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Doubled Otherness in Ethnopsychiatry

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Abstract *Starting from the experience of the Other, phenomenology takes otherness as something which withdraws from my own experience and exceeds the limits of our common orders. Radical otherness is something extra-ordinary, arising in my own body, situated between us and striking us before we look for it. Psychiatry confronts us with a peculiar sort of pathological otherness which in ethnopsychiatry is doubled to an otherness of a higher degree. We encounter the anomalies of other orders as if we were dipping into the Other's shadow. This brings up many questions. How is the pathic related to the pathological, the normal to the abnormal? How can psychiatry take account of the intercultural Other without sacrificing its otherness to universal points of view? How is the unconsciousness of our own culture connected with that of other cultures? To what extent does intercultural otherness affect our intracultural otherness? Is there an alternative to the extremes of fundamentalism and globalism, which tend either to repress otherness or to level it?.*

Key words: ethnopsychiatry, perception of differences, alienness, universalisation

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OTHERNESS Cross-cultural or transcultural psychiatry is faced with faces a series of basic questions. First we have to ask how culturally transmitted life-forms and individual suffering are linked. In this context culture can either be conceived in terms of universal structures which determine human beings as such, or in terms of multiple life-forms which vary historically and geographically. Accordingly, in his *Crisis* Husserl distinguishes between one and the same *life-world*, endowed with universal structures, and concrete *life-worlds*, which always appear in the plural[1]. At the same time we are confronted with the question as to how culture and nature are interlinked Phenomenology, being orientated towards experience as the sphere from which all significant differences arise, assumes that the interplay of culture and nature is deeply rooted in the acts and the habits of our *body*. As Merleau-Ponty already puts it in his *Phenomenology of perception* (1945, p. 221), in our existence as human beings there is nothing to be found which is not at once artificially fabricated and given by nature, be it smiling, fatherhood or our sitting and walking, together with various techniques of the body, which Marcel Mauss has carefully described (1975, p. 199 ff.).

With regard to the status of ethnopsychiatry that we have in mind, it is most important to take into account the motif of otherness (*Fremdheit*)[3], which functions as a corrective against any attempt to place the own in the centre or to globalise all peculiarities[2]. Since in English we are accustomed to speak simply of *otherness* or in German of *Andersheit*, we have to be careful not to fall into a conceptual confusion which would accompany our reflections like a shadow. We must clearly distinguish between logico-ontological otherness (*Andersheit*), a sort of *difference* which comes about through a process of delimitation, and topological otherness or alienness (*Fremdheit*), a sort of *divorce* or separation which emerges from a process of in- and exclusion. Something that is alien does not only appear to be other, rather it arises from elsewhere. Words such as *strange(r)* or

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étrange(r), which are derived from the Latin word *extraneus*, evoke the aspect of place. Thus, there is a *topography* of the alien, which cannot be reduced to an *ontology* of the alien. Our experience of the Other or of the alien (*Fremderfahrung*) consists neither in the fact that we do not yet or no longer know something, nor is it restricted to the fact that something is positively indeterminate[4], rather it emerges in the fact that something affects and appeals to us before we take it *as something*, and in the further fact that something is there in escaping us. We could speak of an incarnate absence (*leibhaftige Abwesenheit*) which is experienced as an absence like our own past. Otherness touches the uncanny (*Unheimliche*) which haunts us in our own house. Such a radical sort of otherness, which cannot be reduced to something else, shapes our *own body*, which simultaneously appears to be an *alien body*, and it permeates our common *life-world* which from the beginning is divided into the *home world* and the *alien world*. In both cases we do not have to do with a strict separation between the own and the alien, rather we meet with manifold transitions, generating something like an 'inter-corporeality', an 'inter-monde', an 'inter-man'. This sort of *between* (*Zwischen*, inter), which also comes up in what we call inter-cultural and which itself becomes a cross-cultural figure in what the Japanese call *ki* (cf. Kimura, 1995), turns out to be much more than a mere saying, it is constitutive for any experience of the Other.

Ultimately the question arises as to how ethnopsychiatry is related to what is alien. The name *transcultural ethnopsychiatry*, which, due to authors like G. Devereux, W. M. Pfeiffer and E. Wittkower, has been prevalent since the seventies, seems to be just as ambiguous as the term otherness. The prefix *trans* can be understood in a double sense, namely as *going beyond*, transcending a borderline and reaching a common third, or as a *passage* from one to the other (see in Latin *transcendere* vs. *transcurrere*). In the first case transcultural psychiatry would gain a foothold beyond the different cultures, in the second case it would move *between* the different cultures[5]. This alternative comes close to the difference between the transubjective validity of arguments or laws and intersubjective interchange, which is also much too readily blurred. Hence, I shall use the unmistakable term *intercultural* whenever the phenomenon of the alien is at stake, or I shall use the term *ethnopsychiatry*, which, by borrowing its title from ethnology and ethnography, explicitly refers to ethnic groups, primarily to those from other cultures and continents. The fact that the so-called ethno-sciences do not come to a halt before what is our own has an additional effect which should not be neglect when one is occupied with the alien. Now, if we follow the ethnologist Karl-Heinz Kohl in defining ethnology as the "science of what is culturally alien or other" (Kohl, 1993), ethnopsychiatry gives rise to a doubling of otherness or alienness. The sick person *as somebody alien* becomes the *sick person as somebody culturally alien*[6]. this marks the path of the following reflections.

THE SICK PERSON AS SOMEBODY ALIEN If we qualify the sick person as somebody alien we have to distinguish between a relative and a radical kind of alienness. On the one hand, illness as something *relatively alien* refers to the level that medicine has reached in its development. Something which exceeds our diagnostic and therapeutic capacities is *not yet* curable, but nevertheless it is fundamentally accessible to the medical gaze and the medical grasp. To what extent the hopes for healing will be fulfilled depends on the ever increasing capacities of technology and pharmaceutics, but in addition it depends on health economics and health policy, which also take the expenditure of time and materials into account. Under the conditions of public health the experience of illness is viewed as a mere case of illness. On the other hand, the patient, who is suffering from a certain disease and generally makes others suffer with him or her, confronts us with the *radical alien*. In spite of the fact that certain traits recur, making us qualify the sick person as a typical diabetic or paranoiac, the core of suffering presents itself as something singular and extraordinary; for it is impossible to open a definitive pain or suffering account for anyone. Pain *behaviour* may be learned, involving considerable cultural differences as we know

from ancient Sparta and from many medical narratives; but this does not hold true for the pain *experience* which has to be characterised as a sort of pathic experience[7]. Pains come as ideas come, even if we try to cause them by our own hand. The mitigation and to an even greater extent the measuring of pain is already part of the medical treatment which responds to a preceding painful pathos. During the process of medicalisation, which starts with the admission interview (or commitment) and the admission record, some *transformation* takes place. The singular experience of suffering is transformed into a general case of illness or disease which is labelled and subjected to general rules. Such a transformation is certainly required by the institution and the profession of medicine. Nevertheless, transformation remains transformation. Feeling low in spirit becomes depression, fixed ideas become delusions, anxiety turns into anxiety neurosis, itching into an allergy and so on. But all these clinical terms are by no means less discourse-dependent than terms like atom, black hole, voltage or perjury and second-degree murder. Schizophrenics, neurotics or the depressed are not simply given as if we only have to sort them out and to register them. Anyone who plays down the corresponding transformations and skips the required translation work, which necessarily runs in both directions, from the doctor's knowledge to the patient's experience, but also vice versa from the experience of suffering to medical knowledge (see Blankenburg, 1989, S. 123), creates a medley of everyday experience, scientific jargon and pharmaceutics, which tends to gloss over every trace of alienness. Moosbrugger, the psychopathic anti-hero in Musil's novel, touches a tender spot when he vehemently revolts against such simplifications: "That's why he hated nobody so ardently as he hated the psychiatrists who believed that they were able to dispose of his difficult being in its entirety by using some strange words, as if in their eyes it were a trivial thing" (Musil, 1978, S. 72). On the contrary, we should admit that the patient crosses a threshold on entering the medical sphere, and that he crosses the threshold again on leaving it, even if on a bier. Therapeutics, which is set in motion by the Other's suffering, itself assumes certain pathic features which are not extinguished by the measures the doctor takes, and it appears to be a responsive kind of therapeutics, responding to the appeal of suffering beings. Each story of illness bears features of a story of alienness[8]. Crossing the threshold involves certain *rites de passage* and hermeneutic skills, unless the consulting room or the sick-room is to be nothing more than a repair-shop. Cross-cultural comparisons might already be instructive when considering the framing of medical actions.

The fact that the medical examination and treatment starts willy-nilly from a specific experience of the Other has immediate effects on our understanding of illness. Each intruding or lingering disease first emerges as something anomalous and unusual even if in the long run one grows accustomed to it. However, it is not so that every anomaly (or even every "mental disorder") is pathological; only those anomalies are deemed to be pathological which are not mere troubles, but affect the total organism and threaten the patient's existence (Goldstein, 1934, p. 268 f.). In general, anomaly means the deviation from a certain norm, from a measure or a level of behaviour, and this too has a relative or a radical form.

Integrated into the frame of an existing medical system, anomaly turns out to be only a relative variation which has its place in the given order. Thus, the pathological aspects are reduced to mere *troubles* or *deficiencies* causing a certain disorder. Suffering pertains, so to speak, to the strains that functional restoration involves. Against such a methodological medicalisation of life, which abstracts from concrete life-contexts, there is nothing more to be said than against the mathematization of nature or the juridicalisation of actions. But we get entangled in problems if we "take for *true being* what is actually a *method*", as Husserl argues against Galileo (1954, p. 52). The normalisation turns into a sort of 'normalism' if the genetic process of normalisation disappears behind the functioning normality. Hence, the radical aspect of deviation which *shocks* the existing health norms is forgotten. One does not become aware of the fact that the experiences,

expectations and anxieties of life, which are considered and treated as *normal*, *are not* simply normal. The oblivion of suffering, together with the oblivion of the life-world, produces a sort of 'medicalism' which constitutes a special form of logocentrism and technicism. The medical expert, who draws a distinction *between* the normal and the anomalous, the healthy and the sick or insane, conveys the impression that he simply stands *above* these differences. Similar kinds of false role presumption are known from other forms of centrism, for example if Europeans are not satisfied with distinguishing themselves from Asians or Africans, but place themselves above all peoples as if Europe were the real incarnation of reason.

All this evokes the indispensable, but also problematic role of the *third party* or simply of the *Third* as introduced by Simmel, Sartre or Levinas. The third party easily appears to be an instance which *overlaps* the difference between the own and the alien such that it surveys and dominates everything and everybody. But provided that there is a process of experience which takes place between the own and the alien, oscillating between pathos and response, the Third cannot do more than *intervene* in this process by clarifying, understanding and regulating. Thus, the medical expert plays a double role. Experts are addressed by the *sick person* as somebody alien, and at same time they observe, assess and treat certain *cases of illness*. In this context radical alienness means that the given illness is always to some extent *incurable*. Medicine has to do with the incurable within the curable, precisely as the fine arts have to do with the unsayable within the said, with the invisible within the visible. It is not some*body* living who can be expected to be totally curable, but only some*thing* manufactured which, if required, can be repaired. The complex of curing and healing[9] does not only mean that certain defects are repaired and normal processes restored, it also means that new possibilities are tested. Hence, being ill would involve not only an *aliter* as in case of any deviation, but also a *minus* (Blankenburg, 1989, p. 139), but this also means that there is not only a *minus*, but also an *aliter*. As long as more minor cases of disease are at stake the process of healing may come close to the well-known *restitutio ad integrum*. But on the whole "recovery never means the return to biological innocence. Regaining one's health means to gain new – sometimes higher – norms of life. Biological normativity is irreversible." (Canguilhem, 1974, p. 155) The irreversibility increases if the disease reaches the heart of the personality, if the patient is affected him- or herself and not only something belonging to him or her. In traditional terms we still speak of psychological illness or mental disorder; this does not imply that they are not at all somatic, it can only mean that they are not primarily somatic[10].

Our previous reflections started from a life-world which is common to patients and doctors. We would be simplifying things if we define everything pertaining to this sphere directly as *intracultura*. Our life-world is *interculturally* formed from the beginning, be it diachronically, due to the sediments of a manifold history of medicine, including the "history of madness", which Foucault discovered in a new sense, be it synchronically, due to the confrontation with heterogeneous patterns of disease and different methods of healing.

Sigmund Freud's discovery of a "foreign country within ourselves", Marcel Mauss and Claude Lévi-Strauss' alienating gaze at one's own society, the doubling of ethnology into "auto-ethnology", exploring the alien in ourselves, and "allo-ethnology", exploring it in others, as stated by Marc Augé (cf. Waldenfels, 1997, p. 99), or the "ethnopsychiatry in our own country", inspired by Georges Devereux, these are quite different approaches, but they all imply problems which transcultural psychiatry has to face. Therefore, the intensification of the alien and its duplication in a sort of alien of the alien is more than something added afterwards, it is inserted into our experience of the culturally alien like a hidden explosive. Nevertheless, its needs our special attention.

THE SICK PERSON AS SOMEBODY CULTURALLY ALIEN Our radical experience of the alien is distributed over different dimensions. It arises as an *ecstatic* sort of alienness, referring to myself, including unconsciousness as something which escapes my own knowing and willing[11]. It further arises as a *duplicative* sort of alienness, confronting myself with the Other as a sort of double. Finally, is comes up as an *extraordinary* sort of alienness, following every order[12]. An order without a shadow would be like an order cage. The last mentioned sort of alienness, nestled on the borderline between the ordinary and the extraordinary, will be especially important for us.

The assumption that our experience of the Other is duplicated in an experience of what is other for the Other is based on a simple argument which only becomes more complicated when further elaborated. On taking a first step, which opens the field of our intercultural experience of the Other, we meet with modes of experience, of behaviour and of expression which for themselves are simply *normal*, even though they deviate from the customs of our own culture, whether it be feudal obligations of fealty within medieval society, the nature-bound character of Japanese ceremonies or architecture, the family ties of ethnic groups in Africa or finally the traditional customs of foreigners which we encounter in our own country. But in addition to this, every alien culture shows its own kinds of alienness. The borderline between the ordinary and the extraordinary does not only separate one's own from the alien culture, rather it runs through the alien culture. There are *anomalous* figures such as the seer in ancient Greece, the augurs in ancient Rome, the Jewish prophets, the Siberian shamans; there are unusual forms of violence such as the 'holy war', the outbreak of blood feuds or a case of murder of honour; there are rituals of sacrifices and a willingness to make sacrifices, culminating in the hara-kiri of the nobleman or in the self-sacrifice of the assassin. Finally, there are special forms of illness. Accordingly, Devereux depicts a great multiplicity of "ethnic disturbances" (1974, pp. 60-103) which are all shaped by culture such as the running amuck, berserk rage, transformation into a wolf man or St. Vitus's dance. He points out that all these disturbances take advantage of specific mechanisms of defence and of proper symptoms. He further remarks that the average distribution of psychiatric symptoms varies from one culture to another, so that e. g. true schizophrenia is simply absent in primitive populations which have not passed through a "brute process of acculturation" (ibid., pp. 77-79). In the meantime many comparative studies focusing on such issues have been published[13]. The idea of monolithic cultures, contrasting as a whole with our own culture, invovles a great simplification which produces clichés of otherness as well as of hostility. Anyone who adheres to such ideas neglects the differences present within a single group or population, differences which make Western orientated inhabitants of Istanbul feel more remote from their compatriots living a traditional life in Anatolia or from fundamentalist imams than they feel from modern Europeans. One also neglects the pathological phenomena which are generated by another normality.

What is alien for the alien does not disappear in a chain of otherness, because it does not exempt us, rather it returns to us. In his *Cartesian Meditations*, a classical text introducing the problem of the experience of the Other and co-translated by Emmanuel Levinas, Husserl writes: I am confronted with the fact, "that I can experience the individual Other not only as the Other, but as being him- or herself related to his or her Others, and at the same time perhaps to myself by way of an iterative mediation" (1950, p. 158). Referring to a kind of mediate experience of the Other, originating immediately from myself as a "primary ego" and from the "sphere of my ownness" as a primary sphere, Husserl misinterprets as many others before and after him have done, the pathic character of our experience of the Other. Radical otherness cannot be derived from my own, as if the Other's gaze had its origin in my constitution of the Other's gaze as an alien gaze, and as if I were an ego before I am touched by the Other's gaze or word. What Husserl does nevertheless notice is the iteration of otherness which returns to myself from my experience of the Other[14]. My

experience *of the Other* culminates in a sort of *othering* that affects my own experience. Through affects like being afraid of the Other or being curious for the Other, otherness invades us. Freud's remark in his essay *Beyond the Pleasure Principle*: "Fear [...] evokes the state in which we fall, when we are faced with a danger without being prepared for it" (GW XIII, 10), also holds true for the fear which originates from the Other. There are parts of the otherness of the Other that we bear in ourselves. The Other is implanted into us, as Jean Laplanche puts it, trying to complete the uncompleted "Copernican revolution of psychoanalysis" (1992). Once purified from affective influences and violations, our experience of the Other would no longer be an experience of the alien, but rather nothing more than a product of sheer exotism, transforming the alien into a counterfeit of our own. Our experience of the Other includes an intertwining of the own and the alien, and this contrasts with a sharp dividing line, drawn on a drawing-board or with the help of a ruler. Our own otherness and the otherness of the Other are closely interlaced; this explains why there is an inner and an outer foreign country, and why the extra-ordinary is never totally outside the ordinary, the anomalous never totally outside the normal and the insane never totally outside the sane. This goes to the extent that over-normality and over-adjustment are in themselves somewhat anomalous, and that norms by themselves produce pathogenic effects, affecting persons who might be called 'normopaths'.

From this point of view the nightmare of relativism vanishes. We free ourselves from a spectre we often attack with the weapons of infra- and supra-cultural universalism, as if the simple difference between the particular and the universal were at stake and not first of all the difference between the own and the alien. It is pretended that all sorts of illnesses and also all sorts of customs, being culturally tinted, were locked in their culture as if in a shell, until they are freed from their cage by means of universalism. But this battle starts from false presuppositions.

There is nothing like a pure culture, rather we encounter a manifold interlacing of cultures which allows for a *more or less of otherness*. In the view of an enlightened European, an assassin, who attempts to purchase a place in heaven by sacrificing him- or herself, certainly appears to be more strange than a neurotic, who clings to all that he or she is or possesses. Going to Africa, we Europeans stumble on the traces of a history of colonialism, full of violence, including the dark chapter of slavery. To that extent Africans belong to our European history, precisely as vice versa Europeans belong to African history – and also do not belong. The otherness of other life-forms is not so far from the otherness of foreign languages. For Germans Dutch is less foreign than Russian or Arabic. But translations are never precluded; a *foreign* language, one that is absolutely foreign, would cease to be a foreign *language* as distinct from a mere sequence of sounds. Similar things can be said about the understanding of mental diseases, which requires that the psychiatrist learn foreign languages of life. The initial fact that what is alien or foreign escapes our grasp does not mean that the alien is *totally different*, as if there were nothing left to compare. On the contrary, it means that the singularity of the Other, which we have already reached through the individual figure of the patient, is *more* than a mere part of a whole or a mere case of a general law. The question remains open as to what part the ethnopsychiatrist has to play.

THE ETHNOPSYCHIATRIST IN THE ROLE OF THE THIRD PARTY The phenomenology of the Other which we advocate here can do nothing more than attempt to determine the place which the psychiatry of the Other can occupy according to its own rules. When we try to find this special place, we encounter the part of the intervening third party which we have already mentioned. In order to clarify the issue I shall draw upon a clinical case with a forensic background which Wolfgang Blankenburg presents as a paradigm case for what he calls ethnopsychiatry in our home country[15].

The story is about a 56-year-old Iraqi who has been living in Germany for ten years and working as a so-called *Gastarbeiter*. He killed his 9-year-old daughter whom he loved more than anybody else. He killed her in a ritual manner, using specially fabricated needles with which he stabbed her in the heart, and he did it on Christmas Eve, during midnight mess and in presence of the church congregation, offering her as a sort of 'holy sacrifice'. The first issue to be settled is the following: Do we have to do with a crime which can be imputed to a guilty person or not? Relying on expert medical opinions, the judges first came to the conclusion that the act of killing was a veiled *act of revenge*. The legal code ranks revenge among the base motives. So the perpetrator was condemned to 15 years imprisonment. It was only after he had attacked the prison chaplain, who much cared about him, in a similarly cruel way some time later, covering him with oil and igniting him, that a new psychiatric assessment was ordered. This time the psychiatrist, namely Blankenburg himself, referring to a preceding long lasting jealousy delusion, came to the conclusion that the perpetrator was suffering from a paranoid psychosis. So he was moved to a closed psychiatric clinic. Up to this point everything seems to be formally all right. Legal and medical people make their decision in their usual manner from the standpoint of a legitimated third party. They do so by classifying the act as a typical crime of a certain kind or of mental illness, and by taking or recommending the right measures. In sum, we are left with certain facts of a case, comparable with other facts, and we are left with a certain profile of a perpetrator, comparable with other profiles, and both make it possible to duly classifying what has happened. This also applies to a domestic alien such as Moosbrugger: "In the eyes of the judges his actions proceeded from himself, in his own eyes they had come upon him like birds which fly upon us. In the judge's view Moosbrugger was a particular case; in his own view he was a world, and it is difficult to say anything convincing about a world." (Musil, 1978, p. 75)

The ethnic feature of our paradigm case would completely vanish, precisely as in legal proceedings the question of gender is neglected, if Blankenburg did not explicitly bring the socio-cultural surplus of the *sacrificial act* to bear. Indeed he mentions the human sacrifices in Greek myths – e. g. the sacrifice of Iphigenie – but he refers in particular to the sacrifice of Isaac, which was interrupted at the last minute – which Jewish and Christian traditions have in common with Islamic traditions. Now, if we were to stop here we would be caught in intracultural, intercultural as well as interreligious conflicts of interpretation[16]. Judgements about delusions or schizophrenia would be based on the normative presuppositions of contingent life-forms. The initial relativity of symptoms would end with the relativism of medical judgements. Therefore, referring to Devereux, Blankenburg proposes transcultural comparisons, taking the *motive of sacrifice* as something common to all human beings into consideration.

But the debate which arises at this point would again take a dubious course, if the discipline of ethno-psychiatry were to be regarded as a mere preliminary to a definitive sort of anthropo-psychiatry. Otherness within one's own culture would then descend to a mere variant within a universal structure-system, precisely as cultural-anthoprological structuralism assumes[17]. But we have good reasons to contest such a belief in an irresistible process of universalisation. Cultural universals are comparable to linguistic universals. One may well concede that all human languages, like all human diseases, have certain features and rules in common, to some extent formed by pre-cultural, natural processes, to some extent based on trans-cultural, rational categories; but this does not prevent us from assuming that all that exists on this side or on the other side of a certain culture provides us with mere forms of *conditio qua non*. These are at best necessary conditions, but by no means sufficient conditions in order to explain what is created by culture. By no means does the undeniable fact that German and Chinese are not *toto coelo* different abolish the difference between native and foreign language. All the unavoidable efforts to learn and to translate, which take place within a linguistic *Zwischenreich*, i. e. within a sort of between-region, can never be completely covered by mental or natural laws, capable of organising our

experience from above or from below. *Mutatis mutandis*, this should also hold true for the multiplicity of medical phenomena and for the relation between the doctor and the patient in his quality as a cultural other. Precisely as there are several orders, without one single order, there are several pathologies, without one single pathology. Deviations are as plural as the orders from which the abnormal behaviour deviates.

In order to characterise those peculiarities of thinking which resist our attempts of universalisation, we assume certain idioms of thinking[18]; in a similar way we may take into account certain idioms of illness. Let us mention a linguistic example, taken from Freud's work *The Unconscious* (GW X, 296 f.): "The eyes are not right, *sie sind verdreht* (they are rolled or twisted) [...], he is a hypocrite, an *Augenverdreher* (distorter of eyes), he has distorted her eyes, now she has distorted eyes, they are no longer her eyes, she sees the world with other eyes." Or another passage: " She stands in the church, suddenly *es gibt ihr einen Ruck* (literally: it gives her a jerk), *sie muß sich anders stellen, als stellte sie jemand, als würde sie gestellt* (she must place herself differently, as if somebody were placing her, as if she were being placed)." These are plays on words produced by a schizophrenic girl who has been taken to the clinic because of a quarrel with her lover[19]. Austrian and German readers cannot help thinking of certain cascades of words in Thomas Bernhard's texts, such as the following sentences, taken from a text called *Gehen* (1971, p. 85): "We cannot say we think as we go, as we cannot say we go as we think, because we cannot go as we think, nor think as we go." To some extent the idiomatic sound of such sentences can be transferred into another language, but by no means can it be universalised. The "cultural materials" from which psychopaths derive their forces of defence, as Devereux assumes, are not raw, but pre-formed materials, so that a certain sense shines through the non-sense.

Every process of generalisation or of universalisation has its limits. If we were to adopt the humanistic perspective articulated in the famous saying *humani nihil a me alienum puto*, my own otherness as well as that of other human beings and of other cultures would be sacrificed to an ideal of unity, to-day associated with a trend to globalisation. We should be on our guard against such attempts. We may well concede that the third party, intervening in the experience of the Other by observation, analyses our regulations, makes comparisons and that he is right to do so, but we should also insist that he is only able to do so in the paradoxical way of "comparing the incomparable" (Levinas, 1974, p. 201 f.). What is *equalised*, *is* not equal – unless we assume that comparisons can be made from nowhere and that measures of comparison are at hand like slide rules. Let us return to our psychiatric example once more. If nothing counts except the legal and medical measures, taken by legal and medical experts, the girl who has been sacrificed and what the whole story is about will disappear in the end, as if her death were nothing more than the trigger for due legal and medical proceedings. The psychopathological phenomena are involved in a similar way, i. e. the source of jealousy which usually derives its force from a disappointed love, and the transition from feeling oneself observed and persecuted to a persecution mania. So the process of becoming sick and insane, which had already begun before the examination and the treatment starts, is at risk of being eliminated.

Ethnopsychiatrists may learn from certain *aporias* which cause a great deal of trouble to ethnology and ethnography. Taken as a kind of "xenology", as a *Fremdwissenschaft*, ethnology is far from being a normal science, an *Allgemeinheitswissenschaft* looking for general or universal laws; the alien would no longer be alien if it were understood and explained[20]. When Boris Malinowski, a pioneer in the domain of ethnology and ethnography, carried out his field work, he found himself faced with the problems of *participating observation*. As some disappointed remarks in his diary illustrate, such a methodological approach will end in disaster if the simultaneity of participation and observation, of adherence and distance, of speaking with... and speaking about...

and finally the simultaneity of speaking and listening is mistaken for a case of pure coincidence. This way one makes one's own experience of the Other collapse with the neutral gaze of the third party. It may be that one returns to the Other, impelled by a bad conscience, but a bad conscience is not a good adviser. An alternative can be expected from an *indirect form* of looking, speaking and acting, one that is aware that it originates outside itself; accordingly, it would have a double gaze, a double ear and a double speech. Speech of this kind, speech that comes *from the Other* and responds *to the Other*, would never coincide with speech *about the Other*[21]. As far as psychiatry is concerned, it is certainly a specific discipline and practice, adhering to its own methods and rules, and one would be wrong to require that it explore all horizons of otherness and penetrate all its depths. But in order to meet its own claim to be an *ethno*psychiatry, it should keep its doors and windows open, letting the gusts of otherness in.

NOTES

[1] The problematic aspects of this conception are discussed in B. Waldenfels, *In den Netzen der Lebenswelt* (1985)

[2] The new conception of otherness or alienness which is at stake here can only be roughly outlined. More about it can be learned from B. Waldenfels, *Topographie des Fremden* (1997) and, written in a more pointed form, *Grundmotive einer Phänomenologie des Fremden* (2006), see especially the final chapter "Zwischen den Kulturen".

[3] In order to render the German word *Fremdheit*, I shall use both terms: 'otherness' and 'alienness'; the second term is more precise, but not so common. The same holds true for the translation of *Fremde(r)* with the 'Other', the 'alien' or the 'stranger'. In any case, we should keep the fact in mind that since Plato the *Andere* (greek: heteron) pertains to the basic assumptions of our Western thinking, whereas to this day the *Fremde* (greek: *xenon* or *allotrion*) is often taken as merely deficient or derivative.

[4] As to the manifold phenomenon of the indeterminate, which does not coincide with the phenomenon of the alien, but does touch it, cf. Gerhard Gamm, *Flucht aus der Kategorie* (1994). The author interlinks rather different approaches from Husserl, Heidegger and Merleau-Ponty up to Wittgenstein, Foucault and Quine.

[5] Georges Devereux, to whom ethnopsychiatry owes a great deal, draws in a later context (1974, p. 129) an explicit distinction between 'cross cultural' and 'trans-' or 'metaethnographic' or 'metacultural psychiatry', and he does so in order to preclude common misunderstandings.

[6] With this two-step model I refer to the chapter „Der Kranke als Fremder" in my book *Grenzen der Normalisierung* (1998) which grew out of the clinical milieu and which will be continued here in a wider perspective. Concerning the phenomenological influence on psychopathology, psychiatry and medical anthropology, which I shall repeatedly draw upon, see my survey in the *Einführung in die Phänomenologie* (1992), pp. 88-94.

[7] The same holds true for other phenomena of life such as pleasure, anxiety, torture or molestation by noise.

[8] In this context I want to mention a good piece of socio-medical research, presented by Gerhard Riemann: *Das Fremdwerden der eigenen Biographie. Narrative Interviews mit psychiatrischen Patienten* (1987). The author learned from sociologists such as H. Garfinkel, E. Goffman, A. Strauss and F. Schütze whose research was closely connected with the clinical practice.

[9] Whereas German only has the one verb *heilen* and French the one verb *guérir*in the transitive and in the intransitive mode, English is equipped with two verbs, one transitive, the other intransitive. But this does not mean that the activity of curing can be completely separated from the process of healing. In addition to the possibility of a so-called spontaneous recovery, curing itself depends on spontaneous forces of healing. In other words, no curing without healing.

[10] The clear dualism is mitigated if we consider that the word *psyche* used to be used to signify the living being as self-moving and that the word *spirit* (*spiritus*, *pneuma*, *ruach, Geist*) suggests the breath of life and not so much the interior of what is called *mind* or *mental*. As to the attempts to renew a non-dualistic view and language, I refer to the analyses in my book *Das leibliche Selbst* (2000) where many new efforts are presented, including those made by medical anthropology.

[11] Following Devereux we can distinguish between an ethnic and an idiosyncratic kind of unconsciousness (1992, p. 23-28).

[12] Concerning the different dimensions of alienness see my extensive explanations in *Bruchlinien der Erfahrung* (2002), ch. V-VI, and concerning unconsciousness as a specific zone of alienness see ibid., ch. VII.

[13] In this context I refer to the wealth of research materials presented during the Annual Meeting organised by the Transcultural Psychiatry Section of the World Psychiatric Association in Vienna 2006.

[14] The concatenation and entanglement permeating our experience of the Other should not be confused with a transitive relation as defined by the logic of relations, where one and the *same* element is related to *another* element and through it to a *further element*. Our *self* cannot be identified with the *same*, precisely as the *alien*, which is separate from me, cannot be identified with the *other*, which is different from me.

[15] See *Ethnopsychiatrie im Inland* (1984a). This essay has been published in a special volume, dedicated to Georges Devereux on the occasion of his 75th birthday.

[16] As one example among others see Stéphane Mosès's Jewish inspired interpretation: "Why Isaac was not sacrificed" (2004, ch. 2).

[17] However, Claude Lévi-Strauss, the protagonist of this movement, balances the trend towards an all-encompassing science of the *universal* with a counter-trend towards a differential science of the *alien*, inspired by Rousseau.

[18] See B. Waldenfels, *Idiome des Denkens* (2005), ch. 17.

[19] The general characteristics of schizophrenic language disturbances include a "short circuit between over-abstraction and hyper-concretism" (see Blankenburg 1984b, p. 105), but even this must not be understood as a senseless gibberish, but as a rather helpless and nevertheless productive attempt to respond to grave disturbances.

[20] Accordingly, chapter 4 of the *Topographie des Fremden* explicitly deals with the "paradox of a science of the alien"; such a paradox is inherent to all ethno-disciplines, including ethnopsychiatry.

[21] See my critical remarks concerning the "paradoxes of the ethnographic representation of others" in *Vielstimmigkeit der Rede* (1999), ch. 6.

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