Viola Hörbst and Angelika Wolf that draws from Arjun Appadurai's concept of '-scapes' (Appadurai 1990):

> [...] globally scattered landscapes of persons and organizations in the health care sector, capable of being locally condensed in one place, but also of connecting spatially distant places, persons and institutions. They include individuals who seek and offer therapy on an international scale, globally acting pharmaceutical companies, the WHO as global guardian of biomedicine, organizations of so-called traditional healers, regional healing practices and their adaptation at other places, globally spread forms of therapy as well as organizations of international development cooperation in medical areas. They are all part of heterogeneous medical flows, which transcend cultural and national boundaries and produce changes on local level, which can in turn have globalizing repercussions (Hörbst and Wolf 2003: 4; original in German).

In the last two decades, various authors have analyzed different aspects of health, illness and healing through the lens of transnational exchanges and circulations of people, ideas, objects and practices. Today, such exchanges are widely acknowledged as vital parts of contemporary and historical health care practice and knowledge formation.[39] Through the introduction of the concept of 'medicoscapes,' Hörbst and Wolf aimed at grasping the creation of health-related knowledge and practice through transnational, transcultural and translocal interactions and circulations. I consider this concept a fruitful analytical framework for capturing the transnational Ayurvedic space that is characterized by persistent and intermittent linkages between people, institutions, objects, ideas and places and interrelated processes and practices across international borders that shape the multiple manifestations

[39] For discussions on transnational Asian health care practice and knowledge see e.g. Alter 2005a; Connor and Samuel 2001; Ernst 2002a; Frank and Stollberg 2004a; Høg and Hsu 2002; Leslie and Young 1992b; Newcombe 2012; Stollberg 2002; Zhan 2009.

of Ayurveda worldwide, be it laboratory research in the drug standardization unit of an Indian Ayurvedic college, a silk glove massage in a German Ayurvedic center or the self-assessment of *prakṛti* with the help of a popular book on Ayurvedic theory in the United States.

The variety of Ayurvedic practice and knowledge is shaped by transnational exchanges mediated by institutions (e.g. the FDA or the Indian government), people on the move (e.g. the Indian Ayurvedic practitioner organizing a workshop on Ayurvedic nutrition in Switzerland or the German tourist taking an Ayurvedic massage in Sri Lanka), traveling knowledge (e.g. representations of Ayurvedic treatment in an Italian news magazine or Ayurvedic concepts taught in an online seminar) and circulating objects (e.g. an Ayurvedic medicine introduced in the Netherlands through an Indian pharmaceutical company or the classical Ayurvedic treatise *Carakasaṃhitā* ordered by an Austrian physician interested in Ayurvedic theory). The spatial transfer of people, objects and knowledge in the form of "heterogeneous [...] flows, which transcend cultural and national boundaries" (Hörbst and Wolf 2003: 4; original in German) in combination with a general mutability of health care results in a wide array of Ayurvedic institutions, practices, objects and knowledge that are enacted on a local level and that constitute a global 'Ayurvedic medicoscape.'

The formation of these 'glocal' (see Robertson 1995) forms of Ayurveda however does not effortlessly and instantly happen through the mere floating of people, things and ideas within a transnational Ayurvedic space but stems from interactions and negotiations between concrete actors – human and non-human, mobile and immobile – within a set location. Only when those actors "present themselves locally condensed in one place" (Hörbst and Wolf 2003: 4; original in German) – a hospital, a massage parlor or a virtual class room – and connections are established, developed and crystalized, do new or reconfigured Ayurvedic institutions, practices and knowledge emerge.

These 'sites of production of Ayurvedic institutions, practice and knowledge' are 'spaces of connectivity,' as Laurent Pordié calls those spaces where transnational networks and circulations converge, connectivity between geographically mobile and immobile actors intensifies and institutions, practices and knowledge are formed (Pordié 2013). By introducing this notion, Pordié emphasizes the interplay between transnational circulations of people, objects and ideas on the one hand and their "anchor[ing] in specific (but changing) grounded spaces" (2013: 9) on the other for the formation of new kinds of medical practice, knowledge and institutions. While transnational circulations, or movements within medicoscapes, are important for this formation, it is immobile actors like physicians or massage therapists

who 'ground' those circulating things and concepts within concrete intersections of the transnational networks such as hospitals or massage parlors and shape and stabilize these institutions together with their practices. The institutions represent spaces of connectivity that foster transnational exchanges and "allow transnationalism to actually take *place*" (ibid: 11, 12).

Such spaces of connectivity include Ayurvedic resorts in India, where 'Ayurvedic transnationalism' takes place through an agglomeration of the global Ayurvedic medicoscape in the course of "the sum of intermittent connections and bodily co-presence" (Pordié 2012: 210) among Indian and non-Indian actors, producing transnational forms of Ayurvedic practice and knowledge. On the first sight, resorts appear as "enclavic spaces" (Rudra 2011: 136) as they are often situated in remote or insular tourist spaces and the interaction between the guests and the local population is usually minimal. But they can also be understood as 'contact zones' or 'trading zones' (Burke 2009: 72, following Pratt 1992 and Galison 1997) where transnational forms of Ayurveda are generated through intercultural encounters between residing and transient people who meet at a particular moment in time (Pordié 2013: 18) and the concentration of transnational Ayurvedic networks and circulations. It is in these 'nodal points' (Pordié 2013) of the transnational Ayurvedic space that 'long-distance interconnectedness' (Hannerz 1996) between various elements of this space can be localized and becomes palpable. Through the interaction between 'mobile' resort guests and 'immobile' practitioners, therapists and resort management,[40] their experiences with different forms of Ayurvedic knowledge, practice, objects, institutions and media representations – made in Indian college class rooms, German beauty parlors or the translocal space of the internet – are exchanged, translated, and negotiated to ultimately produce new forms of Ayurveda that both represent and shape agglomerated versions of the global transnational Ayurvedic space. In this way, Ayurvedic resorts represent transnational micro-spaces that are part of the comprehensive transnational Ayurvedic macro-space.

In what follows, I analyze how such transnational Ayurvedic spaces relate to each other by investigating practice and knowledge formation in Ayurvedic resorts, which has thus far been "woefully under-researched" (Warrier 2011: 86). What are the key elements of the transnational Ayurvedic macro-space that take shape in these Ayurvedic micro-spaces and in which ways do they inform Ayurvedic treatment? How do resort guests, practitioners and operators navigate through a variety of practices and logics, including expectations,

[40] Those 'mobile' and 'immobile' roles are not fixed and might change within the actors' biographies. But it is the actors' (im)mobility at a particular moment of time that is relevant for the notion of space of connectivity and linked transnational practice formation.

motivations, perceptions and knowledge to create new glocal forms of Ayurveda? Finally, in which way do economic aspects, power relations and the resorts' embedding in the Indian tourism industry shape Ayurvedic treatment?

To answer these questions, I conducted eleven months of fieldwork in Kerala between 2009 and 2010, divided into two parts. During a four-week long preliminary research in February and March 2009, I visited eleven Ayurvedic resorts in different parts of the state, chosen for their positive reply to a standard email sent to all 70 Ayurvedic resorts listed on the website of Kerala's Department of Tourism in January 2009 that explained my research project and asked for permission to conduct *in loco* investigations. In those resorts, I conducted interviews with managers and practitioners in order to a) get a first-hand impression of Ayurvedic resorts in general and b) locate a resort where I could conduct long-term fieldwork. After our conversations, the doctor and the management of ten out of the eleven resorts invited me to conduct my research in their property. Next, based on conversations I had with different employees and doctors employed by different resorts, I picked a resort in Varkala to be my primary long-term site of investigation. A key criterion for my choice was the doctor's interest in my research. During the conversation I had with Dr. Praveen[41], he appeared to be well-versed in different aspects related to my research topic, especially the 'translation of Ayurveda for foreigners' when he explained that "Europeans and Indians have a different mind and that's why you have to provide Ayurveda in a different way to Europeans [...] [and] you have to know the European mind to treat Europeans." Such preliminary observations – although brief as it was part of a one-hour long interview – made me realize that Ayuresort would provide me with a rich source of information and insights for my study.[42] Contributing to this impression was the welcoming demeanor by the resort's general manager Vasu, whose kindness, helpfulness and openness to my research project reinforced my conviction that I had found an optimal place to deepen my inquiry. In addition to these aspects, further reasons were the medium size of the resort that promised a substantial amount of visitors while at the same time allowing an overview of different activities within its package of services. Furthermore, its location within a tourist area attracted both guests for long-term treatment and bypassing tourists for single applications. Last but not least, the comparably low costs for accommodation and food would fit my budget and an eight-month period of in-depth observation between September 2009 and May 2010.

[41] The names of all persons and most institutions, organizations and companies involved in this research have been changed in order to protect their identity.

[42] And as it turned out, this impression proved right.

Figure 1.3: Varkala beach with cliff and Papanasam Beach (photo by the author)

Varkala is a municipality in Thiruvananthapuram district divided into two major parts: Varkala town and Varkala beach. Varkala town is a small city with about 40,000 inhabitants close to the Arabian Sea. From Varkala town, a four kilometer long winding road leads one through lush tropical vegetation to Varkala beach, a tourist enclave on top of a sedimentary laterite cliff, stretching for several kilometers along the Malabar Coast. A closer look reveals bamboo and palm-thatch restaurants and cafés that offer a wide culinary range from local South Indian dishes to German bread and Italian pasta, conveniently located next to souvenir and grocery shops, internet cafés and travel agencies along a one kilometer long and one to two meter wide paved walkway. On the other side of the way, impressive escarpments fall vertically up to 20 meters down to the base of the cliff. The rocky shore line is punctuated by two sandy beaches: the small tidal Thiruvambadi Beach with black sand in the north and the large white Papanasam Beach in the south (see Figure 1.3). The northern and central part of the bigger and more frequented Papanasam Beach is usually occupied by foreign tourists keen on sunbathing as well as lifeguards and pineapple vendors; the southern end serves as a site for Hindu rituals. Pilgrims disperse the ashes of deceased relatives in the sea after having visited the nearby Vaishnavite Janardhana Swami Temple or take a ritual bath in the sea, whose waters are considered to be sacred, for washing off their sins (hence the Malayali name *pāpanāśaṃ*, which means 'destruction of sins'). This turns the beach into a unique religious-recreational space.

Although crowded with tourists, at least during a high season that lasts from October till March, the beach is a calm area in comparison to the hustle and bustle on the cliff top along

Figure 1.4: Walkway on the cliff in Varkala beach; Ayurvedic center employee distributing leaflets for Ayurvedic treatment (photo by the author)

the walkway. Kashmiri, Rajasthani, Kannada and Tibetan salespeople are omnipresent, selling jewelry, carpets and silverware. Restaurant employees attempt to entice prospective customers with their catch of the day, displayed in front of their restaurants. And as one walks along the cliff, the question "Yes Sir, nice massage?" is often heard by several employees of the many Ayurvedic centers situated along the way, who distribute leaflets for Ayurvedic treatment. They complement the dense collection of billboards that advertise Ayurvedic treatments on both sides of the pathway (see Figure 1.4). Rafael Wlodarski, writing for the Kerala section in Lonely Planet India, the best-selling travel guide book also known as 'the traveler's bible,' may slightly exaggerate when he pictures the omnipresence of Ayurveda on the cliff with the words "[i]t seems like every man and his dog has an Ayurvedic-related product to sell, from treatments, to massage, to Ayurvedic tea and even Ayurvedic toilets" (Wlodarski 2007: 974). However, it is true that one is constantly – and *sensorially* – confronted with Ayurvedic treatment: for example, as one walks along the pathway, the unmistakable scent of the herbal oil used in Ayurvedic treatments assails one's nose as some tourists pass by.

The majority of the nearly 60 Ayurvedic centers in Varkala are set back in a coconut grove behind the row of cafés, restaurants and shops that line the walkway along the cliff. Only some are situated directly along the walkway, as it is the case for Ayuresort. Built on the ground of a former coconut grove, Ayuresort lies right on the rim of the cliff at the northern end of Varkala beach, only separated from the sea by the walkway and the escarpment. The resort spreads over a plot of 2,100 square meters between the walkway on

the edge of the cliff and an asphalted street that runs parallel to the coast line and connects the southern and central part of Varkala beach with its northern end.

At the time of my research, the resort had 38 employees and could accommodate up to 64 guests. It was opened in 2005 by an estate agent from Kochi who wanted to tap into the emerging tourism industry in Varkala. However, the business did not work as expected, so in October 2008 he leased the resort to a Kerala-based multinational business group with more than 400 employees and an annual turnover that exceeds US$ 50 million. The company, which leased the estate and the facilities for US$ 70,000 a year, is active in diverse business sectors including consultancy, real estate, biotechnology, infrastructure, education and tourism. Besides Ayuresort, the company ran during the time of my research another hotel and two other resorts in Kerala, one of which was Ayurvedic.

The guests of Ayuresort were accommodated in 32 double and twin rooms distributed on one single-story and one double-story concrete building, five square stone bungalows, four octagonal thatched bamboo cottages and twelve octagonal tiled-roof brick and natural stone cottages. While the single-story building and the stone bungalows were located near the street, the cottages were situated in the front part of the resort complex facing the sea. They surrounded a lawn which was crossed by pebbled paths lined with statues of different Hindu deities that connected the various buildings by winding their way along hammocks and around the trunks of a dozen coconut trees that had survived the construction of the resort in the former palm grove.

Under the palm trees, wooden tables and wicker chairs were part of an open-air restaurant. The kitchen was accommodated in a thatched wooden building next to the lawn. In front of this building, a brick-built and thatched bar served as a buffet area during the high commercial season. Another restaurant, built on top of five adjunctive brick cottages, was only used if it was raining. The thatched restaurant was connected by a small bridge with a two-story building that housed two guest rooms, the office of the general manager and the reception on the first floor and the thatched yoga and meditation hall, a little library where guests could borrow books for the period of their stay and the back office on the second (see Figure 1.5).

The lawn area was separated from the walkway through a green wooden knee-high fence that marked the plot as resort estate, but at the same time evoked in many guests sitting in the open-air restaurant the feeling of being displayed like animals in the zoo to the passing people, as they told me. However, they got rewarded by stunning views of the sea and fishermen in their *kaṭṭamaram* log rafts in the morning, occasionally passing dolphins in the

Figure 1.5: Ayuresort with open-air restaurant, kitchen, guest cottages, yoga and meditation hall, and thatched restaurant (photo by the author)

late afternoon and sun sets in the evening; constantly accompanied by the noise of strong incoming waves breaking against the cliff and the croaking of crows, always on the hunt for unattended food on the guests' plates.

Next to the lawn area, behind the kitchen, a thatched bamboo building housed the staff dining room, where all resort employees had their meals, except for the general manager who had his lunch in the open-air restaurant. Behind the dining room, separated by a small stripe of different plants was a beauty parlor, opened in November 2009. Here, a female beautician offered various cosmetic treatments such as haircuts, facials or manicures. The facility was also used for Ayurvedic treatment when the capacity of the Ayurvedic center was exceeded, particularly when big groups came for Ayurvedic treatment. Earlier the building contained an Ayurvedic pharmacy, but through its exposure to maritime air with high salinity levels medicines were spoilt. The color of soft capsules changed and blister prints disappeared, leading to the closing of the pharmacy.

In the back of the staff dining room, there was a double-story concrete building with ten rooms. Seven rooms were reserved for guests, one was used as office for the housekeeping staff, one served as a sleeping room for three female housekeeping employees (the other employees stayed in three houses about two kilometers away from Ayuresort), and one was used for Ayurvedic treatment. I stayed in one of the guest rooms on the second floor of this building, for three reasons: the rooms of this building were comparably inexpensive, the majority of the guests who took long-term Ayurvedic treatment also stayed in this building, and from the balcony I had a good view over different parts of the resort complex, including

Figure 1.6: The Ayurvedic center at Ayuresort (photo by the author)

the Ayurvedic center, allowing me to closely observe the activities of the resort.

The Ayurvedic center was located in the northern part of Ayuresort. Both on the walkway and on the street, a signpost advertised the center, which could be approached from both sides. It was housed in a rose two-story concrete building (see Figure 1.6). On the ground floor, there were the consulting room, two treatment rooms and a waiting area with a reception desk and five chairs. On the second floor, there were two more treatment rooms and a room where medicines, oils, and other treatment equipment were stored. Together with the already mentioned treatment room in the other building, there were five treatment rooms in total. They were named after the *pañcabhūtas* or five elements, which play an important role in Ayurvedic theory: Tejas, Agni, Vayu, Akash and Prithvi. The 13-square meter rooms had a light blue tile floor, crimson-puce or dark-green colored walls and two windows, which were usually covered with curtains. Neon tubes served as electric lighting. Each room had an attached bathroom. Apart from a puce wooden treatment table (*droṇī*) covered with a dark blue rubber mat with foam filling, they were differently equipped, with diverse treatment instruments. Every room contained a wall projection that served as a little altar (see Figure 1.7). In the backyard of the Ayurvedic center, there were about 50 pots with different medicinal plants, of which some were used in treatments.

During the course of my research, the Ayurvedic center was run by one male doctor and two to three male and three to eight female therapists depending on the amount of guests. Dr. Praveen started his work in Ayuresort in December 2008, at the age of 24 and was 25 when I began my research in the resort. He was born and grew up in Alappuzha district

Figure 1.7: Treatment room in Ayuresort's Ayurvedic center (photo by the author)

in southern Kerala as the son of an Ayurvedic practitioner. His father ran an Ayurvedic dispensary in his home town and thereby continued an Ayurvedic family tradition. Both Dr. Praveen's paternal grandfather and great-grandfather were *vaidyas*, as Ayurvedic practitioners without formal, standardized education are commonly called.[43] However, in comparison to his father, grandfather and great-grandfather, who lacked a degree that officially identified them as Ayurvedic practitioners, Dr. Praveen received a B.A.M.S. degree from one of the more than 200 Ayurvedic colleges recognized by the Indian government to run undergraduate courses (Central Council of Indian Medicine 2014a). Between 2001 and 2007, he studied Ayurveda at this private college located in Sullia, Karnataka, about 20 kilometers from the north-eastern Kerala-Karnataka border. But studying Ayurveda was not Dr. Praveen's first choice when he graduated from school. Since he had been exposed to Ayurveda on a daily basis during his childhood and adolescence due to his father's and grandfather's occupation, he was not always interested in it and aspired to study something he did not know much about: engineering. However, Dr. Praveen's father wanted his son to follow his footsteps and continue a family tradition.[44] Hence, Dr. Praveen enrolled in the B.A.M.S. course at the college in Sullia in 2001, where he studied for four and a half

[43] I use the term '*vaidya*' ("possessor of (vedic) knowledge") for Ayurvedic practitioners trained in *guru-śiṣya-paramparā* tradition, who today represent the minority among Ayurvedic practitioners in India, where in 2007 out of 453,661 registered practitioners 324,242 were institutionally qualified, generally through a B.A.M.S. degree (Bachelor of Ayurvedic Medicine and Surgery; Sujatha 2011: 193 [Table 1]). In comparison, I refer to the latter, who Naraindas calls "*modern* doctor[s] of *traditional* medicine" (Naraindas 2006: 2662) to emphasize the 'modern' biomedical influences on their 'traditional ' Ayurvedic education and clinical practice, as 'doctors' or 'physicians,' which are also the self-designated names of most college-educated practitioners in India.

[44] Studying Ayurveda because of an Ayurvedic family tradition appears as a common biographical aspect among many Ayurvedic professionals in Kerala (see e.g. Frank 2004: 167).

years, followed by two compulsory six-month internships, one at the Government Ayurveda Hospital Alappuzha, and one at his college.[45]

After having obtained his B.A.M.S. degree, Dr. Praveen worked for one year as Junior Doctor at Surya Ayurveda Pharmacy in Thuravoor. During this year, his work was mainly restricted to assisting the senior practitioners. He soon longed for a greater area of responsibility, and when he received an offer to work in Ayuresort, he decided to seize this opportunity and started to work in the resort in December 2008. At that time, Dr. Praveen entered a new territory that made him feel "like a frog in a well," as he explained to me several times. He was rather doubtful regarding his ability to treat foreigners. He was even scared of interacting with them. Due to lack of exposure, his spoken English was rather rudimentary. He was encouraged by his predecessors, however, who advised him that foreigners are different from Indians and that you need "a good tongue and psychological skills." He was told that foreigners expect a less hierarchical interaction with the doctor than it is common in Indian hospitals, and rather attach importance to a polite conversation at eye level and an empathic, attentive and caring doctor, especially in the novel context represented by Ayurvedic resorts to many of the guests.

Feeling uneasy in the beginning, his openness to new experiences and his interest in foreign cultures combined with brightness helped Dr. Praveen to rapidly learn "how to handle the Europeans," a phrase he frequently used in our conversations. At the time of my research, he felt at ease in treating all foreign guests. His cheerful and friendly demeanor as well as his personal desire to satisfy every guest contributed to his popularity with the guests, as I learned from my interviews and from reviewing guests' evaluations. Ayutravel, the biggest German travel agency specialized in Ayurvedic travel, even emphasized his character and his way of working in its presentation of Ayuresort in one of its email newsletters: "Dr. Praveen wields a spectacular scepter. The young doctor is a proponent of personal conversations [...] and consults every guest personally and intensely. Here in Ayuresort you should [...] be prepared for maximum commitment" (original in German; substitution of names by the author).

Dr. Praveen was supported by a team of Ayurvedic therapists who had received the governmental 'Diploma in Ayurveda Panchakarma Therapy' after a one-year-long

[45] Initial lack of interest in Ayurveda is not uncommon among B.A.M.S. students in India. The majority of them choose Ayurveda as subject of study because they did not receive the necessary marks at the state entrance examination for enrolling in biomedical colleges (Banerjee et al. 2013: 177f.; Islam 2009: 142; Svoboda 2008: 119). This leaves them with the choice between the study of dentistry, homeopathy and Ayurveda, and many choose the latter because the B.A.M.S. degree allows them to practice a "freestyle, pharmaceutically directed medicine" (Langford 2002: 98; see also Naraindas 2006: 2662f.).

training in different hospitals in Thiruvananthapuram and Ernakulam. Between December and February, three male and up to eight female therapists worked in the resort. In subsequent months, there were two male and three female therapists. The higher number of female therapists results from the combination of the exclusive application of same-gender treatments and the higher percentage of female guests. Cross-gender treatments are rarely practiced in Ayurvedic centers today. Between the late 1990s and the beginning of this century, the Government of Kerala took action against it by closing centers where cross-gender treatments were practiced and by introducing a certification for good practice in Ayurvedic resorts following several complaints by female foreigners against sexual assaults.[46] Although various online and print media warn about Ayurvedic centers offering cross-gender treatments, I came across such a center only once during my fieldwork, when I was offered an "erotic massage" as I passed by an Ayurvedic center in Kovalam, the other major hub for Ayurvedic treatment for foreigners in Kerala.[47] Nonetheless, amongst many locals, Ayurvedic centers catering to foreigners are associated with prostitution. As a result, most female therapists at Ayuresort could not disclose to their relatives that they work in an Ayurvedic resort and pretended to have a different occupation.

At the beginning of my research, two of the three female therapists who worked in Ayuresort for the whole year, Divya and Manju, were 19 years old, Anitha was 20. The two male therapists, Prabhat and Suraj, were 22 and 19, respectively. All three female therapists had started their jobs in Ayuresort in September 2009; the male therapists had begun in July 2008 and September 2009. While four of the five therapists had already been working in different Ayurvedic resorts before they came to Ayuresort, the work experience of Prabhat was restricted to a private Ayurvedic hospital in Thiruvananthapuram, where he and Suraj had also received their education.

This hospital belonged to the company Ayurvedic Care, directed by two Ayurvedic doctors. Apart from the hospital, which also served as a teaching hospital for Ayurvedic therapists, Ayurvedic Care provided logistic and technical support for various Ayurvedic centers in India and run three Ayurvedic centers in Bihar and Kerala, of which one was the one at Ayuresort. While the resort-running company supplied the facilities available, Ayurvedic Care provided the therapeutic equipment, medicines and the medical staff. Both companies took a share in the revenues of the Ayurvedic center in equal proportion.

46 This 'Leaf Certificate' is awarded to Ayurvedic resorts that fulfill certain requirements determined by Kerala's Department of Tourism. I elaborate on this certification and its role in shaping the practice in the resorts in Chapter 4, when I discuss the influence of the resorts' embedding in the tourism industry on the Ayurvedic practice.

47 In high-class spas in India however, cross-gender massage seems to be a common practice due to market demands, as Pordié shows (2012: 209f).

During my time at Ayuresort, approximately 300 people attended the resort's Ayurvedic center. Out of those, about 80 percent received only one or a couple single applications. Half of them resided at Ayuresort and the other half paid the resort a visit only for individual applications. For 'short term guests,' Ayurvedic treatment represented one of many tourist activities during their vacation in Kerala, either individually or as part of a travel group.[48] The remaining 60 people represented 'long-term guests' who resided at the resort and received Ayurvedic treatment for one to three weeks. For many of them, Ayurvedic treatment was the principal reason for coming to Kerala. They were the individuals with whom I interacted most and on whom much of this work is focused. Long-term guests were between 30 and 75 years old (the majority between their mid-forties and mid-sixties) and predominantly female (75 percent). They came from all social classes but were usually well educated and often equipped with a university degree. Only one woman residing in India (Delhi) visited Ayuresort for long-term treatment during my research, while the majority of the guests were Europeans, mainly from German-speaking regions such as Germany, Austria, Switzerland and South Tyrol in Northern Italy. The high prevalence of German-speaking guests can be partly explained by the institutionalization and popularity of complementary and alternative medicine and the establishment of the medical institution of the *Kur* or 'medical spa' in those countries (Maretzki 1987; Maretzki and Seidler 1985; Naraindas 2011a), discussed in Chapter 4.[49]

During my research, I conducted formal interviews and had informal conversations with 59 visitors of Ayuresort.[50] While I had one or two individual interviews lasting between one and two hours, the casual conversations were more frequent, often held during common meals or in the evening during their 'free time,' either in pairs or in bigger groups. While most guests were happy to share their experiences and views with me,[51] observing treatments was more difficult. As the guest is basically naked during most treatments (except for a muslin thong covering the genitals), my first-hand information was based on the observation and video recordings of male guests' and my own treatment. To experience Ayurvedic practice from the guests' perspective, I underwent a 24-day *pañcakarma* treatment. During this time, I also attended and audio recorded the daily yoga classes before breakfast and

[48] In Chapter 4, I present and analyze this connection between tourism and Ayurvedic treatment in greater detail.

[49] For more guest details, such as age, origin, profession, length of treatment or prior experience with Ayurvedic treatment, see Appendix A.3.

[50] I tried to talk to all guests who stayed at Ayuresort for at least five days, but this intention was hampered by the high amount of guests during some periods, especially during peak season in December and January and during the attendance of tour groups. For a list of the guests and all other interlocutors I quote in this work see Appendix A.

[51] Only two couples declined my query for an interview, without providing a specific reason.

meditation classes before dinner. While the present research is based to a substantial amount on guest accounts, vital perspectives come also from resort employees such as Dr. Praveen, with whom I had 39 interviews lasting between 30 minutes to two hours and informal conversations almost on a daily basis. In addition, I regularly talked to many of the resort staff and conducted interviews with the general manager, therapists, the yoga teacher, the kitchen personnel and the administration team. Furthermore, I analyzed numerous case files and different questionnaires used during consultations, notes that Dr. Praveen wrote for the guests during consultations explaining different treatment-related aspects, promotion material produced by the resort-running company and guest reviews about their stay at Ayuresort. In addition, I conducted interviews with the two doctors who run Ayurvedic Care, the company that provided the therapeutic equipment and the staff at Ayuresorts' Ayurvedic center, and a sales manager of the resort-running company in its national headquarter.

Moreover, my fieldwork took me to 23 other Ayurvedic resorts, Kerala's Department of Tourism in Thiruvananthapuram, four Ayurvedic dispensaries in Varkala and eight private and governmental hospitals and clinics in different areas in Kerala. I also spent four weeks at a private Ayurvedic hospital in Ernakulam in order to get a better idea of clinical Ayurvedic practice and be able to better contextualize and analyze the "differences between resorts and hospitals" that Dr. Praveen frequently cited during our first meeting in February 2009. Here, I mainly talked to patients, doctors, observed consultations, joined the doctors on their rounds and analyzed patient charts. My wide and extensive range of primary sources is supplemented by a careful analysis of information and promotion materials of different Ayurvedic resorts, travel agencies and both, the Indian and Keralan Ministries and Departments of Tourism, collected in Kerala and at the world's largest travel trade show – i.e. ITB – held in Berlin during the month of March 2009.

This study proceeds as follows: Chapter 2 serves as the basis for the following chapters and ethnographically studies the origins, actors and the practices at Ayuresort. I start by describing the guests' intentions for visiting the resort and their perceptions of Ayurveda by process tracing the logic underpinning their visits to Ayurvedic resorts. After exploring their distinctiveness from the general motivation prevalent in Ayurvedic clinics and hospitals in India, I connect, compare and contrast the guests' perceptions of Ayurveda with the guests' encounters with Ayurvedic treatment prior to their visit to the resort. The chapter concludes with an analysis of the practices in the resort ranging from long-term treatments to single applications and an assessment of how these differ from practices conducted in Ayurvedic hospitals while recognizing their plurality within the latter. I argue that the formation of

Ayurvedic resort practice is influenced to a large extent by the pragmatic translation of the guests' perceptions and resulting desires on the part of the resort management for entrepreneurial reasons, and is determined by different processes of translation between multiple actors on the level of terminologies, concepts and practices.

With a focus on *śirodhārā*, Chapter 3 examines resort practice and traces the core features that led Ayurveda's current flagship practice of stress relief to gain considerable popularity. Centered on the experience of guests in pursuit of stress relief, I detail the adaptation of the Western concept of 'stress' within Ayurvedic nosology. The end result, 'enacted' through the interaction between the guests and Dr. Praveen, echoes the general argument in Annemarie Mol's *The Body Multiple: Ontology in Medical Practice* (2002) where objects are 'enacted' through socio-material practices that encompass human and non-human actors. Stress, as such, is a particular enactment that is ontologically distinct from stress outside the resort. Instead, it becomes a '*doṣic*-hormonal' manifestation embedded in the nosological category of *manasika roga* or mental illness through the agency of Dr. Praveen and his guests and through the application of *śirodhārā* for treating stress. The chapter traces the Euro-American conceptual underpinnings of stress and its syndrome produced by particular socioeconomic, technological and intellectual developments, before it examines how stress is enacted in the resort space and entered Ayurvedic theory through the interaction between Dr. Praveen and his guests. In the process, the enactment of a new *śirodhārā* connected to relaxation practice ensues as opposed to the *śirodhārā* associated with neurological and skin diseases in Ayurvedic hospitals. I demonstrate how *śirodhārā* at Ayuresort is enacted as a panacea against stress based on both Ayurvedic and biomedical concepts and ultimately as an Ayurvedic practice ontologically unique from *śirodhārā* in Ayurvedic hospitals.

From the micro-level, I broaden and contextualize the analysis of this practice in Chapter 4 by investigating the convergence of medical and wellness dimensions in Ayurvedic resort practice along with the confluence of health care and holiday features by virtue of the resort's embedding in the (health) tourism industry. Here, the German *Kur* tradition synergizes the value of healing, wellness and holidays into 'the *Ayurveda-Kur*' – a new transnational form of a health care legacy now performed in a South Asian setting. The chapter details the origins and the lasting appeal of the *Kur* tradition from an individualized regimen that includes a plurality of therapeutic and health-promoting treatment methods that stem from natural remedies. I show the extent to which *Kur* treatments are forms of (international) health care travel comprising 'health tourism' of which the visit of Ayurvedic resorts is an

important example. Subsequently, I analyze the practice at Ayuresort against its embedding in the tourism industry prior to explaining its convergence into a therapeutic, preventive and wellness package that integrates vacation elements in a resort against the position of the *Kur* in institutionalized biomedicine in Germany. I go on to highlighting how the idea of *Kur* facilitates the process of 'familiarization' of a largely unknown Ayurvedic practice for many German guests visiting Ayuresort.

I conclude the dissertation with a summary of the chapter findings against the background of the notion of Ayurvedic resorts being spaces of connectivity within a transnational Ayurvedic space with its multiple forms of Ayurvedic practice and knowledge existing worldwide discussed above in Chapter 5. Apart from reinforcing the point that the Ayurvedic knowledge and practice observed in Ayuresort is one form of the global variety of Ayurveda resulting from different processes of exchange within transnational networks and circulations, I analyze a linked discourse about commercialization and authenticity of Ayurveda existing in Kerala. I demonstrate how many doctors who do not work in Ayurvedic resorts but clinics or hospitals consider resort practice as 'business Ayurveda' or 'fake Ayurveda,' while Dr. Praveen and the resort guests regard it as 'real Ayurveda,' despite or even due to its acknowledged commercialization. Here I show how different actors have multiple standards of comparison by which to judge the authenticity of the practice in resorts: classic texts, practice of Ayurveda in European institutions, and practice in Indian clinics and hospitals. By analyzing this discourse, I demonstrate not only the dynamism, mutability and variety of Ayurveda, but also the existence of multiple authenticities of Ayurvedic practice – on a local and a global scale.

2 Pragmatics of Imagination: Ayurveda Reconfigured

While checking my emails one evening in March 2010 at Ayuresort, I received a message from a former guest. She asked me to translate the following review she had sent to the travel agency where she had booked her journey to Dr. Praveen (original in German):

> I went on a trip through India with a friend in February, booked through your travel agency, via Cochin, Alleppey to Varkala – for two weeks of Ayurveda – and back via Trivandrum.
>
> In Varkala, we stayed at Ayuresort and received in an adjacent building the medical care and the applications. I want to tell you that I was extremely satisfied. Dr. Praveen and the rest of the staff were competent and looked after us in a caring and professional way. Also, the different massages, each arranged in accordance with my constitution and somatic condition, were very good. I had the same therapists for two weeks. The experience was peaceful, patient – thus no stress – gentle, devoted and hands-on. Even though the ladies / therapists could not speak English that well, this was no problem. In addition, there was yoga in the morning and meditation in the evening as a wonderful complement.
>
> The restaurant was adjusted to Ayurvedic diet and considered the respective orders from the doctor for the individual patients – I had a special diet. However, the food was a bit monotonous, few variations, always the same salads and varieties of vegetables and fruits. Besides treatment and diet, there was enough time for "vacation," that is: city tours, hiking by the sea, visits of temple festivals etc. Or just sitting in the garden, reading or talking to other guests.
>
> I can highly recommend this resort, which has a nice, well-manicured garden and is located directly on the sea, as well as the Ayurvedic treatment (substitution of names by the author).

This feedback from Diana (64, originally from the Netherlands but residing in Germany) points to different aspects of her Ayurvedic treatment that were important to her, and at the same time exemplifies what many guests at Ayuresort expected from their stay and eventually also received: medical care, a qualified and considerate doctor, different massages, gentle applications adjusted to their individual constitution, attentive therapists, accompanying activities such as yoga and meditation classes, sightseeing tours and a nice location close to the sea with a calm and stress-free environment. All these aspects are representative of Ayurveda at Ayuresort and shape a specific form of Ayurvedic practice discussed in this chapter. I provide an ethnographic account of the actors and the practices in the resort, together with an interpretation of the formation of the latter. I demonstrate that the Ayurvedic treatment differs significantly from the practice in Ayurvedic clinics and hospitals. I acknowledge that treatment also differs between and among different public and private hospitals and clinics as mentioned above and I do not consider Ayurvedic practices in clinical context as standard or norm or even authentic in comparison to the practice at Ayuresort – although such a discourse exists among different actors working in resorts and

clinical settings, addressed in Chapter 5. However, as will become clear, many practices at Ayuresort indeed *do* differ significantly from clinical practices described by various authors and observed during my fieldwork. What is even more important: my interlocutors themselves frequently emphasized differences between clinical and resort practice. Just as Dr. Praveen regularly contrasted the practice at Ayuresort with practice "in hospitals" in his explanations, I also have to refer to clinical practice as an occasional point of reference to achieve the objective of this dissertation: to present the practice at Ayuresort including its formation.

I argue that the practices in the resort are formed by an intricate interplay of: a) Dr. Praveen's knowledge of Ayurvedic theory and his experiences with clinical Ayurvedic practice, b) needs and desires on the part of the guests linked to their perceptions of Ayurveda, and c) entrepreneurial considerations from different stakeholders in the tourism industry; combined with translation processes between guests, the doctor and the resort management.

The chapter opens with a description of the guests' intentions for visiting the resort and their perceptions of Ayurveda in an attempt to trace the rationale behind their visits to Ayurvedic resorts. In the process, I demonstrate how they differ considerably from those prevalent in Ayurvedic clinics and hospitals in India, which are mostly visited for therapeutic treatment. The majority of the guests came in pursuit of, and associated Ayurveda with, a wider 'package' of services that included recreation, relaxation, illness prevention and improvement of one's overall wellbeing.

I then link the guests' perceptions of Ayurveda with the guests' encounters with Ayurvedic treatment experienced prior to their visit to the resort that often include massage parlors and day spas in their home countries. At the same time, I demonstrate how the majority of guests who chose to pursue an Ayurvedic treatment in the resort as their first experience with Ayurvedic practice developed their perceptions of Ayurveda from various print and online media and local advertisements that include visual and textual representations produced by Ayurvedic resorts, travel agencies, and the Indian and Keralan Ministry and Department of Tourism.

In the third part of this chapter, I analyze the practices in the resort. I show how long-term treatments at Ayuresort differ in terms of practice and meaning from those conducted in Ayurvedic hospitals, not least by comprising several elements that cannot be found in the latter. These elements include applications labeled as "rejuvenation massage" or "beauty pack," different relaxation elements, a specific opening and closing ritual in

each treatment session, and finally, double daily sessions of yoga and meditation. Also, the consultation includes elements that do not exist in clinical settings, like a questionnaire to assess the 'personal constitution' *prakṛti*, or a doctor-guest interaction that more readily resembles a travel guide-guest relationship as opposed to that of a physician and a patient. In addition to the differences in long-term treatments, single applications have also been modified, or even (re-)invented. I argue that Ayurvedic treatment in the resort does not represent a therapeutic form of health care as it does in Ayurvedic hospitals and clinics, but a blending of different practices with diverse aims such as therapy, illness prevention, recreation or relaxation.

I further argue that this reconfiguration of Ayurvedic practice in the resort is shaped to a large extent by the pragmatic translation of the guests' perceptions and resulting desires on the part of the resort management for entrepreneurial reasons. This process of practice formation however is more circular than linear, as guests' perceptions resulting from representations of Ayurveda in the media and in advertisement material influence Ayurvedic practices, which in turn impact its representations and perceptions. The entire reconfiguration is determined by different processes of translation between multiple actors on the level of terminologies, concepts and practices as shown below.

2.1 Therapy – Illness Prevention – Recreation: Resort Visitors' Perceptions of and Reasons for Choosing Ayurveda

When I asked individual guests about their motivations for visiting Ayuresort, responses varied significantly as the selection of quotes illustrates:

> *When you enter old age, you want to live lively as long as possible.* [...] *I don't suffer from anything. It's rather wellness, and if there even results some beauty and you lose one or two kilograms, it's just great. And this happens in a pleasant way: you can enjoy massages and escape the winter. It's wellness.*[52]
>
> (Sarah, 66, Italy [South Tyrol])

> *Holiday. Just three weeks of holiday. After a stressful year I just needed a time-out, relaxation so to say. So I thought an Ayurvedic treatment here by the sea is perfect for me.*
>
> (Linda, 45, Germany)

> *For two, three years now I have problems with my back. I have a defective position of two ribs, and this results in inflammations at the entrance of the stomach. As a consequence, one muscle is dysfunctional and gastric acid flows up. So the whole system is defective. And I know that Ayurveda helps me pretty much. I have tried it already two times last year and there have been approaches that help me more than Western medicine or other applications you can have in Germany.*

[52] I distinguish between indented quotations from written sources and indented quotations from interlocutors by italicizing the latter.

(Thomas, 49, Germany)

> *I didn't come here to heal something specific. I came here as just somebody who knows that sometimes it's good to have yourself giving a good treatment. If there was one reason why I want to do it, it was general fatigue. That might be a reason.*
>
> (David, 47, Belgium)

> *I wanted to have an intensive everyday sort of treatment to basically deal with the stress of modern life. I needed a complete break from everything.*
>
> (Jennifer, 46, originally from the United States but residing in France)

> *On the one hand to do myself and my health some good. Although I am healthy, I have some* Befindlichkeitsstörungen [minor disorders]*: when you do not feel well after eating because you cannot digest something of what you eat. And on the other hand just to unwind, to have a break.*
>
> (Sandra, 43, Germany; addition by the author)

These statements point to the variety of intentions behind a trip to Ayuresort: they range from recreation and relaxation to disease prevention and the treatment of a specific health problem. However, while the quotes show variation in the reasons for undergoing Ayurvedic treatment at Ayuresort, some reasons for visiting the resort were more frequent than others. Treating a specific illness for instance was rather the exception.[53] For the majority of the guests other reasons were decisive for visiting the resort, and some guests even explicitly stated that they "don't suffer from anything" (Sarah) or that they "didn't come here to heal something specific" (David). Paul, 57, from South Tyrol emphasized that "nothing specific is treated, apart from a little weight reducing; there is nothing wrong with me." He rather "thought it was an interesting experience to try out Ayurveda."

'Trying out' or 'experiencing' Ayurveda was a common reason for visiting Ayuresort. Having read or heard about Ayurvedic treatment, many guests had become curious. This accounts especially for guests who visited Ayuresort as part of their travel through India, but also several long-term guests stayed at the resort only to experience Ayurveda.

With her remark that she wants to "live lively as long as possible," Sarah addressed another frequent reason for visiting Ayuresort: illness prevention. With his explanation that he "came here as just somebody who knows that sometimes it's good to have yourself giving a good treatment," David referred to the benefits of regular health care for maintaining health. Like David and Sarah, many guests wanted to maintain their health status through Ayurvedic treatment.

[53] Apart from Thomas, only six other guests justified their stay with an illness-related explanation. The single disturbances were psoriasis (Jonathan, 44, Germany), diabetes mellitus (Anna, 48, Italy), digestive problems and weak immune system (Alexandra, 45, Germany), varicosis and primary myelopathic polycythemia (Vladimir, 25, Russia), and hypertension and high cholesterol level (Veronika, 65, and Edvard, 72, both from Slovenia).

The most frequent reasons for visiting the resort, however, were the linked notions of relaxation, stress relief and recreation. Ayurveda was considered a weapon against "the stress of modern life" (Jennifer) and the stay at the resort was part of "holiday [...] after a stressful year" (Linda). And even if stress relief or relaxation were not the central focus during their stay at the resort, for almost every guest it played at least a minor role in his or her decision to visit Ayuresort. Interrelated with relaxation and recreation was the association of Ayurvedic practice with wellness[54] treatments. This is best captured by Sarah, whose intentions were to be pampered, to "enjoy massages" and to do herself some good by reducing weight and investing in her beauty. Sarah, together with several other guests, especially those who visited the resort only for some single applications like massages or cosmetic treatments, saw Ayurvedic treatment as a pleasant wellness activity.

At the same time, many guests keen on relaxation or recreation had another goal: to have *minor* ailments treated. Sandra's answer to my question why she visited Ayuresort illustrates this. She wanted to "unwind, to have a break," and, although she said "I am healthy," she wanted to treat her "*Befindlichkeitsstörungen*" (minor disorders) related to digestive problems. These minor disorders are ailments that might cause discomfort but do not conventionally demand a medical intervention. Frequent ailments included digestive problems and different types of back pain and muscle tensions. However, most of the guests put less emphasis on the treatment of these minor disorders than on relaxation, recreation and on "gaining new energy." General fatigue and "lack of energy" featured as major complaints by many guests and were given more importance than treating specific somatic ailments including biomedical disease patterns like psoriasis, as in the case of Laura (50, Germany), whose primary aim was to gain new energy, while the treatment of her psoriasis was only secondary. Even those guests who named a concrete health problem as their reason for visiting the resort mentioned relaxation or recreation or "recharging my batteries" as further motivations.

With these range of 'push factors' in mind, it is important to see how the drivers motivating guests' visits to the resort differed considerably from the reasons why Ayurvedic hospitals or clinics in India are seen. While only seven of the resort guests came to Ayuresort for treating a specific illness, clinical Ayurvedic practice is determined by therapy-oriented

[54] The guests at Ayuresort used the term 'wellness' as a loose umbrella term in the same way as it is used in everyday language in many European countries: it designates both a state and a process involving notions of mental and physical wellbeing, pleasantness and indulgence, which can be achieved or is implemented respectively by different measures and applications often conducted in day spas and massage and beauty parlors. In Chapter 4, I discuss the usage and meaning of the term and concept in detail, both inside and outside the resort. For now, I will use the guests' conceptualization of the term as a working definition.

visit reasons as portrayed in Chapter 1. This was also confirmed by my own observations. During my four-week stay at a private Ayurvedic hospital in Ernakulam, four persons visited the hospital for single massages without having any specific health issues. All other 185 patients came for therapeutic measures. The majority of the outpatients visited the hospital for treating musculoskeletal disorders, primarily osteoarthritis and rheumatoid arthritis. Besides this, patients presented various ailments like digestive disorders, migraine, stomach problems, fever, urinary tract infection, insomnia, or neurological problems. In addition, several outpatients visited the hospital for treating their alcohol addiction. Inpatients had been admitted for musculoskeletal disorders like arthritis or intervertebral disk prolapse, neurological disorders like multiple sclerosis or post-stroke hemiplegia, blood disorders like anemia, and post-accident brain injuries. The patients at the other private and governmental hospitals I visited in Varkala, Thiruvananthapuram, Kollam district and Pathanamthitta district also looked for curative care. The ailments resembled those in the hospital in Ernakulam and those described in other studies on clinical Ayurvedic practice mentioned in Chapter 1.[55]

Many patients who came to the hospitals and clinics were "earnest seekers," as Ursula Sharma calls those patients who are "desperately casting about for a remedy for a specific illness but who seem neither to have settled down with any one system of therapy nor to have abandoned the search as a bad job and accepted their condition as incurable" (1992: 47f.). Many patients I talked to resorted to Ayurvedic treatment for seeking relief from ailments they have experienced for several years and that could not be removed or reduced through other treatments. One of them was Vijay, a 30-year-old patient from Ernakulam with cervical spondylosis: "I have pain in the neck. It also radiates to my hands. And my neck is also stiff. I have this for seven years now. [...] I even went to doctors of Chinese medicine in Singapore and Malaysia, but they said they can't do anything against spinal problems." In their frantic search for curative care, several other patients even traveled from other countries to receive Ayurvedic treatment in India, like Mira (34) from Malaysia:[56] "I have it [anemia] now for three years. I tried several treatments in Malaysia: stem cell therapy,

[55] Most frequent were musculoskeletal disorders; other ailments ranged from colds, skin diseases, digestive problems, functional bowel disorders, allergies, hormonal imbalances, metabolic disorders, respiratory diseases, neurological disorders to mental problems like mood disorders or schizophrenia.

[56] The hospital in Ernakulam was frequented not only by patients from Kerala and other parts of India, but also by non-residential Indians and persons of Indian origin living in the United Kingdom, the United States, Canada, Malaysia and Mauritius, as well as by foreigners without relational ties to India. The latter came from South Africa, Oman, Yemen, Saudi Arabia, and Kuwait. The chief physician of the hospital explained this by his visits to those countries for providing treatment and information campaigns on Ayurvedic treatment. Another Ayurvedic hospital in Kerala that is very popular with foreigners is the famous Arya Vaidya Sala in Kottakkal, which was visited in 2006 by more than one thousand non-Indians (Rudra 2011: 62 [Footnote 39]).

acupuncture, naturopathy. Nothing worked. The doctors now recommended chemotherapy, but I don't want to do that. They also say Ayurveda won't help, but I want to try it" (addition by the author).

In most cases, the impulse for this form of 'healer shopping' common among patients visiting Ayurvedic clinics and hospitals is to address a symptom that is largely absent at Ayuresort: pain. Only a few guests at the resort sought pain-relief, while almost all patients in the hospital in Ernakulam described their health problem by pointing to the pain they feel, which was registered by the doctors in the patient files under the section 'presenting complaints,' e.g. "neck pain for one year (increased for one month), pain while extension, lower back ache for one year." When the chief physician of a private Ayurvedic hospital in Kollam, Dr. Prabhakaran, explained the reasons why the single patients had been admitted, he always added "back pain" or "knee joint pain" to the biomedical nosological diagnosis like "lumbar plexus inflammation" or "rheumatoid arthritis." This omnipresence of pain in clinical settings was also stressed by Dr. Praveen: "When a patient gets to the Ayurvedic doctor in a hospital, one symptom is mainly pain. More than 70 percent of patients have *vāta* problems.[57] And our guests here rarely have pain."

The predominance of other reasons than pain relief and improvement of one's health condition for visiting Ayurvedic resorts was not only observed by other scholars,[58] but also witnessed by me. At Ayuresort, the majority of guests had non-therapeutic motivations for visiting the resort. Essentially, the aims of the visitors were much more diverse than those of patients at clinics and hospitals. Even single guests themselves had multiple motivations to visit Ayuresort, e.g. relaxation, treating digestive problems, enjoying the sun, being pampered, losing weight; all at once. Furthermore, the guests' intentions were often not as specific and tangible as patients' intentions for visiting a clinical setting, as Alice's (62, originally from France but residing in Belgium) reply to my question about why she visited Ayuresort illustrates: "We thought: 'Let's have a good time!' Because I am not sick. And I hate the winter in France, it is much nicer to be here. Reasons like that."

Clearly, the vast majority of the guests at Ayuresort came for relaxation, stress relief and recreation, in combination with the treatment of minor ailments and "doing oneself

[57] In Ayurvedic theory, and emphasized by Dr. Praveen, pain indicates a misalignment of *vāta* and a resulting *vāta* disease always involves pain (see also Edwards 2009: 292 for an example of pain being used as an indicator for a *vāta* disease in clinical practice).

[58] Tirodkar writes that in the Ayurvedic resort she visited in Maharashtra 76 percent of the guests came for "rejuvenation purposes" (2005: 183f.; Tirodkar uses the term 'rejuvenation' as antagonism to therapeutic treatment). Similar numbers are provided by Islam. In the 'holistic health village' he visited near Kolkata, the main motivation of the guests was "relaxation and stress reduction," while only 10 percent came for therapeutic reasons (2012: 226; see also Bindu et al. 2009: 71; Rudra 2011: 63; Spitzer 2009: 143).

something good." Relaxation and recreation were mentioned by almost every guest as a clear goal for visiting Ayuresort, either as a primary or a secondary motivation. Hence, the reasons for visits were more varied than in clinics and hospitals while being detached from a strictly medical context. I suggest that these differences in motivations between hospital patients and resort guests stem from perceptions on the part of the latter group that were divorced from direct experiences with practices in Ayurvedic clinics and hospitals. Except for four guests, no guest I talked to in Ayuresort had ever experienced Ayurvedic treatment in an Indian hospital or clinic. On the contrary, various guests did not even know about the existence of Ayurvedic hospitals and clinics and the perceptions of Ayurveda of the majority of those at Ayuresort were shaped through first-hand experiences with Ayurvedic treatment in Ayurvedic resorts in South Asia, Ayurvedic centers in their home countries, accounts of friends and relatives, and especially by textual and visual representations of Ayurveda in various print and online media. As a result, the majority of the guests of Ayuresort perceived Ayurveda not as a therapeutic medical treatment unlike patients at Ayurvedic clinics and hospitals.

Although perceptions of Ayurveda varied between different guests at Ayuresort, one common belief was that Ayurveda is an ancient Indian tradition. Guests in their majority perceived Ayurveda dating back from 1,000 to 5,000 years. The earliest known Ayurvedic texts, the *Carakasaṃhitā* and the *Suśrutasaṃhitā*, date around 2,000 years back,[59] and although one can assume that certain Ayurvedic concepts, theories and practices had been existing for some time before them to be written down and compiled into a systematic text, they presumably did not already exist 5,000 years ago.[60] However, the exact dating of the origins of Ayurveda seems of lesser relevance than its general identification as an ancient practice. Anne (53, Sweden) for instance wanted to "experience Ayurveda because it's interesting to explore ancient healing therapies and how they use herbs and massages et cetera." The perceived antiquity of Ayurveda did not only trigger interest but even enticed some guests, as the following remark by Silvia illustrates: "Ancient Ayurvedic knowledge

[59] The *Carakasaṃhitā* ('Collection of Caraka') and the *Suśrutasaṃhitā* ('Collection of Suśruta') along with the *Aṣṭāngahṛdaya* ('Collection of the essence of the octopartite science') make up the *bṛhattrayī* or the 'Great Triad' of the Ayurvedic classic treatises. Although the exact dating of these compendia is vague, it can be assumed that they were all written, and even known beyond India, by the 9th century CE (Basham 1976: 21). The earliest version of the *Carakasaṃhitā* was supposedly composed between 200 BCE and 200 CE and the *Suśrutasaṃhitā* between the fourth century BCE and the fifth century CE (Meulenbeld 1999: 112-115, 333-352). The *Aṣṭāngahṛdaya*, a systematic treatise that refers to the contents of the *Carakasaṃhitā* and the *Suśrutasaṃhitā* which is today the most popular of all Ayurvedic classic texts in Ayurvedic education in Kerala, was presumably written between the forth and the eighth century CE (Meulenbeld 1999: 631-635).

[60] Kenneth Zysk delineates the role of the *śramaṇa*s (heterodox wandering ascetics common from the sixth century BCE) for the formation of the first Ayurvedic principles and practices and places the emergence of Ayurveda as medical tradition in the Buddhist *sangha* (monastic community) in the fifth century BCE (1991: 21-49).

is fascinating, and being able to get to know this is priceless." Hence, the perceptions of several guests shaped the imaginary of Ayurveda as an 'ancient tradition' in opposition to 'modern biomedicine,' the former being a subordinate medical practice to the latter, as Rebecca (60, Italy [South Tyrol]) illustrates: "Ayurveda is an old medical tradition. There are chances of recovery if you combine it with modern *Schulmedizin* [biomedicine]" (addition by the author).[61]

Many guests at Ayuresort saw Ayurveda not only as an '*ancient* tradition' but also as an '*Indian* tradition,' linked to an imagined 'Indian culture.' For some of the guests, this so-called 'Indianness' of Ayurveda played a role for their decision to take an Ayurvedic treatment. Vladimir for example visited Ayuresort not only for treating his varicosis and primary myelopathic polycythemia, but also because he was "interested in Indian culture." For many guests, Ayurveda was part of a specific 'Indian heritage,' and the product of a romantic view of India. India was often contrasted with 'the West,' not only implicitly but also explicitly, as done by Catherine (55, United States): "The whole culture is so different from the West; the rhythm, the smells, everything." In this course, not only Ayurveda but India itself was considered by many guests as ancient, as the following remark by Rebecca exemplifies: "The old cultures possess medical knowledge which we maybe do not have."

The perception of Ayurveda as an ancient non-biomedical tradition was already sufficient for some guests to visit Ayuresort, as shown by David:

> *I know that Ayurveda is an old Indian way of healing. And that interested me. I know about acupuncture, I know that the Tibetans have their own traditional medicine, I know that in the Amazon forest they have their own. And I am quite confident that ancient knowledge like this does a good job, in general. And for the Ayurveda part, I had some massages and stuff, but I just trusted that it would be good to do a three-week treatment. Without exactly knowing what it consists of. I didn't know at all how this treatment would work.*

Without deeper knowledge of Ayurvedic practice and theory, David valued Ayurveda by associating it with his positive experiences with other non-biomedical healing practices.[62] His appreciation of non-biomedical treatments in general and hence Ayurveda in particular was based on one characteristic he attributed to non-biomedical treatments, namely their

[61] Several scholars divide Ayurvedic practice into "traditional āyurveda, i.e. the unregulated āyurvedic medical system as it is represented in the classical āyurvedic texts, and modern āyurveda, starting with the processes of professionalisation and institutionalisation in the late nineteenth and early twentieth centuries" (Benner 2005: 186). Others such as Tirodkar, even apply this dichotomy of 'traditional' and 'modern' Ayurveda to contemporary Ayurvedic practice, by conceptualizing "traditional ayurvedic practices" as involving "the methods of diagnosis and treatment laid out in Sanskrit medical texts," and "traditional practitioners," i.e. doctors who have been "trained in *guru-śisya* style (i.e., pupilage), ashram-based settings, or in some sort of oral tradition" (2008: 227f). "Modern practices" for Tirodkar consists of a blending of biomedical and Ayurvedic diagnostic procedures (2008: 228). The guests at Ayuresort, however, did not distinguish between different forms of Ayurveda but used the term 'traditional' as a mere synonym to 'ancient,' as a clear reference to Ayurveda's old roots compared to biomedicine.

[62] The majority of the guests I had talked to regularly resorted to non-biomedical forms of treatment in their home countries, especially Homeopathy and Traditional Chinese Medicine.

transcendence of the Cartesian mind-body dualism:

> *In the West, mental and physical aspects are treated and perceived as distinct entities and different disciplines have evolved from this: the different specialized disciplines are separated from each other and one specialist, like a cardiologist, doesn't have any knowledge about another field, like the brain. But actually psychological and physical things are interconnected, as are different physical things. In Chinese Medicine and Ayurveda these things are considered together, so that's why Asian medicines are good.*

This opinion was shared by many guests. Numerous guests perceived Ayurvedic treatment as being "*ganzheitlich*" (holistic) in terms of addressing both somatic and mental aspects, like Nicole (37, Germany): "The holistic approach is good. In Ayurveda, body and mind are incorporated. Ayurveda does not only work physically but also mentally." Nicole, David and several other guests attributed to Ayurveda an integrated perspective and approach, unlike biomedicine. This perceived 'holism' was for those guests more consistent with their perception of human nature than the somatic reduction of biomedical theory and practice.

The term '*ganzheitlich*' was also used by various guests in another way. Several guests applied the term when they referred to cause-based treatment, like Jessica (42, Germany): "I approve this holistic approach [...] For me this approach, that you fight the cause and not the symptoms, is much more important." These guests perceived Ayurvedic treatment as addressing, and eliminating, the cause of an ailment rather than just providing symptomatic relief which they associated with biomedical treatment.[63]

At first glance, these two understandings of Ayurveda as holistic practice seem to point to different perceptions. However, the following quote by Hannah (48, Austria) reveals the convergence of both meanings and elucidates the underlying perception of Ayurveda's holistic approach:

> *Holistic means to me that pain and diseases have a cause somewhere, in some dysfunction, which however does not only result from bad diet, for instance, but there is always another factor included. Stress maybe. So that I react in this way. I also believe that the whole environment belongs to complete wellbeing. The job must be fun, then stress is not harmful. Then stress is rather stimulating and invigorating. But in a bad environment, stress can change into the negative side. And my holistic approach is that everything has to be in balance. The mind, in other words the environment, has to be right, diet must be right, and also the care for the body, exercise, treatment.*

This statement illustrates the interrelationship between the two aspects of the term 'holistic:' The cause for an ailment is not seen in a mere physical malfunction, but is considered as an interplay of somatic, social and mental issues. Adequate treatment does not (only) address the physical malfunction, or even only its symptoms, but also incorporates these other factors, which contribute to the ailments.

In addition to its perceived holism, almost all guests emphasized the "naturalness" and thus gentleness of Ayurveda. Statements like "Ayurveda is good since it is natural"

63 Interestingly, these guests had this perception of Ayurveda as cause-based treatment even if their intention of visiting the resort was not therapeutic treatment (Jessica's motivation for instance was recreation and relaxation).

(David), "medicines are all natural, it is only herbs, they cannot be bad" (Linde), or "it is a gentle approach, based on herbs" (Kathrin) were very common. The majority of the guests perceived Ayurveda as natural and gentle practice primarily because of a claimed non-existence of side-effects due to the non-usage of synthetic inputs. As a result, some guests were surprised when they experienced weariness in the course of their treatment or when they learned that Ayurvedic treatment involves harsh procedures like enemas or purgations, as the following exchange shows:

Author:	*Was there something that you did not expect?*
David:	*Yes, absolutely. Taking these two pills and empty myself on the toilet and vomit. I didn't know it was part of the system. Until now Ayurvedic treatment for me was massage. And taking some powders or medicines. But I absolutely didn't know that purgation and stuff like this was part of it.*

David's statement refers to evacuative procedures of his *pañcakarma* treatment. While David was astonished by this treatment, many guests considered it a principal constituent of Ayurveda. This was due to the most common 'medicinal' perception of Ayurveda in Ayuresort: Ayurveda as purification treatment. Many guests equated Ayurveda with 'purification' or 'detoxification' and with *pañcakarma*, which various guests perceived as technique for cleansing the gastrointestinal tract and beneficial for treating digestive disorders – together with other ailments that were attributed to result from indigestion – as Alexandra's statement illustrates:

> *The Ayurvedic treatment is a detoxifying treatment which cleanses the intestines and which is more intensive than a fasting cure in Germany. I have several health problems that doctors cannot solve, mainly digestive problems: constipation, diarrhea, I cannot absorb certain substances.* [...] *I hope that after a cleanse it gets better, maybe also in connection with a dietary change according to my type.*

The notion of purification as focusing on the gastrointestinal tract relates to another perception of Ayurveda which was popular at Ayuresort: the idea that Ayurvedic treatment involves a specific diet, a diet in accordance to somebody's "type," as Alexandra said. With "type" she referred to *prakṛti*, the Ayurvedic concept of the constitution of a human being that is based on an individually distinct combination of the three *doṣa*s *vāta*, *pitta* and *kapha* and the three *guṇa*s *rajas*, *tamas* and *sattva*.[64] Almost all long-term guests expected to receive a "healthy diet" that was vegetarian and adapted for their personal *prakṛti*, which

[64] According to Ayurvedic theory, the three *doṣa*s, which are divided into five sub-types each, regulate the 'physiological' processes of the human being, while the three *guṇa*s control the 'mental' processes. They consist of different combinations of the *pañcamahābhūta* or five elements *pṛthvī* (earth), *ap* (water), *agni* or *tejas* (fire), *vāyu* (air) and *ākāśa* (space or ether) and are characterized by different properties and qualities. The individual human constitution or *prakṛti* is determined before birth by a specific ratio of the single *doṣa*s and *guṇa*s. While maintenance and restoration of health are explained by an equal relation between the different *doṣa*s and *guṇa*s, illness is considered to be the result of their imbalance (*vikṛti*) and Ayurvedic diagnosis and treatment are based on their equilibrium and disequilibrium.

is interconnected with the perception of Ayurveda as a cleansing treatment, as pointed out above by Alexandra.

However, while several guests at Ayuresort associated Ayurveda with these health-related aspects, only a few guests perceived Ayurveda as a "way of healing" like David. Many guests did not consider Ayurveda a medical system like Traditional Chinese Medicine or Homeopathy, which they had experienced in their home countries, as shown next: "Chinese medicine is medical for me. But I had never associated Ayurveda with real medical treatment" (Hannah). Two female guests from Germany were even surprised when I told them about the existence of Ayurvedic hospitals. Treating diseases with Ayurveda was difficult to imagine for many guests, who denied Ayurveda the capability of handling more than minor ailments. For instance, Linda stated that "the treatment here is good to unwind, but I would not come here with medical evidence." And Frank (56, Germany) explained: "I have tinnitus on both sides. But I don't think massaging the ear and then pouring oil into it will have positive effects. I think Ayurveda is pretty good for loosening or for getting rid of knee pain or for treating digestive disorders; for negligible things."

For Frank, Linda and the majority of the other guests, Ayurveda was not a therapeutic treatment method for diverse diseases in the same way as biomedicine or other medical systems such as Homeopathy or Traditional Chinese Medicine. It was rather perceived as an ancient Indian tradition that is beneficial for treating "minor disorders" (Sandra) or "negligible things" (Frank) – and for preventing illnesses. In the same way as David wanted to visit Ayuresort because he "know[s] that sometimes it's good to have yourself getting a good treatment" or Sandra because she wanted "to do [her]self and [her] health some good," several guests considered Ayurveda beneficial for maintaining one's health. When I asked Victoria (46, Germany) about her reason for coming to the resort, she replied: "For prevention against possible diseases and for recreation." Isabel (33, Germany) justified her visit with her first experiences with Ayurvedic treatment at Ayuresort about one year before: "This time I am here for prevention. I have not been sick one single time during the last year. So the treatment was beneficial for my health." Several guests associated Ayurveda with preventive treatment that preserves the current state of health and, in this regard, lets the body grow old in a healthy way.

In addition, for many guests Ayurveda was a method for recreation and relaxation. Several guests complained about chronic stress[65] and general fatigue and considered their

[65] The concept and syndrome 'stress,' together with the concept and practice of relaxation, is analyzed and problematized in Chapter 3, when I explore the incorporation of 'stress' into Ayurvedic nosology and the resulting transformation of Ayurvedic practice due to desires and needs of the resort guests.

stay at Ayuresort a proper means for relieving stress and for gaining new strength and energy for managing their daily life: "I was very tired at home. I had the feeling that life was passing me by. Children, house, garden, working. So I thought this [Ayurvedic treatment] is certainly good for me" (Jessica; addition by the author). "I wanted to have Ayurvedic treatment because I am always exhausted, because I constantly take care of many things" (Charlotte, 60, originally from the United States but residing in Germany). "I was stressed. I could not even listen to loud music anymore. I thought Ayurvedic treatment would do me good." (Sophie, 38, Germany). I could almost indefinitely extend this list of quotes that illustrate the perceptions of Ayurveda as remedy against stress and fatigue or as means for relaxation and recreation. This, in short, was the pre-eminent image that most guests had of Ayurveda, either as an all-encompassing perception, or at least a major part of it. As a result, Ayurveda was considered by many guests as 'wellness treatment:' "Since I had heard a lot about Ayurveda I wanted to try it. Here, it is affordable. In Germany, you cannot afford to be massaged every day, so I really like this accessibility to wellness" (Nicole). Similar to how Linda considered Ayurvedic treatment as "wellness" where you can "enjoy massages" (see quote above), other guests perceived Ayurveda as massage-based pleasure treatment. A German couple that stayed at Ayuresort for ten days and had Ayurvedic treatment for three days explained: "We do this [Ayurvedic treatment] because we want to give ourselves a treat. We just allow ourselves some massages" (addition by the author). Massages constituted a major aspect of the perception of Ayurvedic treatment for numerous guests. For several guests, Ayurveda *was* massages: "I thought Ayurveda is only massage and nothing else" (Angeline, 48, France). "What I imagined of Ayurveda, because this is the common image of Ayurveda in Europe, was oil massages, *śirodhārā* and four-handed massages" (Adam, 36, Italy [South Tyrol]).[66]

Interrelated with this perception was another notion of Ayurveda: Ayurvedic treatment as part of a '*feel-good*' holiday package. This perception was especially prominent with guests whose main intention for visiting India was not Ayurvedic treatment but traveling through India, either individually or as part of a tour group. These guests stayed at Ayuresort for a few days and received some applications as part of their holiday trip. Ayurveda was considered as something to experience due to curiosity or desire: "I came here for the combination of beach and the desire for Ayurveda because I was interested in it. I wanted to try it out" (Andrea, 40, Germany). Julie (78, France), leader of a French tour group of 19

[66] I will address the role of massages for the perceptions of Ayurveda and for the formation of Ayurvedic practice in the resort in Section 2.3. At this point, it is important to note how several guests associated Ayurveda with massages and wellness practice as opposed to therapeutic treatment.

persons justified her decision to include a five-day Ayurvedic treatment in their two-week journey through Kerala and the neighboring state Tamil Nadu as follows: "I know Ayurveda for six, seven years. I have done many cures in different places. It appeals to people and it is something different than just traveling from place to place." Here, Ayurvedic treatment is taken for a change and is perceived as a holiday activity like attending the South Indian classical dance drama *kathakaḷi* or taking a cruise in the backwaters, the popular branching network of rivers, canals, lakes and lagoons along the west coast of central Kerala.[67]

Taking stock of guests' perceptions of Ayurveda demonstrates their great variety and at the same time reveals several common elements. For many guests, especially for those whose primary intention for visiting India was Ayurvedic treatment, Ayurveda was an ancient, natural, holistic Indian health tradition, which they contrasted with a modern, synthetic, atomistic Western biomedicine. However, most of those guests perceived Ayurveda rather as treatment for maintaining health or preventing diseases than as therapeutic medical option complementary or alternative to biomedical treatment against a specific ailment. Almost all guests who considered Ayurveda a form of health care, simultaneously regarded Ayurveda as wellness treatment and as beneficial for recreation and relaxation: "The reason for coming here was rather recreation than the belief that Ayurveda can be beneficial for my health. My focus is not on medical treatment but on recreation" (Annabelle, 31, Germany). "I don't have any health problems. For me, relaxation is the main thing" (Barbara, 50, Switzerland). "I am here for recreation. Treatments are only massages. It is not treating a specific disease. I consider this as wellness" (Emma, 46, Germany). These quotes demonstrate that although those guests considered Ayurveda a medical treatment, they pitched on aspects of relaxation, recreation and wellness, which they also associated with Ayurveda. This was not a contradiction for them. In the perception of several guests, two seemingly opposite forms of Ayurveda merged. For them, Ayurveda was a "science of life" or "science of longevity" that includes elements of curative or preventive care on the one side and aspects of wellness, relaxation and recreation on the other side. And the emphasis on the one or the other varied from person to person. For these guests, Ayurveda was neither a medical treatment nor a wellness practice but something betwixt and between. It was a 'technology of the self' (Foucault 1988), through which the guests could actively achieve and maintain health, which they considered rather as a process that needs to be constantly worked on than a state that is given. The dividing line between medical and wellness treatment becomes blurred here,

[67] The perception and practice of Ayurvedic treatment as a holiday activity will be discussed in greater detail in Chapter 4.

as does the distinction between preventive and therapeutic treatments, as the intention and perception of Ayurveda of 'doing something good for yourself and for the body' can refer to pampering practice, illness prevention and treatment of minor ailments.[68]

While wellness, relaxation and recreation were aspects of the perceptions of those guests who considered Ayurveda in general as health care treatment, for all other guests these very aspects represented Ayurveda. These guests, primarily those whose main intention for visiting India was not Ayurvedic treatment, considered Ayurveda as wellness or relaxation treatment or a holiday activity.

Thus, the perceptions of the majority of the guests at Ayuresort, and apparently also of most of the guests at other Ayurvedic resorts in India (see Islam 2012: 225; Spitzer 2009: 143; Tirodkar 2008: 233), differed considerably from those of the patients in Ayurvedic clinics and hospitals. While the latter seek Ayurvedic treatment for curative care and hence generally consider Ayurveda as therapeutic treatment, the perception of Ayurveda in Ayuresort was much less therapy-related and much more multidimensional. The majority of guests considered Ayurveda as a tourist activity, preventive medical treatment, wellness treatment and massage practices, as well as a relaxation practice, either exclusively or in combination. And while aspects of holiday, recreation, relaxation or wellness were absent in the perceptions of patients who visit Ayurvedic clinics or hospitals, they were very prominent in almost every resort guest's perception of Ayurveda.

The variety of visit reasons presented above is the result of a mix of perceptions brought by the guests to the resort that rest upon their experiences with Ayurvedic treatment they had prior to their visit at Ayuresort; by virtue of their exposure to either Ayurvedic practice in Asia or their home countries, or to visual or textual representations of Ayurveda in various print and online media as well as advertisement material. In the following section, I analyze these experiences and illustrate their impact on the guests' perceptions of Ayurveda and consequently on their motivations for visiting the resort. I first describe the experiences guests have had with Ayurvedic treatment before they came to the resort and interpret the correlation between Ayurvedic practice prevalent outside South Asia and the perceptions of Ayurveda of those guests. I will show that the Ayurvedic treatments they experienced differ considerably from Ayurvedic practice in Indian Ayurvedic clinics and hospitals, and that these 'Western' forms of Ayurveda have a fundamental effect on the formation of the guests' perceptions of what Ayurveda entails. I will then analyze the influence of

[68] I delve into this point in Chapter 4 when I scrutinize this convergence of therapeutic, preventive and wellness practice at Ayuresort referring to the common dichotomous differentiation between medical and wellness treatments and popular and scientific concepts of wellness.

promotional material and print and online media representations of Ayurveda in shaping the perceptions of the guests at Ayuresort. In the process, I analyze various visual and textual representations of Ayurveda produced by Ayurvedic centers as well as the Indian and Keralan Ministry and Department of Tourism, and how they attempt to shape guests' perceptions of Ayurveda.

2.2 Imag(in)ing Ayurveda: Ayurvedic Experiences and Media Representations of Ayurvedic Treatment

Out of the 59 guests at Ayuresort I talked to, 36 had experienced Ayurvedic treatment before they visited the resort, either in their home countries or abroad. Interestingly, except for Alice, Charlotte, Martha (60, Germany) and Oliver (49, Germany),[69] no guest had had Ayurvedic treatment in an Ayurvedic clinic or hospital. From the guests with prior experience with Ayurvedic treatment, 28 had visited one or more Ayurvedic resorts in different tourist destinations in India or Sri Lanka, and their perceptions of Ayurveda and the expectations of their stay at Ayuresort had been shaped by their experiences in those resorts. In general, these experiences were similar to those they made at Ayuresort as they told me. The eight guests of Ayuresort who had experienced Ayurvedic practice outside South Asia before they visited the resort, had had Ayurvedic treatment in different day spas, beauty salons and massage parlors. Jennifer, for instance, had several Ayurvedic applications during her business travels to the United Arab Emirates: "I had one-day treatments in Dubai and I quite enjoyed them. It was different from here. It was in a five star resort and I received massages and oil on the forehead. It was just for one day, but several times." Some other guests have had Ayurvedic treatment during vacation trips to other countries. In most cases, they had received single applications in the wellness area of the hotels they stayed at. Some guests had even used these spa areas as 'training centers' for their upcoming visit of an Ayurvedic resort in India, like the Swedish couple Anne and Aaron (55): "In our holidays in Malta, we had three days Ayurveda in a spa. This was our preparation for the stay here in India" (Aaron).

Other guests of Ayuresort had received Ayurvedic treatment in their home countries before they came to the resort. And similar to those guests who have had Ayurvedic treatment during vacation or business trips, they had experienced Ayurveda in massage parlors, beauty salons or wellness centers. Hannah's first encounter with Ayurvedic practice had also taken place in the wellness area of a hotel in Austria:

[69] See Appendix A.3.

> *In fact I really got to know Ayurveda in this wellness hotel. What I learned there was probably only a fraction of Ayurveda as it is practiced in India. I witnessed an Ayurveda group there, and during breakfast everyone of this group knew what type she was and what she can choose from the buffet for breakfast. I saw this and then I just approached this. I received a spoonful of hot water with ghee* [clarified butter] *every day for breakfast. I was fascinated by this diet. I received a diet attuned to the three types. Everyone received different food. Okay, I only got to know the forehead flush and the synchronic oil massage as treatment forms. Only the wellness area, where I booked the Ayurvedic massages. But I was enthusiastic about this combination: a diet that is vegetarian and attuned to types, and in addition a wellness factor, a spa factor. Without knowing much about Ayurveda. The first information for me was that Ayurveda means happy life, healthy life, and this is achieved through different factors: diet, treatments, and that you have to relax in good time* (addition by the author).

Like all other guests of Ayuresort who had experienced Ayurvedic practice outside South Asia, Hannah had taken Ayurvedic treatment not in a hospital or clinic, but in an institution situated within the realm of recreation and wellness. She did not have a consultation with an Ayurvedic practitioner before her treatment, and she was the one who decided which applications she received. She chose the "forehead flush and the synchronic oil massage" from a list of available applications. The absence of an interaction with a doctor and a clinical diagnosis, the lack of an intention for treating a specific ailment, the desire for a treatment for relaxation and recreation, the active role of the visitor in choosing the treatment, and the positioning of the treatment within the realm of wellness and tourism lets Ayurveda assume the shape of a non-therapeutic wellness application for recreation and relaxation.

Hannah experienced Ayurvedic treatment as massage-based wellness treatment and this form of Ayurvedic practice molded the perception of Ayurveda of several guests at Ayuresort. As I have already mentioned above, some guests were surprised when I told them about the existence of Ayurvedic hospitals in India. One of them was Jessica, who claimed that "in Germany the image of Ayurveda as wellness is much more common." This image of Ayurveda as 'wellness treatment' primarily results from the prevalence of day spas, beauty salons, massage parlors, hotels and Ayurvedic centers that offer single Ayurvedic applications for relaxation and wellbeing. Although Ayurvedic treatment can also be found in the therapeutic sphere, Ayurvedic applications that can be clustered as 'wellness treatments' situated in the cosmetic and wellness industries seem to prevail within the German Ayurvedic landscape, informing the perceptions of Ayurveda from German guests at Ayuresort. Having experienced Ayurvedic treatments as a loose cluster of gentle wellness, recreation and beauty practices in different massage salons and beauty parlors, several guests' perceptions of Ayurveda were shaped through these experiences as described above. Ayurveda was considered by almost every guest of Ayuresort as a beneficial relaxation or anti-stress treatment that is taken for recreation. Indeed, the prevalence of Ayurveda in massage parlors and day spas results in many guests' association of Ayurveda with wellness

applications in form of oil massages, as the following dialogue I had with Hannah illustrates:

Hannah:	*In Austria, all people I spoke to and also myself – as I got to know it* [Ayurveda] *in the hotel back then in this way – only know the forehead flush and synchronic oil massage. That's Ayurveda back home.*
Author:	*Did you already know that Ayurveda consists of massages in great part before you came here?*
Hannah:	*Yes, I associated Ayurveda particularly with oil massages. Synonymous with Ayurveda was for me massage or forehead flush* (addition by the author).

As in Hannah's case, several guests of Ayuresort only heard about Ayurveda, at least for the first time, in association with the wellness and massage industry. Thomas' comments are telling: "I have several friends who have to do a lot with massages and I myself was educated in biodynamic massage. In this way Ayurveda comes to the fore." In Thomas' case, Ayurveda's proximity to massage treatments resulted in his first exposure to Ayurveda – in a non-clinical context.

The extent to which Ayurveda is recontextualized is clearly shown by the case of Shannon (43, Canada). She was trained in 'Indian head massage' in Canada, without having heard about Ayurveda before. She learned only about Ayurveda through her instructor during her education. In this example, single elements of Ayurveda were detached in the course of its transfer from South Asia to Canada and took a life of their own. They subsequently spread in a new environment, without the contextual element of Ayurvedic practice, which became only known to Shannon when she was already being trained in it.

Another aspect of Ayurveda prominent in Europe and North America featured in the perceptions of many guests at Ayuresort is the existence and importance of a specific 'Ayurvedic diet.' As Hannah's quote above demonstrates, her first experience with Ayurvedic practice in the Austrian hotel in 2002 was not only marked by the "Ayurvedic massages," but she "really got to know Ayurveda" because she was confronted with a specific diet: a vegetarian diet that caters to *prakṛti*, and that Hannah from that moment on considered to be a basic part of Ayurveda. This is a representative position of guests at Ayuresort as described above. Sandra, for instance, had heard about this particular diet during a consultation with an Ayurvedic practitioner in her hometown, which prompted her to start cooking according to its principles. Interestingly, as Hannah's example illustrates, this diet is not confined to the therapeutic space of curative Ayurvedic treatment, but can also be found in hotels that offer Ayurveda for recreation and relaxation. In this way, a specific 'Ayurvedic diet' becomes a crucial element of many resort guests' perception of Ayurveda as I have demonstrated above, although they never had received therapeutic Ayurvedic

treatment in their home country.

Guests at Ayuresort however did not only learn about Ayurveda through their own experiences with Ayurvedic practice, but also by narrations of friends and relatives who have had Ayurvedic treatment in their home countries. When I asked Paul what he thought of Ayurveda before coming to Ayuresort, he replied: "I imagined wellness, because different friends have already done that. I first thought about diet and certain massages." Jessica told me: "My sister-in-law has had a ten-day Ayurvedic treatment in Germany and was totally thrilled and relaxed afterwards. She said it was like a holiday. Over time, I learned that it is more than eating and massages. However, before I came here I didn't know that you can treat so many diseases with Ayurveda."

Whether having experienced Ayurvedic treatment themselves or having heard about Ayurvedic practice through friends or relatives, many resort guests' perceptions of Ayurveda were shaped by Ayurvedic practice prevalent in Europe and North America, which is marked by its association with a specific Ayurvedic diet, gentle procedures, and wellness elements. The association with wellness is particularly predominant in Ayurvedic practice outside South Asia, forming in this way a core element of an Ayurvedic imaginaries – both in the public perception and consequently in the perceptions of the single resort guests (see also Chopra 2005a: 39, 41). An Ayurvedic practitioner from Germany interviewed by Frank also points to this direction when he explained: "I strictly consider Ayurveda a science. And in Germany, it unfortunately drifted off very much into the realm of wellness. And that is really a shame. People want massages, they want wellness, that is great – indulgence! – that is fantastic, but it is pretty much a fad. In all women's magazines you again and again see something about Ayurveda, but always only wellness-like" (Frank 2004: 233; original in German). While this statement implies an essentialist perception of an existing 'true Ayurveda' which assumes a deficient shape in the course of its transfer to the 'Western world,' the practitioner brings up a crucial (f)actor for the formation of the perception of Ayurveda prevalent outside South Asia: the media. Print and online representations of Ayurveda play an important, if not the most relevant, role in shaping the imaginaries of people outside South Asia. As a result, the perceptions of virtually all guests of Ayuresort, together with their reasons for visiting the resort, were influenced by media representations of Ayurveda; either exclusively or in combination with perceptions stemming from their own experiences with Ayurvedic practice or from narrations of friends and relatives. This was reflected in the guests' comments on the sources of their knowledge and perception of Ayurveda.

The emergence of Ayurvedic practice outside South Asia has been accompanied by specific visual and textual media representations. In Germany, media interest began to grow in the 1990s, through different television broadcasts and print magazines, such as talk shows and news magazines. The media reports primarily focused on massage-like applications in the context of *pañcakarma* treatments and Ayurvedic treatment was predominantly depicted as gentle massage-based therapy practiced in exotic and pleasant surroundings (Frank 2004: 200; Frank and Stollberg 2002: 224). Also in the following years, gentle and pleasant aspects of Ayurvedic treatment were portrayed as its prominent features within German media representations of Ayurveda (Frank and Stollberg 2004a: 82), what eventually resulted in Ayurveda's re-contextualization "in a discourse of luxury, recreation and wellness" (Frank and Stollberg 2002: 241). Apart from that, the German Ayurvedic media coverage includes discourses of spirituality, tradition, holism, and its South Asian origin. Many providers of Ayurvedic treatment represent Ayurveda on their websites as being ancient and Indian, part of a holistic view on the person, i.e. body and soul not being considered separated (Koch 2006: 171), and Ayurveda is frequently – both implicitly and explicitly – offered as "*spirituelles Sinnangebot*" (spiritual mode of meaning, Koch 2006: 170; see also Koch 2005).[70]

Media representations of Ayurveda in other countries consist of similar elements (Zimmermann 1992: 217f.; Svoboda 2008: 127; Langford 2002: 56). While both Zimmermann and Svoboda point to representations of Ayurveda as gentle oil massage treatments, Langford's description of print representations of Ayurveda portrays it as preventive holistic health care treatment. In addition, Ayurvedic treatment is promoted as being natural and thus safe (Malhotra et al. 2001: 71), as "spiritually attuned, antimaterialist, and nonviolent, in contrast to biomedicine" (Langford 2002: 17), and as traditional remedy against "the severe and toxic side effects of both modern lifestyles and modern pharmaceuticals" (Langford 2002: 17). On the contrary, Betina Freidin's and Matías Ballesteros' analysis of representations of Ayurveda in Argentinian newspapers between 1997 and 2010 (Freidin and Ballesteros 2012) shows that Ayurveda is only marginally situated in the realm of medicine and health care. Instead of being covered in health-related sections, reports on Ayurveda are predominantly listed in sections like 'travel,' 'woman,' 'fashion and beauty,' or 'tourism' (Freidin and Ballesteros 2012: 136).

This variety of Ayurvedic media representations is also mirrored in the three ways Ayur-

[70] The only existing study about the content of Ayurvedic representations in the German media is Koch's website analysis of nine German suppliers of Ayurvedic treatment (Koch 2005), which is restricted to therapeutic Ayurveda and excludes all institutions that provide other forms of Ayurvedic treatment, as Koch chose the websites for her sample through a Google search using the keywords "Ayurveda *und Medizin*" (Ayurveda and medicine, Koch 2005: 35; emphasis by the author).

veda is promoted in the North American media according to Sita Reddy: "[...] as a system of vegetarianism and dietary restraint, as a system of rejuvenative tonics and rejuvenation, and as a system of ascetic health techniques practiced by active seekers of health and well-being. While the first revolves around purification, the second revolves around replenishment and power and the third emphasizes personal and spiritual transformations" (2002: 113). In her analysis of representations of Ayurveda in North American mass-distributed print media, Reddy illustrates how the representations of Ayurveda between the end of the 1980s and the end of the 1990s changed from focusing on elements of Indian mysticism to portraying it as an effective non-Western alternative curative medical system to finally concentrating on aspects of naturalistic prevention and health maintenance (ibid: 211, 213f.).

All these different representations of Ayurveda are part of a global Ayurvedic mediascape (see Appadurai 1990) and jointly form the global Ayurvedic "public eye" in the sense of Peter Conrad's understanding of this term as "emblematic of the images and information available in the public sphere [...] [that] includes news, television, film, documentaries, periodicals, fiction, and the so-called information superhighway" (Conrad 1997: 140; addition by the author). And since the public eye "becomes a crucial site [...] that health-seeking individuals use to construct meanings of social phenomena" (Reddy 2004: 207), the Ayurvedic public eye informs the perceptions of Ayurveda that a great number of individuals in many parts of the world develop.

Images of and information on Ayurveda can be found in televisual, radio, print and online reports and advertisements. Since their management wants to sell Ayurvedic treatment, Ayurvedic resorts produce visual and textual representations of Ayurveda for both informative and promotional purpose. These representations do not only manifest locally in the form of brochures and billboards or other advertisement materials, but also have a translocal character since they can be found on the resort's website and also make their way into other print and online media accessible for a broad audience, in form of advertisements and reports in various magazines, travel guides and travel catalogs, as well as a large number of websites. Representations of Ayurveda created by resort managements thus do not only have an impact on the perceptions of Ayurveda of many individuals when they are interested in having Ayurvedic treatment at an Ayurvedic resort, but also assume a major role within the wider Ayurvedic public eye. Therefore, an analysis of such representations demonstrates not only what kind of Ayurveda the resort management wants to sell to potential clients, but eventually hints at the perceptions individuals exposed to the global Ayurvedic public eye develop.

Figure 2.1: Photo shoot of Ayurvedic treatment at Ayuresort (photo by the author)

During the first month of my stay at Ayuresort, I witnessed a photo shoot that was part of an advertisement campaign of the resort. Over two days, a professional photographer and his assistants took pictures of the resort and its surroundings for different print and online advertisements for the upcoming tourist season. Besides the compound, the rooms, the restaurant and the beach, Ayurvedic treatment was photographed (see Figure 2.1). This provided an excellent opportunity to study the creation of visual media representations of Ayurveda by the management of Ayuresort. While the photographer was responsible for the technical aspects of the shoot, all content related aspects, like the selection of motifs or the arrangement and design of the setting, were under the direction of the resort running company in the person of Manu, the manager of its creative department who visited Ayuresort for those two days. Observing the photo shoot and discussing single elements with him revealed the images of Ayurveda that should be communicated to attract guests. These images must not only be attractive to appeal to the guests, they also have to connect with the guests' perceptions of Ayurveda. Hence, analyzing the photo shoot reveals both representations of Ayurveda by the resort and guests' perceptions of Ayurveda, since it can be assumed that the creative manager knows the Ayurvedic zeitgeist that manifests in the guests' perceptions and that has to be triggered to sell the product in question.

Since the treatment rooms with their rose, crimson and dark-green concrete plastered walls were not considered attractive enough by Manu, a treatment table was transferred from a treatment room to one of the wooden guest cottages. A Keralan brass floor oil lamp

(*nilavilakku*)[71], a brass cannikin filled with tulsi leaves[72] and brass mortar and pestle were positioned on a small table standing adjacent to one of the cottage walls. Apart from the missing picture of Dhanvantari, an avatar of Viṣṇu and physician of the gods in Hindu mythology, who is considered the tutelary deity of Ayurveda, the arrangement was similar to the photo described in the opening section of this thesis, which was also produced at Ayuresort in the course of a former advertising campaign and used for promoting Ayuresort on billboards.[73] The female model was a young tourist from Spain who had been asked by Manu at the beach if she liked to participate in the shoot, in return for a massage and a dinner. During the shoot, which took about five hours including all preparations, three different Ayurvedic treatments were staged: *śirodhārā*, *abhyaṅga* and *kiḻi*. The resulting pictures of *śirodhārā* (see Figure 2.2) and *kiḻi* (see Figure 2.3) have later been used to represent the Ayurvedic treatment in the resort on the resort's website, in a resort brochure and calendar, and in advertisements in different travel magazines.[74]

In both pictures, the model conveys a feeling of wellbeing and indulgence. She appears to relax and enjoy the seemingly pleasant treatments, and the usage of the white towels adds to the resemblance to a wellness application in a spa or massage parlor. At the same time, the holiday atmosphere that is communicated by the palm trees and the sea in the background of the *śirodhārā* photo evokes associations of a pleasant application in a relaxing environment. Ayurveda turns from a medical treatment into a wellness product consumable during or in form of the annual holiday. Not surprisingly, the resort management wants to sell exactly this very image of 'Holiday Ayurveda,' as the following statement by Manu shows: "With the picture, we want to tell the foreigners: 'Come for Ayurveda, relax, and take a swim in the sea.' They want to experience nice Ayurveda. Because it's not real

71 These oil lamps can be found in most Keralan households and temples. Lighting this oil lamp is considered auspicious and it is thus an essential element in many rituals and ceremonies. It is however not confined to the Hindu population but also exists in Christian families and churches.

72 Tulsi (Lat. *ocimum tenuiflorum*) is a tropical plant native to Asia and part of the Ayurvedic *materia medica*. It is further considered sacred in Hinduism and used in different Hindu rituals.

73 Interestingly, a picture of Dhanvantari had been placed beside the objects in the background at the beginning of the photo shoot. When I saw the final photos, I realized that the picture had been removed during the shoot – which I did not notice that day –, together with a second brass cannikin filled with tulsi leaves. When I later asked Manu why both the Dhanvantari picture and the second cannikin had been removed, he explained that they had to give away in favor of the visual aesthetic. Thus, the aesthetic image composition was more important for him than an association of Ayurveda with religious elements. During my research I learned that religious elements did not play a role in the perception of Ayurveda of most of the guests.

74 Photos of *śirodhārā* are prominently featured in visual representations of Ayurveda. It is arguably the most frequently portrayed Ayurvedic treatment in print and online media as well as advertisement materials and assumes a crucial role in the prevalent public image of Ayurveda – and in the imaginations of the resort guests. Its omnipresence in the media is co-constitutive with its prominent position within the range of treatments offered in Ayurvedic resorts, and the staging of the treatment during the photo shoot made me realize its central role in Ayurvedic resort practice immediately at the beginning of my research. I analyze this role and the treatment itself, together with its specific formation in the resort sector in detail in Section 3.3.

Figure 2.2: Picture of *śirodhārā*, produced during photo shoot at Ayuresort (courtesy of Jijo John)

Figure 2.3: Picture of *kiḻi*, produced during photo shoot at Ayuresort (courtesy of Jijo John)

Ayurveda here." With "real Ayurveda," Manu referred to the practice in Ayurvedic clinics and hospitals, where the focus is on curative care. In contrast, in Ayurvedic resorts the applications do not aim at the medical treatment of certain ailments but are conducted to entertain the guest according to Manu. Hence Ayurveda is merchandised as one element of an all-round wellbeing package that includes elements of relaxation and recreation.

Another aspect emphasized in the photo shoot is Ayurveda's naturalness. The transfer of the treatment setting from a concrete building where the treatment rooms are located to a wooden cottage, and the sea and the palm trees in the background of the *śirodhārā* picture, add to the image of Ayurveda being close to nature. Through this relocation, Ayurvedic treatment moves away from a medical or hospital sphere to a natural or holiday environment. And by placing tulsi leaves in the picture of *kiḻi*, Manu intended to "make the picture rich" for aesthetic reasons on the one hand, and to convey a "natural image of Ayurveda" on the other hand. At the same time, Ayurveda is commonly regarded and represented as "natural," due to its emphasis on herbal medicines, in comparison to biomedical pharmaceuticals. He opted for tulsi leaves in the *kiḻi* picture since tulsi is a "traditional Ayurvedic drug," according to Manu.[75]

'Tradition' is at the same time the third aspect represented in the photos. Ayurveda is displayed as being "traditional and very old," since "this is the selling part of Ayurveda." Manu staged Ayurveda as "traditional" and "Indian" by incorporating various objects he considered as "traditional Indian things." By placing the cannikin, the oil lamp, and the mortar and pestle in the background, Manu intended to create an "old looking ambiance" which refers to Ayurveda's "rich traditional background." Another element linking Ayurveda with Indian "tradition" is the sari that the female therapist had to wear during the shoot, since Manu considered it the "traditional uniform of India." The relevance of portraying the sari on the photo became further clear during the shoot when the female therapist explained that she did not want to show her face on the photo and Manu thereupon remarked that this is not necessary as long as her sari was clearly visible. By incorporating the sari in the picture, as Manu himself was wearing jeans, polo shirt, and sneakers during the shoot, he sought to create a specific 'traditional Indian' atmosphere. He used the sari as cultural medium in the sense of Terence Turner's notion of the social skin that communicates social identities (Turner 1980): Manu used the more widespread image of the sari as "an emblem of culture and tradition" and "the garment of India" (Banerjee and Miller 2003: 252, 237)

[75] In clinical Ayurvedic practice, tulsi is primarily used for treating colds, digestive disorders, uropathies, and heart complaints (Schrott and Ammon 2012: 412).

to establish an association of Ayurvedic treatment with an imagined 'Indian tradition.'

In short, a specific image of Ayurveda was generated: Ayurveda as natural, traditional and a relaxing wellness treatment. However, there are other elements that are conveyed, rather implicitly, in these images. On the one hand, there are racial connotations. Photos of Ayurvedic treatment usually portray dark hands on fair skin, depicting an Indian therapist treating a European or North American visitor. In many cases, this person has white skin and blonde hair, thus intensifying the mediated cultural and racial differentiation between her[76] and the therapist. The choice for foreign models (see also Islam 2008: 210), mirrors the practice in Indian advertisement campaigns in general (Abu-Er-Rub 2015: 130, 134). The main cause for choosing a foreign model for the shot at Ayuresort though, was presumably the orientation of the marketing efforts towards the European and the North American market, where most guests come from. Employing foreign models in Ayurvedic resort campaigns was certainly intended for both connecting with the target audience and portraying the empiric scenario of an existent majority of non-Asian guests in Ayurvedic resorts, the contrast between the lighter client and darker therapist simultaneously contributes to a racially-informed East-West dichotomization and eventually to an otherness of Ayurveda mediated by the resorts and perceived by the foreign viewer, albeit only implicitly and probably unintended. In the case of the photo shoot at Ayuresort however, this dichotomy was mitigated by the choice of the creative manager for a model with darker skin and hair color – although still foreign and not Indian. His intention behind this choice was however not related to racial connotations, but to marketing purposes. In doing so, he explained to me, he intended "to kill two birds with one stone:" the Spanish woman with moderate brown skin and black hair should represent a person with a neutral nationality to address both Indians and foreigners.[77]

On the other hand, the pictures carry a level of sensuality captured by a body that is only partially covered with a towel, thus exhibiting plenty of skin. Indeed, Ayurvedic treatment is associated with sexual practice by a part of the local population as mentioned in Chapter 1. Female therapists of Ayuresort could not disclose to their relatives where they work since many of the latter group consider Ayurvedic resorts to be immoral institutions where sexual services are part of a daily offer. Nonetheless, while the common rationale 'sex

[76] In most pictures representing Ayurvedic treatment the model is female. This mirrors the dominance of female guests in the resort and of female models in advertisement campaigns for medical and cosmetic products (see e.g. Jäckel et al. 2009: 31 [Figure 5]), including Ayurvedic ones. By using female models for photos of Ayurvedic treatment, the resort management conforms to the marketing theory that the identification with a specific product is increased through its advertisement by a same-gender model (Eck 2008: 101; Zurstiege 1998).

[77] This decision was also influenced by the low number of Indian guests at Ayuresort. During my research, there was only one guest from India (Delhi) who visited the resort with the intention of having an Ayurvedic treatment.

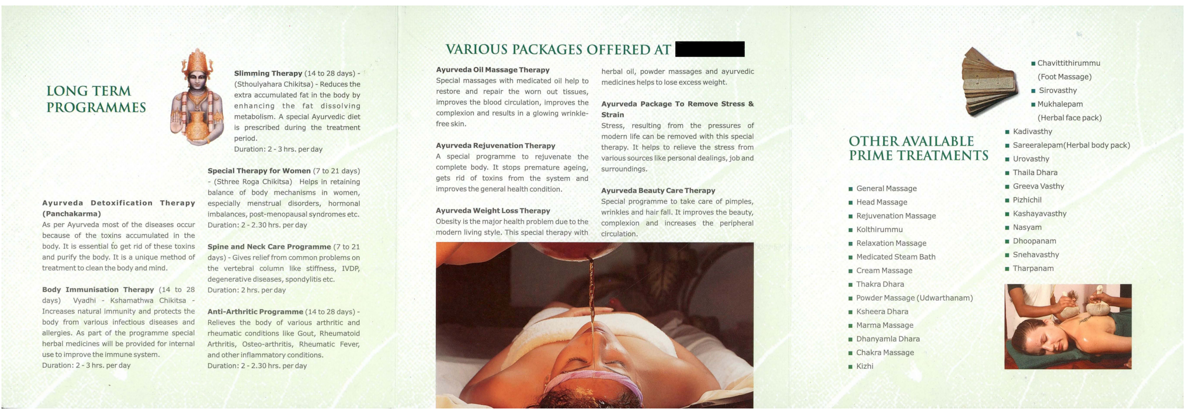


Figure 2.4: Inner face of folder advertising Ayurvedic treatment at Ayuresort

sells' underlies many contemporary advertisement campaigns for all kinds of products and services, this is presumably not the main motivation for 'showing skin' in the pictures aimed at marketing Ayurveda. The product that shall be sold through these pictures, Ayurvedic treatment simply features an extent of nakedness: during the treatment the guests only wear a muslin thong to cover their genitals. On the contrary, sexual connotations are rather contained through the presentation of a female therapist in the photo – although this does not account for same-gender sexual associations of course.

As mentioned above, the two photos of *kiḻi* and *śirodhārā* produced during the photo shoot have been used to visually represent Ayurvedic treatment in different advertisement materials. While a table calender of 2010 produced by the resort-running company depicts the photo of *kiḻi* in the month of June, accompanied by the caption "Discover an extraordinary way to heal the body at our Ayurveda Wellness Spa" – which again emphasizes the imaginary of Ayurveda being a wellness practice –, a two-sided leaflet that advertises "Ayurveda Packages" offered at Ayuresort shows the photo of *śirodhārā* on its front side, while the back side lists the different Ayurvedic long-term treatment courses with their prices, together with the picture of *kiḻi* and a photo of the resort complex. The two photos further visually represent Ayurvedic treatment at Ayuresort in various advertisement announcements in different magazines and travel guides and on Ayuresort's website, where the *śirodhārā* picture represents the Ayurveda section.

The brochure of Ayurvedic treatment at Ayuresort produced before my research also depicts photos of *kiḻi* and *śirodhārā* (see Figure 2.4). Besides these two photos – of which the *śirodhārā* picture stands out due to its big size and central position – the folder's inner face displays a photo of palm leaf manuscripts and a drawing of Dhanvantari. While the pictures of Dhanvantari and the palm leaf manuscripts evoke associations with religion

Figure 2.5: Outer face of folder advertising Ayurvedic treatment at Ayuresort

and ‘tradition’ or ‘ancientness’ in the viewer, the two treatment photos convey elements of wellbeing, pleasantness and indulgence, exactly as the two photos analyzed above.

Another aspect mediated through the brochure is an association of Ayurveda with naturalness. The background of the brochure carries a photo-micrograph of leaf textures – in the folder’s inner face in transparent white and greenish colors, and on the folder’s cover page in natural green color. Moreover, the text printed on the front page emphasizes this association of Ayurveda with naturalness:

> Experience a natural health science that’s 5000 years old.
> Experience the essence of natural herbs and roots.
> Experience complete physical, mental and spiritual health.
> Experience all these at Ayuresort (see Figure 2.5; substitution of resort name by the author).

The cover text does not only promote Ayurveda as being natural, but also as ancient and holistic “health science” that can, or better should, be “experienced.” On its outer face, the folder promises to provide guests of Ayuresort “the very best in Ayurveda, in the most traditional style” through “a team of doctors and masseurs.” It also claims that “Ayurveda’s twin objectives of maintaining good health and treating the ill are carried out” at the resort and that the ambiance at the resort “soothes the body and mind of discerning guests.” The folder thus conveys an image of Ayurveda being a natural, holistic, traditional health science for both curative and preventive massage-focused treatments. At the same time, Ayuresort asks its guests to “discover natural beauty & well-being through the traditions of Ayurveda” on a table display which every guest finds in his/her room (see Figure 2.6). Through two photos of two women who appear to enjoy *śirodhārā* and with the words ‘beauty’ and ‘well-being,’ the display projects associations of enjoyment, relaxation, and beauty care with Ayurvedic treatment.

Clearly, the resort management advertises Ayurvedic treatment as a blend of health care

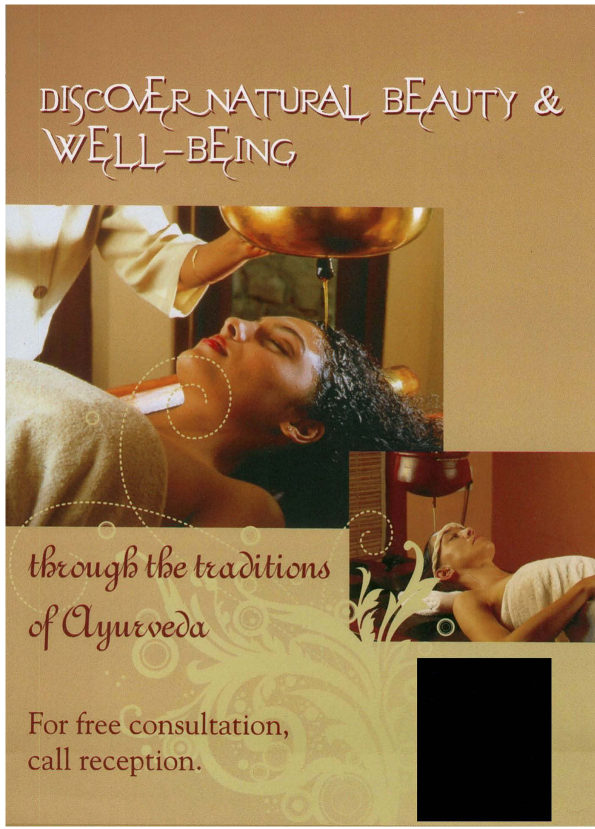


Figure 2.6: Table display advertising Ayurvedic treatment at Ayuresort

and wellness or cosmetic treatment. The mixture between medical and wellness aspects of Ayurvedic treatment also become obvious in the description of Ayurvedic treatment courses and the list of single applications in the folder. The 'long-term programs' and 'packages' include 'Ayurveda Detoxification Therapy (Panchakarma),' 'Body Immunization Therapy,' 'Slimming Therapy,' 'Special Therapy for Women,' 'Spine and Neck Care Program,' 'Anti-Arthritic Program,' 'Ayurveda Oil Massage Therapy,' 'Ayurveda Rejuvenation Therapy,' 'Ayurveda Weight Loss Therapy,' 'Ayurveda Package to Remove Stress & Strain,' and 'Ayurveda Beauty Care Therapy.' The single applications listed in the folder under the heading "Other Available Prime Treatments" comprise both 'classical' Ayurvedic treatments applied in clinical settings like 'Thakra Dhara,' 'Kizhi,' 'Sirovasthy,' or 'Nasyam,' and (re-)invented Ayurvedic treatments specific to the resort sector like 'Relaxation Massage,' 'Cream Massage' or 'Chavittithirummu (Foot Massage).'[78]

The image of Ayurveda as a mixture of medical and wellness treatment, which comprises the mentioned elements of naturalness, pleasantness, holism, ancientness, and tradition,

[78] I will delve deeper into these treatment courses and single applications in the next section, where I discuss the Ayurvedic practice at Ayuresort. At this point, I show how these 'long-term programs,' 'packages' and 'prime treatments' also contribute to the specific representation of Ayurveda that the resort management mediates: a treatment that consists of medical and wellness elements with a focus on the latter.

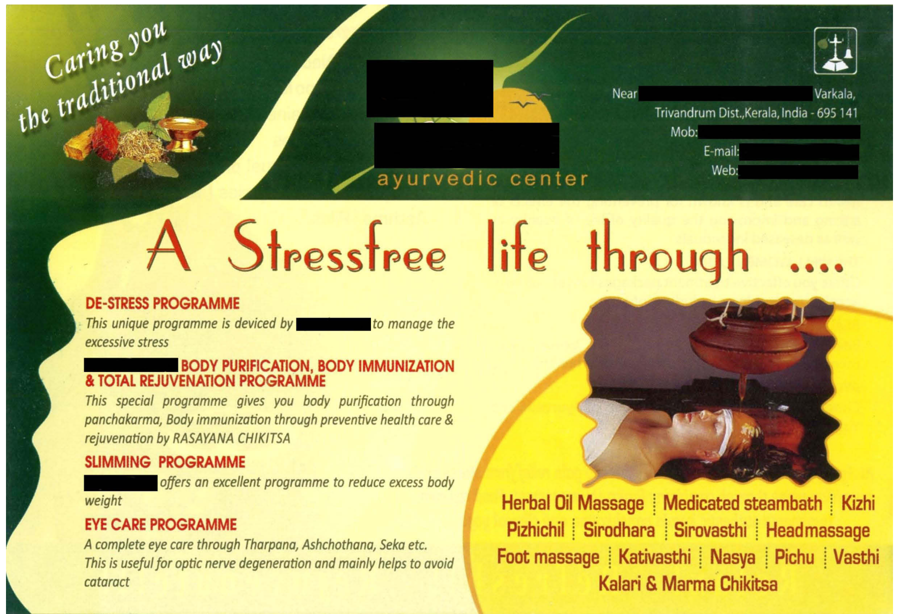


Figure 2.7: Front side of leaflet produced by Ayurvedic center in Varkala beach

is not only conveyed through the different advertisement materials of Ayuresort – which also comprehend various billboards, including the one described in Chapter 1 –, but through all advertisement material produced and distributed by the other Ayurvedic centers in Varkala – and South Asia in general. Although these brochures, leaflets, magazine advertisements, billboards, and websites use different pictures and texts, their content is virtually indistinguishable.[79]

One leaflet that joins almost all elements of common representations of Ayurveda through Ayurvedic resorts is depicted in Figure 2.7 (front side) and Figure 2.8 (back side). While the Ayurvedic center promises in prominent font size in central position on the leaflet's front side a "Stressfree [*sic*] life" through different treatments and invites the reader on the back side to "Relax! Refresh!! Rejuvenate!!!," the statement "Caring you the traditional way" in the front side's upper left corner emphasizes both Ayurveda's 'traditional approach' and the care the center provides for its guests. Similar to the brochure of Ayuresort, the leaflet lists different long-term treatments like 'De-Stress Program,' 'Body Purification, Body Immunization & Total Rejuvenation Program,' 'Slimming Program' or 'Geriatric Care Program,' together with several single applications like 'Herbal Oil Massage,' 'Medicated steam bath,' 'Kizhi,' 'Sirodhara' or 'Foot massage.' On the back side, the center advertises with "special treatments" for various ailments like back pain, migraine, sinusitis,

[79] I have collected leaflets and brochures of 64 Ayurvedic centers located in South India during my research in Kerala and at the world's largest travel trade show ITB in Berlin in March 2009, and they all use the same tropes and buzzwords and similar pictures. The same applies to resort's websites as well as billboards and other advertisement material.

Figure 2.8: Back side of leaflet produced by Ayurvedic center in Varkala beach

skin diseases or asthma. It offers “expert advice to gain relief from stress and agonising pains through combining Prakruthi assesment [*sic*], Food regimen, treatments authentic kerala panchkarma and clinical yoga.”

This textual representation of Ayurveda is accompanied by specific visual representations that presumably shall refer to similar aspects as the different objects and motifs in the photo shoot in Ayuresort did. On the leaflet’s front side, a prominent photo of a Western woman receiving *śirodhārā*, a schematic drawing of two flying birds in front of a rising or setting yellow sun and a light green leaf of the peepul tree (Lat. *ficus religiosa*), a picture of a small brass oil lamp, tulsi leaves, vetiver (Lat. *chrysopogon zizanioides*) roots and presumably a piece of both turmeric and sandalwood, and a rectangular emblem containing an oil lamp, an open book, a bell and a leaf of the peepul tree, are depicted. On the back side, there is a prominent photo of a seemingly South Asian woman receiving *nāsya*, one of the five evacuative measures of *pañcakarma*, a photo of a mortar, a pestle and different fruits and roots, and a small photo of a bowl used for *śirodhārā* in front of a climbing plant.

The leaflet mediates an image of Ayurveda that is characterized through specific practices like *prakṛti* assessment, *pañcakarma*, yoga, stress relief or a particular food regimen, and tropes of naturalness (through the different leaves, fruits and herbs, and not least through the green color of the upper part of the leaflet’s front side), of Keralan ‘tradition’ (through the oil lamp, the different brass objects and the claimed ‘authenticity’), of religion and auspiciousness (through the oil lamp, the sandalwood, the turmeric, the bell, the peepul

tree, the vetiver roots and the tulsi leaves, which are all used in different Hindu rituals), of wisdom or knowledge (through the open book, which is possibly a treatise being studied or referred to), of medicine (through the mortar and pestle, and through the sandalwood, the turmeric, the tulsi leaves and the vetiver roots, which are all ingredients for Ayurvedic medicines or oils), of wellness and relaxation (through the relaxed facial expressions of the two women receiving *nāsya* – although being a considerably unpleasant treatment – and *śirodhārā*), and of recreation and vacation (through the image of the birds and the sunset or sunrise). Virtually all Ayurvedic resorts and smaller centers use several of these tropes to sell their Ayurvedic practice. But not only the providers of Ayurvedic treatment advertise their services through these representations. They are also applied by other actors, both in India and in other countries. Two major Indian players in promoting Ayurvedic treatment in South Indian Ayurvedic resorts are the Indian Ministry of Tourism and Kerala's Department of Tourism.

Through its international marketing campaign 'Incredible !ndia,' initiated in 2002 to promote tourism in India, the Indian Ministry of Tourism advertises Ayurvedic treatment through brochures, websites, video clips, billboards, and a wide range of print and online advertisements – portraying Ayurvedic treatment in a similar way as the Ayurvedic centers in Varkala described above. While some advertisements address foreigners already being in India – for instance a huge billboard that pictures a woman receiving *śirodhārā* in the arrival hall at Indira Gandhi International Airport in Delhi –, the majority of the promotion material is disseminated outside South Asia. Be it on a TV spot featuring a tourist traveling through India and experiencing *śirodhārā* between riding a coracle and washing an elephant as one of a multitude of tourist activities possible in India (Ministry of Tourism, Government of India n.d.b), or a print advertisement that promotes the "Healing Touch of Nature" which "can ease the stress of modern living," "improve immunity," "bring harmony to your mind, body and soul" and "refresh you" through depicting a woman who receives a flow of viscous liquid on her forehead from a golden colored metal cannikin together with drawings of different plants (see Figure 2.9). In brochures presenting tourist attractions in India, South India and Kerala, Ayurveda is displayed as one of the major attractions in Kerala and is promoted as "Wellness unter Palmen" (wellness beneath palm trees; Ministry of Tourism, Government of India 2009) or as "uralte Heilkunst in Indien" (ancient art of healing in India; Ministry of Tourism, Government of India n.d.c). In addition, the Indian Ministry of Tourism issued a brochure exclusively for Ayurveda entitled *Ayurveda: Body, Mind and Soul*,

Figure 2.9: Advertisement for Ayurvedic treatment by India's Ministry of Tourism (taken from the inside front cover of Sylge 2007)

printed in a variety of languages.[80] All these brochures portray Ayurveda in a similar way as the advertisement material produced by Ayurvedic centers in Kerala discussed above do. They are distributed through travel agencies and on tourism trade fairs, e.g. at the ITB Berlin, which takes place every March in Germany's capital.

I visited the ITB Berlin in 2009 in order to collect promotion material and to talk to different stakeholders in the (Ayurvedic) tourism industry of India and Kerala. Besides India's Ministry of Tourism and Kerala's Department of Tourism,[81] ten Ayurvedic resorts from Kerala attended the trade show[82] and four travel agencies advertising travels to Ayurvedic resorts in Kerala. Travel agencies also play a key role in advertising Ayurvedic treatment in South Asia and in shaping the global Ayurvedic public eye. Their representations of Ayurveda in travel catalogs, brochures, advertisements, and websites resemble those produced by Ayurvedic centers and tourism offices from the central and the Keralan government.[83]

---

80 I saw the edition aimed at the Finnish market in Finnish language (Ministry of Tourism, Government of India n.d.a).

81 In the same way as India's Ministry of Tourism runs the marketing campaign 'Incredible !ndia,' the Keralan Department of Tourism runs the international marketing campaign 'Kerala - God's Own Country.' Part of its effort to promote Kerala and its different tourist attractions is advertising Ayurvedic treatment in Kerala, in form of brochures, leaflets, billboards, and other print and online advertisements. At the ITB Berlin 2009, Kerala's Department of Tourism distributed a brochure about Ayurveda entitled *When Life Gets Tiring, Apply Kerala: Ayurvedic Health Holidays in Kerala* (Department of Tourism, Government of Kerala 2008).

82 Ayuresort had a stall at the ITB Berlin in the following year.

83 I develop this point when I analyze the embedding of Ayuresort in the tourism industry and the associated role of travel agencies and Kerala's Department of Tourism for the formation of Ayurvedic practice in the resort in Chapter 4.

However, the reach of representations of Ayurveda produced by the different bodies just mentioned spread far beyond the realm of tourism, as they appear in various print and online reports and advertisements within the global Ayurvedic public eye. For instance, a search for one of the pictures depicted on Ayuresort's table display mentioned above through the web-based reverse image search engine *TinEye* resulted in 31 hits, i.e. the picture was found on 31 websites (search run on April 15, 2014). It was not only used by its producer but also by several other actors – including the management of Ayuresort – and thus appeared on a variety of websites, predominantly of travel agencies and travel magazines. Similarly, the Incredible !ndia picture of *śirodhārā* at Indira Gandhi International Airport in Delhi was found on 35 websites through *TinEye* (on April 15, 2014). Most of the websites belonged to Indian and European travel agencies and other tourism service providers. Other websites that contained the photo included travel information portals, health-related online magazines, travel blogs, and websites that belonged to yoga studios, massage parlors, day spas and Ayurvedic centers in India, Europe, and the United States.

While photos produced by Ayurvedic resorts and governmental institutions spread within the World Wide Web and are thus part of the global Ayurvedic mediascape, other forms of mass media also contribute to the global Ayurvedic public eye, especially European and North American print media and their online editions. Newspapers, news magazines, lifestyle journals, fashion magazines and women's weeklies produce and spread visual and textual representations of Ayurveda,[84] which resemble those produced by Ayurvedic centers in Kerala and both India's and Kerala's Ministry and Department of Tourism. Through both title and content, the magazines and newspapers convey images of Ayurveda that range from being a "3,500-year-old herb-based healing tradition" (Brown 2006) or "indische Medizin" (Indian medicine; Schuhmacher and Weber 2006: 56) to an "intense adventure" where you can "leave behind stress, little ailments and extra pounds" (Engler 2009: 108; original in German) or a guidance towards "the path of relaxation and inner balance" (Strieder n.d.; original in German). Ayurveda is described as an ancient, holistic, gentle,

[84] For instance, in articles like 'Ayurveda: Rosskur unter Palmen' (Ayurveda: Drastic treatment beneath palm trees; Schuhmacher and Weber 2006), 'Ayurveda in Kerala: Detox auf indische Art' (Ayurveda in Kerala: Detox Indian style; Engler 2009), 'Ayurveda: Vollkommene seelische Entspannung' (Ayurveda: Perfect mental relaxation; Mayer-Wolk 2002), 'Ich glaub, ich bin im Paradies' (I believe I am in paradise; Maxwell-Haas 2004), 'Wellness auf indische Art: Die Ayurveda-Glückspille namens Dr. Lalitha' (Wellness Indian style: The Ayurvedic happy pill called Dr. Lalitha; Strieder n.d.), 'Ayurveda-Urlaub in Südindien: Keralas Hexenküche' (Ayurvedic holidays in South India: Kerala's witches' kitchen; Schwertfeger 2012), 'In the Land of Four-Star Asceticism' (Brown 2006), 'Wellness am Himalaya: Ayurveda boomt' (Wellness in the Himalayas: Ayurveda is booming; Winter n.d.), 'Kraftquelle am Berg: Alpen-Wellness oder Ayurveda' (Power source in the mountains: Alpine wellness or Ayurveda; Passarge 2010), or 'Wohlbefinden, äußere Schönheit und innere Harmonie durch Ayurveda' (Wellness, outer beauty and inner harmony through Ayurveda; Heinke 2001). This is only a small random sample of a great number of similar print and online articles existing in the global mediascape.

herb-based healing science, therapy, art of healing, science of healthy life, or wellness treatment, that include practices like yoga, meditation, breathing exercises, detoxification, cleansing, *pañcakarma*, drastic evacuative measures, oil massages, cosmetic treatments, herbal steam baths, *śirodhārā*, *kiḻi*, pulse and tongue diagnoses, vegetarian diet, and diet attuned to *prakṛti*. The articles promise relaxation, recreation, illness prevention, cure of chronic diseases, stress relief, beauty, inner balance, balance between the three *doṣa*s, balance between body and mind, and weight loss through Ayurvedic treatment, and they claim that Ayurveda is beneficial against muscle tensions, minor ailments, and various diseases like psoriasis, joint pain or hypertension. In addition, several articles provide superficial information about different elements of Ayurvedic theory, especially on the *tṛdoṣa* theory and on the concept of *prakṛti*, together with interrelated etiological and nutritional concepts. The textual descriptions are accompanied by pictures of *śirodhārā*, *kiḻi*, oil massages, or people performing *āsana*s (yoga postures) and meditating, usually either beneath palm trees and at the sea or in massage parlors, day spas and yoga studios, depending on whether the articles portray Ayurvedic treatment in South Asia or in Europe and North America.[85]

The content of these articles thus resembles that of the informational and promotional material produced by the Ayurvedic centers in Kerala and the Indian and Keralan Ministry and Department of Tourism. At the same time, it mirrors the potpourri of the resort guests' perceptions of Ayurveda described in Section 2.1. Numerous guests explained that their expectations of the treatment and their perceptions of Ayurveda were based upon representations of Ayurveda in different print and online media, even though most of them could not specify the respective sources. While some guests told me that their knowledge about Ayurveda was shaped by certain leaflets, books, or articles like the brochure on Ayurveda produced by the Indian Ministry of Tourism mentioned above (Lydia, 61, Finland), the book *Ayurveda Live: Heilende Reisen zu den Ursprüngen des Ayurveda*, an account of Ayurvedic treatment in India, Sri Lanka and Germany written by the German journalist and author Siegfried Kogelfranz (2006; Jessica), or a six-page report on Ayurveda in the French

85 Interestingly, religious and spiritual elements are very rare or even missing in the German-language articles – and in most other German media representations of Ayurveda –, which hence differ from the websites of the providers of therapeutic Ayurvedic treatment Koch has analyzed as mentioned above. In comparison, in her *New York Times* article, Patricia Brown uses such tropes frequently: by referring to the therapists in one of the resorts she visited as "healing goddesses," by stating that the resort has a "Mother Superior aura," or by claiming that having treatment there means that "you are less tourist than nun" or "pilgrim" and that "[y]ou have taken the Order, the humble oath of four-star asceticism" (Brown 2006). This is in accordance with Langford's and Reddy's observations described above. My own research at Ayuresort gives me reason to argue that Ayurveda's association with religious and spiritual aspects is generally more pronounced in North America than in German-speaking countries. I explore this issue in Section 2.3, when I discuss religious elements in Ayurvedic practice in the resort.

magazine *Santé Yoga* (Madeleine, 49, France), the majority explained that they received their information about Ayurveda "from the internet" and "from magazines," where "you always see the forehead flush, oil massages, herbal stamps, and you read about a specific diet, and you frequently encounter the catchphrases relaxation and rejuvenation" (Hannah).

One is indeed confronted with representations of Ayurveda in numerous spheres of daily life, be it in the newspaper's classified section, where you stumble across announcements for adult evening classes in Ayurvedic cosmetics ('Ayurveda-Kosmetik in der VHS' 2007) or Ayurvedic cooking ('Malayalin gibt Ayurveda-Kochkurs' 2007), an offer for a 'traditional Ayurvedic massage with herbal oils' with a German alternative practitioner on the German site of the deal-of-the-day website *Groupon*, or the music album *Ayurveda Lounge*, that I found during a flight to India in February 2009 in the on-board entertainment music program's category of 'health and relaxation' and that aimed at "balancing and harmonizing [my] body and soul" (album description).

Floating around within the global Ayurvedic mediascape, these and similar representations and references of Ayurveda, together with personal experiences with Ayurvedic practice, influence people's perceptions of Ayurveda. This also became obvious when guests of Ayuresort expressed their astonishment about the variety of Ayurvedic applications or the administration of medicines, which neither are common subjects within the global Ayurvedic public eye nor were part of the Ayurvedic treatment they had experienced before in their home countries. At Ayuresort, Adam learned that Ayurveda comprises more than "oil massages, *śirodhārā*, and four-handed massages," what is "the common image of Ayurveda in Europe" according to him. And while Hannah did not expect that medicines are used in Ayurveda before she came to Ayuresort because of her experiences with Ayurvedic treatment delineated above, Silvia even "wonder[ed] whether in traditional Ayurveda medicines are or were administered," whereas she considered "massages and the different treatments, like *śirodhārā* and so on" part of 'traditional Ayurveda.'

However, while the guests were confronted with some unexpected knowledge and practices, many aspects they encountered at Ayuresort were as they had anticipated. This results from the interrelation between their perceptions of Ayurveda and the resulting expectations of their stay at Ayuresort, shaped by media representations, experiences, and narrations, on the one hand, and the profit-orientation of the management of Ayuresort on the other. In the last part of this chapter, I present and analyze the Ayurvedic practice the guests experienced at the resort. In discussing different elements of long-term treatment courses, I demonstrate that the practice at Ayuresort differs considerably from treatment in

local hospitals and I highlight the vital role of the media representations in this practice formation. I demonstrate that the practices result from a complex interplay of Dr. Praveen's Ayurvedic knowledge, the media representations and the resulting perceptions of Ayurveda the guests have, the entrepreneurial drive of the resort management, power relations, and processes of terminological and conceptual translation.

2.3 Translating Imagination: Ayurvedic Practice at Ayuresort

Dhanvantari is watching me. Standing on the treatment room's altar, similar to the one pictured in Figure 1.7, the tutelary deity of Ayurveda observes how Suraj is dropping herbal oil on my crown to start my 'head massage.' Surrounded by red hibiscus and yellow buttercup flowers and an oil lamp, which I have lightened for a beneficial treatment after I had entered the darkened treatment room, Dhanvantari himself takes care of me during the treatment, according to the therapist. However, during the 20-minute 'head massage' I quickly forget about Dhanvantari's presence. Sitting on a wooden stool, with Suraj standing behind me, I immerse in the multisensory mélange of the distinctive scent of the Ayurvedic oil heated on a stove, the heat produced by the stove, and Suraj's quick strokes and slight hits on my cortex, occiput, temples, forehead, and ears with his warm oily palms and fingertips.

The 'head massage,' as the application is called by the practitioners and the guests,[86] serves as preparation of the body for its contact with oil during the following applications and initializes every treatment session at Ayuresort. When my body has been sufficiently prepared, Suraj asks me to get up from the stool and lie down in supine position on the black rubber covered foam mattress on the ground of the treatment room, in order to receive the first of my two major treatment applications this day. For about 40 minutes, Suraj, standing on one foot and latching on to a rope hanging from the ceiling with his hands for keeping his balance,[87] strokes and rubs warm medicinal oil[88] in my whole body except for the head with his other foot. After this 'foot massage,' Suraj asks me to get off the mattress on the ground and lie down on the treatment table to receive my second main

[86] In Ayurvedic texts the application is referred to as *śirobhyaṅga*.

[87] The rope is shown on the photo of the treatment room in Figure 1.7.

[88] Oils used in Ayurveda are medicinal oils that are applied externally and internally. They are prepared from decoctions produced from different plant components, a paste produced from grounded and pounded plant components, and a base oil. In the process, the different ingredients are mixed and cooked over several days to release the active agents of the plant extracts, which dissolve in the oil. The most common base oil is made from sesame seeds (Lat. *sesamum indicum*), and the medicinal oils produced from it are called *thailam*s. The names of the specific oils are usually composed of the main plant ingredient name(s) and a term referring to the base oil. For instance, the main plant ingredient of Bala Thailam, the oil used for my *piḻiccil* treatment, is *bala* (Lat. *sida cordifolia*), and the base oil is prepared from sesame seeds.

application: ***piḻiccil***. During this external treatment, warm medicinal oil is distributed all over my body, except for the head, by simultaneously squeezing a cloth soaked with the liquid from about 40 centimeters above my different body parts (with the therapist's right hand) and spreading it over the body (with the therapist's left hand). It is conducted by Suraj and Prabhat simultaneously, with each therapist standing on one side of the treatment table and performing his strokes concurrently as a reflection of the ones carried out by his partner.

After one and a half hours, in which no words were uttered except for Suraj's requests to "turn around," periodic inquiries about the oil's temperature or the strength of the strokes ("too strong?") and his request to move from the mattress to the treatment table, followed by my brief answers ("ok" or "no, it's fine"), Suraj declares the treatment closed with the words "ok, finished." This is an implicit invitation to get down from the treatment table and go to the attached bathroom, where I remove the oil from my body with soap and hot water. Back in the treatment room, I put on my green cotton bathrobe that every guest receives on the first day and Suraj rubs a pinch of Rasnadi Choornam[89] on my crown to prevent colds, and I receive a ***ṭīkā*** from Suraj, or rather from Dhanvantari, as he had explained. The mark on the forehead consisting of ***kuṅkumam***, a vermillion powder prepared from dried turmeric and slaked lime, has been blessed by the deity and will protect me against the evil eye of envious tourists, which I will be exposed to since I am now "a beautiful man" according to Suraj, as I am about to leave the treatment room.

I experienced this sequence daily for more than three weeks during my 'purification treatment.' Since I did not have any health concerns during my research, besides intermittent back pain, my treatment aimed at removing this pain and preventing possible illnesses – apart from my main intention: to experience the treatment from the perspective of a guest. My treatment resembled those of many other guests who "don't have any problems" and hence was "just for rejuvenation," as Dr. Praveen frequently replied when I inquired about the purpose of the treatments different guests received. With 'rejuvenation,' Dr. Praveen referred to one aim of Ayurvedic treatment that is common both amongst guests' perceptions of Ayurveda and within the global Ayurvedic public eye: illness prevention. "Just as your car needs regular checkups, having ***pañcakarma*** once a year is good for your body," was Dr. Praveen's justification as legitimization for this treatment in the absence of any health complaints (just as numerous other doctors I talked to, both in Ayurvedic

[89] Rasnadi Choornam is a powder preparation (*cūrṇam*) with *rasna* (Lat. *pluchea lanceolata*) as a core ingredient. It is used in Ayurveda for the treatment of rheumatic diseases and *vāta*-based ailments in general (Schrott and Ammon 2012: 456), as well as for the prevention of colds, according to Dr. Praveen, Suraj, and package inserts.

hospitals and resorts). However, Dr. Praveen immediately added to his explanation: "in theory; because today this is not possible in practice." Since it takes at least two weeks, and since it is expensive, not many locals can afford to undergo such a preventive *pañcakarma* treatment, in terms of both time and money.

According to my observations and conversations with practitioners, *pañcakarma* treatment for illness prevention seems to be conducted rather infrequently in Ayurvedic hospitals. In contrast, in Ayurvedic resorts, where it is mostly called 'purification treatment' (see below), visitors seem to have both the time and the money for it. They spend their (annual) holiday having their bodies checked. As described in Section 2.1, most of the guests at Ayuresort did not have specific health concerns, but other reasons determined their intentions to visit Ayuresort: recreation, illness prevention and improvement of one's overall wellbeing, often in combination with the treatment of minor ailments. These motivations, I argue, impact the Ayurvedic practice at the resort as shown below.

When I asked David whether it did not seem strange to him that Dr. Praveen had let him fill in a questionnaire during his first consultation that included questions about his life goal and his sexual activities although he had complained about his general fatigue and back pain, he replied: "I know that our doctors don't ask these things. That's why I come to places like this, where they have understood that you better ask these things, because they are so related." The day before, David and his partner Alice had arrived at Ayuresort. Unlike the majority of the other guests who had booked their 'Ayurveda package,' which includes treatment, accommodation, meals, and yoga and meditation classes, from their home country, David and Alice had decided to look for an Ayurvedic resort on site. After their arrival in Varkala, they had visited a few resorts and then had chosen Ayuresort because of its location and their favorable impression of Dr. Praveen. One day later, they were sitting in Dr. Praveen's doctor's office, filling in the five-page bilingual (English and German) 'Ayurvedic Clinical Questionnaire' that consisted of a range of questions about their traits, habits, preferences, somatic functions, and contemporary and former illnesses; all those aspects of personhood that are "so related" for David, since "there is a link between the body we have and the spirit we have, the mind we have," as he had explained in our conversation (for the questionnaire, see Appendix D).

During the one hour and a half long consultation, Dr. Praveen established a treatment plan for both David and Alice by using the information they provided through the questionnaire, by discussing their ailments and intentions for visiting Ayuresort, by physically examining David's back, neck and shoulder pain he had mentioned, by measuring David's

and Alice's blood pressure and pulse rate, and by assessing their *prakṛti* through a list of numerous paired questions related to different physiological, mental, habitual, and personality characteristics listed on a four-page document. Having diagnosed David as having a *vāta-pitta prakṛti* with contemporary increased *vāta* and low *pitta*, and Alice as having a *pitta-vāta prakṛti* with contemporary increased *vāta*, Dr. Praveen made a note of their *prakṛti* in their clinical questionnaire, communicated it to them and decided to provide David with "treatment like for a patient" against his back, neck and shoulder pain, while Alice received "purification and rejuvenation" because "her only problem is her fear of getting old."

In the afternoon of the same day, after having had lunch in the open-air restaurant – typical Keralan cuisine re-branded as 'Ayurvedic,' consisting of chapatis, plain boiled rice, *thoran* (a popular Keralan vegetable dish), tomato curry, slices of raw cucumbers, tomatoes, onions and carrots, and 'Ayurveda herbal water,' as it was labeled in the menu, a reddish water-based warm drink prepared from the liber of the *pathimugham* tree (Lat. *Caesalpinia sappan*) –, David and Alice returned to the Ayurvedic center in their green bathrobes, where they were met by four of the therapists. While Anitha and Divya conducted Alice to one of the treatment rooms on the first floor, Suraj and Prabhat went with David to one of the treatment rooms on the ground floor for the first session of his 21-day *pañcakarma* treatment, which Dr. Praveen had prescribed to him, and to Alice.

The treatment sequence was the same as in my treatment session described above. After David had been asked to put off his bathrobe and wear a thong that Suraj had produced from a piece of muslin before the treatment, he was ushered to the little altar by the therapist, who asked him to light the oil lamp, before he was told to sit down on the wooden stool for receiving a 'head massage.' The 'head massage' started by a short, silent prayer by Suraj asking Dhanvantari for permission for and assistance in the treatment, during which he stood still in front of David with closed eyes, having his arms bent at right angles at belly height and pointing towards David's head. His palms formed a little bowl containing some 'head massage oil,' with which, after Suraj had opened his eyes, he touched consecutively David's earlobes, shoulders, elbows, wrists, knees, and eyes with his oiled fingertips.[90] With

[90] By doing this, Suraj touched different major *marman*s through which he asked Dhanvantari permission to perform the following applications properly to not hurt the *marman*s, as he explained to me. According to Ayurvedic theory, the human body is composed of 107 *marman*s or 'vital spots,' vulnerable unions of *māṁsa*s (muscles), *śirā*s (vessels), *snāyu*s (ligaments), *asthi*s (bones), and *sandhi*s (joints) the size of half an *aṅguli* (fingerbreadth, a common unit of measurement in Ayurvedic theory and practice) to a palm, whose injury results in pain, frailty or death (*Suśrutasaṃhitā*, Śā 6.3, 6.8, 6.15, 6.28-29; for an introduction into Ayurvedic *marman* theory, see Mariana Fedorova's excellent dissertation on this topic (1990; in German) and Thatte 1988: 1-33; for a comparative account of such vital spots in Indian therapeutic and other traditions, see Chapter 2 of Sieler 2015).

the remaining oil on his fingers, he briefly anointed David's cervix and shoulders, before taking new oil from an aluminum bowl on the stove to start with the 'head massage.'[91]

After this pre-treatment, David received his main applications: *abhyaṅga* (an oil massage resembling treatment that represents the major external whole-body Ayurvedic treatment in general and that is usually called 'general massage' or 'synchronic massage' in the resort(s) – depending on whether conducted by one or two therapists), *podi ki̱li* (*ki̱li* with poultices filled with Kolakulathadi Choornam[92]), *nāḍi svedana* (locally applied warm medicinal steam) for David's back, neck and shoulder, and *vaspa svedana* (a whole-body sweating treatment induced by hot medicinal vapor taking place in a wooden or fiberglass box). After the 'steam bath,' as this application is commonly called in Ayurvedic resorts, Suraj invited David to take a hot shower in the attached bathroom and wash off the coat of oil, sweat, and Kolakulathadi Choornam residues covering his body. When David re-entered the treatment room, he received the Rasnadi Choornam on his crown and a mark on his forehead from Suraj, which marked the end of the treatment session.

The structure of Alice's treatment was similar to that of David's. Apart from differences concerning the major applications – she received 'synchronic massage' or *abhyaṅga*, *śirodhārā*, and 'steam bath' during the first three days – and the inaugural ceremony,[93] the treatment session paralleled David's, just as those of the other long-term guests. All treatment sessions were initiated with the lighting of the oil lamp and the 'head massage' as a pre-treatment, consisted of mostly two or three major applications, and were closed with the mark on the forehead.

In the same way as the treatments were all structured equally, the guests' daily routines resembled each other and were structured by different practices. At seven o'clock in the morning, they could attend a one-hour hatha yoga class in the yoga and meditation hall provided by Ramu, a 43-year-old yoga teacher from Kerala who had his own yoga studio in Varkala and additionally worked at Ayuresort,[94] between eight and ten o'clock, guests usually had their breakfast, while lunch was provided between noon and two o'clock in

91 While the 'head massage' was conducted by all therapists, the prayer and the touching of the *marman*s was only performed by a few, including Suraj.

92 Kolakulathadi Choornam is a powder preparation consisting of *kola* (Lat. *ziziphus mauritiana*) and other plant extracts, which is usually used in *podi ki̱li* and *udvartana*, a massage-like treatment, for external application.

93 Not all therapists pray before the start of the treatment or touch the guest's joints with their oiled fingertips.

94 Ramu had studied classical Indian philosophy and Sanskrit literature and grammar in the ashram at Sivagiri, a pilgrimage center near Varkala where the tomb of the Keralan sage and social reformer *śrī* Nārāyana Guru is located, for seven years. After working at the ashram for another five years, he studied yoga therapy in Bangalore for one year, then taught yoga classes in Tiruvannamalai (Tamil Nadu), Russia (his wife was Russian), and Thiruvananthapuram for seven years in total, before he returned to Varkala where he had been working as a yoga teacher for the last six years.

the afternoon. At seven o'clock, there was a meditation class, also provided by Ramu, and between eight and nine o'clock the guests had their dinner. And either between breakfast and lunch or between lunch and dinner, the guests had their daily consultation with Dr. Praveen followed by the treatment session. While the treatment sessions lasted between two and three hours, depending on the respective applications, the consultations took between five minutes and two hours.

The longest consultation was usually the first one. It lasted one to two hours and took place either on the guests' first or second day at Ayuresort, depending on their arrival time. After a brief introduction by Dr. Praveen of himself, he would ask a few basic questions such as how their flight was, whether it is the guest's first time in India, whether it will be his/her first Ayurvedic treatment etc. This was followed by the first part of the anamnesis, in which Dr. Praveen asked the guest about his/her motivation for coming to Ayuresort. As explained in Section 2.1, they rarely included concrete physical ailments in the first place but other things such time-out from stressful life at home or/and doing oneself some good. Some guests also added minor ailments like muscle tensions or digestive problems. When guests told Dr. Praveen that they do not have any ailments, Dr. Praveen would usually inquire more about that by asking if the guest has stress, if he/she suffers from any stiffness or pain in the back or neck region and if his/her digestion is well-functioning.[95]

To get a more precise picture of the guest and their ailments, Dr. Praveen then would proceed to a more detailed diagnosis, by letting the guest fill in the 'Ayurvedic Clinical Questionnaire' mentioned above. The questionnaire was designed by the two Ayurvedic practitioners owning Ayurvedic Care, the company that run the Ayurvedic center at Ayuresort. The first section asked for personal details such as date of birth, height, weight and profession. The second and most comprehensive section dealt with questions on behavioral routines, including eating habits and taste preferences, sleeping behavior or frequency of exercising, personal characteristics such as talking volume, moving speed or being rather optimistic or pessimistic in general, as well as physiological processes like the size of appetite and thirst, strength of digestion or amount of urination. The third section of the questionnaire was only to be filled in by female guests and referred to the onset of menstruation, menstrual cycle, menopause, pregnancy and childbirth. The fourth section

[95] While the latter is a question common also in clinical practice and a major element in Ayurvedic diagnostic theory, during his work with the guests at Ayuresort, Dr. Praveen learned that many of them have back and neck problems, which he attributed to a lack of movement or exercising and stationary work in front of a computer. By asking these things, many guests came up with minor ailments they did not tell Dr. Praveen when being asked about their motivation for coming to the resort, as they were not the main cause and as they did not trouble them in a way that would demand treatment.

comprised questions about present and earlier illnesses, accidents and surgeries as well as family histories of ailments and hereditary diseases. In the last section, Dr. Praveen wrote down the result of the diagnosis and his treatment plan (see Appendix D for the questionnaire).[96]

Before establishing a diagnosis, there was a second part of the anamnesis, in which Dr. Praveen discussed aspects the guests had written down or marked in the questionnaire. In some cases, depending on the ailment, this was followed by a physical examination in form of touching the concerned spot or/and measuring the blood pressure.[97] Another procedure commonly associated with Ayurvedic diagnosis is the examination of the pulse (*nāḍī parīkṣā*). It is a recurrent theme in Western media representations of Ayurvedic treatment, and in clinical Ayurvedic practice in Germany it works not only as a tool of diagnosis but also a method for building trust in the unknown medical practice on the side of the patient (Frank and Stollberg 2002: 230f.). During this practice, the practitioner determines the qualities of the pulse by putting the index, middle and ring finger on the patient's wrist, attributing different sensations associated with movements of specific animals to aggravations of specific *doṣa*s: a '*vāta* pulse' is compared to the movement of a snake or a leech, 'pitta pulse' to the movement of a frog and 'kapha pulse' to the movement of a swan or a peacock (see e.g. Langford 2002: 164 [Figure 10], quoting Athavale 1977: 27). *Nāḍī parīkṣā* entered Ayurvedic theory, and possibly also practice, in the fourteenth century, when it appeared for the first time in the *Sārṅgadharasaṃhitā*, becoming one element of the *Aṣṭasthānaparīkṣā* or eight-fold examination together with examinations of the stool, urine, tongue, voice, skin, eyes and general appearance of the patient (Meulenbeld 1995: 6).

While Frank (2004: 168) and Tirodkar (2005: 60) claim that *nāḍī parīkṣā* is a common Ayurvedic practice today, other authors, like Sharmistha Mallick (2013), argue that is not commonly practiced anymore. This was also my impression of diagnostic practice in the resorts, clinics and hospitals I visited. I rarely saw any practitioner doing *nāḍī parīkṣā*, and most of the practitioners I talked to mentioned that it is rarely practiced in clinical contexts today – including Dr. Praveen. Thus, he usually did not examine the pulse of the guests. However, occasionally he did it for satisfying the guests' desires and expectations of receiving an examination of the pulse. Many guests associated it with Ayurvedic practice, and several asked Dr. Praveen about it during the first consultation. He normally explained

[96] Dr. Praveen only noted on that page the application(s) the guest received on the first (few) day(s). He sometimes consulted the questionnaire during the treatment course, but he did usually not note down the applications he prescribed after the first day.

[97] I oberved that these diagnostic measures have been adopted from biomedical practice and are common in contemporary Ayurvedic practice in resorts, clinics and hospitals (see also Mallick 2013).

to the guest that it is not necessary and not done anymore in contemporary Ayurvedic practice. But while some guests were happy with this explanation, others still insisted on having their pulse examined and then Dr. Praveen conducted *nāḍī parīkṣā* although he did not see any purpose in doing so apart from satisfying the guest's curiosity and expectation.

For the doctor, pulse examination is one of the major misconceptions guests have of Ayurveda. Another one is the explicit assessment of *prakṛti* or the individual constitution, determined by the *doṣa*s and expressed through physiological characteristics, behavior, affinities and aversions (see Footnote 64, Page 47). In Ayurvedic theory, the assessment of *prakṛti* is part of the ten-fold examination of the patient, besides the investigation of the imbalance of the *doṣa*s (*vikṛti*) and other aspects (see e.g. *Carakasaṃhitā*, Vi. 8.94). However, while Ayurvedic treatment is supposed to be conducted in accordance with both individually *vikṛti* and *prakṛti* and thus be inter-individually different due to *prakṛti*'s individual nature, contemporary clinical practice often ignores patients' individualities resulting from their particular *prakṛti* (see e.g. Islam 2010: 795; Mallick 2013). This was also told me by Dr. Praveen, who claimed that in clinical practice, *prakṛti* does not play a vital role. However, in contrast, he assessed the resort guests' *prakṛti* and explicitly let them know if they have a *vāta-pitta prakṛti* or a *pitta-vāta prakṛti* for instance, as demonstrated above in David's and Alice's first consultation.

Dr. Praveen assessed *prakṛti* by observing the guests and listening to them, through information he would receive from the clinical questionnaire and through a specific list of questions. This list included 78 yes-no questions that addressed specific physiological characteristics, behavior, preferences and aversions that are connected with the three *doṣa*s, for instance "Are you impatient?", "Do you tackle difficult tasks offensively?" or "Do you have thick hair?" Such '*prakṛti* self-assessment questionnaires' are quite common in Europe and North America, where one can find them online or in magazines and books (see also Langford 2002: 57f.). While the assessment of *prakṛti* assumes a prominent role in Ayurveda in Europe and North America, in Indian clinical settings, it seems to be much less prominent. But again, Dr. Praveen adapts his practice to the guests' expectations: "The problem is, Europeans are only talking about constitution. Only for satisfaction, I am taking the constitution." As a result, there is an explicit assessment of *prakṛti*, which is communicated explicitly between the doctor and the guest and noted down on the last page of the clinical questionnaire under the heading of "Prakruthi," and above "Vikruthi," whereas it leaves its mark on clinical settings rather implicitly during the diagnostic procedures of observation and interrogation.

After having finished the diagnosis consisting of those single steps, Dr. Praveen would usually generate a treatment plan, based on both the diagnosis and the guest's motivation for coming to Ayuresort and his/her expectations of the treatment, and inform the guest about his decision and the next steps, including an explanation about the applications the guest would receive on the first day(s). Thus, the treatment course for long-term guests was usually determined by Dr. Praveen by taking the preferences of the patient into account and making a decision on her behalf. However, in some cases, the guests did not accept Dr. Praveen's suggestion. This usually happened when the guest did not want to have a *pañcakarma* treatment due to its demanding evacuative measures. Then, the doctor and the guest commonly decided about the treatment program. In general, though, it was Dr. Praveen who decided about the treatment for the long-term guests, although the guests also had a voice, especially during the following consultations when they sometimes asked for specific applications and could even chose the applications on their last treatment day (see below).

At the end of the first consultation, Dr. Praveen would provide the guests with more information on general aspects of their stay at Ayuresort and the treatment course, i.e. he tells them the times for the yoga and meditation classes and for the following consultations, which precede every treatment session. These consultations were shorter than the initial consultation. They usually lasted between five and 30 minutes, depending on a change of the applications, which was accompanied by an explanation from Dr. Praveen, on possible problems the guest experienced, and on potential questions the guest had about the treatment. In his explanation about the treatment the guests received, Dr. Praveen usually referred to Ayurvedic concepts, which he elaborated on for the guests. He usually provided information about treatment procedures and interconnected basic principles. His oral explanations were usually complemented by written notes.[98] Whereas most of his explanations were interconnected with the guest's specific treatment, he also presented further explanations about Ayurveda, including terminological clarification, its textual roots or its mythological origin including its tutelary deity (see Figure 2.12).

For his explanations about Ayurvedic theory, Dr. Praveen found an atypically receptive audience. As he told me, compared to local hospital patients, who are not interested in Ayurvedic theory, long-term resort guests were usually keen on learning more about

[98] See e.g. Figure 2.10 for a brief explanation of the first phase of *pañcakarma* Dr. Praveen provided for one guest. Figure 2.11 represents a note on which Dr. Praveen explained the concept of *saptadhātu* or 'seven tissues' and the influence of the six *rasa*s or tastes on the *doṣa*s, exemplified with *kapha*. With these and similar notes, Dr. Praveen provided some basic explanations of both Ayurvedic practice and theory for the guests.

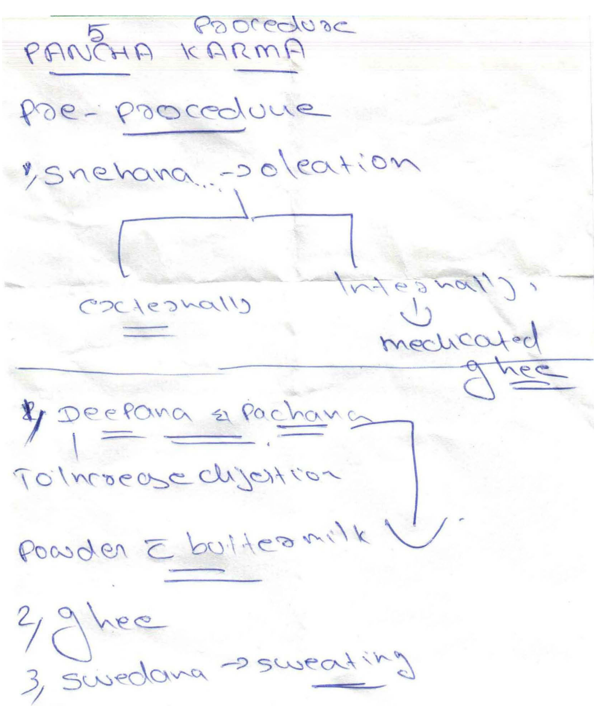


Figure 2.10: Explanation of *pañcakarma* (note written by Dr. Praveen for a guest during consultation)

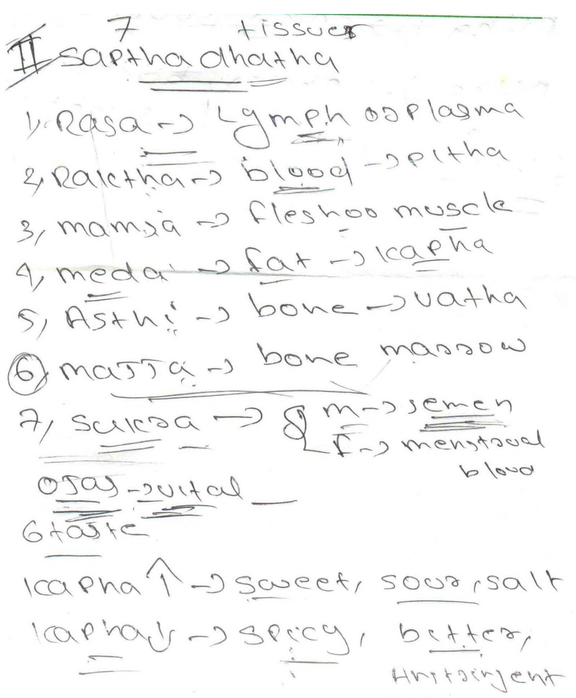


Figure 2.11: Explanation of *saptadhātu* and *rasa* (note written by Dr. Praveen for a guest during consultation)

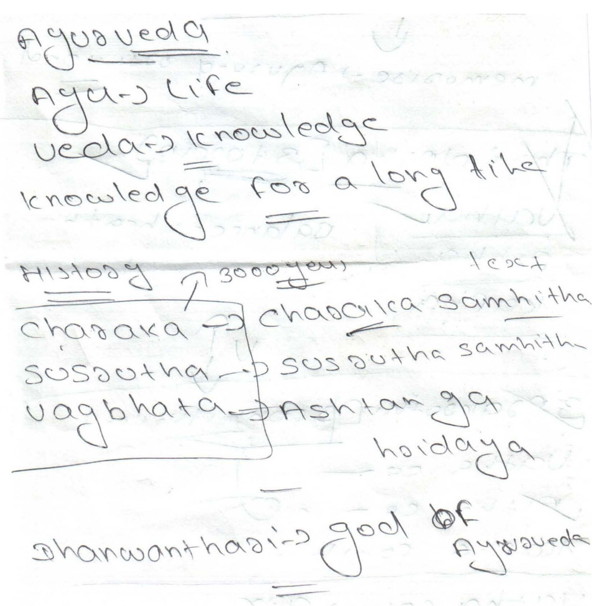


Figure 2.12: Explanation of general aspects of Ayurveda (note written by Dr. Praveen for a guest during consultation)

Ayurvedic concepts and practices. At the same time, he said, the resort guests' knowledge about Ayurveda was deeper than those of local patients. Although the Ayurvedic knowledge of many guests included misconceptions as described above, they had basic knowledge of the *tṛdoṣa* concept, *prakṛti* and the interconnected association of health with *doṣa* balance – a knowledge base that Indian patients at clinics and hospitals would generally not have (see also Langford 2002: 56; Nisula 2006: 215). And by providing the guests with more knowledge on Ayurvedic theory, Dr. Praveen satisfied the guests' inquisitiveness, which local patients also often lacked (see also Langford 2002: 268).

Another major difference between doctor-patient interactions in Ayurvedic clinics and hospitals on the one hand and doctor-guest interaction at Ayuresort on the other hand is related to the content of the conversations. While they are generally restricted to treatment-related aspects in clinical settings, they comprise further topics in the resort. One consultation for Christina for instance started with a discussion about the cold temperature and large amounts of snow in Germany these days, compared to the weather in Delhi. From there, the conversation proceeded to the traffic in the Indian capital, to electric cars, to electrical power supply in India and Germany, to recycling of water and plastic in India, to environmental pollution. Only then, Dr. Praveen directed the conversation to treatment-related aspects by inquiring if everything is alright with the treatment and if the food is not too spicy.

Such topics were rather the rule than an exception. Consultations were characterized

by long conversations covering all kinds of non-medical topics, be it different aspects of 'Indian culture' and 'German culture' or practical advice, as Dr. Praveen told me:

> *Today, she* [a guest] *even told me: "There is a mosquito, what do I have to do?" Normally, they have to tell the front office or housekeeping staff, but they tell me. Then I tell "ya, I will arrange a mosquito net today itself." Because for them I am everything. They ask me everything: "What do we have to do? Where do we have to go? Is there a good place to see? Is it good to purchase stuff from there?" They are not only asking treatment-related things, but each and every thing* (addition by the author).

Besides his role as an Ayurvedic practitioner, Dr. Praveen played the role of a 'contact person' for all kinds of problems and questions the guests had as well as a 'cultural ambassador,' providing different information about India in general and as 'travel guide' capable of recommending sightseeing spots. Morevover, the guests' exposure to an alien treatment in a foreign cultural environment presupposes a doctor-guest interaction in which the guests can build trust in the doctor and the therapists and in the treatment (see also Spitzer 2009: 146). Thus, practitioners working in resorts must not only be experts in Ayurvedic practice, but must also have good knowledge of English and be able to interact with foreigners (see also Langford 2013: 264). As several Ayurvedic practitioners told me, including Dr. Praveen and the two doctors who direct the company that run the Ayurvedic center at Ayuresort, resort doctors must assume the role of 'cultural mediators' and therefore specific personal traits and interpersonal skills were more important in the resort field than theoretical knowledge and practical experience. His personal characteristics helped Dr. Praveen to have been offered his job at Ayuresort, although he had little experience in clinical practice. Additional skills were acquired during the first months at Ayuresort, when he learned "how to handle the Europeans," as he frequently mentioned.

The different demands of working in an Ayurvedic resort versus working in a clinical setting come also from different motivations for visiting these institutions on the one hand. On the other hand, Dr. Praveen regularly emphasized that resort guests expect a form of interaction that differs from doctor-patient interaction in clinics and hospitals, which is characterized by an extremely hierarchical relationship and an authoritative role of the practitioner who does not consider patients' desires (see also Mallick 2013).[99]

In comparison, at Ayuresort Dr. Praveen listened to the guests and their desires and expectations. This difference can certainly be, at least partially, attributed to the money the guests invest in the treatment (see also Spitzer 2009: 146). However, in the end it was Dr. Praveen who decided about the treatment course, even if most of the long-term guests already chose their form of treatment when they booked their 'Ayurveda package'

[99] The passive role of the patient during Ayurvedic consultations was already mentioned by Mark Nichter in his study of doctor-patient interaction in rural Karnataka in the 1970s (1981b: 7).

from their home countries. They could choose between two different packages, which both included Ayurvedic treatment, three meals a day, accommodation and yoga and meditation classes. The 'purification therapy' package comprised a *pañcakarma* treatment and cost US$ 90-145 a day, depending on the room category, whereas the 'rejuvenation therapy' was a long-term treatment course without evacuative measures and associated practices like taking medicated ghee and other *pañcakarma*-related substances. The price for the 'rejuvenation therapy' package was US$ 80-135 a day. However, these offers were intended to help the resort's commercial planning and did not actually determine the particular treatment the guests eventually received. Similarly the other packages and 'long term programs' offered by Ayuresort on their website and brochure (see Figure 2.4) were aimed at attracting guests and informing them about the variety of Ayurvedic practice available at the resort and did not directly determine the treatment practice. Dr. Praveen did not even know the range and content of the single packages like 'slimming therapy,' 'Ayurveda Beauty Care Therapy' or 'Special Therapy for Women' when I asked him about them.

Rather than dividing the long-term treatments into the two categories of 'rejuvenation' and 'purification,' Dr. Praveen had his own set of differential categories, based on the goal of the treatment. He distinguished between 'treatment,' 'prevention' or 'rejuvenation,' and 'wellness,' as he called the different forms. 'Treatment' referred to therapeutic practice whose aim was to treat a specific ailment, as for instance Laura's psoriasis. For long-term guests who did not present any health problems, the resulting non-therapeutic treatment course was considered by Dr. Praveen as being beneficial for preventing ill health and he thus labeled it 'prevention treatment' or 'rejuvenation treatment.' The term 'rejuvenation' – just as 'purification' – is a buzzword in the realm of Ayurvedic resorts and was also adopted by the doctor in this context to distinguish non-curative practice from therapeutic treatments aimed at treating a particular illness. The third category of Ayurvedic practice, 'wellness treatment,' referred to the treatment for guests who only visited the Ayurvedic center for a few days or for single applications. Due to the short treatment duration, Dr. Praveen perceived such treatments as not having any therapeutic or preventive effects and thus received the label of 'wellness,' which he considered a non-medical pampering practice, similar to the common understanding of the term in most European societies.

Dr. Praveen invoked these distinctions in his exchanges with me and with the guests. It was regularly reflected in our discussions, when Dr. Praveen for instance explained that "she [the guest] doesn't have physical problems, so I give rejuvenation treatment" (addition by the author). During his conversations with the guests, Dr. Praveen also referred to the

different treatment categories, as in one consultation with Jonathan and his partner Eva (41, Germany) when he explained to the former: "for you, I give treatment" and to the latter, "for you wellness." This manifested in his practice, as the following explanation about differences in his handling of different guests illustrates:

> *For Laura, I gave 100 percent attention on the treatment. I don't give a big attention for Victoria, for example. She doesn't have any problem, so she will get a result no matter what I do. If you are coming with a disease, the first job is to see that the problem is not increased, it should not get worse. So I have to give attention. When people don't have a problem, I don't have to give attention because it can't get worse. For Laura, I have to reduce* [the problem]. *So every time I have to think what I have to do next, what happens if I do that.* [...] *For wellness persons I won't think like this* (addition by the author).

While Dr. Praveen did not have to give much thought and energy to finding the right treatment for many guests as they had no concrete health concern, he did not disregard their desires and needs. From that group, self-evaluations of their treatment and impressions of Dr. Praveen were highly positive almost without exception. Providing long-term treatment for guests without any health concerns just meant that it was less complicated, since Dr. Praveen had to consider fewer aspects.[100] It also meant that those guests did not only benefit from the treatment in terms of an improvement of their already good health status, but in terms of illness prevention. This was especially the case for those guests who received *pañcakarma*.

Pañcakarma is characterized by evacuative measures from which it derives its name. It usually takes about two to three weeks – depending on the ailments' nature in Ayurvedic hospitals and on the time the guest wants to spend on it in Ayurvedic resorts –, and includes one or more of five (*pañca*) evacuative actions (*karma*s) in total. These actions are *vamana* (vomitus), *virecana* (purgation), *nāsya* (nasal douche) and two forms of *basti* (enema), one with medicinal oil (*anuvāsanabasti*), the other one with medicinal water (*nirūhabasti*).[101] The treatment course is divided into three phases: The first phase, *pūrvakarma*, consists of external sweating and oiling treatments (*svedana* and *snehana*) and the internal administration of medicinal powder preparations and medicinal ghee, in order to activate the vitiated *doṣa*s, remove them from the *dhātu*s and transport them through the *srota*s (channels) into the *koṣṭha*, the biggest *srota* or 'alimentary tract.' From here, the *doṣa*s are expelled in the main procedure (*pradhānakarma*) through the application of one or more of the five *karma*s, depending on the ailment. In Ayuresort, the 'purification,' as it was commonly called, was in most of the cases done through *virecana* by the administration of purges. This purification (*śodhana*) is followed by different external applications and a specific diet in

100 Those guests also did not receive any medicines in comparison to guests with specific ailments.

101 Another existing conceptualization of *pañcakarma* combines the two *basti*s and lists *raktamokṣaṇa* (bloodletting, usually performed with leeches) as the fifth action.

order to build up the body, which has been weakened through the treatment and restoration of the digestion process (*paścātakarma*).

This description of *pañcakarma* is purposefully general. It intends to give an idea of the treatment that is part of Ayurvedic clinical practice in South Asia, commonly represented in media outlets as principal Ayurvedic practice, and frequently conducted at Ayuresort.[102] Its implementation at the resort however differed significantly from *pañcakarma* treatments in clinical settings. While in hospitals ailments that can be localized, such as back pain or arthritis in the knee, are treated locally by applying oil only on the respective body part, at Ayuresort guests always received whole body applications (and additionally local applications if indicated as in the case of David's *nāḍi svedana* mentioned above), since on the one hand the guests expected this, and on the other hand not many guests had concrete localized ailments.

Another difference to Ayurvedic practice in hospitals was the fact that the Ayurveda packages' offered at Ayuresort included two applications a day. As Dr. Praveen told me, the second application was "only for experience" or "for relaxation." Dr. Praveen thus provided one application as part of the treatment course for therapeutic or preventive reasons, and another one, for instance 'rejuvenation massage' or *śirodhārā*, for 'wellness' reasons. As the external applications are more important in the phase before the evacuative measures (which took place usually between the seventh and the tenth day of the treatment) than after, these 'wellness applications' sometimes determined the external applications on the last days of the treatment course exclusively. For instance, on their last three days, Jessica and her cousin Maria (45, Germany) received *śirodhārā*, 'body and face pack' and 'hand and feet massage.' In addition, while Dr. Praveen determined the applications long-term guests receive, on the very last day of the treatment course, it was the guests who decided which treatments they would get.

Thus, *pañcakarma* treatment courses at Ayuresort differed considerably from their implementation in the hospitals I visited, through the presence of elements of relaxation, wellness and cosmetic treatment. In addition, they differed as they were not conducted primarily for therapeutic reasons. Not only guests with a specific ailment for which *pañcakarma* was indicated, like Laura's psoriasis, received the 'purification treatment,' as it was commonly referred to in Ayuresort and all other Ayurvedic resorts I visited, but the majority of the other long-term guests as well. As described above, Dr. Praveen regarded *pañcakarma* as beneficial for maintaining health.

102 See Appendix B.1 for Christina's 13-day *pañcakarma* treatment course.

The notion of Ayurvedic treatment being beneficial for preventing ill health is not only widespread in contemporary media representations of Ayurveda (see Section 2.2) and thus prevalent in many guests' perceptions of Ayurveda (see Section 2.1), but also exists in Ayurvedic theory. Classic Ayurvedic texts describe maintenance of health and 'prolongation of life' as the second goal of Ayurveda besides the treatment of illness (see e.g. *Carakasaṃhitā*, Ci. 1; *Suśrutasaṃhitā*, Ci. 28.3-28, Ci. 29.3-32). However, as mentioned above, Dr. Praveen claimed that this purpose and implementation died off in clinical settings and also my research in Ayurvedic clinics and hospitals indicates that clinical practice primarily consists of curative treatments (see also Dunn 1976: 148, Table pp. 138-140). At Ayuresort, preventive treatments outnumbered curative ones, and the term 'rejuvenation,' commonly identified with illness prevention, was omnipresent: the resort offered 'rejuvenation packages' and 'rejuvenation massages.' Dr. Praveen referred to non-therapeutic treatments as 'rejuvenation treatments,' with and without *pañcakarma* procedures.[103] Guests, in turn, associated Ayurveda with rejuvenation and communicated this, for instance when one member of a tour group from Germany was welcomed by her fellow travelers at lunch with the words "you look ten years younger already on the second day," or when I asked Jessica and Maria if they also visited Ayuresort's beauty parlor and Maria replied in jest that "the Ayurvedic treatment is already rejuvenating enough."

There is a third category of Ayurvedic practice existing at Ayuresort that also cannot usually be found in Ayurvedic clinics and hospitals: 'wellness treatments.' For guests who stayed only a few days at Ayuresort, Dr. Praveen compiled a variety program, which let the guests experience different applications with, according to him, no therapeutic or preventive effect. This was mainly the case for tour groups, who stayed between three and seven days.[104] Other short-term guests and tourists who visited the center for one or several single applications, also received these 'wellness treatments.' They usually chose them from a price sheet that listed 26 Ayurvedic applications (see Appendix E) after a brief dialogue with Dr. Praveen or one of the therapists. The list of applications comprised Ayurvedic treatments that are applied in Ayurvedic hospitals, like *ki<u>l</u>i*, *pi<u>l</u>iccil* or *nāsya*, and applications that cannot be found in clinical settings, like 'rejuvenation massage,' 'relaxation massage' or 'face pack' – similar to the leaflet of the Ayurvedic center in Varkala presented in Section 2.2 (Figure 2.7). Resort-specific applications can be divided into treatments that have been invented, like 'rejuvenation massage,' 'cream massage,' 'foot massage,' 'face pack' and 'body

[103] For an example of a rejuvenation treatment without *pañcakarma* procedures, see Appendix B.2.

[104] See Appendix B.3 for the treatment plan of Julie, the leader of the French tour group that visited Ayuresort for seven days.

pack,' and into treatments that have been reconfigured or reinvented, like 'general massage,' 'relaxation massage,' 'powder massage,' 'head massage,' 'head & neck massage,' 'shirodhara,' 'thakradhara,' 'pizhichil,' 'steam bath,' or 'synchronic massage.'

While *śirodhārā*, *takradhārā*,[105] and *piḻiccil* are offered in Ayurvedic hospitals under the same name, concealed behind the other reconfigured applications were treatments that are also found in clinical settings. General massage, relaxation massage, and synchronic massage are all varieties of *abhyaṅga*, an oil massage resembling treatment that represents the major external whole-body Ayurvedic treatment in general. While during the general massage warm medicinal oil is applied on and 'massaged' into all parts of the body except for the face for about 45 minutes, the relaxation massage also includes an application on the face and takes 15 minutes longer. Usually these two treatments are conducted by one person. However, the general massage can also be administered by two therapists and is in this case called 'synchronic massage.' The head massage opens every treatment session as described in the beginning of this section, and during the head & neck massage, obviously, warm medicinal oil is 'massaged' not only into the cortex, occiput, temples and forehead, but also into the neck. The powder massage, in clinical contexts called *udvartana*, is an external massage-like treatment in which instead of warm medicinal oil a warm powder preparation is used (at Ayuresort usually Kolakulathadi Choornam). Another treatment that can be found in clinical settings and also offered in Ayurvedic resorts, although under a different name, is *vaspa svedana* or 'steam bath,' the whole-body sweating treatment mentioned above.

While all these treatments also exist in Ayurvedic hospitals, they have been reconfigured at Ayuresort. In clinical contexts, *abhyaṅga* (either conducted by one or two therapists, depending on the availability of personnel), *udvartana*, *piḻiccil*, and *vaspa svedana* are common therapeutic applications and usually part of *pañcakarma* treatment. Also *śirodhārā* and *takradhārā* are part of the clinical therapeutic repertoire. They are primarily applied in skin diseases and neurological disorders, albeit infrequently.[106] While during long term treatments some of the applications were used at Ayuresort for the same reasons as in hospitals, for instance, general massage or *piḻiccil* as preparatory *snehana* (oiling) treatment and powder massage or steam bath as preparatory *svedana* (sudation) treatment in *pañcakarma*, the same applications and others were used at the same time for different purposes. Powder massage was applied for weight reduction, and *piḻiccil*, head (& neck)

105 For an explanation of *śirodhārā* and *takradhārā*, see Section 3.3.

106 I discuss this usage in more detail in Section 3.3, where I explain these treatments and analyze their transformation in the course of their transfer from clinical to resort practice.

massage, and especially general massage, relaxation massage, *śirodhārā*, and *takradhārā* (which were the most frequent applications at Ayuresort) were prescribed by Dr. Praveen and chosen by the guests for relaxation, recreation, entertainment, and for experiencing Ayurvedic treatment. This was especially the case in short-term treatments, i.e. when visitors came to Ayuresort for one single application or for not more than a couple of days. Several guests who stayed only for some days at the resort asked Dr. Praveen for *pañcakarma* treatment. After an explanation that *pañcakarma* takes about two weeks, he usually offered the guests "treatment for experience," whereupon they mostly opted for one or several single applications like 'relaxation massage,' *śirodhārā*, or face pack. However, not only short term visitors received Ayurvedic applications without therapeutic – or preventive – purpose. As described above, long-term treatments consisted of two or three applications each session, and one of them was usually "for wellness" or "for experience" but "not for treatment," according to Dr. Praveen.

Besides the applications that were transferred from clinical to resort context and reconfigured within this process, a number of other applications at Ayuresort did not originate from therapeutic Ayurvedic practice. One of them is the 'foot massage' described above that can be traced to full-body oil massages administered by using the feet (*uḻiccil*) from the South Indian martial art *kaḷarippayattu*.[107] Although Ayurvedic – and Yogic – (body) concepts and principles form the foundation of *kaḷarippayattu* theory and practice (Zarrilli 2001: 27, 84-91, 130f., 138f.), *uḻiccil* is not part of contemporary Ayurvedic clinical practice. At Ayuresort, where the foot massage is also part of another application, the rejuvenation massage, consisting of a 30-minute general massage on the treatment table, followed by a 30-minute foot massage, the practice has taken the role of an exotic application provided by Dr. Praveen "for experience," as it is alien to the guests, "something they don't know," as Dr. Praveen explained. Thus, by drawing from other classical South Indian traditions, the resort management incorporated an originally non-Ayurvedic practice at Ayuresort's treatment set for satisfying the anticipated guests' expectations of experiencing

[107] Once a year, during the main south-west monsoon, *kaḷarippayattu* students receive a specific 'body preparation program' for two to three months, which should prepare the practitioner for advanced practice and fighting. It consists of physical exercises and receipt of massages, accompanied by a specific diet and behavioral constraints (Zarrilli 2001: 26, 85, 88). One fundamental element of this body preparation is full-body oil massages (*uḻiccil*), which are administered by the teacher or advanced students. The massages last between 20 and 30 minutes and are primarily given by using the feet – only the head and the shoulders are massaged with the hands (Zarrilli 1984: 120f.). The aim of *uḻiccil* is higher flexibility and strength of muscles, joints and ligaments – the use of the feet allows exerting high pressure which results in greater flexibility (Zarrilli 1984: 105) – together with increased ease and fluidity of movement (Zarrilli 2001: 88). Another aim of the massages is control and stimulation of *prāṇa* (breath, vital energy, life force) and clearance of clogged channels of the subtle body associated with yoga theory to ease the circulation of *prāṇa* through both the physical and the subtle body (ibid: 138f.).

something 'traditionally' (South) Indian. In addition, when visitors came for one treatment and asked for a strong massage, Dr. Praveen usually offered a foot massage or a rejuvenation massage, since the therapists can exert more pressure through their feet than their hands. However, while the massages applied in ***kaḷarippayattu*** body preparation are somewhat painful (Zarrilli 1984: 120), the 'foot massage' at Ayuresort was a rather pleasant treatment, as guests were able to determine the pressure force.

While 'foot massage' was an application that was offered in most of the Ayurvedic resorts in Varkala, two other treatments practices at Ayuresort had been invented by Dr. Praveen: 'hand massage' and 'feet massage.' At the beginning of his work at Ayuresort, he had rejected several requests by short-time visitors for a foot massage, i.e. a massage of the feet (at Ayuresort *feet* massage referred to massage on the feet, whereas *foot* massage referred to massage with the feet), since this was not part of Ayurvedic practice, as Dr. Praveen explained to me. Although there exists an application called ***pādābhyaṅga*** in Ayurvedic practice, which can be translated with 'foot massage,' according to Dr. Praveen this application would not serve the purpose requested by the guests: relaxation and pain relief. He thus decided to create an 'Ayurvedic foot massage' by referring to concepts and practices of other medical systems and combining them with Ayurvedic practice. Through studying an encyclopedia of alternative healing written in Malayalam (Thirumulpad n.d.), which contains a one hundred-page long chapter on acupressure and reflexology, and enriched by information about acupressure and reflexology points he found on the internet, Dr. Praveen developed a feet massage, and also a hand massage through the same principles, that differs form ***pādābhyaṅga*** by the larger degree of pressure exerted and by focusing on acupressure and reflexology points.[108] Hence, Dr. Praveen created a new Ayurvedic treatment by blending the Ayurvedic practice of ***abhyaṅga*** with reflexology and acupressure theory and practice through the interaction with several guests and their desire for a massage for their tired feet.

Further applications that cannot be found in Ayurvedic clinics are cosmetic treatments. At Ayuresort, 'face packs' and 'body packs' are offered.[109] The brown pastes were applied by one therapist on the face or the whole body respectively of supine guest, and the resulting mask was kept for about 15 minutes. Body packs were also applied in combination with

[108] A similar reconfiguration of *abhyanga* has been described by Pordié, who studied the practice at an Indian chain of high-class spas that offered modified Ayurvedic applications for the purpose of relaxation (Pordié 2011 [Paragraph 41f.]).

[109] The face pack ingredients were 'face pack powder' (a cosmetic powder industrially prepared and consisting of different plant extracts), orange juice, egg white, sandal powder, turmeric powder, honey, and water, the ingredients of the body pack were 'body pack powder' (a powder similar to the 'face pack powder'), sandal powder, turmeric powder, banana pulp, carrot pulp, orange juice, carrot pulp, lemon juice, egg white, honey, and water.

a preceding 30-minute general massage in a combined treatment called 'cream massage.' The single ingredients for the packs had been chosen by Dr. Praveen according to both classical Indian and contemporary global beauty care concepts, which he had either heard about during his childhood or read about in lifestyle magazines. The face pack was usually preceded by a 'face massage,' during which an industrially produced *Kumkumadi Lepam* (specified as "Ayurvedic fairness cream" on the package) was massaged into the guest's face for about ten minutes. While the guests usually enjoyed the face massage – Christina even asked Dr. Praveen to receive it since she had loved it during her visit of Ayuresort the year before –, guests' opinions about the face pack were divided. Most of the guests liked the application, while some guests complained about burning and heat sensations. Since most of the guests informed Dr. Praveen about their relative discomfort after the application, he arranged to discontinue it for them, while those who kept silent endured it through the motto 'beauty knows no pain.'

When Dr. Praveen and I discussed the application of the body pack, the face pack, and the face massage, he explained to me that they represented an Ayurvedic practice that exists in Ayurvedic resorts but not in clinics or hospitals. He justified their application with the guests' perceptions and expectations of Ayurvedic practice. Indeed, the Ayurvedic nature of both the packs and the face massage were not called into question by the guests, but were considered as a natural component of Ayurvedic practice, just as the other resort-specific practices like hand massage, feet massage, and foot massage. The fact that they had been invented for satisfying their (anticipated) needs and desires for relaxation, recreation, beauty care, and experiencing Ayurvedic practice was not disclosed to them by neither Dr. Praveen nor the therapists.

Through adapting and catering to the guests' expectations, newly created applications, like cosmetic treatments and specific massages, have entered the treatment set of Ayurvedic practice, while at the same time existing applications, such as *śirodhārā* or different forms of *abhyaṅga*, have been reconfigured in terms of implementation and purpose. Both the detachment of single applications from a strictly therapeutic context and the emergence of new applications contribute to the formation of a new form of Ayurvedic practice which is characterized by a strong emphasis on non-therapeutic objectives like recreation, relaxation, and the satisfaction of visitors who are looking for distraction and an exotic tourist activity.

Another practice performed to fulfill the guests' expectations of Ayurvedic treatment had been introduced by Dr. Praveen shortly after he started working at Ayuresort: the reinvention of the lighting of the oil lamp as a treatment opening ceremony, meant to please

the guests as shown below:

Dr. Praveen:	*The mental satisfaction is the main thing. So, we are adding some traditional things. Every day when they* [the guests] *are coming for treatment, we will light the oil lamp. In hospitals, this is only done before* vasti [enema], *because it's considered as the most powerful and complicated treatment in* pañcakarma. *It's like a sacrifice to get well. I will tell the guests it's like a sacrifice. It's a mental satisfaction, because they haven't done this before. It's a new thing for them. Because what they are doing is a new culture. Or the culture they don't know. We are telling what to do and how to do it and they are doing it. They like it, because every day they are happy to do it. It's done because of the belief that the treatment should be good, efficient, and have a good result for the guest. Like a sacrifice. In Indian culture, light is equal to prosperity. It's a symbol of prosperity. By lighting the lamp, prosperity will come. For the patient, prosperity is health. And here they like it also.*
Author:	*But in hospitals people also have to get healthy. Why don't you do it there?*
Dr. Praveen:	*Because lighting the light is not a big thing for them. They light the light every day in their home. For them it's not a surprise. We have to keep surprise in the resort field.*
Author:	*Why?*
Dr. Praveen:	[laughing] *You know Casino Group Hotels* [a Keralan high-end hotel chain also operating Ayurvedic centers]*? They are number one in guest care. When the guests arrive, they receive flower garlands and a* ṭīkā, *and they get sprinkled with rose water. The guests become very happy. If they would do this to me, I would become angry. Because this is very old for me. Westerners like it because it is the first time in their life and because they don't expect it; it's a surprise for them. You are getting a kind of satisfaction. When I go to Germany, I will be happy when I get German food, not Indian food. Most of the persons like to see what they don't know, what is foreign to them* (additions by the author).

By "adding some traditional things" to the treatment sequence, Dr. Praveen intended to provide the guests with "mental satisfaction" through the experience of foreign practices. Since he assumed that the guests want to see "what is foreign to them," and since he considered the lighting of the oil lamp a 'traditional' Keralan practice on the one hand and a "new thing" for the guests as it belongs to a "culture they don't know" on the other, he incorporated it in the treatment session. In this way, the practice was not only performed prior to a difficult treatment in order to ensure success, as done in Ayurvedic hospitals (difficult procedures like enemas happen very rarely in Ayurvedic resorts) but became a reinvented ritual for entertaining the guests and satisfying their expectations and desires of the Other, staged during every treatment session. Finally, while "for the patient [in hospital], prosperity is health," in the resort, the main intention for lighting the oil lamp is that the guests "like it."

The other "traditional thing" that Dr. Praveen had introduced was to provide the guests with a forehead mark at the end of the treatment session, together with an explanation about its meaning that referred to Ayurvedic and Tantric 'physiology' and the concept of the 'evil eye:' "After the treatment, the guests look very nice. Other persons know that they come from Ayurvedic treatment. They get envious and one eye is coming. To prevent that one." And to prevent the evil eye means to prevent illnesses. As Dr. Praveen elucidated, the

evil eye can cause damage in two vulnerable spots that are located between the eyebrows: the *ājñā cakra*[110] and the *śṛṅgāṭaka marman*[111]. These two spots are prone to suffer damage through the evil eye, which manifests as illness. By applying the forehead mark, both the *cakra* and the *marman* are protected against the negative effects of the evil eye and the person's vulnerability is minimized.

While Dr. Praveen presented this medico-religious explanation to the curious guests, he told me that the principal reason for the introduction of this ritual, which is usually not performed in Ayurvedic hospitals, was the same one as for the lighting of the oil lamp: it was performed "for [the guests'] experience" and "for entertaining the guests." The guests, in turn, did perform these rituals without attaching great value to them. Neither did the majority of the guests consider the lighting of the oil lamp a means for prosperity or a "sacrifice to get well," as Dr. Praveen had explained (which is also reasonable since the majority of the guests did not suffer from any serious diseases), nor did they take the unfamiliar concept of the evil eye very seriously. In general, they considered the two rituals – as well as the little altar with the picture of Dhanvantari and the flowers, and the occasional prayer by the therapist which had not been introduced by Dr. Praveen and was not always performed – as part of 'the Indian culture' package and felt comfortable enough adjusting to the 'local practice' as described below by Hannah:

Author:	*Do you always light the oil lamp?*
Hannah:	*Yes.*
Author:	*And what do you think about that?*
Hannah:	*I did not even wonder about it. I thought it is a different culture and I do what is required. I thought it is some Hindu deity who you pray to, because it is similarly constructed as an altar at home. But I do that by courtesy and out of respect. It has also already become a ritual for me. I do it because it's like that. I have also checked with the doctor what I am actually doing there. He told me that you light the lamp in honor of the god of Ayurveda and that the treatment is efficacious. And that is what I am doing, but without a strong belief that it has better or worse effects. I rather do that out of respect for the local population*
Author:	*And after the treatment, do you receive this mark on the forehead?*
Hannah:	*Yes.*
Author:	*And what value do you attach to it?*

[110] The concept of *cakra*(s) has its origins in Buddhist and Hindu Tantric traditions and can be summarized in a nutshell as trans-physical "energy-centers along the axis of the spine" (Fields 2001: 92). There are seven important *cakra*s according to Hindu Tantric tradition – six of them being located within the body and one, the *sahasrāra cakra*, on top of and above the head –, and the *ājñā cakra* or "the sixth *cakra*," as Dr. Praveen referred to it in his conversations with the guests and with me, is located at the level of the eyebrows, vertically centered between them (for a brief overview of the seven *cakra*s see Fields 2001: 148).

[111] Although the concept of *marman* is part of Ayurvedic theory (see Footnote 90, Page 76), it does not take up much space in the B.A.M.S. curriculum at Ayurvedic colleges in India. As a result, not many Ayurvedic practitioners have extended knowledge about *marman*s, including Dr. Praveen, as he told me. This also explains why in his statements about these "vital parts," as he translated them for the guests, he mistakenly located the *śṛṅgāṭaka marman* between the eyebrows, where according to *marman* theory the *sthapanī marman* is situated.

Hannah: *I thought it is just characteristic of the country. I did not associate it with any divine worship or the like. I just thought in other places you receive a floral wreath or you get a blossom tucked behind your ear, and here you receive the Hindu dot.*

Like Hannah, the majority of the guests complied with the rituals out of courtesy or because they considered them an integral element of 'Hindu culture' or 'Indian culture,' to which they attributed a certain degree of religiosity in general. By contrast, Ayurvedic treatment itself was generally not associated with any spiritual or religious elements and thus the rituals were rather dissociated from the treatment. One of the few exceptions was David, who claimed that

> [...] *by lighting this light you acknowledge and you thank everybody and everything involved in this process that made it possible that it happens.* [...] *And in that way, by doing this, you connect yourself with the whole system and everything that is behind it. So for me this is very important to do this lighting at the beginning. I was very glad that they gave me the occasion to do it.*

And on my inquiry about his opinion of the little altar, David stated:

> *It's love, making an altar. You give attention. You acknowledge that there is a system on which you depend.* [...] *And the flowers give their energy. So you also get the support of the plant kingdom, the plants.* [...] *I strongly believe in this kind of things. And in the wellbeing that comes out of it. Yeah, absolutely. Somebody who gives a treatment and who makes a nice altar, he has an energy which is the energy of somebody I really like to be treated by. Somebody who is just medically correct doesn't give the same treatment to me.*

While David, and some guests from the United States and from Canada, linked Ayurvedic treatment with different spiritual elements as for instance energy flows,[112] for other guests, Ayurvedic treatment was a secular practice. When I asked them if they connect any religious or spiritual elements with it, they usually denied it. Oliver's view in this regard was even changed through the treatment at Ayuresort and other Ayurvedic resorts he had visited before. He explained that before his Ayurvedic treatments in India and Sri Lanka, he believed that Ayurveda was "*magisch-religiös*" (magical-religious), but he "quickly found out that this was not the case."

While the rituals and the altar did not result in an association of Ayurvedic treatment with religious aspects among the guests, the confrontation with these elements of an imagined 'Hindu' or 'Indian culture' contributed to the confirmation and consolidation of the perception of Ayurveda as being 'traditional' and 'Indian,' that almost all guests had brought to Ayuresort. However, in the same way as the different single applications are particular forms of Ayurvedic practice specific to Ayuresort (and other Ayurvedic resorts), the rituals of lighting the lamp and providing the guests with a *ṭīkā* were not as 'traditional'

[112] This is presumably related to David's general affinity for 'spiritual' knowledge and practice on the one hand, and to the 'New Age environment' of Ayurvedic practice and representations in North America discussed in Chapter 1 and in Section 2.2 on the other.

as they were presented by Dr. Praveen and understood by the guests. Due to their creation in the interaction between the doctor and the therapists on the one hand, for whom these practices represented a sacrifice for the guests' health and protection from the evil eye and illness, and the guests on the other hand, who did not realize this background, the rituals represent new, invented hybrid practices rather than an 'old tradition.'

Two other practices at Ayuresort that most of the guests had associated with 'Indian culture' but not necessarily with Ayurveda were yoga and meditation classes. Every morning at seven o'clock, guests could attend a one-hour yoga class that primarily consisted of practicing different *āsana*s (postures) in standing, sitting and lying position under the guidance of the yoga teacher Ramu. These classes were supplemented by 'meditation classes' at seven o'clock in the evening. The one-hour meditation classes comprised a lecture on yoga theory by Ramu (which covered topics like the concept of *oṃ* or the doctrine of the *cakra*s), the performance of two *āsana*s – *sūrya namaskāra* (the popular Sun Salutation) and *śavāsana* (the Corpse Pose) –, *prāṇayāma* exercises (according to yoga theory the regulation of vital energy through breath), and the common chanting of *oṃkāra*, the sacred Hindu mantra, for several times. Both the yoga and the meditation classes always started and ended with a common recitation of a *śāntiḥ* mantra (sacred verse from the *Upaniṣads*) and were accompanied by the sound of the sea and the view on palm trees in front of the yoga hall windows (see Figure 2.13). I will neither go into details regarding the single *āsana*s and the *prāṇayāma* exercises, nor will I discuss the form of yoga practice at Ayuresort, which is but one of many contemporary varieties of yoga practice existing worldwide that are part of a set of transnational products created over the last century.[113] Instead, I will analyze the inclusion of yoga practice by itself within Ayuresort's 'Ayurveda packages,' which points to differences to clinical Ayurvedic settings in India, where yoga practice is not common.[114]

One characteristic element of the forms of Ayurveda prevalent in North America labeled as 'New Age Ayurveda' by Zysk and by Reddy (see Chapter 1) is their close linkage with yoga (Zysk 2001: 13; Selby 2005: 121f.). Some of the guests from the United States and Canada considered yoga to be an integral part of Ayurveda, or at least viewed Ayurveda and yoga as "sister sciences" (Catherine). However, for the majority of the guests, yoga and Ayurveda were distinctive practices, which nevertheless go well together since they

113 See also Alter 2004; De Michelis 2004, 2007, 2008; Hauser 2013a; Singleton 2010, 2013; Strauss 2005, 2008.

114 These conclusions are derived from my observations and the conversations I had with practitioners working in both Ayurvedic resorts and Ayurvedic clinics and hospitals, who told me that yoga is not practiced in clinical institutions and usually not prescribed to patients. However, there seems to be practitioners who incorporate yoga practice in their treatments, as Naraindas' research in an Ayurvedic clinic in South India demonstrates (2014a: 134).

Figure 2.13: Recitation of *śāntiḥ* mantra during yoga class at Ayuresort (photo by the author)

complement each other. Some guests justified this with their belief that Ayurveda rather addresses physical aspects, while yoga addresses mental aspects. David's interpretation that "Ayurveda and yoga really work together" was based on his perception that through yoga "the energy can easily flow" because "all the energy channels in the body are stretched," facilitating Ayurvedic treatment, which he believes to be also "something energetic." While David's explanation for the characteristics and benefits of yoga was spiritually linked, for the majority of the other guests it was not. They regarded yoga either as a mental relaxation technique, physical exercise, therapeutic practice (to a much lesser extent), or as a combination of the aforementioned. It was considered beneficial for "*mentale Reinigung*" (mental purification), for assisting the treatment of musculoskeletal problems, and above all for increasing flexibility of muscles and joints. This mirrors today's transnational "notion of yoga as a form of physical education [...] or as mind-body exercise" (Hauser 2013b), which is paralleled by the practice of *āsana*s – and *prāṇāyāma* – as the primary aspect of contemporary yoga worldwide.[115] Today, the practice of yoga is advocated in both popular and scientific literature as beneficial for the cure and treatment of diseases, for stress relief and for the promotion of overall health and fitness (Alter 2005b: 133). And at least two features of this notion of yoga were prominent perceptions of yoga the guests of Ayuresort had: yoga as beneficial for improving one's fitness and for relaxation.

While most of the guests considered yoga a mixture of workout and relaxation technique 'made in India,' for Dr. Praveen yoga and meditation classes at Ayuresort were nothing but

115 For today's global dominance and the transnational evolution of *āsana*-based or postural yoga with an emphasis on physical exercises and relaxation elements during the last century, see Alter 2005b; Hauser 2013a; De Michelis 2004, 2007; Newcombe 2013; Schnäbele 2013; Singleton 2005, 2010, 2013.

"entertainment" and only held "for business reasons." He further claimed that yoga has become "a fashion" in North America and Europe. He was surprised by the large amount of yoga studios existing in Germany, while yoga was not a common practice in Kerala other than within the tourism industry. The same was true of meditation: "only tourists do it," and if Dr. Praveen did it, "people would laugh and would ask: 'Are you mad?'." This view was also held by Ayurvedic practitioners who talked to Langford (2002: 59), and several Indian scholars I spoke to claimed that the majority of the Indian population do not even know the term 'yoga.' Although Alter (2004) illustrates that different forms of yoga are practiced in India, yoga seems not to be a common practice among the general population but rather to be restricted to either certain places like religious ashrams or to members of a specific socio-economic strata like urban middle- and upper-class women (see e.g. Nichter 2013: 216-218).

But although Dr. Praveen was not familiar with yoga, he was confronted with it during his studies. He explained to me that certain aspects of yoga were taught in college – as part of the subject of *swasthavritta* (code for the maintenance of healthy life)[116] – but they were mainly confined to indications and contraindications of different *āsana*s, thus referring to the contemporary transnationally predominant form of postural yoga, which evolved only during the last century. Although Dr. Praveen and his classmates even had to perform certain *āsana*s in one exam, they did not attach great importance to it within Ayurvedic theory and practice but rather considered yoga as existing distinct from Ayurveda and "studied it only to pass the exam." And now, during his work at Ayuresort, he does not incorporate yogic practice in the treatment courses, it is rather offered "beside Ayurvedic treatment, not as one part of it." He does not interfere in the yoga and meditation classes, except for having instructed Ramu to practice only easy *āsana*s and perform them "slowly, with attention and in a relaxed mode," since muscles are in general tender during Ayurvedic treatment, and he regularly asked Ramu not to teach specific *āsana*s if they are contra-indicated in certain cases.

In general, Dr. Praveen considered yoga as a form of physical exercise, which became clear on the one hand when he claimed that for him yoga was not important and thus he "prescribe[d] stretching exercises, not yoga," and on the other hand when he told me that "Kerala people want to sweat for exercise; yoga is slowly without sweating, that is possibly one reason why Keralites don't do yoga." Thus, yoga at Ayuresort, and also at the other

[116] For more information on *swasthavritta* see Subhash Ranade et al. 2005 and Central Council of Indian Medicine 2010.

resorts I visited, has become a form of exercise that is done mainly for satisfying the desires of the foreign guests, who expect it since they associate it with Kerala or India, and, to a minor degree, with Ayurvedic treatment (see also Islam 2012: 228; Tirodkar 2005: 190). The latter association is certainly influenced by its existence in the Ayurvedic public eye through print magazine and online articles and particularly through several popular science publications in the realm of 'New Age Ayurveda' (see e.g. Frawley 1999, 2001, 2005, 2012; Mohan and Mohan 2004; Stiles 2008).

While these books and other print and online media emphasize the interconnection between yoga and Ayurveda similarly to S. K. Ramachandra Rao's references to linkages between the *Yogasūtra* and classic Indian medicine and between the *Carakasaṃhitā* and yogic theories before the composition of the *Yogasūtra* (1987: 222f.), my own findings indicate that this conjunction is low in contemporary Ayurvedic clinical practice. Not only did Dr. Praveen deny any link between yoga and Ayurveda in clinical Ayurvedic treatment, the practitioners of the different Ayurvedic clinics and hospitals I spoke to did not recommend or even prescribe yoga practice for their patients. By contrast, through the resort management's intention to entertain the guests and to satisfy their expectations, yoga classes have become an inherent part of Ayurveda packages at Ayuresort as well as most other Ayurvedic resorts.

Those packages represent a specific form of Ayurvedic practice that differs considerably from Ayurvedic treatment in clinics and hospitals. Instead of being an exclusively therapeutic form of health care, Ayurveda at Ayuresort represents a blend of different practices with several aims like recreation, illness prevention, treatment of minor ailments and providing the guests an Ayurvedic experience. This form of Ayurvedic practice features a distinct form of doctor-guest/patient interaction with a particular diagnostic procedure, reconfigured and (re-)invented single applications like 'oil massages' and cosmetic treatments or a modified treatment course including elements of relaxation and wellbeing. In addition, Ayurvedic practice at Ayuresort comprises elements of 'cultural entertainment,' like the performance of the two rituals at the beginning and the end of every treatment session or the practice of yoga and the lectures on yoga theory, to satisfy an anticipated guests' desire for experiencing an imagined 'traditional Indian culture.' These practices are intrinsically tied to the guests' motivations for visiting Ayuresort and their perceptions and expectations of Ayurvedic treatment. Dr. Praveen told me that in Ayurvedic resorts "guest is god" and because "guests pay a lot of money, we have to satisfy them." Satisfying the guests means to adapt the practices, at least to a certain extent, to the guests' desires, expectations and imagination of

Ayurveda – given their financial expenditure.

According to Vasu, the general manager of the resort, the company that ran the resort equated Ayurveda with a commercial product for profit increase. In fact, Ayuresort could not be competitive in the hotel industry without its Ayurvedic center. With about 50 percent of the total revenues that the company gained from Ayuresort, resort guests who took Ayurvedic treatment contributed significantly to the economic health of the resort and the company. As a consequence, while Spitzer credits resort owners and managers with "establishing the parameters of Ayurvedic care in their facilities" (2009: 142f.), I suggest that it is primarily the guests themselves who play a leading role in shaping the Ayurvedic practice at the resorts due to the great economic importance that is attached to Ayurveda by the managers and owners.

During consultations at Ayuresort, long-term guests brought their perceptions and expectations of Ayurvedic treatment to Dr. Praveen's attention, either through direct requests or implicitly by presentation of complaints or general motivations for visiting the resort. Dr. Praveen, who had learned how to "read the European mind" and how to "handle the Europeans," as he frequently stated, in turn reacted to the guests' needs and requests, which does not only result in a form of doctor-guest interaction that differs from doctor-patient interactions in clinics and hospitals, but in the long run also contributes to the production of the resort-specific Ayurvedic practice. For instance, the image of Ayurveda being beneficial for relaxation was translated in Ayurvedic practice by Dr. Praveen's invention of the 'hand and feet massage' after guests had asked for such an application. The explicit assessment of the guests' *prakṛti* through the list mentioned above had been incorporated in the diagnosis after many guests wanted to know their *prakṛti* as they considered this an elementary part of Ayurveda. And different relaxation elements had entered the treatment courses since various guests visited the resort for stress relief and recreation because they associated Ayurveda with these aspects.

Dr. Praveen responded to the guests' desires and expectations, for two reasons: personal motivation and power relation resulting from the resort's dependency on the paying guests. The latter became especially obvious in his interaction with tourists who visited Ayuresort for only one or more single applications, which they usually chose from a list mentioning the applications available. The doctor considered these situations as "a business," which transforms his role from an Ayurvedic practitioner into a businessman: "We just give them what they want. They will get a massage and Ayuresort will get money. In these situations I have a business mind, not a doctor mind" (substitution of resort name by the author).

As extension of the resort's management, Dr. Praveen sold Ayurveda to clients who were regarded as consumers in a free Ayurvedic market.

Such service structures even lead anthropologists to produce, at least subconsciously, consumerist anticipations of Ayurvedic treatment, as the following statement of Langford illustrates. Referring to her personal experience undergoing Ayurvedic treatment, she describes that she felt "irritated" in the course of an application because a meditative aspect, which had appeared before, was missing:

> How quickly I had developed a consumerist expectation for the meditative experience that in Dr. Vijayan's discourse worked as a metonym of Indian wisdom. In the context of my pañcakarma treatment, meditation had turned from a mental discipline to a mood-altering commodity, something I could passively receive through a slow anointment of oil on my forehead (Langford 2013: 286 [in French; English version taken from Langford's original manuscript in English]).

Not only are single treatment effects perceived as commodities as in the case of Langford's illustration, but Ayurvedic practice as such is considered as a commodity by different stakeholders in what Rakesh, the front desk manager of the resort, summarized with a brief but meaningful statement: "The guest pays, we give service. If we don't deliver they can ask to deliver."

And to please and to attract the paying clients, various Ayurvedic applications were created or reconfigured. The variety of 'massages' listed on the single applications price sheet for instance, was explained by Dr. Praveen as follows:

> *Nobody will come for* abhyaṅga. *They don't know the word. So we call it 'massage.' And we cannot only offer massage, because it would be boring. In a hotel* [South Indian term for restaurant], *you also cannot only offer chicken, but you have to offer grilled chicken, chicken 65, and so on. Every day the same dish would be boring. So we offer four different massages. 'Rejuvenation' is only added for Europeans, rejuvenation massage doesn't exist in classical Ayurveda* (addition by the author).

In order not to bore them, new Ayurvedic treatments have been created, which were conducted to entertain the visitors and to increase their wellbeing, but not for therapeutic reasons. This applied for both visitors who took single applications and for long term treatment guests, since the latter received a variety of applications out of the broad treatment set aimed at also satisfying their curiosity.

The whole process of adapting Ayurvedic practice is facilitated due to the specific economically-determined power structures within Ayurvedic resorts, following Dr. Praveen's explanation that in resorts, the Sanskrit verse and Hindu code of conduct '*atithi devo bhavaḥ*' (the guest is god) is reinforced by the resort management's ambition to make a profit from the paying guest. In addition, practice formation is promoted by several processes of terminological and conceptual translations among the different actors, so that

Ayurvedic concepts and practice 'make sense' for the guests who are thus willing to engage in Ayurvedic treatment. With different translations, Dr. Praveen and the resort management make Ayurvedic practice meaningful to the guests, who in turn make Ayurveda plausible for themselves through their own translations in what constitutes a set of reconfigurations of Ayurvedic practice.

As described above, Dr. Praveen justified the terminological translation of '*abhyaṅga*' into 'massage' – which is possible due to *abhyaṅga*'s massage-like appearance – with the guests' lacking knowledge of the Ayurvedic term and application. However, this translation implies a modification of the meaning and implementation of the concept and eventually practice: from a therapeutic application conducted for *snehana* (oileation) and *svedana* (sudation) and a major element of *pañcakarma* treatment, *abhyaṅga* is translated into a practice that still includes these aspects but also reduces muscle tension, improves blood circulation and provides mental relaxation, which characterize the European and North American concept of massage and what many guests at Ayuresort associated with the application. While for Dr. Praveen the benefit of single massages was "only relaxation of the muscles and improvement of blood circulation," their main purpose in long-term treatment courses was to permeate the body with medicated oil and not to relax muscles and mind, what most of the guests associated with the applications. When I talked to Hannah one evening after she had done a short sightseeing trip in the morning that included a strenuous motor rickshaw ride, she told me that she enjoyed the treatment in the afternoon since after this trip she "needed a massage" for her exhausted body. Adam wondered how the massages could be effective, as the therapists perform their strokes only on the body surface and do not penetrate into the muscles. Thus, *abhyaṅga* was not only translated into massage through terminological substitution by Dr. Praveen and the resort management but also through processes of interpretation based on associations of the unknown Ayurvedic practice with other familiar, seemingly similar practices by the guests. Through these processes of translation, the guests can make sense of the application and engage with it, which eventually contributes to the creation and consolidation of new Ayurvedic practice in form of particular new single applications on the one hand, and an emphasis of relaxation aspects in Ayurvedic practice in general on the other hand.

Another example for such processes is related to the translation of '*pañcakarma*' into 'purification' by the stakeholders of the resort(s) and into '*Entschlackung*' or 'cleansing' by the guests. As described above, Ayuresort and many other Ayurvedic resorts offered *pañcakarma* treatments under the name of 'purification' treatments. Through this terminological

translation, many German-speaking guests made sense of the treatment by referring to the idea of '*Entschlackung*.' The concept is popular in different forms of complementary and alternative medicine in Germany, where it refers to the elimination of toxins and harmful by-products of the metabolism (*Schlacke* or slag) in blood and tissues.[117] It was known by most of the German-speaking guests at Ayuresort, who used it to make the unknown treatment of *pañcakarma* plausible for themselves due to seeming similarities, on the level of practice in form of purges and enemas and on the level of concepts in terms of *Schlacke* on the one hand and *doṣa*s on the other (which were often translated as 'toxins' by Dr. Praveen), that functioned as *tertium comparationis.* Although the underlying theoretical conceptualizations are different, guests could make sense of *pañcakarma* as they could associate the concept of expelling *doṣa*s with expelling *Schlacke* or toxins, as it was the case for non-German speaking guests, who translated *pañcakarma* into similar, known notions of 'detox' or 'cleansing.'[118] This conceptual translation through the guests did not only let them engage in *pañcakarma*, it also contributed to the treatment's focus on illness prevention, as *Entschlackung* or cleansing was associated by many guests with maintaining health and preventing ill-health.

Those two examples only cover some of several translation processes through which Ayurveda is made plausible for the guests and which eventually contribute to the formation of Ayurvedic practice at Ayuresort. Walter Benjamin claimed already in 1923 in the preface to his translation of one section of Charles Baudelaire's *Les Fleurs du mal* (1857), entitled *Die Aufgabe des Übersetzers* (The Task of the Translator), that translation is not merely a representation of the original but rather a production of new meaning (Benjamin 1923). Translation "articulates difference explicitly and creates something new" (Fuchs 2010: 118; original in German). Similarly, the translations taking place at Ayuresort do not merely represent a one-to-one transfer of meaning. They rather constitute a bridge-building 'social action' (Solomon 2009: 53) that removes or at least reduces differences, through which an altered meaning is transferred and finally a modified practice is created. The guests, the doctor and the resort management are "social actors [who] translate, negotiate meaning, adapt their understanding of contexts, without falling back on a major theoretical device" (Fuchs 2010: 115f.; original in German; addition by the author) and in this way

117 The German term '*Schlacke*' originated in European industrialization, where it described the by-product of the process of smelting ore. From the beginning of the twentieth century, the term and the concept were transferred to the medical context, where *Schlacke* and *Entschlackung* ('de-slagging' or the process of diverting the *Schlacke* out of the body) is prominent since then for instance in German naturopathy.

118 Similar interpretations have been observed by Naraindas and by Frank and Stollberg in their studies on Ayurvedic practice in Germany (Frank and Stollberg 2002: 233f.; Naraindas 2014b: 116 [Footnote 24]).

eventually contribute to the formation of practice existing at Ayuresort. The different non-representational, interactive translations can heuristically be divided into two forms: implicit, non-intentional interpretation or subsumption of unknown things in familiar categories and explicit, intentional substitution of terms and concepts where the new terms and concepts are exploited and treated as reflections of the old ones (Fuchs 2010: 128). Through the translation of terms from the source language Sanskrit or Malayalam into the target language English, not only the terms are substituted, but also the interrelated meanings. Through implicit interpretations of both the 'original' and the translated terms, their meaning is modified as well. I suggest that it is mainly the intentional translations in form of substitutions done by the doctor and the resort management that result in reconfiguration of Ayurvedic practice: they change terms and practices so that the guests can understand and accept these terms and practices in particular and Ayurveda in general. While the guests' interpretations also influence reconfigurations of practice, their impact is arguably greater in supporting and stabilizing the new practices: only through their implicit translations, the guests engage in these practices, which eventually contributes to establishing the latter on the long run. Thus, in addition to the perceptions and expectations that guests bring to the resort and the profit-orientation that underlies the managements' intentions, translation processes are a vital element of shaping the resort practice.

While the concern for profits along with processes of translation commonly influence the practice formation at Ayuresort, Dr. Praveen kept a largely independent approach, unaffected for the most part by an exclusive desire to accommodate guests' expectations. Although resort guests had a greater voice than patients in clinics and hospitals, their expectations and desires did not determine the practice completely since in the end it was still Dr. Praveen who had the authority to make decisions about treatment. He adapted the practice only as far as it was still, in his view, in accordance with core principles of textual Ayurveda and with clinical practice. For instance, he never provided *pañcakarma* treatments for guests who stayed less than ten days, as a proper implementation of this treatment is not possible in a shorter time – in comparison to other resorts that offer *pañcakarma* treatments within a week or even only some days. In another situation, Dr. Praveen refused to treat a visitor's back pain due to differing perceptions of Ayurvedic theory (and connected practice). When Dr. Praveen explained her that the treatment includes *kati vasthi*, the visitor did not accept this because she considered the application as being bad for her 'pitta constitution,' whereupon Dr. Praveen told her to look for another practitioner as he did not let the guests dictate him his practice, especially if their perceptions were wrong. While Dr. Praveen

catered to several of the guests' perceptions of Ayurveda, in this case their overemphasis of *prakṛti* resulted in the treatment not being performed.

Thus, while guests' perceptions of Ayurveda mainly resulting from media representations influence the practice in the resort in several aspects, they do not determine them completely. In addition, images of Ayurveda and Ayurvedic practice reinforce each other in a mutual way so that the process of practice formation is more circular than linear: through constant reiterations of Ayurvedic practice in terms of media representations and narrations by individuals who have experienced treatment at Ayurvedic resorts, Ayurvedic practice is shaped which in turn informs and confirms representations and perceptions of Ayurveda. This co-constitutive interplay – mediated by doctor-guest interaction, influenced by different stakeholders in the tourism industry and the media, and determined by various translation processes – results in the formation and consolidation of specific forms of Ayurvedic practice and knowledge that are unique to Ayurvedic resorts.

Conclusion

This chapter aimed at presenting the practice at Ayuresort together with its underlying foundation as well as describing the guests' motivations for visiting the resort and their general perceptions of Ayurveda. I demonstrated how pragmatic decisions translate imagination into practice, resulting in the creation and consolidation of a specific form of Ayurvedic practice and knowledge employed in resorts that differs considerably from common practice in Ayurvedic clinics and hospitals in India. Due to two inter-connected reasons in the form of the resort's profit-orientation and power relations between the guests and the resort management/staff, guests' perceptions and expectations of Ayurveda end up shaping the very practice that exists at Ayuresort.

By presenting the guests' intentions for visiting Ayuresort, the chapter showed how a great majority of visitors sought relaxation, stress relief and recreation in combination with treatments for general wellbeing and for minor ailments for which most guests would not necessarily seek health care treatment in their home countries. The guests' motivations for coming to the resort thus differed significantly from local patients' intentions for resorting to an Ayurvedic clinic or hospital, which are primarily visited for therapeutic treatments, in most of the cases after failure of biomedical therapy. These differences in motivations between hospital patients and resort guests result from the fact that the intentions of the latter for visiting a resort, together with the guests' expectations of Ayurvedic treatment

and their stay at the resort, rest on the guests' perceptions of Ayurveda. Ayurveda was not perceived as a form of therapeutic medical treatment, as it is in Ayurvedic clinics and hospitals, but rather as an ancient, natural, holistic Indian health tradition – in comparison to modern, chemical, fragmentary Western biomedicine – that is beneficial for health maintenance, illness prevention and the treatment of minor ailments, while simultaneously serving as a treatment and/or holiday activity aimed at recreation and relaxation.

These perceptions have not been shaped by experiences with practices in Ayurvedic clinics and hospitals but are based on exposure to Ayurvedic treatment and Ayurveda's media representations. In this chapter, I traced the origin of the perceptions back to Ayurvedic practice in Europe and North America on the one hand, and to representations of Ayurveda in Indian, European and American print and online media and promotional material on the other. The perceptions of the majority of the guests without prior exposure to Ayurvedic resorts in South Asia are greatly influenced or even completely formed by those guests' experiences with Ayurvedic treatment in day spas, beauty salons and massage parlors outside South Asia and by visual and textual representations of Ayurveda in Western magazines, books and newspapers, advertising material displayed and distributed in Indian tourist destinations, travel agencies in and outside South Asia, international tourism trade fairs, and in the transnational space within the World Wide Web. While in India Ayurveda is primarily part of the national health care system and is one of several alternatives to the dominant medical system of biomedicine, with its transfer from South Asia to other countries, Ayurveda has been de- and re-contextualized. In the process, different new forms of Ayurvedic practice evolved, ranging from gentle practices in the area of preventive and curative health care to a loose cluster of wellness, relaxation and cosmetic treatments. While the perception of Ayurveda of some guests at Ayuresort was influenced by these practices they had experienced themselves, most of the guests' imagination of Ayurveda resulted from various media representations, which were either produced in the wake of this modification of Ayurvedic practice in Europe and North America or by different stakeholders in the Indian tourism industry. These representations convey images of Ayurveda being a wellness procedure, recreation practice and gentle alternative health care treatment with a focus on oil massages, which in turn manifest into imaginaries of those guests exposed to these images.

The guests' perceptions do not only form the foundation for their visits though. They also represent a vital element in the formation of the Ayurvedic practice that prevails at the resort. The practice is not exclusively disease-focused and therapeutic like common

Ayurvedic treatment in clinics and hospitals, but includes preventive treatments and practices for wellbeing and recreation, which are labeled as 'wellness treatments' by different actors. While practice and meaning of Ayurvedic treatment as such has been modified through this shift away from exclusively therapeutic practice, this new form of Ayurvedic treatment contains various elements specific to Ayurvedic resorts. Single applications have been created and reconfigured, such as feet massages or rejuvenation massages. In addition, the doctor-guest interaction is more comprehensive, less hierarchical and includes a different form of diagnosis than in clinics or hospitals, while specific rituals as well as yoga and meditation classes have been introduced in order to entertain the guests and satisfy their expectations and neo-orientalist perceptions of Ayurveda and India. Clearly, Ayurvedic practice is to a certain degree adapted to the imaginations of the guests for the pragmatic reasons of generating revenue. The resort represents an institution in the service sector and its management considers it as a source of income and thus the expectations of the financially strong guests have to be fulfilled for economic reasons. These adaptations are influenced by different intentional and non-intentional translations on the level of terminologies, concepts and practices, through which Dr. Praveen and the management can make Ayurvedic treatment plausible for the guests, who in turn can make sense of the practice through these processes of translation. As a result, a specific form of Ayurvedic practice has been created, which comprises elements similar to Ayurvedic treatment prevalent in Indian hospitals and clinics, as well as elements that can be found in Ayurvedic practice in other parts of the world. Combined in a unique way, the different elements constitute a new transnational form of Ayurveda.

On the one hand, through the incorporation of relaxation elements like the extensive use and (re-)invention of massages and massage-like treatments or through the administration of applications 'for experience' and for cosmetic purpose, Ayurvedic practice is detached from a purely therapeutic context. On the other hand, it does not represent a sheer wellness practice as it also involves unpleasant aspects, such as evacuative procedures, a strict diet plan or the administration of medicines[119] – elements that constitute Ayurvedic treatment in Indian clinical settings, and which are rarely covered by media representations. Although those representations certainly have a great impact on the practice at the resort, it is Dr. Praveen who decides about the treatment the long-term guests receive, who makes the practice meaningful for them and who is eventually responsible for the practice formation, even if the guests' expectations have an impact. The latter are however also modified

[119] This coexistence of pleasant and unpleasant elements in resort practice will be analyzed in detail in Chapter 4.

during the guests' stay at Ayuresort. Not only does the practice at the resort influences the production of media representations at a macro level, as argued above, there is also a similar influence taking place at a micro or individual level: through their contact with Ayurvedic practice and theory at the resort, various guests' imagination of Ayurveda changed. Only after experiencing specific treatment elements like purgation or medication, Ayurveda became something 'medical' to some of the guests. While those guests were open to such unexpected aspects of Ayurveda and engaged with them, other guests complained about things they had not expected, particularly those guests for whom the Ayurvedic treatment was not the main intention of their travel to India and represented only a tourist activity rather unfamiliar to them. One member of an American tour group for instance complained about the smell of the oil used in her 'relaxation massage' and requested "aromatherapy" with better smelling oils and she complained that "the therapists don't transmit energy" during her massages. These complaints point to certain expectations that were probably formed in the guest's home country, as this was her first experience with Ayurvedic treatment in India. They were influenced by widespread images of Ayurveda as pleasant cosmetic or wellness treatment and through the New Age movement, with which Ayurveda is associated in the United States. However, the Ayurvedic practice at Ayuresort was primarily adapted to the expectations of the European guests, who represented the great majority, and who did not associate Ayurveda with particularly spiritual elements. In addition, most of the resort guests did not consider Ayurvedic treatment as a pure wellness or cosmetic treatment, even though many saw these aspects as a vital part of it, and thus could handle unpleasant aspects, like an uncomfortable odor of the oil, in a better way.

Thus, such complaints were not very common during the time of my research. Most guests were happy with their treatment and received more or less what they had expected: various kinds of massages, medical care, gentle applications adjusted to the individual constitution and yoga classes, as Diana wrote in the email I quoted at the beginning of this chapter. While this chapter sought to present these practices and analyze their formation and thus served as an introduction to the practice and the actors at Ayuresort, an additional aspect mentioned by Diana in her email will be featured in Chapter 4: 'vacation elements.' Those elements, such as city trips, strolling at the sea, temple visits or the mere location of the resort close to the sea, are part of a more comprehensive analysis of the practice at Ayuresort against the background of its embedding in the tourism industry and the theoretical context of health tourism. Before analyzing the resort practice through such a macro perspective, however, I will zoom into the practice and subject it a more

thorough investigation by analyzing one specific treatment method. In the following chapter, I explore the transformation of the Ayurvedic application *śirodhārā* from an infrequently used treatment against primarily neurological and skin diseases in clinical settings into a widespread technique for stress relief in Ayurvedic resorts. In the process, I demonstrate how a new kind of 'stress' was produced, which has contributed to the creation of new Ayurvedic practice.

3 The New *Śirodhārā*: A Panacea for Stressed Europeans

One morning in March 2010, Dr. Praveen told me "now I know what stress is." During that time, 28 people from two tour groups from the United States and France received Ayurvedic treatment at Ayuresort. The Ayurvedic center with its five treatment rooms was designed to provide adequate care for up to 15 guests a day and its full capacity was rarely reached during the time of my research, except for this first week of March 2010, when an unexpectedly high number of guests demanded an atypically heavy work load for the doctor, exposing him, at last, to something he only knew at that point from his guests: *stress*.

Before joining Ayuresort, Dr. Praveen had never heard about stress, both as a concept and a syndrome so omnipresent in North American and European day-to-day lives. Through his work at the resort though, he was regularly confronted with the conceptual underpinnings and various manifestations of stress through guests who complained about it and sought stress relief. Ultimately, in March 2010, he himself would claim to experience something he was meant to cure. By catering to the needs of his guests, Dr. Praveen incorporated stress into his knowledge and eventually also into his practice. One example for the translation of the concept of stress into Ayurvedic practice is the transformation of the Ayurvedic application *śirodhārā* from a medical treatment for neurological and skin diseases into a means for stress relief.

This chapter analyzes this transformation of *śirodhārā*. I illustrate how the guests' need for stress relief coupled with their perception of Ayurveda as beneficial for relaxation, resulted in the transfer of the Western concept of 'stress' to the resort, where it is incorporated in Ayurvedic nosology. In the process, a new kind of stress was 'enacted,' which prompted the modification of Ayurvedic practice including the 'enactment' of *śirodhārā* as a popular relaxation technique and ultimately the iconic Ayurvedic treatment for stress. I suggest to understand both stress and *śirodhārā* in the resort as ontologically different from stress and *śirodhārā* outside the resort. In claiming this, I reinforce Annemarie Mol's argument in *The Body Multiple: Ontology in Medical Practice* (2002) that objects are produced or 'enacted' through particular practices in a specific context. Mol develops her argument through her ethnographic data on distinct enactments of lower-limb atherosclerosis in different sections

of a Dutch university hospital. She illustrates how the syndrome is 'done' or 'enacted' differently, by human and non-human actors, in the department of pathology and the outpatient clinic (and again differently within the respective sections). In the pathology laboratory, atherosclerosis is an abnormally thickened *tunica intima* (the innermost layer of an artery or vein), which the pathologist examines through a microscope after having cut it from an amputated leg. In the outpatient clinic, the doctor interacts with patients, rather than only (dead) body parts. In an interview, he localizes the pain the patient feels and inquires about the patient's abilities to walk. And during an additional physical examination, he looks at the skin color and texture and tests the pulsation of the artery by touching the concerned spot. The findings, such as thin skin, cold feet and weak pulsation, represent what atherosclerosis is in the outpatient clinic (Mol 2002: 25, 29f., 37f.).

And just as atherosclerosis is 'done' differently in the department of pathology and the outpatient clinic of the hospital in the Netherlands, are both stress and *śirodhārā* enacted differently inside and outside Ayuresort. Stress in the resort is made a discrete enactment characterized by a '*doṣic*-hormonal' conceptualization and its linked incorporation into the nosological category of *manasika roga* or mental illness, primarily through the interaction between Dr. Praveen and his guests and through its treatment rooted in *doṣic* concepts. The latter happens through the application of *śirodhārā*, which is part of the specific enactment of stress and which in turn is itself done in a unique way through the discrete enactment of stress in the resort.

Dr. Praveen's previous unfamiliarity with the concept of 'stress' is partly due to its epistemological roots in European and North American scientific and popular discourse. By providing a historical overview of the development of the concept in the first section of this chapter, I show that stress is a Western (i.e. Euro-American) concept enacted through biomedically informed physiological theories and socioeconomic, technological and intellectual developments interconnected with a discourse and workday pattern that remains largely atypical in India – hence, the novelty experienced and acknowledged by Dr. Praveen.

The second part of the chapter offers an ethnographic description of the enactment of stress in the resort. I illustrate how stress is produced in the resort space and entered Ayurvedic theory through the interaction between Dr. Praveen and the predominantly European guests. I start the section by demonstrating that many guests visited the resort for stress relief and made a point to complain about stress during the first consultation with Dr. Praveen. After discussing the rarity of the concept in Kerala, I illustrate how the

doctor developed 'his own stress' after being exposed to his foreign guests. Attributing the high prevalence of stress in Europe to differing work regimes and distinct levels of social and emotional support, he ultimately enacts stress in interaction with his guests as a "*vāta* problem" that fits the Ayurvedic nosological category of *manasika roga* or mental illness. I further demonstrate how a doctor working in another resort enacts stress through the translation of stress-related etiological and physiological processes into Ayurvedic terms and concepts.

In the third section, I show how the enactment of stress in the resort results in modifications of Ayurvedic practice. I analyze *śirodhārā*'s transformation from a rare medical treatment for primarily neurological and skin diseases in clinical context into a frequently applied treatment for relaxation and stress relief in Ayurvedic resorts. After outlining its usage as described in classic Ayurvedic texts and its application in Ayurvedic hospitals, I discuss its enactment in the resort. I show how Dr. Praveen refers to both Ayurvedic and biomedical theory for justifying the use of *śirodhārā* against stress in his explanations for the guests. Since *śirodhārā* is, according to Dr. Praveen, the major treatment for diseases grouped in the nosological category of *manasika roga*, to which, according to him, stress also belongs, he applies it for relaxation and stress relief. At the same time, the doctor justifies the application of *śirodhārā* by a biomedical explanation of its mode of action: the stimulation of the pituitary gland that results in the secretion of a certain hormone that reduces stress. In doing so, he does not only connect his explanations about *śirodhārā* to the cognitive field of the guests by using concepts with which they are familiar, but enacts *śirodhārā* as a panacea against stress based on both Ayurvedic and biomedical concepts and eventually as an Ayurvedic practice in its own right, ontologically different from *śirodhārā* in Ayurvedic hospitals.

3.1 Stress: A Largely Western Creation?

In its feature article 'Streß: Neue Krankheit des Jahrhunderts' (Stress: New Disease of the Century), the popular German weekly news magazine *Der Spiegel* presented its readers in 1976 a syndrome which was just about to enter public awareness in Europe and North America. Today, about four decades later, 'stress' has permeated North American and most European societies. The word 'stress' has become an inherent part of everyday conversations. Within the English-speaking world, complaints about being stressed, under stress, or stressed out are a daily occurrence. In Germany, France, Spain, Italy and Portugal,

der Stress, *le stress*, *el stress*, *lo stress*, or *o stress* respectively is a popular umbrella term for an elusive burden of diverse origins linked with personal discomfort. But not only is the *term* 'stress' an integral part of everyday language, the *syndrome* 'stress' is covered by countless articles and books, in both popular and academic discourse. Institutions and positions for (applied) stress research have mushroomed.[120] Moreover, mass media broadcast the image of a post-industrial fast and hectic lifestyle, characterized by a pressure to perform and restlessness that are presented as triggers of stress.

Although stress is familiar to most Europeans and North Americans, it remains a rather elusive concept, and currently no consistent universal definition of the term 'stress' exists. In North American and European public discourse, stress is commonly considered a result of an imbalance between external demands and individual resources to cope with them. It is further linked to occupational pressures and worries. Demanding working conditions, such as deadline constraints, pressure to perform or simultaneous execution of various tasks, are perceived as 'stressful' and result in people complaining about 'having stress.' The high prevalence of such 'workplace stress' is demonstrated by statistical data on workers in Europe and the United States who often feel 'stressed' by their work or 'burned-out,' a concept considered by many psychiatrists as a euphemistic substitute for 'depression' that excludes the stigmatization the latter commonly involves.[121]

Linked to work-related stress are not only loss of motivation and deterioration of performance, but also different mental and physical health concerns. Although insight into the complex interaction between stress and mental as well as physical health is limited, different scholars postulate a causal relation between psychological pressure and various ailments, such as cardiovascular diseases (see e.g. Backé et al. 2012), musculoskeletal disorders (see e.g. Da Costa and Vieira 2009), metabolic syndrome (see e.g. Chandola et al. 2006) or depression (see e.g. Rugulies et al. 2006). This is not only a burden for the individuals concerned, but has wider socioeconomic implications. As studies in various European countries demonstrate, workplace stress is responsible for a large number of sick days and early retirements in these countries, and is becoming more and more a cost factor

[120] These include the Stress Research Institute in Stockholm, Sweden, or the senior professorship for work stress research at the University Hospital Düsseldorf, Germany.

[121] A recent survey conducted in Germany revealed that 57 percent of the thousand participants 'are stressed' sometimes or frequently (Techniker Krankenkasse 2013: 4). In a large-scale survey of 31 European countries from 2007, 22.3 percent of respondents reported 'having stress' (European Foundation for the Improvement of Living and Working Conditions 2007: 62 [Table 7.1]). And in a telephone survey conducted in the United States in 2014, 80 percent of the 1004 participants "said that they can identify at least one thing that stresses them out at the workplace" (Everest College 2014: 4).

for employers and, by extension, national economies.[122]

While the bare figures suggest a widespread prevalence of a phenomenon conceptualized conceptualized today as work-related stress in North America and Europe, the language of stress, the public interest in the concept, and the scientific inquiry of the syndrome are relatively young phenomena. Next, I demonstrate this point by illustrating that the conceptualization of stress is inseparably linked with North American and European socio-cultural developments and can thus be consid-ered as a 'Euro-American creation.'

Historically, the concept of stress can be traced to the late nineteenth century, when major transformations in North American society through urbanization and industrialization were blamed for the emergence of nervous exhaustion or 'neurasthenia' in segments of the population. The term 'neurasthenia' was supposedly coined in the 1850s but only became popular through the article *Neurasthenia, or Nervous Exhaustion* published in 1869 by the American neurologist George Beard (Jackson 2013: 25). Beard defined neurasthenia as a "morbid condition or state," which could be both the effect and the cause of an acute or chronic disease (1869: 217). Symptoms of neurasthenia could be "dyspepsia, headaches, paralysis, insomnia, anaesthesia, neuralgia, rheumatic gout, spermatorrhoea in the male and menstrual irregularities in the female" (Beard 1869: 217).

Historically, the concept of stress can be traced to the late nineteenth century, when rapid urbanization and industrialization were blamed for the emergence of nervous exhaustion or 'neurasthenia' in North America. The term 'neurasthenia' became popular through the article *Neurasthenia, or Nervous Exhaustion* published in 1869 by the American neurologist George M. Beard. He defined neurasthenia as a "morbid condition or state," which could be both the effect and the cause of an acute or chronic disease (1869: 217). Symptoms could be "dyspepsia, headaches, paralysis, insomnia, anaesthesia, neuralgia, rheumatic gout, spermatorrhoea in the male and menstrual irregularities in the female" (Beard 1869: 217). In his book *American Nervousness: Its Causes and Consequences*, published in 1881, Beard claimed that the rapid spread of pioneering technological inventions such as the telegraph, the press or steam power, together with the advance of science and mental activities of women resulted in 'American nervousness' (1881: 96). Associating the disease with industrialization, Beard wrote that "nervousness is a result and accompaniment and barometer of civilization" (1881: 186). Due to this popular assumption of a linkage between the American way of life and nervous exhaustion, the phenomenon was occasionally referred

[122] See e.g. Bundesministerium für Arbeit und Soziales 2013; DAK-Gesundheit 2013: 139f. [Tables A5 and A6]; Directorate-General for Employment and Social Affairs, European Commission 2000: 13; Health and Safety Executive, Government of the United Kingdom 2014: 2; Trontin et al. 2007: 4.

to as 'Americanitis' (Jackson 2013: 27). Yet the concept rapidly spread to Europe, where it was likewise associated with 'modern civilization' (Jackson 2013: 34; Kury 2012: 45f.). As in the United States, the cause for *Neurasthenie* in Germany was seen in industrialization, 'technologization' and urbanization (Kury 2012: 46).

There are astonishing parallels between complaints about the 'modern life' at that time and the 'stressful life' today. While today many people criticize a 'fast and hectic life' based on global interconnectedness through extensive travel opportunities and internet and mobile communications technology, in the late nineteenth century the German neurologist Wilhelm Erb complained about developments such as increased traffic or global-scale telephone and telegraph networks, which resulted in major transformations that involved haste, agitation and 'exertions for the nervous system' (1893: 20).

However, while Erb and others saw a direct impact of 'modern living conditions' on neurasthenia, from the mid 1890s on, three new interpretations of neurasthenia emerged. While Sigmund Freud saw the causes for neurasthenia in an interplay of cultural sexual moral and individual suppression of sexual drives, the German psychiatrist Oswald Bumke attributed neurasthenia to psychological and social factors (Roelcke 1999: 178, 190f.). The third school favored biological explanations (ibid: 124), which were influenced by pathological models of the German psychiatrist Emil Kraepelin, who considered hereditary factors as the defining factors in the pathogenesis of diseases (ibid: 193) – a view that was influenced by the emergence of the biological paradigms of 'race' and heredity in medical and psychiatric sciences in the late nineteenth century. In comparison to American physicians postulating a socio-genetic pathogenesis of neurasthenia that located causes in living conditions, in German-speaking areas biological interpretations for the pathogenesis of neurasthenia that foregrounded hereditary disposition within the individual body became dominant (Kury 2012: 49f.).

The focus on biological pathogenesis eventually contributed to the collapse of the concept of neurasthenia with its environmental etiology during the first decades of the twentieth century on both sides of the Atlantic. Besides, people could not afford therapy for neurasthenia during post-war years. And for the huge amount of traumatized disabled war veterans, 'civilizations diseases' like neurasthenia became trivial ailments (Kury 2012: 50). At the beginning of the twentieth century, the term neurasthenia had degenerated into a "household word" (Jackson 2013: 37, quoting Blumer 1906: 336).

At about the same time, the foundations for early stress research were laid. During the second decade of the twentieth century, the American surgeon George Crile formulated a

mechanistic theory of disease, which proposed that both organic and psychological ailments primarily result from specific physiological reactions to environmental circumstances that included emotional strain and high demands of professional life (Crile 1915). In the following decades, clinicians increasingly considered deficient adaptations to the environment in general and excessive environmental strains in particular as causing physical and psychological diseases, and scientific interest concentrated on decoding the physiological processes of adaptation (Jackson 2013: 17). This eventually resulted in a physiological concept of stress.

The groundwork for this development was done by the American physiologist Walter Cannon, whose laboratory studies during the first decades of the twentieth century are widely acknowledged as seminal for an understanding of the linkage between physiological stability and health. Influenced by Crile's work and by Claude Bernard's concept of *fixité du milieu intérieur* (Bernard 1865), Cannon investigated physiological processes in animals "during periods of emotional stress" (Cannon 1922: 18) and introduced the concept of 'homeostasis.' The concept explains the ways in which organisms preserve functional stability in adverse conditions by maintaining certain physiological parameters within acceptable ranges. Noxious stimuli like low temperatures or traumatic pain activate the sympathico-adrenal system consisting of the sympathetic nervous system and the adrenal medulla, which restores homeostasis by producing compensatory adaptations of physiological variables like blood glucose or oxygen tension (Cannon 1929, 1932).

Although Cannon had not developed a medical theory that explicitly referred to the stress concept, he was "largely responsible for promoting the notion of stress as a means of describing and measuring the impact of environmental factors on emotional and physical health" (Jackson 2013: 70). Not only did Cannon regularly use the term 'stress' for the description of physiological processes as early as 1914.[123] His research on the physiology of emotions, along with his concept of homeostasis, was a cornerstone for successive scientific studies on stress. His ideas informed the research of various scientists, including the endocrinologist Hans Selye, who popularized the concept of stress around the middle of the twentieth century.

Between the early 1930s and the 1950s, Selye developed the concept of the General Adaptation Syndrome, which is characterized by non-specific physiological responses of the organism to diverse non-specific noxious agents such as temperature changes, drugs or muscular exercise (Selye 1936: 32). An initial general alarm reaction when the organism

123 See Cannon 1914, where he introduces his famous idea of the fight-or-flight response – the activation of the autonomic nervous system as a reaction to potential threats.

realizes a noxious condition (Selye 1946: 119) is followed by a stage of resistance or adaptation, during which the organism seeks to recover through physiological processes to a functional level (ibid: 121). If the restoration of homeostasis of functional processes is not possible, the final phase of exhaustion sets in (ibid: 121). The physiological processes then become pathological to the organism, which results in 'diseases of adaptations' as "by-products of abnormal adaptive reactions to stress" (ibid: 131) with a wide range of symptoms such as a decrease in the size of lymph glands, disappearance of fat tissue, an enlargement of the adrenal glands or loss of muscular tone (Selye 1936: 32). Selye, and many other physicians and scientists who adapted the concept of the General Adaptation Syndrome and the etiological model of 'diseases of adaptation,' considered maladaptation to adverse conditions or sustained effort to adapt effectively to the environment as causes for chronic diseases such as cancer, rheumatoid arthritis or heart disease (Jackson 2013: 11).

The concentration on organism stability maintenance was part of the interwar zeitgeist with debates about adaptations and diseases increasingly being interconnected with concerns regarding social stability, economic depression or failing international relations (ibid: 12). Biological principles of the preservation of stability were considered as blueprints for industrial or social organizations (ibid: 18). While there was a shift from neurological and psychological to endocrinological explanatory models of the relation between adaptation and diseases in the middle decades of the twentieth century, notions of physiological stability were still framed by political and socio-economic developments. Scientists and clinicians explained health and disease in term of perpetuation and dysfunction of hormonal and biochemical balance due to stress (ibid: 18).

Those years also represent an essential era in the history of the concept of 'stress.' During World War II and in the subsequent years, the term 'stress' began to be applied regularly in the context of ill health.[124] Since 1941, Anglo-Saxon military physicians labeled different physically and psychologically demanding situations for aviation soldiers as well as the resulting physical and mental ailments as 'stress' (Kury 2012: 73-76).

In 1946, Selye adopted the notion of stress for his General Adaptation Syndrome, which he defined as "[...] the sum of all non-specific, systemic reactions of the body which ensue upon long continued exposure to stress" (1946: 119). By the 1950s, numerous scientists and clinicians used the term 'stress' when they referred to environmental determinants of illness (Jackson 2013: 18f.). While Selye's notion of stress initially only referred to external demands

[124] Before that time, the term 'stress' had been primarily used in physics, where it refers to the area of a material object affected through the object's exposure to external forces that results in 'strain' or deformation of the object (Cooper and Dewe 2004: 3).

for the organism, the term was soon also applied to the resulting reaction of the organism, and 'stress' or 'stress syndrome' increasingly replaced the 'General Adaptation Syndrome' (Jackson 2013: 11, 18f.). Seyle later defined stress as "the nonspecific response of the body to any demand made upon it" (1974: 27), and this rather unspecific and broad definition of stress is still popular in contemporary public and scientific stress discourses.[125]

During the second half of the twentieth century, the biological notion of stress was adopted and refined by other disciplines like psychology, psychosomatic medicine and social medicine. While Selye considered stress as a primarily physiological-endocrinological process, after World War II psychosocial concepts of stress won recognition in the Anglo-Saxon and Scandinavian regions, and by the mid 1970s also in West Germany (Kury 2012: 53). Major contributions were made by the American neurologist Harold Wolff and the American psychologist Richard Lazarus in the Anglo-Saxon region, and by the Swedish physician Lennart Levi in Europe in the 1950s and 1960s. Focusing on the perception and interpretation of the relation between man and environment, these scientists considered social and cultural influences as well as individual strategies of interpretation and coping as crucial in experiencing stress (Kury 2012: 13). Ultimately, this socially, culturally and psychologically determined stress was increasingly held responsible for the causation of diseases (Kury 2012: 292).

Levi is regarded as the pioneer of psychosocial stress research in Europe. Following Cannon and Selye, Levi thought that the human body possessed a limited number of adaptation mechanisms capable of restoring the imbalance of the organism provoked by a stressor (Levi 1964: 34f.). In contrast to Selye, Levi argued that stress response does not only happen in response to actual danger, but also to the threat of danger, or merely to its remembrance. And in comparison to a real threat situation, the body's defense mechanism in an imagined threat situation is dangerous for the organism (1964: 35). Levi considered culturally determined personality-related stress conditions and interpersonal relations, which are in turn influenced by social norms (1964: 52f.).

Levi's research was inspired by North American psycho-social stress research during the first post-war years, based on military medicine's understanding of stress during World War II. Scientists with a background in psychology, social medicine and psychosomatic medicine criticized Selye's notion of the unspecificity of the physiological adaptation response in

[125] In 1979, Selye acknowledged that he initially had overseen his mistake of labeling both stress and its cause 'stress.' He coined the term 'stressor' for the external demands that evoke stress in the organism to differentiate terminologically between the external demand and the resulting bodily reaction (Selye 1979: 70). However, in both academic and popular discourse, the term 'stress' was and still is today regularly applied to both demands and response, thus confusing or blending two different elements of the stress concept.

his stress concept. They emphasized the importance of specific stressors and subjective appraisal of a situation for the adaptation response of the body and the development, experience and handling of stress (Kury 2012: 90). Psychosocial stress researchers looked for specific factors that trigger stress and rejected Selye's idea of non-specific agents. They focused on psychological stressors – and interconnected social and interpersonal causes – while studying individual abilities of reacting to stressors and coping with stress (Kury 2012: 91).

One of the most important figures for the development of psychosocial stress research was Harold Wolff, a pioneer of psychosomatic medicine during the 1940s and 1950s. Like Selye, Wolff considered stress a burdening challenge that contributes to the emergence of disease if the body does not react appropriately to the challenge. However, in contrast to Selye, Wolff claimed that the body does not only react to "the actual existence of danger, but to threats and symbols of danger experienced in his past" (Wolff 1953: 3). Wolff saw causes for stress in defective interpersonal interactions and social pressure (1953: 4). One central element in Wolff's notion of stress is the subjective appraisal of external demands and dangers for the experience of stress, which depends on various aspects, including "genetic equipment, basic individual needs and longings, earlier conditioning influences, and a host of life experiences and cultural pressures" (1953: 10).

The notion of subjective appraisal of possibly threatening situations in experiencing stress and development of disease was taken up a decade later by Lazarus. In his Transactional Model of Stress and Coping, Lazarus claims that stress responses are mediated by psychological evaluation of demands. Situations of stress are interpreted as complex transactions between environmental demands and individual coping potential. In a first step or primary appraisal, the person evaluates the potential threat of a perceived stressor. This is followed by secondary appraisal, in which the person assesses the social and cultural resources available for coping with the situation. If the coping strategies fail, threat-perceived stress develops and diseases can be generated (Lazarus 1966; Lazarus and Launier 1978; Lazarus and Folkman 1984). Thus, according to Lazarus stress rather results from the individual's inability to handle external demands than from the demands themselves. And the focus was not on physiological reactions to those demanding situations, but on the impact of cognitive processes on the stress response.

The nowadays widely accepted notion of stress is both physiologically and psychosocially conceptualized in biomedical and psychological language: Cognitive processes in form of an appraisal of a potential threat to the organism interact with a response of the

hypothalamic-pituitary-adrenal axis in form of the release of adrenaline and cortisol in the attempt to maintain or restore homeostasis; and the organism's failure to adequately adapt to the (potential) threat misbalances homeostasis, resulting in stress and possibly diseases. Although the cognitive aspect of the stress response, introduced by Lazarus and other psychologists, is widely acknowledged in stress theory today, biological theories remain the foundation of stress theory that "relies for its validation on the physiological models" (Pollock 1988: 381). Although stressors are no longer exclusively conceptualized in terms of physical threats as was done by Selye and early researchers, but can also include psychosocial factors or psychological conflicts, the stress response is usually described, evaluated and measured in resulting physiological processes and parameters. Current theories on stress focus on neuronal, cellular, molecular and neuroendocrine processes (see e.g. Rensing et al. 2013).[126]

Lazarus was not only among the first scientists who emphasized the psychological element of stress. His work also influenced stress research in the following decades that scrutinized the relation between work and stress. From the 1970s onwards occupational psychologists and other specialists studied different aspects of work life and developed various academic models of stress. For instance, Robert Karasek's Job-Demands-Control Model suggests that job control or decision latitude is a resource that influences the potential negative consequences of work-related stressors (Karasek 1979; Karasek and Theorell 1990) and the Effort-Reward Imbalance Model developed by Johannes Siegrist attributes the development of stress to an imbalance of demands or efforts and rewards (Siegrist 1996). Although there are differences between occupational psychological models of stress, they all rest upon the notion that work-related stressors result in health-related ailments. Several models suggest that some work tasks are more stress-provoking than others (Vahle-Hinz and Plachta 2014: 105).

The coupling of work/modern life style with stress has also become central to public discourse and lay perceptions in Europe and North America. The convergence between

[126] Central to the organism's stress response according to those theories are two signal transduction pathways that transfer the stress perception from the brain to the different body organs and tissues where they control the physiological reactions of the organism: the sympathetic-adrenal-medullary axis and the hypothalamic-pituitary-adrenal axis (Rensing et al. 2013: 124). These two neuroendocrine axes produce the hormones noradrenalin, adrenalin and cortisol, which represent key elements in the stress response. Adrenalin and noradrenalin influence the heart, circulation, blood vessels, respiration, skeletal muscles, liver, intestine and fat tissue and thus increase the physical responsiveness of the organism. Cortisol increases concentration of glucose in the blood and the allocation of fatty acids in the catabolism and intensifies the effect of adrenalin and noradrenalin in the heart and in blood circulation (ibid: 124-126, 182f.). Through overproduction of these 'stress hormones' and prolonged hormonal activity in the organism's attempt to meet physiological demands, the stress response is considered pathogenic, i.e. the organism fails to return to the state of homeostasis and different forms of ill-health can develop.

scientific research and public discussions on stress began in the 1970s and 1980s. Against the background of the research on the biological stability regulation in form of the allostasis concept – a theory developed by Peter Sterling and Joseph Eyer describing the body's ability to achieve homeostasis through physiological and behavioral change (Sterling and Eyer 1988) – stress made its way from the laboratory to the public domain:

> [N]ot only did journalists, for example, regularly cite scientific research to legitimate concerns about the rising burden of unhappiness and ill health among stressed populations, but scientists also made efforts to popularize their findings and apply them to broader social and philosophical problems. [...] For stressed and unhappy inhabitants of modern societies, the science of stress offered a conceptual framework for analyzing and adapting to the political systems, environmental pressures, and personal experiences that shaped the pattern and rhythm of life and death (Jackson 2013: 14).[127]

The *Time* magazine article 'Stress: Can We Cope?' in June 1983 represented a crucial moment in the public discourse on stress in the United States (Jackson 2013: 2f.). Similar to the *Spiegel* article from 1976 cited above, it familiarized the readers with the emerging "stress epidemic" among the American population (Wallis et al. 1983). Already from the 1970s on, popular and scientific sources had linked acute and chronic stress increasingly to different forms of ill health, such as respiratory and cardiovascular diseases, cancer, fatigue or depression.[128] At the same time, both academic texts and popular mass media emphasized the prevalence of stress at the workplace.[129] National governments and health organizations carried out large-scale surveys on work-related stress. The public discourse on the interconnection between work and stress fomented fear in the public about the effects of working life on health and happiness, which resulted in the implementation of various programs to minimize health consequences of occupational stress by both governmental and non-governmental organizations (Jackson 2013: 7). In addition, new academic disciplines emerged that explored the impact of emotions on the human body, like behavioral medicine and psychoneuroimmunology. Psychologists tried to quantify the effects of stressful life events on health and to develop strategies for patients to cope with stressors. Companies started stress management programs to improve health and productivity of their employees. And people tried to fight stress by attending classes in relaxation, yoga or meditation, with massages, or through visiting stress counselors and stress management consultants

[127] Jackson's usage of terms like 'modern' societies reflects an epistemological split between pre-modern and modern societies which I see as problematic. Different scholars have illustrated that there is not 'one modernity' that can be opposed to a 'static pre-modernity' or 'tradition' and that the first is characterized by a distinct otherness from the latter, often connected with a claimed objectivity and rationality of science (see e.g. Eisenstadt 2000; Kahn 2001; Kaviraj 2000; Latour 1993; Sax 2009).

[128] See e.g. Cooper 1996; Day 1986; Eliot 1974; Glass 1977; Selye 1976; 'Streß: Neue Krankheit des Jahrhunderts' 1976; Taché et al. 1979; Wallis et al. 1983.

[129] See e.g. Cooper and Payne 1978, 1988; House 1981; Levi 1981; McLean 1979; 'Streß: Neue Krankheit des Jahrhunderts' 1976; Wallis et al. 1983.

(Jackson 2013: 3f., 8). Apart from that, a broad range of self-help literature on stress-reduction strategies emerged, together with magazines dedicated to stress.[130] By the turn of the millennium, a huge stress management industry had been emerged.[131] In addition, anti-stress programs are now part of national preventive healthcare programs (Altgeld 2014: 304).[132]

Not surprisingly, political anti-stress campaigns are the latest developments in the 'age of stress' (Jackson 2013). In most European societies and North America, "[...] stress had gained credibility as a keyword, a multidimensional linguistic marker of a particular time and place" (Jackson 2013: 14). However, this 'rise of stress' has to be considered in the specific historical and socio-cultural context. Jackson argues that

> [...] stress is a hybrid phenomenon, the product of both biological and cultural forces rendered visible by the technology and language of biomedical science. At one level, the proliferation of stress during the twentieth century reflects the manner in which shifting patterns of disease and experience that have been revealed in the clinics and laboratories of stress researchers have been shaped by significant changes in human environments and circumstances: stress exemplifies the physiological, ecological, and social impact of modern civilization. As this formula suggests, however, scientific and popular accounts of stress have themselves been determined by broader cultural anxieties about social order, political stability, and ecological harmony. Both the emergence of stress as a cause of unhappiness and ill health and its mobilization as a vehicle for articulating concerns about the hazards of civilization are thus direct products of the industrial, technological, political, and intellectual contours of modern secular societies (Jackson 2013: 16).

By emphasizing the socio-cultural roots of the concept of stress, Jackson takes on similar views that already existed in the 1980s. Kristian Pollock goes further to claim that stress "is not something naturally occurring in the world, but a manufactured concept which has by now become a 'social fact' " (1988: 390). Allan Young, in a Marxist line of argumentation, points to the "congruence between the ideological content of the stress literature and [...] the beliefs most middle class Americans hold about man's social nature" (1980: 133) and considers scientific conceptualizations of stress "the products of certain historically determined factors – i.e. specific sets of social relations and theoretical knowledge" (1980: 133). According to Young, the social relations that produce scientific facts about stress "reflect the social division of labor which characterizes the general mode of commodity production" (1980: 133f.) and these facts "are constructed in ways which produce only conventional meanings, i.e. ones resonant with the dominant ideology" (1980: 133f.).

130 See e.g. *Combat Stress*, a magazine quarterly published by the American Institute of Stress.

131 In the United States alone, this industry was worth approximately US$ 11 billion in 1999 (Jackson 2013: 8).

132 In 2006, almost € 27 billion were spent for the treatment of mental illness in Germany (Bundesministerium für Arbeit und Soziales 2013) and the coalition agreement of the current German government states that new prevention concepts for psychological demands shall be developed in cooperation with the *Gemeinsame Deutsche Arbeitsschutzstrategie* (collective German work safety strategy) (Altgeld 2014: 305). Currently, the European Agency for Society and Health at Work (2014) is running the campaign 'Healthy Workplaces Manage Stress,' aimed at providing support to both employers and employees to recognize stress factors at work as well as appropriate coping mechanisms.

Hence, the current proliferation of stress must be attributed to an interplay between scientific developments, like biological medical research with a resulting focus on physiological conceptualizations of the stress concept, on the one hand, and socio-cultural, political and socio-economic events and developments such as World War II, technological transformations, or changing working environments on the other. Building on Young's argument that the conceptualization of stress reflects neoliberal ideology and on Jackson's view that stress results from both biological forces and socio-cultural developments, I suggest to think of stress as a recent 'creation' of European and North American researchers in Mol's sense. Stress has been 'enacted' by socio-material practices that encompass human and non-human actors (Mol 2002: 25f.) within a specific socio-economic and political context. Speaking of creation and enactment, I do not want to downplay or even deny the suffering experienced by those 'under stress' or people with ailments attributed to 'situations of stress,' which are definitely 'real.' Nor do I want to challenge the idea that there are biological responses to stressors. Instead, I want to underscore that the contemporary popular and scientific enactment of the syndrome is inseparably linked to scientific, economic, technological and political developments in Europe and North America.

From considering stress an enactment that developed against the background of national developments and transnational exchanges mainly restricted to the Western world, it follows that the concept of stress is more prevalent in these places than in other parts of the world. Indeed, although research on the prevalence of the concept of stress in Asia, Africa and Latin America is very limited, single studies confirm that stress is not (yet) a popular concept among local populations in these regions (see e.g. Obrist and Büchi 2008: 251, 255; Strümpell and Ashraf 2011: 27f., 32). I wish to deny neither the existence of physical and mental demands with resulting somatic, mental and socio-economic effects in Europe and North America, nor their prevalence in other parts of the world (thus echoing the "myth of a stress-free 'primitive' existence;" see Foster and Anderson 1978: 93). As in Europe and North America, where both physical and psychological demands have existed from time immemorial (perhaps to an even greater extent than today, for example due to mass starvation, wars or epidemics), other regions have also felt the combined effect of such demands as a result of individual and social burdens. For example, the most frequent motivations for suicide attempts in Kerala, the state with the highest suicide rate in India, include family conflicts, financial problems or acute diseases (Halliburton 1998: 2342) that constitute 'stress factors' according to common Euro-American notions of stress. And not least through the global spread of neoliberal market paradigms, working conditions

considered as (extremely) 'stressful' by those familiar with the concept of stress are prevalent in many parts of the world today, as Christian Strümpell's and Hasan Ashraf's ethnographic study of garment factories and rolling mills in Dhaka, Bangladesh, demonstrates. Their work shows that a stress discourse is not common among the textile workers in Dhaka, but that managers and factory owners use the term 'stress' when they talk about Bangladesh's ready-made garment industry (2011: 28). In addition, Strümpell and Ashraf point to the mention of 'stress' in university curricula, middle-class newspapers, and in form of anti-stress medicines and anti-stress teas in Bangladesh (2011: 32). Also in India the concept of (work) stress is 'on the rise,' featured in scientific publications on occupational stress among IT professionals (Darshan et al. 2013; Vimala and Madhavi 2009) or articles on work stress in general in newspapers or business magazines (Chhapia 2012; Press Trust of India 2009, 2013). However, just as the stress discourse in Bangladesh is limited to the middle and upper classes (Strümpell and Ashraf 2011: 28), my research in Kerala indicates that the discourse of stress has not yet permeated the major segments of the population as it has in Europe and North America, where it continues to inform everyday discourse. Hence, given that the concept of stress is not common among the Keralan population and was not known to Dr. Praveen until his work at Ayuresort, how did it come to be enacted at Ayuresort where it was addressed in conversations, practices and both visual and textual representations?

Below, I discuss this enactment of stress in the resort. I analyze how stress entered both the resort space and Ayurvedic theory through the interaction between Dr. Praveen and the predominantly European guests. I begin with an account of the guests' search for stress relief at Ayuresort and their notions of stress, before discussing the low prevalence of the concept in Kerala in general in comparison to other idioms of distress as well as its non-existence in Ayurvedic clinics and hospitals in particular. I then illustrate and analyze how Dr. Praveen, by developing 'his own stress' through his interactions with the guests in order to cater to their needs, is central to the enactment of stress at Ayuresort. First, I analyze his incorporation of stress into Ayurvedic nosology and demonstrate how in this way stress is done differently than in biomedical textbooks or European clinics by referring to it as a "*vāta* problem." Second, I closely examine Dr. Praveen's conceptualization of stress and its causes as a condition for the enactment of stress at Ayuresort. His perceptions of life in Europe, fueled by his interaction with European guests during consultations, are thereby central. I conclude the section by presenting different practices for stress relief offered at Ayuresort as a point of departure for the concluding section in this chapter where I discuss the transformation of *śirodhārā* into one such stress relief treatment and illustrate

how in the enactment of stress at the resort the doing of Ayurveda confluences with the doing of stress.

3.2 *Manasika Roga* Extended: The Incorporation of Stress in Ayurvedic Nosology

As described in Section 2.1, many guests visited Ayuresort for relaxation and stress relief like Jennifer, who wanted to "deal with the stress of modern life," Linda, who visited Ayuresort after having had "a stressful year," or Sophie, who was "so stressed that [she] could not even listen to loud music anymore." Numerous guests considered their visits as an opportunity to temporarily "escape the treadmill of life," as Yasmin (53, Germany) mentioned. In a discussion Christina had with her father Maximilian (71, Germany), she requested him to calm down since he had come there to relax when he complained about politics in Germany. Other guests stated explicitly that they had come for stress relief, for example Maria who told me that she "had stress" in her company due to high pressure and responsibility to implement many new things or address the under-performance of particular tasks, prompting her to visit Ayuresort to relieve this stress.

Maria's statement is representative of the notion of stress most of the guests had: by using the term, they usually referred to different stressors and the resulting stress response, mostly in the context of work demands. Their notion of stress thus reflected common contemporary perceptions of the concept in Europe and North America outlined above: a combination of external demanding situations and the individual's inability of handling these situations, which leads to the manifestation of various symptoms. And although there were differences regarding subjective experiences of mental and physical symptoms, the majority associated stress with restlessness, feelings of being overworked, disturbed sleep, and aggressive behavior and thinking.

Several guests established a causal relation between stress and their ailments. For instance, Hannah saw the cause for her headache primarily in stress resulting from unaccomplished tasks and her perfectionism at work. Christina attributed all her problems, i.e. headache, back pain, weight gain and digestive problems, to work stress. Here, it is worth noting that guests did not just link stress to the onset of 'minor ailments.' Jonathan considered work stress a factor in the development of his psoriasis. Anna regarded her diabetes mellitus type 2 as psychogenic, seeing stress in the relationship with her partner as one of its causes. Samantha (37, United States), leader of a twelve-person tour group from the United States that spent one week at Ayuresort, considered diseases in general

resulting from stress and tension. This is already obvious through the term 'dis-ease' itself, she told me, and relaxation treatments are important in preventing any kind of diseases. Stress was thus not only defined in terms of diffuse external demands in combination with resulting negative wellbeing by many guests, but also as being responsible for different forms of ill-health.

While stress figured prominently in various guests' explanatory models of illness, and in most guests' intentions for visiting Ayuresort, Dr. Praveen's relation to the concept of stress was markedly different. He had heard about 'stress' the first time only when he started working at Ayuresort in 2008. When foreign guests complained about 'having stress' during consultations, Dr. Praveen was confronted with a term and a concept unknown to him and which, according to him, did not exist in Kerala, neither in the clinical realm nor in public discourse. His assertion is difficult to verify, but my field investigations suggest that 'stress' is indeed not a commonly used expression and concept in Kerala. Throughout fieldwork, I never heard a Malayali complaining about 'stress' and most of the Malayali with whom I talked were unfamiliar with the concept. Several clerks in dispensaries and shops selling Ayurvedic proprietary drugs did not know what it meant to have medications against stress. Most importantly, stress does not exist in Ayurvedic clinics and hospitals in Kerala. As several Ayurvedic practitioners told me and as I learned from my observations at Ayurvedic clinics and hospitals, the concept of stress is not common among local patients.

Although the concept of stress is alien to clinical Ayurvedic settings, Ayurvedic treatment is nonetheless sought against ailments resulting from mental distress which would be labeled 'stress' in Europe and North America. Dr. Veena from the Government Ayurveda College Thiruvananthapuram told me that some patients visiting the department of *kāya cikitsā* (internal medicine) present symptoms that are caused by "stress" resulting from work demands or defective social relationships. Dr. Veena used the term "stress" in our conversation after I had asked her if patients visit the hospital for stress relief. When she explained that they seek treatment for specific symptoms interconnected with stress but "are not realizing that it is stress," Dr. Veena implicitly stated that while she is familiar with the concept of stress, it is rather unknown to the patients visiting the hospital.[133] A similar story was told by Dr. Vineetha, one of the five residential doctors of the Ayurvedic hospital in Ernakulam. She told me that no patient visits the hospital complaining about stress, but occasionally patients seek treatment against mental distress resulting from work demands,

[133] Most of the Ayurvedic doctors I talked to had heard about stress. While this is not remarkable for practitioners working in Ayurvedic resorts since foreign guests regularly bring the term and concept to their attention, other doctors probably knew the term since it is increasingly used in popular and scientific literature as mentioned above.

most typically, those who work in the information technology sector.

This was also confirmed by the German anthropologist Claudia Lang, who investigated the Ayurvedic appropriation of depression in Kerala. At the annual conference of the *Arbeitsgemeinschaft Ethnomedizin* in Heidelberg in October 2010, she told me that no patient complained about stress in the hospital, the college and the two clinics where she and her colleague Eva Jansen had conducted their research. Instead, other 'idioms of distress' (Nichter 1981a) prevailed. This was reflected in the outpatient services for " 'viṣādam, tenṣan, utkantham' (depression, tension, anxiety)" provided by the department of *kāya cikitsā* at the P. S. Varier Ayurveda College in Kottakkal every Tuesday (Lang and Jansen 2013: 28). In their account of the emergence of depression in both biomedical and Ayurvedic psychiatry in Kerala, Lang and Jansen illustrate that the term 'depression' is increasingly used "as an English word or translated into the Malayalam term *viṣādam* or medicalized as *viṣāda rōgam* (the disease depression or depressive disorder) as a form of mental disease (*manasika rōgam*)" (2013: 26; see also Halliburton 2002: 1131, 2003: 172, 2005: 113, 132f., 2009: 15, 105, 130f.).

However, at Ayuresort, Dr. Praveen never diagnosed 'depression' in any of the guests, although this expression of distress was familiar to him even before he started working there. While depression was not prevalent in the resort, 'tension' was commonly featured as a source of complaint in Ayuresort along with another idiom of mental distress: *bhayaṅkara talavēdana* (literally 'dreadful headache'), commonly translated as 'big headache.' Those two expressions were mainly used by the staff of Ayuresort with tension representing as the more intense form of distress. As Vasu, the general manager of Ayuresort, exemplified, he suffers from 'big headache' when he has to do a lot of work in preparing an upcoming meeting. Tension, instead, is what he feels when he has to inform the managing director of Ayuresort about not having met the sales target of the company.

Yet while all the staff I asked knew the terms 'tension' and 'big headache' and also applied them regularly, 'stress' was not familiar to most of them. Also Dr. Praveen told me that the most common expressions to describe mental distress similar to stress in Kerala are big headache and tension. However, he himself developed an understanding of stress when he was confronted with it after he had started working at Ayuresort. Through his knowledge of these idioms of distress, as well as through accounts of the guests, information from the internet, and help of Ayurvedic nosological categories, Dr. Praveen adopted a diffuse and elusive concept of stress "related to the mind" that fit the needs of his patients. According to him, "it's not only like tension, it's more than tension." While he considered tension an

occasional, *not unhealthy* form of mental imbalance that can last from several minutes to some hours, stress is an *unhealthy* form of mental imbalance of longer duration that can become chronic. For Dr. Praveen, tension is "a normal form of mental imbalance," while "stress is above the normal level." Stress is an "unhealthy state of mind" or a "mild mind disorder," which is situated between a "normal state of health" and a "disease state." With the term 'disease state' he referred to biopsychiatrically defined mental disease patterns like schizophrenia or depression. While Dr. Praveen did not categorize stress as a disease, he saw it as a pre-stage of depression. Just as tension can transform into an unhealthy state of stress, as he explained, chronic stress results in depression. While Stefan Ecks and Soumita Basu describe that Rural Medical Practitioners in West Bengal perceive a linkage between chronic tension and depression (2014: 210), Dr. Praveen inserted an additional link in this causal chain. According to him, stress results from chronic tension while a chronic form of stress can result in depression, which he considered a disease.

As he conceptualized stress against biopsychiatric diseases and local idioms of distress, Dr. Praveen also drew on Ayurvedic nosologies by connecting stress to his knowledge about Ayurvedic categories of mental problems. Together with other doctors working in Ayurvedic resorts and clinics, Dr. Praveen categorized stress as a mental problem[134] and incorporated it into the Ayurvedic nosological category of *manasika roga* or 'mind disorder,' as the different practitioners I talked to frequently translated and explained the Sanskrit term.[135] *Manasika roga* is generally translated with 'mental illness' and linked to the Ayurvedic disease *unmāda* – both by Ayurvedic practitioners and in scientific Ayurvedic literature. *Unmāda* is usually translated with 'psychosis,' 'madness' or 'insanity.' In the *Carakasaṃhitā*, *unmāda* is defined as the unsteadiness of mind, intellect, consciousness, knowledge, memory, inclination, manners, activities and conduct (*Carakasaṃhitā*, Ni. 7.5). According to classic

[134] In comparison to a widely held belief, classic Ayurvedic theory differentiates between mind or *mānasa* and body or *śarīra* (see e.g. *Carakasaṃhitā*, Sū. 1.55), for instance in form of a distinction between diseases of the mind and diseases of the body (see e.g. *Suśrutasaṃhitā*, Sū. 1.19). And all Ayurvedic practitioners I talked to, including Dr. Praveen, differentiated between 'mind' and 'body,' thus reflecting both this classic Ayurvedic conceptualization and the Cartesian mind-body dualism, which pervades conceptualizations of mind and body in most parts of the world due to its global spread with biomedical practice and knowledge. However, although most of the Ayurvedic practitioners I talked to referred to mind and body as distinct entities, they considered them as being inseparably connected by claiming that Ayurveda provides 'holistic' treatment which considers both the mind and the body. This notion reflects Ayurvedic theory, according to which the relationship between mind and body is characterized by a continuum rather than a dichotomy (see e.g. Sujatha 2013).

[135] In classic Ayurvedic texts, '*manasika roga*' does not represent a nosological category in its own. However, these texts list diseases such as *unmāda* and *apasmāra*, which are today associated with *mānas* or mind. The nosological category of *manasika roga* exists in syllabi for Ayurvedic education in both India and Sri Lanka (see e.g. Central Council of Indian Medicine 2014b: II.11B; Institute of Indigenous Medicine, University of Colombo 2011: DC4201), and the doctors I talked to used this category when they mentioned these diseases. They referred to diseases like *unmāda* and *apasmāra* as '*manasika roga*' or 'mind disorders,' and conceptualized them as such through their claimed association with *mānas* or mind instead of *śarīra* or body.

Ayurvedic theory, *unmāda* is divided into four sub-types which are caused by *doṣa* vitiation (*Carakasaṃhitā*, Ni. 7.3). In addition, there is one sub-type of *unmāda* that is triggered by exogenous forces (*Carakasaṃhitā*, Ni. 7.3). While these exogenous forces or *bhūta*s represented supernatural entities in former times (the literal translation from Sanskrit is 'being,' 'ghost,' 'demon' or 'spirit'), in the twentieth century they were interpreted as microorganisms, bacteria, fungi and viruses in textbooks and by practitioners in order to secularize and biomedicalize Ayurvedic theory (Langford 2002: 87). This secularization of *manasika roga* can also be found in contemporary Ayurvedic practice in Kerala, as observed by Halliburton and by Lang and Jansen.[136]

In addition to *unmāda*, clearly the most prominent form of 'mental illness' in Ayurvedic theory, another one that is commonly described as a mental disorder both by scholars (see e.g. Obeyesekere 1977, 1982) and contemporary Ayurvedic practitioners is *apasmāra*, generally translated as epilepsy. Along with the biopsychiatric disease category of depression, these two classic Ayurvedic diseases, and the nosological category of *manasika roga* in general, provided the theoretical foundation for Dr. Praveen for adapting the concept of stress – and for eventually providing treatment against it, as I illustrate in the next section. As he explained, his knowledge about *manasika roga* was limited, since mental complaints are very rare in Ayurvedic hospitals and clinics as patients suffering from mental disorders resort to psychiatrists or to ritual healers. This explains why *manasika roga* is rather neglected in the B.A.M.S. curriculum. Nonetheless, in his conversations with his guests and with me, he frequently referred to disorders which he considered as *manasika roga*: depression, epilepsy, correlated with *apasmāra*, and schizophrenia, which he correlated with *unmāda*.[137] These biopsychiatric diseases were mental disorders for Dr. Praveen, which he grouped into the category of *manasika roga*. Since he also regarded stress as a mental disturbance, he considered it a *manasika roga* too. At the same time, he did not incorporate stress on the same level of disease classification as depression, schizophrenia and epilepsy. Ultimately, stress was not defined as a disease but seen as an "unhealthy condition of the mind" and a pre-stage to depression.

[136] While Halliburton states that in Kerala's Government Ayurveda Mental Hospital patients' ailments are diagnosed only on the basis of affected *doṣa*s (2005: 125), Lang and Jansen observed that diagnoses based on *bhūta*s are scarce (2013: 30).

[137] While Dr. Praveen correlated *apasmāra* with epilepsy and *unmāda* with schizophrenia, practitioners specialized on mental illness, such as those working in the Government Ayurveda Mental Hospital Kerala, provide a different and more differentiated translation of the Ayurvedic diseases. Dividing *unmāda* in different sub-types, following the classic texts, most Ayurvedic practitioners Lang and Jansen talked to identified *kapha unmāda* with severe depression, while they correlated the other forms of *unmāda*, *pitta unmāda* and *vāta unmāda*, with the biopsychiatric disorders of mania and schizophrenia respectively (Lang and Jansen 2013: 35). In comparison to this subdivision described by Lang and Jansen, Smith claims that *unmāda* is usually diagnosed as a *vāta* affliction (Smith 2006: 552).

This incorporation of stress into *manasika roga* is part of a long history of the assimilation of biomedical and psychological ailments in Ayurvedic nosology stemming from an asymmetric relation between the historically grown and institutionalized dominant position of biomedicine on the one hand and the inferior position of Ayurveda on the other hand.[138] With the first contacts between Ayurveda and European medicine in the sixteenth century, the emergence of diseases derived from European medicine in Indian medical sources began, and these 'foreign diseases' increased to enter Sanskrit medical texts during the eighteenth and the nineteenth century (Meulenbeld 1995: 8f.).[139] From the nineteenth century onwards, 'Western' natural science became the golden standard also in India (see e.g. Kapila 2010), so Ayurvedic proponents had to reconfigure their episteme in accordance with this standard.

One result of this development was for instance to free *bhūtavidyā* or 'the science of existing or living beings,' one of the eight classical branches of Ayurveda, from its non-scientific connotations like demonology or exorcism and to institutionalize it as a scientific Ayurvedic approach to psychiatric disorders. Other developments included the incorporation of biomedically, psychologically and biopsychiatrically conceptualized ailments into Ayurvedic nosology by processes of correlation and translation. One example, which is interrelated with the transformation from *bhūtavidyā* into 'Ayurvedic psychiatry,' is the appropriation of biopsychiatric disorders and their redefinition within Ayurvedic theory. Lang and Jansen for instance reveal how different forms of depressive disorders – defined as such by ICD-10[140] and DSM-IV[141] – are incorporated into the Ayurvedic nosological category of *mansika roga* through an identification with Ayurvedic diseases and their etiologies in contemporary clinical practice.[142]

In another example of such appropriations, Chopra illustrates how AIDS was incorporated into Ayurvedic nosology by translating it with the Ayurvedic disease terms '*ojaḥkṣaya*' and '*rājayakṣman*,' which can be translated as 'loss of *ojas*' or 'vital force' and 'royal con-

138 For recent research on the asymmetric relation between biomedicine and other forms of healing, see Naraindas et al. 2014. Contributing authors in the volume discuss different types of asymmetries resulting from the hegemonic position of biomedicine world-wide, vis-à-vis ideas, practices and institutions.

139 For instance, in the sixteenth century, Indian medical texts mention the disease *phiraṅga roga* for the first time as a reference to the European disease pattern of syphilis, translated as the 'disease of the Franks' (Meulenbeld 1995: 8; although the name '*phiraṅga roga*' refers to the Franks or French, the disease was most likely introduced to India by the Portuguese).

140 *International Statistical Classification of Diseases and Related Health Problems, 10th revision*, 2015 [1990].

141 *Diagnostic and Statistical Manual of Mental Disorders, 4th edition*, 1994.

142 While severe depression and agitated or reactive depression were identified with two sub-types of *unmāda* (*kapha unmāda* and *ādhija unmāda*), mild depression is translated into 'vāta vitiation with concerned *manas*' and depressed mood into *viṣādam* and not identified with the disease pattern of *unmāda* (Lang and Jansen 2013: 37 [Table 3]). While different practitioners explained that diagnosis happens in terms of ICD-10 categories, the subsequent correlation with Ayurvedic concepts and diseases is done to determine the appropriate Ayurvedic treatment in terms of applications and medicines (Lang and Jansen 2013: 35).

sumption' respectively (2005b: 213). Ayurvedic scholars and practitioners associate *ojas* with the biomedical concept of immune system and eventually with the biomedical syndrome AIDS (Chopra 2005b: 213) whereas *rājayakṣman* is literally identified as the 'king of diseases' (see e.g. *Aṣṭāṅgahṛdaya*, Ni. 5.3) in a similar vein as AIDS today, hence AIDS is translated with the classic Ayurvedic disease (Chopra 2005b: 213, quoting Śivahare 1998: 41). Other reasons for this translation are the symptoms of *rājayakṣman* since they correspond well with symptoms AIDS patients have and the analogy between both diseases in terms of a perceived connection between sexual behavior and affection (see e.g. *Carakasaṃhitā*, Ni. 6.8; Chopra 2005b: 213f., quoting Śivahare 1998: 41).

However, since these diseases have been produced in the context of biomedical epistemologies, their incorporation into Ayurvedic nosology is characterized by epistemic violence, even if they are conceptualized in Ayurvedic terms. Chopra and Quack (2011) categorize two different patterns of translation of biomedical disease terminologies into Ayurvedic ones. In the first pattern, which is rather rare, a Sanskrit neologism is coined by looking for correspondences between the biomedically conceptualized physiology and equivalent Sanskrit terms, as in the case with arterial hypertension, translated as *raktacāpa*, literally meaning 'blood pressure.' In this process of translation, the biomedical disease is considered a separate disease that is not found in classic Ayurvedic literature (Chopra and Quack 2011: 20). The other translation pattern, which is very common, is based on the correspondence of physiological processes and symptoms. In some cases, the translation is additionally made on the basis of terminological and semantic equivalences. This is illustrated by Chopra and Quack, who demonstrate how diabetes mellitus type 2 is correlated with and translated into the Ayurvedic disease *prameha*, based on their common symptoms and shared literal meaning of 'excessive urination' (2011: 21). This translation process represents a form of epistemic violence in two ways. Although Ayurvedic terminologies are used and the diseases are adapted to Ayurvedic theory, they are actually adapted to biomedical nosology, which represents the "universal nosology" (Naraindas 2014b: 126), as diseases are categorized on the basis of biomedical physiological processes and symptoms.

Also, the integration of biopsychiatric concepts happens at the cost of epistemic violence done to Ayurvedic theory through adherence to 'scientific rational elements.' Ayurvedic disorders characterized by supernatural entities (*graha unmāda*) are not relevant anymore or are reframed as 'personality disorders' (Lang and Jansen 2013: 40). *Bhūta*s are removed from etiological theory, which concentrate on 'physiological' elements (*doṣa*s) in both theoretical conceptualization of the disorder and in their diagnosis. As a result, the nosological category

of *unmāda* is narrowed down and 'non-scientific' sub-types of *unmāda* lose importance. In addition, the local Malayalam expression *viṣādam* is biomedicalized, by transforming it from an existential and moral problem into a biomedical condition (Lang and Jansen 2013: 26).

While the asymmetric relation between biomedicine and Ayurveda determines this form of epistemic violence, another asymmetric relation is responsible for the translation processes. Against the background of the superior position of biomedicine, the question arises why Ayurvedic authors and practitioners do not just adopt the biomedical terms. In answering this, Chopra and Quack (2011: 22) take up Sheldon Pollock's argument that in classic Indian understanding of science and knowledge theory precedes and governs practice (Pollock 1985: 499). *Śāstra* (theory, knowledge, 'traditional science') is of divine origin and does not change or grow, and "[...] there can be for the thinker no originality of thought, no brand-new insights, notions, preceptions [*sic*], but only the attempt better and more clearly to grasp and explain the antecedent, always already formulated truth" (Pollock 1985: 515). Applying this notion to the translation of biomedical disease terms, Chopra and Quack, and other scholars (see e.g. Das 1993), argue that from the point of view of Ayurvedic theory, there cannot exist any diseases which are not or were not part of the *śāstra* of Ayurveda. The identification of biomedical diseases with Ayurvedic diseases and the accompanying translation of the disease name in Sanskrit represents a rediscovery of components of the ancient originally complete Ayurvedic knowledge (Chopra and Quack 2011: 22). In this process, the asymmetric relationship between Ayurveda and biomedicine is turned around, when complete (divine) Ayurvedic knowledge is contrasted with fragmented biomedical knowledge.

In the process of incorporating the biomedical-psychological syndrome 'stress' in Ayurvedic theory, the practitioners I talked to did not come up with terminological translations. Neither did they identify stress with existing Ayurvedic diseases, as described by Chopra and Quack in the case of diabetes and '*prameha*,' and by Chopra for AIDS and *ojaḥkṣaya* or *rājayakṣman* respectively, nor did they create a neologism, like *raktacāpa* for hypertension. Nor did any of the different practitioners explicitly claim that stress was an ancient Ayurvedic disease that has now been rediscovered in accordance with *śāstric* theory. Stress was rather considered a disease separate from known Ayurvedic disease patterns. No doctor I talked to identified stress with any other existing Ayurvedic disease, for instance with one of the seventeen types of *unmāda* listed in M. Visweswara Sastry's college text book *Rugviniścaya: Clinical Methods in Āyurveda* (Leslie 1992: 201, referring to Sastry 1956). It

was incorporated into the loose nosological category of '*manasika roga*' – not on the base of terminological or physiological correspondences, but based on a common central point of reference with other ailments grouped in this disease category: 'the mind.' However, while Dr. Praveen referred to the three *guṇa*s *sattva*, *rajas* and *tamas* as influencing mental processes analogous to the role of the three *doṣa*s *vāta*, *pitta* and *kapha* in somatic processes when explaining the Ayurvedic conceptualization of 'the mind' in his conversations with the guests, he did not elaborate further on their role in the development of mental diseases or stress.[143] However, he provided an explanation in *doṣic* terms: he associated stress with increased mental activity, which he in turn related to a vitiation of *vāta*, to conclude that stress is a "*vāta* problem."[144]

A more elaborate adaptation of stress to Ayurvedic nosology was provided by Dr. Madhu, the residential doctor of an Ayurvedic resort in Varkala beach, who explained the etiology and physiology of stress with an increase in specific *doṣa*s. Like all practitioners working in resorts, he was confronted with guests who complained about being stressed, which made him work out a conceptualization of stress that comprises both Ayurvedic and biomedical concepts and terminologies. He differentiated stress into three different types – mental, emotional, and physical – and associated each type with the deviation of one or more *doṣa*s, specifically with one or more sub-types of the single *doṣa*s *vāta*, *pitta* and *kapha* which are differentiated into five sub-types according to Ayurvedic theory. On his own website (accessed on April 10, 2010, but currently offline), he specified the three manifestations of stress as follows:

> Mental stress, according to Ayurveda, is caused by an overuse or misuse of the mind. For instance, if you perform intense mental work many hours a day, or if you work long hours on the computer, it can cause an imbalance in Prana Vata, the mind-body operator concerned with brain activity, energy and the mind. The first symptom of Prana Vata imbalance is losing the ability to handle day-to-day stress. As the person becomes more stressed, it impacts mental functions such as acquisition, retention, and recall. The person's mind becomes hyperactive, yet the person loses the ability to make clear decisions, to think positively, to feel enthusiastic, and even to fall asleep at night.
>
> Emotional stress can be caused by a problem in a relationship, the loss of a relative, or any situation that might hurt the heart. Emotional stress shows up as irritability, depression, and emotional instability. It affects sleep in a different way than mental stress – it can cause you to wake up in the night and not be able to go back to sleep. Emotional stress disturbs Sadhaka Pitta, the mind-body operator concerned with the emotions and functioning of the heart.

---

143 According to Ayurvedic theory, the three *guṇa*s *sattva*, *rajas* and *tamas* are fundamental substances of the mind – *sattva* is responsible for clarity, *rajas* for passion and *tamas* for lethargy – and are considered as analogous to the role of the *doṣa*s in the body (Weiss 2003: 30). While the three *guṇa*s play a crucial role in personality formation, according to Ayurvedic theory they are not important in the etiology of *manasika roga* like *unmāda*, which is based on *doṣic* vitiation or external influences.

144 This interpretation resembles a classroom exchange on mental illness in an Ayurvedic college described by Langford, in which the teacher explains to a student that a disproportion of the *guṇa*s always involves disturbances in the *doṣa*s (2002: 170f.).

> Physical stress is caused by misuse or overuse of the body, such as exercising too much or working for extended periods at a job that is physically taxing. This can cause a person to experience physical fatigue, along with mental fogginess, difficulty in concentrating, and dullness of the mind. Excessive physical strain causes three sub-doshas to go out of balance: Shleshaka Kapha, the sub-dosha concerned with lubrication of the joints and moisture balance in the skin, Vyana Vata, which governs the circulation, nerve impulses and the sense of touch, and Tarpaka Kapha, which governs the neuro humors.

Although Dr. Madhu refers to biomedical physiological concepts like "nerve impulses" or hybrid ones like "neuro humors," his explanations of stress responses are based on Ayurvedic conceptualizations. He thus provides an interpretation, just as Dr. Praveen when he defines stress as a "*vāta* problem," that differs considerably from explanations common in Europe and North America that are presented in Section 3.1: The explanation in *doṣic* terms is distinctive from endocrinological interpretations, even if there may exist similarities between the biomedical model of homeostasis and the Ayurvedic theory of *doṣa* balance.

Apart from connecting stress to his Ayurvedic knowledge, Dr. Praveen developed an occidentalist explanation of the omnipresence of stress in Europe and North America, based on two factors: a "fast, hectic Western lifestyle," as he called it, and lacking family support due to the non-existence of joint families that provide stress-preventing social and emotional support. Through his interaction with foreign guests and by studying different popular and scientific sources on stress available on the internet, Dr. Praveen concluded that the main cause for stress is professional overwork, which is specific for Europe: "Compared to Indians, Europeans are workaholic. Working, working, working, there is no time to relax." While life in India is "slow and calm," the "hectic life in Europe" is characterized by heavy workload and restlessness – the latter being reinforced by the importance of punctuality and the strictness of adhering to time schedules in Europe and especially in Germany.[145]

The high prevalence of stress in Europe in comparison to India is further attributed by Dr. Praveen to different levels of social and emotional support. According to the doctor, work-related stress is facilitated by missing social relationships. While the doctor considered joint families to be the norm in India, he inferred from narrations of the guests, and from the fact that the majority of the guests at Ayuresort were single women between 40 and 60, that they are not prevalent in Europe. And while joint families in India provide distraction from different kinds of problems and act as an outlet for stress relief, loneliness at home in Europe, exemplified by the different single guests from Germany, prevents people from relieving stress through communication and social support. This notion of the 'Indian joint family' as a 'stress buffer' was quite popular amongst Ayurvedic practitioners, captured

[145] Interestingly, Dr. Praveen explained to me and to several guests that he believes that the mere practice of using a pocket diary – he had never owned one – can lead to stress.

below by Dr. Vineetha:

> ***Indians also have tension but not so much because of their family network. Their big family supports them. Everyone is there for another person so that the person has someone to talk to. People feel save. When they have problems they have people that support them. In Europe, people are becoming independent early, after school. That is also good, but also not so good. They don't have someone to lean on. Otherwise a 21-year old boy would not have tension.***

Drawing on the joint family as a source for preventing and reducing stress, my interlocutors' statements resemble the narratives of joint families being the major criterion for wellbeing in aging in India, described by Lawrence Cohen (1998). Contrary, however, to Indian gerontology and for other informants of Cohen that see the decline of the system of the joint family and accompanying absence of family support for elder persons as the central narrative in explaining senility (Cohen 1998: 7, 17), the practitioners I talked to postulated the existence of health-promoting joint families in India versus stress-promoting loneliness and the 'Bad Family' (Cohen 1998) in Europe.

The effects of social and emotional support on health have been highlighted since the mid-1970s. In the context of stress relief and prevention, Western scholars have emphasized that these forms of 'social capital' are beneficial for buffering the effects of 'stressful' working conditions (Cohen and Wills 1985; Karasek 1979, 1990; Kiritz and Moos 1974; Siegrist 1996). Paradoxically, due to the high workload that for instance German employees face, many of them also work during the weekend and overtime and can therefore rarely cater to family interests (Lohmann-Haislah 2012: 50f.). Thus, the source of stress itself restricts the aspects that contribute to preventing or buffering stress.

Still, Dr. Praveen considered stress to also be a status symbol and "a prestige thing," since by claiming to be stressed one demonstrates one's importance. And indeed, in Europe, at least in Germany, stress is symbolically charged and comprises social values. In many areas, it is socially desirable to be stressed, which prevents one from being considered idle. By saying that one is stressed, one makes a moral claim to be a hardworking person, who is valued by the dominant social values of contemporary German society. By virtue of this appreciation, stress becomes "a fashion" in the same way as having diabetes or a high cholesterol level in India some years ago in the eyes of Dr. Praveen, who perceived a parallel development between stress and 'life-style diseases' prevalent in India.

Clearly, through the interaction with foreign guests, Dr. Praveen connected the concept of stress presented by the guests to his perceptions of specific socio-cultural phenomena existing in Europe and North America. Dr. Praveen's statements mirror the image of the 'fast and hectic lifestyle' in 'Western' or 'modern' societies prevalent in contemporary global media. They resemble moral judgments opposing cultural stereotypes of a 'traditional,

spiritual India' to a 'modern, materialistic West,', which are and were central to many Indian nationalists (see e.g. Harder 2011: 309). For him stress develops through a matrix of professional overwork against the background of a 'hectic lifestyle' and missing social relationships. This homogenized view of a 'modern, materialistic and hectic West' is a common trope articulated by different stakeholders in Ayurvedic resort industry, such as practitioners, resort managers, employees of travel agencies and tourism departments. Many of these actors oppose these cultural stereotypes to a 'traditional, spiritual and calm India' that provides 'traditional' and 'natural' Ayurvedic treatment to heal one from the cultural ills from Europe and North America (see also Spitzer 2009: 149).

At Ayuresort, Ayurvedic practice was directed at the effects of 'the stressful lifestyle of the West with its fractured kinship ties.' Although Ayurvedic treatment against stress was unknown to Dr. Praveen before he worked at Ayuresort, at the time of my research the practice at the resort was punctuated by initiatives for stress relief and relaxation (terms that were used by both the doctor and the guests interchangeably). The fact that the majority of the guests complained about having stress[146] and that Dr. Praveen considered relaxation an appropriate means to restore one's wellbeing affected by stress resulted in an omnipresence of (re-)invented relaxation treatments and relaxation aspects within the treatment course. For instance, Dr. Praveen had changed the treatment regimen some months after he started his work at Ayuresort from one application in the morning and one in the evening to two applications provided back-to-back to condense the duration of the treatment and allot the guests "more time to relax," as he told me. And while one of the usually two daily applications was part of the 'therapeutic regimen,' the other one he provided "for relaxation or for experience." In addition, the soundscape during the treatment had to be kept low so that "it's easier for the guests to relax." For that reason, the therapists were supposed to talk in a low voice during the treatment and reduce any noise in front of the treatment rooms when a guest was inside as much as possible.[147] While yoga classes (and also meditation) were considered as relaxing by many guests in general (see Section 2.3), their relaxing nature was especially obvious during *śavāsana*, the 'Corpse Pose,' where the supine person is advised by the Yoga teacher to "relax your whole body and mind."

[146] Usually, Dr. Praveen found out about the guests' stress by directly asking them if they have stress and / or by their answer to the question "Do you suffer from stress?" as part of the clinical questionnaire. Dr. Praveen linked stress to different ailments during the consultation by asking the guests directly if they think these problems, for instance headache or bad sleep, are related to stress or by concluding this from their explanations about their ailments and their life in general.

[147] I also witnessed one day how Suraj even broke David's treatment session for a minute to leave the room and tell the resort's gardener to discontinue with mowing the lawn in front of the Ayurvedic center as long as the treatment session was ongoing.

Apart from these relaxation elements that were incorporated in the treatment course, the practice at Ayuresort consisted of several specific applications aimed at providing relaxation for the guests. As described in Section 2.3, Ayuresort offered 'relaxation massages,' which was basically *abhyaṅga* repackaged. For Dr. Praveen, these massages were "relaxing for the body and for the mind," although their main purpose during long-term treatments was *snehana* (oileation) and *svedana* (sweating). Even the 'face massage' was not applied by Dr. Praveen solely as a cosmetic treatment but also for being "very relaxing." Indeed, he has invented one application exclusively for relaxation purposes: the 'hand and feet massage' (see Section 2.3). Still, the major weapon for relaxation, and thus against stress, was another application: *śirodhārā*.

In the following section, I describe the usage of this application as it went from being a rare therapeutic application against primarily neurological and skin diseases in clinical settings to serving a popular means for relaxation and stress relief within Ayurvedic resorts. I analyze this reconfiguration while illustrating how Dr. Praveen legitimized the new area of application for both himself and the guests by linking it to his incorporation of stress into the nosological category of *manasika roga* on the one hand and an endocrinological explication of its mode of action on the other hand, thus combining Ayurvedic and biomedical theory. Eventually, a new kind of *śirodhārā* is enacted in the resort, through a combination of the guests' need for stress relief and their resulting visit of Ayuresort, multiple enactments of stress (inside and outside the resort), *śirodhārā*'s usage for *manasika roga*, the association between stress and relaxation practices present in guests' minds that fosters resort doctors and managers to adjust Ayurvedic practice, and Dr. Praveen's endocrinological interpretation and explanation of *śirodhārā*'s mode of action.

3.3 From Therapeutic Treatment to Relaxation Technique: The Transformation of *Śirodhārā*

"Deep relaxation and interior tranquility," "renewal of life's sweetness," "peaceful floating in a blissful space" – these are some of the sensations that can be expected from *śirodhārā*, judging from statements of diverse Ayurvedic centers' advertisements featuring the application. The latter is defined by the steady flow of warm medicinal oil, warm medicinal milk or cold medicinal buttermilk on the forehead of the supine guest in a pendulum stream for 30 to 45 minutes. The liquid flows through a muslin thread tucked in a small hole at the bottom of a clay vessel, which hangs about 15 cm above the guest's forehead and is

continuously swayed back and forth by one therapist (see Figure 3.1 and 3.2). The vessel is about 20 centimeters in diameter and has a capacity of approximately two liters (see Figure 3.3). It is attached by cotton ropes to a cross piece of a gallows-shaped, almost two meter high wooden post standing next to the *droṇī*'s head. The thread that hangs from the vessel is fixed inside by half of a coconut shell and a piece of wood. The thread is put through a hole made at the top of the coconut shell, and then tied to a piece of wood, which is placed inside the vessel over the shell's hole with the shell's mouth downwards. In short, the thread runs through both holes of the vessel and the coconut shell while the piece of wood prevents the thread from slipping off (see Figure 3.4). In turn, the coconut shell acts like a dam, ensuring an even flow of the liquid. To prevent the liquid from flowing into the guest's eyes, the latter are covered with a piece of cotton in glasses shape resembling a sleeping mask. For additional protection from the liquid, a plaited muslin thread, whose ends are clamped behind the guest's ears, covers the lower part of the forehead. During the treatment, the vessel is moved back and forth in a slow rhythm by one therapist, so that the liquid is poured over the whole width of the forehead. With the other hand, the therapist 'massages' different parts of the guest's head (see Figure 3.1).[148] A second therapist is in charge of heating the liquid and of regularly refilling the vessel with the out-flowing liquid collected in a metal bowl underneath the drainage of the *droṇī* behind the guest's head (see Figure 3.2). After the last round, one therapist removes the cotton piece and the thread from the guest's eyes and forehead and proceeds to dry the guest's head with a towel.[149]

The term '*śirodhārā*' is a composite of the two Sanskrit words '*śiras*' (head) and '*dhārā*' (stream, flush). It is an umbrella term for three different applications: *thailadhārā*, *kṣīradhārā* and *takradhārā*. The most commonly applied type at Ayuresort and in Ayurvedic resorts in general is *thailadhārā*, which refers to the usage of heated '*thailam*s' or 'medicinal oils' (see Footnote 88, Page 73). In *kṣīradhārā*, a rare application never applied during my

[148] This was done at Ayuresort in different ways by the therapists. While most of them gently swept through the guest's hair with their fingertips from top to bottom, some massaged only the forehead and the temples with their fingertips, others the top and the back of the guest's head, while a few did both. In addition, some stroke gently over the hairline from one temple to the other with their thumb in circular movements. While massaging the back part of the head was done to reduce pain caused by the hardness of the *droṇī*, as Prabhat explained, massaging and stroking the other parts of the head was done "for relaxation," as I was told by the different therapists and Dr. Praveen.

[149] At the beginning of my research, the guests were told by Dr. Praveen not to wash their hair during the following shower but leave the oil (in the case of *śirodhārā* applied with oil) on the head for 30 minutes, as the body takes about half an hour to completely absorb the oil. Exposure to the sun directly after the treatment is harmful for the regulation of the body temperature according to Dr. Praveen. He mentioned how after the application perspiration pores are filled with oil which impedes sweating; this, in turn, hinders a cooling of the body. And since some guests had chosen to go outside in the sun directly after the treatment, ignoring Dr. Praveen's recommendations, during the time of my research he changed this routine to make guests remove the oil directly after the treatment. In some other Ayurvedic resorts, guests are told to leave the oil on the head for several hours. Dr. Praveen considered this as being an advertising method: "This is only for business; when other tourists see them sitting there with oiled hair they get curious and also want treatment."

Figure 3.1: Guest receiving *śirodhārā* at Ayuresort I (photo by the author)

Figure 3.2: Guest receiving *śirodhārā* at Ayuresort II (photo by the author)

Figure 3.3: *Śirodhārā* vessel Ayuresort (photo by the author)

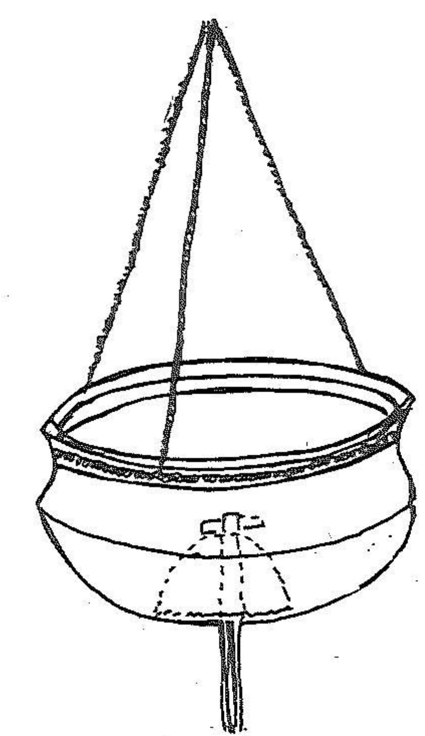


Figure 3.4: Sketch of *śirodhārā* vessel with string, coconut shell and piece of wood (Dash 1992: 63 [Figure 10])

research at Ayuresort, the liquid used is warm medicated milk (*kṣīra*). The third type of *śirodhārā*, *takradhārā*, refers to the usage of medicated *takra* or buttermilk, applied in a cold temperature. In general, the different qualities of the liquids (hot – cold, oily – dry) determine their application in clinical practice. For example, *vāta*-related diseases (qualities of *vāta* are cold and dry, amongst others) are usually treated with *thailadhārā*, whereas pitta-related diseases (pitta's qualities are hot and greasy, besides others) are normally treated with *takradhārā*.[150]

I received *śirodhārā* eight times during my stay at Ayuresort – six times *thailadhārā* and two times *takradhārā*. While I had the two *takradhārā*s and five *thailadhārā*s during the course of my 24-day *pañcakarma* treatment in the fifth month of my research, I had my first *thailadhārā* in the sixth week. During a conversation with Dr. Praveen about *śirodhārā*, he said: "You cannot explain *śirodhārā*, you have to experience it!" So, the next day I found myself lying on the *droṇī* receiving the stream of oil on my forehead. It took me a few minutes to realize that the application had already started. Lying with covered eyes, initially I mistakenly thought the oil stream was a series of gentle sweeps from the therapist's hands on my forehead. After this realization and surprised about the feeling, I attempted to immerse into the experience which I had so closely followed through visual and textual representations and first-hand accounts for several months. In the process, I sought to conduct a 'blind participant observation' by feeling, hearing, smelling and mentally noting down everything I could perceive within the obvious limitations.

I felt rather like the blind observer than the participant. Trying to perceive and memorize as much as possible, my *śirodhārā* experience was markedly different than the one from the guests. While I was fascinated by the intense potpourri of the oil flow, the oil's smell and the soundscape of oil ripples, the burning flame of the gas cooker, chirr of crickets, the rushing sea, and the occasional whispering of the therapists, I realized I had problems to concentrate. I struggled to retrieve different observations I had made directly before the application to start that I wanted to memorize. Later, during other *śirodhārā*s, I had the very same experience. As such, it felt easier to 'switch of the brain,' as guests usually do, and let go. In some ways, I felt anesthetized in a state that oscillated between feeling gently awake and asleep. I felt extremely relaxed, hardly noticing any of the sounds around me which were so prominent during my first experience with *śirodhārā*.

This feeling of relaxation and pleasant tiredness that lasted for some time after the

[150] This explanation fails to capture nuances as the interplay between *doṣa*s and treatment ingredients is much more complex, as the three liquids are medicated through different parts of various plants, characterized by specific qualities, which can alter the qualities of the liquid.

treatment was over, was repeatedly accounted by many guests at Ayuresort in addition to other experiences I detail below. And this feeling was intended by Dr. Praveen. *Śirodhārā* was primarily applied for relaxation and for stress relief at Ayuresort – and in all other Ayurvedic resorts I visited. Its popularity and its field of application stand in strong contrast with *śirodhārā*'s usage in clinical practice and textual references.

The *Aṣṭāṅgahṛdaya* lists *śirodhārā* as one of four types of *mūrdha thaila* or oil applications on the head, albeit under a different name. The treatment category of *mūrdha thaila* involves *abhyaṅga* ('oil massage'), *picu* (local application of a cloth soaked with oil), *basti* (keeping oil within a leather sleeve on the head), and *seka*, which is described as 'pouring oil in a continuous stream' (*Aṣṭāṅgahṛdaya*, Sū. 22.23-26). *Seka* is described as being beneficial for headache, burning sensation, ulcerations and wounds of the head. However, recommendations for applying *seka* in the *Aṣṭāṅgahṛdaya*'s sections dealing with treatments for specific ailments are very rare. In *ūrdhvāṅga cikitsā*, a section covering the treatment of diseases related to organs of the head, *seka* is proposed in three cases of eye diseases as one treatment amongst others like cutting, *sirāvyadha* (bloodletting), *lepam* (local application of pastes) and *nāvana* (nasal medication). The medicated liquids are however to be poured over or into the eyes and not on the forehead as it is done in contemporary *śirodhārā* treatments (*Aṣṭāṅgahṛdaya*, Ut. 11.23, 11.29, 13.63-64). Another area of application is mentioned in the section on *vāta vyādhi cikitsā* or treatment of diseases of *vāta* origin.[151]

This scarce appearance of *seka* in therapeutic directives reflects today's practice of *śirodhārā* in clinical settings in India, where it plays a minor role in comparison with other external treatments. As I was told by different practitioners working in Ayurvedic hospitals, clinics and resorts, *śirodhārā* is applied in neurological disorders such as multiple sclerosis or hemiplegia, specific skin diseases like psoriasis, certain types of headache, hair loss, diseases of the eye, sleeping disorders, schizophrenia, depression and in conditions loosely defined as "related to the mind."[152] However, this wide range of utility seems to belie the extent of its actual implementation in clinical settings. Dr. Praveen, Dr. Veena, and other practitioners working in both resort and clinical settings told me that not more than ten percent of the patients in Ayurvedic clinics and hospitals receive *śirodhārā*, a figure confirmed by my observations and analysis of patient charts at the hospital in Ernakulam. In addition, some ailments of the panoply such as 'mental diseases' seem to be much less treated with

[151] For *ardita*, commonly construed as the biomedical disease pattern of facial palsy, *mūrdha thaila*, of which *seka* is one element, is recommended, together with *nāvana*, *tarpaṇa* (filling eyes and ears with medicated oil), *vamana* (emesis) and *sirāvyadha* (*Aṣṭāṅgahṛdaya*, Ci. 21.43).

[152] When I asked the different practitioners about when *śirodhārā* is applied in clinical practice, they all listed these ailments with their biomedical or biopsychiatric names, as they usually did in their interaction with local patients.

śirodhārā than others. Although most of the doctors told me that *śirodhārā* is applied in cases of schizophrenia and depression in general (see also Langford 2002: 237), the majority also explained that they do not see any patients with those diagnoses. This presumably results from the fact that patients with forms of mental illness visit other practitioners. Even at Kerala's Government Ayurveda Mental Hospital, alternative applications like *piccu* and *thalapothiccil*,[153] and not *śirodhārā*, are used in treating patients with different forms of mental illness (pers. comm. with Claudia Lang, October 22, 2010; see also Halliburton 2009).

During my stay at the hospital in Ernakulam, *śirodhārā* was applied for neurological disorders like multiple sclerosis, post-stroke hemiplegia, Friedreich's ataxia and 'diffuse axonal injuries' due to post-accident brain damages, and for people who visited the hospital as inpatients for alcohol withdrawal.[154] Dr. Vineetha divided the area of application for *śirodhārā* into "brain complaints" on the one hand and "conditions where we need relaxation" on the other hand. While the first category refers to neurological disorders classified according to biomedical nosology, the latter represents a conglomerate of diverse ailments and behavioral abnormalities like insomnia, hyperactivity, aggressiveness or certain alcohol withdrawal symptoms such as anxiety, depression and hallucinations, which she classified as "mind problems." Dr. Vineetha referred to both biomedical and Ayurvedic concepts in explanations of the mode of action of *śirodhārā* for 'brain complaints,' including a conceptual translation of the Ayurvedic notion of *vāta* with the biomedically conceptualized neurological brain functions. She claimed that *śirodhārā* improves nerve functions controlled by the brain as the treatment is efficient against problems of *vāta*, which regulates, as she put it, activities of the nervous system (see Langford 2002: 237f. for a similar explanation).[155] The purpose of implementing *śirodhārā* for 'mind problems,' characterized by an increase of *pitta* and thus requiring cold treatments due to the *doṣa*'s hot quality, such as *takradhārā*,

[153] During *piccu*, two cloths soaked with medicated oil are tied around the top of the patient's head and left on the head until the skin has absorbed the oil. In *thalapothiccil*, a mixture of medicated paste and *takra* is applied on the patient's head and tied in place with a banana leaf.

[154] See Appendix C for the treatment plan of Mohanan, a 39-year old patient from Thrissur who stayed at the hospital in Ernakulam for a three-week multiple sclerosis treatment and who received *śirodhārā* for six days as one of nine different applications in total, and the treatment plan of Velu, a 44-year old patient from Ernakulam who visited the hospital for eight days for alcohol withdrawal treatment and received *takradhārā* for seven days, apart from two other applications.

[155] In most of the neurological conditions or 'brain complaints,' *śirodhārā* is implemented with warm or lukewarm *thailam* to reduce *vāta* whose qualities are, amongst others, cold and dry. Another form of *śirodhārā* applied in neurological conditions is *kṣīradhārā*, whose dry quality (*rūkṣa*) is transformed into an oily quality (*snehana*) through the adding of certain herbs. Evidence for the efficacy of *śirodhārā* can be found with the help of biomedical imaging techniques as in "a decrease of white granulates" on magnetic resonance images in cases of multiple sclerosis, as Dr. Vineetha explained. With this explanation, she referred to the disseminated patches of demyelination in the white matter in the brain, which develop in Multiple Sclerosis and which can be detected by magnetic resonance images.

was in contrast explained exclusively in Ayurvedic (*doṣic*) concepts and terminologies.

However, while all forms of *śirodhārā* – *thailadhārā*, *kṣīradhārā* and *takradhārā* – were applied rather rarely in the hospital in Ernakulam and in the other clinics and hospitals I visited, this was not the case in Ayurvedic resorts. There, it is applied to a considerable greater extent than it is in hospitals and clinics. Various tourists who visited the Ayurvedic center at Ayuresort for a single application without staying at the resort chose *śirodhārā* or to be more precise *thailadhārā*, which is applied much more frequently in Ayurvedic resorts than *kṣīradhārā* or *takradhārā*.[156] Moreover, Dr. Praveen offered *thailadhārā* to most of the guests who stayed only for a couple of days at Ayuresort and to all long-term guests.[157]

While for all long-term guests Dr. Praveen provided *śirodhārā* for reasons that were not common or rather inexistent in clinical settings – for stress relief, "for experience," and "because the guests like it," as he told me – the purpose of applying *śirodhārā* for Laura and Jonathan was disease-related (their psoriasis) and thus similar to the application of *śirodhārā* in clinical settings.[158] Besides *śirodhārā*, both Laura and Jonathan received *abhyaṅga*, *piḻiccil* and steam bath. For Dr. Praveen, these two applications played a greater role in this specific treatment than *śirodhārā* by claiming that "the major treatment is oileation and sweating, not *śirodhārā* – *śirodhārā* is like boosting only."

The major reason for the frequent application of *śirodhārā* is interrelated with its reconfigured usage as a treatment that provides relaxation and reduces stress. Since Dr. Praveen considered *śirodhārā* as relaxing and even as the most relaxing Ayurvedic treatment, he applied *śirodhārā* for relieving stress. The use of *śirodhārā* for relaxation and stress relief is theoretically and conceptually legitimized by him through categorizing stress as a '*vāta* problem' and incorporating it into the Ayurvedic nosological category of *manasika roga*. In his explanations of *śirodhārā* during consultations, Dr. Praveen informed the guests that *śirodhārā* is the major treatment for *manasika roga* – what he translated literally for the guests with "*mansika* means mind, *roga* means disease" –, in which he included stress, depression, epilepsy and schizophrenia (see e.g. the note he wrote for a guest during a consultation, Figure 3.5).

---

156 Many long-term guests also received *takradhārā* during their treatment, although less frequently than *thailadhārā*. Dr. Praveen provided *takradhārā* primarily to let the guest experience a cool treatment which is pleasant as "the brain is hot because of the hot weather" and which is "a nice change from all the other applications that work with heat."

157 The amount of *śirodhārā*s every guest received differed. While short-term guests received it one or two times during their stay at Ayuresort, the amount for long-term guests ranged from three to eight times, depending on the length of their stay, other applications they received and their need for relaxation based on Dr. Praveen's assessment.

158 During her 17-day treatment, Laura received *śirodhārā* every day (nine times *thailadhārā*, seven times *takradhārā*) except for the day when she had her evacuative treatment. Jonathan had a seven-day treatment course in which Dr. Praveen applied *thailadhārā* everyday.

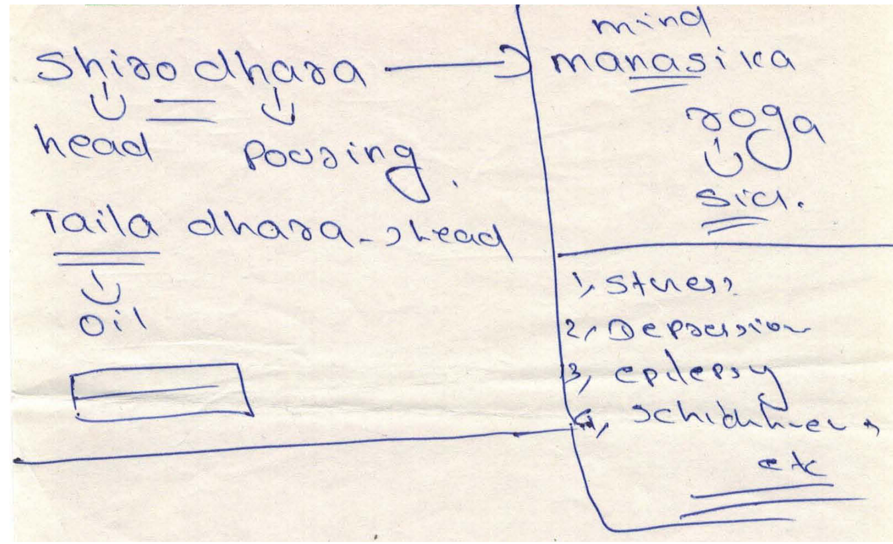


Figure 3.5: Explanation of *śirodhārā* I (note written by Dr. Praveen for a guest during consultation)

While some guests were surprised about the fact that they receive an application which is used against schizophrenia, the link to stress through the mind is a point of reference familiar enough that made sense to them. And due to the guests' association of stress with the mind, Dr. Praveen could establish a connection between *śirodhārā* and anti-stress treatment by pointing out that *śirodhārā* is effective against illnesses related to the mind. This reasoning echoes the justification for the application of *śirodhārā* of Dr. Vineetha illustrated above, who described one of the two areas of application for *śirodhārā* with mind problems or "conditions where we need relaxation."

While Dr. Vineetha explained the application of *śirodhārā* for 'mind problems' exclusively in Ayurvedic concepts, Dr. Praveen used both Ayurvedic and biomedical concepts in his explanations. In the process of referring to the Ayurvedic nosological cluster of *manasika roga* and the *doṣic* disease conceptualization of '*vāta* problem' for the legitimization of *śirodhārā*'s usage against stress, he drew on biomedical terms and concepts for explaining *śirodhārā*'s mode of action to the guests. In his description of the way in which *śirodhārā* leads to relaxation and removes stress, he alluded to some "latest studies in modern medicine," which were said to have discovered that "through the flow of the oil on the forehead in a monotonous rhythm, the pituitary gland is stimulated and secretes a hormone against stress" (see Figure 3.6). Dr. Praveen referred to the production of "a hormone [which] has relaxing effects" (addition by the author) in his explanations for the guests. The evidence for this endocrinological explanation was seen by Dr. Praveen in the sudden feeling of relaxation which emerges in the guest during the treatment. He justified this with a conceptual distinction of physiological reactions in the human body, one of them being

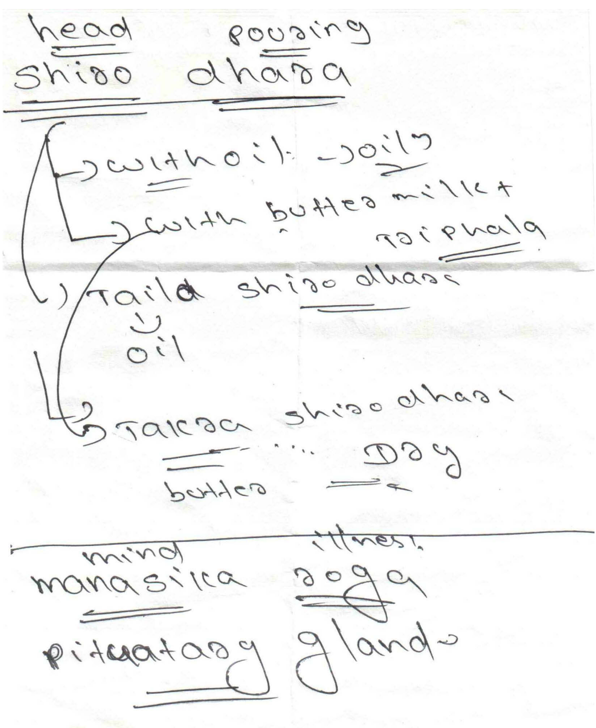


Figure 3.6: Explanation of *śirodhārā* II (note written by Dr. Praveen for a guest during consultation)

interconnected with endocrine processes:

> *I think it's related to hormones. There are generally two kinds of action in our body, also in modern medicine. For example, in wintertime our skin is getting dry. It's a protection of the body from the winter. It's a slow system. The brain is realizing that the season is changing, so the skin changes, slowly. It's not a hormonal one. This is a slow process. Other processes are fast. Like a cut, when blood is moving out. It should be closing. Action should be very sudden from the brain. Like that, in* śirodhārā *– everyone is telling, I'm also thinking the same: pituitary gland stimulation is coming. If it's secreting the hormone, it's very fast. For example, after the* śirodhārā *for 10 or 15 minutes the guest is feeling relaxation. If something is not happening in our body we won't get relaxation. And the relaxation means total relaxation.*

One reason for referring to this biomedical explanation according to Dr. Praveen was that classic Ayurvedic texts only state that *śirodhārā* is beneficial for *manasika roga* according to him, but not in which ways it acts. Hence, he looked for other sources to explain the mode of action, especially since many guests not only liked to know what should be good for them but also why. And since they were rather used to biomedical concepts and terminologies, this biomedical explanation also made more sense for the guests as they could link this explanation better to their knowledge.

It is plausible to think that the characteristics and biography of the doctor himself may also account for his reference to the biomedical explanation. In the Ayurvedic college he studied in Sullia, Karnataka, the proportion of biomedical knowledge was greater than in most of all other Ayurvedic colleges in India. Besides basic biomedical physiological and anatomical knowledge which is taught in every Ayurvedic college in India today, the

curriculum included the study of the biomedical equivalent to all Ayurvedic illnesses and diseases patterns. In addition, for half of his one year long internship period after his studies, the doctor worked in an (biomedical) orthopedic clinic that exposed him to more (practical) knowledge of various aspects of biomedicine, and which increased his interest in biomedical knowledge that he enriched by studying different books and websites with biomedical content.

The interpretation of *śirodhārā*'s effect in terms of hormonal changes has certainly also to be considered against the background of a contemporary and common interpretation of modes of action of non-biomedical treatments in biomedical terms and theories (see e.g. Naraindas 2006: 2660). This reflects and is accounted for by the institutionally dominant position of biomedicine, through which non-biomedical clinical practice, education and policies in India and other countries are interlaced with biomedical practices, concepts and terminologies. This biomedical influence also shapes the Ayurvedic practice in the resort and manifests itself in the parallel use of Ayurvedic and biomedical concepts and terminologies regarding *śirodhārā*'s use as a means of relaxation (see also Langford 2002: 237f.). Dr. Madhu developed the elaborate conceptualization of stress in *doṣic* and biomedical terms presented above on his website:

> Stress, according to Ayurveda, is a state of imbalance of prana vayu, sadhaka pitta and tarpaka kapha. Shirodhara reestablishes the functional integrity between these three doshic subtypes and thus helps to alleviate stress. Shirodhara stimulates the pituitary gland which helps bring hormonal balance. Shirodhara indirectly helps strengthen ojas, maintains the life function of the vital organs, the heart and the brain and it's [*sic*] immunological and rejuvenate actions. In relation to the doshas, Shirodhara is specifically indicated for vata and pitta imbalances. Vata individuals, plagued with fear, nervousness, anxiety, insecurity and ungroundedness, typically experience a calming and centering effect from Shirodhara. Through the use of cooling oils such as coconut, sunflower and brahmi, Shirodhara relieves pitta individuals of anger, irritability, judgment, criticism, and excess heat in the head. Through its balancing effect on the doshas and its stress relieving capabilities, Shirodhara thus enables the natural expansion of consciousness, thereby leading one to experience his/her natural state of bliss.

Just as in his conceptualization of stress, Dr. Madhu lists both Ayurvedic and biomedical terms and concepts for the justification of *śirodhārā* against stress, which reflects the incorporation of the concept of stress in (his) Ayurvedic medical theory.

The other two reasons for applying *śirodhārā* besides relaxation at Ayuresort were interrelated with guests' expectations and perceptions of Ayurveda (Section 2.1), and Dr. Praveen's and the resort management's orientation towards the guests' (anticipated) desires for both personal and economic reasons (Section 2.3). From his experience with former guests, Dr. Praveen learned that many of the guests would like to try *śirodhārā* out of curiosity after reading or hearing about the application. This curiosity was intensified by *śirodhārā*'s foreignness for the guests on the one hand, and an assumed general interest in

unknown things amongst the guests on the other hand: Since "everyone wants to experience new things," the unfamiliar application triggers curiosity in the guests and provokes their desire to "try it out."

With the phrase "for the guests India means Taj Mahal, Ayurveda means *śirodhārā*," Dr. Praveen succinctly captured how the omnipresence of *śirodhārā* representations in popular print media, travel catalogs and television broadcasts in Europe, advertisement brochures and on billboards of Ayurvedic centers in Kerala, as well as in online resources such as Ayurvedic resort and travel agency websites in the translocal space of the World Wide Web has shaped the guests' image of *śirodhārā* (and Ayurveda). According to him, and confirmed by my findings, just as all tourists in India have heard about the world's famous mausoleum in Agra, most of the resort guests know about *śirodhārā*, "even if they don't know anything else about Ayurveda."

Images of *śirodhārā* are especially prominent in all kinds of print and online media. In many documentations about and advertisements for Ayurveda, a picture of *śirodhārā* – in most of the cases *thailadhārā* – can be found, even if the text does not refer to the application. And various websites use pictures of the application to visually represent Ayurvedic treatment – as in the example described above, where the photo of *śirodhārā* produced by India's Ministry of Tourism is used by tourism service providers, health-related online magazines, travel magazines and guides, massage parlors, day spas and Ayurvedic centers in India, Europe, and the United States on their websites. Also the TV spot produced by India's Ministry of Tourism mentioned in Section 2.2 represents Ayurvedic treatment (for tourists) in the form of *śirodhārā*, while in the !ncredible India promotion presented in Figure 2.9 the photo of the application takes half of the size of the advertisement.

In the state of Kerala itself, Ayurvedic treatment is represented through images of *śirodhārā*. The *śirodhārā* picture produced during the photo shoot at Ayuresort described in Section 2.2 (Figure 2.2), was used for advertising Ayurveda on the resort's website, in a resort brochure and calendar, and in different travel magazines. And while the brochure of Ayuresort produced before my research showcases a very prominent photo of *śirodhārā* (Figure 2.4), the table display comprises yet two additional photos of *śirodhārā* (Figure 2.6). And while the back side of the leaflet analyzed in Section 2.2 portrays the Ayurvedic application *nasya* – and a small drawing of the vessel used for *śirodhārā* in the top left corner – (Figure 2.8), on the front side the only application pictured is *śirodhārā* (Figure 2.7). Out of 41 leaflets from Ayurvedic centers I collected during my research, 32 included at least one picture of *śirodhārā*, either illustrating the application or representing (and

advertising for) Ayurvedic treatment in general as prominent media vehicle. From the ten leaflets without a picture of *śirodhārā*, five contained only text and no pictures at all, one did not list any pictures of treatments but only of its facilities, and three portrayed a photo of *kizhi*, similar to the one produced at Ayuresort described in Section 2.2.

The omnipresence of visual representations of *śirodhārā* as being a fundamental element of Ayurveda in both print and online media in and outside India has transformed the treatment into *the* symbol of Ayurveda.[159] This is also suggested by Dr. Praveen, when he claims that "*śirodhārā* is a common thing. Most of the people who come here – more than 80 percent – know *śirodhārā*. In every resort brochure, it's there. *Śirodhārā* is an unavoidable thing. And in Europe for some people Ayurveda means *śirodhārā*. Like India means Taj Mahal. It's very popular." Being 'unavoidable' was also one characteristic that guests at Ayuresort ascribed *śirodhārā*. Many told me that they knew the treatment before they came to Ayuresort. While some mentioned women's magazines or websites of travel agencies and Ayurvedic resorts, most could not specify the sources – except for websites of Ayurvedic resorts and local advertisements in Kerala. Most of the guests told me "you see it everywhere," or "when you google Ayurveda, you get a lot of images of *śirodhārā*" (Catherine). Some of the guests, like Charlotte, argued that *śirodhārā*'s omnipresence results from its high potential as advertising medium: "The *śirodhārā* image is so appealing and eligible for marketing purposes, so that it is used everywhere: deep relaxation, wellbeing, exotic, that is different from everything else that you know."

Indeed, the latter point was mentioned by several guests when I asked them about their opinion on *śirodhārā*. David told me that you remember *śirodhārā* because "it is exotic." And Laura said that "everywhere you read about Ayurveda in Germany, there are images of *śirodhārā*. And they stick in your mind, because it is something special. Massage is massage, but this is different." Thus, *śirodhārā*'s otherness on the one hand helps to sell the application (and, by extension, Ayurveda), a point reinforced by Dr. Praveen when he says that "they [the creative director and the resort management] choose *śirodhārā* because it is different – why should they take photos of massage?" (addition by the author). On the other hand, it facilitates guests' memory of it which results in associations of Ayurveda with *śirodhārā* and in the expectation of receiving the application.

For most of the guests at Ayuresort, *śirodhārā* represented an integral part of Ayurveda. Only in Ayuresort, Adam learned that Ayurveda consists of many more things than *śirodhārā*

[159] Even scientific publications on Ayurveda refer to this iconic image (see e.g. the book cover of Schrott and Ammon's *Heilpflanzen der ayurvedischen und westlichen Medizin* (Medicinal plants of Ayurvedic and Western medicine, 2012), which portrays a blossom of *saraca indica* next to a picture of *śirodhārā*).

(Section 2.2). Before he visited the resort, "Ayurveda was *śirodhārā* – *śirodhārā* was the thing that you have in your mind when you hear about Ayurveda." And Silvia even considered *śirodhārā* a crucial element of "traditional Ayurveda," in comparison to administration of medicines, because she had never heard about that. The hierarchy of treatments in terms of relevance had thus been upside down in her understanding of Ayurveda. The central role that *śirodhārā* assumes in most of the guests' perceptions of Ayurveda makes *śirodhārā* one of the three misconceptions Dr. Praveen imputes to the guests – besides the centrality of *prakṛti* and interconnected diet, and pulse diagnosis, as described in Section 2.3.

Still, the guests' perception of Ayurveda and the interconnected desire to experience *śirodhārā* influences the Ayurvedic practice in the resort and results in a frequent application of the treatment. Some of the guests asked explicitly for it – or 'bought it' like a tourist activity such as a seat in a *kathakaḷi* performance or on a houseboat in the backwaters as in the case of those guests who visited Ayuresort for a single application. Others received it because Dr. Praveen presumed their desire to try it out and since "it's great for experiencing Ayurveda – it's the Europeans' favorite one [treatment]" (addition by the author).[160]

According to Dr. Praveen, nearly every person who experienced it liked *śirodhārā*. This was also reflected in many guests' statements, who perceived the application as "great and relaxing" (Alice), "relaxing for the head area and thus very pleasant" (Jessica) or "de-stressing," as Barbara stated: "That [*śirodhārā*] was really good! It was calming, relaxing, de-stressing. I am a stress person. It's something magical, almost a trance-like state, which makes me fall asleep" (addition by the author).[161] However, while the majority of the guests liked *śirodhārā* – reflected in the fact that many opted for it when Dr. Praveen let them choose the applications they received on their last treatment day – some guests had negative experiences, resembling the description of Brown about her experience with *śirodhārā*:

> I actually had a vision of Dick Cheney when I finally experienced sirodhara, a signature ayurvedic treatment that Dr. Sreelatha and others had cautioned could lead to emotional melt-down. Warm oil is released above you in a steady pendulum stream, your forehead a windshield and the oil, the wiper. Feelings of deep panic were eventually supplanted by one of utter defenselessness in which, I was certain, all dark information about my past could be gleaned. Sirodhara struck me as an immensely powerful tool for extracting secrets (Brown 2006).

Some guests at Ayuresort reported similar negative experiences. Anna for instance told me

160 In the same way as visual and textual representations of Ayurveda on the one hand and Ayurvedic resort practice on the other hand are co-constitutive as described in Section 2.3, the multitude of media images of *śirodhārā* as relaxation treatment influence the very practice of *śirodhārā*, which is in turn represented in the media. Although the connection between images and practice is rather circular than linear, the influence of the images on the practice certainly exists and *śirodhārā* would not be the popular relaxation treatment it is today without these representations.

161 While Barbara and others reached a level of relaxation through *śirodhārā* that induced sleep, others, like Diana (see below), stayed awake and followed the movement of the oil stream mentally.

that she asked her therapist to reduce the time of the application because after a certain time in which she enjoyed the treatment, negative thoughts would surface. After a particular time, she had to think of her former husband, work and of financial pressures. During her first and second *śirodhārā* session, Diana felt anger without any obvious reasons, which was channeled into an impulse to kick. In addition, she slightly panicked because she felt she had no control over the situation, lying on the *droṇī* completely at the mercy of the therapist with covered eyes and without the possibility to run away. Reflecting on this experience, she came up with a psychological explanation in terms of processing a childhood trauma through bifocal stimulation triggered by *śirodhārā*.[162]

However, although these examples point to '*śirodhārā*'s dark side,' guests' negative experiences with *śirodhārā* at Ayuresort were rare and most guests enjoyed the application. Guests' interpretations of the relaxation effect of *śirodhārā* varied. While Hannah explained it with the fact of 'having oil on your head' and Barbara and Diana hypothesized that the application united the two brain hemispheres, the majority either provided diffuse explanations that focused on a stimulation of 'the mind' or 'the brain' by the oil flow, without going into detail. Or they provided the explanation of the stimulation of hormones that they had received from Dr. Praveen – and sometimes interpreted these hormones as endorphins.

Thus, through the largely pleasant nature of the application, its widespread representation in different media, the guests' need for relaxation, a specific enactment of stress, together with an underlying entrepreneurial drive of Dr. Praveen and the resort management, *śirodhārā* has been enacted in Ayuresort (and other Ayurvedic resorts). It has transformed into a means of relaxation for stressed Europeans, although stress is neither part of Ayurvedic nosology, nor does a specific Ayurvedic treatment against stress exist in classical Ayurvedic textual sources or in Ayurvedic clinical practice (nor did Dr. Praveen study anything about the syndrome stress and a treatment against it during his education).

Against this background, both stress and *śirodhārā* in the resort can be understood as ontologically different from stress and *śirodhārā* outside the resort. Mol points to the multiplicity inherent in atherosclerosis resulting from different enactments: "It is a matter

[162] A very similar story is told by Naraindas who reports that a male guest of an Ayurvedic center in Germany receiving *śirodhārā* relived a traumatic episode of his adolescence, when allied forces bombed his town which was not far away from the spa where he received *śirodhārā* (2011a: 81). Naraindas further states that several persons who he had talked to reported experiencing panic attacks during *śirodhārā*. However, like at Ayuresort, for the majority of the individuals Naraindas spoke to, the application was "immensely pleasurable" (Naraindas 2011a: 81). As a result, both doctors and patients referred to *śirodhārā* as "Ayurvedic psychotherapy, where the analyst and the analysand was the patient" (ibid: 81). This is also mentioned by Langford, who states that during her research one Ayurvedic practitioner called *śirodhārā* a "powerful psychotherapy" (2002: 3, 238, 266, 2013: 285).

of patients who speak as against body parts that are sectioned. Of talking about pain as against estimating the size of cells. Of asking questions as against preparing slides. In the outpatient clinic and in the department of pathology, atherosclerosis is *done* differently" (2002: 35f.; emphasis in original). With her understanding of the production of multiple enactments of atherosclerosis, Mol opposes common notions of "perspectivalism," as she calls the notion according to which various actors, for instance patients and practitioners, have *different views on one object*, like atherosclerosis, and which supposes the existence of a unified object (2002: 10-12). By contrast, for Mol an object, like a disease, is not a singular entity existing by itself but is always constituted or enacted through a multitude of practices which determine the object's ontology – *the ontology of a multiple object*: "If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being – and disappear – with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies" (2002: 5).

In this sense, also the reality of stress multiplies. Just as atherosclerosis is done differently in the department of pathology and the outpatient clinic of the hospital in the Netherlands, resulting in the simultaneous prevalence of several atheroscleroses, stress is enacted differently inside and outside the realm of Ayurvedic resorts which leads to multiple stresses. By claiming that the doing is done by "several people and lots of things," including for instance words, paperwork, buildings or the insurance system, Mol argues that ontologies of diseases are determined by socio-material practices that encompass human and non-human actors (2002: 25f.). In the same way, specific 'people and things' are responsible for a distinct enactment of stress in Ayuresort, which differs from stress enacted outside the resort(s): guests with their perception of stress and desire for stress relief, Dr. Praveen with his (non-)knowledge of stress and Ayurvedic theory, the resort management with their entrepreneurial drive, visual and textual representations of stress and stress relief techniques in different types of print and online media in India, North America and Europe and in the World Wide Web, specific Ayurvedic applications, work life and social relations in India and Europe or the environmental setting of Ayuresort, to only mention the most apparent ones. Through a complex interplay between those human and non-human actors in form of practices ranging from a guest reading about 'anti stress packages' on the website of a German travel agency to the identification of stress with a '*vāta*-related *manasika roga* by Dr. Praveen, a specific syndrome is enacted, which differs from other enactments

of the syndrome – be it a cluster of neuronal, cellular, molecular and neuroendocrine processes dominating contemporary German medical school classrooms, an elusive mental and physical burden prevalent in today's global media, or specific physiological parameters in relation to homeostasis as in Cannon's laboratory during the first decades of the last century. At Ayuresort, stress is a *manasika roga* that is characterized by its '*doṣic*-hormonal' conceptualization and that is fought with an Ayurvedic treatment which is rooted in *doṣic* concepts.

If stress is considered as being multiple, the question becomes: what unites the single enactments? According to Mol, an enacted object "[...] is more than one – but less than many," as the various enactments are still connected through commonalities or/and interactions despite their differences and separateness (2002: 55). Also stress in Ayuresort is both distinctive from and related with other enactments of stress. Connections involve its characterization by endocrinological processes (that result in a common ground between Dr. Praveen and his guests), its suppression through relaxation practices or its work-related causes. The major aspects making stress in the resort a discrete enactment on the other hand are its *doṣic* (which represents an Ayurvedic treatment basis) conceptualization and its incorporation into the nosological category of *manasika roga* by various practitioners, together with the application of *śirodhārā* for its elimination, which is part of the specific enactment of stress and which in turn is itself enacted in a unique way through this enactment of stress. *Sirodhārā* is enacted in the resort as a frequent relaxation practice and is thus ontologically different from the *śirodhārā* applied against neurological and skin diseases in Ayurvedic hospitals. This new *śirodhārā* is done through multiple enactments of stress (inside and outside the resort), the association between stress and relaxation practices present in guests' minds that fosters resort doctors and managers to adjust Ayurvedic practice and in media representations that open a dynamic field within which Ayurveda and biomedicine, guests' perceptions and Dr. Praveen's knowledge of Ayurveda and Stress are negotiated, *śirodhārā*'s usage for *manasika roga*, internet reports on endocrinological interpretations of stress responses together with Dr. Praveen's affinity towards information available on the internet which he regularly paraphrased with "google is god," its omnipresent association with stress relief in media representations, the profit orientation of the resort management or Dr. Praveen's personal and economic interest in satisfying the guests and resulting practices.

Conclusion

In his book *Crazy Like Us: The Globalization of the American Psyche* (and in his New York Times Magazine article *The Americanization of Mental Illness*), Ethan Watters argues that American and European mental health professionals transferred American and European biopsychiatric conceptions of mental disorders to other parts of the world in the last decades (Watters 2010, 2011). While the attempts to provide these regions with 'mental health literacy' – i.e. public knowledge about mental disorders defined by American and European biomedical and psychiatric science and officially categorized in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) – led to a global spread of American and European notions of mental illness, the notion of stress seems to not have reached all parts of the world uniformly. It was only after his exposure to (the needs and problems of) international guests at Ayuresort that Dr. Praveen acquired knowledge about a syndrome and a concept which was unknown to him before. While the concept of stress did not exist for Dr. Praveen before he started working in the resort, over time he developed 'his own stress' through extensive interactions with guests, his knowledge of Ayurvedic nosology and information on public and biomedical scientific knowledge on stress. His cognitive comprehension of stress was later complemented by an adoption of the term in his own parlance and embodied first-hand understanding, when he 'felt stress' during busy weeks of work at the resort. After a particularly 'stressful' period, he told me: "Now I know what stress is. Work wasn't fun. It was only business, I wasn't a doctor. I don't even know exactly what I did. It was like at the assembly-line. My sleep was bad. I always thought of the next treatments on the next morning."

As illustrated in Section 3.1, the concept of stress was developed in North America and Europe against the background of distinct scientific, political, social and economic circumstances. For Dr. Praveen's perception, the prevalence of stress is restricted to 'the West' while in India it is largely not existent. For him and many of my interlocutors, stress represents a 'culture-bound syndrome' intrinsically tied to a specific 'Western lifestyle' and social relations which differ from life in India. While Dr. Praveen situates stress outside India, he and other practitioners like Dr. Madhu incorporate it in Ayurvedic theory and practice by considering it as 'mind-related' and thus *manasika roga* when asked about by foreign guests. Through this adaptation, Dr. Praveen can make sense of it and simultaneously legitimize the usage of *śirodhārā* for stress relief, for both the guests and himself.

At the same time, the doctor connects his explanation of *śirodhārā* to the cognitive field

of the guests by referring to biopsychiatric disorders such as depression or schizophrenia as examples for *śirodhārā*'s scope of application in clinical context and by using an endocrinological explanation of *śirodhārā*'s mode of action. The value of such an explanation can for instance be seen in Diana's interpretation of *śirodhārā*'s mode of action in terms of secretion of endorphins and by her interpretation of her weight loss in terms of a processing of her childhood trauma through the bifocal stimulation of her brain through the oil flow. While this explanation certainly benefits the interaction between the Indian doctor and international guests, it also reflects the institutionalized global hegemonic position of biomedicine, even visible in contemporary Ayurvedic education and clinical practice, where college syllabi comprise biomedical anatomy and physiology and diagnoses are informed by biomedical terms and concepts.

Still, this biomedical hegemony is undermined in Dr. Praveen's and Dr. Madhu's conceptualization of stress. While stress is defined by certain endocrinological processes (which Dr. Praveen could not determine more specifically), it is also conceptualized in Ayurvedic notions. By referring to stress as a '*vāta* problem' (Dr. Praveen) or by identifying it with a 'Prana Vata imbalance,' a 'disturbance of Sadhaka Pitta' or an 'imbalance of Shleshaka Kapha, Vyana Vata and Tarpaka Kapha' (Dr. Madhu), stress is enacted completely distinctive from its different biomedically and psychologically centered enactments existing in North America and Europe.

In order to reestablish those imbalances, Ayurvedic resorts offer 'anti-stress packages' – for instance the 'Ayurveda Package To Remove Stress & Strain' at Ayuresort, see Figure 2.4 –, which comprise different practices. One of them is *śirodhārā*, which is adapted to the guests' need for relaxation and in this course transformed from a rare application for primarily neurological diseases in clinical context into a frequently applied technique for relaxation and stress relief.

While websites of German Ayurvedic centers and massage studios describe it as being "perfect for stress" or "leading to deep relaxation," in Varkala most Ayurvedic centers promote *śirodhārā* in their brochures as beneficial against 'mental stress,' 'mental tension,' 'tension and stress,' and 'stress.' Besides this terminological connection of the treatment with relaxation and stress relief, specific images of *śirodhārā* shall further evoke this association. As described in Section 2.2, during the production of the *śirodhārā* photo at Ayuresort, Manu wanted to mediate an image of Ayurveda as relaxation treatment. Through explicitly claiming *śirodhārā*'s benefit of stress-relief and by implicitly addressing feelings of relaxation through images, a certain meaning of the application is mediated by the language of text and

images (see e.g. Hall 1997: 1), which shapes the perception of the addressee. Furthermore, while textual and visual representations of *śirodhārā* form the guests' perceptions of it being a treatment for relaxation and stress relief, their frequent occurrence in print and online media simultaneously shapes the guests' image of *śirodhārā* as an integral part of Ayurvedic practice. It follows that through the interplay between these perceptions, the guests' need for stress relief and their resulting visit of Ayuresort, the resort-specific enactment of stress, *śirodhārā*'s usage for *manasika roga*, Dr. Praveen's endocrinological interpretation of *śirodhārā*'s mode of action, the guests' positive evaluation of *śirodhārā* and the resort management's profit orientation, *śirodhārā* has become an extremely popular application for stress relief, ontologically different from *śirodhārā* in clinics and hospitals.

But is the new *śirodhārā* the panacea that its advertisements imply? Most of the guests considered their stay at Ayuresort as relaxing and recreational. Several guests also justified their visit at Ayuresort with the positive experiences they made with former long-term treatments in Ayurvedic resorts in India and Sri Lanka, which they considered as having relieved stress and 'provided energy' for the following months (for instance Barbara, Christina, Isabel, Julie, Maria or Silvia). As *śirodhārā* is only one element within a whole panoply of relaxing aspects long-term treatment at Ayuresort offers, it is difficult to accurately isolate and assess its effect in terms of relaxation and stress relief. As mentioned above, different applications were offered for stress relief and also perceived in this way by the guests. For instance, David claimed that *piḻiccil* "was also taking away stress" and that he "could literally feel it [stress] fall off [his] back with the oil" (addition by the author). Also yoga was considered as relieving stress by most of the guests. Lydia, in turn, stated that "breathing exercises lead to stress relief" and Hannah mentioned that "yoga is good for stress relief and for flexibility of muscles and joints." Furthermore, the resort setting and the environment contribute to relaxation. Half an hour after Linda had arrived at Ayuresort, I had lunch with her in the open air restaurant facing the sea and she told me: "This is already relaxing here – the heat, the breeze, the sea view. You almost don't need any treatment." And last but certainly not least, the sheer fact of absence from/of work definitely contributes to stress relief, as confirmed by several guests.

But while stress relief and relaxation can presumably be attributed to the combination of all these factors, many guests also reported a perceived but explicit effect of *śirodhārā*. While Gabriel told me that he "cannot imagine that oil on the forehead should be good for my health," the testimonies of the other guests were more positive. For most of the guests, *śirodhārā* provided relaxation. For many guests, *śirodhārā* was the most relaxing treatment.

Christina said: "My subjective imagination: *śirodhārā* helps me particularly to unwind." And most of the guests were convinced that it was beneficial for stress relief, just like Hannah: "I am convinced that Ayurveda is good against stress. Especially the forehead flush. I think that the oil does not only have a good effect on the skin, but it serves as relaxation and stress relief – warm oil on the head."

These statements point to a subjective impression or even conviction of *śirodhārā*'s favorable impact in stress relief, which was also sensed by Dr. Praveen. He attributed *śirodhārā* a relaxation effect, even if it is temporary. Although he claimed that the application is beneficial for relaxation and he thus applied *śirodhārā* in cases of stress, Dr. Praveen did not consider *śirodhārā* a means for permanent stress removal. He explained to me and to the guests that stress can be only removed permanently by eliminating its source. And since he attributed the cause of the guests' stress primarily to the 'hectic Western life' with its 'stressful working conditions' and unfavorable social relationships, he considered this an unsolvable task for him since he cannot request the guests to escape this system. Nonetheless, he tried to ameliorate the consequences of 'life in Europe' by offering *śirodhārā* and other applications to provide at least a temporary effect (which in fact lasted much longer, i.e. for several months, according to various guests).

This relaxation effect also contributed to the guests' health and was part of Dr. Praveen's disease management. Just as guests established a causal link between their ailments and stress (see Section 3.2), Dr. Praveen associated ill health with stress. However, he himself and his guests could not explain this relation: "in most of the diseases stress plays a role, but how and why I don't know," the doctor explained. While not being able to provide an interpretation of the role of stress in the development of particular diseases, he was convinced that removing stress is beneficial in treating the respective disease: "you have to treat stress and the disease itself to get a good result." Although stress did not exist for Dr. Praveen before he worked at Ayuresort and although he did not have a theoretical explanation for the interconnection between stress and disease after he had developed a notion of stress, he considered stress relief as contributing to a positive treatment outcome. This view was based on his assumption that stress relief can be equated with wellbeing which in turn is beneficial for any treatment.

Clearly, the new *śirodhārā* is not only a panacea against stress but an indirect panacea against all other ailments the guests presented to Dr. Praveen. Hence, stress relief and relaxation are not only provided for reasons of wellness but also from a medical standpoint. This 'medical relaxation' applied in Ayurvedic resorts points to a fuzzy fault-line between

wellness and medical practice and a more comprehensive concept of relaxation and of health. The convergence of medical and wellness aspects in Ayurvedic resort practice – and underlying conceptualizations of health and wellbeing – is discussed in the following chapter, together with the conjunction of health care and holiday elements due to the resort's embedding in the (health) tourism industry. I illustrate how a specific German health care tradition, the *Kur*, provides the fertile ground for this juxtaposition of healing, wellness and holidays and turns the practice at Ayuresort into a new transnational form of this health care tradition: the *Ayurveda-Kur*.

4 Taking the Oils: *Ayurveda-Kur* and the Merging of Therapy, Wellness and Vacation

When Hannah leafed through the German travel magazine *Reise & Preise* in September 2009 on the search for a destination for her upcoming vacation trip, she stumbled upon the following brief account on Ayurvedic treatment in Kerala:

> A relaxing oil massage in the morning, lying in the sun in the afternoon – even though this is nice, it has not much to do with a serious *Ayurveda-Kur*. For a "real" *Kur*, you should at least schedule two weeks. Alcohol is then as a taboo as swimming, physical exertion or sunbathing are. The Ayurvedic doctor decides about the treatment individually, the diet is exclusively Ayurvedic food (Schwertfeger and Kühn 2009: 36; original in German).

Portraying different travel destinations and tourist attractions in Kerala, the six-page article 'Malabar-Küste: Hingehen wo der Pfeffer wächst'[163] presents Ayurveda as one of several holiday activities, besides elephant rides in tea estates, houseboat trips in the backwaters and tiger spotting in a national park. The report triggered Hannah's interest in undergoing an Ayurvedic treatment in India.

Those days, Hannah had been suffering from overweight and migraine, which she had attributed to digestive disorders as she traced the origins of health and illness to the intestine. She had considered doing an '*F. X. Mayr-Kur*' for treating her migraine and for improving her general wellbeing. Fitting Hannah's explanatory model of illness, this therapeutic regimen situates the cause for most health problems in the intestine, and the curative as well as preventive main treatment method is a cleansing of the intestine through a combination of a specific diet and natural purgatives (see e.g. Rauch 1994). However, when she read about Ayurveda in Kerala in the travel magazine, she changed her mind and favored an Ayurvedic treatment in India.

At that time, Ayurveda was not new for Hannah. As described in Section 2.2, she had undergone Ayurvedic treatment before during a short vacation in the wellness area of an Austrian hotel in 2002. However, this experience had been restricted to different single Ayurvedic applications such as oil massages or *śirodhārā*, which she classified as

[163] Literal English translation: 'Malabar Coast: Go where the pepper grows;' the subheading is a German proverb similar to the English saying 'Jump in the lake!' and is applied here as a wordplay referring to the 'spice gardens' in Kerala, a tourist attraction where pepper and other spices are grown.

'relaxation applications,' and to a vegetarian diet tailored to one's individual constitution. Ayurveda was for Hannah at that time a 'wellness treatment' with a focus on a specific diet. Considering this diet as beneficial for her poor digestion and the resulting overweight and migraine, along with her perception of Ayurveda as involving applications for her general wellbeing and the promising aspect of combining a health care treatment with vacation in India, Hannah abandoned her plans of undergoing an *F. X. Mayr-Kur* and decided to have a two-week Ayurvedic treatment in Kerala.

The same day that she had read about Ayurveda in the travel magazine, Hannah called the travel agency Ayutravel and asked for more information. Two days later she found a catalog in her mailbox, listing various Ayurvedic resorts in India and Sri Lanka and providing information about Ayurvedic treatment. Reading through this information, Hannah consistently stumbled upon the terms '*Reinigungs-Kur*' (purification regimen) and '*Verjüngungs-Kur*' (rejuvenation regimen), the two omnipresent buzzwords and most frequently offered long-term treatments in the realm of Ayurvedic resorts in India. At that point, she realized that Ayurvedic practice is not restricted to single wellness treatments and a concentration on a specific diet, as she had experienced in Austria, but also includes preventive and curative long-term treatment courses. Furthermore, the frequent mention and description of 'purification' supported her decision to undergo an Ayurvedic treatment for cleansing her bowel. She chose one resort, Ayuresort, due to its pleasant ambiance and comparatively low prices, and after a look at Ayuresort's website and a longer telephone conversation with an employee of Ayutravel, she booked an all-inclusive package that comprised flight, treatment, daily yoga and meditation classes as well as accommodation and food for 16 days. Two weeks later, she boarded an airplane to Thiruvananthapuram, the main flight destination for foreigners seeking Ayurvedic treatment in India.

I will return to Hannah's story later in this chapter, which discusses the embedding of Ayurvedic resort practice in the global (health) tourism industry. I argue that Ayurveda in Ayurvedic resorts manifests as a new transnational form of the *Kur*, a century-old German health care practice. Similarities between *Kur* treatment and the practice at Ayurvedic resorts have resulted in the emergence of the neologism '*Ayurveda-Kur*.' *Kur* and Ayurveda were frequently, implicitly as well as explicitly, equated by German-speaking resort guests, travel agencies and media. The description of Ayurvedic treatment in India as an *Ayurveda-Kur* by the travel magazine *Reise & Preise* and Hannah's decision to visit Ayuresort instead of having an *F. X. Mayr-Kur* (one type of the comprehensive *Kur* complex) in Austria are only two examples for that. This translation of Ayurvedic treatment into *Kur* practice in

the 'German-speaking world of Ayurveda' not only makes Ayurveda plausible to potential customers but also influences the guests' motivation for visiting Ayuresort and the practice at the resort, including its 'de-medicalization' at Ayuresort described in Chapter 2, and eventually turns Ayurvedic resort practice into a transnational form of the *Kur*.

In the first part of this chapter, I introduce the *Kur*, which makes up one pillar of the German National Health System, in addition to general practitioners and the hospital system. The *Kur* is a health care practice centered around an individualized regimen with treatment methods mostly based on natural remedies. It is situated at the intersections of therapy and wellness and health care and holidays, which I illustrate by providing a detailed account of its historical development and contemporary situation. By providing an overview of the global history of the medical institution of the spa, a century-old facility in continental Europe that combines therapeutic and health-promoting treatments through environmental stimuli and leisure activities, I show that the *Kur* is the 'German version' of the medical spa.[164] This includes a discussion of its shift from the public health system to the private tourism industry in the last decades. Both spa and *Kur* treatment are forms of (international) health care travel and manifestations of so-called 'health tourism.'

In the second part of this chapter, I discuss the practice at Ayuresort against its embedding in the tourism industry, before I analyze the merging of therapeutic, preventive and wellness aspects in resort practice, together with its interplay with vacation elements. I demonstrate that by bringing the notion of *Kur* to the resort, and by using it in advertisements and representations of Ayurvedic resorts, German-speaking guests, travel agencies and media make sense of this unknown Ayurvedic practice. Among the many similarities between the latter and the *Kur* are the inclusion of both health care and holiday aspects on the one hand and a fuzzy fault-line between therapeutic, preventive and wellness elements on the other, along with an individualized austere regimen combined with periods of rest situated in a pleasant natural environment. These similarities let the different German-

[164] Today, the term 'spa' is often associated with "a site only for the posh and well-heeled" (Naraindas and Bastos 2011: 2), visited for relaxation, fitness and cosmetic treatments. The International Spa Association has categorized these places into 'club spas,' 'destination spas,' 'spa hotels,' 'resort spas,' 'sport spas' or 'day spas' (Puczkó and Bachvarov 2006: 85, quoting the International Spa Association). However, such 'wellness institutions' represent only one type of spa. According to the Merriam Webster Dictionary, the term spa does not only refer to such a "commercial establishment providing facilities devoted especially to health, fitness, weight loss, beauty, and relaxation" or "a fashionable resort or hotel," but also to "a mineral spring" or "a resort with mineral springs" (Merriam-Webster Online Dictionary 2015). Those spas have a much longer tradition, dating back to the Roman Empire, and are primarily found in continental Europe. Usually built around waters associated with healing properties, those spas have a more medical component and offer therapeutic and preventive treatment through natural elements like water, climate and soil. The term spa was also first used in this context, before it was transferred to the 'modern wellness spa.' The term is often said to represent the acronym of the Latin phrase '*sanitas per aquam*' (health through water) or originating from the Belgium town Spa, one of the first widely known spa towns, although the origin of the term is not exactly clear (Ellis 2008; Pordié 2012: 199 [Footnote 1]).

speaking actors consider the stay at the resort as an *Ayurveda-Kur* and eventually Ayurvedic resort practice into a new transnational form of the old German health care tradition.

4.1 Traveling for Health Care: Medical Tourism, Spas and the German *Kur*

When one visits Bumrungrad International Hospital in Bangkok, Thailand, he/she could easily mistake it for a luxury hotel: the entrance hall resembles more the lobby of a five star hotel than of a hospital, it accommodates its patients in 'single deluxe rooms' and 'premier royal suites' and it houses a number of restaurants, boutiques and a travel agency (Bumrungrad International Hospital 2015; CBS n.d.). With all these facilities and services, the hospital aims at attracting international patients, who fly to Bangkok for a hip replacement, an eye sight correction surgery or a nose job. With more than one million patients a year, 580 beds, over 1,200 doctors and 30 specialty centers (Bumrungrad International Hospital 2015), Bumrungrad is more than just one of the largest private hospitals in South East Asia. By providing medical treatment for annually more than 200,000 patients whose main intention for visiting the country is to receive biomedical treatment, the hospital is also a leading institution in the world of transnational health care and is representative of the booming phenomenon of 'medical tourism' on which I will elaborate below.

In the last two decades, an increasing number of medical centers that specialize in treating international patients similar to Bumrungrad have emerged worldwide, primarily in Asian and Latin American countries. More and more people from all over the world visit these destinations for undergoing different kinds of health care procedures – mainly for reasons linked to treatment costs (Milstein and Smith 2006; Mitka 2009; Warf 2010: 57 [Table 3]), quality and access such as reduced waiting times (Eggertson 2006; Sack 2014; Scheper-Hughes 2003). Another reason is engaging in treatments that are illegal or not approved in one's home country or community, like stem cell interventions (Barclay 2009; Enserink 2006: 160f.) or reproductive techniques (Inhorn 2011; Jones and Keith 2006) and the anonymity that may be more convenient for procedures such as sex changes or aesthetic surgery (Connell 2006: 1097).

There has been a significant increase in medical travel in the last decades attributed to developments that make health care treatments abroad more accessible: cheap and frequent air travel, the prevalence of information about medical treatments in distant places, connection between home and destination countries through new telecommunication technologies or the emergence of medical tourism agencies that assist interested patients in

their decisions and travels (Kangas 2010: 349).

While one aspect of overseas medical travel in the twenty-first century is its quantitative increase, the other one is a reversion of the direction of patient flows. Until the end of the twentieth century, patients primarily traveled from developing countries to elite medical centers in the United States and Europe (Bookman and Bookman 2007: 5; Turner 2007: 307). With the turn of the millennium, this direction has been reversed (Carrera and Bridges 2006; Connell 2006: 1094). The United States and other Western countries, once the "centers of the health care universe" (MacReady 2007: 1849), attracted less international patients, as more people started to visit medical facilities in Latin America or Asia. A point of departure for many contemporary medical travel destinations in these regions was a diversification of their economies (Bradley and Kim 1994; Goodrich 1993). Asia is the region that currently dominates the medical travel industry (Connell 2013: 6), the rise of medical travel was triggered by the privatization of the health system and the promotion of international medical health care by national and regional governments in the aftermath of the Asian financial crisis of the late 1990s. While hospitals such as Bumrungrad revised their marketing strategies and started to expand their services for international clients (Turner 2007: 312), different governments also recognized international medical travel's potential for economic development (Pachanee and Wibulpolprasert 2006: 311f.; Turner 2007: 313, 315). In India, the finance minister Jaswant Singh initiated in 2003 different measures to transform the country into a "global health destination" (Chinai and Goswami 2007: 164) that included the development of advanced hospital chains and state of the art technologies, tax concessions and infrastructure subsidies for medical travel providers. Through these measures and national and regional campaigns for medical travel, the country stands in the forefront in the field of medical travel today (Connell 2013: 6; Chinai and Goswami 2007: 164).[165]

Common representations in Western media usually portray international health care

[165] The significance of medical travel can also be seen in the introduction of a specific medical visa for foreign patients in India (Chinai and Goswami 2007). High annual growth rates of medical travel in India (Laing and Weiler 2008: 383) and other Asian countries (Henderson 2003: 114; Reddy, S. [Sunita] and Qadeer 2010: 70) underline this significance. A joint report by the Confederation of Indian Industry and the management consulting firm McKinsey & Company in 2002 predicts that India's profit through medical travel is US$ 2.2 billion per year by 2012 and the industry in Asia as a whole would be worth US$ 4 billion at that point (Confederation of Indian Industry and McKinsey & Company 2002). The total numbers, both of patients and revenues, sound impressive. In 2004, India received 150,000 international patients (Connell 2006: 1096). While impressive at face value, these numbers should be interpreted with caution since they lack reliability (Connell 2006: 1096, 2013: 2; Lunt and Carrera 2010: 29). One reason for the unreliability of numerical data is the absence of authoritative data and numbers of patients and revenues often rest on industry sources and national estimates and are usually inflated for marketing purposes (Connell 2013: 2, 5; Lunt and Carrera 2010: 29). Definitional imprecision also adds to the challenge, especially in the usage of the term 'international patients' (Connell 2013: 5f.).

travel as combining elements of health care and holidays: you travel to India, have a surgery, recover on the beach, visit some temples and fly back. Indeed, several touristic aspects are involved in this form of 'medical tourism,' as this phenomenon is generally labeled in the media and in most academic publications: Hospitals specializing in international patients resemble luxury hotels (Bookman and Bookman 2007: 91) and treatments can be booked through special companies resembling travel agencies (Turner 2007: 306). However, due to an absence of data, it is not clear how many patients do indeed engage in common tourist activities and if patients consider themselves as tourists and their trip as vacation (Connell 2013: 9). For example, it is questionable if someone flying to Thailand for a cardiac bypass surgery would equate this journey to a holiday trip or find it as pleasant as an annual beach holiday in Spain. Connell also argues that "[c]ertain conditions exist where any sense of tourism (associated with pleasure, frivolity, relaxation or education) is nonsense, with patients so weak or incapacitated afterwards that any semblance of tourism is impossible and the notion would be regarded as demeaning" (2013: 3). This also includes all cases of desperate patients traveling to other countries for access to health care that is limited in their home countries, which represent a major part in international medical travel (see e.g. Kangas 2010: 344-347). Those medical journeys generally involve other emotions and feelings than those usually associated with holidays.

Many people traveling for health care reside in developing countries. According to the International Wellness and Healthcare Travel Association, in 2010 at least 19 percent of people visiting India for medical treatment came from other South Asian countries, 43 percent from the Middle East and Afghanistan and 22 percent were Non-Resident Indians and second-generation overseas Indians from different parts of the world, while only a small percentage were Europeans and North Americans (Connell 2013: 4, quoting International Wellness and Healthcare Travel Association 2010). Migrants returning to their home countries represent a significant proportion in medical travel. Diasporic patients also contribute to one widespread form of medical travel that is often overlooked in popular or scientific discussions of medical tourism: cross-border medical travel, which implies similar facilities and lower travel costs (Connell 2013: 3f., 8).

Thus, most forms of traveling for health care do not fit the widespread notion of medical tourism of people from industrial nations traveling to distant destinations in developing countries for medical treatment in a tourist environment. Consequently, the term 'medical tourism' so widely used in both public and academic discourse although lacking of a standard definition (Connell 2013: 2, 5), has recently been criticized and alternative terms

have been coined.[166] Kangas suggests the "neutral" terms "medical travel," "medical care abroad" or "treatment abroad" and "medical or therapeutic journeys" (2010: 353). These terms are more adequate for capturing the above mentioned forms of traveling for medical treatment than 'medical tourism.' However, they are not comprehensive enough to cover all existing forms of traveling for health care, since people do not only travel to ***hospitals*** for biomedical interventions, but also visit spas, ashrams, spiritual retreat centers, massage parlors or leisure centers to maintain or enhance their health status – and, not least, resorts such as Ayuresort where wellness and healing, vacation and health care, overlap and cannot be looked at separately.

Journeys to destinations such as Ayuresort are usually labeled as 'health tourism' in lay and scientific discourse, focusing on general health and wellbeing and emphasizing the absence of (bio-)medical, therapeutic interventions as in 'medical travel' or 'medical tourism' (see e.g. Henderson 2003: 113; Turner 2007: 308).[167] While the term 'tourism' is equally problematic in this context – although maybe less than in the case of medical tourism as treatments in resorts or leisure centers often comprise holiday aspects, as I will show below for the case of Ayuresort –, I endorse the term 'health tourism' or better 'health-related travel' since it can comprise both, those travels for health care that do involve (bio-)medical interventions and those to non-medical facilities other than hospitals that do not.

Coming back to the practice itself, journeys that may be subsumed under 'health-related travel' are much older than trips such as Hannah's to treat her migraine and improve her general wellbeing in a holiday atmosphere. To underline this point, I will trace below the history of health-related travel and the formation of spas in the West. Two of the oldest health-related travel destinations in Europe include Lourdes in France and Fatima in Portugal that have been visited by pilgrims seeking cure for several centuries (Kangas 2010: 349). But even before that, Romans traveled to consult oracles in Delphi (Greece) or Claros (Asia Minor) during the Augustan Age (Smith and Puczkó 2009a: 22). In ancient Greece, people visited the sanctuary of the healing deity Asclepius in Epidauria, who disclosed them remedies in their dreams (Bookman and Bookman 2007: 4f.). In Europe, the history of medical travel is closely interconnected with water-based treatments with sea, thermal

166 For instance, Arnold Milstein and Mark Smith refer to American patients seeking medical treatment abroad as 'refugees' (Milstein and Smith 2006). However, this term implies life-threatening conditions in the patients' home countries. Roberto Matorras (2005) and Marcia Inhorn and Pasquale Patrizio (2009) suggest the term '(reproductive) exile' in the context of transnational travel for reproductive medicine. However, the term is considered inadequate by other scholars (Pennings 2005: 3571; Kangas 2010: 353).

167 Some authors oppose health tourism to medical tourism due to this reason (see e.g. Carrera and Bridges 2006: 449), whereas for others medical tourism is a subset of health tourism (see e.g. Laing and Weiler 2008: 380; Smith and Puczkó 2009b: 7 [Figure 1.2]).

and mineral water being attributed health-promoting characteristics. As those waters were thought to lose their therapeutic efficacy if moved to another place, people traveled to them (Weisz 2011: 138). The foundation for such travels aiming at 'taking the waters' in form of bathing and drinking was laid by the Ancient Romans, who traveled to seaside resorts and healing springs and who established baths around thermal and mineral springs throughout the Roman provinces, including in those places that should later become the most popular destinations for people seeking water-based treatments, such as Bath (England), Spa (Belgium) or Baden-Baden (Germany) (Cook 2008: 3; Smith and Puczkó 2009a: 22, 25). The Roman *thermae* were complex bathing installations that were a substantial element of every city and open to everyone who could afford the entrance fee (Wood 2004: 32). As they also included rooms for social gatherings, libraries and even theaters (Nahrstedt 2004b: 42; Wood 2004: 32), the *thermae* were more than simple bathing facilities. They represented social spaces for therapeutic treatments, leisure activities and social interaction (Hembry 1990: 20; Smith and Puczkó 2009a: 25). However, with the decline of the Roman Empire, the Roman bathing culture perished (Hembry 1990: 1; Wood 2004: 28, 34). Although the practice of bathing did not completely die out,[168] curative bathing started to regain wider popularity again only from the fourteenth century on (Hembry 1990: 2; Smith and Puczkó 2009a: 25). In the fifteenth century, thermal bathing establishments spread rapidly and were popular destinations for both nobility and burghers who bathed together in communal basins. Though the major reason for visiting these baths was curative, amusement and dissoluteness played also an important role (Wood 2004: 35f.).

The early modern period witnessed a further increase in visits to mineral baths (Bleile 1985: 9). 'Taking the waters' became fashionable among the English royalty and nobility, who went on long journeys to popular bath destinations (Hembry 1990: 2f.; Smith and Puczkó 2009a: 25). In Italy, several baths were established and in 1553 the first European Spa Directory was published in Venice listing over 200 spas (Smith and Puczkó 2009a: 23). In the last decades of the sixteenth century, baths were promoted all over France, after the therapeutic potential of mineral waters had been recognized by major parts of the court, aristocracy and urban elite (Brockliss 1990: 23, 25). By the turn to the seventeenth century, in England a regime for the water cure had been designed with instructions of leading physicians and under noble patronage (Hembry 1990: 20). In the mid-seventeenth century,

[168] Some Roman bathing complexes survived and were used together with steam bath huts during the Middle Ages, presumably primarily by the local population for pleasurable diversion and relaxation (Maretzki 1987: 1063; Maretzki and Seidler 1985: 395). Also single springs were still visited for both religious and healing purposes, as for instance different wells dedicated to saints in England (Hembry 1990: 1).

the mineral and chemical properties of healing waters, together with their effects on both bathing and drinking, were studied and many European kings and queens encouraged the visiting of baths (Smith and Puczkó 2009a: 23). They represented communal facilities that were visited by locals and travelers as well as by members of all social classes (Brockliss 1990: 36; Hembry 1990: 20; Wood 2004: 38). While these baths were generally used for therapeutic treatment, and many visitors were in poor health (Brockliss 1990: 39), they also offered social contacts and even epicurean experiences, such as good food and drink or sexual adventures (Maretzki and Seidler 1985: 395). By the end of the seventeenth century however, communal bathing tubs disappeared. Due to the spread of syphilis and an increased sense of shame concerning nudity, bathing was shifted to individual cabinets or avoided completely, especially by the social upper classes. During this time, spa culture underwent two major changes. Instead of bathing in communal basins, drinking the healing waters came into fashion.

But more important for my argument, leisure activities at the spa began to be considered not as supplementary to the cure, but as therapeutic element of the healing process (Wood 2004: 36f.). As the century progressed, an increasing number of middle-class guests joined the nobility and gentry at the spas, as curative and health-promoting benefits of spa treatments were widely promoted and acknowledged by the educated public (Wood 2004: 40f.). Medical practice in Europe was strongly influenced by Galenic humoral theory at that time, and both practitioners and laypeople considered water as permeating the body and improving the humoral balance (LaFauci 2011: 9). While the medical value drew many visitors to spas, entertainment in form of social interaction, dining, casino gambling, ballroom dancing, promenading or theater watching was presumably equally important for the guests' decision to travel to a spa in the eighteenth century (Bastos 2011: 41; Steward 2002: 23; Wood 2004: 2, 41). Spas were not only medical establishments but simultaneously centers of social, cultural and political life, where physical ailments were treated, cultural events were attended, and business and political deals were made (Mlejnková 2004: 60f.).

In the wake of the French Revolution, the aristocratic characteristics of the spas were replaced by those of commercial enterprises and supported by state sponsorship and government policies (Steward 2002: 28; Wood 2004: 44). The nineteenth century was the period of the greatest popularity of 'taking the waters' in continental Europe (Gojcic and Rumbak 2005: 73; Speier 2011: 56; Steward 2002: 24; Wood 2004: 46). This expansion of water cures was strongly influenced by forms of water-based treatment becoming part of medical science in different parts of Europe (Claridge 1842: 60; Steward 2002: 29).

Water-based treatments were part of the emerging scientific discipline of 'hydrotherapy,' which started to become a respected branch of medicine at the end of the nineteenth century in continental Europe. With the institutionalization of water cures, water-based facilities and practices became more medicalized and water-based treatments had to be conducted and supervised by qualified physicians (Bastos 2011: 39; Steward 2002: 28). The ailments patients wanted to treat were manifold, including rheumatic, circulatory, digestive, respiratory, dermatological, menstrual-related and nervous diseases (Bastos 2011: 43; Weisz 2001: 455).

Although the focus was put on medical treatments in nineteenth-century spas, the leisure component already existing in the preceding centuries remained. Especially the more fashionable spas provided a great variety of entertainment in forms of theaters, casinos and ballrooms (Bastos 2011: 42; Weisz 2001: 455-457). Medicine and leisure were intertwined during these "disciplined, medically-supervised vacations" (Bastos 2011: 50; see also Mackaman 1998: 10; Maretzki 1987: 1064; Weisz 2011: 138), which eventually resulted in the development of extended tourist infrastructure in spa towns (Minghetti and Furlan 2006: 156; Speier 2011: 56).

While the historical development of the spa, as an institution, was similar across different European regions over the preceding centuries, the beginning of the twentieth century witnessed its diversification, which eventually formed the institution of the *Kur* in German-speaking countries. The emergence of many new medicines and therapies, together with the authoritative nature of random clinical trials for testing clinical efficacy, challenged spa treatments. While the medical spa continued to exist in many parts of mainland Europe, it virtually died out in the United Kingdom (Weisz 2001: 452).[169] Meanwhile, the industry flourished in many parts of continental Europe, primarily in Germany, France and the countries that formerly comprised the Austro-Hungarian Empire. While state-managed German capitalism provided a favorable environment for spas in Germany, market-oriented Anglo-Saxon capitalism hindered the development of English spas for being predominantly private (Bacon 1997). Governmental protection and promotion of the spa industry manifested for instance in financial support of spa treatments through governmental subsidies or public health insurance coverings in various European nations. Overall, continental Europe's

[169] The same development took place in the United States, where spas for mineral water treatments had been established especially in the nineteenth and early twentieth century, although less pronounced than in Europe (see e.g. Křížek 1990: 218f.; LaFauci 2011; Maretzki and Seidler 1985: 413; Smith and Puczkó 2009a: 23). However, most of those spas have disappeared in the twentieth century (Weisz 2001: 452), and today the term 'spa' is used in the United States – and in the English-speaking world in general – for places that provide diet and exercise regimens, cosmetic treatments or massages instead of water-based therapy and which rather have a pampering than a medical connotation.

position, then and now, differs significantly from (medical) institutional perceptions in the Anglo-American world. In the case of the former, the very institutionalization within medical science made a huge difference for its continued popular appeal. In many European countries, spa therapy became part of mainstream medical practice (Weisz 1995, 2001, 2011). After World War I the institutional environment of spa therapy expended rapidly in continental Europe, including Germany (Weisz 2001: 463f., 477, 2011: 142; Quintela 2011: 25f., 34 [endnote 7]). While in large parts of continental Europe medical hydrology, balneology (the study of the therapeutic value of natural remedies, predominantly mineral springs) and climatology became part of conventional medicine and even evolved into the specialty of spa medicine (Naraindas and Bastos 2011: 1), in the Anglo-American world spa treatments were excluded from the realm of biomedicine and became part of alternative medicine. Britain and the United States saw the de-medicalization of spas as there was little support from the medical elites for spa therapy, who considered spas as places of tourism and even charlatanism (Maretzki 1989: 23; Weisz 2001: 453, 2011: 139, 141).

A further reason for the different development of the spa industry between continental Europe and the Anglo-American world is the governmental support of spa therapy through reimbursements of its costs by the health insurance system in various European countries.[170] The mid 1970s saw the peak of spa treatment in continental Europe, when spas were "caught in a web of science, medicine and socialised insurance" (Naraindas and Bastos 2011: 3). It is worth noting that while the amount of spa visits that were covered by the national health insurance systems decreased, by the end of the twentieth century the majority of visits were still subsidized at least to some extent in many countries on the European Continent (Puczkó and Bachvarov 2006: 87; Weisz 2001: 451f.). By contrast, no visits of spas in Britain in the same year were reimbursed by the National Health Service (Weisz 2001: 452).

Today, spas in mainland Europe are continued to be attended for both therapeutic and recreational reasons, be it in Slovenia (Gojcic and Rumbak 2005: 75), Italy (Ferrari 2009: 311f.), Portugal (Quintela 2011: 32) or the Czech Republic (Speier 2011: 57, 59). Patients seek spa treatments for illness prevention and rehabilitation measures as well as for treating specific ailments such as rheumatic pains, kidney disorders and different chronic conditions, with a focus often on symptom relief rather than on cure.[171] Spa visits usually take between two and four weeks and involve an intensive and austere regimen comprising water-based

170 See e.g. Bleile 1985: 9; Frost 2004: 85; Gojcic and Rumbak 2005: 74; Maretzki and Seidler 1985: 408; Mlejnková 2004: 61; Nahrstedt 2004a: 191; Puczkó and Bachvarov 2006: 87; Speier 2011: 56; Weisz 2011: 142.

171 See Maretzki 1987: 1062-1066; Maretzki 1989: 25; Maretzki and Seidler 1985: 395; Nahrstedt 2004a: 191; Naraindas 2011a: 70; Naraindas and Bastos 2011: 2; Speier 2011: 57, 59; Weisz 2011: 139.

therapies and other treatments prescribed individually by the spa physician, including acupuncture, fitness training, massage therapy and herbal medicines.[172] At the same time, spas are not only visited for their medical services but also for pleasure and recreation. Medical and sybaritic elements are blended in two ways: first, people visiting spas for therapeutic reasons often also look for relaxation (see e.g. Quintela 2011: 32); second: spas represent spaces where patients looking for health care meet guests or tourists who seek exclusively recreation and amusement (see e.g. Speier 2011).

The second aspect, the blending of tourism and health care as in health-related travel discussed above, is part of a recent and growing phenomenon. In the last 20 years, one could observe a shift from therapeutic and convalescent treatments to applications for relaxation and wellbeing in European spas. This "movement from 'medicine' to 'wellness' " (Naraindas 2011a: 69) primarily results from a cutback in the funding of spa visits (Nahrstedt 2004a: 182; Naraindas and Bastos 2011: 3; Weisz 2011: 142). With the collapse of socialism in Central and Eastern Europe and the shrinking of the welfare state in Western Europe, the spa industry moved from the public health system to the private (health) tourism industry. Other therapies were considered to work faster and more effectively and the requirement to prove spa treatments' therapeutic efficacy through double-blind randomized clinical trials contributed to a changing attitude (Weisz 2011: 142f.). The reduced financial support of spa treatments resulted in a decline of people visiting the spas. Some spas resorted therefore to different forms of alternative medicine for which clinical trials were not needed for demonstrating efficacy, while others added wellness and cosmetic applications to their medical treatments (Weisz 2011: 142). Through the incorporation of pleasure, cosmetic and relaxation elements and in the context of the globally increasing leisure and wellness-based health orientation (Nahrstedt 2004a: 182), spa treatment in Europe was partially transformed into a "trendy consumer product" (Naraindas and Bastos 2011: 3) and spas underwent a "de-medicalization" (Bastos 2011: 48).[173] Today, most spas offer treatments that emphasize relaxation, fitness and beauty in order to attract not only ill patients but also healthy tourists.

Contemporary spas are situated within spaces of healing and tourism composed of treatment and recreational facilities, hotels, souvenir shops and restaurants. Spa visits are booked by the guests on the internet like any other vacation trip (Speier 2011: 59). And spas run promotional campaigns for attracting tourists from all over the world, in which

---

172 See e.g. Maretzki 1987: 1066; Maretzki 1989: 25, 29f.; Maretzki and Seidler 1985: 396, 408; Naraindas 2011a: 70, 80; Speier 2011: 56, 61, 63; Weisz 2001: 483 [Footnote 75].

173 See Bastos 2011: 49f.; Ferrari 2009: 312; Gojcic and Rumbak 2005: 77-81; Speier 2011: 62ff. for case studies.

they advertise themselves as places not only for healing, symptom relief, rehabilitation and illness prevention but particularly for recreation, relaxation, pleasure and vacation. As a result, spas are attended by different 'types' of guests, namely "patient tourists" (Speier 2011: 60) or "patient vacationers" (Naraindas 2011a: 69) who look for health-related treatments accompanied by vacation elements, and "disbelieving tourists" (Speier 2011: 61) or "vacationer patients" (Naraindas 2011a: 69) who look for recreation and not for preventive or therapeutic treatment. The latter are mostly British and American guests, who have little to no experience with the 'traditional European spa' and do not expect the medical aspects that characterize these spas. Through the long and still existing tradition of the therapeutic spa in continental Europe on the other side, many guests from this region are equipped with a proper "spa etiquette" (Naraindas 2011a: 69) and are familiar with medical spa practice. They perceive spas as having a therapeutic or at least rehabilitative or illness preventive character. For surviving in the competitive tourism industry though, spas cannot afford to host only guests who "know what to do here at the spa" (Speier 2011: 62), but must also adapt to the desires and expectations of their new clientele (see e.g. Speier 2011: 61ff.). This eventually results in the described de-medicalization of the traditional European spa.

A major group of those guests with a 'spa-etiquette' are Germans, who nowadays are the "most active spa visitors in the world" (Nahrstedt 2004a: 192).[174] Together with the amount of visitors, the number of ***Heilbäder*** (spas or therapeutic baths) and ***Kurorte*** (spa towns or places of curing) in Germany has risen over the last decades[175] and approximately 20 percent of all European spas are currently located in Germany (ibid).[176] A ***Kur***,[177] as spa treatment is called in Germany and other German-speaking regions, is described by the Deutscher Heilbäderverband (German Spa Association) as being conducted by qualified physicians and as involving individual therapy schedules, "remedial and wellness treatments [...] using natural local remedies," "healthy food," a peaceful and beautiful environment

174 The number of guests at German spas has been increasing exponentially. While in 1963, 3.2 million people went to to German spas (Bleile 1985: 10, quoting Deutscher Bäderverband 1983), in 1981 6.1 million (Bleile 1985: 10, quoting Deutscher Bäderverband 1983) and in 1994 ten million, in 2013 German spa towns saw 22.7 million guests (Deutscher Heilbäderverband n.d.c).

175 The amount of *Kurorte* and *Heilbäder* recognized by the Deutscher Heilbäderverband (German Therapeutic Baths Association) increased from 258 in 1983 (Bleile 1985: 10, quoting Deutscher Bäderverband 1983) to 318 in 1995 (Nahrstedt 2004a: 193 [table 12.1], quoting European Spas Association 1995) to over 350 today (Bundesministerium für Wirtschaft und Technologie 2011).

176 Their accreditation as official *Heilbad* or *Kurort* receive German spas and spa towns through possessing "***natürliche Heilmittel***" (natural remedies) or through offering "***klassische Heilverfahren***" (traditional healing procedures) like Kneipp therapy, and by meeting further requirements set out by specific governmental and regional laws and ordinances as well as quality standards established by the Deutscher Heilbäderverband (Deutscher Heilbäderverband n.d.j).

177 The term '*Kur*' stems from the Latin word '*cura*' (concern, care) and entered the German language at the end of the fifteenth century to mean medical care or treatment (Berlin-Brandenburgische Akademie der Wissenschaften n.d.).

with sea, lakes, mountains, forests or landscaped gardens that "offer plenty of space to relax and to enjoy being active," different recreational activities such as nordic walking, Qi Gong, yoga or painting courses as well as "mental stimulation and *joie de vivre*" in form of concerts, art galleries and museums (Deutscher Heilbäderverband n.d.j). And the Deutscher Heilbäderverband is increasingly committed to attract people for a *Kur*. On its website, the association describes *Kur* as a health-oriented stay at a *Heilbad* or *Kurort* that comprises a wide range of therapeutic means implemented for therapy, prevention or rehabilitation (Deutscher Heilbäderverband n.d.b). A more elaborate definition is provided by Bäderland Deutschland, an online information portal for spa treatment in Germany, according to which *Kur* is

> [...] a complex, medically conducted treatment for prevention and rehabilitation and for selected chronic diseases and complaints [...] within the scope of a necessary, individual, lifelong health program. [...] The term *Kur* comprises a widely ramified system of preventive, curative and rehabilitative treatments, in which the so-called stimulus-response therapy, i.e. the activation of the 'inner doctor' through place-specific *Kur* means, physical treatment and exercise therapy, plays an important role. The change of place, climate and milieu is beneficial both mentally and physically, amongst other things also for illness prevention or for dealing better with an existing disease (Bäderland Deutschland 2015a; original in German).

A *Kur* is usually undertaken away from home in a suitable natural environment that provides the necessary 'stimulants' found in specific climatic conditions, high altitude or ocean air and mineral, thermal and sea waters that influence the "total physio-chemical regulatory system of the human organism" (Maretzki and Seidler 1985: 407; Maretzki 1987: 1062). Through their specialization on particular ailments and their manifold health care offers, the single *Heilbäder* and *Kurorte* turn the German *Kur* system into a complex, diversified and comprehensive health care system, which represents the third leg of the German National Health System, besides the general practitioner and the hospital system (Andritzky 1997: 51; Bleile 1985: 10; Naraindas 2011a: 69).

The foundation for this prominent position was laid with the medicalization and scientific legitimation of German spas in the nineteenth century, which had its roots in the water-based treatments developed by laymen like Vincenz Prießnitz and Sebastian Kneipp. Just as the Kur does today, these treatments were usually combined with other health-oriented practices, such as exercises and diet prescriptions (Maretzki 1989: 25; Maretzki and Seidler 1985: 396f.). By the late nineteenth century, therapeutic bathing cures became popular all over Germany, where they were conducted in spas, sanatoria, clinics and even at home (Maretzki 1987: 1064). Besides the institutionalization of *Kur* treatments within medical science such as in the case of hydrology and balneology, a range of political decisions helped the *Kur* system to obtain a prominent status in the German health system. While the

introduction of a cure tax by the German government 1893 secured spas necessary resources (Weisz 2001: 461), Chancellor Otto von Bismarck's social welfare policies represented a major foundation for the growth of the *Kur* system. The liberal social legislation included the Health Insurance Bill passed in 1883 to provide health care for most German workers and also covered *Kur* treatments (Maretzki 1989: 25). However, it took about half a century until the *Kur* had its great breakthrough in the (West) German medical landscape. Through new expansions of social legislation, particularly with the Pension Reform of 1957, the *Kur* became part of a comprehensive medical prevention and rehabilitation program funded by social insurance (Bleile 1985: 10; Maretzki 1987: 1065). As a result, numerous new *Kurorte* and *Heilbäder* emerged and many communities sought official recognition by the Deutscher Bäderverband[178] as *Heilbad* or *Kurort* (Maretzki 1987: 1062, 1066, 1989: 25f.).

After the *Kur* system grew considerably in the 1950s and 1960s, it experienced a crisis in the following two decades. In the post-war recession years of 1974 and 1975, the number of applications for *Kur* treatments decreased and the amount of applications granted but not utilized increased due to social and financial insecurities among the population. In the wake of the economic crisis, new health and pension insurance laws were passed by the German government (in 1977 and 1981). Consequently, *Kur* applications were only approved by the pension scheme provider when a considerable threat of working capacity existed, which meant the extinction of preventive *Kur* treatments. The early 1980s would see the peak of the post-war crisis of *Kurorte* and *Heilbäder*, when the fall in demand was reinforced by the fiscal austerity measures of the German government and the insurance providers so that many spas and spa towns faced severe financial difficulties (Bleile 1985: 11-13).

After this brief period of economic hardship for German *Kurorte* and *Heilbäder*, the state funding of *Kur* therapy did rise again from 1984 on, together with its utilization by the German population (Maretzki 1989: 26). A significant reason for this development was the efficacy and interconnected savings potential of *Kur* therapy. Important for the renewed economic and political support of *Kur* therapy were scientific studies of the working mechanisms and efficacy of *Kur* treatments partly commissioned by insurance companies (Maretzki and Seidler 1985: 411). Such studies provided the *Kur* with cultural authority, political and economic legitimacy and scientific respectability (ibid).

Another major reason for the revived public support of *Kur* therapy – and the *Kur*'s continuity in West Germany in comparison to other regions – was its inclusion in German mainstream medicine. By the end of the 1980s, the *Kur* had established its position

[178] The former name of today's Deutscher Heilbäderverband.

within institutionalized biomedicine. *Kur* therapy was part of the German medical field of '*Physikalische Medizin*' (physical medicine) (Maretzki and Seidler 1985: 400), institutes of balneology existed in most universities with medical schools (Maretzki 1989: 27), and physicians could qualify as *Badeärzte* or *Kurärzte* (bath or spa physicians).[179] But although being official elements of biomedical practice and education, the *Kurarzt/Badearzt* was generally considered as less prestigious than other medical specializations, balneology institutes rated low in medical research hierarchy and *Kur* therapy was situated on the margins of biomedicine (Maretzki 1989: 27).

However, despite its marginal position within institutionalized biomedicine, *Kur* therapy remained a part of the German national health and welfare systems. Patients were generally sent to a *Kur* covered by social insurance through a referral by a general practitioner, when the latter and a medical consultant for the insurance carrier stipulated that the therapy promised to restore the worker's earning capacity or to ease chronic complaints in the case of retired persons. The four to six week long insurance-subsidized[180] *Kur* could be accessed once every three years (Maretzki 1989: 28; Maretzki and Seidler 1985: 408). It was predominantly utilized by older individuals (Maretzki 1987: 1066).[181]

In the last decade of the twentieth century, political and financial support of *Kur* abated again. In the course of the *Gesundheitsreform* (health care reform) of 1996, the *Beitragsentlastungsgesetz* (contribution relief act) was passed, which prompted cuts in several health care benefits, including the support of *Kur* therapy.[182] As a result, the number of *Kur* visits covered by pension and health insurance in 1997 dropped by a third and in the following years about 40 percent of *Kur* clinics and hospitals had to be closed (Nahrstedt 2004a: 194, 2004b: 42; Weisz 2001: 484 [Footnote 75]).

The reduction of governmental financial support by the turn of the new millennium transformed *Kur* therapy into a mélange of rehabilitative, preventive and wellness treatments. In the year 2000, the word '*Kur*' was erased from the Social Security Code and replaced by the legal term '*Präventions- oder Rehabilitationsmaßnahmen in anerkannten Heilbädern*

179 Today, physicians can obtain the additional qualification in '*Physikalische Therapie und Balneologie*' (Physical Therapy and Balneology) (Verband Deutscher Badeärzte 2016). About 450 physicians with this specialization were registered with the Verband Deutscher Badeärzte (Association of German Bath Physicians) in 2015 (Deutscher Heilbäderverband n.d.a).

180 The insurance covered 90 percent of all expenses. The remaining costs, usually around DM 500 (ca. US$ 300 at that time), had to be paid by the patient (Maretzki 1989: 28).

181 People under 40 years attended the *Kur* mainly for rehabilitation after an accident or for treating a serious or chronic disease in those days (Maretzki 1987: 1066).

182 The deterrent fee was raised (AOK-Bundesverband n.d.) and the length and interval of reimbursed therapies was reduced. Visits were covered only every four instead of three years, and only for three to five weeks rather than four to six (Nahrstedt 2004a: 194; Weisz 2001: 483 [Footnote 75]).

und Kurorten' (preventive or rehabilitative measures in recognized spas and spa towns) (Kirschner 2015).[183] The new denomination refers on the one hand (rehabilitation) to the restoration of a person's somatic, mental and social function after an illness or accident, during a chronic condition or in the course of a permanent handicap following a disease. On the other hand (prevention), it relates to strengthening debilitated forces, functions and abilities and to developing protective factors (Kirschner 2015). A third aspect of the new *Kur* therapy, described by Naraindas as the "recreational side" of the contemporary *Kur* in comparison to the medical side of rehabilitation and prevention (2011a: 70), is wellness services. Although not part of the official designation, the importance of this component manifests in the existence of the seal of quality '*Wellness im Kurort*' (wellness in spa town) as one of four quality control stamps issued by the Deutscher Heilbäderverband, the other three being '*Die Kur*' (the *Kur*), '*Prävention im Kurort*' (prevention in spa town) and '*Park im Kurort*' (park in spa town) (Deutscher Heilbäderverband n.d.g; see also Naraindas 2011a: 70).

With the struggles for survival of the *Kur* clinics and hospitals, the latter adjusted their health care offerings in order to win back guests (Bundesministerium für Wirtschaft und Technologie 2011: 7). As in other European countries described above, spas in Germany entered the global wellness-based health market in the 1990s and developed new offers for self-paying guests (see e.g. Nahrstedt 2004a: 194). The new focus on preventive, wellness and relaxation rather than curative treatments is also made evident by the content of the Deutscher Heilbäderverband website that acts as an information portal for people interested in undergoing a *Kur* in Germany. "Prevention services" are advertised as follows:

> When you notice your body's batteries getting weaker, or you're not feeling really fit, or an illness is underway – this may be the best time to shift down a gear and **do something good for yourself!** [...] These preventative services are characterised by their **wholistic treatment philosophy** and naturopathic healing remedies and remedial methods. Your state of health is improved and you'll feel fit to take on all your daily challenges again (Deutscher Heilbäderverband n.d.e; emphases in original).

The "wholistic treatment philosophy" is further specified with the explanation that the treatment comprises "exercise, nutrition and relaxation" (Deutscher Heilbäderverband n.d.e). "Wellness services" are described as being beneficial for your "health and wellbeing" and as "mak[ing] you feel good" (Deutscher Heilbäderverband n.d.i). The Deutscher Heilbäderverband further promises the visitor of its website "a distinguished level of relaxation and recuperation" at those centers awarded with its quality seal '*Die Kur*' (Deutscher Heilbäderverband n.d.g). And *Heilbäder* keep these promises by offering wellness

183 Although the term has been deleted from the official lexicon for social insurance, it is still alive in general linguistic usage. Both lay people, most of whom are not even aware about its abolishment, and *Kur* providers or associations (e.g. the Deutscher Heilbäderverband) usually use the term '*Kur*' when referring to spa therapy (see also Naraindas and Bastos 2011: 4).

packages such as 'a weekend for your senses,' an anthroposophically oriented cosmetic treatment or a '7-days-I-treat-myself' package (Andritzky 1997: 52; original in German). Massages, cosmetic treatments, meditation classes, different relaxation techniques, sauna, solarium, fitness training and aroma baths are only a random selection of wellness offers provided by various *Heilbäder* (Körber 2002: 85-105), which are constantly growing. Wellness treatments have become a vital part of the contemporary *Kur* landscape.[184] Focusing on recreation and relaxation, they are not only offered for indulgence and as leisure activities, but also justified with their alleged health-promoting character and potential to increase overall life quality, vital forces and fitness (Kirschner 2015). With this shift of focus from cure to prevention and wellness, *Kur* therapy today represents a comprehensive health-oriented form of health care and distinguishes itself from most biomedical fields with their disease-oriented approach.

However, despite a general development of Western health care towards a comprehensive preventive health-oriented medicine (Kirschner 2015), health insurance and the pension fund usually only cover curative and rehabilitative treatments (Deutscher Heilbäderverband n.d.k; Kirschner 2015).[185] Thus, most guests today follow the suggestion of the Deutscher Heilbäderverband on its website to "simply choose any treatment in consultation with the resort physician and pay as you go" (Deutscher Heilbäderverband n.d.k) in their aspiration to actively maintain their health status, prevent illness and 'do something good for themselves,' which results in the still existing – and even growing – popularity of the *Kur* in Germany. However, those self-paid treatments do not only differ by their length from government-funded therapies but also by their nature, as they generally focus more on wellness aspects like relaxation or cosmetic treatments. Accordingly, the German *Kur* today represents a conglomerate of different 'types' of guests with different motivations for using diverse treatments which are individually prescribed or chosen.

The official categorization of *Kur* therapy comprises two forms: *Vorsorge-Kur* or *Präventionskur* (*Kur* for prevention) for "people who are fundamentally symptom-free and would

[184] As a result, the neologism '*Wellness-Kur*' (as a complement to the neologism '*Reha-Kur*') has emerged (Naraindas 2011a: 70, 82).

[185] In order to be covered by social insurance, *Kur* treatments have to be either directly arranged by a hospital as after-treatment, or be prescribed by a general practitioner or specialist after all therapeutic options have been exhausted. They must be approved by the insurance provider (Deutscher Heilbäderverband n.d.h; Naraindas 2011a: 70). In 2013, about two million *Kur* therapies in Germany were subsidized by health insurance companies or the pension fund (Deutscher Heilbäderverband n.d.d). Since 22.7 million people visited German *Kurorte* and *Heilbäder* in the same year (Deutscher Heilbäderverband n.d.c), the majority of the guests paid for their treatments out of pocket. Although the number of 22.7 million guests does not refer to the actual number of people having experienced *Kur* treatments but to the amount of guests stayed in a *Kurort*, it can be assumed that many of them also underwent *Kur* treatments.

like to stay that way" and *Rehabilitationskur* or *Kur zur Rehabilitation* (*Kur* for rehabilitation) for "recovery from a disabling symptom" (Deutscher Heilbäderverband n.d.k). Both therapies are either residential or non-residential, where the guest or patient resides in a hotel outside the spa (Deutscher Heilbäderverband n.d.k). Both *Vorsorge-Kur* and *Rehabilitationskur* are characterized by specific treatment modalities and nonspecifically acting general therapeutics with special properties. The latter comprise natural healing resources such as water, soil, air, landscape and climate, exclusion of stress, noise and air pollution, a healthy diet, exercise and rest (Andritzky 1997: 51; Kirschner 2015). The range of *Heilbad* and *Kurort* specific therapies has been expanded in the last decades, provoked by the decline in governmental financial support and the therapeutic pluralism that characterizes the German National Health System (Naraindas and Bastos 2011: 3). In addition to 'traditional' climate-, air-, balneo- and hydrotherapy, procedures include kinesiatrics, relaxation therapies and physical therapies such as thermotherapy and massages, but also homeopathy, acupuncture, yoga, meditation, tai chi, shiatsu massage, ozone therapy, colon-hydro therapy for intestine detoxification or therapeutic fasting. Besides those treatment forms, the specific impact factors also include health education and specific diets (Andritzky 1997: 51f.; Bäderland Deutschland 2015b; Kirschner 2015).

While several elements of this eclectic therapeutic panoply that draws from diverse healing traditions have been added to the therapeutic repertoire of the *Kur* in the course of its reconfiguration as well as the transnational transfer of different medical practices, the *Kur* has already been an "elaborate and eclectic therapy system" (Maretzki and Seidler 1985: 408) in the 1980s (and certainly also before). Contemporary *Kur* still represents a complex therapy that includes a regimented, individualized treatment plan that comprises specific pleasant and unpleasant applications, environmental stimuli, a restricted diet, exercise programs and periods of rest and relaxation (see e.g. Deutscher Heilbäderverband 2001). People visit spas for a wide range of primarily chronic illnesses, such as digestive and metabolic disorders or urologic diseases, and for post-operation rehabilitation (Speier 2011: 57, 59-61; Maretzki 1987: 1065). The Deutscher Bäderkalender of 2001 recommends *Kur* therapy further for major clinical pictures: cardiovascular diseases, musculoskeletal complaints, respiratory problems, gynecological diseases, gastrointestinal disorders, urinary tract complaints, skin and eye diseases, neurological disorders, general debility, amongst other ailments (Deutscher Heilbäderverband 2001: 13). However, recreation and diversion through different leisure activities within pleasant and natural surroundings represent also an inherent part of the Kur (Maretzki and Seidler 1985: 409). As mentioned above, spas

offer short-term and long-term packages, that "promise them [the guests] an overall 'health, wellness, medicine, beauty and fitness' regimen" and that "emphasize active relaxation and leisure" (Speier 2011: 61; addition by the author). Guests whose primary intentions are not (only) recreation and wellness also enjoy the fruits of the latter, which are part of all *Kur* therapies independent of their aim and represent the counterbalance to the disciplined behavior and austerity that the strict regimen implies.

With leisure time and various sporting and cultural activities in addition to the therapeutic repertoire being a vital part of the *Kur*, it represents a health care complex situated at the intersection of medical treatment and vacation. While it involves a vital medical constituent, the *Kur* also revolves around vacation and tourism elements, be it recreational practice, environmental change, various activities such as sight-seeing or attending local cultural events, or the mere fact of spending time in a tourist setting away from home and work. Spa visitors, usually called guest (*Kurgast*) and not patient, look for a combination of health care treatment and vacation (Maretzki 1989: 32f.; Speier 2011: 60), for which already several decades ago the term '*Kurlaub*,' composed by the words '*Kur*' and '*Urlaub*' (vacation) was coined (Maretzki and Seidler 1985: 409).

Its embedding in tourist infrastructure and institutional connection with tourism organizations further strengthens the *Kur*'s linkage with tourism and vacation. As described above, many *Heilbäder* could only survive the cuts in governmental financial supports by redirecting their offers towards new practices and clients and positioning themselves on the global tourism market. *Kurorte* have become"prime-rated touristic product[s]" to satisfy the guests' demands, who attach importance to the existence of attractive leisure activities and a certain "vacation atmosphere" (Körber 2002: 53). The connection between *Kur* treatment and vacation also manifests in the close cooperation between the Deutscher Heilbäderverband and the Deutsche Zentrale für Tourismus (German National Tourist Board).[186]

Clearly, the connection between *Kur* and 'health tourism' is a common association.[187] In the same way represent Ayurvedic resorts a component of Kerala's and the global (health) tourism industry, as they are equally situated at the intersection of health care and holidays. In addition, the blending of therapeutic, preventive and wellness treatment cannot be found only in the *Kur* but also in Ayurvedic resorts. Those and other similarities between the *Kur*

[186] A national marketing organization promoting tourism in Germany in cooperation with the German government (Deutscher Heilbäderverband n.d.f).

[187] See e.g. Bundesministerium für Wirtschaft und Technologie 2011: 7; Deutscher Heilbäderverband n.d.f; Nahrstedt 2004b: 37; Speier 2011: 61; Weisz 2001: 452.

and resort practice, together with the long tradition and prominent position of the *Kur* in the German National Health System, transforms the latter into a new transnational form of the *Kur* at the intersection of therapy and wellness and health care and holidays, as I argue in the following section.

I start the section with a presentation of the embedding of Ayurvedic resorts in the (health) tourism industry and the resulting influence of the Keralan government, travel agencies and the resorts' location in a tourist destination on Ayurvedic practice. I then discuss the common focus of *Kur* and resort practice on improving general wellbeing and illness prevention while combining medical and wellness aspects. I claim those and other similarities turn resort practice into a transnational *Ayurveda-Kur*: Resort guests, travel agencies and different media consider the stay at the resort as a *Kur* and make it plausible for themselves – and their clients – by implicitly and explicitly referring to the notion of the German health care tradition and act accordingly.

4.2 The Familiar in the Foreign: The Practice of *Ayurveda-Kur* in India

When I asked an auto rickshaw driver in April 2010 outside Thiruvananthapuram's train station to take me to the city's Kerala's Department of Tourism to conduct an interview about the link between Ayurveda and the tourism industry, he thought immediately in the latter. Instead of hitting the road, he suggested to take me to the nearby popular coastal area of Kovalam because of its numerous Ayurvedic resorts – without me having mentioned Ayurvedic treatment or anything else except for the office's address. The exchange vividly highlighted how embedded Ayurvedic treatment is within the realm of tourism in Kerala.

The tourism sector is one of the fastest growing industries in the state.[188] Considered by the Keralan government as a driving force in economic development, it was officially announced as such by the then Chief Minister of Kerala Oommen Chandy in 2005 (Hannam 2009: 342). Ayurvedic treatment is seen by the state government as a "cornerstone of [Kerala's] tourism market" (Spitzer 2009: 139; addition by the author) and a "Unique Selling Proposition" (Department of Tourism, Government of Kerala n.d.) in the competitive global tourism industry. The market potential of Ayurveda was recognized already in 1994, when

188 While Kerala ranked ninth among all Indian states and union territories in terms of total number in foreign tourist arrivals in India in 2010 with around 659,000 tourists, the state moved up two positions by 2014, with approximately 923,000 foreign visitors (representing 4.1 percent of all foreigners arriving in India) (Department of Tourism, Government of Kerala 2015: 42 [Table 2.3.1], 120 [Table 5.8]). Kerala's foreign exchange earnings increased in 2014 by 15 percent over the previous year to ca. US$ 0.9 billion and the total revenue generated from tourism by 12 percent to US$ 3.7 billion (Department of Tourism, Government of Kerala 2015: 40 [Table 2.2.9]). The importance of Kerala's tourism sector is further apparent in the fact that in 2009, 1.2 million people out of a total population of around 35 million worked either directly or indirectly in the industry ('Tourism Site Opened' 2009).

promotion efforts started and the Kerala Tourism Development Corporation established Ayurvedic centers in its premium hotels (Ramesh and Joseph 2012: 37).[189] Besides direct financial support, the state of Kerala also promotes Ayurvedic treatment through large-scale advertisement starting in the early 2000s (Ramesh and Joseph 2012: 37). It includes various celebrities who act as so-called 'brand ambassadors' (Kurian 2015; Ravikanth 2008: 184). As part of its marketing strategy, the Keralan tourism board further promotes Ayurveda in road shows, travel and trade fairs and expositions in Asia, Europe and Australia (Ramesh and Joseph 2012: 32; Ravikanth 2008: 181). In a more concerted effort to promote Ayurvedic treatment, the Keralan government also created the brand 'Kerala Ayurveda' (Pordié 2013: 13) spread through online and print advertisements on a global scale. The success of this campaign could be observed at Ayuresort, where many guests thought that Ayurveda primarily exists in Kerala or at least originates in the south Indian state.

In addition to marketing activities and financial support of Ayurvedic resorts, the Department of Tourism also introduced a quality seal for Ayurvedic centers "in order to promote tourism in the State" (Department of Tourism, Government of Kerala n.d.). The main reason for the introduction of the 'Leaf Certificate' in 1998 was malpractice accompanying the rapid growth of the Ayurvedic resort industry in the 1990s (Department of Tourism, Government of Kerala n.d.).[190] The Leaf Certification shall ensure certain standards concerning safety, hygiene and service quality in order to sell 'Kerala Ayurveda' on the global tourism market. As incentive for resort managements to obtain the seal of approval, the state government provides recognized resorts subsidies and tax incentives (Department of Tourism, Government of Kerala n.d.; Madhavan 2013: 34). Ayurvedic centers further profit from the Certification since the Keralan government only promotes those

[189] In 2009, the state's tourism industry obtained more than half of the total loans of US$ 1.4 million distributed by the Kerala State Industrial Development Corporation and 82% of those funds went to Ayurvedic resorts (Madhavan 2013: 33). These investments seem to be lucrative, as about 40 percent of the state's tourism revenues are generated through Ayurvedic treatment (Ramesh and Joseph 2012: 30; Spitzer 2009: 142, quoting Neogi 2004).

[190] For obtaining the basic 'Olive Leaf Certificate,' the center has to provide treatment through a B.A.M.S. or B.A.M. qualified practitioner and by at least one female and one male therapist (to guarantee same-gender treatment) educated in institutions approved by the government; treatments authorized by the advisory committee; medicines produced by companies recognized by the government; specific treatment equipment; certain hygienic standards; at least two treatment rooms with a minimum size of nine square meters and attached bathroom; a consultation room with specific equipment including blood pressure meter and stethoscope as well as a "suitable" locality, ambiance and accessibility of the center in addition to cleanliness of the building and the surroundings. For a 'Green Leaf Certificate,' the Ayurvedic center has to provide all facilities and services necessary for a Olive Leaf Certificate plus a "very high standard" interior and exterior architecture; adequate parking space; a separate room for meditation and yoga classes; a herbal garden and a "picturesque [location] with greenery in abundance and quiet atmosphere" (Department of Tourism, Government of Kerala n.d.; interview with Jayan, who works for the section of the Department of Tourism that is responsible for issuing and renewing the certification). In 2013, 114 Ayurvedic centers in Kerala were approved by the state government through the Leaf Certificate, 86 with Green Leaf and 28 with Olive Leaf (Department of Tourism, Government of Kerala 2013). For a picture of Ayuresort's Green Leaf Certification see Appendix F.

centers in their information and advertising campaigns that have been awarded the seal of quality (Department of Tourism, Government of Kerala n.d.). The significance of the certificate was mentioned by Vasu, the general manager of Ayuresort. He claimed that many guests consider it an essential requirement, as they equate it with "good quality and genuine" Ayurvedic practice, seen as fundamental for them. This was confirmed by several guests. David for instance told me that he had read about the Leaf Certification during his research on Ayurvedic resorts in Kerala on the internet in preparation of his travel to India and that it influenced his decision of which resort to visit since he considered it a relevant "quality criteria because it is a certificate issued by the government." While the Leaf Certification was known by the majority of long-term guests at Ayuresort, several short-term visitors had heard about it and directly asked the therapists or Dr. Praveen if Ayuresort has been awarded with the seal of quality. By introducing the Leaf Certification, Kerala's Department of Tourism indirectly influences the practice in Ayurvedic resorts as well as the guest's decision about the place where to go for Ayurvedic treatment. The different criteria are both medical (e.g. education of the practitioner and therapists, form of treatments, origin of medicines) and non-medical (e.g. size of the treatment room, plants on display, pleasant surrounding). But while a certain minimum standard of medical quality is guaranteed in terms of the Ayurvedic staff's education and the employment of 'approved' medicines, the quality of Ayurvedic treatment as such (which includes the practitioners' and therapists' skills) is not – and maybe cannot be – reviewed. Hence, the promotion, certification and financial support of Ayurveda in Kerala by the Department of Tourism does not only have a vital impact on the guests' decision in their choice of the institution, but also strengthens the non-medical aspects of Ayurveda in foregrounding relaxation and holiday and by framing it as a touristic practice in the first place.

The connection between Ayurveda and tourism is further consolidated through travel agencies. Ayurveda is either offered as part of an organized travel through Kerala, India or Sri Lanka that includes the visit of different tourist attractions and Ayurvedic treatment for testing or tasting. The other form of 'Ayurvedic travel' advertised and sold by travel agencies is a long-term Ayurvedic treatment as part of an 'all-inclusive package' covering flight, airport shuttle, accommodation and food besides the treatment itself.[191] Most long-term guests at Ayuresort had booked their stay through a travel agency, many of them

[191] Travel agencies and Ayurvedic resorts usually have a cooperation which ensures the agencies a commission for each guest they send to the resort. At Ayuresort, the commission used to be 25 percent of the resort's revenues for a guest who came for long-term Ayurvedic treatment, in comparison to 20 percent for all other guests. The difference results from the higher earnings from the Ayurvedic treatment and accommodation due to the longer stay.

through the German agency Ayutravel. Ayutravel provides its clients with information about specific resorts and Ayurveda in general already before their travel to India. When Hannah had considered undergoing Ayurvedic treatment after she had stumbled upon its description in the travel catalog described at the beginning of this chapter, the next step was for her to call Ayutravel, which had placed an announcement for Ayurvedic treatment in India in the catalog. She then preselected Ayuresort as her preferred resort due to a combination of its comparable low price, its location at the sea and its alleged sustainable practices as she had misinterpreted the Green Leaf symbol for a sign for environmental protection and sustainable services. During a longer telephone conversation with one of Ayutravel's employees, Hannah "was told that Ayurveda does not necessarily only mean 'wellness' or 'spa' but that it is also slightly tiring for the body," explaining possible differences to her experiences in the spa hotel where she had made her first experience with Ayurvedic treatment. The employee of Ayutravel described the daily schedule, different single applications and *pañcakarma* and also provided practical advices, for instance to not bring sensitive clothes as the oil will leave non-removable stains. In addition, the employee of the agency advised Hannah in her selection of the suitable resort by suggesting different resorts for different preferences in terms of natural environment, remoteness, level of comfort, degree of interaction with other guests and price range. Her conversation with the agency's employee eventually reinforced Hannah's pre-selection and she booked her Ayurveda travel to Ayuresort.

Clearly, Ayutravel – together with other travel agencies – replaces to some extent the general practitioner as the main agent for referring the patient to the Ayurvedic specialist. In the process of finding the adequate resort, the medical consultation is rather superficial and consists of general information on Ayurvedic treatment, while the decision about the specific treatment is made only in India by the resort practitioner after the guest had already chosen the resort, mainly according to touristic, social and economic criteria which outplay medical aspects. Nonetheless, the information about Ayurveda that clients of Ayutravel receive translates into basic Ayurvedic knowledge that is bigger than that of other guests at Ayuresort and the common patient at Ayurvedic clinics and hospitals in India according to Dr. Praveen. Ayutravel thus influences not only the decisions of its clients concerning their choice of the resort but also the practice at Ayuresort such as the interaction between Dr. Praveen and various guests and eventually also Ayurvedic treatment as this is shaped by the guests' knowledge and perception of Ayurveda.

While travel agencies contribute to the embedding of Ayurvedic resorts in the tourism

industry, their location also plays a vital role for the shift of Ayurvedic practice towards the realm of vacation. Similar to holiday resorts that do not offer Ayurvedic treatment, Ayurvedic resorts are generally situated in tourist destinations in calm, picturesque locations, usually close to the sea, next to rivers or at lakes (see also Rudra 2011: 64). Like other resorts that are advertised in promotion material as "being close to nature" or "the gateway to serenity" (Rudra 2011: 66), Ayuresort was also promoted with reference to its surrounding nature, for instance through the slogan 'sea, sand and serenity.' For several guests, the setting (see Figures 1.3 and 1.5), especially the location by the sea, was important and even decisive for their resort choice. At the same time, Ayuresort, together with all other Ayurvedic centers in Varkala, is situated within a tourism enclave with dozens of restaurants, shops and street vendors selling clothes, textiles, jewelry and handicraft,[192] internet cafés, travel agencies, an art center that offers *kathakaḷi* and *kaḷarippayattu* performances, and two beaches used by foreigners for sunbathing and swimming, as described in Chapter 1. While the restaurants were usually not attended by long-term treatment guests of Ayuresort as they received a specific diet at the resort itself, the other amenities, together with short sightseeing trips and temple visits, provide a nice change from the rather monotonous Ayurvedic treatment and the permanent stay on the resort compound, utilized and appreciated by various guests.[193] Several guests emphasized that they enjoyed these "touristic offers" (Paul).

The natural environment of Ayuresort embedded within a touristic infrastructure stands not only as a major difference to Ayurvedic clinics and hospitals, but was also highly rated by most guests, who considered their stay as a combination of health care and holidays. This was not a contradiction for them, on the contrary, many saw benefits in the entanglement, especially vis-á-vis the resort location. David for instance advanced the view that "they should put all hospitals on beaches, people would get healthier much quicker." This notion of the resort's natural environment as a 'therapeutic landscape' (see e.g. Gesler 1992; Williams 1999) was prominent among several guests, especially in the context of relaxation and stress-relief – the major motivation for many guests for visiting Ayuresort. Besides the natural surroundings, the touristic environment promoted relaxation and regeneration. Alice told me that she wanted to have her Ayurvedic treatment at a resort and not at a hospital[194] because she wanted to "stay at a place where [she] feel[s] good during the time when [she] do[es]n't receive treatment." Dr. Praveen generalized this statement by claiming

192 During the treatment sessions, one could often hear the sound of drums some vendors sold on the path along the cliff top, as a reminder of one's presence in a tourist destination.

193 See e.g. Diana's email feedback at the beginning of Chapter 2.

194 Alice was one of the few guests who had visited an Ayurvedic clinic in India before for treating a cold.

Figure 4.1: Male ward in a governmental Ayurvedic hospital in Kerala (photo by the author)

that

> *[p]eople don't come with serious problems like in a hospital, they want to go outside. In the resort field, we have to give a holiday mood. That's why health tourism is growing in resorts, not in hospitals. Europeans don't choose Kottakkal*[195]*, because they don't want the hospital mood.*

Dr. Praveen told me several times that "Europeans want a holiday mood, not a hospital mood." The location of the resort in a holiday destination along with tourist activities and the natural environment all contribute to the 'holiday mood.' But so does the resort itself. According to Dr. Praveen, the guests of Ayuresort could not stand the atmosphere in an Ayurvedic hospital, where they would feel like being "in a prison" due to the constraints, regulations and monotony of a hospital (see Figures 4.1 and 4.2 for an impression of the contrast between 'hospital atmosphere' and 'resort ambiance'). The atmosphere in Ayurvedic hospitals would eventually intensify the stress that most guests complain about, instead of contributing to relieving it as the resort setting does. Consisting with the goal of providing the visitors of Ayuresort with a 'holiday mood' is calling them 'guests' instead of 'patients.' The visitors considered themselves as patient, guest, tourist or *Kurgast* (see discussion below), depending on the form of treatment they received.

Accordingly, the visit to Ayuresort assumed different shapes, ranging from a health care treatment with vacation elements to a tourism activity. Ayurveda is not only advertised as one of various holiday activities, but also practiced as one. This applies primarily to members of tour groups and to individual guests who visited Ayuresort for a couple of

195 With "Kottakkal," Dr. Praveen referred to Arya Vaidya Sala, a famous Ayurvedic hospital in the Keralan town Kottakkal.

Figure 4.2: Open-air restaurant / common area at Ayuresort (photo by the author)

days of single treatments. Those guests took one or more single applications to 'get to know' or 'experience' Ayurveda, as they and Dr. Praveen told me. Ayurvedic treatment in this context extends the varieties of touristic highlights that tour operators can offer their clients, as becomes clear when Julie, the leader of the French tour group mentioned above, told me that including Ayurvedic treatment in their travel is superior than "just traveling from place to place." For long-term guests however, Ayurvedic treatment was more than a tourist activity. Nonetheless, they generally also associated it with vacation, to a varying extent. Like Linda, who visited Ayuresort for "three weeks of holiday" and a time-out after a stressful year, many of those guests who traveled to India for receiving Ayurvedic treatment at Ayuresort perceived their stay as a form of holiday that provides relaxation and recreation. Adam for instance considered his stay as "vacation with bag and baggage," Maria did not attend the yoga classes in the early morning because she "[did] not want to set the alarm on vacation" and Maximilian was happy that his daughter Christina had arranged "such a beautiful holiday" for both of them. Several guests used the term "*Ayurveda-Urlaub*" (Ayurvedic holidays), which they regarded as providing "more regeneration than a normal holiday" (Annabelle).

While guests associated their stay at Ayuresort with vacation and while Ayurvedic treatment has been shifted to the tourism industry, the stay at Ayuresort was "more than normal vacation" (Annabelle) for most long-term guests. Resort practice is still located in the realm of health care, more precisely between the realm of medical and wellness treatment, as I argue. As demonstrated in Section 2.1, guests have different motivations for

their visits of Ayurvedic resorts similar to *Kur* guests, ranging from treating an ailment to illness prevention to recreation and relaxation. Consequently, Dr. Praveen has established three categories of Ayurvedic practice: 'treatment,' 'rejuvenation' and 'wellness.' This makes Ayurvedic treatment at the resort a comprehensive phenomenon characterized by a blurred boundary between medical and wellness practice. This boundary is not only blurry concerning the practice at Ayuresort as a whole but is also permeable within single long-term treatments, as they generally involved wellness elements even if they were implemented as therapeutic or preventive treatments. Below, I will elaborate on the concept of wellness that marries health care and vacation, mind and body, and advocates a neoliberal concept of the person.

Since its first record in 1654 as an antonym to illness, the term 'wellness' was used in this sense until the middle of the twentieth century (Miller 2005: 84). Based on notions of maintenance of health promoted by different intellectual and religious movements of nineteenth-century America (see e.g. Miller 2005: 85-87), the American physician and public health professional Halbert Dunn introduced the term 'wellness' in 1957 on the basis of the WHO's notion of 'positive health.' Dunn saw a necessity in "keep[ing] a person fit until he dies," for which the recognition of "various levels of wellness" was important (Dunn 1957: 229f.). His concept of wellness was not restricted to physical aspects but also included social, mental and spiritual dimensions, which he considered as vital for positive health (Miller 2005: 88-90). In the 1970s, Dunn's concept gained wider acceptance and was extended by an emphasis on the individual's responsibility for his/her own health and strategies for reaching a higher level of wellness such as relaxation practices, nutrition awareness and physical fitness (Körber 2002: 7, 14; Miller 2005: 91, 93f.).

In the last two decades of the twentieth century, the concept of wellness also traveled to various countries in Europe, including Germany. Notions of wellness centering on individual life quality and lifestyle and physical, mental and emotional wellbeing gained popularity (see e.g. Körber 2002: 8f.). Besides the individual responsibility for one's own health, the other central part of the contemporary notion and practice of wellness in European countries, is a 'hedonistic aspect,' influenced by the fitness movement of the 1980s and a new event and pleasure-orientation (Hörner 2013: 19; Illing 2009: 22; Körber 2002: 17; Miller 2005: 98). In Europe, the general perception of wellness is rather associated with cosmetic and relaxation treatments primarily located in (day) spas and beauty parlors (Hörner 2013: 17; Miller 2005: 84) than with health promotion and behavior change programs in the realm of public and company health initiatives and an active 'healthy' and 'holistic' conduct

of life as in its original American context. The different definitions were generated in the context of an emerging wellness trend in Germany in the 1990s that was based on a privatization of health care due to increased public health care expenditure, countered by the decisions of several governments to privatize healthcare and were rooted in an emerging individualization paradigm that resulted in a re-evaluation of the body and a focus on self-fulfillment (Hörner 2013: 19). Indulgence, pampering, feeling well, beauty and (passive) relaxation are the key words in the popular understanding of wellness in the German public, for which not least hotels, day spas, wellness centers and beauty parlors are responsible by claiming that by buying their wellness offers clients can 'treat themselves all around' to relaxation and cosmetic applications and receive 'new wellbeing, vitality and energy for life' (Körber 2002: 5).

Such wellness offers also include Ayurvedic treatment, to be more precise 'wellness Ayurveda.' As described in Chapter 1 and 2, day spas, hotels and massage and beauty parlors offer Ayurveda in form of cosmetic and massage-based applications for relaxation, beauty and wellbeing in accordance with Ayurveda's contextualization in the German media as wellbeing, beauty and relaxation practice.[196] Adding further to linking medicine and vacation, wellness is often associated with leisure and vacation and rooted in the tourism industry. Here wellness refers to a variety of touristic services from 'luxury offers for body, mind and soul' to various activities that are sold with the buzzword 'wellness' without any connection to the definitions of the concept presented above (Körber 2002: 13f.). Also tourism stakeholders in India portray Ayurvedic treatment as 'wellness beneath palm trees' (Ministry of Tourism, Government of India 2009), and the photo representing Kerala's product 'Ayurveda' at the ITB Berlin 2016[197] on its website (see Figure 4.3) as well as the photos produced at Ayuresort analyzed in Section 2.2 (see Figures 2.2 and 2.3) trigger associations with indulgence rather than with medical therapy.

Consequently, several guests at Ayuresort perceived Ayurvedic treatment as massage-based wellness practice before they visited the resort (see Section 2.2). While for some of them this perception changed during their stay, for others it remained. Sarah considered her treatment as 'wellness' in the common German parlance and "enjoy[ed her] massages." Deepa (58, India)[198] saw her treatment in a similar way. With her professional background in

[196] This association of Ayurveda with wellness is not restricted to representations of Ayurvedic treatment in Germany though, as for instance Kim Inglis' book *Ayurveda: Asian Secrets of Wellness, Beauty and Balance* (2009) or the wellness travel guide *Body & Soul Escapes: Where to Retreat and Replenish around the Globe* (2007) by Caroline Sylge demonstrate.

[197] The same photo was used in the previous years too.

[198] She was the only Indian long-term guest during my research at Ayuresort.

Figure 4.3: Advertisement picture for Ayurveda by Kerala's Department of Tourism (taken from ITB Berlin 2016)

the cosmetic and wellness industry as a former aesthetician, hairdresser and owner of three beauty farms in Delhi, Deepa perceived Ayuresort as a wellness center where she could "pamper [her]self."[199] This resulted from the form of Ayurvedic treatment she and other guests received and which Dr. Praveen labeled as 'wellness treatment.' Those were generally one or more single applications – primarily including 'relaxation massage,' 'rejuvenation massage,' 'hand and feet massage,' 'face massage,' *śirodhārā* and 'face and body pack' – for guests who visited Ayuresort only for one or a few days, where a 'proper' preventive or therapeutic treatment was not possible due to the short time, not needed or not desired. Like the German couple mentioned in Section 2.1, those guests wanted to 'give themselves a treat.'[200]

The treatment courses conducted for 'treatment' and 'rejuvenation,' the two other categories established by Dr. Praveen, also included 'wellness elements.' One of the two or three daily applications was usually one of the mentioned applications that short-term treatments guests received and was implemented "for wellness" according to Dr. Praveen. In addition, the similarity of several applications to massages attaches long-term treatments a wellness aspect, as does the inclusion of relaxation techniques like yoga and meditation.

[199] When Deepa had looked for an Ayurvedic resort on the internet, she had even used the search item 'Ayurvedic wellness treatments in India.'

[200] The number of long-term guests receiving such 'wellness treatments' was very low. Apart from Sarah and Deepa, there were only four other guests, two of whom were friends of Sarah who visited Ayuresort together with her.

Moreover, the provision of a 'holiday mood' instead of a 'hospital mood,' which includes intensive caring for the guests, and providing the treatment in a pleasant environment with appealing resort architecture and natural surroundings on the other, contribute to a 'wellness atmosphere.'

Indeed, many guests also perceived their treatment in this way while generally conceptualizing wellness similar to perceptions common among the German population, i.e. as distinct from medical treatment. Frank for example explained that his visit of Ayuresort was based "not on a medical motive but a wellness motive," and also other guests perceived Ayurvedic resort practice as "to relax, treatments for wellbeing and feel-well atmosphere" (Hannah) and as comprising massages, cosmetic treatment, 'doing oneself some good,' 'feeling well' and weight loss. For Hannah, several factors contributed to the wellness factor at Ayuresort:

> *I think it's not only a question of oil being on the skin, but whether you are massaged on the whole body. Through the touch, I think, also the mind relaxes. Then also the yoga – the atmosphere, for instance waking up early with the sound of the ocean. Or going for a walk for hours through palm groves along the sea. Yes, I think there are several factors that create this wellness factor.*

Guests were also drawn to the treatment at Ayuresort for 'aesthetic reasons' (see Halliburton 2003): because it is pleasant and feels good. They were "looking forward to every treatment session," as several guests told me and various guests had returned to Ayuresort for a second or third time because they "liked it a lot." At the same time, curative and preventive treatments did not represent pure 'treat-yourself' wellness programs but generally also involved unpleasant elements. Some guests considered the massage-like applications rather exhausting than relaxing or felt it "pretty tough to lay on your belly and to inhale in the meantime" (David). Others experienced *piḻiccil* as painful since one received the 'oil bath' by lying on the blank treatment table. The major harsh practice was the evacuative measurements, which most guests received in form of *virecana* (purgation). Most guests had a tough time (or "horror time," as Gabriel phrased it) on their 'cleaning day,' as the purges triggered not only frequent bowel movement for several hours – which was already pretty exhausting and unpleasant – but also stomach cramps, vomiting, palpitations, dizziness and extreme sweating in several cases. Also the purgation-preparatory practice of ghee-drinking for three to six days, where many guests, and me as well, had a strong gag reflex and were close to vomit,[201] was definitely not a practice that one would associate with indulgence or

[201] As Dr. Praveen told me, some guests who had received *pañcakarma* treatment at Ayuresort before my research also vomited indeed. This is however in accordance with Ayurvedic theory, as the main purpose of external and internal oileation (*snehana*) through different forms of massage-like applications and through drinking of medicinal ghee should be done until the body cannot take any more oil and disgust, which can result in vomiting, is a sign for that.

'feel-good' practice.

Long-term treatment courses at Ayuresort thus represent a practice that includes pleasant and unpleasant elements as well as wellness and medical aspects. The blending of the latter was also emphasized by various long-term guests. They considered their stay at the resort as health care and wellness treatment at the same time, which was not a contradiction for them as their conceptions of the wellness elements in the treatment courses went beyond common notions of wellness as mere pampering practice. While considering them as pleasant and indulgent, at the same time many guests associated what they perceived as 'wellness elements' also with health-care, by claiming that they are beneficial for their health.

Emphasizing physical and mental – and in some cases also social – wellbeing rather than the mere absence of illness, many guests' notion of health resembled the WHO's definition (2016). While for Christina health was a result of "doing sports regularly, eating healthy and not having too much stress," she attributed her health problems (headache, back pain, weight gain, digestive problems) to stress. Similarly, for Hannah "a healthy life means three things: caring for the body, that means exercise or treatment, healthy food and healthy mind, that means any form of relaxation." And "bad nutrition, bad environment – the job has to be fun – and stress" can trigger illness. Also most of the other long-term guests had similar comprehensive, dynamic concepts of health, which generally related to a physical, mental and social wellbeing that has to be achieved and maintained through body techniques like regular exercise or different (wellness) treatments, relaxation, healthy nutrition and a beneficial social environment. This dynamic understanding of health as a process for which oneself is individually responsible[202] is in accordance with many guests' perception of Ayurvedic treatment. As described in Section 2.1, guests perceived Ayurvedic treatment as 'holistic,' i.e. to include both mental and somatic aspects on the one hand, and as beneficial for 'maintaining health' and 'preventing illness' on the other. Thus, for many guests Ayurveda matched their positive, process-related conceptualization of health or wellbeing. Many guests also considered Ayurveda as a 'science of life' or 'science of longevity' with a focus on proactively establishing and maintaining overall wellbeing, which also represents a vital element in Ayurvedic theory (see e.g. Alter 1999).

When Ayurvedic treatment is implemented for physical and mental wellbeing, for illness prevention and for healthy aging at Ayuresort, it becomes a 'technology of the self' (Foucault 1988), which represents one means of the continuous pursuit of general

[202] This notion of health roots in the neoliberal, biopolitical shift of responsibilities for health-promoting activities and overall wellbeing from the welfare state to the individual in Europe and North America in the last three decades of the twentieth century (see e.g. Rose 2001: 6).

wellbeing to which the neoliberal individual is constantly exposed. Hannah, Christina and various other long-term guests had similar notions of wellness as generated in scientific discourses that center on the personal responsibility for one's health, physical fitness and stress management (Körber 2002: 7, 14; Miller 2005: 91; Opaschowski 1987: 34). At the same time, they associated wellness with physical and mental wellbeing, feel-good practice, healthy nutrition, relaxation and indulgence, similar to the common notion of wellness prevalent in the German public. Through those explanatory models of health and wellness, 'wellness aspects' of Ayurvedic treatment at Ayuresort become health-related elements and the fault-line between medical and wellness practice is blurred, both on the level of practice and on the level of the underlying notion of health promotion. Relaxation and stress-relief was perceived by most guests as contributing to mental wellbeing and thus generating and maintaining overall health. This happened most prominently at Ayuresort through relaxation techniques such as *śirodhārā*, which thus represented wellness-cum-medical practices. Hence, while 'relaxation elements' at Ayuresort are often associated with indulgence, they are also a form of 'medical relaxation practice' as they not only aim at pampering the guests, but also preventing and curing illness.

Thus, Ayurvedic practice at Ayuresort is characterized by both medical aspects and 'feel good elements,' whereupon the latter do not merely promote relaxation but also clinical benefits. In addition, by being at the intersection of health care and tourism, aspects of healing and holidays merge in the practice at Ayuresort and Ayurvedic resorts in general, similar to practices at continental European spas and the *Kur*. In both, the connection to holidays does not only manifest in the environmental change but is further visible in their embedding in tourist infrastructure. Just like Ayurvedic resorts, *Kur* centers also try to attract guests from all over the world by offering recreation, relaxation and pleasure. In the same way as Dr. Praveen provides a 'holiday mood,' *Kurorte* and *Heilbäder* too offer their guests a vacation atmosphere. While the German government considers *Kur* treatment as a major component of "health tourism" (Bundesministerium für Wirtschaft und Technologie 2011: 7; original in German) and financially and structurally supports *Kur* centers, the Keralan government equally regards Ayurvedic treatment at resorts as important factor for the tourism industry and local economy and promotes 'Ayurvedic tourism.'

Like Ayurvedic resort practice, *Kur* practice is a complex of curative, preventive, recreational and wellness treatments in pleasant natural environment. Both institutions are visited by healthy and ill individuals for treatments ranging from single applications to two or three week regimens. The latter are generally austere, individualized health care

programs. They are usually perceived by resort and *Kur* guests as centering on a gentle "holistic approach and natural healing" (Maretzki 1989: 30). Both long-term *Kur* and resort packages are usually characterized by pleasant and unpleasant elements. They include a collection of several daily applications, often a form of 'cleansing procedure,' active relaxation techniques, a specific restricted 'hospital diet' (Sandra) and the renunciation of certain items such as alcohol and cigarettes, and periods of rest and relaxation. In both Ayurvedic resorts and *Kur* centers, pleasant elements, like massages and relaxation techniques, are perceived by the guests and sold by the management as wellness practices. In both, they are not only offered as leisure activities, but as health-promoting practice for increasing general wellbeing which guests actively seek as they are "consumers concerned about their health" (Speier 2011: 59). Activities available during a *Kur* or a stay at an Ayurvedic resort, such as excursions or cultural entertainment, at the same time connect both *Kur* and Ayurvedic treatment with recreation and relaxation.

Due to these similarities between the *Kur* and Ayurvedic resort treatment, German-speaking guests at Ayuresort as well as German travel agencies and media explicitly refer to the stay at the resort as '*Ayurveda-Kur*' (see also Naraindas 2011a: 80; Otten 1996: 83) and implicitly equate resort practice with *Kur* practice. For example, travel agencies use the term in their newsletters and on their websites.[203] Various information material on Ayurvedic resorts and resort websites that address their clientele in German widely use the term *Kur*.[204] At Ayuresort, virtually all German-speaking guests referred to *Kur* treatment when they talked about their stay at the resort. While almost all of them used the terms '*Kur*' or '*Ayurveda-Kur*,' some guests also used modifications of the term *Kur* similar to the application of the terms '*Reha-Kur*' or '*Wellness-Kur*' in the German *Kur* context what Naraindas had described (see Section 4.1): *Entgiftungskur* (detox *Kur*, Edvard), *Kur-Urlaub* (*Kur* vacation, Laura and Maximilian), or *Schnupperkur* (trial *Kur*, Miriam, 50, Germany). Guests referred to the term '*Kur*' both explicitly and implicitly. When I asked Hannah if she considered her stay at Ayuresort as treatment or vacation, she answered: "I would call it a *Kuraufenthalt* (*Kur* stay)." When I subsequently dug deeper by asking if she had coined the term '*Ayurveda-Kur*' by herself or had read about it before coming to India, she replied: "No, I have developed it on my own."

[203] Ayutravel for instance divides the treatment at Ayurvedic resorts in '*Vorsorgekur*' (preventive *Kur*) or '*Rejuvenation-Kur*' and '*Reinigungskur*' (purification *Kur*), including in its description of Ayuresort. Indeed, Ayurvedic travel to Ayuresort on Ayuresort's website includes 'single room with *Kur* and flight.'

[204] For example, the guide book *Ayurveda erleben in Indien und Sri Lanka* (2004) constantly uses the terms *Ayurveda-Kur* and *Kurzentrum* (Kur center), just as the article on Ayurveda in Kerala in *Reise & Preise*, which triggered Hannah's interest in having an Ayurvedic treatment in India through terms such as '*Ayurveda-Kur*' and 'real *Kur*.'

One may wonder why Hannah claimed to have coined the term *Ayurveda-Kur* although both the information material she had received from Ayutravel and the *Reise & Preise* article use the term. What is more important here though, is that, although seemingly not aware of having read about the term before visiting Ayuresort, she used the term when referring to her stay at the resort through an association between the latter and her knowledge of *Kur*. Hannah, like most other German-speaking guests, considered the stay at Ayuresort or at Ayurvedic resorts in general to *be* a *Kur* due to perceived similarities. As illustrated at the beginning of this chapter, Hannah had equated the Ayurvedic treatment presented by *Reise & Preise* and Ayutravel with a *Kur*, which made her choose the *Ayurveda-Kur* at Ayuresort over the *F. X. Mayr-Kur* in Austria. During the preparation for her travel, Hannah conceptualized 'purification,' the buzzword she frequently stumbled about while reading through Ayutravel's information material, with the help of her experiences in *Kur* centers, which offer cleansing and fasting cures: "Purification for me means *Reinigung* [cleansing/purification]. I just thought that it works through the many herbal extracts. [...] There are similar offers in Austria; like fasting cures in hotels or *Kur* centers. That is what I imagined" (addition by the author). Hannah's experience with *Kur* treatment in Austria did not only influence her decision to undergo a *pañcakarma* treatment in India; the many similarities between both treatments she noticed during her stay at Ayuresort, such as daily applications, a specific vegetarian light diet and purgation besides general vacation and wellness aspects, confirmed her perception of Ayurvedic treatment being a *Kur* for bowel cleansing, *Entschlackung* and weight reduction, which she associated with healing and illness prevention.

Similarly, other guests, influenced by their perceptions of *Kur* treatment or direct experience, associate different aspects of their stay with *Kur* practice and referred to it in several instances, both implicitly and explicitly. During a conversation, Isabel complained about a noisy group of Indian tourists who visited Ayuresort for two days by saying: "We are taking a *Kur* here and they make a great hullabaloo." For her, a *Kur* included switching off by reducing all external influences of everyday life and consciously living in the moment with concentrating on her senses and her body. While Isabel associated her stay at Ayuresort with a *Kur* and was thus annoyed by the 'hullabaloo' the tour group had produced in the mentioned situation, Adam and other guests established this linkage primarily because of the strict regimen around which long-term treatments at Ayuresort are built. Asked by Andrea, who had visited the resort only for a couple of days, if receiving the same applications for three days in a row was not boring, he replied: "What we are doing is

not necessarily only wellness, but rather *Kur.*" The blending of pleasant and unpleasant elements in a *Kur* let Adam consider his treatment as *Ayurveda-Kur.* Also the position at the intersection of health care practice and vacation of both *Kur* and resort treatment let guests perceive their stay at Ayuresort as a *Kur.* When I asked Silvia if she considers herself a patient or a tourist, she replied: "Neither one, rather a *Kurgast.*"

By interpreting the stay at an Ayurvedic resort as a *Kur* and giving it the same label, guests can make sense of the Ayurvedic treatment they find in the resort. In addition, the promotion of '*Ayurveda-Kur*' by travel agencies and the representation of resort practice as *Kur* treatment in German-speaking media makes Ayurvedic treatment plausible for people exposed to these descriptions and let some of them even opt for an '*Ayurveda-Kur.*' Taking the waters becomes taking the oils. Based on their own experiences with or at least perceptions of *Kur* treatment in continental Europe, the different German-speaking actors account for the practice at Ayurvedic resorts due its similarities to *Kur* practice in terms of blending holiday and health care, a mixture of curative, preventive and wellness treatments, the focus on improving general wellbeing, a 'natural,' 'gentle' and 'holistic' practice in a pleasant setting, an individualized regimen with pleasant and unpleasant applications including massages or massage-like treatments and a restricted diet.

Naraindas claims that "[...] in the German context, [...] the notion of the Kur (poorly translated as spa), with its variety of *entschlacken*, provides a ready template for the embedding of Ayurveda, [...]" (2014b: 116 [Footnote 24]). This very process of conceptual translation[205] took place for instance during Hannah's decision process before her travel to Ayuresort, when Austrian fasting cures and *Entschlackungskur* represented the template through which she implicitly embedded Ayurvedic treatment in her cognitive field eventually equated both practices. Similar observations have been made by Frank and Stollberg in their research on Ayurvedic practice in Germany, when they illustrate how *Entschlackung* and fasting cures represent "a powerful tool for explaining how Ayurveda works" for patients they interviewed (Frank and Stollberg 2002: 234). As a result, the different German-speaking actors involved in Ayurvedic resort practice transform the latter into a new transnational form of the *Kur* by selling (travel agencies), portraying (media) and consuming (guests) it as *Kur.*

[205] A similar process has also been described by Otten in her analysis of the German 'Pancha Karma Kur.' Otten argues that in the course of its transfer from South Asia to Germany, *pañcakarma* has been renamed as 'Pancha Karma Kur' so that the single elements are comprehensible for the German patients, who connect the term *Kur* with healing and recreation in certain setting (1996: 83; see also Naraindas 2011a: 80).

Conclusion

In his book ***Kurgast: Aufzeichnungen von einer Badener Kur*** (1987 [1925]), Hermann Hesse describes his experiences during two *Kur* treatments in Baden in 1923 as follows: "It was necessary to stand three, four weeks of daily bathing, walking as much as possible, distancing yourself as much as possible from excitement and worries [...] because the opposite of intensive life was prescribed here" (Hesse 1987 [1925]: 14). While rheumatism-ridden Hesse visited the Swiss *Kur* town in the following three decades annually with the aim of being "rejuvenated and cured" (Hesse 1987 [1925]: 15), several Germans travel to Varkala at the beginning of the twenty-first century for taking a *Kur* for enhancing their general wellbeing in a pleasant, supporting holiday environment. The practice at Ayuresort in specific and many Ayurvedic resorts in Kerala in general represents a transnational form of this German health care tradition, which is part of the century-old global phenomenon of traveling for health care.

In the first section of this chapter, I discussed different varieties of health care travel and the historical development of the institution of the spa and its German version of the Kur. Starting off with a description of how and why an increasing number of patients visit countries in the developing world, predominantly in Asia, for medical treatment, I then elaborated on health care travel. In addition, by reviewing the practice of bathing across time and space for treating different ailments and improving general wellbeing, I showed that the European history of health care travel is closely interconnected with the institution of the spa. Spas offer therapeutic and health-promoting treatments, leisure activities and social interaction. Situated in the realm of conventional medicine, spa treatment in continental Europe represented institutionalized and government-supported "disciplined, medically-supervised vacations" (Bastos 2011: 50) located in a touristic environment. However, mainly because of a cutback in state funding of spa visits in the last decades, the spa industry has shifted in most countries from the public health system to the private (health) tourism industry and spas underwent a "de-medicalization" (ibid: 48) in order to attract not only ill patients but also healthy tourists. Since the beginning of the twenty-first century, the continental European spa represents an institution situated at the intersection of health care and tourism, offering healing, illness prevention, enhanced wellbeing, recreation, pleasure and vacation.

In the last part of this section, I introduced the 'German version' of the spa, the *Kur.* As the most popular model of the European spa, the *Kur* aims at curing ailments,

rehabilitation, illness prevention, health maintenance, recreation and relaxation by resorting to both individualized intensive regimens and wellness applications. Subsiding political and financial support by the German government at the end of the twentieth century led to a shift of *Kur* treatment from cure to prevention and wellness. Contemporary *Kur* practice thus centers on single applications and austere regimens with pleasant and unpleasant elements, environmental stimuli, a restricted diet, exercise programs and periods of rest and relaxation. The *Kur* is not only situated at the intersection of medical and wellness practice but also between health care and holidays. Its general embedding in tourism infrastructure strengthens the *Kur*'s linkage with tourism and vacation.

The historical development and present-day practice of *Kur* as a regionally specific version of the spa along with its linkage to health tourism represents the basis for my argument in this chapter, more fully detailed in Section 4.2. I started the section with a presentation of the embedding of Ayurvedic resorts in the tourism industry and its influences on Ayurvedic practice. Considered as an excellent means to foster economic development by the government of Kerala, the latter promotes 'Ayurvedic health holidays' through marketing activities, financial investments and a quality seal for Ayurvedic centers. . Travel agencies shape the guests' decisions and expectations what eventually influences practice. The resorts' location in a tourist destination contributes to a 'holiday mood' rather than a 'hospital mood' in many guests, who generally did not consider themselves as patients and their stay as a combination of health care and holidays. As a result, Dr. Praveen acted not only as a medical specialist but also as a 'cultural ambassador' and 'travel guide.' The resort's location in a tourism environment further influenced Ayurvedic practice by fostering the transformation of single Ayurvedic applications into massages for tired tourists.

While all these different aspects of 'Ayurvedic tourism' influence the practice at Ayuresort, they also resemble the tourism-related elements of the *Kur*. In addition, Ayurvedic resort practice and *Kur* treatment share a focus on improving general wellbeing and illness prevention while combining medical and wellness aspects, what I illustrated in the second part of this section. By discussing the concept of wellness, I disclosed differences between popular Anglo-American and German understandings of the term. Developed in the 1950s in the United States and later commonly understood in the Anglo-American world as a way of living aimed at increasing and maintaining health-promoting social, mental and emotional wellbeing, with its transfer to Germany and other European countries in the 1980s and 1990s it moved from public health programs to day spas and beauty parlors. Notions

of indulgence, pleasure, beauty, relaxation and consumption determine the conventional understanding of the concept. The same understanding prevailed in Ayuresort and in the realm of Ayurvedic resorts in general when Ayurvedic treatment was associated with wellness practice. Yet, most long-term treatments were not exclusive wellness treatments but aimed at illness prevention and curing minor ailments and also involved different unpleasant elements. Long-term treatment courses at Ayuresort thus represent a practice that includes pleasant and unpleasant elements as well as therapeutic, preventive and wellness aspects, although the fault-line between those aspects is rather fuzzy.

The similarities of this practice to contemporary *Kur* practice, together with the other described analogies, especially the inclusion of both health care and holiday aspects and the individualized austere regimen combined with periods of rest situated in a pleasant natural environment, turn resort practice into a transnational *Ayurveda-Kur*. Resort guests, travel agencies and different media explicitly and implicitly refer to the stay at the resort as a *Kur*. Their use of the term *Ayurveda-Kur* reflects on the one hand the image of Ayurvedic practice in Kerala's resorts sold by tour operators and conveyed by print and online media, and on the other hand the perception of German-speaking guests of their treatment at the resort. Through associating resort practice with the familiar notion of the *Kur*, various stakeholders in the tourism industry and the media make Ayurvedic treatment plausible for resort guests who can make sense of the practice they find at the resort. This also explains the complaints by some non-European guests about their treatment, what I already addressed in Chapter 2. While several German guests also experienced some aspects of their stay as unpleasant, they usually did not complain but regarded them as a 'necessary evil' for a 'proper *Kur* treatment.' Ayuresort was visited by 'vacationer-patients' and 'patient-vacationers' (Naraindas 2011a: 69). While the latter could and would engage with the unknown practice due to the notion of *Kur* they brought to the resort, the vacationer-patients struggled with coming to terms with parts of the treatment as they lacked the 'spa etiquette' (ibid).

At the same time, the history of the *Kur* and its status as institutionalized biomedical practice in Germany may also explain the high number of German guests at Ayuresort.[206] Representing a basic part of those guests' image of medicine, the *Kur* enters new territory by moving to other geographical regions and by building on other forms of health care practice. Ayurvedic resort practice represents a new transnational form of the *Kur*, and

[206] There may be other reasons too, such as the long tradition of complementary and alternative medicine in Germany, a general German tradition of having a rather 'active vacation' than passive recreation or the greater prevalence of Ayurvedic medicine in Germany than in several other countries. But I presume that the tradition of the Kur also contributes significantly to this fact.

instead of taking an *F. X. Mayr-Kur* in Austria or a *Kneipp-Kur* in Germany, Europeans concerned about their health and interested in enhancing their general wellbeing fly to India for having an *Ayurveda-Kur*.

5 Conclusion: Ayurveda's Multiple Authenticities

In October 2009, Dr. Sudhakaran, the chief physician of the private Ayurvedic hospital in Ernakulam invited me to give a presentation on the global spread of Ayurveda at a conference organized by the Ayurveda Hospital Management Association (AHMA)[207] in Kollam. While reading the introductory note to the conference program, I came across the following: "AHMA could bring a new work culture and was able to tame the mushrooming of fake Massage mafia and fake Ayurveda clinics, who were exploiting the new status which Ayurveda enjoyed recently in the international level" (Ayurveda Hospital Management Association 2009). With 'fake massage mafia' and 'fake Ayurveda clinics,' the association referred to Ayurvedic resorts and smaller Ayurvedic centers in touristic areas whose practices deviate from standard clinical practice – precisely the sort of thing that is offered at Ayuresort, the principal site of this study's field investigation.

In the process of providing an ethnographic account of Ayurveda at this resort, this study advanced a novel interpretation of Ayurveda's transnational formation. By seeing Ayurveda as a boundary object, I argued that multiple forms of Ayurvedic practice and knowledge worldwide shape a global Ayurvedic 'scape' at a state of constant development and re-development. In contrast to AHMA's essentialist view, this study would challenge the existence of a 'fake Ayurveda.' Instead, I show Ayurvedic practices come in distinct forms based on a particular space of connectivity in which transnational circulations and networks are localized. It follows that transnational interactions and negotiations in this space mold a new kind of Ayurvedic institution and practice, which are as 'fake' or *real* as Ayurvedic hospitals and clinical practice. Human and non-human actors such as the staff at Ayuresort and its management, resort guests, public tourism authorities, travel agencies, Ayurveda textbooks, Ayurvedic massages at Austrian luxury hotels, the *Kur* in Germany or the concept and syndrome of stress, all contribute to the production of a unique practice at Ayuresort. Through processes of exchange, negotiation and translation between 'mobile' and 'immobile' actors, a new form of Ayurveda is enacted to simultaneously represent an

[207] AHMA is a Kerala-based professional organization of Ayurvedic hospitals, practitioners and students founded in 2004 with the aim to promote Ayurveda and enable access to Ayurvedic treatment for a broad segment of the population.

agglomerated version of the global transnational Ayurvedic space and shape the latter.

To this end, the study analyzed the Ayurvedic practice at Ayuresort forming a transnational space that assembles people, ailments, concepts, perceptions, expectations and knowledge from different cultural contexts that are embedded in power relations between various actors related to economic interests. I have also illustrated that the practice at Ayuresort constitutes a new form of Ayurveda that is situated at two intersections: first, of wellness, preventive and curative practice, and second, of health care and tourism. Characterized by new forms of treatment, this new kind of Ayurveda is primarily based on an interplay of several factors including: the guests' specific needs and perceptions stemming from experiences with Ayurveda in their home countries and media representations of Ayurveda, their search for stress relief, knowledge of the *Kur* and proactive understanding of health; Dr. Praveen's knowledge of Ayurvedic theory and practice coupled with his readiness to adapt this knowledge for pragmatic reasons to new circumstances while maintaining certain Ayurvedic core principles; and the resort management's profit orientation and power relations between different actors. Against this background, Ayurveda can be conceived of as a boundary object in which different actors invest distinctive meanings, histories and practices that cut through multiple boundaries such as those between wellness and medical treatment, health care and tourism, patient and tourist, hospital and hotel, Asia and Europe, local and global.

Chapter 2 provided an overview about the practices at Ayuresort, due to entrepreneurial reasons largely influenced by the guests' motivations for visiting the resort and their perceptions of Ayurveda. I have illustrated that these motivations and perceptions in turn are based on representations of Ayurveda in Indian and foreign promotion and information material on the one hand and guests' experiences with Ayurveda in and outside India on the other hand. The chapter has further argued that treatments and consultations differ from those conducted in Ayurvedic hospitals: While Ayurvedic clinics and hospitals in India are primarily visited for curative reasons and offer therapeutic treatments, Ayuresort offers preventive, 'wellness' *and* therapeutic treatments in accordance with the guests' wide scope of motivations for visiting the resort, ranging from the treatment of minor ailments and health maintenance to wellbeing, recreation and relaxation.

Chapter 3 discussed the enactment of 'stress' and the Ayurvedic treatment *śirodhārā* for stress relief in the resort, in response to the guests' expectations and the articulation of their ailments as stress, that played an important role in forming Ayurveda at Ayuresort. After demonstrating how stress is primarily a Euro-American concept and syndrome produced by

particular socioeconomic, technological and intellectual developments and largely unknown in India, I showed how Dr. Praveen developed 'his own stress.' The chapter described how Dr. Praveen on the one hand enacted a new kind of stress and created relaxation treatments on the other hand, one of them being *śirodhārā*, which was enacted as a popular technique for relaxation and stress relief against this background.

In Chapter 4, I analyzed the convergence of therapeutic, preventive and wellness aspects in Ayurvedic resort practice against the backdrop of a comprehensive, pro-active conceptualization of health and wellbeing guests brought to Ayuresort commonly featured in the German health care tradition of the *Kur*. After an introduction to the institutions of the medical spa in continental Europe and the *Kur* in Germany, I investigated the practice at Ayuresort against its embedding in the tourism industry. This was followed by an examination of the merging of therapeutic, preventive and wellness aspects in resort practice, together with its interplay with vacation elements. I demonstrated how German-speaking resort guests, travel agencies and media make sense of the resort practice due to similarities between the latter and the *Kur*. The chapter has shown that German guests seek Ayurvedic treatment at Ayuresort because of their experiences and knowledge of the *Kur* and that the practice at Ayuresort can eventually be labeled as a transnational *Ayurveda-Kur*.

This '*Kur-Ayurveda*' at Ayuresort comes into existence through transnational entanglements and the mutability of medical practice in general and Ayurveda in particular. *Kur-Ayurveda* represents one part of the transnational Ayurvedic space established by and consisting of multiple forms of Ayurvedic practice, knowledge and institutions. Yet often assessed through an essentialist lens, these multiple forms of Ayurveda are attributed different degrees of authenticity by resort and hospital practitioners, resort managers, resort guests and travel agencies thus resulting in a discourse about 'real Ayurveda' and 'fake Ayurveda.' During my fieldwork, I regularly heard statements like the following one by Dr. Karunan from a private Ayurvedic hospital in Kollam: "Resort Ayurveda is fake Ayurveda. It's for business. In hospitals, you find real Ayurveda." Dr. Ajayan from a governmental Ayurvedic hospital in Varkala explained to me: "Here we provide genuine treatments – for healing purpose, not for business. In resorts it's mainly for business." Dr. Sankar, working in a private Ayurvedic hospital near Tiruvalla, said: "In resorts it's a business. [...] Europeans are cheated with wrong Ayurveda." And Dr. Sudhakaran from the private hospital in Ernakulam claimed that in comparison to Ayurvedic resorts, Ayurvedic hospitals and clinics provide "serious and authentic Ayurveda." Echoing the statement from the AHMA conference program quoted at the beginning of this chapter, these and other doctors

opposed Ayurvedic resort practice, which they considered as 'wrong Ayurveda,' 'fake Ayurveda' and conducted 'for business,' to clinical practice, regarded as 'serious,' 'authentic,' 'genuine' and 'real Ayurveda.' Several practitioners I spoke to saw in Ayurvedic resort practice Ayurveda's alienation from an 'original' perceived context of therapeutic practice in clinical settings. This was said to happen in the wake of Ayurveda's embedding in the tourism industry that fostered Ayurveda's transformation from a therapeutic practice into a tourism service subject to resort owners' and managements' interest in profit maximization. Several practitioners complained about a negatively connoted 'commercialization' of Ayurvedic practice in the course of its transfer from medical institutions to the tourism sector. Statements like "they only do it for making money" (Dr. Ajayan) referring to the provision of Ayurvedic treatment by resorts were supported by the claim of Ayuresort's general manager Vasu, that the company that ran the resort equated Ayurveda with a commercial product for profit increase. Similarly, during the photo shoot described in Chapter 2, the creative director Manu claimed that for the company "Ayurveda is only business" and the practice at Ayuresort "is not real Ayurveda," in comparison to that practiced in Ayurvedic clinics and hospitals.

In the same way hospital practitioners considered Ayurvedic practices in resorts as not 'genuine' or 'serious' as they would deviate from the practice common in clinics and hospitals in order to please the guests and benefit economically in the process.[208] However, although doctors frequently authenticated clinical Ayurveda over resort practice, they rarely elaborated on the differences and specified reasons for their judgments. When I pressed the issue, most common answers stated that clinics and hospitals provide therapeutic treatment while resorts offer "only massages and no real treatment" (Dr. Karunan). Dr. Sankar provided a more 'medical' justification for these claims by arguing that the practice in Ayurvedic resorts does not represent "proper treatment" as single applications such as *ki<u>l</u>i* or *pi<u>l</u>iccil* are offered without any indication. Several practitioners also condemned resort practice because specific activities such as swimming or sun-bathing, which resort guests would usually engage in, would be prohibited during 'proper Ayurvedic treatment.' Dr. Sudhakaran in addition claimed that many resort practitioners would not be formally educated in contrast to clinic and hospital doctors who almost all own a B.A.M.S. degree.[209]

208 Similar observations have also been made by other scholars (Rudra 2011: 145; Spitzer 2009: 145; Tirodkar 2005: 234).

209 The assertion that a great amount of practitioners in Ayurvedic resorts are unqualified was very common among clinic and hospital doctors. In addition, information materials for Ayurvedic treatment and travel guide books frequently warn of unqualified practitioners. However, fourteen out of the eighteen practitioners working in Ayurvedic resorts I discussed with during my research held a B.A.M.S. degree, while out of the remaining four two had earned a Diploma of Ayurvedic Medicine. Only two did not have any official degree. Similarly, a survey by Ramesh and

Several scholars have also attributed Ayurveda at resorts to a commercialized – and, by extension, bastardized – version to argue for its lack of authenticity. Repeating the practitioners' use of the term 'commercial' to denominate resort practice, Tirodkar (2005: 234) distinguishes it from 'modern' and 'traditional' practice at Ayurvedic clinics and hospitals (see Chapter 1). Similarly, Langford labels her *śirodhārā* treatment "a mood-altering commodity" (2013: 286; emphasis by the author; see also Chapter 2), and Islam describes Ayurveda at resorts as a "consumer product," which has lost its purpose of restoring health (2012: 230).

But is Ayurvedic resort practice really more 'commercial' than Ayurvedic treatment in hospitals? Are single applications offered to resort guests rather 'commodities' than Ayurvedic drugs sold at pharmacies or in clinics? Adam Kaul defines commercialization as "the introduction or intensification of monetary exchange *in relation* to the production and/or consumption of a thing" and commodification as "a particular commercializing process whereby a produced thing or activity *itself* is given a consumptive market value" (Kaul 2007: 706f.). Accordingly, many forms of health-related objects and practices worldwide – biomedical and non-biomedical – can be considered as commercialized, commodified and subject to consumerism.[210] This also counts for different forms of Ayurveda.[211] Yet, Ayurvedic practitioners not only label resort practice as commercialized and commodified but they also judge it as 'inauthentic.' However, in contrast to scholars who disapprove of different forms of Ayurveda in the Euro-American world by measuring them against classic Ayurvedic textual sources considered as 'authentic' – both implicitly (see e.g. Selby 2005; Zimmermann 1992; Zysk 2001) and explicitly (see e.g. Das 1995; Schmädel 1993) – the doctors I talked with assessed the authenticity of resort Ayurveda in distinction to clinical practice.

Is the Ayurvedic treatment found in Ayurvedic resorts really less authentic than treatment in Ayurvedic clinics and hospitals? Implications of commercialization or commodification for the authenticity of practices, experiences, objects and places have been extensively discussed in tourism studies and the anthropology of tourism, which also included discussions about the notion of 'authenticity' itself.[212] Dr. Sudhakaran's, Dr. Ajayan's or Dr. Karunan's

Joseph of 43 Ayurvedic centers in Kerala shows that all practitioners had a B.A.M.S. (37) or even M.D. (6) degree (2012: 32 [Table 2]).

210 This has also been argued by numerous authors. See e.g. Cant and Sharma 1999 (Chapter 2); Fishman 2004; Hanson 1999; Henderson and Petersen 2002; Martin and Frost 2003; Nichter 1989b; Pellegrino 1999; Sharp 2000; Timmermans and Almeling 2009.

211 See e.g. Abraham 2013; Banerjee 2002; Bode 2006, 2008; Frank and Stollberg 2004b; Madhavan 2013; Nichter and Nordstrom 1989.

212 See e.g. Cohen 1988; Handler and Saxton 1988; Kaul 2007; Kim and Jamal 2007; MacCannell 1973, 1976; Reisinger

description of the practice at their hospitals as "authentic," "genuine" or "real" in distinction to the 'commercial' tourist practice found in Ayurvedic resorts mirrors the notion of 'cultural commoditization' introduced by Davyyd Greenwood in 1977. This view holds that practices lose their 'original meaning' through their marketing for touristic consumption and become meaningless and 'inauthentic' for their producers in their commodified form (Greenwood 1989 [1977]: 179). According to Dean MacCannell, the result is a "staged authenticity" in which the 'original authenticity' of practices is destroyed and the latter are transformed into 'fake experiences' that are specifically produced for the tourists or consumers (or resort guests in our case; MacCannell 1973, 1976).

These positions framing 'authenticity' as original, true or genuine echo the dominant tendency in tourism studies until the 1990s (see e.g. Cohen 1979, 1988; Littrel 1990; MacCannell 1973, 1976). Such an 'objective authenticity' (Wang 1999) is based on the assumption that objects, practices, events and places can be attributed an 'original' or 'true' character and can be measured against objective criteria or standards in order to determine whether they are authentic or not (Kim and Jamal 2007: 183). In the last two decades, this conceptualization of authenticity has been questioned by post-structuralist and constructivist approaches, which considered authenticity to be constantly created in social processes through negotiated meaning-making and interpretation (Bruner 1994; Hughes 1995; Olsen 2002). The idea of the *authentic nature* of an object, practice or place has been replaced by *perspectives on authenticity* that different stakeholders have (see e.g. Hughes 1995; Jackson 1999; Xie and Lane 2006: 546). This 'constructive authenticity' (Wang 1999) is conceptualized as relative, negotiable and contextually determined projection of beliefs, expectations, perceptions, stereotypes, preferences, ideologies and power (Bruner 1994: 408; Waitt 2000: 846, 848; Wang 1999: 351, 355) rather than as inherent in an object, practice or event. Hence, it can be considered as a process rather than a property, as it is subject to constant change and created in relation to the specific present context (see also Kaul 2007: 713). It is constructed through the co-existence of different perspectives. However, acknowledging authenticity multiple, relative and contextually determined does not preclude value and moral judgments inherent in notions of authenticity.

Also the hospital practitioners' statements presented above articulate such value or moral judgments. The perceived commercialization of Ayurvedic resort practice is considered as something bad that is not only commercially polluting but also morally corrupting Ayurveda. Ayurveda means for these doctors clinical practice, to which they attribute an

and Steiner 2006; Trilling 1972; Waitt 2000; Wang 1999.

inherent, objective authenticity and which represents the yardstick against which resort practice is measured – and judged as inauthentic, unreal and fake. Here, I do not intend to discuss the practice at Ayurvedic resorts in terms of authenticity or inauthenticity, but rather analyze the discourse about the authenticity of Ayurvedic treatment at resorts in Kerala in the context of the emergence of the global multiplicity of Ayurvedic practice. Instead of investigating the authenticity of resort and clinical practices, I assess their (in)authentication through different actors. I discuss *perceived* (in)authenticity of Ayurvedic treatment, which is conceived in an *essentialist form* by the different actors who have dissimilar perspectives on the authenticity of Ayurveda's multiple forms.

Since authenticity is relational, context-dependent constructed and not inherent to a specific object, place or practice, something judged as inauthentic by some people can be considered as authentic by others (see also Waitt 2000: 846f.; Wang 1999: 353). This can be applied to the practice at Ayurvedic resorts in Kerala. While many hospital doctors deny resort practice authenticity and attribute the latter to clinical practice, which they consider as 'the norm,' other actors however consider Ayurveda at resorts as authentic – multiple forms of Ayurveda produce multiple authenticities.

Ayurvedic resorts and travel agencies promote resort practice as "authentic." For example, on its website, Ayutravel describes Ayurveda at Ayuresort as "traditional, authentic and down to earth" (original in German). In Varkala, many resorts and smaller Ayurvedic centers advertized their services with "authentic Ayurveda" in their leaflets.[213] Though the promotion material of Ayuresort did not include terms like 'authentic' or 'genuine,' by promoting Ayurveda "in the most traditional style" and as a "health science that's 5000 years old" (see Figure 2.5) or by including 'traditional items' such as saris, brass cannikins and oil lamps in the photos produced for advertisement, Ayuresort actively seeks to address attributes characterizing the common public notion of authenticity. In this context, the generally claimed incongruity between authenticity and commercialization of practices and objects dissolves. The concept of authenticity is used as a key element in marketing processes and is 'commercialized' itself.

Although authenticity could in this case be considered as a 'mere marketing tool,' other actors in fact do perceive Ayurveda at Ayuresort as 'authentic' or 'real' – above all Dr. Praveen. Dr. Praveen even considered parts of his practice as more authentic than the practice one finds in clinics and hospitals while acknowledging its commercialization and

[213] See also the leaflet portrayed in Figure 2.8, which claims that the Ayurvedic center offers "treatments authentic kerala panchkarma."

modification. His claim is based on three major points, which in his view characterize resort practice: less financial constrictions, a higher level of hygiene and a more intensive doctor-patient interaction.

As discussed in Section 2.3, Dr. Praveen admitted that certain practices at Ayuresort were exclusively conducted for economic reasons. For instance, during short-term treatments and single applications he turned from a practitioner into an entrepreneur and Ayurveda resembled for him a commercial product for profit maximization that was sold to well-paying consumers in a free market: "They [the guests] will get a massage and Ayuresort will get money. In these situations I have a business mind, not a doctor mind." This was also the case when the capacity of the Ayurvedic center at Ayuresort was at its limits due to large tour groups looking for Ayurvedic treatment.[214] After Miriam, the leader of a German tour group, had asked Dr. Praveen after their arrival to provide "genuine Ayurveda" (Dr. Praveen), he complained to me: "How shall I do genuine Ayurveda for so many people? And in such a short time? Here we have to think practically. It's a business." This meant in detail that he reduced the duration of the consultations – which also meant that instead of filling in the *prakṛti* questionnaire together with the guest during the first consultation, he had asked the guests to fill it in on their own before – and that he compiled a range of single applications that did not have a specific therapeutic or preventive objective and were rather 'for experiencing Ayurveda.' In these situations 'money rules.' Although Dr. Praveen did not approve of providing treatment under these circumstances and in this form, he bowed to the pressure of the management, which had to rely on such forms of practice in order to stay competitive on the Ayurvedic market.

In the context of these treatments, Dr. Praveen's opinion resembled those of the hospital practitioners quoted above. He did not only consider these practices as 'business Ayurveda' which has been created to satisfy the desires and needs of foreign consumers for economic reasons – not least by offering single applications on a 'treatment menu' and by extending the treatment array through adding for example relaxation and rejuvenation massages or by inventing new treatments like hand and feet massages –, he also worried about such practices being adverse for Ayurveda's reputation, as guests could get a wrong picture of Ayurveda.

However, it is only in the context of such 'leisure treatments' that Dr. Praveen assumes the role of a businessman and frames Ayurvedic treatment as a commercial practice. In

[214] See also Dr. Praveen's complaint about the high amount of guests and his resulting experience of stress at the beginning of the conclusion of Chapter 3.

contrast to that, he considers the treatments for long-term guests as "pure Ayurveda" and similar to the practice at Ayurvedic hospitals – and to some extent even more authentic. In the eyes of Dr. Praveen, long-term guests of Ayurvedic resorts are customers in the same way as patients of Ayurvedic hospitals. In both settings, they visit the doctor to consume health care services or related products. And in both settings the doctors have to satisfy the customer for both business and professional reasons. Patients expect services in return for the money they pay the practitioners, in both resorts and hospitals. However, while in Ayurvedic hospitals the doctor-patient relation is rather superficial, the doctor-guest relationship in resorts is much closer, what Dr. Praveen considers a basic element of 'good Ayurvedic practice' – not least because only by a close interaction and good relation "we will get a persons' disease." He described the two different forms of relationships that doctors in clinical and resort settings establish with patients and guests as '*mechanical relation*' and '*mental relation.*' According to Dr. Praveen, physicians in hospitals deal with their patients in a brief way, mainly due to the high number of patients. Consultations are superficial without a detailed anamnesis and physical examination, and doctors only prescribe medicines while "patients don't get sufficient care." The work of those doctors would be an impersonal business and the doctors themselves "machines" without human traits. By contrast, most of the Ayurvedic resort doctors would build a 'mental relation' with the long-term guests (by which he meant a personal relation with the guests that is characterized by empathy, interest and respect). They listen to them extensively, they build trust with them and convey the impression that they care about them: "Here it's like you are the only person. You can talk to the doctor, about whatever issues you have got. You'll be taken care of very personally." This is certainly also due to the fact that resort guests pay a considerable amount of money for their treatment, as mentioned in Section 2.3. However, while influenced by commercial structures, in the eyes of the doctor this form of doctor-guest interaction characterizes the Ayurvedic norm rather than the interaction between doctors and patients in the clinical setting and is hence more "pure" or 'authentic.'

Dr. Praveen further considers resort treatment more authentic than clinical treatment because of two aspects interrelated with the fact that the majority of the resort guests are Europeans: 'European hygienic standards' and the financial strength of the guests. Due to the high prices of the treatment, Dr. Praveen does not face financial restrictions in his practice. He told me that he can draw on all procedures and utilities necessary, which is not the case in clinical settings, where doctors have more financial constraints, what eventually influences the treatment quality. At Ayuresort, he can apply high quality oils and medicines,

all required equipment is available and treatments can be conducted by two or even three therapists simultaneously, what increases the effectiveness of certain applications as Dr. Praveen states:

> *It's a truth: the pure Ayurveda exists in the resort, not in the hospital. Because in resorts, we get more money for the treatment – three to five times more. So we don't have to calculate so precisely with the money and I can apply my style and don't have to act according to financial restrictions from the management. The quality of the medicine and the oils is better. And we only apply the oil for three times maximum. After this, the oil will be heavy and loses its quality. In hospitals, oils are used more often.* [...] *In the resort field, there are no limitations for prescribing medicines and oils, like for IPs* [inpatients] *in hospitals. I'm free in my decisions what I prescribe. Last year, a lady from Serbia came here with Parkinson and I gave her costly tablets – one for 50 Rupees. And costly oil. Vasu* [the general manager] *doesn't have any problems with this. Because on the long run, high profit is coming. You don't have to cut on minor things* (additions by the author).

Changing used oil more frequently does not only influence the treatment quality. While according to Dr. Praveen it is not uncommon in hospitals to use the same oil for several patients for economic reasons, the possibility to change the oil more often due to greater financial scope also contributes to another aspect that makes resort practice more authentic than hospital practice in the eyes of Dr. Praveen: the level of hygiene. Since European resort guests expect high standards of hygiene and cleanliness, oil is usually not used for several guests and equipment and the treatment rooms with attached bathrooms are generally cleaner than in Ayurvedic hospitals, according to Dr. Praveen. Treatment tables, oil vessels and bathrooms are usually cleaned by the therapists after each treatment, what is not the case in the majority of Ayurvedic hospitals, as he further explained.[215] And cleanliness would be a pillar of 'authentic Ayurveda,' what he justified by referring to a *sūtra* in the *Carakasaṃhitā* that lists cleanliness as one of the four qualities (*guṇas*) of a practitioner.[216] Thus, a closer relationship between the doctor and the guest, fewer compromises in treatment applications due to less financial restrictions, and higher cleanliness and hygienic standards let Dr. Praveen claim that "real Ayurveda" is found in Ayurvedic resorts rather than in Ayurvedic hospitals.

New forms of Ayurveda coming into being in Ayurvedic resorts are thus considered as authentic Ayurvedic practice by Dr. Praveen – despite, or even because of, increased monetization. But how does he legitimize the reconfigurations through which resort practice differs from clinical practice as authentic Ayurvedic practice? Just as he referred to classic Ayurvedic texts when claiming to practice "pure Ayurveda," Dr. Praveen also justified

[215] Similar statements were also heard by Spitzer in her interaction with practitioners working in Ayurvedic resorts (Spitzer 2009: 146). Also Jayan from Kerala's Department of Tourism told me that the hygienic standard in hospitals was in general lower and that foreigners preferred resorts over hospitals because "they need a clean place, a hygienic place." Indeed, high hygienic standards are one prerequisite for obtaining the leaf certification discussed in Chapter 4.

[216] The other three are excellent theoretical knowledge, extensive practical experience and dexterity (*Carakasaṃhitā*, Sū. 9.6).

the transformation of Ayurveda through the interaction with his guests by referring to the *Carakasaṃhitā*. As described in Section 2.3, he claims to adapt the practice only as far as it is still in accordance with core principles of textual Ayurveda. In addition, the reconcilability of the seemingly incompatibility of transformation and authenticity of Ayurvedic treatment was facilitated through Dr. Praveen's personal approach to Ayurveda, which was based on two interrelated principles: First, he did not perceive Ayurvedic knowledge as a rigid doctrine one has to adhere to strictly but rather as a flexible companion which provides a skeleton that can be filled with flesh in different ways depending on the specific context. He frequently paraphrased this with the statement "every doctor has his own style." He based this assumption on one section of the *Carakasaṃhitā*, which he summarized as follows: "Don't follow it [the content of the text] blindly, take it as a reference and create own ideas. Caraka says: 'You have to create your treatment style, don't follow other doctors'" (addition by the author). And as "we live in a fast world, we have to adjust Ayurveda to the circumstances." Second, he let his practice be guided by a motto that was portrayed on a poster in his consulting room picturing Dhanvantari. Underneath the tutelary deity, it read "Authentic Ayurveda... Modern Approach." Dr. Praveen told me that he liked this caption a lot and when I asked him why and what it exactly means, he replied: "It says what I think. We have to provide very old Ayurveda, but with a modern approach. There are changes in Ayurveda. It doesn't stay the same like it was in former days. As Caraka says, you have to create your treatment style." Thus, Dr. Praveen on the one hand equated 'authentic' with old, which stands for certain core principles and elements that constitute Ayurveda and which he found in the *Carakasaṃhitā* as well as in clinical and resort practice, such as the *tṛdoṣa* theory or the framework of *pañcakarma* treatment. On the other hand, he saw the necessity of a 'modern approach' to Ayurveda, i.e. the transformation of Ayurvedic practice, in order to adapt to new developments and circumstances that our "fast world" brings along. After he illustrated this with the production of tablets on a biomedical model that increasingly replace *kaṣāyam*s (decoctions) for practical reasons, I followed up on this by asking what this means for the practice at Ayuresort. He provided the examples of the reduction of treatment durations adapted to the guests' vacation period, the inclusion of non-Ayurvedic elements like acupressure theory or *kaḷarippayattu* practices to create new treatments, and the adding of "some traditional things" to the treatment sequence, like the two rituals described in Section 2.3 for "mental satisfaction" for the guests.

Although constituting new, invented practices rather than an 'old tradition' as argued in Section 2.3, these rituals were associated by most of the guests with an imagined ancient

'Hindu' or 'Indian culture' and thus confirmed their assumption of Ayurveda as being 'traditional' and 'Indian.' This in turn contributed to the guests' perception of the treatment at Ayuresort as being 'authentic Ayurveda.' Such a connection between Ayurveda and India, 'Indian tradition' or 'Indian culture,' which many guests made as illustrated in Section 2.2, was the point of reference for most of the guests in their evaluation of the treatment's authenticity. Many guests' notion of authentic Ayurvedic treatment was not framed around a distinction between resorts and hospitals, but between South Asia and Europe. For them it was important to receive Ayurvedic treatment in its place of origin, and not at home where it was perceived as not 'authentic' or 'original,' as for instance Hannah's statement from one of our conversations demonstrates: "Here [at Ayuresort], we have Ayurveda in its original form. In Austria, it has a Western touch. And it is pushed into a wellness corner" (addition by the author). Like Hannah, several guests saw the practice at Ayuresort as authentic or original because it was located in India or more specifically Kerala, which many guests considered as the cradle of Ayurveda. The perceived authenticity of Ayurvedic practice in India in comparison to Europe is however not only rooted in specific treatment practices as in Hannah's case but in further 'Indian-specific' aspects, as the following remark by Sarah shows:

> *My family doctor advised me against a treatment in Italy and suggested to come here because it is more authentic here. There is much more involved* [in Ayurvedic treatment] *than only diet and massage. It also involves the authenticity of the landscape, the population, the completely different lifestyle, this tranquility* (addition by the author).

The majority of the resort guests attributed importance to treatment-related and other aspects that were allegedly 'Indian' and missed in European Ayurvedic practice for considering Ayurvedic treatment to be authentic. These aspects include Indian practitioners and therapists, special Indian food products and dishes, Ayurvedic medicines and oils that are not available in Europe and the fact that the treatment takes place in Ayurveda's place of origin. As a result, for many guests, resort practice was the only existing authentic Ayurveda – for them, Ayurveda was resort Ayurveda.

To conclude, with the emergence and spread of Ayurvedic resorts as part of the global multiplicity of Ayurvedic practice, new forms of Ayurveda have evolved, to which are attributed different degrees of authenticity. The latter depend on actors' backgrounds in terms of experiences and interests, and the resulting yardsticks against which they measure the practice's authenticity in their evaluations. Different groups of actors generate a subjective framework of what constitutes 'authentic Ayurveda' by resorting to dissimilar standards of comparison, against which they (in)authenticate resort practice and from which

eventually the existence of multiple authenticities of Ayurvedic practice results: classic Ayurvedic texts and college education (Dr. Praveen), Ayurvedic practice in Europe together with its representations in different media (resort guests), and Ayurvedic treatment in clinics and hospitals in India (hospital practitioners).

Rather than evaluating the authenticity of Ayurveda practiced in resorts on the one hand and in clinics and hospitals on the other, my discussion on this debate aimed at looking at the dynamism of Ayurveda and the resulting variety of Ayurvedic practice and knowledge from another perspective. The conceptualization of Ayurveda as a boundary object that produces multiple forms of Ayurvedic practice and knowledge (including clinical treatment and college education, which could also be, and indeed were, considered as 'inauthentic' for their biomedical elements[217]), as illustrated in Chapter 1, implies the non-existence of an objective (in)authenticity of Ayurvedic practice. Instead, the multiplicity of Ayurvedic practice and knowledge results in multiple authenticities of Ayurveda, which I suggest to be considered of equal value, and which assume a vital role in the contemporary Ayurvedic landscape in Kerala. The concept of authenticity is applied as a marketing tool by various travel agencies and resort managements, it is resorted to by many guests as a distinct identity marker based on which treatment in India is preferred over treatment in their home country, and it is used as strategic moves by different doctors as value judgments and means of legitimization of their own and other practitioners' practice.

In this process, modified Ayurvedic practice is attributed 'authenticity' by different actors (Dr. Praveen, resort guests), despite or even due to its acknowledged commercialization, by which the seeming incongruity between commercialization (and resulting reconfiguration of practice) and authenticity dissolves to a certain extent. Increased monetization, which is perceived by many actors as commercialization, facilitates 'more authentic' treatments according to Dr. Praveen – 'authentic Ayurveda' is resort Ayurveda for Dr. Praveen and his guests. Perceived commercialization of Ayurvedic practice thus does not necessarily result in the latter's reception as less authentic. At the same time, the concept of authenticity gets 'commercialized' itself, when it is applied as a key element in marketing activities for Ayurvedic tourism.

In one of his articles on Ayurvedic treatment in Germany, Dieter von Schmädel wondered about the future of Ayurveda as a diasporic medical tradition transferred from South Asia to Europe, with the title asking *Ayurveda: Quo vadis?* (Schmädel 1993). Similar questions

---

[217] See for instance the debate about professionalized Ayurveda by the integrationists and purists delineated in Chapter 1.

are asked by Ayurvedic practitioners in India about the future of Ayurveda in its place of origin. As the health care market in India – as virtually all over the world – is dominated by biomedicine, various doctors worry about Ayurveda's ability of remaining competitive with the hegemonic medical system. And for several of them, Ayurvedic resorts represent one advantage in this 'struggle for survival,' even for some of those practitioners who criticize their practices and consider them as 'not real.' While many practitioners caution against the damage that Ayurvedic resort practice might do to 'real' Ayurveda by misrepresentations of Ayurvedic treatment, others also consider them as positive since they contribute to increasing the popularity of Ayurveda – both in and outside India. Dr. Praveen revealed a similar view, when he told me: "Young Ayurveda doctors say: 'We have to promote Ayurveda all over the world.' And the resort field is the perfect place for doing that." He considered Ayurvedic resorts as the perfect point of departure for a global spread of Ayurvedic knowledge and eventually practice, foremost by returning guests spreading knowledge about Ayurveda in their home countries.

Those statements, together with the general discourse about the authenticity of Ayurvedic resort practice disclose parallels to the reactions of Ayurvedic practitioners in the course of the spread of European medicine to India and the following decline and revivalism of Ayurveda in the nineteenth and twentieth century outlined in Chapter 1. On the one hand, the criticism expressed by various hospital doctors resembles the criticism uttered by Ayurvedic practitioners in reaction to the import of European medicine and its subsequent influence on Ayurvedic practice and knowledge during the colonial period. Similar to the 'purists' who disapproved of the 'integrated approach' to Ayurveda, today hospital practitioners who are largely 'integrationists' – or modern doctors of traditional medicine, as Naraindas (2006: 2662) calls them – condemn resort Ayurveda. On the other hand, Ayurvedic resorts' claimed potential for enhancing the popularity of Ayurveda (both in and outside India) could be considered as a new revitalization of Ayurveda – on a smaller local but greater global scale. Initiated by Indian nationalists in the twentieth century, this time 'Ayurveda's revival,' including the production of new forms of Ayurvedic practice and knowledge, is mainly triggered by international visitors in interaction with local stakeholders. In both forms of revivalism, Ayurveda is deployed as 'traditional' Indian heritage on the one hand and as 'modern' medical practice influenced by Western paradigms and standards on the other. While in colonial and early post-colonial India the first aspect primarily served as identity construction on a socio-political level, in the Ayurvedic resort context it mainly satisfies the resort guests' orientalist desire and longing for 'authentic Ayurveda'

in its place of origin embedded in the country's cultural heritage for economic reasons. At the same time, in both instances promoters of Ayurveda connect it with practices, theory and organizational structures based on biomedicine. As integrationists during the first revivalism reconfigured Ayurveda based on biomedical institutions, research, theory and practice in order to secure Ayurveda's survival, tourist stakeholders emphasize not only Ayurveda's 'ancient tradition' but also display "a modern and professionalized stance supported by scientific research and grounded in the rigorous training of practitioners at officially recognized Ayurvedic colleges" (Spitzer 2009: 139) to attract visitors. And while the former revitalization of Ayurveda was considered by Indian nationalists as "the best means for curing the ills of India" (Berger 2008: 112), the new revivalism of Ayurveda represents a means by which "the ills of the West can be healed" (Spitzer 2009: 148; see also Langford 2013) – both in and outside India.

References

Abraham, L.
2009. Medicine as Culture: Indigenous Medicine in Cosmopolitan Mumbai. *Economic & Political Weekly* 44(16): 68–75.

———
2013. From Vaidyam to Kerala Ayurveda. *The Newsletter (International Institute for Asian Studies)* 65: 32–33.

Abu-Er-Rub, L.
2015. *Goldene Zeiten: Mode und Körper im neoliberalen Indien.* Ph.D. dissertation, Ruprecht-Karls-Universität Heidelberg, Heidelberg.

Alter, J. S.
1999. Heaps of Health, Metaphysical Fitness: Ayurveda and the Ontology of Good Health in Medical Anthropology. *Current Anthropology* 40: 43–66.

———
2004. *Yoga in Modern India: The Body between Science and Philosophy.* Princeton: Princeton University Press.

Alter, J. S., ed.
2005a. *Asian Medicine and Globalization.* Philadelphia: University of Pennsylvania Press.

Alter, J. S.
2005b. Modern Medical Yoga: Struggling with a History of Magic, Alchemy and Sex. *Asian Medicine: Tradition and Modernity* 1(1): 119–146.

Altgeld, T.
2014. Zukünftiger Stellenwert des Betrieblichen Gesundheitsmanagements. In *Fehlzeiten-Report 2014: Erfolgreiche Unternehmen von morgen – gesunde Zukunft heute gestalten*, B. Badura, A. Ducki, H. Schröder, J. Klose, and M. Meyer, eds., pp. 299–309. Berlin: Springer.

American Psychiatric Association
1994. *DSM-IV™: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.* Washington: American Psychiatric Association.

Andritzky, W.
1997. *Alternative Gesundheitskultur: Eine Bestandsaufnahme mit Teilnehmerbefragung.* Berlin: Verlag für Wissenschaft und Bildung.

AOK-Bundesverband
n.d. *1997: Beitragsentlastungsgesetz sowie 1. und 2. NOG.* Electronic document, http://www.aok-bv.de/politik/reformaktuell/geschichte/index_00517.html, accessed January 12, 2016.

Appadurai, A.
1990. Disjuncture and Difference in the Global Culture Economy. *Public Culture* 2(2): 1–24.

Arnold, D.
1993. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India.* Delhi: Oxford University Press.

Aṣṭāṅgahṛdaya
2009. *Vāgbhaṭa's Aṣṭāṅga Hṛdayam.* Translated by K. R. S. Murthy. Reprint. Varanasi: Chowkhamba Krishnadas Academy.

Athavale, V. B.
1977. *Bala-Veda: Pediatrics & Ayurveda.* Bombay: Municipal Medical College.

Ayurveda Hospital Management Association
2009. *2nd State Conference: 29, 30 October 2009.* Conference Program.

'Ayurveda-Kosmetik in der VHS'
2007. *Süddeutsche Zeitung,* Landkreisausgabe München Nord, October 10: R5.

Backé, E.-M., A. Seidler, U. Latza, K. Rossnagel, and B. Schumann
2012. The Role of Psychosocial Stress at Work for the Development of Cardiovascular Diseases: A Systematic Review. *International Archives of Occupational and Environmental Health* 85(1): 67–79.

Bacon, W.
1997. The Rise of the German and the Demise of the English Spa Industry: A Critical Analysis of Business Success and Failure. *Leisure Studies* 16(3): 173–187.

Bäderland Deutschland
2015a. *Fragen zur Kur.* Electronic document, http://www.baederkalender.de/kurinfo.fragen.php, accessed January 8, 2016.

———
2015b. *Indikationskriterien.* Electronic document, http://www.baederkalender.de/indikationskriterien.php, accessed January 8, 2016.

Baer, H. A.
2003. The Work of Andrew Weil and Deepak Chopra – Two Holistic Health/New Age Gurus: A Critique of the Holistic Health/New Age Movements. *Medical Anthropology Quarterly* 17(2): 233–250.

Banerjee, B. G., K. G. Singh, and A. K. Sinha
2013. *Ayurveda: A Traditional System of Medicine in India.* New Delhi: Northern Book Centre.

Banerjee, M. [Madhulika]
2002. Power, Culture and Medicine: Ayurvedic Pharmaceuticals in the Modern Market. *Contributions to Indian Sociology* 36(3): 435–467.

———
2008. Ayurveda in Modern India: Standardization and Pharmaceuticalization. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 201–214. Albany: State University of New York Press.

———
2009. *Power, Knowledge, Medicine: Ayurvedic Pharmaceuticals at Home and in the World.* Hyderabad: Orient BlackSwan.

Banerjee, M. [Mukulika] and D. Miller
2003. *The Sari.* Oxford: Berg.

Barclay, E.
2009. Stem-Cell Experts Raise Concerns about Medical Tourism. *The Lancet* 373(9667): 883–884.

Barnes, P. M., E. Powell-Griner, K. McFann, and R. L. Nahin
2004. Complementary and Alternative Medicine Use among Adults: United States, 2002. *Seminars in Integrative Medicine* 2(2): 54–71.

Basham, A. L.
1976. The Practice of Medicine in Ancient and Medieval India. In *Asian Medical Systems: A Comparative Study*, C. Leslie, ed., pp. 18–43. Berkeley: University of California Press.

Bastos, C.
2011. From Sulphur to Perfume: Spa and SPA at Monchique, Algarve. *Anthropology & Medicine* 18(1): 37–53.

Baudelaire, C.
1857. *Les Fleurs du mal.* Paris: Auguste Poulet-Malassis.

Beard, G. M.
1869. Neurasthenia, or Nervous Exhaustion. *Boston Medical and Surgical Journal* (New Series) 3(13): 217–221.

———
1881. *American Nervousness: Its Causes and Consequences.* New York: G. P. Putnam's Sons.

Benjamin, W.
1923. *Charles Baudelaire: Tableaux Parisiens.* Deutsche Übertragung mit einem Vorwort über die Aufgabe des Übersetzers. Heidelberg: Verlag von Richard Weissbach.

Benner, D.
2005. The Medical Ethics of Professionalised Āyurveda. *Asian Medicine: Tradition and Modernity* 1(1): 185–203.

Berger, R.
2008. Ayurveda and the Making of the Urban Middle Class in North India, 1900-1945. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 101–115. Albany: State University of New York Press.

———
2013a. *Ayurveda Made Modern: Political Histories of Indigenous Medicine in North India, 1900-1955.* New York: Palgrave Macmillan.

———
2013b. From the Biomoral to the Biopolitical: Ayurveda's Political Histories. *South Asian History and Culture* 4(1): 48–64.

Berlin-Brandenburgische Akademie der Wissenschaften
n.d. *Das Digitale Wörterbuch der Deutschen Sprache.* Online dictionary, http://www.dwds.de/?qu=kur, accessed January 7, 2016.

Bernard, C.
1865. *Introduction à l'étude de la médecine expérimentale.* Paris: J. B. Baillière et Fils.

Bhattacharya, S., M. Harrison, and M. Worboys
2005. *Fractured States: Smallpox, Public Health and Vaccination Policy in British India 1800-1947.* New Delhi: Orient Longman.

Bhopal, R. S.
1986. The Inter-Relationship of Folk, Traditional and Western Medicine Within an Asian Community in Britain. *Social Science & Medicine* 22(1): 99–105.

Bindu, V. T., P. Chitramani, and B. P. George
2009. Perception of Tourists towards Kerala as a Preferred Alternate Health Tourism Destination: A Study. *South Asian Journal of Tourism and Heritage* 2(1): 68–76.

Bleile, G.
1985. Kurorte und Heilbäder in der Bundesrepublik Deutschland: Struktur und Entwicklung. *Tourism Review* 40(3): 9–14.

Blumer, G. A.
1906. The Coming of Psychasthenia. *The Journal of Nervous and Mental Disease* 33(5): 336–353.

Bode, M.
2002. Indian Indigenous Pharmaceuticals: Tradition, Modernity and Nature. In *Plural Medicine, Tradition and Modernity: 1800-2000*, W. Ernst, ed., pp. 184–203. London: Routledge.

———
2006. Taking Traditional Knowledge to the Market: The Commoditization of Indian Medicine. *Anthropology & Medicine* 13(3): 225–236.

———
2008. *Taking Traditional Knowledge to the Market: The Modern Image of the Ayurvedic and Unani Industry, 1980-2000.* Hyderabad: Orient BlackSwan.

———
2013. Traditional Indian Medicine: Heritage, Health Security, Ontology. *The Newsletter (International Institute for Asian Studies)* 65: 21–22.

Bookman, M. Z. and K. R. Bookman
2007. *Medical Tourism in Developing Countries.* New York: Palgrave Macmillan.

Bradley, R. and E. Kim
1994. Loosening the Reins: Autonomy Boosts Cuban Medical Industry. *Harvard International Review* 16(4): 66–67.

Brand, F. S. and K. Jax
2007. Focusing the Meaning(s) of Resilience: Resilience as a Descriptive Concept and a Boundary Object. *Ecology and Society* 12(1): 23 [online], available at http://www.ecologyandsociety.org/vol12/iss1/art23/, accessed April 13, 2016.

Brass, P. R.
1972. The Politics of Ayurvedic Education: A Case Study of Revivalism and Modernization in India. In *Education and Politics in India: Studies in Organization, Society, and Policy*, S. H. Rudolph and L. I. Rudolph, eds., pp. 342–375. Cambridge: Harvard University Press.

Brockliss, L. W.
1990. The Development of the Spa in Seventeenth-Century France. *Medical History* 34 (Supplement S10): 23–47.

Brown, P. L.
2006. In the Land of Four-Star Asceticism. *New York Times,* August 13: TR1.

Bruner, E. M.
1994. Abraham Lincoln as Authentic Reproduction: A Critique of Postmodernism. *American Anthropologist* (New Series) 96(2): 397–415.

Bumrungrad International Hospital
2015. *Factsheet.* Electronic document, https://www.bumrungrad.com/en/about-us/bumrungrad-factsheet, accessed June 13, 2015.

Bundesministerium für Arbeit und Soziales
2013. *Studie zur psychischen Gesundheit in der Arbeitswelt.* Electronic document, http://www.bmas.de/DE/Service/Presse/Pressemitteilungen/psychische-gesundheit-veranstaltung-2013-01-29.html, accessed December 5, 2014.

Bundesministerium für Wirtschaft und Technologie

2011. *Innovativer Gesundheitstourismus in Deutschland: Branchenreport "Kurorte und Heilbäder"*. Electronic document, http://www.bmwi.de/BMWi/Redaktion/PDF/Publikationen/innovativer-gesundheitstourismus-in-deutschland-kurorte-und-heilbaeder,property=pdf,bereich=bmwi,sprache=de,rwb=true.pdf, accessed January 8, 2016.

Burke, P.

2009. *Cultural Hybridity*. Cambridge: Polity Press.

Cameron, M. M.

2008. Modern Desires, Knowledge Control, and Physician Resistance: Regulating Ayurvedic Medicine in Nepal. *Asian Medicine: Tradition and Modernity* 4(1): 86–112.

Cannon, W. B.

1914. The Interrelations of Emotions as Suggested by Recent Physiological Researches. *The American Journal of Psychology* 25(2): 256–282.

———

1922. New Evidence for Sympathetic Control of Some Internal Secretions. *The American Journal of Psychiatry* 79(1): 15–30.

———

1929. Organization for Physiological Homeostasis. *Physiological Reviews* 9(3): 399–431.

———

1932. *The Wisdom of the Body*. New York: W. W. Norton & Company.

Cant, S. and U. Sharma

1999. *A New Medical Pluralism? Alternative Medicine, Doctors, Patients and the State*. London: UCL Press.

Carakasaṃhitā

2008. *Caraka-Saṃhitā: Agniveśa's Treatise Refined and Annotated by Caraka and Redacted by Dṛḍhabala*. Text with English translation. Edited and translated by P. Sharma. Reprint. Varanasi: Chaukhambha Orientalia.

Carrera, P. M. and J. F. Bridges

2006. Globalization and Healthcare: Understanding Health and Medical Tourism. *Expert Review of Pharmacoeconomics and Outcomes Research* 6(4): 447–458.

CBS

n.d. *Bumrungrad International Hospital*. Documentary broadcasted in the American television news magazine *60 Minutes*, available at https://www.bumrungrad.com/en/about-us/watch-our-videos, accessed June 13, 2015.

Central Council of Indian Medicine

2010. *Syllabus of Ayurvedacharya (BAMS) Course*. Electronic version available at http://ipu.ac.in/UnivSyllabus/syllabusmedical/syllbams221012.pdf, accessed June 17, 2014.

———
2014a. *Status of Ayurveda Colleges for the Year 2013-2014.* Electronic document, http://www.ccimindia.org/colleges_status_ayurveda_2013-14.html, accessed April 18, 2014.

———
2014b. *Syllabus for Post-Graduate Course in Ayurved.* Electronic version available at http://www.ccimindia.org/first_year_syllabus.html, accessed February 27, 2015.

Central Research Institute (Ayurveda), Government of India
2004. *Annual Progress Report 2003-04.* Calcutta: Dept. of AYUSH, Ministry of Health and Family Welfare, Government of India.

Chalmers, R. A.
1990. Maharishi Ayur-Veda. *The Lancet* 336(8726): 1322–1323.

Chandola, T., E. Brunner, and M. Marmot
2006. Chronic Stress at Work and the Metabolic Syndrome: Prospective Study. *British Medical Journal* 332(7540): 521–525.

Chhapia, H.
2012. Stress Levels Rise in India. *The Times of India* (online edition), September 10, http://timesofindia.indiatimes.com/india/Stress-levels-rise-in-India/articleshow/16335683.cms, accessed January 11, 2015.

Chinai, R. and R. Goswami
2007. Medical Visas Mark Growth of Indian Medical Tourism. *Bulletin of the World Health Organization* 85(3): 164–165.

Chopra, A. S.
2005a. Globaler Āyurveda: Eine Āyurveda-Klinik in Deutschland. *Curare* 28(1): 39–42.

———
2005b. Neue Krankheit – Alte Wissenschaft: Aids in der Nosologie des Āyurveda. *Curare* 28(2+3): 211–216.

———
2008. Practicing Ayurveda in the Western World: A Case Study from Germany. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 243–255. Albany: State University of New York Press.

Chopra, A. S. and J. Quack
2011. Asymmetrical Translations of Biomedicine in India: The Cases of Contemporary Āyurveda and Psychiatry. *Viennese Ethnomedicine Newsletter* 13(2-3): 13–24.

Claridge, R. T.
1842. *Hydropathy; or the Cold Water Cure, as Practiced by Vincent Priessnitz, at Graefenberg, Silesia, Austria.* London: James Madden and Co.

Clarke, A. E. and S. L. Star
2008. The Social Worlds Framework: A Theory/Methods Package. In *The Handbook of Science and Technology Studies*, E. J. Hackett, ed., pp. 113–137. Cambridge: MIT Press.

Cohen, E.
1979. Rethinking the Sociology of Tourism. *Annals of Tourism Research* 6(1): 18–35.

———
1988. Authenticity and Commoditization in Tourism. *Annals of Tourism Research* 15(3): 371–386.

Cohen, L.
1998. *No Aging in India: Alzheimer's, the Bad Family, and Other Modern Things.* Berkeley: University of California Press.

Cohen, M. H.
1996. Holistic Health Care: Including Alternative and Complementary Medicine in Regulatory Schemes. *Arizona Law Review* 38(83): 83–164.

Cohen, S. and T. A. Wills
1985. Stress, Social Support, and the Buffering Hypothesis. *Psychological Bulletin* 98(2): 310–357.

Confederation of Indian Industry and McKinsey & Company
2002. *Healthcare in India: The Road Ahead.* New Dehli: Confederation of Indian Industry.

Connell, J.
2006. Medical Tourism: Sea, Sun, Sand and . . . Surgery. *Tourism Management* 27(6): 1093–1100.

———
2013. Contemporary Medical Tourism: Conceptualisation, Culture and Commodification. *Tourism Management* 34: 1–13.

Connor, L. H. and G. Samuel, eds.
2001. *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Societies.* Westport: Bergin & Garvey.

Conrad, P.
1997. Public Eyes and Private Genes: Historical Frames, News Constructions, and Social Problems. *Social Problems* 44(2): 139–154.

Cook, P. S.
2008. *What is Health and Medical Tourism?* Paper presented at the Annual Conference of the Australian Sociological Association, Victoria, December 2-5, 2008. Electronic version available at http://eprints.qut.edu.au/16804/2/c16804.pdf, accessed July 10, 2015.

Cooper, C. L.
1996. *Handbook of Stress, Medicine, and Health.* Boca Raton: CRC Press.

Cooper, C. L. and P. Dewe
2004. *Stress: A Brief History.* Malden: Blackwell Publishing.

Cooper, C. L. and R. Payne, eds.
1978. *Stress at Work.* Chichester: John Wiley & Sons.

———
1988. *Causes, Coping and Consequences of Stress at Work.* Chichester: John Wiley & Sons.

Crile, G. W.
1915. *The Origin and Nature of the Emotions.* Philadelphia: Saunders.

Da Costa, B. R. and E. R. Vieira
2009. Risk Factors for Work-Related Musculoskeletal Disorders: A Systematic Review of Recent Longitudinal Studies. *American Journal of Industrial Medicine* 53(3): 285–323.

DAK-Gesundheit
2013. *DAK-Gesundheitsreport 2013.* Electronic document, http://www.dak.de/dak/download/Vollstaendiger_bundesweiter_Gesundheitsreport_2013-1318306.pdf, accessed December 5, 2014.

Darshan, M. S., R. Raman, T. S. S. Rao, D. Ram, and B. Annigeri
2013. A Study on Professional Stress, Depression and Alcohol Use among Indian IT Professionals. *Indian Journal of Psychiatry* 55(1): 63–69.

Das, R. P.
1993. On the Nature and Development of 'Traditional Indian Medicine'. *Journal of the European Āyurvedic Society* 3: 56–71.

———
1995. Paths Straight and Crooked to Indian Medical Knowledge. *Journal of the European Āyurvedic Society* 4: 196–206.

Das, V. and R. K. Das
2006. Pharmaceuticals in Urban Ecologies: The Register of the Local. In *Global Pharmaceuticals: Ethics, Markets, Practices*, A. Petryna, A. Lakoff, and A. Kleinman, eds., pp. 171–205. Durham: Duke University Press.

Dash, B.
1992. *Massage Therapy in Ayurveda.* New Delhi: Concept Publishing Company.

Day, S. B.
1986. *Cancer, Stress, and Death.* New York: Plenum Publishing Corporation.

De Michelis, E.
2004. *A History of Modern Yoga: Patañjali and Western Esotericism.* London: Continuum.

———
2007. A Preliminary Survey of Modern Yoga Studies. *Asian Medicine: Tradition and Modernity* 3(1): 1–19.

———

2008. Modern Yoga: History and Forms. In *Yoga in the Modern World: Contemporary Perspectives*, M. Singleton and J. Byrne, eds., pp. 17–35. London: Routledge.

Department of Tourism, Government of Kerala

2008. *When Life Gets Tiring, Apply Kerala: Ayurvedic Health Holidays in Kerala.* Advertising brochure, Thiruvananthapuram.

———

2013. *Ayurveda Health Centres Classified by Kerala Tourism.* Electronic document, https://www.keralatourism.org/ayurvedacentres/, accessed February 12, 2016.

———

2015. *Kerala Tourism Statistics 2014.* Electronic document, https://www.keralatourism.org/pdfs/statistics-2016.pdf, accessed February 9, 2016.

———

n.d. *Scheme for Classification of Ayurveda Centres.* Electronic document, http://keralatourism.gov.in/classificationofayurvedacenters/AyurvedaClassification.html, accessed February 12, 2016.

Deutscher Bäderverband

1983. *Geschäftsbericht 1983.* Bonn: Deutscher Bäderverband.

Deutscher Heilbäderverband

2001. *Deutscher Bäderkalender.* Gütersloh: Flöttmann Verlag.

———

n.d.a. *Der Verband.* Electronic document, http://www.deutscher-heilbaederverband.de/Vorstellung-698737.html, accessed January 8, 2016.

———

n.d.b. *Die Kur.* Electronic document, http://www.deutscher-heilbaederverband.de/Die-Kur-671737.html, accessed January 8, 2016.

———

n.d.c. *Gäste- und Übernachtungszahlen in den deutschen Heilbädern und Kurorten 1999 bis 2014.* Electronic document, http://www.deutscher-heilbaederverband.de/Baederstatistik-1999-2014-765887.pdf, accessed January 8, 2016.

———

n.d.d. *Kurorttherapeutische Vorsorge-, Rehabilitations- und Anschlussheilbehandlungs-Maßnahmen: Fälle von 2001 bis 2013.* Electronic document, http://www.deutscher-heilbaederverband.de/Fallzahlen-2001-2013-Kurorttherapeutischer-Massnahmen-743539.pdf, accessed January 8, 2016.

———

n.d.e. *Resort Prevention Services.* Electronic document, http://www.die-neue-kur.de/en/quality-standards/for-resort-prevention-services.html, accessed January 8, 2016.

———

n.d.f. *Resort Therapy: A Holiday for Your Health.* Electronic document, http://www.die-neue-kur.de/en/, accessed January 8, 2016.

———

n.d.g. *Resort Therapy: Highest Quality Standards.* Electronic document, http://www.die-neue-kur.de/en/quality-standards.html, accessed January 8, 2016.

———

n.d.h. *Resort Therapy on Prescription.* Electronic document, http://www.die-neue-kur.de/en/resort-therapies-wellness/resort-therapy-on-prescription.html, accessed January 8, 2016.

———

n.d.i. *Resort Wellness Services.* Electronic document, http://www.die-neue-kur.de/en/quality-standards/for-resort-wellness-services.html, accessed January 8, 2016.

———

n.d.j. *Spas and Health Resorts in Germany.* Electronic document, http://www.die-neue-kur.de/en/spas-and-health-resorts-in-germany.html, accessed January 8, 2016.

———

n.d.k. *Types of Resort Therapies.* Electronic document, http://www.die-neue-kur.de/en/resort-therapies-wellness/types-of-resort-therapies.html, accessed January 8, 2016.

Directorate-General for Employment and Social Affairs, European Commission
2000. *Guidance on Work-Related Stress: Spice of Life or Kiss of Death?* Luxembourg: Office for Official Publications of the European Communities. Electronic version available at http://www.av.se/dokument/inenglish/European_Work/Slic_2012/Guidance_workrelated_stress.pdf, accessed December 5, 2014.

Dunn, F. L.
1976. Traditional Asian Medicine and Cosmopolitan Medicine as Adaptive Systems. In *Asian Medical Systems: A Comparative Study*, C. Leslie, ed., pp. 133–158. Berkeley: University of California Press.

Dunn, H. L.
1957. Points of Attack for Raising the Levels of Wellness. *Journal of the National Medical Association* 49(4): 225–235, 211.

Durkin, M.
1988. Ayurvedic treatment for jaundice in Nepal. *Social Science & Medicine* 27(5): 491–495.

Eck, C.
2008. *Schattenbilder: Männlichkeit und Weiblichkeit in Werbeanzeigen.* Hamburg: Verlag Dr. Kovač.

Ecks, S. and S. Basu
2014. “We Always Live in Fear”: Antidepressant Prescriptions by Unlicensed Doctors in India. *Culture, Medicine, and Psychiatry* 38(2): 197–216.

Eden, S.
2011. Food Labels as Boundary Objects: How Consumers Make Sense of Organic and Functional Foods. *Public Understanding of Science* 20(2): 179–194.

Edwards, J. H.
2009. A Modern Incarnation of Ayurveda: Hybrid Practice at Naradevi Hospital. *Contributions to Nepalese Studies* 36(2): 289–298.

Eggertson, L.
2006. Wait-List Weary Canadians Seek Treatment Abroad. *Canadian Medical Association Journal* 174(9): 1247.

Eisenberg, D. M., R. C. Kessler, C. Foster, F. E. Norlock, D. R. Calkins, and T. L. Delbanco
1993. Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use. *New England Journal of Medicine* 328(4): 246–252.

Eisenstadt, S. N.
2000. Multiple Modernities. *Daedalus* 129(1): 1–29.

Eliot, R. S.
1974. *Stress and the Heart.* New York: Futura Publishing Company.

Ellis, S.
2008. Trends in the Global Spa Industry. In *Understanding the Global Spa Industry: Spa Management*, M. Cohen and G. Bodeker, eds., pp. 66–84. Amsterdam: Butterworth-Heinemann.

Engler, T.
2009. Ayurveda in Kerala: Detox auf indische Art. *Shape* (Germany edition) 12/2009: 108–112.

Enserink, M.
2006. Selling the Stem Cell Dream. *Science* 313(5784): 160–163.

Erb, W.
1893. *Über die wachsende Nervosität unserer Zeit.* Heidelberg: Koester.

Ernst, W., ed.
2002a. *Plural Medicine, Tradition and Modernity: 1800-2000.* London: Routledge.

Ernst, W.
2002b. Plural Medicine, Tradition and Modernity: Historical and Contemporary Perspectives – Views from Below and from Above. In *Plural Medicine, Tradition and Modernity: 1800-2000*, W. Ernst, ed., pp. 1–18. London: Routledge.

European Agency for Society and Health at Work
2014. *Healthy Workplaces Manage Stress.* Electronic document, https://www.healthy-workplaces.eu/en, accessed December 31, 2014.

European Foundation for the Improvement of Living and Working Conditions
2007. *Fourth European Working Conditions Survey.* Luxembourg: Office for Official Publications of the European Communities. Electronic version available at http://eurofound.europa.eu/sites/default/files/ef_files/pubdocs/2006/98/en/2/ef0698en.pdf, accessed December 5, 2014.

European Professional Association of Ayurveda Practitioners and Therapists
n.d. *Doctors/Therapists.* Electronic document, http://www.ayurveda-verband.eu/therapeuten.html?L=1, accessed November 8, 2013.

European Spas Association
1995. *Spas and Health Resorts in Europe.* Bonn: European Spas Association.

Everest College
2014. *2014 Work Stress Survey.* Electronic document, http://gallery.mailchimp.com/893163b900efdcd50e4a7f0c5/files/2014_Work_Stress_Survey_Report_FINAL.1.pdf, accessed December 5, 2014.

Fedorova, M.
1990. *Die Marmantheorie in der klassischen indischen Medizin.* Ph.D. dissertation, Ludwig-Maximilians-Universität München, Munich.

Ferrari, S.
2009. The Luigiane Thermal Baths: A Tool for the Deseasonalization of the Tourist Demand in Calabria (Italy). In *Health and Wellness Tourism*, M. K. Smith and L. Puczkó, eds., pp. 307–312. Amsterdam: Elsevier.

Fields, G. P.
2001. *Religious Therapeutics: Body and Health in Yoga, Āyurveda, and Tantra.* Albany: State University of New York Press.

Fishman, J. R.
2004. Manufacturing Desire: The Commodification of Female Sexual Dysfunction. *Social Studies of Science* 34(2): 187–218.

Foster, G. M. and B. G. Anderson
1978. *Medical Anthropology.* New York: John Wiley & Sons.

Foucault, M.
1988. Technologies of the Self. In *Technologies of the Self: A Seminar with Michel Foucault*, L. H. Martin, H. Gutman, and P. H. Hutton, eds., pp. 16–48. Amherst: University of Massachusetts Press.

Frank, R.
2004. *Globalisierung "alternativer" Medizin: Homöopathie und Ayurveda in Deutschland und Indien.* Bielefeld: Transcript-Verlag.

Frank, R. and G. Stollberg
2002. Ayurvedic Patients in Germany. *Anthropology & Medicine* 9(3): 223–244.

———
2004a. Conceptualizing Hybridization: On the Diffusion of Asian Medical Knowledge to Germany. *International Sociology* 19(1): 71–88.

———
2004b. Sind Patienten asiatischer Medizin aktive Konsumenten? *Forschende Komplementärmedizin* 11: 83–92.

———
2006. German Medical Doctors' Motives for Practising Homoeopathy, Acupuncture or Ayurveda. In *Multiple Medical Realities: Patients and Healers in Biomedical, Alternative and Traditional Medicine*, H. Johannessen and I. Lázár, eds., pp. 72–88. New York: Berghahn Books.

Frawley, D.
1999. *Yoga and Ayurveda: Self-Healing and Self-Realization.* Twin Lakes: Lotus Press.

———
2005. *Neti: Healing Secrets of Yoga and Ayurveda.* Lotus Press.

———
2012. *Soma in Yoga and Ayurveda: The Power of Rejuvenation and Immortality.* Lotus Press.

Frawley, D. and S. Kozak
2001. *Yoga for Your Type: An Ayurvedic Approach to Your Asana Practice.* Twin Lakes: Lotus Press.

Freidin, B. and M. Ballesteros
2012. La difusión transnacional de medicinas alternativas: La presencia del Ayurveda en la prensa argentina. *Papeles de Trabajo* 6(10): 128–159.

Frost, G. J.
2004. The Spa as a Model of an Optimal Healing Environment. *The Journal of Alternative and Complementary Medicine* 10(Supplement 1): 85–92.

Fuchs, M.
2010. Diskontinuierliche Prozesse: Die transformative Kraft der Übersetzung. In *Identität und Unterschied: Zur Theorie von Kultur, Differenz und Transdifferenz*, C. Alvarado Leyton and P. Erchinger, eds., pp. 113–131. Bielefeld: Transcript-Verlag.

Galison, P.
1997. *Image and Logic: A Material Culture of Microphysics.* Chicago: University of Chicago Press.

Ganesan, U.
2010. Medicine and Modernity: The Ayurvedic Revival Movement in India, 1885-1947. *Studies on Asia* Series IV, 1(1): 108–131.

Gesler, W. M.
1992. Therapeutic Landscapes: Medical Issues in Light of the New Cultural Geography. *Social Science & Medicine* 34(7): 735–746.

Glass, D. C.
1977. *Behavior Patterns, Stress, and Coronary Disease.* Oxford: Lawrence Erlbaum.

Gojcic, S. and R. Rumbak
2005. Kur- und Wellness-Tourismus in Slowenien. *Spektrum Freizeit* 27(1): 72–83.

Goodrich, J. N.
1993. Socialist Cuba: A Study of Health Tourism. *Journal of Travel Research* 32(1): 36–41.

Greenwood, D. J.
1989 [1977]. Culture by the Pound: An Anthropological Perspective on Tourism as Cultural Commoditization. In *Hosts and Guests: The Anthropology of Tourism*, V. L. Smith, ed., pp. 171–185. Philadelphia: University of Pennsylvania Press.

Hall, S.
1997. Introduction. In *Representation: Cultural Representations and Signifying Practices*, S. Hall, ed., pp. 1–11. London: Sage Publications.

Halliburton, M.
1998. Suicide: A Paradox of Development in Kerala. *Economic & Political Weekly* 33(36/37): 2341–2345.

———
2002. Rethinking Anthropological Studies of the Body: *Manas* and *Bōdham* in Kerala. *American Anthropologist* 104(4): 1123–1134.

———
2003. The Importance of a Pleasant Process of Treatment: Lessons on Healing from South India. *Culture, Medicine, and Psychiatry* 27(2): 161–186.

———
2005. "Just Some Spirits": The Erosion of Spirit Possession and the Rise of "Tension" in South India. *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 24(2): 111–144.

———
2009. *Mudpacks and Prozac: Experiencing Ayurvedic, Biomedical, and Religious Healing.* Walnut Creek: Left Coast Press.

Handler, R. and W. Saxton
1988. Dyssimulation: Reflexivity, Narrative, and the Quest for Authenticity in "Living History". *Current Anthropology* 3(3): 242–260.

Hannam, K.
2009. Ayurvedic Health Tourism in Kerala, India. In *Health and Wellness Tourism*, M. K. Smith and L. Puczkó, eds., pp. 341–344. Amsterdam: Elsevier.

Hannerz, U.
1996. *Transnational Connections: Culture, People, Places.* London: Routledge.

Hanson, M. J.
1999. Biotechnology and Commodification Within Health Care. *Journal of Medicine and Philosophy* 24(3): 267–287.

Harder, H., ed.
2011. *Verkehrte Welten: Bengalische Satiren aus dem kolonialen Kalkutta.* Heidelberg: Draupadi-Verlag.

Harrison, M.
1994. *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914.* Cambridge: Cambridge University Press.

Hauser, B.
2013a. Introduction: Transcultural Yoga(s) – Analyzing a Traveling Subject. In *Yoga Traveling: Bodily Practice in Transcultural Perspective*, B. Hauser, ed., pp. 1–34. Cham: Springer.

———
2013b. Touching the Limits, Assessing Pain: On Language Performativity, Health, and Well-Being in Yoga Classes. In *Yoga Traveling: Bodily Practice in Transcultural Perspective*, B. Hauser, ed., pp. 109–134. Cham: Springer.

Health and Safety Executive, Government of the United Kingdom
2014. *Stress-Related and Psychological Disorders in Great Britain 2014.* Electronic document, http://www.hse.gov.uk/statistics/causdis/stress/stress.pdf, accessed December 5, 2014.

Heinke, N.
2001. Wohlbefinden, äußere Schönheit und innere Harmonie durch Ayurveda. *FAZ.NET*, October 29, http://www.faz.net/aktuell/wohlbefinden-aeussere-schoenheit-und-innere-harmonie-durch-ayurveda-152042.html, accessed April 17, 2014.

Hembry, P.
1990. *The English Spa 1560-1815: A Social History.* London: Athlone Press.

Henderson, J. C.
2003. Healthcare Tourism in Southeast Asia. *Tourism Review International* 7(3-4): 111–121.

Henderson, S. and A. R. Petersen, eds.
2002. *Consuming Health: The Commodification of Health Care.* London: Routledge.

Hesse, H.
1987 [1925]. *Kurgast: Aufzeichnungen von einer Badener Kur.* Gesammelte Werke in zwölf Bänden, Siebter Band, pp. 5–113. Frankfurt am Main: Suhrkamp.

Høg, E. and E. Hsu
2002. Introduction (Special Issue: Countervailing Creativity – Patient Agency in the Globalisation of Asian Medicines). *Anthropology & Medicine* 9(3): 205–221.

Hörbst, V. and A. Wolf
2003. Globalisierung der Heilkunde: Eine Einführung. In *Medizin und Globalisierung: Universelle Ansprüche – lokale Antworten*, A. Wolf and V. Hörbst, eds., pp. 3–30. Münster: LIT.

Hörner, J.
2013. Wellness: Unhinterfragter Teil medizinischen Handelns? *Curare* 36(1+2): 17–26.

House, J. S.
1981. *Work Stress and Social Support.* Reading: Addison-Wesley.

Hughes, G.
1995. Authenticity in Tourism. *Annals of Tourism Research* 22(4): 781–803.

Humes, C. A.
2008. Maharishi Ayur-Veda™: Perfect Health™ through Enlightened Marketing in America. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 309–331. Albany: State University of New York Press.

Illing, K.-T.
2009. *Gesundheitstourismus und Spa-Management.* München: Oldenbourg Wissenschaftsverlag.

Inglis, K.
2009. *Ayurveda: Asian Secrets of Wellness, Beauty and Balance.* Tokyo: Tuttle Publishing.

Inhorn, M. C.
2011. Globalization and Gametes: Reproductive 'Tourism,' Islamic Bioethics, and Middle Eastern Modernity. *Anthropology & Medicine* 18(1): 87–103.

Inhorn, M. C. and P. Patrizio
2009. Rethinking Reproductive "Tourism" as Reproductive "Exile". *Fertility and Sterility* 92(3): 904–906.

Institute of Indigenous Medicine, University of Colombo
2011. *Bachelor of Ayurveda Medicine and Surgery (BAMS): Course Unit System – Rules and Regulations Course Curriculum 2011.* Electronic version available at http://iim.cmb.ac.lk/wp-content/uploads/2010/08/BAMS-CURRICULUM-2011.pdf, accessed February 27, 2015.

International Wellness and Healthcare Travel Association
2010. *Countrywise Patients Inflow Analysis of Hospitals.* Newsletter 35/38.

Islam, N.
2008. *Repackaging Ayurveda in Post-Colonial India: Revivalism and Global Commodification.* Ph.D. dissertation, The University of Hong Kong, Hong Kong.

———
2009. Reviving Ayurveda in Modern India: Prospect and Challenges. *International Review of Modern Sociology* 35(1): 137–147.

———

2010. Indigenous Medicine as Commodity: Local Reach of Ayurveda in Modern India. *Current Sociology* 58(5): 777–798.

———

2012. New Age Orientalism: Ayurvedic 'Wellness and Spa Culture'. *Health Sociology Review* 21(2): 220–231.

ITB Berlin

2016. *Ayurveda: Product of Kerala Tourism.* Electronic document, http://www.virtualmarket.itb-berlin.de/en/Ayurveda,p1059508, accessed March 10, 2016.

Jäckel, M., J. Derra, and C. Eck

2009. *SchönheitsAnsichten: Geschlechterbilder in Werbeanzeigen und ihre Bewertung.* Baden-Baden: Nomos.

Jackson, M.

2013. *The Age of Stress: Science and the Search for Stability.* Oxford: Oxford University Press.

Jackson, P.

1999. Commodity Cultures: The Traffic in Things. *Transactions of the Institute of British Geographers* 24(1): 95–108.

Jeannotat, F.

2008. Maharishi Ayur-Ved: A Controversial Model of Global Ayurveda. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 285–307. Albany: State University of New York Press.

Jeffery, R.

1979. Recognizing India's Doctors: The Institutionalization of Medical Dependency, 1918-39. *Modern Asian Studies* 13(2): 301–326.

———

1982. Politics towards Indigenous Healers in Independent India. *Social Science & Medicine* 16(21): 1835–1841.

———

1988. *The Politics of Health in India.* Berkeley: University of California Press.

Jones, C. A. and L. G. Keith

2006. Medical Tourism and Reproductive Outsourcing: The Dawning of a New Paradigm for Healthcare. *International Journal of Fertility and Women's Medicine* 51(6): 251–255.

Joos, S., B. Musselmann, A. Miksch, T. Rosemann, and J. Szecsenyi

2008. The Role of Complementary and Alternative Medicine (CAM) in Germany: A Focus Group Study of GPs. *BMC Health Services Research* 8(127); online publication available at http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-8-127.

Kahn, J. S.
2001. Anthropology and Modernity. *Current Anthropology* 42(5): 651–680.

Kangas, B.
2010. Traveling for Medical Care in a Global World. *Medical Anthropology* 29(4): 344–362.

Kapila, S.
2010. The Enchantment of Science in India. *Isis* 101(1): 120–132.

Karasek, R. A.
1979. Job Demands, Job Decision Latitude, and Mental Strain: Implications for Job Redesign. *Administrative Science Quarterly* 24(2): 285–308.

Karasek, R. A. and T. Theorell
1990. *Healthy Work: Stress, Productivity, and the Reconstruction of Working Life.* New York: Basic Books.

Kaul, A. R.
2007. The Limits of Commodification in Traditional Irish Music Sessions. *Journal of the Royal Anthropological Institute* (New Series) 13(3): 703–719.

Kaviraj, S.
2000. Modernity and Politics in India. *Daedalus* 129(1): 137–162.

Kim, H. and T. Jamal
2007. Touristic Quest for Existential Authenticity. *Annals of Tourism Research* 34(1): 181–201.

Kiritz, S. and R. H. Moos
1974. Physiological Effects of Social Environments. *Psychosomatic Medicine* 36(2): 96–114.

Kirschner, C.
2015. *Grundlagen der zeitgemäßen Behandlung in den Heilbädern und Kurorten.* Electronic document, http://www.baederkalender.de/broschuere/9/Grundlagen-der-zeitgemaessen-Behandlung-in-den-Heilbaedern-und-Kurorten, accessed January 8, 2016.

Koch, A.
2005. Spiritualisierung eines Heilwissens im lokalen religiösen Feld? Zur Formierung deutscher Ayurveden. *Zeitschrift für Religionswissenschaft* 13(1): 21–44.

———
2006. Wie Medizin und Heilsein wieder verwischen. Ethische Plausibilisierungsmuster des Ayurveda im Westen. *Zeitschrift für medizinische Ethik* 52(2): 169–182.

Kogelfranz, S.
2006. *Ayurveda Live: Heilende Reisen zu den Ursprüngen des Ayurveda.* München: Goldmann.

Körber, R.
2002. *Wellness als eine Ausprägungsform des Gesundheitstourismus in traditionellen Heilbädern und Kurorten.* Trier: Forschungskreis Tourismus Management e.V.

Křížek, V.
1990. *Kulturgeschichte des Heilbades.* Stuttgart: Kohlhammer.

Kumar, A.
1998. *Medicine and the Raj: British Medical Policy in India, 1835-1911.* New Dehli: Sage Publications.

Kurian, V.
2015. Steffi Graf to Be Brand Ambassador of Kerala Tourism. *The Hindu Business Line* (online edition), June 24, http://www.thehindubusinessline.com/news/national/steffi-graf-to-be-brand-ambassador-of-kerala-tourism/article7349832.ece#comments, accessed February 11, 2016.

Kury, P.
2012. *Der überforderte Mensch: Eine Wissensgeschichte vom Stress zum Burnout.* Frankfurt am Main: Campus Verlag.

LaFauci, L. E.
2011. Taking the (Southern) Waters: Science, Slavery, and Nationalism at the Virginia Springs. *Anthropology & Medicine* 18(1): 7–22.

Laing, J. and B. Weiler
2008. Mind, Body and Spirit: Health and Wellness Tourism in Asia. In *Asian Tourism: Growth and Change*, J. Cochrane, ed., pp. 379–389. Amsterdam: Elsevier.

Lang, C. and E. Jansen
2013. Appropriating Depression: Biomedicalizing Ayurvedic Psychiatry in Kerala, India. *Medical Anthropology: Cross-Cultural Studies in Health and Illness* 32(1): 25–45.

Langenohl, A.
2008. How to Change Other People's Institutions: Discursive Entrepreneurship and the Boundary Object of Competition/Competitiveness in the German Banking Sector. *Economy and Society* 37(1): 68–93.

Langford, J. M.
1995. Ayurvedic Interiors: Person, Space, and Episteme in Three Medical Practices. *Cultural Anthropology* 10(3): 330–366.

———
1999. Medical Mimesis: Healing Signs of a Cosmopolitan "Quack". *American Ethnologist* 26(1): 24–46.

———
2002. *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance.* Durham: Duke University Press.

———
2013. Guérir le consumérisme: Le *pañcakarma* dans une économie du tourisme. In *Les nouveaux guérisseurs: Biographies de thérapeutes au temps de la globalisation*, L. Pordié and

E. Simon, eds., pp. 263–289. Paris: Éditions de l'École des hautes études en sciences sociales.

Latour, B.
1993. *We Have Never Been Modern.* Cambridge: Harvard University Press.

Lazarus, R. S.
1966. *Psychological Stress and the Coping Process.* New York: McGraw-Hill.

Lazarus, R. S. and S. Folkman
1984. *Stress, Appraisal, and Coping.* New York: Springer.

Lazarus, R. S. and R. Launier
1978. Stress-Related Transactions between Person and Environment. In *Perspectives in Interactional Psychology*, L. A. Pervin and M. Lewis, eds., pp. 287–327. New York: Plenum Press.

Leslie, C.
1973. The Professionalizing Ideology of Medical Revivalism. In *Modernization of Occupational Cultures in South Asia*, M. Singer, ed., pp. 216–242. Durham: Duke University Press.

———
1976a. The Ambiguities of Medical Revivalism in Modern India. In *Asian Medical Systems: A Comparative Study*, C. Leslie, ed., pp. 356–367. Berkeley: University of California Press.

———
1976b. Introduction. In *Asian Medical Systems: A Comparative Study*, C. Leslie, ed., pp. 1–12. Berkeley: University of California Press.

———
1992. Interpretations of Illness: Syncretism in Modern Āyurveda. In *Paths to Asian Medical Knowledge*, C. Leslie and A. Young, eds., pp. 177–208. Berkeley: University of California Press.

Leslie, C. and A. Young
1992a. Introduction. In *Paths to Asian Medical Knowledge*, C. Leslie and A. Young, eds., pp. 1–18. Berkeley: University of California Press.

Leslie, C. and A. Young, eds.
1992b. *Paths to Asian Medical Knowledge.* Berkeley: University of California Press.

Levi, L.
1964. *Stress: Körper, Seele und Krankheit – Eine Einführung in die psychosomatische Medizin.* Göttingen: Muster-Schmidt Verlag.

———
1981. *Preventing Work Stress.* Reading: Addison-Wesley.

Littrel, M. A.
1990. Symbolic Significance of Textile Crafts for Tourists. *Annals of Tourism Research* 17(2): 228–245.

Lohmann-Haislah, A.
2012. *Stressreport Deutschland 2012: Psychische Anforderungen, Ressourcen und Befinden.* Dortmund: Bundesanstalt für Arbeitsschutz und Arbeitsmedizin.

Lunt, N. and P. Carrera
2010. Medical Tourism: Assessing the Evidence on Treatment Abroad. *Maturitas* 66(1): 27–32.

MacCannell, D.
1973. Staged Authenticity: Arrangements of Social Space in Tourist Settings. *The American Journal of Sociology* 79(3): 589–603.

———
1976. *The Tourist: A New Theory of the Leisure Class.* Berkeley: University of California Press.

Mackaman, D. P.
1998. *Leisure Settings: Bourgeois Culture, Medicine, and the Spa in Modern France.* Chicago: University of Chicago Press.

MacReady, N.
2007. Developing Countries Court Medical Tourists. *The Lancet* 369(9576): 1849–1850.

Madhavan, H.
2013. Revisiting the Kerala Ayurvedic Sector. *The Newsletter (International Institute for Asian Studies)* 65: 32–35.

Mahomet, D.
1997. *The Travels of Dean Mahomet: An Eighteenth-Century Journey through India.* Edited by Michael H. Fisher. Berkeley: University of California Press.

'Malayalin gibt Ayurveda-Kochkurs'
2007. *Süddeutsche Zeitung,* Landkreisausgabe München Süd, May 21: R3.

Malhotra, S., G. S. Bhatia, and P. Pandhi
2001. Patterns of Use of Unconventional Therapies in the Medical Outpatient Department of a Tertiary Care Hospital in India. *Journal of Ethnopharmacology* 75(2-3): 71–75.

Mallick, S.
2013. From Heritage to Practice: Ayurveda in Delhi's Public Healthcare System. *The Newsletter (International Institute for Asian Studies)* 65: 27.

Manohar, P. R.
2013. A Narrative Review of Research in Ayurveda. *The Newsletter (International Institute for Asian Studies)* 65: 34–35.

Maretzki, T. W.
1987. The *Kur* in West Germany as an Interface between Naturopathic and Allopathic Ideologies. *Social Science & Medicine* 24(12): 1061–1068.

———
1989. Cultural Variation in Biomedicine: The *Kur* in West Germany. *Medical Anthropology Quarterly* (New Series) 3(1): 22–35.

Maretzki, T. W. and E. Seidler
1985. Biomedicine and Naturopathic Healing in West Germany: A Historical and Ethnomedical View of a Stormy Relationship. *Culture, Medicine, and Psychiatry* 9(4): 383–421.

Martin, P. and R. Frost
2003. Regulating the Commercial Development of Genetic Testing in the UK: Problems, Possibilities and Policy. *Critical Social Policy* 23(2): 186–207.

Matorras, R.
2005. Reproductive Exile versus Reproductive Tourism. *Human Reproduction* 20(12): 3571.

Mattausch, J.
2004. *Ayurveda erleben in Indien und Sri Lanka.* Bielefeld: Reise Know-How Verlag.

Maxwell-Haas, M.
2004. Ich glaub, ich bin im Paradies. *Für Sie* 1/2004: 140–144.

Mayer-Wolk, E.
2002. Ayurveda: Vollkommene seelische Entspannung. *FAZ.NET,* July 16, http://www.faz.net/aktuell/sport/alternative-heilmethoden-ayurveda-vollkommene-seelische-entspannung-159402.html, accessed April 17, 2014.

McLean, A. A.
1979. *Work Stress.* Reading: Addison-Wesley.

Medicines Control Agency, Government of the United Kingdom
1996. *Medicines Act 1968.* London: HMSO.

———
2001a. *Review of Herbal Ingredients for Use in Unlicensed Herbal Medicinal Products.* London: MCA.

———
2001b. *Traditional Ethnic Medicines: Public Health and Compliance with Medicines Law.* London: MCA.

Menon, I. and A. Spudich
2010. The *Ashtavaidya* Physicians of Kerala: A Tradition in Transition. *Journal of Ayurveda and Integrative Medicine* 1(4): 245–250.

Merriam-Webster Online Dictionary
2015. *Spa.* Electronic document, http://www.merriam-webster.com/dictionary/spa, accessed April 11, 2016.

Meulenbeld, G. J.
1995. The Many Faces of Āyurveda. *Journal of the European Āyurvedic Society* 4: 1–10.

———
1999. *A History of Indian Medical Literature.* Volume I A: Text. Groningen: Egbert Forsten.

Miller, J. W.
2005. Wellness: The History and Development of a Concept. *Spektrum Freizeit* 27(1): 84–106.

Milstein, A. and M. Smith
2006. America's New Refugees: Seeking Affordable Surgery Offshore. *New England Journal of Medicine* 355(16): 1637–1640.

Minghetti, V. and M. C. Furlan
2006. From Medical Holiday to Global Wellness Experiences: The New Age of Health Tourism. Paper presented within the 22nd International Congress of the History of Science, Beijing, 24th to 30th July, 2005. In *Time Shift, Leisure and Tourism: Impacts of Time Allocation on Successful Products and Services*, K. Weiermair and P. Ankomah, eds., pp. 155–164. Berlin: Schmidt.

Ministry of AYUSH, Government of India
2010. *State-Wise Statistics of Ayurveda as on 1.4.2010.* Electronic document, http://www.indianmedicine.nic.in/writereaddata/linkimages/7976103845-InfrastructureSystemwise%20Statistics%20AYURVEDA.pdf, accessed January 18, 2016.

Ministry of Tourism, Government of India
2009. *Incredible !ndia: Ein besonderer Grund 2009 nach Indien zu reisen.* Advertising brochure, Frankfurt am Main.

———
n.d.a. *Ayurveda: Ruumis, henki ja sielu.* Advertising brochure, Amsterdam.

———
n.d.b. *Incredible India: TV Commercial.* Video clip, available at http://www.tourism.gov.in/Video/VideoList.aspx, accessed April 15, 2014.

———
n.d.c. *Incredible !ndia.* Advertising brochure, Frankfurt am Main.

Mitka, M.
2009. Surgical Tourism: Some US Patients Travel Abroad for Less Costly Surgery. *Journal of the American Medical Association* 302(14): 1519.

Mlejnková, L.
2004. Wellness im tschechischen Kurwesen. *Spektrum Freizeit* 26(2): 60–70.

Mohan, A. and I. Mohan
2004. *Yoga Therapy: A Guide to the Therapeutic Use of Yoga and Ayurveda for Health and Fitness.* Boston: Shambhala Publications.

Mol, A.
2002. *The Body Multiple: Ontology in Medical Practice.* Durham: Duke University Press.

Moore, K.
1996. Organizing Integrity: American Science and Creation of Public Interest Organizations, 1955-1975. *American Journal of Sociology* 101(6): 1592–1627.

Nahrstedt, W.
2004a. Wellness: A New Perspective for Leisure Centers, Health Tourism, and Spas in Europe on the Global Health Market. In *The Tourism and Leisure Industry: Shaping the Future*, K. Weiermair and C. Mathies, eds., pp. 181–198. Binghamton: Haworth Hospitality Press.

———
2004b. "Wellness im Kurort": Neue Qualität für den Gesundheitstourismus in Europa? *Spektrum Freizeit* 26(2): 37–52.

Naraindas, H.
2006. Of Spineless Babies and Folic Acid: Evidence and Efficacy in Biomedicine and Ayurvedic Medicine. *Social Science & Medicine* 62(11): 2658–2669.

———
2011a. Of Relics, Body Parts and Laser Beams: The German Heilpraktiker and His Ayurvedic Spa. *Anthropology & Medicine* 18(1): 67–86.

———
2011b. Von Korallen, Chipkarten, medizinischen Informationen und der Jungfrau Maria: Heilpraktiker in Deutschland und die Ayurveda-Therapie. *Zeitschrift für Ethnologie* 136(1): 93–114.

———
2014a. My *Vaidya* and My Gynecologist: Agency, Authority, and Risk in Quest of a Child. In *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*, H. Naraindas, J. Quack, and W. S. Sax, eds., pp. 118–161. New York: Berghahn Books.

———
2014b. Nosopolitics: Epistemic Mangling and the Creolization of Contemporary Ayurveda. In *Medical Pluralism and Homoeopathy in India and Germany (1810-2010): A Comparison of Practices*, M. Dinges, ed., pp. 105–136. Stuttgart: Franz Steiner Verlag.

Naraindas, H. and C. Bastos
2011. Healing Holidays? Itinerant Patients, Therapeutic Locales and the Quest for Health. *Anthropology & Medicine* 18(1): 1–6.

Naraindas, H., J. Quack, and W. S. Sax, eds.
2014. *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries.* New York: Berghahn Books.

Neogi, S.
2004. Ayurvedic Spas of Kerala. *Sanghamam Magazine on Ayurveda: The Science of Life* 1(2): 11–14.

Newcombe, S.
2008. Ayurvedic Medicine in Britain and the Epistemology of Practicing Medicine in "Good Faith". In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 257–284. Albany: State University of New York Press.

———
2012. Global Hybrids? 'Eastern' Traditions of Health and Wellness in the West. In *The Gaze of the West and Framings of the East*, S. N. Nair-Venugopal, ed., pp. 202–217. Basingstoke: Palgrave Macmillan.

———
2013. Magic and Yoga: The Role of Subcultures in Transcultural Exchange. In *Yoga Traveling: Bodily Practice in Transcultural Perspective*, B. Hauser, ed., pp. 57–79. Cham: Springer.

Nichter, M. [Mark]
1980. The Layperson's Perception as Perspective into the Utilization of Multiple Therapy Systems in the Indian Continent. *Social Science & Medicine* 14B: 225–233.

———
1981a. Idioms of Distress: Alternatives in the Expression of Psychosocial Distress – A Case Study from South India. *Culture, Medicine, and Psychiatry* 5(4): 379–408.

———
1981b. Negotiation of the Illness Experience: Ayurvedic Therapy and the Psychosocial Dimension of Illness. *Culture, Medicine, and Psychiatry* 5(1): 5–24.

———
1989a. Lay Perceptions of Medicine: A South Indian Case Study. In *Anthropology and International Health: South Asian Case Studies*, M. Nichter, ed., pp. 187–213. Dordrecht: Kluwer Academic Publishers.

———
1989b. Pharmaceuticals, Health Commodification, and Social Relations: Ramifications of Primary Health Care. In *Anthropology and International Health: South Asian Case Studies*, M. Nichter, ed., pp. 233–277. Dordrecht: Kluwer Academic Publishers.

Nichter, M. [Mark] and C. R. Nordstrom
1989. A Question of Medicine Answering: Health Commodification and the Social Relations of Healing in Sri Lanka. *Culture, Medicine and Psychiatry* 13(4): 367–390.

Nichter, M. [Mimi]
2013. The Social Life of Yoga: Exploring Transcultural Flows in India. In *Yoga Traveling: Bodily Practice in Transcultural Perspective*, B. Hauser, ed., pp. 201–224. Cham: Springer.

Nisula, T.
2006. In the Presence of Biomedicine: Ayurveda, Medical Integration and Health Seeking in Mysore, South India. *Anthropology & Medicine* 13(3): 207–224.

Nordstrom, C. R.
1988. Exploring Pluralism: The Many Faces of Ayurveda. *Social Science & Medicine* 27(5): 479–489.

———
1989. Ayurveda: A Multilectic Interpretation. *Social Science & Medicine* 28(9): 963–970.

Obeyesekere, G.
1977. The Theory and Practice of Psychological Medicine in the Ayurvedic Tradition. *Culture, Medicine, and Psychiatry* 1(2): 155–181.

———
1982. Science and Psychological Medicine in the Ayurvedic Tradition. In *Cultural Conceptions of Mental Health and Therapy*, A. J. Marsella and G. M. White, eds., pp. 235–248. Dordrecht: Springer.

Obrist, B. and S. Büchi
2008. Stress as an Idiom for Resilience: Health and Migration among Sub-Saharan Africans in Switzerland. *Anthropology & Medicine* 15(3): 251–261.

Olsen, K.
2002. Authenticity as a Concept in Tourism Research. *Tourist Studies* 2(2): 159–182.

Opaschowski, H. W.
1987. *Sport in der Freizeit: Mehr Lust als Leistung – Auf dem Weg zu einem neuen Sportverhältnis.* Hamburg: BAT.

Otten, T.
1996. Die *sanfte* Veränderung ayurvedischer Heilverfahren am Beispiel der Pancha Karma Kur. In *Die gesellschaftliche Konstruktion von Befindlichkeit: Ein Sammelband zur Medizinethnologie*, A. Wolf and M. Stürzer, eds., pp. 75–87. Berlin: Verlag für Wissenschaft und Bildung.

Pachanee, C. and S. Wibulpolprasert
2006. Incoherent Policies on Universal Coverage of Health Insurance and Promotion of International Trade in Health Services in Thailand. *Health Policy and Planning* 21(4): 310–318.

Panikkar, K. N.
1992. Indigenous Medicine and Cultural Hegemony: A Study of the Revitalization Movement in Keralam. *Studies in History* (New Series) 8(2): 283–308.

Passarge, G.
2010. Kraftquelle am Berg: Alpen-Wellness oder Ayurveda. *Süddeutsche Zeitung*, May 20: V2/8.

Pellegrino, E. D.
1999. The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic. *Journal of Medicine and Philosophy* 24(3): 243–266.

Pennings, G.
2005. Reply: Reproductive Exile versus Reproductive Tourism. *Human Reproduction* 20(12): 3571–3572.

Pillai, R. K., S. V. Williams, H. A. Glick, D. Polsky, J. A. Berlin, and R. A. Lowe
2003. Factors Affecting Decisions to Seek Treatment for Sick Children in Kerala, India. *Social Science & Medicine* 57(5): 783–790.

Pole, S.
2008. Practicing Ayurveda in the United Kingdom: A Time of Challenges and Opportunities. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 215–226. Albany: State University of New York Press.

Pollock, K.
1988. On the Nature of Social Stress: Production of a Modern Mythology. *Social Science & Medicine* 26(3): 381–392.

Pollock, S.
1985. The Theory of Practice and the Practice of Theory in Indian Intellectual History. *Journal of the American Oriental Society* 105(3): 499–519.

Pordié, L.
2011. Se démarquer dans l'industrie du bienêtre: Transnationalisme, innovation et indianité. *Anthropologie et Santé* 3 (online journal). Article available at http://anthropologiesante.revues.org/805, accessed August 18, 2015.

———
2012. Branding Indian Aromatherapy: Differentiation Through Transnational Networks. In *Integrating East Asian Medicine into Contemporary Healthcare*, V. Scheid and H. MacPherson, eds., pp. 199–213. Edinburgh: Churchill Livingstone Elsevier.

———
2013. Spaces of Connectivity, Shifting Temporality: Enquiries in Transnational Health. *European Journal of Transnational Studies* 5(1): 6–26.

Prakash, G.
1999. *Another Reason: Science and the Imagination of Modern India*. Princeton: Princeton University Press.

Pratt, M. L.
1992. *Imperial Eyes: Travel Writing and Transculturation.* London: Routledge.

Press Trust of India
2009. Stress Levels Rising in India Inc: Survey. *Business Standard* (online edition), November 27, http://www.business-standard.com/article/economy-policy/stress-levels-rising-in-india-inc-survey-109112700063_1.html, accessed January 11, 2015.

———
2013. Stress-Related Ailments in Indian Employees Due to Job Fears. *The New Indian Express* (online edition), December 19, http://www.newindianexpress.com/business/news/Stress-related-Ailments-in-Indian-Employees-Due-to-Job-Fears/2013/12/19/article1953924.ece, accessed January 11, 2015.

Puczkó, L. and M. Bachvarov
2006. Spa, Bath, Thermae: What's behind the Labels? *Tourism Recreation Research* 31(1): 83–91.

Quintela, M. M.
2011. Seeking 'Energy' vs. Pain Relief in Spas in Brazil (Caldas da Imperatriz) and Portugal (Termas da Sulfúrea). *Anthropology & Medicine* 18(1): 23–35.

Ramesh, U. and K. Joseph
2011. A Study to Develop an Advanced Marketing Strategy for Wellness Tourism in Kerala Based on the Prevailing Scenario. *ZENITH: International Journal of Multidisciplinary Research* 1(6): 211–222.

———
2012. The Holistic Approach of Ayurveda Based Wellness Tourism in Kerala. *International Journal of Advanced Research in Management* 3(2): 29–39.

Ranade, S., R. R. Deshpande, and R. B. Bobade
2005. *A Textbook of Swasthavritta.* Delhi: Chaukhamba Sanskrit Pratishthan.

Rao, S. K. R.
1987. *Encyclopaedia of Indian Medicine.* Volume II: Basic Concepts. Mumbai: Popular Prakashan.

Rauch, E.
1994. *Lehrbuch der Diagnostik und Therapie nach F. X. Mayr: Kriterien des Krankheitsvorfeldes, der Gesundheit und Krankheit.* Heidelberg: Karl F. Haug Verlag.

Ravikanth, P.
2008. Health Tourism in Kerala: The Ayurvedic Way. In *Medical Tourism: A Growth Industry*, R. Anand and S. Gupta, eds., pp. 172–184. Hyderabad: Icfai University Press.

Reddy, S. [Sita]
2002. Asian Medicine in America: The Ayurvedic Case. *The ANNALS of the American Academy of Political and Social Science* 583(1): 97–121.

———
2004. The Politics and Poetics of "Magazine Medicine": New Age Ayurveda in the Print Media. In *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America*, R. D. Johnston, ed., pp. 207–229. New York: Routledge.

Reddy, S. [Sunita] and I. Qadeer
2010. Medical Tourism in India: Progress or Predicament? *Economic & Political Weekly* 45(20): 69–75.

Reed, K.
2002. Local-Global Spaces of Health: British South Asian Mothers and Medical Pluralism. In *Plural Medicine, Tradition and Modernity: 1800-2000*, W. Ernst, ed., pp. 171–183. London: Routledge.

Reisinger, Y. and C. J. Steiner
2006. Reconceptualizing Object Authenticity. *Annals of Tourism Research* 33(1): 65–86.

Rensing, L., M. Koch, B. Rippe, and V. Rippe
2013. *Mensch im Stress: Psyche, Körper, Moleküle.* Berlin: Springer.

Robertson, R.
1995. Glocalization: Time–Space and Homogeneity–Heterogeneity. In *Global Modernities*, M. Featherstone, ed., pp. 25–44. London: Sage Publications.

Roelcke, V.
1999. *Krankheit und Kulturkritik: Psychiatrische Gesellschaftsdeutungen im bürgerlichen Zeitalter (1790 - 1914).* Frankfurt am Main: Campus-Verlag.

Rose, N.
2001. The Politics of Life Itself. *Theory, Culture & Society* 18(6): 1–30.

Rudra, P.
2011. *Impacts of Medical and Wellness Tourism Centers on the Communities around Them: Case Studies in Delhi and Kerala.* Ph.D. dissertation, Rutgers, The State University of New Jersey, New Brunswick.

Rugulies, R., U. Bültmann, B. Aust, and H. Burr
2006. Psychosocial Work Environment and Incidence of Severe Depressive Symptoms: Prospective Findings from a 5-Year Follow-Up of the Danish Work Environment Cohort Study. *American Journal of Epidemiology* 163(10): 877–887.

Sack, K.
2014. Kidneys for Sale. *New York Times,* August 17: A1.

Saks, M.
2008. Plural Medicine and East-West Dialogue. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 29–41. Albany: State University of New York Press.

Sastry, M. V.
1956. *Rugviniścaya: Clinical Methods in Āyurveda.* Madras: College of Integrated Medicine.

Sax, W. S.
2009. *God of Justice: Ritual Healing and Social Justice in the Central Himalayas.* Oxford: Oxford University Press.

Sax, W. S. and H. K. Bhaskar Nair
2014. A Healing Practice in Kerala. In *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*, H. Naraindas, J. Quack, and W. S. Sax, eds., pp. 200–236. New York: Berghahn Books.

Scheper-Hughes, N.
2003. Keeping an Eye on the Global Traffic in Human Organs. *The Lancet* 361(9369): 1645–1648.

Schmädel, D. v.
1993. Ayurveda: Quo Vadis? Maharishi Ayur-Veda – Fortschritt oder Sackgasse? *Journal of the European Āyurvedic Society* 3: 229–249.

Schnäbele, V.
2013. The Useful Body: The Yogic Answer to Appearance Management in the Post-Fordist Workplace. In *Yoga Traveling: Bodily Practice in Transcultural Perspective*, B. Hauser, ed., pp. 135–153. Cham: Springer.

Schrott, E. and H. P. T. Ammon
2012. *Heilpflanzen der ayurvedischen und der westlichen Medizin: Eine Gegenüberstellung.* Berlin: Springer.

Schuhmacher, A. and C. Weber
2006. Ayurveda: Rosskur unter Palmen. *Focus* 32/2006: 56–61.

Schwertfeger, B.
2012. Ayurveda-Urlaub in Südindien: Keralas Hexenküche. *Spiegel Online,* November 21, http://www.spiegel.de/reise/fernweh/ayurveda-urlaub-in-indien-oele-kraeuter-massagen-fuer-die-gesundheit-a-867430.html, accessed November 23, 2012.

Schwertfeger, B. and O. Kühn
2009. Malabar-Küste: Hingehen wo der Pfeffer wächst. *Reise & Preise* 3: 34–39.

Selby, M. A.
2005. Sanskrit Gynecologies in Postmodernity: The Commoditization of Indian Medicine in Alternative Medical and New Age Discourses on Women's Health. In *Asian Medicine and Globalization*, J. S. Alter, ed., pp. 120–131. Philadelphia: University of Pennsylvania Press.

Selye, H.
1936. A Syndrome Produced by Diverse Nocuous Agents. *Nature* 138(3479): 32.

———

1946. The General Adaptation Syndrome and the Diseases of Adaptation. *The Journal of Clinical Endocrinology & Metabolism* 6(2): 117–230.

———

1974. *Stress without Distress.* Philadelphia: J. B. Lippincott Company.

———

1976. *Stress in Health and Disease.* Reading: Butterworths.

———

1979. *The Stress of My Life: A Scientist's Memoirs.* New York: Van Nostrand Reinhold.

Shackley, S. and B. Wynne
1996. Representing Uncertainty in Global Climate Change Science and Policy: Boundary-Ordering Devices and Authority. *Science, Technology, & Human Values* 21(3): 275–302.

Shankar, D.
2013. Directions for the Revitalization of Ayurveda in the 21st Century. *The Newsletter (International Institute for Asian Studies)* 65: 23.

Sharma, H. M. and C. Clark
1998. *Contemporary Ayurveda: Medicine and Research in Maharishi Ayur-Veda.* Philadelphia: Churchill Livingstone.

Sharma, U.
1992. *Complementary Medicine Today: Practitioners and Patients.* London: Routledge.

Sharp, L. A.
2000. The Commodification of the Body and Its Parts. *Annual Review of Anthropology* 29: 287–328.

Siegrist, J.
1996. Adverse Health Effects of High-Effort/Low-Reward Conditions. *Journal of Occupational Health Psychology* 1(1): 27–41.

Sieler, R.
2015. *Lethal Spots, Vital Secrets: Medicine and Martial Arts in South India.* New York: Oxford University Press.

Singleton, M.
2005. Salvation through Relaxation: Proprioceptive Therapy and its Relationship to Yoga. *Journal of Contemporary Religion* 20(3): 289–304.

———

2010. *Yoga Body: The Origins of Modern Posture Practice.* New York: Oxford University Press.

———

2013. Transnational Exchange and the Genesis of Modern Postural Yoga. In *Yoga Traveling: Bodily Practice in Transcultural Perspective*, B. Hauser, ed., pp. 37–56. Cham: Springer.

Śivahare, H. R.

1998. *Eḍsa evam Āyurveda.* Varanasi: Chaukhambā Surabhāratī Prakāśana.

Skolnick, A. A.

1991. Maharishi Ayur-Veda: Guru's Marketing Scheme Promises the World Eternal 'Perfect Health'. *The Journal of the American Medical Association* 266(13): 1741–1750.

Smith, F. M.

2006. *The Self Possessed: Deity and Spirit Possession in South Asian Literature and Civilization.* New York: Columbia University Press.

Smith, F. M. and D. Wujastyk

2008. Introduction. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 1–28. Albany: State University of New York Press.

Smith, M. K. and L. Puczkó

2009a. Historical Overview. In *Health and Wellness Tourism*, M. K. Smith and L. Puczkó, eds., pp. 21–38. Amsterdam: Elsevier.

———

2009b. Introduction. In *Health and Wellness Tourism*, M. K. Smith and L. Puczkó, eds., pp. 3–20. Amsterdam: Elsevier.

Solomon, J.

2009. The Proactive Echo: Ernst Cassirer's *The Myth of the State* and the Biopolitics of Global English. *Translation Studies* 2(1): 52–70.

Speier, A. R.

2011. Health Tourism in a Czech Health Spa. *Anthropology & Medicine* 18(1): 55–66.

Spitzer, D.

2009. Ayurvedic Tourism in Kerala: Local Identities and Global Markets. In *Asia on Tour: Exploring the Rise of Asian Tourism*, T. Winter, P. Teo, and T. C. Chang, eds., pp. 138–149. Abingdon: Routledge.

Star, S. L. and J. R. Griesemer

1989. Institutional Ecology, ''Translations' and Boundary Objects: Amateurs and Professionals in Berkeley's Museum of Vertebrate Zoology, 1907-39. *Social Studies of Science* 19(3): 387–420.

Sterling, P. and J. Eyer

1988. Allostasis: A New Paradigm to Explain Arousal Pathology. In *Handbook of Life Stress, Cognition and Health*, S. Fisher and J. Reason, eds., pp. 629–649. Chichester: John Wiley & Sons.

Steward, J.
2002. The Culture of the Water Cure in Nineteenth-Century Austria, 1800-1914. In *Water, Leisure and Culture: European Historical Perspectives*, S. C. Anderson and B. H. Tabb, eds., pp. 23–35. Oxford: Berg.

Stiles, M.
2008. *Ayurvedic Yoga Therapy.* Twin Lakes: Lotus Press.

Stollberg, G.
2001. Asian Medical Concepts in Germany and the United Kingdom: Sociological Reflections on the Shaping of Āyurveda in Western Europe. *Traditional South Asian Medicine* 6: 1–9.

———
2002. Heterodoxe Medizin, Weltgesellschaft und Glokalisierung: Asiatische Medizinformen in Westeuropa. In *Krankheit verstehen: Interdisziplinäre Beiträge zur Sprache in Krankheitsdarstellungen*, G. Brünner and E. Gülich, eds., pp. 143–158. Bielefeld: Aisthesis-Verlag.

———
2005. *Ayurvedic Medicine in Germany.* Paper presented at the 22nd International Congress of History of Science, Beijing, July 24-30, 2005. Electronic version available at http://www.unibielefeld.de/soz/pdf/PaperStollberg.pdf, accessed November 11, 2008.

———
2010. Welche Motivation haben deutsche Ärztinnen und Ärzte, Homöopathie, Akupunktur oder Ayurveda auszuüben? Welche Vorstellungen von einem "guten Arzt" haben sie und ihre Patientinnen und Patienten? In *Der gute Arzt aus interdisziplinärer Sicht: Ergebnisse eines Expertentreffens*, C. Witt, ed., pp. 239–257. Essen: KVC-Verlag.

Stone, J. and J. Matthews
1996. *Complementary Medicine and the Law.* Oxford: Oxford University Press.

Strauss, S.
2005. *Positioning Yoga: Balancing Acts across Cultures.* Oxford: Berg.

———
2008. "Adapt, Adjust, Accommodate": The Production of Yoga in a Transnational World. In *Yoga in the Modern World: Contemporary Perspectives*, M. Singleton and J. Byrne, eds., pp. 49–74. London: Routledge.

'Streß: Neue Krankheit des Jahrhunderts'
1976. *Der Spiegel* 7: 46–59.

Strieder, S.
n.d. Wellness auf indische Art: Die Ayurveda-Glückspille namens Dr. Lalitha. *Stern* (online edition), n.d., http://www.stern.de/reise/fernreisen/wellness-auf-indische-art-die-ayurveda-glueckspille-namens-dr-lalitha-638810.html, accessed April 17, 2014.

Strümpell, C. and H. Ashraf
2011. Stress and Modern Work: Ethnographic Perspectives from Industries in Bangladesh. *Viennese Ethnomedicine Newsletter* 13(2-3): 24–33.

Sujatha, V.
2011. Innovation within and between Traditions: Dilemma of Traditional Medicine in Contemporary India. *Science, Technology & Society* 16(2): 191–213.

———
2013. Globalisation of Ayurvedic Massage. *The Newsletter (International Institute for Asian Studies)* 65: 36.

Suśrutasaṃhitā
1963. *An English Translation of the Sushruta Samhita.* Edited and translated by K. K. Bhishagratna. Varanasi: The Chowkhamba Sanskrit Series Office.

Svoboda, R. E.
2008. The Ayurvedic Dispora: A Personal Account. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 117–128. Albany: State University of New York Press.

Sylge, C.
2007. *Body & Soul Escapes: Where to Retreat and Replenish around the Globe.* Bath: Footprint.

Taché, J., H. Selye, and S. B. Day, eds.
1979. *Cancer, Stress, and Death.* New York: Plenum Medical Book Company.

Techniker Krankenkasse
2013. *Bleib locker, Deutschland! TK-Studie zur Stresslage der Nation.* Hamburg: Techniker Krankenkasse Pressestelle. Electronic version available at https://www.tk.de/centaurus/servlet/contentblob/590188/Datei/115474/TK_Studienband_zur_Stressumfrage.pdf, accessed December 5, 2014.

Thanner, M.
2010. Geld oder Glaube? Warum Schulmediziner alternative Heilverfahren anbieten. In *Neue Wege in der Medizin: Alternativmedizin – Fluch oder Segen?*, R. Becker, S. Sertel, I. Stassen-Rapp, and I. Walburg, eds., pp. 187–202. Heidelberg: Winter.

Thatte, D. G.
1988. *Acupuncture, Marma and Other Asian Therapeutic Techniques.* Varanasi: Chaukhambha Orientalia.

Thirumulpad, R., ed.
n.d. *Vaidyavinjanakosam: Encyclopaedia of Holistic Therapies.* Kottayam: Bharath Books.

Timmermans, S. and R. Almeling
2009. Objectification, Standardization, and Commodification in Health Care: A Conceptual Readjustment. *Social Science & Medicine* 69(1): 21–27.

Tirodkar, M.
2005. *Adaptations of Contemporary Ayurvedic Medical Practice in Urban India.* Ph.D. dissertation, The University of Chicago, Chicago.

———
2008. Cultural Loss and Remembrance in Contemporary Ayurvedic Medical Practice. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 227–241. Albany: State University of New York Press.

'Tourism Site Opened'
2009. *The Hindu (City Edition Kochi),* September 20: 3.

Trilling, L.
1972. *Sincerity and Authenticity.* London: Oxford University Press.

Trontin, C., M. Lassagne, S. Boini, and S. Rinal
2007. *Le côut du stress professionnel en France en 2007.* Institut National de Recherche et de Sécurité.

Turner, L.
2007. 'First World Health Care at Third World Prices': Globalization, Bioethics and Medical Tourism. *Biosocieties* 2(3): 303–325.

Turner, T.
1980. The Social Skin. In *Not Work Alone: A Cross-Cultural View of Activities Superfluous to Survival*, J. Cherfas and R. Lewin, eds., pp. 112–140. London: Temple Smith.

Vahle-Hinz, T. and A. Plachta
2014. Flexible Beschäftigungsverhältnisse. In *Fehlzeiten-Report 2014: Erfolgreiche Unternehmen von morgen – gesunde Zukunft heute gestalten*, B. Badura, A. Ducki, H. Schröder, J. Klose, and M. Meyer, eds., pp. 103–111. Berlin: Springer.

Van der Geest, S. and S. R. Whyte
1989. The Charm of Medicines: Metaphors and Metonyms. *Medical Anthropology Quarterly* 3(4): 345–367.

Verband Deutscher Badeärzte
2016. *Zusatzweiterbildung "Physikalische Therapie und Balneologie".* Electronic document, http://www.badeaerzteverband.de/kurse.html, accessed January 11, 2016.

Vimala, B. and C. Madhavi
2009. A Study on Stress and Depression Experienced by Women IT Professionals in Chennai, India. *Psychology Research and Behavior Management* 2: 81–91.

Waitt, G.
2000. Consuming Heritage: Perceived Historical Authenticity. *Annals of Tourism Research* 27(4): 835–862.

Wallis, C., D. Thompson, and R. M. Galvin
1983. Stress: Can We Cope? *Time* 121(23): 52–61.

Wang, N.
1999. Rethinking Authenticity in Tourism Experience. *Annals of Tourism Research* 26(2): 349–370.

Warf, B.
2010. Do You Know the Way to San José? Medical Tourism in Costa Rica. *Journal of Latin American Geography* 9(1): 51–66.

Warrier, M.
2009. Seekership, Spirituality and Self-Discovery: Ayurveda Trainees in Britain. *Asian Medicine: Tradition and Modernity* 4(2): 423–451.

———
2011. Modern Ayurveda in Transnational Context. *Religion Compass* 5(3): 80–93.

———
2012. Revisiting the Easternisation Thesis: The Spiritualisation of Ayurveda in Modern Britain. In *Autonomous' Spiritualities beyond Religious Tradition (Volume III of Spiritualities in the Modern World: Within Religious Tradition and Beyond)*, P. Heelas, ed., pp. 299–319. London: Routledge.

———
2014. Ayurveda in Britain: The Twin Imperatives of Professionalization and Spiritual Seeking. In *Asymmetrical Conversations: Contestations, Circumventions, and the Blurring of Therapeutic Boundaries*, H. Naraindas, J. Quack, and W. S. Sax, eds., pp. 237–259. New York: Berghahn Books.

Watters, E.
2010. The Americanization of Mental Illness. *New York Times Magazine,* January 10: MM40.

———
2011. *Crazy Like Us: The Globalization of the American Psyche.* New York: Free Press.

Waxler-Morrison, N. E.
1988. Plural Medicine in Sri Lanka: Do Ayurvedic and Western Medical Practices Differ? *Social Science & Medicine* 27(5): 531–544.

Weiss, M.
2003. Ayurveda and Cultural Concepts of Mental Illness. In *Ayurvedic and Allopathic Medicine and Mental Health: Proceedings of Indo-US Workshop on Traditional Medicine and Mental Health, 13-17 October, 1996*, V. Ravindranath, L. Brady, A. D. Vaidya, G. V. Coelho, N. Nand, and S. H. Koslow, eds., pp. 28–43. Mumbai: Bharatiya Vidya Bhavan.

Weisz, G.
1995. *The Medical Mandarins: The French Academy of Medicine in the Nineteenth and Early Twentieth Centuries.* New York: Oxford University Press.

———
2001. Spas, Mineral Waters, and Hydrological Science in Twentieth-Century France. *Isis* 92(3): 451–483.

———
2011. Historical Reflections on Medical Travel. *Anthropology & Medicine* 18(1): 137–144.

Welch, C.
2008. An Overview of the Education and Practice of Global Ayurveda. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 129–138. Albany: State University of New York Press.

Williams, A., ed.
1999. *Therapeutic Landscapes: The Dynamic between Place and Wellness.* Lanham: University Press of America.

Winter, U.
n.d. Wellness am Himalaya: Ayurveda boomt. *RP Online,* n.d., http://www.rp-online.de/leben/reisen/wellness-am-himalaya-aid-1.2410580, accessed April 17, 2014.

Wlodarski, R.
2007. Kerala. In *India*, S. Singh and J. Bindloss, eds., pp. 960–1024. Footscray: Lonely Planet Publications.

Wolff, H. G.
1953. *Stress and Disease.* Springfield: Charles C Thomas.

Wolfgram, M. S.
2009. *Ayurveda in the Age of Biomedicine: Discursive Asymmetries and Counter-Strategies.* Ph.D. dissertation, The University of Michigan, Ann Arbor.

Wood, K. E.
2004. *Spa Culture and the Social History of Medicine in Germany.* Ph.D. dissertation, University of Illinois at Chicago, Chicago.

World Health Organization
2015 [1990]. *ICD-10: International Statistical Classification of Diseases and Related Health Problems, Tenth Revision.* Electronic version available at http://apps.who.int/classifications/icd10/browse/2015/en, accessed April 13, 2015.

———
2016. *Health.* Electronic document, http://www.who.int/trade/glossary/story046/en/, accessed March 4, 2016.

Wujastyk, D. [Dagmar] and F. M. Smith, eds.
2008. *Modern and Global Ayurveda: Pluralism and Paradigms.* Albany: State University of New York Press.

Wujastyk, D. [Dominik]
2005. Policy Formation and Debate Concerning the Government Regulation of Āyurveda in Great Britain in the Twenty-First Century. *Asian Medicine: Tradition and Modernity* 1(1): 162–184.

———
2008. The Evolution of Indian Government Policy on Ayurveda in the Twentieth Century. In *Modern and Global Ayurveda: Pluralism and Paradigms*, D. Wujastyk and F. M. Smith, eds., pp. 43–76. Albany: State University of New York Press.

Xie, P. F. and B. Lane
2006. A Life Cycle Model for Aboriginal Arts Performance in Tourism: Perspectives on Authenticity. *Journal of Sustainable Tourism* 14(6): 545–561.

Yamashita, T. and P. R. Manohar
2008a. Memoirs of Vaidyas: The Lives and Practices of Traditional Medical Doctors in Kerala, India (1). *EJournal of Indian Medicine* 1(2): 43–60.

———
2008b. Memoirs of Vaidyas: The Lives and Practices of Traditional Medical Doctors in Kerala, India (2). *EJournal of Indian Medicine* 1(3): 141–163.

Young, A.
1980. The Discourse on Stress and the Reproduction of Conventional Knowledge. *Social Science & Medicine* 14 B(3): 133–146.

Zarrilli, P. B.
1984. *The Kathakali Complex: Actor, Performance & Structure.* New Delhi: Abhinav Publications.

———
2001. *When the Body Becomes All Eyes: Paradigms, Discourses and Practices of Power in Kalarippayattu, a South Indian Martial Art.* New Dehli: Oxford University Press.

Zhan, M.
2009. *Other-Worldly: Making Chinese Medicine through Transnational Frames.* Durham: Duke University Press.

Zimmermann, F.
1992. Gentle Purge: The Flower Power of Āyurveda. In *Paths to Asian Medical Knowledge*, C. Leslie and A. Young, eds., pp. 209–223. Berkeley: University of California Press.

Zurstiege, G.
1998. *Mannsbilder: Männlichkeit in der Werbung – Eine Untersuchung zur Darstellung von Männern in der Anzeigenwerbung der 50er, 70er und 90er Jahre.* Opladen: Westdeutscher Verlag.

Zysk, K. G.
1991. *Asceticism and Healing in Ancient India: Medicine in the Buddhist Monastery.* New York: Oxford University Press.

2001. New Age Āyurveda or What Happens to Indian Medicine When it Comes to America. *Traditional South Asian Medicine* 6: 10–26.

Appendix

A Quoted Interlocutors

A.1 Ayurvedic Practitioners

Dr. Ajayan (48, Kerala): Government Ayurvedic hospital in Varkala

Dr. Karunan (34, Kerala): Private Ayurvedic hospital in Kollam

Dr. Madhu (35, Kerala): Ayurvedic resort in Varkala

Dr. Prabhakaran (60, Kerala): Private Ayurvedic hospital in Kollam

Dr. Praveen (25, Kerala): Ayuresort

Dr. Sankar (in his seventies – exact age unknown, Kerala): Private Ayurvedic hospital near Tiruvalla

Dr. Sudhakaran (in his forties – exact age unknown, Kerala): Private Ayurvedic hospital in Ernakulam

Dr. Veena (30, Kerala): Department of Kayachikitsa at the Government Ayurveda College Thiruvananthapuram

Dr. Vineetha (38, Kerala): Private Ayurvedic hospital in Ernakulam

A.2 Staff members at Ayuresort

Anitha (20, Kerala): Therapist

Divya (19, Kerala): Therapist

Manju (19, Kerala): Therapist

Prabhat (22, Kerala): Therapist

Rakesh (25, Kerala): Front desk manager

Ramu (43, Kerala): Yoga teacher

Suraj (19, Kerala): Therapist

Vasu (34, Kerala): General manager

A.3 Guests at Ayuresort

Aaron (55, Sweden, engineer): 5 days, with his partner Anne, experience with Ayurvedic treatment through a three-day treatment at a spa in Malta, stay at Ayuresort as part of a three-week travel through South India.

Adam (36, Italy [South Tyrol], travel guide): 11 days, with his partner, no experience with Ayurvedic treatment.

Alexandra (45, Germany, secretary): 18 days, *pañcakarma*, alone, no experience with Ayurvedic treatment.

Alice (62, originally from France but residing in Belgium, entrepreneur): 21 days, *pañcakarma*, with her partner David, experience with Ayurvedic treatment through a four-day stay at an Ayurvedic resort in Kerala and two outpatient treatments in an Indian Ayurvedic clinic during a business trip.

Andrea (48, Germany, supply chain manager): 6 days, alone, experience with Ayurvedic treatment through a ten-day stay at Ayuresort one year before, stay at Ayuresort as part of a three-month travel through India.

Angeline (48, France, nurse): 7 days, with a tour group, no experience with Ayurvedic treatment, stay at Ayuresort as part of a two-week group tour through India.

Anna (48, Italy, beautician): 7 days, with two friends, experience with Ayurvedic treatment through regular Ayurvedic applications in her own cosmetic parlor and several visits of Ayurvedic resorts in India, stay at Ayuresort as part of an eleven-day travel through India.

Annabelle (31, Germany, psychologist): 13 days, *pañcakarma*, alone, experience with Ayurvedic treatment through stay at Ayuresort one year before.

Anne (53, Sweden, director of a company): 5 days, with her partner Aaron, experience with Ayurvedic treatment through a single application at a spa in Malta, stay at Ayuresort as part of a three-week travel through South India.

Barbara (50, Switzerland, remedial teacher): 13 days, alone, experience with Ayurvedic treatment through a stay at Ayuresort one year before.

Catherine (55, United States, producer, writer and yoga teacher): 7 days, with a tour group, no experience with Ayurvedic treatment, stay at Ayuresort as part of a 24-day group tour through India.

Christina (36, Germany, personnel development manager): 13 days, *pañcakarma*, with her father Maximilian, experience with Ayurvedic treatment through a *śirodhārā* session in Singapore, a five-day treatment in Goa and a two-week treatment at Ayuresort the year before.

Charlotte (60, originally from the U.S. but residing in Germany, actress): 7 days, with her friend Martha, experience with Ayurvedic treatment through a stay at a hospital immediately before her visit of Ayuresort, where she had originally planned to undergo treatment but canceled it after a couple of days because she and her friend could not stand the rough atmosphere and the superficial interaction with the practitioner.

David (47, Belgium, photographer): 21 days, *pañcakarma*, with his partner Alice, experience with Ayurvedic treatment through a four-day stay at an Ayurvedic resort in Kerala.

Deepa (58, India, retired aesthetician, hairdresser and owner of three beauty farms): 13 days, experience with Ayurvedic treatment through several wellness treatments in India.

Diana (64, originally from the Netherlands but residing in Germany, psychotherapist): 14 days, *pañcakarma*, with her friend Silvia, no experience with Ayurvedic treatment.

Edvard (65, Slovenia, dentist): 7 days, with his wife Veronika, experience with Ayurvedic treatment through a previous stay at Ayuresort, stay at Ayuresort as part of a two-week travel in Kerala.

Emma (46, Germany, architect): 7 days, with her partner Frank, experience with Ayurvedic treatment through two previous visits of Indian Ayurvedic resorts, stay at Ayuresort as part of a three-week travel through India.

Eva (41, Germany, engineer): 7 days, with her partner Jonathan, experience with Ayurvedic treatment through long-term Ayurvedic treatments at two Ayurvedic resorts in Sri Lanka.

Frank (56, Germany, designer): 7 days, with his partner Emma, experience with Ayurvedic treatment through a nine-day treatment at an Ayurvedic resort in Kerala the year before, stay at Ayuresort as part of a three-week travel through India.

Gabriel (44, Germany, IT consultant): 13 days, *pañcakarma*, with his wife Victoria, no experience with Ayurvedic treatment.

Hannah (48, Austria, commercial clerk): 14 days, *pañcakarma*, alone, experience with Ayurvedic treatment during a stay at a wellness hotel in Austria.

Isabel (33, Germany, industrial clerk): 20 days, *pañcakarma*, with her mother, experience with Ayurvedic treatment through a visit of Ayuresort one year before.

Jacob (58, Germany, airline employee): 8 days, with his friend Oliver, experience with Ayurvedic treatment through several stays at Ayurvedic resorts in India and Sri Lanka before, stay at Ayuresort as part of a three-week travel through India.

Jennifer (46, originally from the U.S. but residing in France, event manager): 10 days, with a friend, experience with Ayurvedic treatment through several spa visits in the United Arab Emirates, stay at Ayuresort as part of a three-week travel through India.

Jessica (42, Germany, optician): 20 days, *pañcakarma*, with her cousin Maria, no experience with Ayurvedic treatment.

Jonathan (44, Germany, sales manager): 7 days, with his partner Eva, experience with Ayurvedic treatment through long-term Ayurvedic treatments at two Ayurvedic resorts in Sri Lanka.

Julie (78, France, guesthouse owner): 7 days, leader of a French tour group, experience with Ayurvedic treatment through several visits of Ayurvedic resorts in India during the previous seven years, stay at Ayuresort as part of a two-week group tour through India.

Laura (50, Germany, health care administrator): 18 days, *pañcakarma*, alone, experience with Ayurvedic treatment through a visit of an Ayurvedic resort in Sri Lanka one year before.

Linda (45, Germany, team leader): 23 days, *pañcakarma*, alone, experience with Ayurvedic treatment through a visit of Ayuresort the year before.

Lydia (61, Finland, retired teacher): 14 days, with a friend, no experience with Ayurvedic treatment, stay at Ayuresort as part of a four-week group tour through India.

Madeleine (49, France, opera singer and yoga teacher): 7 days, with a tour group, no experience with Ayurvedic treatment before, stay at Ayuresort as part of a two-week group tour through India.

Maria (45, Germany, project manager): 20 days, *pañcakarma*, with her cousin Jessica, experience with Ayurvedic treatment through a visit of Ayuresort the year before.

Martha (60, Germany, actress): 7 days, with her friend Charlotte, experience with Ayurvedic treatment through a stay at a hospital immediately before her visit of Ayuresort, where she had originally planned to undergo treatment but canceled it after a couple of days because she and her friend could not stand the rough atmosphere and the superficial interaction with the practitioner.

Maximilian (71, Germany, retired teacher): 12 days, with his daughter Christina, no experience with Ayurvedic treatment.

Miriam (50, Germany, teacher): 5 days, leader of a German tour group, experience with Ayurvedic treatment through studying Ayurveda during a five-year stay in Bangalore, stay at Ayuresort as part of a two-week group tour through India.

Nicole (37, Germany, secretary): 21 days, alone, no experience with Ayurvedic treatment, stay at Ayuresort as part of a six-week travel through India.

Oliver (49, Germany, flight attendant): 8 days, with his friend Jacob, experience with Ayurvedic treatment through several stays at Ayurvedic resorts in India and Sri Lanka as well as one visit of an Ayurvedic hospital in Karnataka before, stay at Ayuresort as part of a three-week travel through India.

Paul (57, Italy [South Tyrol], director of housing for senior citizens): 13 days, *pañcakarma*, alone, no experience with Ayurvedic treatment.

Rebecca (60, Italy [South Tyrol], writer): 13 days, with Sarah and another friend, experience with Ayurvedic treatment through several single applications at an Ayurvedic resort in Sri Lanka one year before.

Samantha (37, United States, yoga teacher): 7 days, leader of an American tour group, experience with Ayurvedic treatment through treatments in the United States and in Indian Ayurvedic resorts, stay at Ayuresort as part of a 24-day group tour through India.

Sandra (43, Germany, medical doctor): 14 days, *pañcakarma*, alone, experience with Ayurvedic treatment through a consultation with an Ayurvedic practitioner in Germany.

Sarah (66, Italy [South Tyrol], retired musical school director): 13 days, with Rebecca and another friend, no experience with Ayurvedic treatment.

Silvia (60, Germany, architect): 14 days, *pañcakarma*, with her friend Diana, experience with Ayurvedic treatment through a visit of an Ayurvedic resort in Sri Lanka four years before.

Sophie (38, Germany, travel agent): 14 days, with a friend, no experience with Ayurvedic treatment.

Thomas (49, Germany, consultant): 16 days, alone, experience with Ayurvedic treatment through two long-term treatments at Ayurvedic resorts in Kerala and Sri Lanka during the two previous years.

Veronika (65, Slovenia, dentist): 7 days, with her husband Edvard, experience with Ayurvedic treatment through a previous stay at Ayuresort, stay at Ayuresort as part of a two-week travel in Kerala.

Victoria (46, Germany, restaurant owner): 13 days, *pañcakarma*, with her husband Gabriel, no experience with Ayurvedic treatment.

Vladimir (25, Russia, sales manager): 14 days, *pañcakarma*, with a friend, no experience with Ayurvedic treatment.

Yasmin (53, Germany, secretary): 18 days, alone, experience with Ayurvedic treatment through a prior visit of Ayuresort.

A.4 Other Interlocutors

Jayan (31, Kerala): Employee of the Department of Tourism, Government of Kerala

Manu (31, Kerala): Head of the creative department at the company that ran Ayuresort

Mira (34, Malaysia): Inpatient at a private hospital in Ernakulam for 38 days

Vijay (30, Kerala): Inpatient at a private hospital in Ernakulam for 21 days

B Treatment Plans Ayuresort

B.1 Christina (Therapeutic treatment: lower back pain, overweight, migraine; *pañcakarma*)

Treatment	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Udvartana	x	x	x	x	x		
Picu (Lower Back)	x	x	x				
Steam Bath	x	x	x	x	x	x	x
Podi Kiḷi				x	x		
Abhyaṅga						x	x
Piḷiccil						x	x
Face Massage						x	x

Treatment	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13
Udvartana	x					
Sirodhārā	x	x	x			
Steam Bath	x		x			
Foot Massage		x				
Abhyaṅga			x			
Face Massage			x			x
Virecana			x			
Face Pack			x			x
Njavara Kiḷi				x	x	x
Takradhārā				x	x	x
Body Pack						x

Medication: Hinguvachadi Choornam, Lomedus Tablets, Dhanwantharam Gulika, Sukumara Ghrita, Virechana Gulika

B.2 Barbara (Rejuvenation treatment; no *pañcakarma*)

Treatment	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Relaxation Massage	x	x	x				
Śirodhārā	x	x	x	x	x	x	
Face Massage	x	x	x	x	x	x	
Steam Bath	x	x	x	x	x	x	
Podi Kiḷi				x	x	x	
Foot Massage							x
Piḷiccil							x

Treatment	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13
Foot Massage	x	x				
Piḷiccil	x	x				
Udvartana			x	x		x
Face Massage			x	x		x
Face Pack			x	x		x
Njavara Kiḷi					x	
Takradhārā					x	
Body Pack						x
Śirodhārā						x

No medication

B.3 Julie (Wellness treatment; no *pañcakarma*)

Treatment	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Powder Massage	x						
Sirodhārā	x	x				x	
Steam Bath	x	x					
Kiḷi		x					
Synchronic Massage			x		x	x	
Feet Massage			x				
Face Pack			x	x	x		x
Rejuvenation Massage				x			x
Hand and Feet Massage					x		
Body Pack							x

No medication

C Treatment Plans Private Ayurvedic Hospital Ernakulam

C.1 Mohanan (Multiple Sclerosis)

Treatment	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Thalam	x	x	x	x	x	x	x
Neck Piccu	x	x	x	x	x	x	x
Nasyam							x
Piḷiccil							x

Treatment	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Thalam	x	x	x				
Neck Piccu	x	x	x				
Nasyam	x	x	x	x	x	x	
Piḷiccil	x	x	x	x	x	x	
Sirodhārā							x

Treatment	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20
Piḷiccil		x	x	x	x	x
Sirodhārā	x	x	x	x	x	
Abhyanga	x	x	x	x	x	
Njavara Kiḷi	x	x	x	x	x	
Matra Vasthi		x	x	x	x	x
Kṣīra Vasthi						x

Medication: 24 different tablets, powders, decoctions and ghees

C.2 Velu (Alcohol Withdrawal)

Treatment	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8
Thalam	x	x	x	x	x	x		
Takradhārā		x	x	x	x	x	x	x
Njavara Kiḷi					x		x	x

Medication: a specific medicine produced by the hospital for alcoholism treatment

D Clinical Questionnaire Ayuresort

Ayurvedic Clinical Questionnaire Ref.No................

Klinisher ayurvedischer Fragebogen

Die ist ein Fragebogen basierend auf dem ayurvedischen Prinzip. er beinhaltet Fragen zu ihrem Gesundheitszustand, um unseren Artz eine gera Diagnose zu erleichdern. Wir bitten sie diesen Fragebogen mit besonderer Sa"ttigung auszufu"llen.

Die Informationen werden vertraulich behandelt und liegen nur dem Artz und seinen Technischen Mitarbeiter vor.

1. Personal Data (to be filled by the patient)

1. Personliche Daten (auszufu"llen vom Patienten)

Name/Name*:*

Address/ *Adresse:*

Date of birth/Geburtsdatum*:*

Nationality/*Nationalita"t:*

Sex/*Geschlecht:*

Height/ *Gro"be:*

Weight/ *Gewicht:*

Marital status/Familienstand*:*

Profession/*Beruf:*

2. Constitutional Data (Please tick in the appropriate box. (You can write additional information, if any)

2Konstitutionelle Information (bitte kr euzen sie die entsprechende Antwort an. Sie ko"nnen zusa"tzliche Infornationen ausfu"gen)

Are you a …..? Sind sie...?

1.Vegetarian/Vegetarier 2. Non vegetarian */Nicht vegetarier*

What temperature of food do you prefer? Welche Essenstemperatur bevorzugen sie?

1.Warm/Warm 2. Cold */Kalt* 3. Medium/Lau

What taste do you prefer? *Welchen Geschmack bevorzugen sie?*

1. Sweet/Su"b solita ss 2. Sour/Sauer 3. Salty/Salzig

4. Spicy/Pikant 5. Bitter/Bitter 6. Astringent/Zusammenziehend

Describe your appetite? *Beschreiben sie ihren Apetit?*

Small/Klein medium/Mittel large/Grob solita ss (regular/ irregular) regelna"ssig/unregelna"ssig

Do you wake up hungry at night? *Wochen sie nachts hungrig auf?*

Yes/Ja No/Nein

What about thirst? Beschreiben sie ihr Dunstgefu"hl

Weak/Swach Medium/Mittel Strong/Stark (regular/ irregular*)* regelna"ssig/unregelna"ssig

● Page 1

What temperature of liquid do you prefer? Welche Flumgkeitstemperatur bevorzugen sie?
Warm/Warm Cold/ *Kalt* Medium/Lau
What quantity of liquid do you prefer? *Wieviel trinken sie?*
Small/Wenig Medium/Mittel Large/Viel
What about your digestion? *Wie it ihre Verdauung?*
Weak/Schwach Normal/Normal Strong/Stark
What about your bowel movements? *Wie sind ihre Larmbewegungen?*
Loose/Leicht Normal/Normal Constipated/Versto"pft (Regular/Irregular) regelna"ssig/unregelna"ssig
How many times per day do you urinate? Wie oft am tag mussen sie Wasser lassen?
1-4 times/ 1-4 Mal 4-6 times/ 4-6 Mal more than 6 times/ Mehr als 6 Mal
Do you feel any burning sensation or pain when urinate? *fu"hlen sie beim Wasser lassen Schmerzen?*
Yes/ja No/Nein
What about sleep? Wie ist ihr Schlaf?
Sound/*Gut* Bad/Schlecht Disturbed/Gesto"rt
How many hours do you sleep at night? Wieviele Stunden schlafen sie pro Nacht?
Below 3hours/ Unter 3 Stunden 3-6hours/3-6 Stunden 6-8hours/6-8 Stunden
more than 8hours/Mehr als 8 Stunden
Do you have naps? Machen sie wahrend des tages kleine Schlafchen?
Yes/Ja N o/*Nein* (Regular/Irregular) regelna"ssig/unregelna"ssig
How do you feel when you wakeup? *Wie ist das gefu"hl leeim aufwachen?*
Tired *(Stanco)* Normal/Normal Refreshed/E*rhalt*
What about Dreams? Wie oft traumen sie?
Usually/Gelegentlich Rarely/ No dreams/Nie
What type of dream do you usually have? Welche Tra"ume haben sie hauptsa"chlich?
Pleasant/Angenehme Unpleasant/Unangenehme Fearful/Angsterregende
Can you remember every dream? Erinnern sie sich an alle Tra"ume?
Yes/Ja No/Nein Sometimes/Manchmal
Is your sex drive.. Wie ist ihr Sexualantrieb?
Low/Nieder Medium/Mittel High/Hoch
How is your sex life? Wie ist ihr Sexualleben?
Excellent/Excellent Satisfactory/Befriedigent Unsatisfactory/Unbefriedigent
Are you worried about any particular disease? Sind sie u"ber bestimmte Krankcheiten besorgt?
Yes/Ja No/Nein
If so, what disease (specify) Wenn ja, welche?
What about your habits? *Welche Angewohnheiten haben sie?*
Smoking /Rauchen*:* Yes/Ja No/Nein
Drinking alcohol/ Alkohol trinken *:* Yes/Ja No /Nein
Narcotics/Beruhigungs,Schlafmittel*:* Yes/ *Ja* No /*Nein*
● Page 2

Others/ Andere? Welche

Do you exercise? Machen sie Bewegung?

Regularly/Regelna"stig *Irregularly/Unregelna"stig* Never/Nie

Do you practice yoga and meditation? Machen sie yoga oder Meditationen?

Regularly/Regelna"stig *Irregularly/Unregelna"stig* Never/Nie

Are you happy with your partner? Sind sie glu"cklich mit ihrem Partner?

Yes/Ja No/Nein No partner/ich habe keinen Partner

How many children do you have?(specify) Wieviele Kinder haben sie?

Do you suffer from stress? Leiden sie unter Stress?

Yes/Ja No/Nein

If so is this related to? Wenn ja, bezieht er sich auf…?

Personal life/Privat Leben Friends/Freunde Marriage/Heirat

Partnership/Beziehung Profession/Arbeit

Others (specify) Andere…

What is your main aim in life? Was ist ihr Lebens ziel

No aim/Keines Not sure/Nicht sicher Secret/Ein Geheimnis

Others (specify) *Andere…*

What is the state of the spiritual side of your life? Wie ist ihr Glaubeennstand?

Atheist/Atheist Seeker/Suchender Believer/Gla"ubiger

What do you do when you have a failure in your life? Was machen sie, wenn sie einen Fehler in ihrem Leben begehen?

Face it/Konfrontation Be weak/Schwach sein Try to relax/Entspannen

Look at it objectively/ Objektiv betrachten

Are you? *Sind sie ein…?*

Optimist/Optimist Pessimist/Pessimist Depends/Nerschieder

If you see an accident, what will you do? Sie sehen einen Unfall, was machen sie?

Face it/Hinschauen Faint/bewunstlos werden Try to ignore it/ignorieren

Will be stuck and then react/Blockiert sie und dann reagieren

What is your resistance to disease? Wie ist ihre Resistenz gegenu"ber anderen Krankenheiten?

Low/Nieder Average/Normal High/Hoch

You speak? Wie sprechen sie?

Softly/Leise Normally/Normal Loudly/Laut

Your words are? *Ihre Aussagen sind..?*

Clear and continuous/Klar und zusammenha"ngend Interrupted/Stotternd

You move? Wie bewegen sie sich?

Slowly/Langsam Normally/Normal Briskly/Agil

Do you need correction for good sight? Beno"tigen sie Schnilfen?

Yes/Ja No/Nein

If so what type? (Specify) Wenn ja, welche Arf?

● Page 3

For women only

Fu"r Frauen

At what age did you experience first sign of puberty? Mit welchem Alter bemerken sie die ersten Zeichen ihrer Puberta"t?

Under 12 years/Unter 12 Jahre 12-18 years/12-18 Jahre Over 18 years/U"ber 18 Jahre

Is your menstrual cycle regular? Explain Ist ihr Men struationszuflus regelna"stig? Bitte beschreiben sie gerauer…

If the menopause reached, when was it? Fals sie ihre Menopause schon erreichten,wann war sie?

Associated symptoms, if any/ Damit verbundene Symptome:

Do you feel, there is any relationship between your illness and your menstrual cycle*? Glauben sie, dass es einen Zusammenhaup zwischen ihre Mestruation und ihren Krankekheit gibt?*

Yes /Ja No/Nein

History of pregnancy, childbirth, if any/ Wie verliefenschwargerschaft und Geburt, fals sie Kinder haben.

………

Clinical Data (to be filled by the patient)

Klinische Daten (vom Patienten auszufu"llen)

Present illness/ Derzeitige Krankheit

History of present illness/Entstehung dieser Krankheit

History of childhood diseases, if any/ Welche Kinder Krankheit halten sie?

History of accidents, if any/ Hatten sie Unfa"lle?

History of operations, if any/ Hatten sie Operationen?

Any family history regarding diseases? If so please specify/
Gibt es Familienberagene Krankheiten, erbkrankheiten? Wenn ja, bitte beschreiben sie gerauer.

Signature of the patient

………

Additional findings, if any (to be filled by Doctor*)*

- Page 4

Ashtasthana Pareeksha

Diagnosis

Prakruthi

Vikruthi

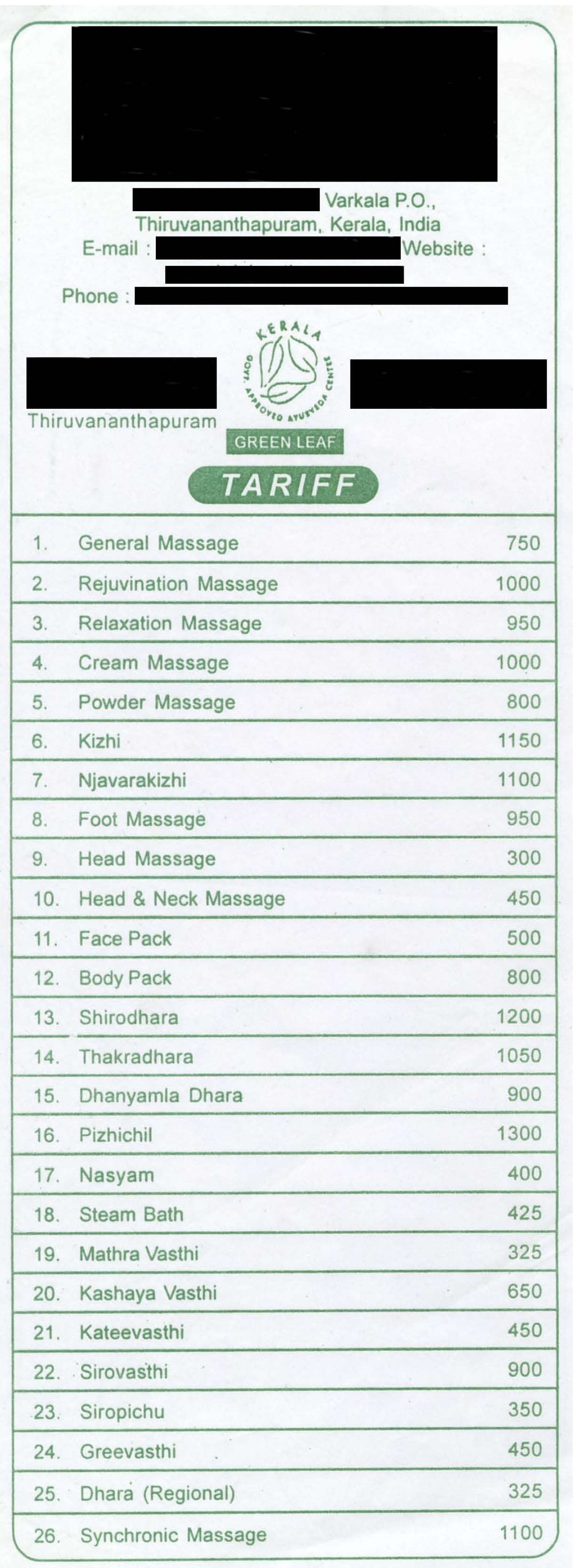
Treatments

Date:..........................

Signature of the Doctor

● Page 5

E Price Sheet Single Applications Ayuresort



Varkala P.O.,
Thiruvananthapuram, Kerala, India
E-mail : Website :
Phone :

Thiruvananthapuram

TARIFF

1.	General Massage	750
2.	Rejuvination Massage	1000
3.	Relaxation Massage	950
4.	Cream Massage	1000
5.	Powder Massage	800
6.	Kizhi	1150
7.	Njavarakizhi	1100
8.	Foot Massage	950
9.	Head Massage	300
10.	Head & Neck Massage	450
11.	Face Pack	500
12.	Body Pack	800
13.	Shirodhara	1200
14.	Thakradhara	1050
15.	Dhanyamla Dhara	900
16.	Pizhichil	1300
17.	Nasyam	400
18.	Steam Bath	425
19.	Mathra Vasthi	325
20.	Kashaya Vasthi	650
21.	Kateevasthi	450
22.	Sirovasthi	900
23.	Siropichu	350
24.	Greevasthi	450
25.	Dhara (Regional)	325
26.	Synchronic Massage	1100

F Ayuresort's Green Leaf Certification

Application No.: C10 - 2712/06 (19)
Year: 2006

Certificate No.: GL-013/06

Government of Kerala

Department of Tourism

Ayurveda Centre Classification

[GO (MS) No. 35/2002/GAD. Dated 28.01.2002]

The Department of Tourism, Government of Kerala, after examination by the duly appointed Ayurvedic Classification Committee, confers the status of Green Leaf on

Varkala. P.O.

Thiruvananthapuram.

The status is valid for a period of 3 years starting 17-08-2006. *To retain the status for the said period, it is mandatory for the management of the Ayurveda centre to abide by all the regulations laid down by the Department of Tourism from time to time.*

KERALA GOVT. APPROVED AYURVEDA CENTRE

GREEN LEAF

kerala
God's Own Country

Place: Thiruvananthapuram
Date: 29-08-2006

DEPARTMENT OF TOURISM GOVT OF KERALA

Director
Department of Tourism

Erklärung gemäß § 8 Abs. (1) c) und d) der Promotionsordnung der Fakultät für Verhaltens- und Empirische Kulturwissenschaften

Promotionsausschuss der Fakultät für Verhaltens- und Empirische Kulturwissenschaften der Ruprecht-Karls-Universität Heidelberg
Doctoral Committee of the Faculty of Behavioural and Cultural Studies, of Heidelberg University

Erklärung gemäß § 8 (1) c) der Promotionsordnung der Universität Heidelberg für die Fakultät für Verhaltens- und Empirische Kulturwissenschaften
Declaration in accordance to § 8 (1) c) of the doctoral degree regulation of Heidelberg University, Faculty of Behavioural and Cultural Studies

Ich erkläre, dass ich die vorgelegte Dissertation selbstständig angefertigt, nur die angegebenen Hilfsmittel benutzt und die Zitate gekennzeichnet habe.
I declare that I have made the submitted dissertation independently, using only the specified tools and have correctly marked all quotations.

Erklärung gemäß § 8 (1) d) der Promotionsordnung der Universität Heidelberg für die Fakultät für Verhaltens- und Empirische Kulturwissenschaften
Declaration in accordance to § 8 (1) d) of the doctoral degree regulation of Heidelberg University, Faculty of Behavioural and Cultural Studies

Ich erkläre, dass ich die vorgelegte Dissertation in dieser oder einer anderen Form nicht anderweitig als Prüfungsarbeit verwendet oder einer anderen Fakultät als Dissertation vorgelegt habe.
I declare that I did not use the submitted dissertation in this or any other form as an examination paper until now and that I did not submit it in another faculty.

Vorname Nachname
First name Family name ______________________________

Datum, Unterschrift
Date, Signature ______________________________