Department of Psychology

In search for natural health

A phenomenological study of the motives behind seeking Ayurvedic healthcare in India

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Abstract

This phenomenological study focuses upon the phenomenon of health tourism and Swedes going to India for Ayurvedic treatments. An emergent design was used in attempt to discover the underlying motive forces for seeking Ayurvedic health-care in India. Five participants volunteered to share their experiences of Ayurvedic treatments by filling out self-report. The softwares of Sphinx Lexica and MCA Minerva were used, enabled an analysis that unveiled the participant´s meaning constitution. The outcome gave indications of two tendencies contributing to the participant's choice of seeking healthcare abroad. The first were a discontent with the Swedish healthcare and the second a difficulty of living healthy in the Swedish society. Furthermore, it revealed an underlying individualistic thinking showing the importance of the context a human being is situated in.

Keywords; Ayurveda, India, Phenomenology, Health tourism, Allopathic medicine, Treatments.

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1 Introduction

This thesis is about Swedish people who chose to go abroad, seeking alternative healthcare in a developing country, namely India. These people are part of a tourist phenomenon known as health tourism or medical tourism. People from developed countries travels to developing countries to do medical surgery on hospitals or wellness treatments and therapies on spas and retreats. Considering the medical surgery the costs are often lower in those countries so why not travel to India if you can get the same treatment there but for half of the price? But, there are a lot of Swedes going to India but not for the allopathic medicine but for one of the traditional medicines known as Ayurveda and in Sweden classified as alternative medicine.

The fundamental question for this thesis is; How come that some Swedish people travel a flight distance of 6,600 km in approximately 10 hours to get to India, a country full of contrasts, poverty and a teeming multitude of people to get treated for different diseases and ailments? What has driven those people with diseases, such as diabetes and multiple sclerosis, to board an airplane and go to India and be treated by traditional ayurvedic medicine instead of the allopathic medicine that is based upon hard evidence from the nature of science?

These are the questions which have motivated us to investigate some of these people's motives and compile it in this thesis. We have been interested in health psychology for a long time and we´ve seen that the society creates an environment which gives its inhabitants minor ailments which can become chronic after a while. Stress could be the main factor which causes a lot of ailments but also the way we live causes diseases such as diabetes, depression and obesity. But even if our healthcare system is very well developed and could be seen as a role model for many countries there is still a discontent with the way the healthcare treats people. Long waiting lists, tight resources, an absence of doctors and too little time for examination are just some factors building up dissatisfaction with Swedish healthcare. But has it gone too far when some Swedish people travel abroad to seek healthcare?

During a small essay about Yoga and its positive effect on reducing stress we came in contact with people going on yoga retreats in India to get a general higher wellbeing. What we also discovered was a tourism connected to this phenomenon, what some people would call health tourism. People traveled to south India where fully equipped hospitals and medical resorts with herbal medicine, treatments and food programs were developed for

treating westerners suffering from different illnesses. As one of us is partially working with alternative medicine and as we both do yoga, what struck us as odd was that these people went abroad to get this when there are great possibilities having Ayurvedic medicine and treatment here in Sweden. When looking closer into this health tourism, a lot of Swedes are traveling to these Indian hospitals and resorts. We even found a dozen Scandinavian tourist agencies specialized in Ayurvedic health trips (ex, www.ayurvedaresor.com, ayurveda-resor.se, www.getaway.se. www.rasayana.se).This showed us that it is not an uncommon thing and we therefore decided to investigate this phenomenon further and develop a research project suitable for a bachelor thesis.

1.1 Phenomenological approach

The aim of this study is to investigate and understand the phenomenon of health tourism and under careful analysis try to look for the components constituting it. We intend to understand the phenomena in its situated context and by this approach concentrate on the way that individuals actually perceive things, as it is appearing to them.

By our interpretation we also give meaning to the phenomenon. In phenomenology there are two aspects of a phenomenon. On the one hand there are the objectified qualities of an object, the existence of it as it stands in the world. At the other side there's the un-objectified quality that refers to the meaning of the object, which implies "in the way it appears to me." The object appears to the subject thanks to its act of intentionality which is the orientation towards an object. The intention is the inner experience of being conscious about something. Earlier knowledge, the situation, the context and the individual itself affects the meaning constitution of the appearance in the process of its particular act of intentionality. So, people may not share the same understanding of an object since it appears to each of us different and are affected by each person's former knowledge and life world experiences as well as the context or situation the object appears in. The life-world, which is intersubjective, is a central concept in phenomenology and refers to the conscious world the individual lives in. The intersubjective life-world consists of personal experiences, thoughts and history which, for the subject, are both personal and shared. There are active and passive syntheses building up our life-world, creating new knowledge. The active synthesis is how we meet new knowledge that helps to change our relation to the world around us. When this new knowledge is confirmed by the subject, it becomes passive. This shows clearly how we, as humans, are in constant change and development. The meaning constitution is both a dynamic

and ongoing process and as humans, we are also in constant change building up our life-world by meaning constitution and active and passive syntheses (Sages, 2003). Thanks to the fact that people are both equal and distinct, it is possible to share experiences in a mutual context. shares therefore a part of their life world (Sages 2003, Arendt as cited in Maykut and Moorehouse 1994, Maykut and Moorehouse 1994).

Instead of finding causal connections or conclude the effects of the Ayurvedic treatment, we will try to see what the people themselves feel, think and say about their trips to Ayurvedic hospitals in India. We emphasize the meaning a participant puts in his/her story as well as looking at its constitution.
Hanna Arendth uses the name, “human as instrument” when talking about the human’s ability to understand one another. “The human is the only instrument capable of understanding the complexity and the ever changing situation that is the human experience. Our sageness makes us capable of understanding and deal with situations like no other instrument” (Moustakas, 1994). Because we are human which includes us as both equal and distinct we are about to understand the phenomenon as humans. We do not stand apart from what we are studying and this closeness makes it possible to understand the subjective life-world but also the greatest danger, when analyzing the meaning. Our own pre-comprehension about the studied subject will always be there, but by careful consideration of this fact we can set aside it and study the object with clear eyes.

By the method of indwelling the researcher spends time in the given situation where the studied objects are. This to gain important knowledge about the phenomenon studied, to se similarities and differences and new thing unveil in the situation (Arendth, as cited in Maykut & Morehouse, 1994). This is what we have done during our visit in India. During 18 days, we traveled in the south of India, mainly in the Goa province and made interviews with teachers, trainers and tourists to render a picture of the health tourism in that area.

It is not to forget that we, as authors to this thesis, are contextualized and as we are working with the peoples perspective and apprehensions of things, we also work through our perceived reality of the phenomenon studied. According to Forrest B. Taylor (2002) the researcher should see himself as a participant in the context of what is going to be studied i.e.: an acknowledgment that we are contextualized and social beings affected by the society and the culture we live in, but not let us be limited by it.

1.1.1 Validity and generalization. In qualitative research, the concept of generalization is problematic. In the positivistic tradition it refers to categorize and draw general conclusions about human behavior but, for a phenomenologist this is not the goal. According to the phenomenological way of understanding the world, individuals construct meaning trough their daily acts and behavior and are the only possible producers of meaning. The meaning constitution differs between individuals because the individual's identity is in constant change. This is why knowledge claims can never be presented as absolute "true" (Polkinghorne, 2003). In the positivistic tradition, validity is built upon the question of possibility to presume that a knowledge claim is true. But the question of validity is, according to Polkinghorne (2003) a process between the individual making the claim and the individuals in the community which the claim is to be accepted. It is in the reviewer's eyes to judge if the claims can be considered as true. The reviewers have their own knowledge and experiences according to the current area which will be affected by their understanding of the claim. Hence, the "truth" or validity of a knowledge claim lies in the eyes of the viewer. And the only thing which can be controlled to be certain, is weather the actions based on the claim, actually produced the intended result (Polkinghorne, 2003).

Through a careful analysis of meaning, as it is constituted by the individual, we get indications of possible generalizations and classifications above the state of the individual subject. Focusing on the individual´s lived experience creates the possibility to reach the invisible of the meaning constitution (Sages 2003). This is what we have done by using the softwares MCA Minerva and Sphinx Lexica. The software enables us to get indications of the individuals meaning constitution and subsequently, single out horizons in order to understand the constituted meaning. The data we have analyzed are texts produced by our five participants. The software´s let the data speaks for itself and from this we gain results that can be considered as valid.

1.2 Purpose

The purpose of this thesis was to search for eventual motive forces behind seeking Ayurvedic healthcare in India. Motive forces, according to us, refer to possible factors motivating people to choose health-care abroad.

Our intention was to make an explorative study and reveal the meaning constitution of a substantial sample of Swedes who were in India, were about to travel to India or had been in India because of health issues. Unfortunately that would have been too

comprehensive according to a bachelor thesis and therefore not practically implementable. Consequently, it became a pilot study with focus upon people that have experienced Ayurvedic medicine in India. The use of an emergent design for this study was considered optimal because it aims to discover the unknown by using an open ended question. This means the question in its nature is open and the direction is not certain. It supports discoveries of important meanings that were unknown before. For example, in quantitative research the question is often formulated by hypothesis with focus upon finding causal connection or not between two subjects. This is done by confirm or disprove the hypothesis. In an emergent design, the research subject is studied in a less limited way and the research can take any directions depending on the studied subject. Further in this thesis, the open ended direction will be more comprehensible when exemplified by our self reports in the method section (part 2).

1.3 Ayurveda

Ayurveda is a traditional medicine mainly developed in the north of India. It is one of the most common traditional medicines used in western countries and Ayurvedic schools have been raised in order to educate the knowledge of Ayurveda and its medical contents.

Ayurveda, which means "science of life", reflects the unity of the body and mind. It concentrates on balancing the five elements that human, as well as nature, are unitized of. The life of humans consists of four states which can be divided in childhood, youth, middle age and agedness. Similar to the four seasons in nature, the elements influence vary depending on which state a human are situated in. Childhood is connected to growing and the water element dominates. The adult ages (youth and middle ages) are characterized by maintenance and dominated by the fire element while in agedness the air element is dominant. The elements and the human condition are sources affecting our balance and should be regulated in order to keep that balance stable.

As living creatures we are also part of the nature, wherefore creating a balance by living in harmony with nature and the universe is critical for maintaining good health. The life energy of humans, *prana* are to be stabilized through a specific lifestyle suited for each individual due to *prakriti*, the nature of each unique individual. The five primary elements that human contains of is ether, air, fire, water, and earth which decides the prakriti of each individual. These elements also exist in nature and are in constant integration with the human beings. An example of the impacts of different elements is food or weather that can help stabilize or

destabilize ones balance according to his/her prakriti. People are sensitive to various impacts depending on which type of person they are. This is determined by the *doshas*, a kind of bodily states related to the elements known as *Kapha*, *Vata* and *Pitta*. These three body-states also reflect diverse types of persons and personalities.

Ayurvedic philosophy focuses upon keeping already healthy individuals healthy. The method concentrates on preventing rather than curing illnesses and poor health. The medicine is based on a holistic view implying that physical health cannot be achieved without mental, spiritual and emotional balance. As humans we are exposed to stressful and demanding environments with changes in weather, personal relationships and eating habits. These external influences can easily disturb the balance and result in diverse forms of illnesses. The Ayurvedic medicine offers an opportunity to stabilize this unbalance by different treatments which are adjusted according to the individual´s prakriti. In treatment of diseases in Ayurvedic tradition the doctor deals first with the symptoms and then he/she focus on the source of it. Ayurvedic disease management is called *chikitsa* and refers to restoring health. In the program of chikitsa there are five components in focus. The first thing is to identify the problem and then eliminate the cause to that problem, i.e. the illness. Together with this comes purify the body, reestablish and restore the balance and last improve and revive affected organs, tissues and systems in purpose to prevent reoccurrence. As one can see, remedial is an extended and comprehensive process that is difficult to compare with the allopathic medicine (ayurvedhealthcare.com; nccam.nih.gov; Vaidya, 2011).

To ward oneself at an Ayurvedic clinic in India are very demanding for the individual. The treatments are adjusted to each patient own constitution and health issue and a doctor ordinates different treatments and medications. Each patient gets a timetable indicating when and where it is time for physical exercises, detox treatments, medication and food. It is very common to begin the day with yoga followed by different herbal medications and physical treatments such as massage and acupuncture. The food, which is mostly vegetarian, is adjusted to each patient´s need and prepared and served at special times. Non-healthy habits such as smoking, drinking alcohol or eating unhealthy food are unacceptable. The Ayurvedic treatments focuses upon breaking bad-habits and give the patient tools to create a new and healthier way of living.

1.4 Previous research

It is hard to find previous research about our subject basically because there is no research done on Swedes going to India for healthcare. But there are a lot of factors surrounding this

subject such as health tourism, culture, society and the concepts of health, wellness and holism. To be able to draw conclusions of the results in this thesis it is important that we go through these factors and evaluate them in order to get a broader and richer perspective when we discuss the analyzed data. First, definitions of central concepts for this thesis will be made followed by a review of some possible contributors to health tourism. After that, a presentation of Ayurveda will be done to make the reader aware of its interesting content.

1.4.1 Definitions of concepts. Health. Western culture defines health as a biological phenomenon and according to the biomedical model illnesses, both physical and medical, are caused by pathogens. The definitions of health according to this biomedical model, and which is widely used is; if a person is free from illness, then he is healthy (Matsumoto & Juang, 2004). According to Ryden and Stenström (2008) one can say it is the opposite of being ill or the natural state of being a human being. Clearly, there is also a tendency to take it for granted because it is first in its absence one really understands what it means to be healthy.

There has been a strict limitation about the meaning of sickness and in science of nature, especially the biology has had a monopoly of explaining its existence and effects on the body. This view has slowly loosened its grip and to have a strict biomedical point of view is not possible because the individual is not only flesh and blood. He is also a psychological and social being. Therefore as Rydén and Stenström (2008) points out, a human being is not only sick in the terms of biology but there is a bio-psycho-social system (also known as a model) referring to the individual as both a biological, psychological and social human being which the sickness is affecting. It is the individual's bio-psycho-social system that determines how the individual are going to cope with the situation of being ill and how they assimilate the rehabilitation/medication. There are critics against the biological explanation because it still gets an interpretative prerogative (Ryden & Stenström, 2008).

But is the biomedical model suitable for everyone? According to the health manual, Vårdhandboken (2011), the Swedish allopathic medicine are based on the biomedical perspective and have focus upon epidemiology, treatments and its consequences, the organs and physiological deviations. The treatments are based on evidence of its function and effect. What´s interesting is the Swedish healthcare´s viewpoint takes its origin in the humanism, putting the patient in the center and recognizes both his unhealthiness and healthiness. Every patient is unique and should be treated according to that with great respect and the best health care are when the treatments are customized for the patient. It is interesting to see, when

reading the health manual, that the *Husserlian phenomenology* is a take-off point for the treatment. The individual's life-world is to be recognized, in fact, they even use the term life world in the health manual. By having a life-world perspective, the subjective thoughts and feelings of the patient are considered and the staff can treat the patient with better care and respect. The health manual is teaching health care staff to see people as they have their own life-world and worldview. But the Swedish allopathic medicine is viewed from a biomedical perspective and strongly positivistic, saying that there is one truth that is right for everyone. But is this the case?

This problem rises especially when considering culture. For example, in China, bad health is a result of an imbalance between self, the nature and the different societal roles and between the two energies yin and yang, an approach that combines Chinese religion and philosophy with medical science. Even if it scientifically can be proven how diabetes occurs, a person from Iraq may not share this explanation but refer to the power of "the evil eye". Diseases are classified and cured in diverse ways among different countries and cultures. What is considered as a disease depends on the cultural condition that is underlying. An example is a person diagnosed with Schizophrenia in Sweden, because of his/her submitted capacity talking to spirits, is conceived as hallucinations in this country. Simultaneously that talent could have been received in a different way in a culture where the religious beliefs would explain the Schizophrenia as possessions of evil spirits. The worldview could thereby be very different from the biological view of the human consisting of flesh and blood and can be cured through different forms of evidence based treatments (Matsumoto & Juang, 2004).

In East Asian traditional medicines the imbalances between energies are the main factors to health problems and the medicines are based upon the theory of energies that is present in our body and environment. When an unbalance occurs in the body, it takes shape in different ailments and sickness and the cure consists theoretically of balancing the energies (Matsumoto & Juang, 2004). According to Ryden and Stenström (2008) the word balance are frequently used in medicine and healthcare and often refers to the bio-psycho-social model and to find a balance between these three parts.

We can see that a definition of health is somewhat problematic due to cultural issues. In the Swedish healthcare there is also an ambition to treat every people as unique individuals from a life-world perspective. At the same time, the medical science is based upon a positivistic tradition where only one world is correct. Somehow the healthcare and medical science are trying to cooperate as well as they can but one can ask, are the results of this

cooperation a contributing factor to why Swedes go abroad for treatments? And if so, has the cooperation failed?

Wellness and holism. The word wellness is used frequently all over Europe despite linguistic problems. Actually, wellness as a word does not exist in some languages and the meaning of the word varies across countries and what is said to improve wellness differs as well. To take a few examples, in southern Europe there is an emphasis on recreation at the sea, with sunlight, sea air and thalassotherapy (therapies including sea water). In north Europe the importance of outdoor exercising, such as hiking and walking is emphasized. Some countries also stress the importance of healthy eating habits as well as rest and relaxation (Smith & László, 2009).

People who consume wellness services are in general interested in fitness and having a healthier lifestyle. These people are more conscious about their physical wellbeing and how they live their lives. With the concept of wellness, a more comprehensive and holistic view is addressed and its focus lies upon prevention rather than curing (Smith & László, 2009). This leads us in to the next big concept, namely *holism*, or that something is holistic. The view can be traced back to the old religious and spiritual philosophies of Asia, Buddhism, Confucianism and Taoism where the nature is unified and interpenetrating (Lim, Kim & Kim, 2005).

Patterson (1998) expresses her opinions about talking of definitions of holism in a healthcare perspective. A definition is an exact description of the nature of the thing. But when hearing the word holism, every individual has his/hers own interpretation of the word and what it includes which makes it impossible to have only one definition. Therefore, Patterson (1998) suggests that the definition of the concept will be dependent on the individual interpreting it. The concept can also be discussed in abstract terms without going into its specific parameters.

To have a holistic view in healthcare points to the bio-psycho-social model Rydén and Stenström (2008) discussed. That we integrate body, mind and spirit in the concept of health and that we see the human being as social as well. Openness towards alternative treatments is also included in the holistic view, but it does not automatically call for alternative medicine or therapy. It should rather be seen as a complement in finding the balance between body, mind and soul.

Health tourism. It is not hard to find webb-pages specialized at health tourism on Internet. They offer help to find the right country and the right hospital to attend to in

relation to each customer's personal needs. It is no doubt that health tourism is a great phenomenon these days and hospitals all over the world promote themselves as the best choice for the customers.

Goodrich and Goodrich (1987) define health tourism as following; "… an attempt on the part of a tourist facility (e.g. hotel) or destination (e.g. Baden, Switzerland) to attract tourists by deliberately promoting its health-care services and facilities, in addition to its regular amenities. These health-care services may include medical examinations by qualified doctors and nurses at the resort or hotel, special diets, acupuncture, transvital injections, vitamin-complex intakes, special medical treatments for various diseases such as arthritis, and herbal remedies."

A website with lot of experience of health tourism writes that there should be a distinction between medical tourism, which focuses on surgery and allopathic medicine and the phenomenon of health tourism (http://www.discovermedicaltourism.com). The latter aims to retreats with a feel-good atmosphere rather than medicine and focus lies upon making the people feel healthier and happier when they leave the resort. Alternative medicine is very popular as well as yoga and meditation. This suggest a distinction between tourists also and in a study made by Mueller and Kaufmann (2001) a distinction between tourist who wants to be cured and tourists who wants to live healthy is made.

Reddy, York and Brannon (2010) showed in their article that traveling from developing countries to developed countries is not a new thing but what is remarkable is the shift in the stream of healthcare tourists. Today, there are a lot of people from developed countries traveling to developing countries such as India, Thailand and Malaysia. An interesting point in the article is that Reddy, York and Brannon (2010) compares some treatments, such as bypass or knee replacement surgery with costs of doing them in India for a tenth of the cost in US. There is even a certain Visa that can be issued to individuals coming to India for medical purposes. According to Gupta (2004) the Indian health-care industry turn over 17 billion US dollars a year, an remarkable sum for a developing country. The healthcare Reddy, York and Brannon brings up in the article is strictly medical and surgeries are in focus.

The interest for some special treatments can also contribute to health tourism. According to László and Smith (2009) there is an increasing globalization of wellness products on the market. Eastern philosophies, religion and medical assets infiltrate the concept of health when put in relation to spas and treatments. Spiritual and emotional

activities to enhance health and wellbeing are getting a lot more space and there is a great market if one wants to do yoga or meditation.

By traveling, according to Lázló (2009), there are both physical and mental benefits of relaxation and intellectual stimulation and the fact that it is possible to mix pleasure with healthcare is another great factor in the rise of health tourism Reddy (2010) writes in his article.

The label tourism is not unproblematic when talking about people looking for the right treatment. The word tourism refers to a group of people or a categorical group of people with the only similarity to travel. To refer to some people as health tourists is to categorize individuals with different health problems, reasons, motivations and life worlds into one group defined by one label – health tourist. The diversity and variety that each individual stands for is thereby automatically erased. We should be aware that in using the label health tourism, it is a superficial label constructed to cover a phenomenon of people traveling abroad for healthcare.

1.4.2 Contributive factors to health tourism. When doing the research for this thesis we discovered a number of contributive factors to why people choose healthcare abroad. These were a mix of societal and cultural factors and when looking at research done on the area there are some parts that may contribute to the rise of health tourism.

Cultural factors. There is no absolute definition of culture but Matsumoto and Juang (2004) defines it as a system of inspiration and meaning that is shared by a group and transmitted across generations. It allows the group to meet basic need of survival and to pursue happiness and well being. Culture can also be defined by the concepts of its content, process, social individual dimensions and social axioms.

As a country, India differs a lot in culture from Sweden and also the western world. It is a country with religious pluralism, diverse climate, big gaps between the social classes and limitations due to the caste system. What tourist might favor so much is the countries richness in historical places and temples, breath-taking nature, delicious food and warm climate. This is a pre-comprehension of the “explicit India” (from our perspective as Swedes); and here we can find some contributors for health tourism. This explicit cultural experience will be further explained together with the implicit experience of the Indian culture later in the section of 1.8.

A culture can also be collectivistic or individualistic and in the case of India, the society and culture are highly collectivistic in comparison to Sweden. It is interesting to see

that a lot of authors (Brewer & Chen, 2007; Lázsló, 2010; Lim, Kim & Kim, 2005) have noticed that there is an increasing need for community in the search for wellness. This takes shape by the activities derived from a holistic viewpoint. Lázsló (2010) point out that even if the individual's main goal is self-development or healing, they have this wish of entering into a communion with others by taking part in treatments, exercises and spiritual developments. Could it be that it is a quest of searching for collectivism when one is choosing resorts and spas in India?

Brewer and Chen (2007) identify two sub dimensions of collectivism, namely group-based collectivism where a strong obligation to the rest of the group dominate as well as obedience to norms and authority. The second one is relational collectivism that has a great emphasize on dependence, mutual cooperation and relationships. They also write that North Americans are more sensitive to the fact that being in a group makes you a member and with a membership come responsibilities. In comparison to people from East Asia, who remain less concerned about the group membership and put more focus upon personal relationships in the group. In Asia then, are relational collectivism predominated and in North America the group collectivism (Lim, Kim & Kim, 2005).

Often the two concepts are seen as antipoles to each other and sometimes the concepts have a sound of negativity. Therefore, using the concept of holism as a label instead of collectivism on the East Asian countries has been suggested. To be a holist means a resisting of breaking something into pieces, they rather see a family of four persons as a single entity with shared identity, not as a collective of four persons. To see the society as holistic and not collectivistic has no contradictions between the "I" and "we", they rather have to be compatible thus joining the group or the whole entity. Further Lim, Kim and Kim (2005) defines holism as "a worldview regarding humans as parts of various holistic entities who adopt identities from the wholes they are parts of and strive to act in unison with other parts in the whole".

Societal factors. Factors in the community can also be contributors to health tourism. Swedish society calls for an individualistic lifestyle and that people are independent and self-active and to follow the norm. Some self-axiom of our society is never to complain, never ask for help and "to do right for one self". This is building up a pressure on the individual to do his/her best for the society to maintain our construction of it. But people are not robots, they can´t just work without feeling anything. High numbers of burn outs, diseases being attributable to life style choices and stress and high rates of depression are just some

indicators that it is a tough society to live in. As Rydén and Stenström (2008) briefly writes about, the Swedish healthcare system might be very prestigious but a huge failure is the long waiting lists where it is acceptable to wait for a medical investigation for 90 days. The healthcare has suffered great from lack of resources and downsizing, given a shortage of medical doctors as well.

There has been a transformation of the communities in a lot of western countries. The industrialization, increasing globalization and a growing international mobility bring about more single people, smaller families and a reduction in birth rate. Communities have also developed through secularization and individualism, where the collectivistic thought of everyone taking care of each other no longer are so powerful (Halman, 2006; Matsumoto & Juan, 2004). Can this be a contributing fact that some people don´t feel as they belong somewhere, a feeling of alienation and loneliness. Often people are defined, not by their name but by attributes such as “the guy who works at the supermarket” or “the girl from Stockholm”. An atmosphere of anonymity is thereby created which might have a negative effect upon health.

Medical and psychological factors. According to Rydén and Stenström (2008), there are surveys showing that around 40 – 50 percent of the ones who seek healthcare in Sweden do not get a diagnosis or a whole answer to what causes their symptoms and problems. The symptoms can be rather vague and it is sometimes hard to establish a final diagnose based on them. The patients are referral back and forth by specialists, sometimes feeling hopeless or frustrated because of the impossibility to get an answer. Rydén and Stenström (2008) clearly states that the Swedish healthcare system has a lot to offer but apparently cannot meet the expectations from the patients.

There has been a change in the view of health. Smith and László (2009) mentions the shift towards an increasing consciousness about lifestyle choices and self responsibility when it comes to wellness. This implies that people have to take care of their lives in a healthy and good way. The ways which people live their lives and its importance upon health has not always been received very well from patients in Sweden. A feeling of having the personal integrity violated when doctors ask questions about eating habits and physical exercises are common (Rydén & Stenström, 2008).

1.5 Language

As we differ from each other in personality, culture, external attributes and perspective we also have diverse ways of saying what we think or mean. Even though, knowing the right

translation of a word in another language than our native, we can never be sure to understand what the other person really mean by his expression. It is not only the language itself that differs, in various countries and cultures people may talk about the same phenomena in diverse ways. According to the Ayurvedic doctor and lecturer Janesh Vaidya (2011), people talking about medicine may refer to the same things, but using different words. Therefore, it is of great importance to conceive the possibility that the distinction between ayurvedic medicine and allopathic medicine actually can be a cultural construction. Perhaps these two sciences are comparable to one another, but hidden behind values and conceptions in our culture?

The constitution of meaning is expressed by our own words and terms which might differ a lot from another person´s expression of the same thing, in particular if that person has another language. So, what the concept of Ayurveda means to us in Sweden may not have the same meaning to the people in India. Ayurveda is an essential part of the Indian society and taken for granted in those people´s eyes. In our culture it is something else.

1.6 India

1.6.1 Indwelling. To develop both explicit and implicit knowledge of a phenomenon it is of great importance for the scientist to locate in the place where the phenomenon is situated. We shall not forget that in phenomenology every person is in constant interaction with the world and affected by it. Hanna Arendt calls this *indwelling* which means that the researcher should act as an interactive spirit in the situation where the phenomenon is studied (Maykut & Morehouse, 1994). Thus, the decision of travelling to India was a natural step for us. We wanted to know what these people faced when they entered India. Tough, we are bound to consider the problem of pre-comprehension and the critical way of bracketing this.

1.6.2 Going to India. We traveled to Mumbai the 15th of Mars and then continued to the Goa province and the tourist villages Anjuna and Palolem. After two weeks we continued south to Kerala and the city Kochi, known for their Ayurvedic clinics where almost all the participants in this study have been. The study were conducted during 18 days and consists mostly of phenomenologically based interviews, meaning the person´s are encouraged to talk freely about their knowledge of Ayurvedic treatments and the tourists coming there. It is like a conversation rather than an interview. Our aim was to talk to as many people as possible, Ayurvedic doctors, tourists as well as Indians working in the tourist

branch.

Situated in India, our purpose was to gain an understanding of the phenomena's health tourism and Ayurvedic medicine. To get further insight in Ayurveda we participated in different yoga-classes and a few healing assemblies. We visited different Ayurvedic facilities to contact people who had knowledge of the phenomenon in order to get several and different perspectives of it. Unfortunately, much of the activities in Anjuna and Palolem were closed due to the ending season. The clinics in Kochi were, however, open. Most of our collected data comes from conversations with people from several countries, with different cultural backgrounds, with whom we spoke to in diverse ways. These people all experienced India in their own ways, just like we did.

In India there were several places to practice yoga. Everything from small tents with only one instructor to big yoga centers where a few instructors worked full days. It was possible to chose between Indian or western instructors with varying competences and qualities. What is interesting is that most of the classes held in India were attended by tourists. Indian people, from what we came to understand, only practiced yoga when they were ill and advocated to exercise by their doctor. The phenomenon of yoga classes where a teacher leads a group of participants seems to be some kind of westernized construction, inspired by Indian yogis and their philosophy. The tourists travelling to India for practicing yoga may change environment and teachers, but the classes are still equivalent to the classes they attend back in their home country. In a dialogue with one of the yoga teachers we discovered that most people coming to her yoga classes (Hatha- yoga) where from developed countries and in fairly good health. She told us that her classes would be the best option in a position of poor health, but it was unusual with participants in that condition coming there.

In the touristic areas of Goa, a lots of Ayurvedic treatments such as massage were very popular and the Ayurvedic business were located along the beach. The price varied and so did the competence. There were also clinics with a middle standard, located in bungalows offering overnight stays and longer treatments. Located in Kochi, high class and luxurious resorts offered treatments from educated Ayurvedic doctors in pleasant and high fashioned atmospheres. Almost every hotel in those parts of India where we traveled, offered Ayurvedic treatments. What was interesting with this observation was the great variety of Ayurvedic clinics and what could be called a clinic. Our cultural context immediately reminded us off its effect on us. As Swedes, we are not used to small shacks or masseurs walking down the beach offering any kind of physical treatments. In Sweden everything are

very well regulated and there are certain criteria's that has to be fulfilled in order to do Ayurvedic treatments. In India, this is not the case.

1.6.3 Our individual experiences. The journey to India extended our life-world with experiences from India. This has gotten us one step closer to the participant's experience of Ayurveda and India and we now share this life-world experience. Individual statements of our experiences will be done in this section.

Felicia. When first putting our feet on Indian ground, it felt like everyone tried to take advantage of our naivety and to get our money, which is something that I´ve experienced before but still got chocked by. Our first day became quite intense in relation to this. In every corner someone was there, trying to get our money. And that is of course defendable in relation to the situation many Indian people are situated in. But still, we never felt threatened, only lost and deceived during the process. Though this first impression, combined with a traffic that, in our perspective, only can be seen as in chaos, together with a non existing system for garbage management, miraculously changed the day after. Because after a second thought, the people living in this mess (at least from my perspective), seemed to feel calmer than the people in our country of residence, Sweden. The Indians had a peace in their eyes reflecting an acceptance about their position in life. At the same time some people we met had great dreams. One boy, for example, told me he dreamed about going to USA, for a musical education. The next second, he said that he was broke after buying the bottle of water he held in his hand. This really reflects my experience of India. Hope along with acceptance of the situation which these people are situated in. A country that simultaneously with a rapid development in some matters still stands with a foot in the ancient traditions and religious views. What stroke my mind is how it can be like this? Is it something about religion, or culture? Or is it resignation in the presence of their hopeless situation, that´s not necessary are hopeless in their eyes, but in ours?

Since I have been backpacking through Asia a few times before, I never imagined that travelling to India would be such a shocking experience to me. Of course there are large cultural differences among India and other Asian countries, but to me it was a lot of the things I had experienced before that felt shocking. Certainly, this trip had another purpose than my earlier journeys in Asia, which aimed to help me in "the search for myself". This time I travelled in search for something referred to school, wherefore my experiences probably became different from the earlier. Despite the fact that individuals subjective

awareness of things differs, we all share a common life world experience. This means that all experiences shared by humans coming across the way of each other, interpret their individual unique life-world experience. Consequently, travelling to India with Alexandra probably affected my experience, because her intersubjective life-world differs from my former companions life- worlds. And because I, through my actions, constitute meaning, my sole ability to understand things in the way that it's appearing to me, are based on the knowledge that I´ve found through my own experiences in my intersubjective life-world. And thanks to time and history (background) I perceived India and Asia in a different way than I had imagined before.

Alexandra. Without romanticize India, I can say that the country is wonderful even if it is very poor and chaotic. The contrasts between our countries are enormous, or at least, it appears that way to me. Explicit factor such as their lack of garbage disposals and the poverty are immediate factors which make the environment very strange and unpleasant in comparison to what I, a Swedish citizen are used to. The fact that I traveled in India with Felicia, my very close friend but also a person sharing my cultural context, made those contrasts stronger. We could both relate to the strange feeling inside us when we came to look upon the many kilometers of shantytowns or the Ayurvedic "clinics" in Goa. This simply doesn't exist in Sweden. By the first look, the traffic is chaotic and there is a never ending multitude of people crowding the street together with the cars, cows, rickshaws and the homeless. When the first shock passed I realized that these people are actually living in this chaos, but do they look the least as stressed as I did, on my brink of having a nervous breakdown? It was on the streets in Mumbai that I experienced the implicit culture of India, the inhabitant's tranquil way of existing despite the chaotic environment. Two Indian boys told us that there is a word for this calmness, "shanti shanti". "If you cross the road in a hurry, they will definitely hit you because they will think you´re going to get over anyway, so they won´t pull the breaks. If you take it easy and walk slowly, they will be forced to stop and letting you pass. If you are calm, they are calm!" one of the guys said to me.
Shanti, shanti, became the concrete word of the calmness affecting both me and Felicia and leaving us with a resignation towards the destitution around us. When the first chock of the explicit India settled I could appreciate the wonderful country that India is. The smells are overwhelming sometimes, a mixture of spices, dirt, garbage, fires, perfume and human perspiration. Religion plays a big part in the native people´s life, prayers are conducted regularly during the day and altars have candles burning all day long. This was not something

new to me since I have been traveling quite a lot in the Middle East countries where religion is more notable in the culture in comparison to Sweden. But the religious altars and burning essences in India gave the whole aspect of medicine and healing a new dimension in the sense of relaxing and calmness. It could be compared to the feeling of going in to a church in Sweden, the atmosphere is relaxing and calm and it is a place where you come to find peace and forgiveness. It is like coming in contact with the source of existing, to be in peace. Shanti shanti is imprinted in the Indians very existing, and that creates an atmosphere which gives us, from the highly individualistic and effective western countries, a chance to relax and just exist. Maybe it is this atmosphere which makes India such a great country for the Ayurvedic health tourism.

2 Method

2.1 Procedure

In the quest of finding potential motive forces for seeking Ayurvedic healthcare in India the sampling was made through internet sites, personal contacts, flyers in the supermarket and also by asking people in real life. On internet, we used forum where we presented ourselves and our work and asked for people who wanted to participate in the study. We were contacted by twelve individuals whereof five fulfilled their participation by filling in a self report. Other information about yoga, Ayurveda and India were collected at the journey in India by conversations, experiences and interviews.

2.2 Participants

Our sample contains of five women (N=5) varying in age from forty to seventy years old. Due to integrity and ethic, they are all anonymous renamed as P1, P2, P3, P4 and P5. The participants were informed that they, whenever they liked, could cancel their participation. They were offered to take part of the results.

2.3 Instrument

2.3.1 Self reports. The decision of using self reports as instrument was certain in the view of our choice of method. The phenomenological question was developed so the participants had the opportunity to answer and argue with their own words. The meaning constitution is an ongoing process which originates from the deepest part of the subjective individual. The individuals own experiences are the only source of meaning and to cease that, the participant had to express themselves by their own words (Maykut & Morehouse, 1994, Sages, 2003).

The question had a few key topics that offered the participant an opportunity to freely describe information of importance. A more specific or general question would probably have putted our participants in a direction where the answering process resulted in a mechanical way of answering the questions. The open ended question forced the participants to get in contact with their real thoughts considering the phenomenon.

We presented two main questions that were applied to all of our participants. The first question were formulated as this;

Skulle du vilja berätta, med dina egna ord, om vad som får dig att söka dig till Ayurvedisk medicin, till Indien och den Ayurvediska traditionen? Vad för känslor, funderingar,

erfarenheter, reflektioner, associationer... har du om den Ayurvediska livsfilosofin (som exempelvis Yoga och så vidare...) Finns det något som är mer viktigt för dig inom den Ayurvediska traditionen och som är extra meningsfullt för dig? Ta gärna med alla dina erfarenheter, intryck, funderingar, emotioner, associationer, tankar och känslor som dyker upp när du skriver om detta.

Var snäll och bry dig inte om stavfel, grammatik eller konstigt formulerade meningar, utan skriv direkt från hjärtat! Du får skriva precis så mycket som du själv vill, några få meningar eller flera sidor, det är upp till dig!

The second question was formulated;

Tänk att du träffar en vän som undrar om han/hon skall söka sig till Ayurvedisk medicin, eventuellt även åka till Indien. Vad skulle du säga, vad skulle du berätta för honom/henne? Ta gärna med alla dina erfarenheter, intryck, funderingar, emotioner, associationer, tankar och känslor som dyker upp när du skriver om detta.

Var snäll och bry dig inte om stavfel, grammatik eller konstigt formulerade meningar, utan skriv direkt från hjärtat! Du får skriva precis så mycket som du själv vill, några få meningar eller flera sidor, det är upp till dig!

2.3.2 Computer programs. Individuals are, from a phenomenological perspective, the only valid instrument to gain conceptions about the phenomenon since the individual are the one constituting meaning. The lived experience of the individual is seen as the sole source of valid knowledge and hence, all participants should be treated equally from the beginning. The meaning is a constant process, derived from the experience of the object rather than the object itself. By a careful analysis of the individual´s meaning constitution their subjective experience can be revealed. To enable a the meaning of the text to be as untouched by our pre-comprehension as possible , the computer program MCA Minerva, created by Sages, R (2003), were used as one of the softwares to analyze data. By using MCA Minerva we got the opportunity to practically apply the *epoché* and *the phenomenological reduction* in the analyzing process. The main purpose with epoché is to set aside our own thinking and feelings and see the studied object with new and clear eyes (Sages, 2003).

Before analyzing the data in MCA Minerva we used another computer program for qualitative data called Sphinx Lexica. The software of Sphinx Lexica made it possible to analyze all the self reports in one process, which gave us the opportunity to get an overview

of the main topics that were frequently mentioned among the participants. At first, we got a statistical report of all the words used in the text and by those we got indications of potential themes which would be interesting to analyze.

MCA Minerva enabled us to make an in depth analysis that gave us detailed information about the participant´s experience of the phenomenon under study. Due to this analysis, the source of meaning as it was given to the experience at first, were found. In the meaning constitution analysis the text were reduced to different levels of modalities, entities and predicates which enabled us to come closer to our participant's life world. The software provided us with the statistical information necessary to get a complete picture of our participants experience (by the result of the modalities, entities and predicates) (Sages et al, 2002).

2.4 The use of Sphinx Lexica

By combining the use of MCA Minerva with using the software of Sphinx Lexica, we also got the opportunity to find general themes, which further in this thesis will be mentioned as the semantic groups, in the self- reports. Sphinx Lexica is conducted so that we could group words which were included in diverse themes that we found interesting for our study. Subsequently we also compared them to each other and got statistical reports of frequently used words. To reveal what way the participant´s spoke of the words we used the "Corpus tool" showing the context for our collected words. Those words that were selected are presented below in semantic groups.

2.5.1 Diagram over semantic groups

Jag (I), relating to the person behind the text; *jag, mig, min, mitt, mina and själv.* 156 occurences. The words in this group all refers to the participants themselves and are the most common words used in the text. It appears 156 times.

Behandling (treatment); *behandling, råd, constitution, råden, behandling, återställa, balanser, obalanser, medicin, kryddor, daglig, massage, hälsohem, behandlingar, akupunktur, maten, balansen, behandlingen, dagligen, oljor, sjukhus, klinik and behandlingarna.* 57 occurences. The words in this group all refers to the Ayurvedic treatments and its content. The words appeared 57 times in the text.

Ayurveda; *AyurVeda, Vedisk, Veda, AyurVedisk, Ayurvediska, Ayurvedakunniga, Ayurvedan, Ayurvediskt and Yoga.* 51 occurences.

The group contains words about Ayurveda as a phenomenon. It includes the philosophy and the medicine as such. These words occurred 51 times in the text.

Allopatisk medicin (allopathic medicine); *Allopatisk medicin, skolmedicin, kunskap, utbildning, lärt, kursen, skolan, kurser, skolmedicinare, akademiskt, akademiskt utbildat, enligt, skolade, gammalt, organiserad, sjuksköterskan, professionen, kritisk, läkemedelsindustrin, kompetent, utbildningen, doktor.* 49 occurences.
When forming the group of allopathic medicine we chose the words that strongly related to medicine, education, science and critical thinking. The words appeared 49 times in the text.

Indien (India); *därifrån, duktiga, Indien, Rajaklinikerna, Cocin, monsunregn, Joytish, Indisk, verksamheten, enkelheten, indiska, Rajas, omhändertagna, byborna, Sangeeta, balaprakash, Casinor, Rajhas, hospital, casino, enkelhet.* 44 occurences.
The words in this group, which occurred 44 times in the text, are all related to India.

Ohälsa (unhealthiness); *ohälsa, livstilskrämpor, migrant, övervikt, krämpor, magsjuka, obalans, sjukdom, godismissbrukare, överviktig, överätare, diabetes, överäta, överätning, förkylning, hälsoproblem, diagnos, besvär, psoriasis, reumatism och fibromyalgi.* 40 occurences. In this group the words of unhealthiness were collected. Some words refer to specific diseases and other refers to general pain and ailments. The words appeared 40 times in the text.

Resa (Journey); *resa, reste, indienresenär, vistelse, resa, åka, välbesökta, reser, besökte, åkte, hälsoturismen, hälsoresor and semestrar.* 28 occurences. The words in this group are related to the traveling (to India in particular).

Holistisk (Holistic); *balans, helhet, Holistisk, holism, själ.* 11 occurences. These words are related to sentences concerning a holistic view.

Hälsa (health); *hälsa, frisk, friskt, tillfrisknande, hälsosamt, mående, healthy.* 10 occurences. The group of health contains words relating to a person's state of being healthy.

Västerländsk (occidental/western); *västerländskt, västerländska, världsbild, samhället, utbildade svenskar, individer, västerlänningar and vanligt.* 10 occurences. In this group we collected words relating to the western world, such as worldview, society and Swedes.

2.5 The use of Meaning Constitution Analysis, MCA Minerva.

By MCA Minerva, we made a deeper analysis of the text through the steps of epoché and phenomenological reduction. The process will be explained in the presentation further down.

After our pre-comprehension were put aside in accordance with the step of epoché, the last step of the phenomenological reduction followed. The reduction aims to illuminate all the general and specific components of the meaning by reducing the text to its constituent part. It is the actual *intentional analysis*, analyzing the meaning content that is acquired by epoché (Sages & Jacobsdóttir, 1999). In this section we present the analysis as thorough as possible in order to make the reader understand the analyzing process.

A participant argued about the effect that Ayurveda had upon her and she said;
Det känns som om jag läker min kropp och själ utefter dess förutsättningar istället för att tillföra "främmande" saker. (It feels like I´m healing my body and soul according to its natural conditions instead of taking external things.)

We will make an example of this sentence, and use it in the different steps of MCA Minerva. The first step in epoché is to break the sentence into meaning units. The meaning units are created to reveal the *pure, expressed meaning* and are divided in small units that contain meaning. The result of this are:

Meaning unit 1.	det känns som om (it feels like)
Meaning unit 2.	jag läker min kropp och själ (I´m healing my body and soul)
Meaning unit 3.	utefter dess förutsättningar (according to its natural conditions)
Meaning unit 4.	istället för att tillföra främmande saker (instead of taking external things)

The meaning units will then be analyzed by categorizing them into the following modalities, which are each meaning unit´s personal form of expression. The modalities indicate the position of the individual related to his/her expressed meaning. The way in which the act of consciousness constitutes the meaning can be given by the modalities. The modalities help us to see how our subject experiences the phenomenon in focus (Sages, 2002). The modalities will be presented below.

Belief. This aims to define the person´s way of telling something. In this category there are doxa-affirmation, doxa-negation, possibility, probability and question. The meaning unit *Jag läker min kropp och själ* (I am healing my body and soul) is categorized as doxa-affirmation because of the persons assuredness. The other four categories do not suit the meaning unit, because there are no negations, possibilities, probabilities or questions in the

unit.

Function. The modality aims to show the way the meaning unit is written and on what fact, perceived fact, thoughts or speculations, it is based on. The modality includes signitive, perceptive and imaginative. The meaning unit *Det känns som om* (It feels like) is categorized as signitive because of its rootedness in feelings, reflecting a process of thinking. If the meaning unit should be perceptive or imaginative, the unit would have been more like *Det känns som att* (It feels like that) which is perceptive or *Det hade kunnat kännas som om* (It could have felt like) which is imaginative.

Time. The modality makes it possible to analyze the tense of the meaning unit. Following tense are possible to choose; Past, Present, Present-Future, Present-Past, Always-recurrent and Empty. The meaning unit *Jag läker min kropp och själ* (I am healing my body and soul) would be categorized as present-future due to its present tense and its slight direction of future.

Affects. This aims to point out any feelings embedded in the meaning unit. In this modality we choose from the following categories; positive-prospective, negative-prospective, positive present, negative present and positive retrospective, negative retrospective and neutral. The meaning unit *Jag läker min kropp och själ* (I am healing my body and soul) are categorized as positive-prospective due to its underlying positive meaning and its direction towards the future.

Will. This modality shows the activity or the will in the meaning unit. The categories are; engagement, whish-positive, whish-negative, aspiration, unengagement and none. *Det känns som om* (It feels like)would be categorized as aspiration because of its feelings and emotions. The feeling is partially directed to the future but there are no signs of wish or unengagement. It is not only an engagement in the unit, but also an aspiration and therefore we chose aspiration.

Subject. The modality tells us about who is writing the sentence and the categories to choose from here are, I, we, one-all and none. In the meaning unit *Det känns som om* (It feels like) we choose none because the unit does not show the subject behind the words.

Property. The modality reflects the genitive in the unit. It is possible to choose from my, yours, his, hers, its, our, theirs, others and none. In a meaning unit like *Det känns som om* (It feels like) there are no property stated and therefore we choose None.

Spirituality. This modality is new and were constructed by us for the purpose to render any spiritual or holistic viewpoints that marks the meaning unit. We made five categories; strong, midstrong, low, reluctant and none. So the meaning unit *Jag läker min kropp och själ* (I am healing my body and soul) are categorized as low because the meaning unit contains a recognition of the soul. To be categorized in a higher level of spirituality, we wanted to see a direct focus on spirituality, religion or God.

The third phase of the analysis is the phenomenological reduction, beginning with the creation of partial intentions, the entities and the predicates. A sentence is constituted by several partial intentions and shows the many components that contribute to the fullness of meaning. The entity (the existing object) in the partial intention refers to the meaning and the predicate refers to the how the entity are expressed by the individual (Sages et al 2003).

Meaning Unit	Partial intentions	Entity	Predicate
Ayurvedan talar om att mat är medicin	Ayurvedan existerar	Ayurvedan	Som existerar
	Mat existerar	Mat	som existerar
	Mat är medicin	Mat	som är medicin
	Ayurvedan kan tala om	Ayurvedan	som kan tala om
	Ayurvedan talar om att	Ayurvedan	som talar om att

The entities reveal the subject of which the individual are talking about in both direct and indirect ways. The predicates unveil words and expressions that the individual use when speaking of the entities. It shows the individual- subjective way that the entities are "intended" by the individual. When these three steps in Minerva are completed we can picture the intended meaning as it was intended by the individual (Sages, 2003).

Through the modalities we can draw conclusions of the way of expressions characterizing the participants, and together with the entities and predicates a picture of the intended object, as it is intended by the individual, are accomplished.

3 Outcomes

Notice that the outcomes presented in the tables will be in its expressed language, Swedish. The reason of that is to avoid potential language bias in this part, which is intended to be as pure and free from assumptions as possible. In the notifications related to each table, a sum of the content contained in the tables will be presented in English. Through this we explain the outcomes without modifying the actual result of the self- reports.

At first we will present figure 1 – 2 and table 1, which in different ways presents the distribution of themes in relation to the participants. The way our participants talk about the themes have been analyzed in MCA Minerva. Below, we will present this by showing how the entities are given meaning by their predicates (Table. 2- 11). An illustration of how much each participant has used the words containing the semantic groups will also be presented (figure 3- 12). The words we have selected are, according to us, the ones that best describes the participant´s attitudes towards each theme.

Since all of the participants speaks out of their own experiences it is obvious that the semantic group of "Jag"(I) is the largest. An exception is P4, who only talks in terms of herself in 3 occasions. However, this will be discussed in part 4, since we have concentrated on the remaining ten groups in the analysis. Those participants who are not represented in some of the tables did not speak relevant about, or simply did not use words connected to the theme.

Figure 1. Distribution of participants and semantic groups

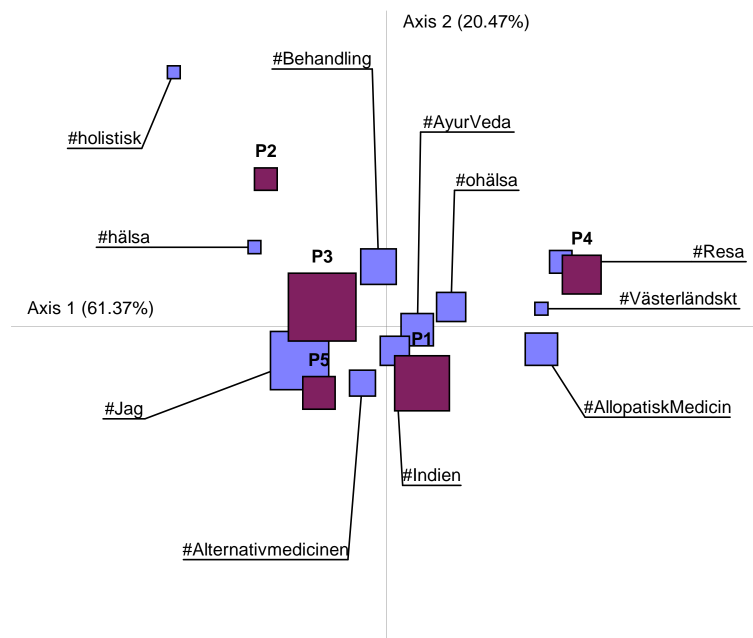

Figure 1. This is one way of presenting the distribution of semantic groups in relation to our participants. The distribution gives a picture of the size of the semantic groups which were conducted in the analyzing process. It also presents the size of the five obtained self- reports. The figure is adapted from the Software of Spinx Lexica.

Figure 2. Distribution of the frequency of the participant´s usage of words placed in each of the semantic groups

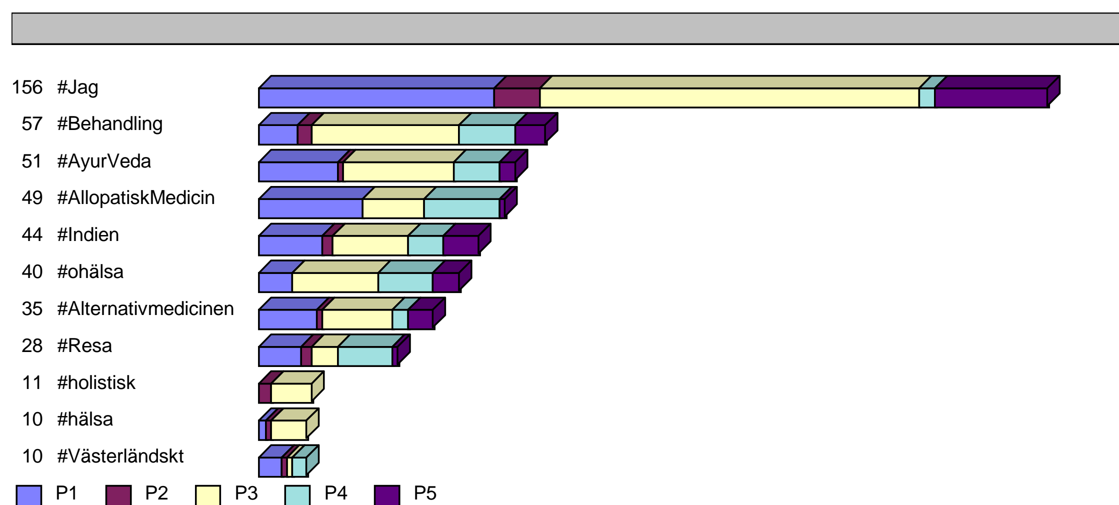

Figure 2. This figure presents how many times each participant have used words from each of all semantic groups. This is a more specific presentation of the distribution than figure one. The figure is adapted from the software of Spinx Lexica.

Table 1

Semantic groups as they are distributed in every participant´s Self- Report.

WORDS/CAT	P1	P2	P3	P4	P5	TOTAL
#Jag	47	9	75	3	22	**156**
#Behandling	8	3	29	11	6	**57**
#AyurVeda	16	1	22	9	3	**51**
#AllopatiskMe	21	0	12	15	1	**49**
#Indien	13	2	15	7	7	**44**
#ohälsa	7	0	17	11	5	**40**
#Alternativme	12	1	14	3	5	**35**
#Resa	9	2	5	11	1	**28**
#holistisk	0	3	8	0	0	**11**
#hälsa	2	1	7	0	0	**10**
#Västerländsl	5	1	1	3	0	**10**
TOTAL	**140**	**23**	**205**	**73**	**50**	**491**

Note. Numerous description of the distribution of words used by each participant in relation to the semantic groups.

Figure 3. The semantic group of " behandling" (treatment)

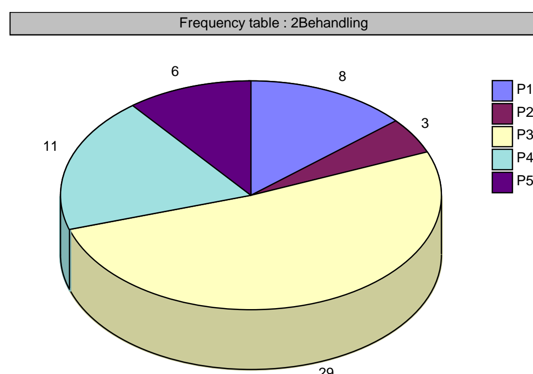

Figure 3. Distribution of participants frequency use in the semantic group of "Behandling" (treatment) which was the largest semantic group. Adapted from the software of Sphinx Lexica.

Table 2

Entities and Predicates from MCA Minerva regarding the semantic group of "behandling" (treatment)

Participants	Entity	Predicate
1	behandling	som jag rest till Indien för att få
		som är Ayurvedisk
	råd	som fungerade
2	råden	som man inte kan strunta i så fort du lämnar hälsohemmet
		som görs upp för att få ut mesta möjliga
3	maten	som är medicin
		som är portionerad till mig
	yoga	som jag gör dagligen
	råden	som jag var duktig på att följa
4	sjukhus	som är seriöst
		som är ayurvediskt
		som har professionella läkare och behandlare
5	behandlingarna	som gör dig trött och även känslomässigt påverkad
		som kan vara enstaka eller flera

Note. P1 traveled to India to get Ayurvedic treatment and she emphasizes that the advices she got there worked. P2 also writes about the advices and the importance to stick to them even if the treatment at the hospital is over. To get the most out of it, you have to follow the advices. P3 focuses upon the content of Ayurvedic treatment such as food as medicine and daily yoga. She points out that she *was* great at following the advices, indicating the experience was situated in India. P4 focuses upon the hospital and its credibility to offer professional Ayurvedic doctors and therapists. P5 talks about the treatments side effects (fatigue, emotional) as well as the frequency of the treatments.

Figure 4. The semantic group of "Ayurveda"

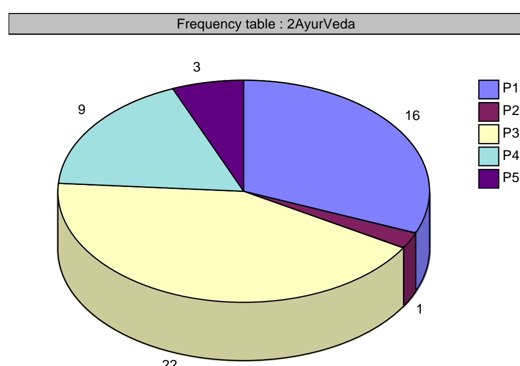

Figure 4. Distribution of participants frequency use in the semantic group of "Ayurveda" which was the second largest semantic group. Adapted from the software of Sphinx Lexica.

Table 3

Entities and Predicates from MCA Minerva regarding the semantic group of "Ayurveda"

Participants	Entity	Predicate
1	Ayurveda	som man kan vara kunnig i
		som någon kan berätta om
		som man kan praktisera råd ifrån
		som han eller hon är insatt i
2	Ayurvediska principer	som kroppen kan få läkning enligt
	Kroppen	som kan bli påmind när den får läkning enligt ayurvediska principer
3	Ayurvedan	som är en holistisk filosofi
		som hjälpte mig bli av med begynnande ledbesvär

		som numera är min ledstjärna och jag vill leva efter
4	Ayurveda	som kan studeras i både USA och Indien som har en främsta uppgift att förebygga
	ayurvediskt sjukhus	som lever upp till de kriterier som krävs för att ta emot västerlänningar som innebär strikt diet och daglig regim
5	ayurveda	som man åka till indien och prova är något jag varmt rekommenderar som jag provat här i Sverige har visst varit bra

Note. In the semantic group of Ayurveda the participant´s way of talking about Ayurveda differs from each other. Those predicates used to describe the entities do have some similarities but in general they differ. Ayurveda as it is appearing to the participant is revealed through the entity which is given meaning by the predicates. For P1, Ayurveda appears as a knowledge that someone can possess and share. P2 focuses on Ayurvedic guidelines as something that can heal the body and thus focuses more upon the medical aspects of Ayurveda. For P3, Ayurveda seems to be a philosophy, a leading star to strive after, because of the positive effects it has had on her. She found help for her ailments and now she´s practicing Ayurveda daily. P4 points out that Ayurveda can be studied at many places, both USA and India. She emphasizes as well, the criteria's the Ayurvedic hospitals need to fulfill in order to meet the expectations of western people. P 4 also stresses that Ayurveda´s aim is to prevent diseases. P5 points out that it is to India we should go if we want to take Ayurvedic treatments even if the treatments here in Sweden are okay.

Figure 5. The semantic group of "allopatisk medicin"

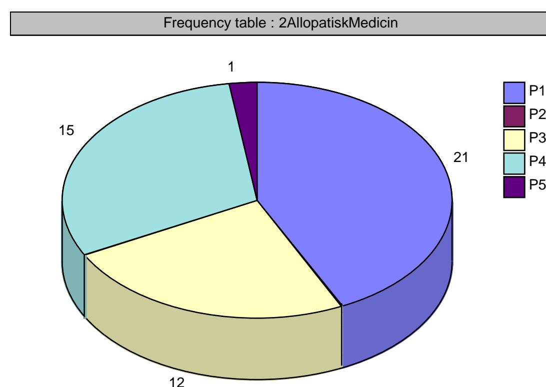

Figure 5. Distribution of participants frequency use in the semantic group of "allopatisk Medicin" (Allopathic Medicine) which was the third largest semantic group. Adapted from the software of Sphinx Lexica.

Table 4

Entities and Predicates from MCA Minerva regarding the semantic group of "allopatisk medicin"(Allophatic Medicine)

Participants	Entity	Predicate
1	skolmedicinen	som behövde kompletteras med alternativ kunskap
	skolmedicinare	som i Indien samarbetar med ayurvedautbildade
3	kritisk	som min inställning till skolmedicinen i många fall är
	skolmedicinen	som är styrd av läkemedelsindustrin
		som inte ser hela människan utan enbart symptomen
4	helhet	som jag sökte efter att ha studerat både friskvård och skolmedicin
	ayurvedan	som gav svar på mycket som vår medicin inte har några förklaringar till

Note. According to P1, the allopathic medicine needs to be complemented by alternative knowledge and this is something that is done in India. P3 has a critical view upon our allopathic medicine which, according to her, concentrates on symptoms rather than the whole individual. She also criticizes the allopathic medicine for being controlled by the drug industry. P4 are slightly characterized by "seeking" something which she possibly found in the Ayurveda and not in the allopathic medicine or health care.

Figure 6. The semantic group of "Indien"

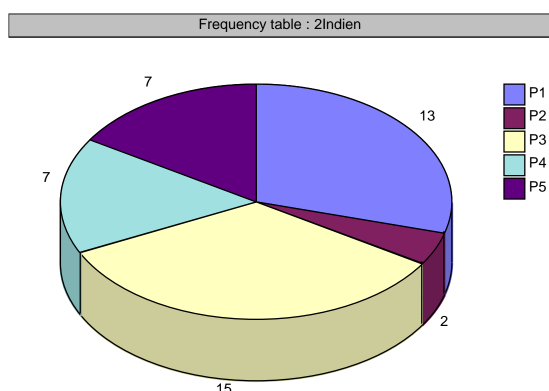

Figure 6. Distribution of participants frequency use in the semantic group of "Indien" (India)

which was the fourth largest semantic group. Adapted from the software of Sphinx Lexica.

Table 5

Entities and Predicates from MCA Minerva regarding the semantic group "Indien" (India)

Participants	Entity	Predicate
1	Problemet	som finns i Indien som är att de akademiskt utbildade ayurvedaläkarna har kollegor som utbildats enligt den gamla traditionen
2	Indien	som jag haft förmånen att resa till med olika grupper
3	Indien	som jag inte åkte till för att jag fått ont i lederna igen som jag åkte till för att jag ville leva ayurvediskt
4	Rajah	som är ett sjukhus med professionella läkare som jag samarbetar med som du kan unna dig att åka till
5	Indien	som är ett underbart land som har otroligt varma människor som skiljer sig från Sverige

Note. P1 talks about the discrepancy of the Ayurvedic doctors that are educated at the university and the doctors educated in the old traditional way. This is a problem in India according to P1. P2 only tells us that she has been traveling to India with different groups of people. P3 states that she did not go to India because of her returning bone-ache but to live "Ayurvedic". P4 mentions Rajah clinic in Kerala, which she has contact with and so "selling" it to us. P5 says that India is a wonderful country with warm people and this differs from Sweden.

Figure 7. The semantic group of "ohälsa"

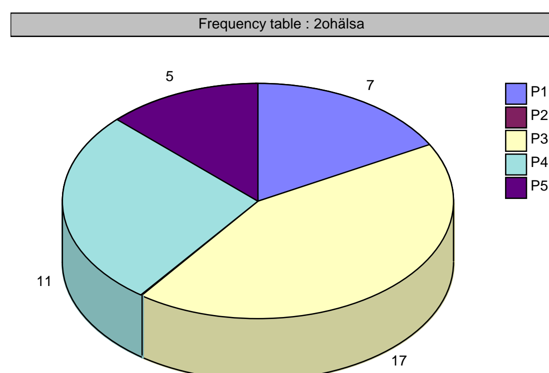

Figure 7. Distribution of participants frequency use in the semantic group of "ohälsa" (unhealthiness) which was the fifth largest semantic group. Adapted from the software of Sphinx Lexica.

Table 6

Entities and Predicates from MCA Minerva regarding the semantic group of "ohälsa" (unhealthiness)

Participants	Entity	Predicate
1	dålig hälsa	som kan innebära livstilskrämpor
	livstilskrämpor	som kan vara flera
		som är mina
	mina krämpor	som det inte fanns något bot för hos den vanliga skolmedicinen
3	jag	som är godismissbrukare
		som har ont i lederna
		som får ont i lederna och då inte får det liv jag vill ha
	inre stress	som jag lider av
4	problem	som är kroniska men där ayurvedan är framgångsrik
	någon diagnos	som det också är vanligt att man har
		som den västerländska medicinen inte har mycket hjälp att erbjuda
5	min fibromyalgi	som förbättrats betydligt på dom 3 senaste åren då jag varit i Indien

Note. P1 talks about the quality of life that can be enhanced by knowing the constitution of the body. Hence, she refers to Ayurveda. P3 refers to herself and her ailments. The bone-ache stops her from having the life she wants. P4 says that one can have ailments that are chronic

but this can be treated by Ayurveda. There are diagnoses which the allopathic medicine can´t help but were Ayurveda are more effective. P5 states that her fibromyalgia has been better thanks to her journeys to India.

Figure 8. Semantic group of “alternativ medicin”

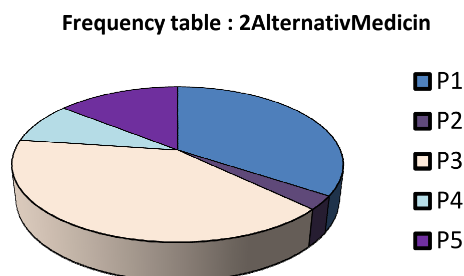

Figure 8. Distribution of participants frequency use in the semantic group of “alternativ medicin” (alternative medicine) which was the fifth smallest semantic group. Adapted from the software of Sphinx Lexica.

Table 7

Entities and Predicates from MCA Minerva regarding the semantic group “alternativ Medicin” (alternative Medicine)

Participants	Entity	Predicate
1	Vedaintresse	som bidragit till att jag utbildat mig till Vedic Art och Jyotish-uttolkare
	AyurVedaläkare	som kan vara akademiskt utbildade
		som har kollegor som utbildats enligt den gamla traditionen
		som inte har samma standard som de akademiskt skolade
3	Alternativmedicinen	som kan hjälpa till som rättesnören
	örter	som jag tror kan bota

Note. P1 talks about Alternative medicine in terms of education and Ayurveda. She further writes that her interest for Veda has contributed to her own education in Vedic arts. P3 focuses on alternative medicine which can work as a guideline.

Figure 9. Semantic group of "resa"

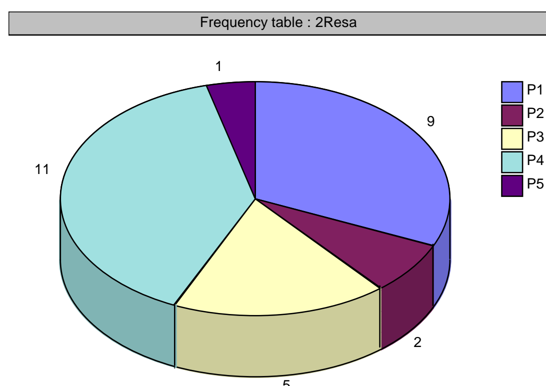

Figure 9. Distribution of participants frequency use in the semantic group of "resa" (Journey) which was the fourth smallest semantic group. Adapted from the software of Sphinx Lexica.

Table 8

Entities and Predicates from MCA Minerva regarding the semantic group of "resa" (Journey)

Participants	Entity	Predicate
1	en familjär känsla	som existerar
	jag	som reste dit
		som hade krämpor under nästan hela vistelsen
		som reste tillbaka igen
		som ska resa dit igen
	Rajaklinikerna	som är välbesökta av svenskar som övertygats om att åka dit
2	Folk	som reser dit för vad det nu kan vara
	Jag	som haft förmånen att resa till Indien varje år med grupper
3	Jag	som åkte till indien
		som åkte helt privat och tillsammans med en väninna
	anledningen	som var att leva Ayurvediskt och få vara frisk
4	hälsoturismen	som existerar
	en del	som reser dit via mig har inga stora hälsoproblem
	flera	som också reser för att få en nystart
	du	som under vistelsen förväntas leva förhållandevis strikt
5	Indien	som jag kan åka till och prova Ayurveda

Note .P1 talks from her own experiences and puts herself in focus. She talks about her trip as a rough time but are still looking forward to going there again. She also mentions the familiarity feeling and points out I clinic that a lot of Swedes travel to.P2 tells us that she has travelled with different groups of people to India and is questioning the motives of these people going India.P3 also refers to herself and her own experiences about India when talking about travelling. She says that the reason she is travelling to India is to live "Ayurvedic".P4 talks about other people who have gone to India in health purpose. She points out that people are going there by different reasons but are expected to live strictly during the stay. P5 mentions that you can travel to India to experience Ayurveda.

Figure 10. Semantic group of "holistisk"

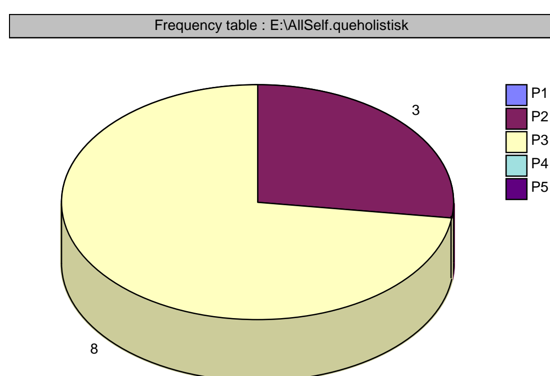

Figure 10. Distribution of participants frequency use in the semantic group of "holistisk" (Holistic) which was the third smallest semantic group. Adapted from the software of Sphinx Lexica.

Table 9

Entities and Predicates from MCA Minerva regarding the semantic group of "holistisk" (Holistic)

Participants	Entity	Predicate
2	själ	som hon läker utefter dess förutsättningar
	kropp	som hon läker utefter dess förutsättningar
	holistisk	
3	filosofi	som är Ayurveda
	andliga	som existerar
	själsligt	som existerar
	jag	som vill leva naturligt och riktigt
	naturen	som jag vill leva nära

Note. P2 emphasizes the body and soul´s own ability to heal according to its conditions. P3 refers to Ayurveda as a holistic philosophy and mentions her own wish for living a natural life. She also refers to spiritual concepts.

Figure 11. Semantic group of "hälsa"

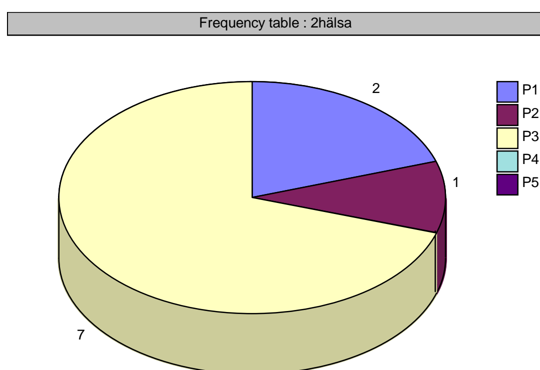

Figure 11. Distribution of participants frequency use in the semantic group of "hälsa" (Health) which was the second smallest semantic group. Adapted from the software of Sphinx Lexica.

Table 10

Entities and Predicates from MCA Minerva regarding the semantic group of "hälsa" (Health)

Participants	Entity	Predicate
1	livskvalitet	som existerar som man kunde förändra genom att ta reda på vilken konstitution man hade
2	tillfrisknande	som man själv har ansvar för
3	hälsosamt	som man behöver leva
	sjukt och friskt	som man inte talar om utan om balanser och obalanser
	ansvar	som man har för sitt liv och sitt mående

Note. P1 uses the concept of life quality which can be adjusted by knowing your constitution. P2 mention the individuals own responsibility to recover from whatever illness it is. P3

stresses that one talks about balance and unbalance rather than healthy or sick. She also talks about the individuals own responsibility for one´s life and healthiness.

Figure 12. Semantic group of "västerländsk"

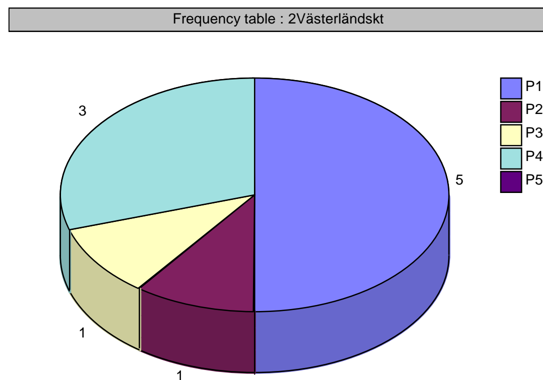

Figure 12. Distribution of participants frequency use in the semantic group of "västerländsk" (occidental) which was the smallest semantic group. Adapted from the software of Sphinx Lexica.

Table 11

Entities and Predicates from MCA Minerva regarding the semantic group of "västerländsk" (western)

Participants	Entity	Predicate
1	västerländsk världsbild	som inte överenstämmer med Vedisk filosofi
2	individen	som själv måste ta ansvar för sitt tillfrisknande
3	Västerländsk värld	som är en artificiell tillvaro av flärd som vi lever i
4	medicinen	som är västerländsk som inte har så mycket hjälp att erbjuda

Note. P1 stresses that there is a large difference between the western view of the world and the Vedic philosophy. P2 concentrates on the individuals own responsibility in the recovery process. P3 criticizes the western world, which we are living in, by calling it an artificial world of luxury. P4 says that the western medicine doesn't have a lot of help to contribute.

4 Discussion

The aim of this pilot study was to find underlying motive forces behind our participant's choice of travelling to India in order to take Ayurvedic treatments. To make this possible, we focused upon how the participants constituted meaning when talking about the reviewed phenomenon . We required to get closer to their life-world experiences, which was done by giving the participants self-reports. Those were conducted in order to give the participants an opportunity to express their experience freely and with their own words. Through our jorney to India we enhanced our understanding of the phenomenon by gaining knowledge and new perspectives, which also brought the possibility for us to share a part of the participant's life-worlds.

It is important to notice that some semantic groups in the outcomes are quite similar to each other concerning the words they contain. When analyzing the self-reports in MCA Minerva, the results indicated that one participant could argue about Ayurveda but refer to another category of word such as alternative medicine. What appeared as an expression about Ayurveda to us as researchers, did not necessarily have the same meaning to the participant of expression. These indications enhance the fact that each individual constitutes meaning in their own intersubjective Life-world. The participants used their own words and expressions to communicate the phenomenon appearing to them. Regardless of our journey to India, we as researchers are still separate individuals constituting meaning in our own way. Our pre-comprehension of the phenomena cannot be denied and are a consequence of the indwelling. As pointed out by Maykut & Morehouse 1994 indwelling certainly gives t e opportunity to apprehend other people´s way of seeing things when situated in their context/culture. Though, a consequence of that is the risk of taking crystal clear phenomenon`s for granted.

4.1 From horizon to life-world experiences

According to the analysis in Sphinx Lexica and MCA Minerva we deduced the following.

*P1.*The most central themes for P1 were allopathic medicine, Ayurveda, India and alternative medicine. Considering the frequent use of "I" in the self report, the participant refered to herself when talking about her experiences. Ayurveda appears to be a valuable knowledge which she is very familiar with and gladly spoke of. Her education in the Vedic arts probably affects the way she presents her experiences. She emphasized that Ayurveda are

effective and can improve the life quality if an individual have knowledge of the constitution of the body and live in accordance with it. India appears to her as a country where Ayurveda can be practiced but where there is a problem between the varied educational qualifications among Ayurvedic doctors. The participant stressed the importance of education, preferably academically education, for practicing Ayurveda and become trustworthy. This is certainly problematic due to the different ways of becoming an Ayurvedic doctor. From the journey in India, we were told that “the real Ayurvedic doctors” are the ones educated by the old tradition. But, how can we know which one is the best? By stressing the importance of education, P1 increase her own professional trustworthiness which is indicated by her frequent referring to herself.

P2. Participant number two gave us the smallest Self-report of 23 words. This participant talked most about holism, treatment, India and travelling. It seems to be important to her that the curing takes place in relation to the body´s own conditions. She pointed out that the healing process is both physically and mentally (spiritual) which is considered in the Ayurvedic philosophy. At the same time she also stressed the importance of the individual´s own responsibility of following the Ayurvedic advices and guidelines. What´s notable is the tendency towards individualism. An example is when she talked about the entity “råd” (advice), with the predicate ”…som man inte kan strunta i så fort du lämnar hälsohemmet” (that you cannot disregard at the same second as you leave the health clinic). This indicate the participant´s willingness to put responsibility upon the individual alone considering ones state of health or to be cured. The Ayurvedic guidelines have to be followed even after the treatment at the clinic, which P2 emphasized. She also argued that starting over with old and destructive habits likely would bring bad health back to the person that was supposed to be cured.

P3. The most comprehensive self report of 205 words was given by participant number three. The words she used most frequently were placed in the semantic groups of treatment, Ayurveda, unhealthiness and India. The participant is very displeased with the lifestyle in Sweden and said that our world is artificial and stressful which have resulted in her ailments. According to participant number three our healthcare is built upon medical products and she is convinced that allopathic medicine is controlled by the drug industry. Exemplified by the entity “skolmedicin” (school medicine) and it by its predicate “...som är styrd av läkemedelsindustrin” (which is ruled by the industry of medical products). It is possible that the critic against the allopathic medicine is based on bad experiences with the Swedish

healthcare or the failure to cure her ailments. To this participant the medicine of Ayurveda is not only treatment, but also food and exercises. The participant noted that it is much easier to be healthy in India than in Sweden which was the reason for her journey to India. As she wrote, she wanted to live a “natural” life, close to nature which was not possible in Sweden. Her predicates to the entity “råd” (advice), ”…som jag var duktig på att följa” (as I was good at following) indicates that she had no problem to follow the advices while still in India. The participant has a way of leading her own ailments back to how our society is constructed and blame the society for her health problems. It appears to us that participant three makes herself a victim of our Swedish society. She wants to take responsibility for her health but it’s impossible while still being in our society. In India, she got a whole new control over her bad habits due to the clinics strict treatment programs, which may be the reason of why she found the ayurvedic treatment so providing.

P4. Participant number four focused upon the themes of allopathic medicine, travelling, unhealthiness and treatment. What she makde clear from the beginning is the importance of well educated, professional and reliable Ayurvedic doctors and therapists. According to her, there are criteria´s that have to be fulfilled in order to satisfy western patient’s expectations. Her self-report shows strong critics against the allopathic medicine which, according to P4, do not have a lot to offer. She referred to chronic problems which Ayurvedic medication can improve and where the allopathic medicine cannot. This is revealed in her way of saying “någon diagnos…som den västerländska medicinen inte har mycket hjälp att erbjuda” (some diagnosis…which the western society don´t have a lot of help to offer) and “problem…som är kroniska men där Ayurvedan är framgångsrik” (problems…that are chronic but where Ayurveda is successful). The participant searches for a more holistic health care perspective and recommends the alternative medicine for curing ailments. The participant also stressed the importance of knowledge about the treatments and its content of strict regimes, diets and exercises.

P5. Participant number five gave us a self report of 50 words which mostly contains of words connected to India, treatment, unhealthiness and alternative medicine. The treatment seems to be very tough with side effects but also had positive effects upon her fibromyalgia. According to her there are Ayurvedic treatments to experience both here in Sweden and India but it is different in India. If she refers to the difference in treatments or at something else is not foretold. But in her self-report she portrayed India in a very beautiful and emotional way, focusing upon the country as such and compared it with the differences in

Sweden. For example when talking about the entity “Indien” (India) she used the predicates “…som är ett underbart land” (which is a wonderful country) and “…som skiljer sig från Sverige” (which differs from Sweden). It reveals a distinction between what is beautiful and not made by the participant, further suggesting that India is a better place than Sweden.

4.2 Motive forces and new horizons

The main question of this thesis is; how come that some Swedish people travels to India to get treated by the Ayurvedic medicine? The outcomes of our study are not possible to generalize and our participants do not speak for every Swede going to India for medical or health issues. The outcomes should only be seen as possible indicators to why Swedes seek health-care abroad. In the self- reports two tendencies where found, *dissatisfaction* and the *problems with living healthy in the Swedish society*, which could be interpreted as motive forces for our five participants.

Dissatisfaction with the Swedish healthcare. Some of our participants (P1, P3, P5) turned to the Ayurvedic medicine in India because they were dissatisfied with the Swedish healthcare. When the participant´s writes about of Swedish healthcare it is by negative terms and there is an underlying disappointment in their reasoning. The other participants (P2, P4) level criticism against the allopathic medicine and questions the ontology of the conventional medicine. Apparently, the holistic view found in Ayurveda is more attractive to our participants though it is only participant number three that seems to emphasize holism and participant number two briefly mentioned it. The fact that holism is not mentioned that much could be because of what Patterson (1998) stresses concerning the definition of holism being founded upon an individual interpretation rather than a general picture of the object. It is possible that the participant´s, except from number three, have their own interpretation of holism and speaks of it in a way that we, as authors, cannot distinguish in the text. We can problematize this by the limitation of using language. The participant´s may have used other words to express holism than what we, as authors and analyzers, would do and therefore holism does not get represented in the self- reports.

There has been interventions in the Swedish health care, Ryden and Stenström (2008) mentions the bio-psycho-social model and the strive after balance between the body, mind and soul. The later referring to the concept of holism according to them. These interventions are great steps forwards in the healthcares integration with the patients but despite that the participants criticize the healthcare? Probably because the healthcare did not

treat them the way the participants expected. They did not get cured of their ailments. This rises the questions of a greater bias in the healthcare than the treatment of patients. Maybe it is the science of medicine in it self that needs to be changed? Because in reality, how does our medication work? The answer we can think of is integrated in the next tendency we found in the self reports.

The difficulty of living healthy in our society. The reason why participants number three wanted to travel to India to get Ayurvedic treatments was the wish of living healthy and natural, to live "Ayurvedic". She further explained her difficulties with living healthy here in Sweden because of the society. As we have seen earlier in this thesis, the treatments are extensive and include different kinds of exercises, diets, and therapies. The treatment is composed like a lifestyle and it is advocated to keep doing this even after the visit at the clinic. But how is it possible to live "Ayurvedic" in our western society where you are supposed to work eight hours per day and then complete all the requirements that is placed upon you? Is our society even constructed in a way that permits a holistic worldview in the healthcare? To P3, the society does not, because it has constructed aunnatural way of living which she implies by the entity and predicate, "västerländsk värld…. som är en artificiell tillvaro av flärd" (western world…which is an artificial life of vanity). In our industrialized and highly efficient part of the world, time is getting more valuable. This results in a society that strives for fast solutions. And this is where the medication comes in. The drug industry supports this stressful environment by helping people "postpone" their aliments simply by taking a pill instead of dealing with the cause of the problem. But it might be more complex than that. Clearly there is sensitivity when talking about the increasing consciousness of health. Ryden and Stenström (2008) mentions that it has not been very welcomed from the patient's side when the doctors ask about their personal lifestyle. This could be traced back to our individualistic society and the feeling of having ones integrity threaten. The doctor might come close to you when examining you as a patient, but when asking about personal habits and lifestyles he might just come to close. So the way of treating through pills are also convenient in the case of personal integrity.

4.2.1 New horizons. According to the use of an emergent design in this study, we discovered new and important horizons besides what was intended by our open ended question. One thing is the constant recurring of the individuals own responsibility for good health (see the example stated by P4, table 8). Interestingly, this refers back to the individualism that according to Shulruf (2007) are an subgroup in the concept of

individualism and Lim et al (2005) calls it the very essence of individualism. Our participants are not only individualistic, but Swedes as well, and our society are built upon individualism. We have a culture that requires that everyone takes care of themselves and presupposing that they *want to* take care of themselves because no one else will do it.

The analysis in MCA shows clearly that the individualistic thinking, manifested in the concept of responsibility, showed by P2: "individen… som själv måste ta ansvar för sitt tillfrisknande"(the individual…that have to take responsibility for its own recovery) are a cultural conditioning existing in each participant´s life-world. But they do not seem to be aware of the emphasis they put on responsibility. In relation to this, what else that is interesting is their other emphasis upon the education and reliability on the doctors giving treatments in India. It is very important to our participant´s that the doctors are well educated, at least university degree, and that the clinics lives up to the criteria of treating westerners. The expression stated by P4, "Ayurvediska sjukhus…som lever upp till de kriterier som krävs för att ta emot västerlänningar" (Ayurvedic Hospitals…which fulfills the criterions that is claimed to receive western patients) reflects this opinion. This kind of reasoning among the participants reflects our Swedish construction of the society build upon academic facilities and research institutes. The national board of health and welfare regulates certain licenses such as medical doctors and psychologists and diplomas and licenses works as evidence for reliability. So despite that our participants want to have the natural and holistic treatment of Ayurveda, it should still be based upon research and university-graduated practitioners. This enhances the fact that we, as Swedes, share the same history and life world. We are contextualized and cultural creatures that apply our new experiences in relation to what we already know. The phenomenon of university and education becomes the evidence of reliability in our society and we are still captured and situated in that thinking either we deny it or not.

Regarding the information we obtained from local people in India, the traditionally educated Ayurvedic doctors were considered as the "real" instead of those who were academically educated. Those traditionally educated doctors can be found in the more rural areas of India and it is doubtful if they can fulfill any criteria needed to treat western people. This is a question of how different subjects appear to us. According to our participants, a doctor must be academically educated. This indicates, not only the concrete societal difference that lies behind our understanding of an object, but also the implicit cultural difference that is the base of how we interpret things appearing to us.

India as a country for health tourism is definitely showing their best sides when it comes to hospitality and service. As a patient you get Ayurvedic healthcare for a descent sum of money at a residence with western standards. The traveling with climate change is not to underestimate either, the climate is good and the Goa province is imprinted by tourism making it comfortable for tourists who want to combine a healthy vacation with sunbathing, excursions and shopping. This seems not to have been of interest to our participant´s visits in India. It is possible to get both a more substantial treatment lasting for months and an easier and more relaxed treatment, lasting from a few days up to a week. If this goes hand in hand with the Ayurvedic philosophy is a matter of discussion but what is clear is that the Ayurvedic resorts and hospitals in India try both to adapt to the tourists personal needs and whishes and at the same time keeping their own genuine Indian tradition.

The conclusion of this study is that there are a discontent directed to our Swedish (western) society and our healthcare. Those two tendencies are interpreted as the motive forces for our participant´s. We also discovered a tendency towards individualistic thinking which appeared through the participant´s way of putting the responsibility of health on the individual. This probably derives from our cultural context. Our society does not permit an holistic view in healthcare because we simply don´t have time to be sick!

4.3 Discussion of method

The method we used appeared to be rewarding towards the subject of our thesis. The phenomenological approach and the use of an emergent design resulted in new information that previously were unknown to us. The software's also helped us to gain a deeper knowledge of our participant´s self reports and thereby Life-worlds. A critical reflection of the use of Sphinx Lexica is the ambiguity concerning the distribution of themes in figure 1 and 2. The figure is based on the same data as the remaining figures. But they are presented in two different ways. How to interpret these outcomes is in the viewer's comprehension. By using the analysis of MCA Minerva we got the ability to see how the participants spoke about the themes, and not only by numbers.

From the beginning we had a sample of 12 persons that volunteered for the study, but only five of them decided to complete the participation. To notice is that the original sample contained only 3 males and no one of them decided to go further with their participation. The small sample we based our research upon, can be problematic due to the fact that all of them are women and around the same age. But the participants actually

volunteered and thereby wanted to tell us about their experiences, which strengthens the validity of the self reports. Though, this bias could be interesting to investigate in further research.

We as authors to this thesis would like to point out that our discussions concerning individualism and culture does not intend to make statements of what is right or wrong. The fact that our participants all emphasize the educational aspect in relation to Ayurveda and India are very appropriate and we do not level criticism against it.

4.4 Suggestions of further research

We advocate further research in this area, not only referred to the outcomes of our study, but also because the absence of previous research about Swedish health tourism. The fact that Swedes go abroad in search for healthcare reflects a problem, that could be both societal, cultural and medical, which needs to be emphasized in social science research. Our pilot study indicates that there are some people that are dissatisfied with both the Swedish health care system and the structure of our society, which makes it hard to live a healthy life. Our concrete suggestion about further research is to conduct a study similar to this where the participant´s are measured during different states of their treatment. A larger and more varied sample is also something to pursue in purpose to strengthen the validity and opportunity of generalization of further outcomes. Another suggestion is to further investigate tendencies towards dissatisfaction among a larger sample of people in a social psychologically directed study.

References

Ayurveda. Received 2001- 02- 22, from http://www.ayurvedhealthcare.com/

Brewer, M. B. & Chen, Y. (2007). Where (who) are collectives in collectivism? Toward conceptual clarification of individualism and collectivism. *Psychological Review*, 114, 133–151.

Discover Medical Tourism. Received 2011- 05- 10, from http://www.discovermedicaltourism.com

Green, E. G. T., Deschamps, J. & Paez, D. (2005). Variation of individualism and collectivism within and between 20 countries. *Journal of Cross-Cultural Psychology*, 36, 321–339

Goodrich, N. J., Goodrich E. G. (1987). Health- care tourism – an exploratory study. *Tourism Management*, Volume 8, Issue 3, September 1987, Pages 217-222

Gupta, S. (2004). Medical tourism and public health. *People's Democracy 28* (19), May

Halman.L., Draulan.V. (2006). How secular is Europe? *The British Journal of Sociology*. Vol. 57:2

Hörnsten, Å. (2010) *Patient eller livsvärldsperspektiv?*. Received 2011- 05- 15, from http://www.vardhandboken.se/Texter/Bemotande-i-vard-och-omsorg-patientperspektiv/Patient--eller-livsvarldsperspektiv/

Hörnsten, Å. (2010) *Vårdar- eller biomedicinskt perspektiv. [Bemötande i vård och omsorg, patientperspektiv*]. Received 2011- 05- 15, from http://www.vardhandboken.se/Texter/Bemotande-i-vard-och-omsorg-patientperspektiv/Vardar--eller-biomedicinskt-perspektiv/

Lim, Tae-Seop , Kim, Sang-Yeon and Kim, Jihyun. (2011). Holism: A Missing Link in Individualism-Collectivism Research, *Journal of Intercultural Communication Research*, 40: 1, 21 — 38

Matsumoto, D, Kouznetsova, N, Ray, R, Ratzlaff, C, Biehl, M, Raroque, J, (1999). *Psychological Culture, Physical health, and Subjective wellbeing*. Journal of Gender, Culture and Health, vol4 , no 1

Matsumoto. D., Juang. L. (2004).*Culture and Psychology.*Wadsworth/Thomson Learning, USA

Moustakas, C. (1994). *Phenomenological Research Methods.* Thousand Oaks, California: sage publications

Monk-Turner., E., Turner., Charlie. (2010). Does yoga shape body, mind and spiritual health and happiness: Differences between yoga practitioners and college students. *International Journal of Yoga*. 3: 2, 48-54. Medknow Publications

Maykut. P., Morehouse. R. (1994). *Beginning qualitative research: A philosophic and practical guide.* The Falmer Press. London

Mueller, H., & Kaufmann, E. L. (2001). Wellness tourism: Market analysis of a special health tourism segment and implications for the hotel industry, *Journal of Vacation Marketing*, 7 (1), 5-17

National Center for Complementary and Alternative medicine. Received 2011- 05- 05, from http://nccam.nih.gov/health/ayurveda/introduction.htm

Patterson., F.E. (1998). The philosophy and physics of holistic health care: spiritual healing as a workable interpretation, *Journal of advanced nursing.* 27: 2. 287-293. Blackwell Publishing

Reddy. S.G., York. V.K., Brannon., L.A. (2010). Travel for treatment: students´perspective on medical tourism, *International Journal of Tourism.* 12: 5, 510-522

Rydén . O., Stenström U. (2008). *Hälsopsykologi*. Bonnier Utbildning

Sages, R, Jakobsdottir, Y, E. (1999). Phenomenological research method in intercultural psychology. Paris: L´Harmattan

Polkinghorne., D. (2003). Validation in physical organic and human realms. I Lindén, J. & Szybek, P (Eds.), Validation of knowledge claims in Human Science (pp. 51-80). Lyon: I´lnterdiciplinaire

Sages, R. (2003). Truth as Unveiling. I Lindén, J. &Szybek, P (Eds.), Validation of knowledge claims in Human Science (pp. 51- 80). Lyon: I´lnterdiciplinaire.

Smith.M., László. P. (2009). *Health and Wellness Tourism.* Elsevier Ltd

Shulruf, B., Hattie, J., & Dixon, R. (2007). Development of a new measurement tool for individualism and collectivism. *Journal of Psychoeducational Assessment*, 25, 385–401

Tyler, F. B. (2002). Transcultural Ethnic Validity Model and Intracultural Competence. *Online Readings in Psychology and Culture* (Unit 16, Chap 1)

Vaidya. J. (2011). *Ayurveda för ditt sinne*. Bonnier Fakta