GÖRAN VIKTOR STÅHLE

A Matter of Balance in a Fast Paced Society

Performing Ayurvedic health counselling

This paper concerns the practice of so called 'Ayurvedic health counselling' in Sweden today. It is a case study involving semi-structured interviews with six practitioners in the Stockholm area. The focus is on how the practitioners construe the therapeutic processes involved in their practice. The aim of the case study is to develop theoretical interpretations of these processes in terms of a performance perspective based upon Catherine Bell's concept of 'ritualization'.

Ayurvedic health counselling is one example of the multifaceted practice of Ayurveda in Sweden today. Different aspects of this ancient South Asian 'knowledge of longevity' are common in products and services related to holistic health and fitness. It is related to what Paul Heelas (2006) calls 'spiritualities of life', that is ways of life in the modern Western cultures 'which attain importance to the cultivation of the quality of one's own life; the quality of one's subjective well-being' (p. 224). The Sanskrit scholar Kenneth Zysk has called this 'New Age Ayurveda' (2001) to distinguish these 'globalized' Ayurveda from how it is described in the classical textual sources.

Deepak Chopra is probably the most well-known exponent of these forms of Ayurveda. In a number of publications Chopra has included elements of Ayurveda in an approach for the promotion of 'physical, mental, emotional, spiritual and social wellness', which purports to integrate Western and Eastern ideas and techniques (The Chopra Center 2008). A few of Chopra's publications are also available in Swedish translation, for example his first book *Perfect Health*. The practitioners interviewed in the present study acknowledge the importance of Chopra, but make reservations against what they call his 'commercialization' of the practice.

Another very influential approach of this kind of 'globalized' Ayurveda is *Maharishi Ayurved*. This approach is very influential in the Swedish context, as the supplier of the majority of the products in the market. This model of Ayurveda was founded in the 1980s by Maharishi Mahesh Yogi, the leader of the Transcendental Meditation movement, in an attempt to revive the

Ayurvedic tradition to suit the Western cultures (e.g. Humes 2008; Jeannotat 2008). The practitioners in the present study do not identify with Maharishi Ayurved, but they report that they primarily use these kinds of product. This is because they claim that the products from Maharishi Ayurved are safe, that they do not contain any poisonous substances, as for example heavy metals. Recently, this has been a controversial question in relation to Ayurvedic preparations in the Swedish mass media. As the interest in Ayurveda is increasing, new businesses are being established, businesses that import products from new manufacturers, some directly from South Asian manufacturers.

As a system of health care, Ayurveda is also a part of the field of complementary and alternative medicine (CAM) as a part of Western medical pluralism (Saks 2008). Degree programmes for training as an Ayurvedic physician are not available in Sweden. Training is offered in some other European countries, for example in Great Britain, where universities have exchange programmes with South Asian Ayurvedic colleges. In South Asia a 'modernized' form of Ayurveda has been established as a formal medical system. This form of Ayurvedic medicine displays influences from its complementary status in relation to biomedicine, with college programmes for the training as an Ayurvedic physician (*vaidya*), hospitals and a pharmaceutical industry (e.g. Banerjee 2008; Leslie 1992).

As to the field of CAM in general in Sweden, there are neither official or legislative regulations for practicing Ayurveda, nor a consensus for a minimum level of training. As a consequence, the practice of Ayurveda shows a rather multifaceted picture. Commonly, one or another aspect of Ayurveda, such as Ayurvedic massage, health counselling or diet, is combined with other techniques of personal/spiritual development or practices of maintaining fitness and well-being. Often these are integrated in the sphere of activities of various centres for personal development, fitness, health and well-being (e.g. yoga studios, spas). However, there do exist a few organizations that specialize in Ayurveda proper. These organizations sell Ayurvedic products, offer different kinds of treatments or counselling, and host courses, workshops and events to promote the knowledge of Ayurveda.

Since the early 1990s two ten-week courses for training in 'Ayurvedic health counselling' have been established in Sweden by two organizations specializing in Ayurveda. The practitioners interviewed in this study all have been trained in Ayurvedic health counselling at one of these ten-week courses.

A case study generating a performance model

The research strategy used in this study is a case study approach. The purpose is to obtain in-depth knowledge of the specific case of Ayurvedic health counselling and the aim is generating theoretical tools in terms of a performance model for interpreting (some of the) processes involved.

The case study includes semi-structured interviews with six practitioners. The interview subjects were found by searching the Internet for web-pages offering Ayurvedic health counselling in the Stockholm area. Each interviewee was asked for further appropriate interview subjects. This overview of the field made it clear that the persons advertising Ayurvedic health counselling usually had their training from one of the two ten-week courses available in Sweden. Finally, three men and three women that had trained at the same ten-week course were selected. They all combine Ayurvedic health counselling with other activities of mind–body healing, for example yoga, spa-treatment, etc.

There exists a range of various performance approaches, with different epistemological bases. Common to the performance approaches to health and healing is that they call for recognition of action and process (e.g. Csordas 2002). Here I will use a practice-oriented performance perspective inspired by Catherine Bell (1998, 1992), specifically the concept of 'ritualization'. This perspective could illustrate how the practices involved in the case of study are constituted, and how these practices make a person engage in and experience transformations.

Thus, it is not in the scope of this study neither to assess the efficacy of the treatment, nor to scrutinize the metaphysical discourses involved in the Ayurvedic tradition. These questions are 'kept in the background' as the processes involved in the practice (as they are construed by the practitioners) are 'put at the forefront'. In this way, I am concerned with certain dimensions of the consultation process (not the entire system of Ayurvedic health counselling) that could be seen as psychological side-effects of the treatment. But, as will be shown, these dimensions are not unknown to the practitioners, and are explicitly attained to in the treatment process. The practitioners attribute this to the holistic nature of the treatment.

The following sections of this article will concern the activities of the practitioners concerning what sorts of conditions are treated, how the afflicting forces are understood, what recommendations are given, and how the conditions are explained. The final section of the article will develop analytical arguments in terms of ritualization.

Why does one seek Ayurvedic health counselling?

The practitioners interviewed report trends similar to what have been found in resent research about CAM in Sweden. The prevalence of the usage of CAM is increasing generally and is higher among women, individuals with higher education and in the age group of 30–59 years (Hanssen *et al.* 2005). The practitioners interviewed in the present study report being usually booked up and the courses that are given are usually quickly fully booked. An interesting detail is that the practitioners report a clear increase in the numbers of phone-calls in connection with Ayurveda being mentioned in the media, for example when it was a part of Anna Skipper's programme on channel TV3 in 2004. All the six practitioners also report that women form the majority of their clients, but two of the interviewees report that these gender differences have been decreasing in the last couple of years, with male clients being almost as numerous as the female.

Based upon what the practitioners interviewed report, the clients can be divided into three broad categories according to their motives for seeking Ayurvedic health counselling:

The majority of the clients seek Ayurvedic health counselling as a direct complement, or alternative, to biomedical treatment. The client wants to try alternative treatment(s) in conjunction with conventional medical treatment, or the client experiences the ongoing treatment as not effective, or that it has negative side-effects. These clients typically have diffuse, vague complaints that are not easy to diagnose in conventional biomedical terms, such as sleeping disturbances, weariness, fatigue, uneasiness, or anxiety. These clients may also suffer from persistent problems that are difficult to cure, such as digestive disorders, obesity, allergic disorders, asthma, or musculoskeletal problems. The practitioners claim that they attend to the whole person, in contrast to the biomedical approach. Therefore they should be better equipped to deal with these conditions, as they consider the holistic view, not only the symptoms.

A second category of clients have no specific problems, but seek counselling in response to a wish to keep fit, to find an appropriate diet or just out of curiosity. They are interested in hygiene, diet and self-help in health, and want to see what Ayurveda is and what it can give them.

Some (but not all) of the practitioners report of having had a few clients of a third category: clients with serious conditions, such as diabetes. Obviously this is not very common, and when we touched upon this subject all the practitioners interviewed were very careful to emphasize that it is not within their competence area to cure these kinds of conditions. They restrict themselves

to support and rehabilitation in complement to biomedical treatment, for example restorative treatment after medication or after surgical operations. One interviewee says that it is important not to give the client the impression that Ayurvedic health counselling can be a means of curing these kinds of diseases, and refers to risks of charlatanry and laws which restrict medical quackery.

How are the consultations carried out?

The practitioners interviewed usually use 1.5 hours for one consultation. The total number of visits of the client depends upon the nature of her/his problem. It is most common that the clients are recommended one further visit in about two to three months, for a follow-up interview. It is common that people come for one consultation only, and do not take the opportunity of a follow-up visit.

More visits are needed for certain types of problem, such as obesity, which require a greater effort on the part of the client. A few of the practitioners also have some clients that make visits regularly or occasionally. Several of the practitioners are also available on the telephone or through email, if the client has any further questions.

Usually the first part of the consultation is used for 'anamnesis'; to learn to know the client's mind–body constitution (*dosha*) and her/his present way of life. This is done through a pulse diagnosis and an interview. The other part of the consultation is used for recommendations, prescriptions and dialogue with the client. I will consider the two parts separately.

The first part of the consultation: pulse diagnosis and interview

At the beginning of the first consultation all the practitioners interviewed let the client fill in a form on the general state of her/his health and situation in life. This information is used as a background for the rest of the consultation. After the form has been filled in, a pulse diagnosis and an interview is conducted.

The principal purpose of this first part of the consultation is to establish the mind–body constitution of the client and in addition to this, to learn about the client's way of life. Ayurveda recognizes three humors (*dosha*) that are derived from five fundamental elements of nature. These are *vata* (wind), *pitta* (bile) and *kapha* (phlegm) and they exist in various combinations in

all forms of life, which make up the variability and diversity of the material world. Therefore an individual is born with a particular constitution of the three *dosha* as they are combined in specific ways in the individual person's mind and body.

Pulse diagnosis is a common technique in many Oriental medical traditions. By taking the pulse the practitioner claims to be able to get a picture of the functioning of the entire mind–body system of the client and to establish the humoral balance of the client. In traditional Ayurveda the practitioner might not only examine the client's pulse, but also the client's skin, hair, eyes, tongue, etc. In some expressions of 'modernized' Ayurveda these procedures are left out, for example in college educations in India. It is interesting to note that in this Swedish postmodern version of Ayurvedic practices, pulse diagnosis have become a common ingredient.

The interview lets the practitioner supplement what she/he has found through the pulse diagnosis. However, in addition to establish the humoral balance of the client, the aim of the interview is also to learn about the client's way of life. Primarily, the focus is upon habits of diet, sleep and physical activity. One of the interviewees says:

> Mostly it [the consultation] is about a dialogue with the client: What is your problem? What symptoms have you got? What do you think has started this? How do you live? How do you eat? How do you sleep? How is your stomach working? How is your life working?

Second, the participants stress that it is important to take a comprehensive view and discuss the client's everyday life situation. One practitioner says that he always tries to ask about family circumstances and the situation at work:

> Because that is also quite common, that yes, alright it was perhaps only . . . you find out that this stomach-ache was really about that I wanted to get a divorce, or to change my job, or whatever else it might be.

I will not scrutinize the appropriateness of the metaphysical ideas and concepts involved in the consultation process, but will view them as 'conceptual tools'. According to this, the important features are the emphasis on the interactions of a mind–body (i.e. an embodied agent) and a physio-social environment.

The holistic emphasis of the practitioners' approach is in direct correspondence with the South Asian categories of the person. The constituents of the person are not conceptualized according to the Cartesian dualism that

is characteristic to biomedicine. Instead, the individual mind and body are seen as being in constant exchange with the larger social and physical environment. This can be viewed as processes in dynamic interaction, through the ways of life of the person, as for example diet, hygiene, sleeping patterns, physical exercise, specific regional ecology, season of the year, and so on (e.g. Trawick 1992; Marriott 1990).

Gananath Obeyesekere (1977) points out that the view of mind–body contingence implies that there is a recognition of psychosomatic illnesses, for example, that fever can be caused by grief and anxiety, stomach problems by grief and fright. But an important qualifier is that this is 'somato-psychics', not psychosomatics, because the body is seen as central through the emphasis on humors. The mind is seen as dependent on physiological factors (p. 160 f.).

Other scholars (e.g. Kakar 1991; Nichter 1981) have noted how this view of the person involves the psychosocial, as well as the physical, aspects of illness in the treatment process.

The second part of the consultation: recommendations and prescriptions

The second part of the consultation focuses on recommendations and prescriptions by the practitioners. This naturally concerns advice on the same principal areas that have been covered in the first part of the consultation: diet, sleep, rest and physical activity. It also includes general advice on lifestyle and, if needed, specific prescriptions or plans of actions to follow. This might (but does not necessarily) include preparations or medicaments.

The practitioners view health and illness in terms of balances between the specific inborn mind–body constitution (*dosha*) of the client and her/his ways of life. The principal cause of affliction is attributed to disturbances of these balances due to the fast pace of the Swedish society of today.

The advice given on eating habits concerns how you eat and what you eat. One practitioner says:

> In this fast paced society people often need to be reminded of the importance of eating in peace and quiet. To chew well and concentrate on the eating, not to read the newspaper or watch television at the same time as eating. And not to use too much coffee, and to drink a sufficient amount of water. A common problem is not to drink adequately, to drink too little during the day.

Sleeping habits concern the vital balance of activity and rest. The practitioners stress the importance of sufficient sleep and at the adequate time. This is according to the theory that different times of the day are governed by the different *dosha*. And this, one of the informants claim, is in concordance with modern medical research on sleep:

> The best is to ease off and move into low gear in the evening and go to bed early, preferably before 10 pm, and to rise early, preferably before 6 am. After 10 pm there is an increase in *pitta* that promotes deep sleep, but this will give the reverse result and give you more energy if you are awake. After 6 am there is an increase in *vata*.

The recommendations on physical activity also emphasize that rest should be in balance with activity. To begin or to continue regular physical exercises is recommended. The practitioners stress that this should be in line with the individuals' own preferences. This can be any kind of physical exercise that the person feels is good for him/her, from regular walks and habits of taking the stairs instead of the elevator, to practices of yoga and aerobics. But at the same time, there is a tendency that the practitioners advocate meditation and yoga. This is most obvious among the practitioners that combine their Ayurvedic practice with teaching yoga. One of the interviewees is a yoga teacher and usually includes yoga postures in the recommendations to the client:

> Here in Sweden we have lost the knowledge that you actually have to take care of yourself and your body. People think that you can work 60 hours a week without this hitting back at them, that you can sleep at weekends instead of the weekdays, that you can skip lunch without it having any consequences, and such things.

The changes that are sought are supposed to be moderate, step-by-step processes. It is important to begin with the client's situation today and make small changes in the right direction. One of the practitioners stresses that the clients should not strain themselves too much or be over-ambitious, but the recommendations should successively be integrated in the client's everyday habits:

> Small, small changes are enough to get significant effects in the long run. It is important to take the long view and see one's condition as a part of a greater whole. In ten years we will see effects of small changes today.

In this there is a tendency to try to avoid rationalization and over-emphasis on cognitive aspects. Instead, the practitioners refer to 'natural ways' of being, a 'naturalness' that is equated with health and well-being. As one of the practitioners says, the forms of advice given are not to be followed 'like an idea'. The clients' 'ideas' about food, as, for example, through different dietary programmes, sometimes prevents them from listening to the 'natural' ways of eating.

A matter of coaching, not of therapy

In addition to this, the practitioners stress that it is important to link the symptom to the situation of life at large, or, as one practitioner expresses it, to take 'the emotional element' into consideration, because emotions will have effects on the physical health. It is important to help the client to cope with the problem emotionally. How thorough this conversation is depends upon the client, if the client is willing to share this with the practitioner. As one interviewee puts it: 'some *pitta*-persons have a more instrumental turn of mind and only want concrete plans of action and medicaments'.

In this way the practitioners underscore their roles as a coach or guide of lifestyle, rather than as a therapist in the manner of a medical doctor. They also underline that they are not involved in some kind of psychotherapy, they can recommend the person to change his life, but how to do it is up to the client. One practitioner explains:

> A significant group of clients are people who are in a situation of life where they are not able to take care of themselves for some reason, because of stress or something; they feel that they are stuck in their situation of life and are frustrated. And, I mean, this I cannot do much about but to say that: 'You are starting to get ill from your situation of life, and you have to do something about it. You know yourself that it is your situation of life that is the problem, and I cannot tell you what to do, but you have to do something, since now you are beginning to get ill because of it.'

The role of the practitioner as a coach rather than as a medical doctor or psychotherapist becomes even more pronounced in their attitude towards Ayurvedic medicaments. Usually, but not always, the consultation includes prescriptions of Ayurvedic preparations, medicaments or other products. Commonly, the client is given a programme to follow which includes Ayur-

vedic oils for massage, herbal teas, and various household remedies (e.g. squeezed lemon in a glass of water, etc.). In some cases Ayurvedic medicaments are prescribed. The purpose of these preparations and products is to assist in the re-balancing process, for example there are different types of oils and *vata* is characterized by dry skin.

There is no scientific basis of evidence for most Ayurvedic medicaments, but the practitioners interviewed stress that Ayurvedic medicaments have strong effects, for example with indigestion or arthritis. However, there is a tendency among the interviewees to down-play the importance of the Ayurvedic products and medicaments in the treatment process. Instead there is a focus upon the clients' own responsibility for a health promoting lifestyle. As one interviewee puts it:

> I see myself as a guide, a coach, who is helping them to understand themselves, to create a control of their own. It is about how you live your life, not about giving medicaments.

Actually, it is a common view among the practitioners that their emphasis on lifestyle advice is quite contrary to the dominant way of practicing Ayurveda in India today. Several of the practitioners interviewed claim that the more authentic Ayurveda is preserved in the West, where this emphasis on holism is more pronounced. In India it is common that prescription of medicines is the principal part of a consultation and that advice on lifestyle is not even included. One practitioner says:

> It is of course very different depending on the person, but even if there are no big changes that need to be done, I always start by talking about food and eating and how important it is, these . . . sort of . . . basic sides: the food, how much you are awake, what you do during the day, which activities, physical exercise, how you sleep at night, what time you go to bed, what time you get up, all this basic stuff, I talk with the patient about it. I also prescribe some household remedies or medicaments, if needed. But often it is these basic forms of advice on lifestyle that many persons need. The kinds of advice on lifestyle that exist in Ayurveda, but which are not mentioned in the Western medical practice.

A matter of balance in a high-speed society

In the preceding parts of this article I have tried to describe the processes in Ayurvedic health consultation through the descriptions and comments of six practitioners in Stockholm. I have tried to highlight that the practitioners are engaged in the psycho-social as well as the physical well-being of their clients. In the presentation it has also become clear that the way Ayurveda is practiced is 'tuned in' to the postmodern Swedish culture. I have tried to show how the practitioners view health and illness in terms of balance; mainly in terms of an innate constitution of the body that is affected by the individuals' ways of life. This is seen by the practitioners as a 'natural' homeostasis, where a state of health is attained when the ways of life are concordant with the innate constitution. The principal causes of imbalance are attributed to the fast pace of the postmodern Swedish society. The practitioners clearly state that the Ayurvedic health counsellor is primarily engaged in health promotion and life-style advice, not in the treatment of chronic conditions. The aim of the practitioner is to serve as a guide to move from a condition of imbalance to one of increased well-being and health.

In terms of a performance perspective, I would argue that the practitioners' activity in relation to the client implies two interdependent processes: First, it involves the contextualization of the client's symptoms in the association of illness and health with the lifestyle and the context of the client. Second, it implies the practical grounding of the symptom in the efforts of the practitioner to make the mind–body connection explicit and to increase the client's awareness of the concrete ways of life that promote health.

In the following and final part of the article, I will consider how these processes can be analyzed from a performance perspective using Catherine Bell's concept of 'ritualization'. I will argue that the activities of the practitioners and their (actual or proposed) clients can be interpreted in terms of a ritualized space, a space which is constituted by the practical participation by both the practitioners and the clients, in which the clients are invited to engage. It is in relation to this engagement of the clients that the treatment can be said to have transformative abilities.

Employing Catherine Bell's practice-oriented approach

To conclude, I will turn to a more analytical perspective and see how (some of the aspects of) the Ayurvedic health counselling can be interpreted in terms

of a practice-oriented performance approach, specifically the concept of 'ritualization' developed by Catherine Bell (1998, 1992). Applying a practice-oriented performance perspective it is possible to recognize the interconnectedness of mind, body and environment. And, since this interplay is seen in terms of embodiment and action, this kind of perspective also makes it possible to conceptualize the principal focus on bodily processes and everyday habits, rather than cognitive meaning, in Ayurvedic health counselling.

Bell's approach to performance is practice-oriented in that she underlines the need to approach action as action, 'the very doing of the act within the context of other ways of acting' (1992: 74). She uses the term 'ritualization' to get beyond the tendency to project pre-established (intellectualized) understandings of ritual on particular activities. Therefore, in Bell's approach the task of the researcher is not to discern ritual-like meanings in activities, but to attend to how a particular activity 'does what it does' according to the particular circumstances and cultural strategies that generate the very same activity (1992: 74). Critical to this is that the activities in a specific ritualized space implicate a differentiation of the performed activities from other similar activities. In the words of Bell, ritualization 'involves the very drawing, in and through the activity itself, of a privileged distinction between those acts being performed and those being contrasted, mimed or implicated somehow' (1992: 90).

Following Bell, I will first consider the ritualized space involved in the process of consultation. Specifically, I will focus on how this environment is structured according to distinctions that are based on the performances of the actors engaged in the space. Second, I will consider the ritualized agency implicated in the participation of the clients.

The ritualization of space

Many parts of the activities of the practitioners are related to a focus upon 'alternativeness'. Most fundamentally this can be seen in the claims of taking the best from (and combining) the knowledge of the East and the West, a claim that rests upon a fundamental dualism of Eastern spirituality versus Western materialism.

This is also repeated on another level in the claims of holism as distinct from the one-sided nature of biomedicine; the emphasis on taking the whole lifestyle of the clients into consideration rather than only focusing on symp-

toms and medication; the acknowledging of the mind–body connection and not just focusing on either bodily or mental aspects.

More concretely this is expressed in the consultation process when the practitioners, by reference to taking the comprehensive view, primarily attribute the cause of ailments to imbalances in the clients' situation of life in the postmodern Swedish fast paced society.

Not considering the appropriateness of this practice (there could be good medical reasons for this), this positioning as 'alternative' can be seen as structuring a ritualized space that is associated with coveted features, which in the end signify health and healing. To the extent that this ritualized space is invested in and identified with, the Ayurvedic practitioner is positioning her/his practice as 'the Other' in relation to the fast paced society and, as an extension to this, also biomedicine. The client can be said to 'be invited' to participate in this 'alternative' ritual space. The practitioner is on the client's side as a counterpart to the illness-producing factors of the one-sided Western/Swedish fast paced society.

This 'alternative' quality of Ayurvedic health counselling in 'resistance' to the fast paced society is probably very decisive in the treatment process. This makes the practitioners context-sensitive and 'tuned in' to people's experiences in the late-modern Swedish society. The types of complaints are typical of this context with the majority of the clients having vague, diffuse complaints that are seen as stress-related. The majority of the clients are persons that 'fall through' the conventional health care system. The majority of the clients are also women.

However, this alternative quality is not to be seen as something 'outside' or in opposition to the Swedish postmodern society, but as one of the trends that are part of this pluralistic society. This connects to anti-modernistic trends that are an intrinsic part of the complex postmodern culture. These discourses are commonly employed in what Heelas calls 'spiritualities of life'. Heelas (2008) has shown that this is an intrinsic part of the European history of ideas; it has its historical antecedents in the counter-culture of the 1960s and 1970s, and can be traced back to the Romantic philosophy of the 1800s and its opposition to the Enlightenment thinking.

In this way, this 'alternative' nature is probably not something that is thoroughly 'alien' to the client. On the contrary, it is probably in some way 'recognized' by the client, even if this 'recognition' requires seeing life in novel and alternative ways, and therefore could have transformative, 'eye-opening' characteristics.

The ritualization of agency

Thus far I have discussed how a ritualized space is inhabited. Now I want to go further, to discern how ritualized agents are implied by their (actual and potential) participation and investment in this ritualized space. This takes the distinctions of 'alternativeness' to another level, associating it with active agency, in contrast to passivity, in relation to illness (and health).

The cause and cure of the illness is attributed to the 'naturalness' of the relation between the mind–body and the environment (both physical and psycho-social). The 'natural' harmony and balance have been disturbed. The focus of both the cause and the cures of the illness are primarily related to everyday habits of diet, rest, sleep, and physical activity, paired with a suspicion of intellectualism. The changes sought are small, step-by-step changes, appropriate for the client's constitution and situation of life. The practitioners take careful steps to explain the various parts of the treatment to the client.

In this way the clients' responsibility for and control of the treatment process is stressed by the practitioners. From a performance-perspective, what is involved here is a change in the attribution of illness that is establishing the person as an active agent in relation to the illness, not a passive victim of disease. Thus, one of the performative dimensions of the consultation is that this provides the client with a coping strategy, a plan of action, in relation to illness and health. This could have transformative abilities and beneficiary effects on the clients situation in itself, in that this could provide a sense of practical mastery of the situation.

This practical mastery is structured according to the ritualized space of the practitioners. There is a negotiation about the character of the illness with the client and explanations are emphasized to the client. It is also acknowledged by the practitioners that the effectiveness of the treatment is dependent upon the involvement of the client, as they recognize that the more the client invests in the treatment, the more efficacious it tends to be.

Another aspect of this is that it positions the individual person in authority, in contrast to the health care professionals. To consult different, alternative health care professionals increases the person's chances to get 'second opinions' and alternative interpretations of her/his illness. The person is made an authority in how her/his illness (or health) is to be approached, that is, an active subject in a pluralistic context of many alternatives.

This is in concordance with the ideals of individualism in pluralistic societies. Paul Heelas and Linda Woodhead call this the 'subjective turn of modern

culture' (2005: 3). The authority is attributed within the individual, and it is the individual that has responsibility for his/her own life in all its aspects:

> The subjectivities of each individual become a, if not the, unique source of significance, meaning and authority. Here the good life consists in living one's life in full awareness of one's states of being; in enriching one's experiences; in finding ways of handling negative emotions; in becoming sensitive enough to find out where and how the quality of one's own life – alone or in relation – may be improved. (Heelas & Woodhead 2005: 3–4.)

To sum up, the performative dimensions of Ayurvedic health counselling can be interpreted in terms of ritualization in the following way.

The practitioners inhabit a ritualized space that the clients are invited to participate in. This participation might have transformative potentialities of its own, in that participation implies changes in how agency is accrued and that certain ways of life are strengthened and others undermined. Activity and control are related to an alternative counter-position to the postmodern, fast paced Western/Swedish society. The latter is associated with passivity, not being in control, and a materialistic, unhealthy lifestyle. This distinction employs an orchestration of common cultural discourses.

The client's participation can be interpreted as a ritualized agency with a sense of practical mastery of the specific ritualized space. The cause and cure of the illness is attributed to concrete factors through the emphasis on body and habits, a contextualization and embodiment of the illness. By being recognized as a person that is active in relation to her/his life problems, a person with responsibility and control of the illness, the client's engagement in (and recognition of) the ritualized space is made an integral part of the ritualization.

References

Banerjee, Madhulika

2008 Ayurveda in Modern India: Standardization and Pharmaceuticalization. In: Dagmar Wujastyk & Frederick M. Smith (eds), *Modern and Global Ayurveda*; pp. 201–14. Albany: SUNY Press.

Bell, Catherine

1992 *Ritual Theory, Ritual Practice*. New York & Oxford: Oxford University Press.

1998 Performance. In: Mark C. Taylor (ed.), *Critical Terms for Religious Studies*; pp. 205–24. Chicago: University of Chicago Press.

Chopra Center
2008 Home page of the Chopra Center. http://www.chopra.com (accessed on 31 October 2008).
Csordas, Thomas J.
2002 *Body/Meaning/Healing*. New York: Palgrave.
Hanssen, B., S. Grimsgaard, L. Launso, V. Fonnebo, T. Falkenberg & N. K. Rasmussen
2005 Use of complementary and alternative medicine in the Scandinavian countries. *Scandinavian Journal of Primary Health Care* 23 (1): 57–62.
Heelas, Paul
2006 The Infirmity Debate: On the Viability of the New Age Spiritualities of Life. *Journal of Contemporary Religion* 21: 223–40.
2008 *Spiritualities of Life: New Age Romanticism and Consumptive Capitalism*. Malden: Blackwell.
Heelas, Paul & Linda Woodhead
2005 *The Spiritual Revolution: Why Religion is Giving Way to Spirituality*. Malden: Blackwell.
Humes, Cynthia-Ann
2008 Maharishi Ayur-Veda: Perfect Health through Enlightened Marketing in America. In: Dagmar Wujastyk & Frederick M. Smith (eds), *Modern and Global Ayurveda*; pp. 309–32. Albany: SUNY Press.
Jeannotat, Francoise
2008 Maharishi Ayur-Ved: A Controversial Model of Global Ayurveda. In: Dagmar Wujastyk & Frederick M. Smith (eds), *Modern and Global Ayurveda*; pp. 285–308. Albany: SUNY Press.
Kakar, Sudhir
1991 *Shamans, Mystics and Doctors: A Psychological Inquiry into India and Its Healing Traditions*. Chicago: University of Chicago Press.
Leslie, Charles
1992 Interpretations of illness: Syncretism in Modern Ayurveda. In: Charles Leslie & Allan Young (eds), *Paths to Asian Medical Knowledge*; pp. 177–208. Berkeley: University of California Press.
Marriott, McKim
1990 *India through Hindu Categories*. New Delhi: Sage.
Nichter, Mark
1981 Negotiation of the Illness Experience: Ayurvedic Therapy and the Psychosocial Dimension of Illness. *Culture, Medicine and Psychiatry* 5: 5–24.
Obeyesekere, Gananath
1977 The Theory and Practice of Psychological Medicine in the Ayurvedic Tradition. *Culture, Medicine and Psychiatry* 1: 155–81.
Saks, Mike
2008 Plural Medicine and East-West Dialogue. In: Dagmar Wujastyk & Frederick M. Smith (eds), *Modern and Global Ayurveda*; pp. 29–42. Albany: SUNY Press.

Trawick, Margaret

1992 Death and Nurturance in Indian Systems of Healing. In: Charles Leslie & Allan Young (eds), *Paths to Asian Medical Knowledge*; pp. 129–59. Berkeley: University of California Press.

Zysk, Kenneth G.

2001 New Age Ayurveda, or What Happens to Indian Medicine When It Comes to America. *Traditional South Asian Medicine* 6: 10–26.