Introduction

During tourist season in the early to mid-1990s, Dr. Vijayan practised *pañcakarma*, an Ayurvedic purification regimen, out of a hotel room at a popular beach resort in Kerala. On the door to this room was tacked a life-size technicolour poster of an Indian goddess. The poster was an apt facade, suggesting a link between Dr. Vijayan’s practice and an Indian, specifically Hindu, spiritual imaginary attractive to a tourist gaze. For it was only foreign tourists, merging healing with holiday, who received *pañcakarma* in this room. For a middle-class Indian consumer, the glossy print of the goddess would have been, to borrow a catchphrase from advertising agencies, decidedly ‘downmarket’ (Mazzarella 2003: 121). Although, as William Mazzarella (2003) has noted, the marketing of Indian cultural difference to Indian consumers was on the rise in the 1990s, it required a careful management of images to evoke national-culture while simultaneously conveying a ‘world-class’ ‘Western-aspirational’ aesthetic. The very images that lacked cachet for Indian consumers, however, held local spiritual colour for tourists who were less compelled by Western-aspiration than Western-escape. Dr. Vijayan’s foreign clients, as he represented them to me in conversations in the mid-1990s, sought out *pañcakarma* either for general revitalization or for chronic illnesses with no clear biomedical remedy. Yet he also described their problems in psycho-spiritual terms that creatively interwove New Age and classical Ayurvedic concepts.

From a twenty-first century perspective Dr. Vijayan can be viewed as an early entrepreneur of Ayurvedic tourism, adopted as formal policy in 2002 by the Central Council of Indian Medicine (CCIM), which specified that ‘facilities for *panchakarma* [sic] and yoga would be encouraged to be offered in hotels’ (Ministry of Health and Family Welfare, Government of India, quoted in Islam 2012: 226). Although *pañcakarma* and yoga are rooted in very different traditions (see Warrier, this volume), the CCIM lumped them together as tourist commodities for an international market. Dr. Vijayan was an exemplar of what Nazrul Islam nearly 20 years later called ‘spa culture,’ in which Ayurveda is repackaged for the ‘consumption of spirituality’ (Islam 2012: 225, 229). Today this spa culture, as Islam shows, is increasingly attractive to upper-class Indians as well as foreigners.

Dr. Vijayan’s practice, however, reflected an earlier historical moment, in which, as will be apparent later, the desires and diseases of his foreign patients were diagnosed very differently.
from those of his Indian patients, in obliquely psycho-spiritual terms. Although he never spoke explicitly to me about the spiritual lives of his foreign patients, he nonetheless conveyed through chance phrases and stories a subtle diagnosis of their psycho-spiritual impoverishment. In so doing, he exemplified the potential of a Euroamerican ‘preoccupation with . . . spiritual self-development’ to influence contemporary Ayurveda (Warrier, this volume). The goddess on the door is a reminder that his pañcakarma was marketed not only through its medical efficacy but also through its spiritual aura.

I use the word aura here in dialogue with Walter Benjamin, for whom the aura of a work of art is the value it draws from ‘its unique existence at the place where it happens to be’ (1968: 220). Dr. Vijayan spoke of the benefits of pañcakarma in language that emphasized its Indian provenance. Like the Western Buddhist pilgrims to Kathmandu discussed by Peter Moran (2004), Vijayan’s patients were touristic consumers of local culture, which they imagined as a source of spiritual growth. The intimate experience of a foreign land that they pursued was one intended to transform their bodies and subjectivities.

I also use the word aura in dialogue with New Age discourse, where an aura is an etheric energy field that can be read as an allegory for the soul. While he never used the term ‘aura’ (at least in my hearing), Dr. Vijayan freely acknowledged that his language for pañcakarma derived as much from his encounters with his patients’ eclectic notions of energy and spirit as it did from Ayurvedic texts and training. In one of our first conversations, he observed that his treatment of foreign patients had radically changed his practice of pañcakarma. ‘It altered my path,’ he said. His eclecticism, I suggest, was not simply a consequence of global traffic in Euroamerican healing fashions, but also a postcolonial response to colonial constructions of Indian and European bodies and subjectivities. His practice demonstrates not only how discourses of body and subjectivity travel along transcontinental trajectories, but more importantly how they become sites for renegotiating the postcolonial terms of cultural and religious difference. In this, Dr. Vijayan may or may not be representative of a larger trend within Ayurveda. What interests me, rather, is the inventiveness through which a course of treatment can powerfully, if indirectly, address questions of national stereotypes and religious hegemony.

In this chapter, I consider two aspects of Dr. Vijayan’s ‘altered path’: the massage techniques oriented toward white (or as he would say ‘Western’) angst and the psycho-energetic idioms that frame pañcakarma as an antidote to materialism. I show how Dr. Vijayan reimagined pañcakarma as a cure not only for physical diseases like arthritis and asthma but also for cultural ills of excess materialism and anxious interiority, which in his discourse become symptoms of implicit spiritual deficit.

**Spa culture**

In a resort where there were, in the mid-1990s, frequent signs, scattered among the beachside cafes, for Ayurvedic massage, suntan lotion, and hair oil, Dr. Vijayan had more institutional credentials than most practitioners. He had graduated from an Ayurvedic college and his parents were both institutionally trained physicians who had held important positions in Ayurvedic teaching hospitals. Yet when he first opened his own practice, he failed to attract patients until a friend who worked at one of the beach hotels connected him with foreign guests seeking Ayurvedic massage. One of his first patients was an Austrian who practised Transcendental Meditation. She promoted his practice to other tourists, and within a few months, he was grossing more than the hotel itself. Dr. Vijayan recalled that he learned a great deal in those months, both about communicating with ‘Westerners’ (as he referred to his European, North American, and Australian patients) and about performing massage.
In classical *pañcakarma* (literally, five actions), massage (*maliś*) is used to saturate the body with medicinal oils, softening the tissues and loosening aggravated doshas (usually translated as humours) or āma, (undigested food essence), so they can be removed by watery or oily *vasti* (enemas), *vaman* (emesis), or *virecan* (purification) (which along with *nasya*, the administration of nasal drops, and *raktmokśan* or bloodletting, compose the ‘five actions’). In Kerala, however, *snehan* (satisfaction with oil) is itself a central treatment of *pañcakarma*, in part because it acts directly against *vāta*, the dosha associated with wind, dryness, and movement, which has a prominent place in Keraliyan Ayurveda. As Dr. Vijayan once commented to me, *vāta* is the ‘driving force’ of all three doshas.

The emphasis on Ayurvedic massage that characterizes ‘spa culture’ has also been intensified by medical tourism. As Francis Zimmermann (1992) observed, *pañcakarma* has been increasingly promoted internationally (both by Ayurvedic practitioners and tourist agencies) as massage and sweat baths (*swedan*), rather than purgation, emesis, or bloodletting, in order to satisfy the expectations of foreigners who seek out Ayurveda for a presumed gentleness and nonviolence that they associate with Hinduism. Even massage and sweat baths are evacuative therapies in Ayurveda insofar as they draw the excess doshas toward the digestive tract in preparation for removal through enemas or purgation. In Europe and North America, however, massage and sweat baths are understood as relaxation therapies, which reduce muscle tension and enhance circulation and elasticity. Anticipating Islam’s argument, Zimmermann argued that in the international marketplace *pañcakarma* clinics had come to resemble health spas.

In catering exclusively to foreign tourists in his beach resort practice, Dr. Vijayan had reason to satisfy such desires for ‘gentleness.’ It was not surprising, then, that despite his conviction that one should first administer internal medicines in order to ‘ripen’ the body for *pañcakarma*, he often initially treated his foreign patients with massage alone, before gradually introducing them to *vasti* (medicinal enemas). While he routinely used both oily (*matra* or *anuvāsan*) vasti and watery (*kṣay* or *niruha*) vasti, he used *virecan* (purification) only occasionally for arthritis and certain pitta disorders, and *vaman* (emesis) far more rarely for certain kapha disorders (and then, only with Indian patients). He never used *raktmokśan* (bloodletting), explaining that he was rarely visited by patients with the severe injuries or skin problems that would warrant it. He was, he said, especially ‘liberal’ with his foreign patients, using milder *vasti* herbs, for instance, because the usual formula containing cardamom and pepper for optimal absorption would be ‘too spicy’ for ‘Westerners,’ and could result in diarrhoea. Since ‘Westerners’ were not habituated to such spices, their ‘minds might trigger their bodies into a more extreme purification,’ leading to dehydration and depletion. ‘The intention of *vasti,*’ he cautioned, ‘is not purgation.’

**Pañcakarma as ‘energy exchange’**

If Dr. Vijayan rarely employed purgatives, he nevertheless had developed massage techniques to induce a psychological purge especially designed for tourists. For him, massaging Westerners meant not simply removing aggravated doshas from their bodies but also extracting distress from their minds. Along with the milder *vasti* formula he developed for foreign bodies, he devised an emotionally evocative massage stroke especially designed for foreign psyches, which I describe more fully later. Typically, Ayurvedic massage in Kerala was performed by five to seven masseurs simultaneously, two or more on each side of the body, one at the head, and often one to handle the oil. Dr. Vijayan, however, had invented a massage that he could perform alone or with one other member of his family. He argued that since massage involves an ‘energy exchange,’ masseurs should be practitioners who lead a *sattvik* lifestyle, and not
simply labourers who smoke and drink in their off-hours. Within Samkhya philosophy (which is foundational to Ayurvedic theory), sattva, the root noun of the adjective sattvik, is one of three guna (qualities) found throughout creation; within Ayurveda, it is also one of three manasik (mental) dosha. In either usage, the word connotes a purity and virtue that is simultaneously physical, social, and spiritual. In his remark, Dr. Vijayan transposed an idea with linkages to Hindu caste practices into a semiotics of economic and social class accessible to his foreign clientele. Even more importantly for my argument here, he also represented Ayurvedic massage as not just a manipulation of dosha but a shifting of ‘energy’ in the direction of spiritual purity.

In order to reproduce the sensation of many hands, Dr. Vijayan created a method of moving his hands rapidly in long sweeps up and down the body. He also used a kneading stroke, which he compared to Swedish massage, and a light trailing of fingers over the skin, which he compared to Reiki (see Stein, this volume). His fourth and most innovative stroke, however, was aimed at marma, points of vulnerability in the body identified in the classical text Śuśruta Samhita as well as in the Keraliyan martial arts of Kalari. In the standardized curriculum of Ayurvedic colleges, students are typically taught only about the consequences of injuring various marma points. Outside of academic Ayurveda, however, there are practitioners who specialize in the art of marma cikitsa, a therapeutic stimulation of marma. These practitioners, who in Kerala were often bonesetters as well, learned their craft through five- to ten-year apprenticeships to gurus. ‘Marma is really in the hands of local people,’ Dr. Vijayan said. ‘If you give them one million dollars, they won’t tell you.’ A few of these practitioners worked as freelance ‘marma technicians’ in the marma department (otherwise known as orthopedics) of the Ayurvedic hospital where Dr. Vijayan trained. They used tiny seeds to concentrate precise pressure on particular marma. ‘They can concentrate like a laser beam,’ he said. Dr. Vijayan portrayed the marma technicians as both experts in an esoteric art about which they were highly secretive, and ‘heavy drinkers’ who, like the average massage labourer, did not lead ‘sattvik’ lives. In the hospital, they might show up drunk for work and then perform mysterious revivals of comatose car accident victims, pressing marma points under cover of a sheet.

Given the warnings about marma in his college instruction Dr. Vijayan was reluctant to attempt marma therapies for fear of causing injury. Over time, however, he developed a massage stroke that he believed stimulates marma gently and safely. In this stroke, the masseur’s curled hand skips quickly up and down the body, fingertips pressing lightly and randomly on the skin. When touch is concentrated on a particular point, he argued, a patient may experience a ‘hyper-effect’ or a ‘dull effect.’ In Maharishi Ayurveda, he said, marma therapy had to be discontinued because of the extreme reactions of the patients. In pressing haphazardly over the whole body, he utilized what he called a ‘kind of blind shooting,’ which he thought was less dangerous and ‘more beneficial’ since it only indirectly stimulated the marma or points close to them. While, in classical pañcakarma, marma are sites of physical vulnerability, Dr. Vijayan has reconceived them as sites of psycho-spiritual disquiet, as became apparent during my own pañcakarma treatment.

Ayurvedic catharsis

My five weeks at Dr. Vijayan’s family’s inpatient clinic were the sensory antidote to my recent life in Mumbai. There I rode clanging trains to crowded hospitals, wove my way across traffic clogged streets, cooked solo meals on a two-burner hotplate in a bare apartment, and fell asleep to the shouts and clattering dishes of other occupants of the compound. At Dr. Vijayan’s clinic, nestled in a quiet coconut grove in a village about forty-five minutes by rickshaw from
the beach resort, I woke to a golden light filtering through the coconut fronds, drank a glass of warm water from a thermos on my desk, then climbed the stairs to the rooftop to watch the sun rise. A pot of chai was brought to my room each morning by Dr. Vijayan’s father and his tiny granddaughter, who soon developed the habit of running down the open hallway into my arms. A little later, Dr. Vijayan’s assistant Mira (whose responsibilities ranged from massage to brewing up medicines in the pharmaceutical shed) brought me breakfast, often idli (rice cakes) with coconut chutney accompanied by tiny yellow bananas. After breakfast, I wrote or talked to Dr. Vijayan or his father until noon when I received my massage.

As I lay on a bare wooden table covered with a thin residue of gritty oil, Mira and Dr. Sita Vijayan, (Dr. Vijayan’s wife) first applied a grainy oil formulated to calm pitta and kapha, rubbing me down in long fast strokes. Next, they moved their hands rapidly up and down my body, poking their fingertips into my skin in the massage stroke meant to stimulate marma, and trailed their fingertips languidly over my skin in the stroke meant to simulate Reiki. Finally, they lightly pummelled me with warm fragrant cloth bundles of fresh herbs (elai kizhi in Malayalam) designed to calm pitta and vāta. During the final week of pañcakarma I also received njavar kizhi, during which my body was softly pounded with warm cloth bundles of rice and milk. Dr. Vijayan described njavar kizhi as a nourishing treatment that replenished the dhātu (bodily tissues). During the middle weeks of my treatment, I received either matra or kśay vasti (oily or watery enema) after massage. After treatment, I scrubbed myself with an abrasive powder mixed with water, rinsed off with jugfuls of hot water, towelled, dressed, and rested until lunch. My afternoon was spent napping, reading, drinking tea, and climbing to the roof to watch the sun set through the palms, before being served another delicious meal.

This course of treatment was extremely pleasurable with one exception: the stroke meant to stimulate marma. During that stroke, I often tensed up. On the fifth day of treatment, I admitted to Dr. Vijayan that I found the sensations of the stroke unpleasant. He replied that usually such reactions would fade after a few days. I said that mine seemed to have intensified. Perhaps, I speculated, I had been stoical for the first few days but had eventually acknowledged my discomfort. He smiled knowingly. ‘That’s typical,’ he said. After a few days of treatment, people begin to release feelings that they are unwilling to express earlier. During that stroke, which was designed to release ‘blocked energy,’ many of his foreign patients burst into tears. It was the one massage stroke that he never used with his Indian patients, since most of them had no need for ‘psychological release.’

At that moment, I realized that Dr. Vijayan had learned to exceed Westerners at their own psychological discourse. What I presented as physical irritation was deftly reinterpreted by him as a symptom of psychic distress. The language of blockage and release, of buried feelings rising to the surface, was one I knew well though I had not heard it employed by other Ayurvedic practitioners. No other practitioner had drawn a connection between marma and emotion. In Dr. Vijayan’s narrative, the language of blockage and release skilfully evoked both the accumulation and removal of doshas and the suppression and surfacing of embodied sorrow. He thus blended an Ayurvedic idiom with a New Age idiom that emerged in late twentieth century Europe and North America out of a backlash against anatomical medicine, an interest in the energy bodies of Eastern religion, and a psychodynamic psychology of repressed feelings. In the language of New Age healing, ill health is not self-evident in visible anatomical tissues, but concealed in invisible (though kinesthetically or intuitively perceptible) meridians, channels, and auric paths, which evoke the ‘subtle body’ posited within yogic traditions (see Alter 2004 and Stein, this volume). While the comparison is a crude one, this subtle body is akin to the Christian concept of soul, with the crucial difference that it is decidedly embodied. In
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referencing the etheric ‘subtle body,’ Dr. Vijayan invoked a psycho-spiritual etiology involving body, mind, and spirit.

Marketin g difference

Dr. Vijayan recalled that before he began to treat Westerners, he, like many twentieth century practitioners, framed explanations of Ayurveda in terms of materialist concepts such as ‘enzymes’ and ‘pharmodynamics.’ Such translations, in wide use by Ayurvedic scholars during the middle decades of the twentieth century, served to legitimize Ayurveda by subsuming it within a universalist science, or even more often, as Lawrence Cohen (1995) has noted, by subsuming science within a universalist Ayurveda. Dr. Vijayan now understood that ‘these correlations are nonsense.’ Such biochemical explanations, he said, were very ‘primitive,’ whereas many of the Westerners he met were ‘very advanced.’ ‘Analyzing,’ he clarified in another conversation, is more ‘primitive’ than intuition, which requires a ‘pure quality of mind’ that he attributed to ancient Indian physicians. His foreign patients, by implication, were moving beyond the crude materialism of modern science toward a more intuitive knowledge grounded in ancient wisdom. Dr. Vijayan, like other practitioners, now understood that he could more effectively promote Ayurveda by emphasizing a uniqueness tied to Hinduism, rather than a universalism that anticipated biomedicine. Since Ayurvedic thought has always entailed elements that can be classified as religious (see Warrier, this volume), the change in Dr. Vijayan’s representation of Ayurveda required only a shift in emphasis.

This emphasis involved a neo-Orientalist mystique of India as a land of powerful numinosity. India, in his conversations with me, is a place where healers once had the ‘purity of mind’ to ‘intuit’ the medicinal powers of a plant simply by contemplating it, receiving its darśan, imbibing knowledge as a disciple might from a guru. It is a place where Sanskrit stanzas (today heard only in religious ritual or in Brahminical and Ayurvedic study) enhance the ‘sattvik qualities of the mind,’ their syllables ‘massaging the nervous system,’ a place where even the most cosmopolitan Indians function on ‘specific energy levels,’ possessing an intuitive grasp of Indian philosophy that allows them to absorb Ayurvedic knowledge more easily than foreigners. It is a place where a uniquely ‘subtle pattern of thought’ is protected from outside influence by mysterious obstacles that discourage most foreign visitors. It is a place, moreover, that forever changes those foreigners who do manage to make the journey, a place that moderates their inclination toward competition and consumerism. When I asked Dr. Vijayan why he had not recommended for me the course of šaman (soothing) therapy he typically administered to calm the doshas in preparation for pañcakarma, he said those medicines were unnecessary in my case, partly because I had been taking Ayurvedic medicines and partly because I had ‘absorbed Ayurveda at a mental level.’ I knew, for instance, that if I became angry I would increase my pitta. ‘This different understanding alone is curative,’ he continued. In his view, I had already been partially transformed by my ingestion not only of Ayurvedic dravya (substances), but of Ayurvedic ideas.

Ali Behdad (1994) has noted two contradictory ways that tourism may inflect Orientalism. On the one hand, it may solidify and systematize the Orientalist viewpoint, making it more totalistic and more difficult to elude. On the other hand, it may convert the relationship between the traveller and the indigenous from one of domination to one of desire. Dr. Vijayan’s references to sattvik qualities, Sanskrit syllables, subtle thought patterns, and mental purity orient his pañcakarma toward foreign desires for a medical experience infused with spiritual ambiance. Dean MacCannell (1976) argued that tourists are driven by a desire for self-transformation through an experience of the ‘back regions’ of local communities that might counter the
Diagnosing materialism

alienation they experience from fragmented communities and cultural uprootedness at home. The intimate massage tables of Ayurvedic tourism seem the ultimate ‘back region.’ Here, touristic consumption involves not just acquisition but ingestion, while touristic impressions are not merely snapshots but the pressure of hands on skin and the flushing of medicinal oils through bodily orifices. As the patients’ bodies are washed with medicinal oils, inside and out, their selves are similarly cleansed with Hindu wisdom and sattvik hands.

Dr. Vijayan identified many of his patients as ‘allopathic drop-outs.’ If biomedicine is often portrayed as a site where the lived body is mediated by the distancing effects of anatomical imagery, diagnostic tests, and pathological labels, then ‘allopathic drop-outs’ engage in a search for a less mediated or more ‘natural’ bodiliness, often associated by tourists with particular cultural locales. The value of Dr. Vijayan’s pañcakarma in a transnational marketplace derives not merely from its massage strokes and herb packs, but also from its geography and its association with Hinduism. Pañcakarma is made intelligible to foreigners by signs advertising traditional Ayurvedic massage, by the poster of the goddess on the door to a consultation room, and by Dr. Vijayan’s explanations of pañcakarma as a therapy for ‘Western’ cultural ills. Yet he out-theorized theorists of tourism by diagnosing in his white patients not simply touristic desire, but pathological need. In his practice, a need for spiritual renewal was reimagined as a culture-bound syndrome unique to the cosmopolitan centres of late capitalism. As I address in the next section, his seeming neo-Orientalism, with its apparent romanticism about ancient India, was complicated by a sophisticated occidentalism that reworked colonial constructions of cultural and religious difference.

The frailty of foreign selves

In order to orient his practice to foreigners, Dr. Vijayan expanded his interest in neurological diseases into an interest in psychological ailments. Once at an ethnobotany conference he heard a lecture by an allopathic researcher associated with a large pharmaceutical company. The doctor had spent six years researching the chemical properties of the Ayurvedic herb brāhmi (bacopa), which is used to treat numerous problems related to mental function. At the end of the lecture, the doctor invited the practitioners in the audience to inform him of any brāhmi formulae that they had found effective for mental illnesses. He promised to subject the formulae to a full course of clinical research culminating in a patent. After the lecture, Dr. Vijayan approached the allopath with an account of his successful use of brāhmi to treat a neurological illness in which the patient could not walk, focus her eyes, or perform simple motor tasks. The allopath responded that that was a rare problem, but that Dr. Vijayan should be sure to contact him if he had any success treating neurosis or psychosis. The allopath added that a large number of Europeans were taking Valium for such complaints. For Dr. Vijayan, this interaction was a valuable lesson regarding the kinds of manasik rog (mental diseases) of concern to international consumers.

By the time of our conversations, Dr. Vijayan spoke very authoritatively about the mental disturbances of his white patients. ‘Westerners,’ he told me, ‘have far more psychological problems than Indians.’ During massage, his foreign patients often sobbed or recalled painful incidents from their childhoods. Although such embodied memory was neither mentioned in Ayurvedic literature on massage nor evident in his Indian patients, Dr. Vijayan concluded that pañcakarma has an effect that extends beyond the tissues, touching ‘something on a development level’ at the ‘subtlest’ layers. Once he noticed that the facial expression of a German woman changed as he massaged the area around her navel. When he asked what she was feeling she said she was angry. She added that it was a usual response for her: when her boyfriend
touched her belly, she felt like killing him. ‘So she had a big problem,’ Dr. Vijayan said. Reminding the patient that a child receives nourishment from her mother through the umbilicus, he suggested that she might have absorbed violent feelings from her mother while in the womb. The patient then revealed that three days before she was born her father had kicked her mother in the stomach. The next day when Dr. Vijayan massaged the patient’s belly, he saw in her face that she was no longer angry. In classical Ayurvedic theory, he emphasized, this kind of occurrence is ‘totally omitted.’

In the first year of his practice at the beach resort, Dr. Vijayan was alarmed and embarrassed by foreigners’ dramatic emotional responses to pāṇcakarma. By the time of our conversations, he not only expected it but also seemed to read it into nearly every interaction with his foreign patients. He made it his custom to warn tourists that pāṇcakarma could have profound effects on their psyche. Once a group of Germans arrived for three weeks of treatment. Dr. Vijayan immediately suspected that some of them would experience strong reactions. On the second day of pāṇcakarma one woman said she could not continue treatment. She told Dr. Vijayan that he was ‘too powerful.’ Later she warned another member of the group, ‘Dr. Vijayan is dangerous: he will alter your mind.’ She said that she had found herself thinking in a less consumerist way. Dr. Vijayan concluded that she was afraid this new way of thinking would interfere with her materialistic lifestyle. While a tension between materialism and psycho-spiritual health is integral to certain versions of Protestant Christianity, it is arguably irrelevant to the philosophies that inform Ayurveda (see Langford 2016). Yet Dr. Vijayan tellingly invoked this conflict in his assessment of his German patient, who herself may have imagined Indian spirituality to be at odds with materialism.

In his interactions with foreign patients, Dr. Vijayan exercised what Michel Foucault called ‘pastoral’ power, so named because it is a power of Christian provenance that ‘cannot be exercised without knowing the inside of people’s minds, without exploring their souls, without making them reveal their innermost secrets’ (1982: 214). For Foucault, pastoral power is at the root of a modern confessionalism that gave rise to psychodynamic therapy, wherein a subject is encouraged to plumb her depths for the hidden feelings that are signs of a true interior self. Charles Taylor (1989) has detailed several historical strands that reinforce the imagination of this interior self, from Romanticism through Freudianism and beyond, into contemporary ‘human potential’ movements. One crucial strand of this genealogy is Christian, ranging from Augustianian ‘inwardness’ to a ‘Protestant culture of introspection’ (Taylor 1989: 132, 184). While British colonialists steeped in Christian values urged disciplines of interiorized subjectivity on Indian subjects in such contexts as language and domestic relations, Indians often resisted or reworked these disciplines to sustain other ideas of self (Cohn 1985; Chakrabarty 1992).

Kapha masks

By his own account, Dr. Vijayan had stumbled inadvertently upon interior selfhood through encounters with the emotional outbursts of his Western patients. By the time we met, he confidently diagnosed this interior self and its reservoir of hidden feeling, identifying the defences and denials of his wounded Western subjects. Once he treated a European woman for lethargy that an allopathic doctor had diagnosed as depression. Suspecting an accumulation of āma, Dr. Vijayan tried dry massage and sīrodhara (a slow drip of medicinal oil onto the forehead). During treatment, she released many emotions and in three weeks her lethargy disappeared. Because she was experiencing such dramatic results, her husband also decided to come for treatment. He was a military officer with a thick beard. Dr. Vijayan had reservations;
he warned him, ‘Listen, you seem like a tough guy, but underneath, I’m not so sure.’ Fifteen minutes into the massage the man rose from the table, claiming that he could not tolerate the smell of the massage oil. The next day the wife told Dr. Vijayan that he had accomplished what she had been trying to achieve for many years: her husband had shaved off his beard. The man explained that he shaved to rid himself of the stink of the massage oil. Dr. Vijayan, however, thought that when he pressed the marma points he had touched a ‘deeper thing,’ perhaps, he seemed to imply, a hidden vulnerability.

When I asked Dr. Vijayan to discuss my own health, he offered an explanation that creatively interwove dosik terms with psycho-energetic metaphors. He said that while I seemed to be pitta there was a ‘kapha mask or wall’ in my body which prevented the natural movement between mental and physical levels. The first task in treatment would be to remove this mask in order to allow my body to ‘communicate with itself.’ He said that he found the kapha mask primarily in those whose constitutions are dominated by pitta. These patients were sensitive, but did not express their feelings as ‘natural pitta’ people do, because the mask prevented the emergence of pitta. A kapha mask was a blockage that developed over many years, he said. Kapha mask people were subdued and quiet, but it was not a ‘natural quietness.’ ‘These people,’ he said, ‘are holding a lot. They suffer silently.’ They are ‘aloof,’ with ‘slow, dull eyes.’ They have a habit of sighing deeply out of a need to ‘release something.’ Just as he told the military officer he looked tough but underneath he might be otherwise, so he said to me, ‘You appear to be pitta, but there are hidden things.’ When the kapha mask was dissolved, he said, I would look lighter and more cheerful. My eyes would become ‘lustrous and sharp.’ ‘Already,’ he said, ‘your eyes are becoming clearer.’ I would also become more extroverted and expressive. With kapha mask people, Dr. Vijayan took what he called a ‘psychological approach.’ These people, he cautioned, could be very fragile. Kapha mask people released their sadness in frequent bursts of laughter to avoid crying all the time. He added that, in his opinion, ‘Westerners’ laughter’ often sounded like crying. Usually these people did not have any ‘real pathological problem,’ though they were always searching for alternative therapies. Actually, he said, what they needed was ‘vāta-balancing comfort,’ a sense of security.

Taken together, the qualities he attributed to kapha mask patients added up to a profile of a restless consumer of alternative medicine, vaguely unhappy, emotionally repressed, and insecure. While the profile did not exactly fit my personal biography, it slid easily into a particular image of late-capitalist malaise. Amidst the touristic sensual pleasures of my course of pāncakarma, it also introduced a slightly bitter postcolonial aftertaste. The sense of displacement I felt during fieldwork—my aloneness, the whiteness of my skin, the first simply peculiar, the second both peculiar and paradoxically indexical of social power—was reflected back to me in a startling exposé of vulnerability, in which what I imagined as a temporary feeling of insecurity was renamed as a deeply rooted cultural malady, linked to a Christian, or in my case post-Christian, interiority.

The pathology of independence

When I asked Dr. Vijayan if he ever spoke to his Indian patients the way he spoke to me about my kapha mask he said ‘No.’ Whenever he used such language with Indian patients, they looked at him strangely or simply walked away. By implication, Indian selves did not need to be plumbed for their hidden interior layers. When I asked Dr. Vijayan why Westerners had more psychological problems than Indians, he said that as children, Westerners did not receive enough attention and affection. As a consequence, they were overly independent yet constantly
beset by ‘stress,’ ‘worry,’ and ‘helplessness.’ By contrast, in Dr. Vijayan’s view, Indians were
secure and loved as children, and continued to lean on their parents’ guidance into adulthood.
In his thinking, then, the interiority of Western selves was symptomatic of their isolation and
the fragmentation of their families. Losing any connotation of introspection, Euroamerican
interiority became a receptacle for sensations of inadequacy.

When Indians did develop mental problems, Dr. Vijayan told me, they were more apt to
develop what he described as ‘real diseases’ like schizophrenia or neurological disorders.9
His discussion of these cases was free from metaphors of interiority and surface. One
Indian patient had been diagnosed at a neurological institute with an idiopathic neuropathy.
When he arrived at Dr. Vijayan’s clinic he had severe tremors, could hardly walk, and was
unable to grip a toothbrush. Dr. Vijayan explained that his kapha dosha was blocking his
vāta dosha. In addition to vasti (enema), the patient received massage with a dry powder,
medicines to clear the vāta ‘pathways,’ and nasya (nasal wash) ‘to nourish the cranial
nerves.’ After a week, his tremors disappeared. He could walk almost unaided and had
regained some ability to grasp objects. In this narrative there were aggravations, move-
ments, and blockages of dosha, as well as damage to dhātu (physical tissues), but there
were no walls or masks, no hidden feelings or sad laughter, no reference to the body’s need
to ‘communicate’ with itself.

During the colonial era, the qualities of passivity and effeminacy projected on Indian
subjects by the British were inventively reimagined within a Gandhian politics of non-
vviolent resistance. In the late twentieth century, similar images, projected by neocolonial
consumers of Indian culture, began to be reimaged within indigenous rhetorics of heal-
ing. Just as some business executives, in the neoliberal moment of the mid-1990s, found
an opportunity to redress colonial humiliations by celebrating the failures of multinational
corporations (Mazzarella 2003: 263), so Dr. Vijayan reversed pejorative colonial catego-
rizations of Indian subjects by focusing on the frailty of foreign bodies and subjectivities.
His constructions of the psycho-spiritual ailments of European bodies and minds starkly
contrasted with his constructions of the purely physical (and emphatically not psychoso-
matic) problems of Indian bodies, not to mention the ‘subtle patterns of thought’ intrinsic
to Indian minds. He countered neocolonial imagery of Indian bodies as sites of pathologi-
cal dependence, unworldliness, and hyper-gentleness, with imagery of Western bodies as
sites of pathological independence, materialism and troubled interiority. As ethnographers
once explored the permeability of Indian bodies, he now probed the defences of European
bodies. The terms ‘mask’ and ‘wall,’ carrying connotations respectively of a split between
social presentation and inner self, on the one hand, and a territorialized identity on the
other, served uncannily well as signs of a modern European selfhood that owes much to
Christianity, as mentioned earlier. Dr. Vijayan framed the impermeable, bounded, interior
selfhood of his Western patients as pathological, while implicitly recasting the porosity
of Indian personhood or the symbiotic nature of Indian relationships (as characterized
by ethnographers), as symptoms of psychological and spiritual health.10 His diagnoses
of foreign patients served as an incisive corrective to colonial and neocolonial medical
projections of somatization and magical thinking onto Indian patients. Moreover, just
as Indian bodies had served as experimental subjects within an imperialist laboratory
of medical science (Arnold 1993), so in Dr. Vijayan’s practice, white bodies implicitly
served as experimental subjects within a laboratory of Ayurvedic insight. It was through
his treatment of foreign bodies that he was able to refine pañcakarma as a technique to
resolve psycho-spiritual anguish.
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Purifying the mind

There was one *pañcakarma* practice, *śirodhara*, a slow dripping of medicinal oil (or sometimes a yoghurt mixture) onto the forehead, which Dr. Vijayan had found to act directly on the mind. In his clinic, the coconut-oil-based concoction dripped from a cotton thread dangling through a hole drilled in the base of a clay pot. The thread was twisted in a particular way to fine-tune the volume of flow, avoiding either under- or over-saturation. The temperature of the oil was also carefully regulated. *Śirodhara* was routinely used in Ayurvedic hospitals in northern and western India to treat insomnia, headache, depression, paralysis, schizophrenia, and other ailments associated with the nervous system. It was only in conversation and treatment with Dr. Vijayan, however, that *śirodhara* was represented to me as a way to enhance spiritual attitudes of mind.

Typically, Dr. Vijayan performed *śirodhara* toward the end of a three- to five-week sequence of treatments. It was important that the body be as pure as possible, lest the effects of *śirodhara* be overly intense. It was also essential to prepare for *śirodhara* with *nasya*. During my own treatment, I received *nasya* directly after my morning chai for two weeks prior to *śirodhara*. I lay on a wooden table spread with newspaper while Dr. Vijayan’s father rubbed coconut oil onto my face and hands, massaging the oil into *marma* between my eyebrows and behind the lobes of my ears. Dr. Vijayan explained that these points were ‘connected to the brain’ and their stimulation would enhance *nasya*’s effects. His father poured four or five drops of stinging oil into each nostril, bringing tears to my eyes and instantly loosening phlegm along my nasal passages. A successful *nasya* treatment, I was told, would cleanse the sinuses, remove the bags under the eyes and enhance the sense of smell, and colour perception. *Nasya*, Dr. Vijayan said, made the nerves more sensitive to *śirodhara* by cleaning away the kapha coating. Over time, he had decided that the rhythmic dripping of *śirodhara* acted on the nerves through vibration. (He was not unique in his attention to *śirodhara*’s musicality. At another clinic, I was told that the rhythm of *śirodhara* reestablished the somatic rhythm that is Siva’s dance in the body.)

According to Dr. Vijayan, *śirodhara* was a particularly ‘powerful psychotherapy,’ which disengaged the conscious mind, allowing subconscious feelings to surface. Indeed, those who received *śirodhara* for too long might ‘explode.’ During *śirodhara*, some patients accessed sad memories and wept. *Vāta* people in particular sometimes underwent dramatic responses, crying or feeling crazy. One young German man saw all his childhood friends during treatment. ‘It was wonderful,’ he reported. Then on the sixth day, after only a few minutes of *śirodhara*, he tore the handkerchief off his eyes saying, ‘I’ve had enough.’ Dr. Vijayan concluded that some emotion had been triggered which the young man was unwilling to face. *Śirodhara*, he said, touched the ‘subtle levels.’

Yet the effects of *śirodhara* went beyond quasi-Freudian abreaction, approaching mystical experience. It was impossible, Dr. Vijayan said, to explain the effects of *śirodhara*. People lost track of time. A half hour might seem like only two or three minutes. ‘It produces instant alpha waves,’ he said. Many patients entered a state of meditation, seeing vivid colours that reflected the *rajasik* (active, frenetic), *tamasik* (inert, heavy), or *sattvik* qualities of their mind. Thirty per cent of his patients, Dr. Vijayan said, thought in a completely different way after *śirodhara*. People relinquished their materialist values. ‘Those patterns are totally out,’ he said. At first, their friends worried that they had become less competent. Within a few months, however, it became obvious that they were simply contented and fulfilled. *Śirodhara*, he said, shifts the mind in a *sattvik* direction.
My own śirodhara treatments were administered by Dr. Sita and Mira. Prior to treatment, they laid a strip of cotton over my eyes and smoothed back my hair. Then they allowed pitta śamak (pitta calming) oil to drip slowly onto my forehead. The sensation was like that of a fingertip softly caressing my skull, tracing tight hypnotic circles. I felt peaceful and alert. Once when someone inadvertently clanged the śirodhara pot, the sound produced in my mind an image of a flowering cluster of deep indigo points of light. Now and then I experienced lightning-quick dream scenes, but for the most part, my mind remained still. As Dr. Vijayan had predicted, śirodhara induced a mild meditation. Afterward, my mind felt quiet. There was one day of treatment, however, when the oil seemed to simply drift into my hairline instead of pressing subtly on my forehead. Rather than feeling tranquil, I felt irritated, suspecting that Mira had made a mistake in adjusting the flow. How quickly I had developed a consumerist expectation for the meditative experience that in Dr. Vijayan’s discourse worked as a metonym of Hindu 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.

In Dr. Vijayan’s discourse it was only śirodhara that directly affected the manasik (mental) dosha (rajas, tamas, and sattva) which classical Ayurveda considers to be variously vitiated during mental illness. Significantly, it was also śirodhara that was considered to unfailingly relieve patients of their compulsively materialist lifestyles. For him, rajas and tamas, like sattva, were simultaneously social, psychological, and spiritual categories, used to characterize the habits not only of non-professional classes of bonesetters and massage labourers but also of white tourists. While in the bonesetters and labourers, rajasik dosha was indexed by drunkenness, in the tourists it was indexed by excess materialism. Sattvik doṣa, on the other hand, was indexed by a turn away from materialist values.

Conclusion

Margaret Trawick (1991) noted that her Ayurvedic preceptor’s explanation of cancer was linked to a moral discourse on capitalist excess, exploitation, and greed. Similarly, Dr. Vijayan’s explanations of the effects of pañcakarma were laced with a psycho-spiritual discourse on the culture-bound syndrome of late-capitalist consumerism (including a restless hunger for alternative therapies) and materialism. In his foreign patients, aggravated doshas were entangled with deep-seated insecurities due to endemic childhood neglect. He identified these subterranean reservoirs of ailing selfhood as evidence of a pathological interiority to be healed by bodily encounters with Ayurvedic wisdom. His treatments involved not just saturation with medicinal oils, but immersion in a Hindu religiosity characterized by purity and meditation. His massage strokes were designed to draw out not simply the aggravated humours of classical Ayurveda but the hidden struggles posited by a Christian confessionalism. In these ways, his practice was aligned with a wider trend to promote Ayurveda as Indian spirituality, as identified by Islam (2012), Yet his practice also illuminates the ways that such an apparent neo-Orientalism can serve as compelling corrective to colonial and postcolonial imaginations of Indian bodies and subjectivities.

Notes

1 All names are pseudonyms. I first wrote about Dr. Vijayan in Fluent Bodies (Langford 2002). Here I focus more specifically on the ‘religious’ implications of his practice.
2 Dr. Vijayan spoke to me and his other foreign patients in English.
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3 For accounts of the institutionalization of Ayurveda in the twentieth century, see Leslie 1992 and Langford 2002, among others.
4 Sometimes raktmokśan is excluded, and watery and oily vasti are counted separately.
5 The other two doshas are pitta and kapha. Briefly, pitta is associated with bile, heat, and activity, while kapha is associated with phlegm, coolness, and inertia.
6 The other two guṇa are rajas, connoting activity and passion, and tamas, connoting inertia and lethargy.
7 Thatte (1988) describes a marma cikitsa that involves pressing antidotal points known as adankala.
8 Maharishi Ayurveda is a brand of Ayurvedic practices and products associated with Transcendental Meditation, founded by Maharishi Mahesh Yogi.
9 The reference to ‘real diseases’ is either a reference to biomedical disease categories and/or a reference to Ayurvedic ‘rog’ (disease), which signifies a phase of ill health when the disturbed doshas have gathered in a particular organ, interfering with its function.
10 For characterizations of the permeability of Indian selves and/or the symbiosis of Indian relationships see Shweder and Bourne 1982, Roland 1988, and Marriott and Inden 1973.

Bibliography


