

De Martino's concept of critical ethnocentrism and its relevance to transcultural psychiatry

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Abstract

Ethnography and hermeneutics help us think of the clinical encounter as a meeting of cultures. In this paper, we examine Ernesto De Martino's concept of critical ethnocentrism and its relevance for psychiatry, arguing for the necessity of a cultural self-assessment on the part of the clinician as a means of optimizing analyses of the patient's culture. Conceptualizing the clinician as an "ethnologist," we argue that clinicians should be able to describe and acknowledge patients' cultural backgrounds, while remaining aware of their own culturally rooted prejudices. Focusing on the case of persons affected by schizophrenia, we suggest that De Martino's work invites an openness to hermeneutic dialogue that aims for the coconstruction of shared narratives by clinician and patient.

Keywords

critical ethnocentrism, culture, De Martino, hermeneutics, psychopathology, schizophrenia

The idea that the clinical encounter in the mental health field is a hermeneutic one, or a meeting of cultures, is not new (see e.g., Atwood & Stolorow 1984; Frank, 1973; Frankl, 1984). Indeed, this follows from the more general claim that every encounter between persons is also a meeting between the different horizons of historically determined meanings in which these persons are

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embedded (Gadamer, 1960). In this paper, we develop this idea, drawing on the work of Ernesto De Martino, an Italian philosopher, anthropologist, and psychopathologist. De Martino's work lies at the juncture of psychiatry, anthropology, and philosophy (Charuty, 2010; Gallini, 2005; Gallini & Massenzio, 1997) and offers a useful heuristic for transcultural psychiatry (Bartocci & Prince, 1998; Beneduce & Martelli, 2005). We examine De Martino's concept of critical ethnocentrism and its relevance for psychiatry, arguing for the necessity of a cultural self-assessment on the part of the clinician as a means of optimizing analyses of the culture embodied by patients affected by mental disorders—especially schizophrenia. Conceptualizing the clinician as an “ethnologist,” we argue that he should be able to describe and acknowledge his patients' cultural background, while remaining aware of his own culturally rooted prejudices. We suggest that De Martino's work invites an openness to hermeneutic dialogue that aims for the coconstruction of shared narratives by clinician and patient.

In what follows, we discuss De Martino's work, with the aim of developing a methodology of the clinical encounter. We begin with De Martino's concept of “culture” as the valorization of the intersubjective dimension that allows for the sharing of a common world. This is followed by a consideration of the theory of the ethnographic encounter and the perspective of critical ethnocentrism as a desirable point of view that fosters openness towards other cultures and, simultaneously, the acquisition of greater knowledge of one's own culture. The discussion then turns to the clinic. We present De Martino's conceptualization of mental illness and of phenomenological psychopathology. In concluding, we argue for the clinical application of critical ethnocentrism based on the perspective of clinical hermeneutics, especially in work with persons affected by schizophrenia.

De Martino on culture

According to De Martino, culture is the moral energy that allows a person to separate himself from the merely natural, in order to found a human world (De Martino, 1977, p. 659). It is an individual “initiative which is consolidated in a tradition, a tradition that conditions and feeds that same individual initiative in a circularity” (De Martino, 1948, p. 121). In fact, the initiative of the individual takes place inside of a “cultural homeland”—a concept that has much in common with Husserl's notion of “homeworld” (Husserl, 1973), the sphere in which we feel at home and at ease. One's cultural homeland is shared with other members of the community—it is not a world of a single individual, rather an intersubjective world of tradition, religion, myth, collective values, etc. (Luft, 1998; see also Cherchi, 1996). Every culture is called upon to intersubjectively resolve the problem of separation from nature (De Martino, 1977, p. 175). De Martino calls the moral impetus that regulates this separation the “ethos of transcendence.” The ethos of transcendence is a kind of fundamental human moral drive defined by De Martino (1977) as an *élan moral* (that has much in common with Levinas' [1979] concept of

“transcendence”), a “primordial force” that makes community possible because it is founded on intersubjectively shared values. Although its content varies from one cultural setting to another, the ethos of transcendence represents both a vital impetus and a moral principle that mediates the passage from nature to cultural institutions and sustains the structure of those institutions once they have been built.

Therefore, from a De Martinian perspective, “being-in-the-world” means *to have to be* in the world by giving value to the things of life—a value that is realized intersubjectively in culture. If there is to be a world, and a way for the individual to be situated in that world, it is necessary that we not coincide immediately with the situation but that we be separated from it. The parameters that maintain the distance established through this separation are called *values* and they are culturally conditioned (De Martino, 1977, p. 674). In every culture there is the chance that this ethos of transcendence may collapse, and so life in a culturally significant world is always exposed to the risk of not being able to be in any culturally possible world. Specifically, for De Martino mental illness represents the “permanent anthropological possibility” (De Martino, 1977, p. 669) of this risk. Culture, then, constitutes a “solemn exorcism” against the risk of mental illness (De Martino, 1977, p. 669).

Cultural encounters and critical ethnocentrism

For De Martino, ethnology is the critical comparison of the histories of ethnic groups, beginning with the history of Western culture as point of reference (De Martino, 1977, p. 5). The fundamental methodological problem of the ethnologist is to acknowledge the inevitable contradiction of having to understand and evaluate a cultural system which is not one’s own, making the effort to understand and evaluate it according to “objective” criteria. Ethnographic travel leads one to systems of cultural choice that are different from one’s own, different from those in which one was born and raised (De Martino, 1961). Therefore, ethnographic travel provides an opportunity for self-analysis: one retraces the formative process of one’s own culture critically, questioning the genesis and evolution of its cultural institutions. The ethnographic encounter permits us to gain access to “other ways of being human that go beyond the awareness the West has of being human” while also revealing to us what it means “to be human” within Western culture (De Martino, 1977, p. 391).

De Martino criticizes the long-held distinction between Western civilization and “non-Westernized humanity” and maintains that we are instead witnessing a shortening of distances, an increase in intercultural encounters, and a mixing of traditions that undercut this distinction. Ethnography is called upon to develop a “critical consciousness” (De Martino, 1962, p. 90), involving a shift away from its traditional orientation to the study of *other* cultures, toward a stance that is simultaneously open to other cultural settings, and critical toward its own (De Martino, 1962).

Such a “double thematization of the self and the other” (De Martino, 1977, p. 391) in the ethnographic encounter is accomplished by focusing simultaneously on both one’s own categories of observation and the categories of the foreign culture under observation, thereby arriving at a greater knowledge of the other as well as enhanced self-knowledge. This thematization illuminates the paradox of ethnographic observation: in order to observe those from cultures that are not our own, it is necessary to establish categories of observation, but this necessarily results in an ethnocentric distortion of the phenomena that are to be observed. As numerous philosophers have argued, one difficulty in understanding and appreciating “world views” that are very different from our own stems from the fact that we view the other’s world with the categories of our own epistemology (see e.g., Pepper, 1942). De Martino indicates how this paradox can be resolved by following a number of steps. First of all, it is necessary from the outset to have an awareness of the ethnocentric limitations of one’s own categories of observation. This means that the history of each of the categories must be explicitly traced. Once one’s own categories have been fully understood by situating them in their historical horizon, they are bracketed, neutralized, in order to allow a sense of the other’s alterity to appear. Through the use of this concept of “ethnographic *epoché*” (De Martino, 1977, p. 391), De Martino theorizes a systematic and explicit confrontation between the history of the other culture, as it emerges in certain behaviors, and the Western history sedimented in the categories employed by the ethnologists who are observing and interpreting that behavior. Ethnographic *epoché* makes it possible for the ethnologist’s own culture and the culture he is studying to be thematized and compared. The comparison with the culture of the other leads to a revision of the categories of observation and to an increase in anthropological knowledge (De Martino, 1977, p. 410).

An analysis adequate to the cultural setting being studied requires a method which goes beyond the limitations of the ethnologist’s own culture, and which opens its own categories to those of the other culture (De Martino, 1977, p. 412). The method invented by De Martino is called “critical ethnocentrism” (see also Saunders, 1993). In this method the Western ethnologist adopts the history of his own culture as the baseline for his analysis of the history of the other culture, but while he is engaged in the act of understanding the other, he is also gaining knowledge of the limitations of his own set of categories.

Ethnocentrism is an attitude that develops inside any cultural world. The tendency to assume that the categories and modes of expression of one’s own culture are naturally given, obvious in themselves and universal, has its origins in a human need for identity and for identification (Lanternari, 1983, p. 39). This “ethnocentric (or noncritical) attitude” operates, moreover, on an implicit level, predisposing the individual to formulate interpretations that are linked to his own cultural models. The individual, however, can exercise control over his own criteria for knowledge gathering and evaluating. In order to do so, he needs to be cautious and self-critical and to have a general—as well as a particular—knowledge of the “other” (Lanternari, 1983, p. 21).

In a cultural encounter, the experience of being faced with a person who has different values, and a different perspective of the world, has the advantage of throwing light on one's own values and perspective, which normally remain implicit. In the ethnographic encounter, according to De Martino, a "double thematization" is accomplished, involving one's own interpretive categories as well as those of others. A relevant consequence of this is the equalization of the relationship between the ethnologist and her informant—through its transformation from a subject–object relation into a subject–subject partnership.

Culture and mental disorders

For De Martino, mental disorders and culture are mutually exclusive. Mental disorders imply the dislocation of subjective experience from one's own cultural context. Individuals with mental disorders do not participate in the "inter-subjective valorisation" (De Martino, 1977, p. 50) of events and everyday objects performed by the other members of their community; they are instead isolated in their own private experience, which they are unable to communicate. Health, for De Martino, is connected to a "perspective of functionality that is socially and culturally conditioned" (De Martino, 1977, p. 50), and it is through this perspective that the behavior of an individual takes on an intelligible meaning for other individuals in society.

The human subject (which De Martino calls *presenza*, "presence") is configured, following the teachings of Heidegger (1927), as a being-in-the-world (*Dasein*), and this being-in implies a moral energy that is manifested by the recognition of inter-subjective values within one's own culture. The world of mental disorders, for De Martino, cannot be considered to have its own culture because it is not built on a tradition that is recognized and shared by others. Indeed, mental illness is a sign of the collapse of culture itself as a possibility (De Martino, 1977, p. 170).

Throughout his work, De Martino constantly places historical analysis of cultural phenomena in contrast with psychopathological data. He maintains that the research conducted by cultural historians and psychopathologists, are complementary in that the evaluations of the one and the judgments of the other are two sides of the same coin. For the cultural historian, psychopathological analysis is important because it demonstrates the risk of mental disorders against which cultural institutions must fight (De Martino, 1977, p. 63). The psychopathologist, for his part, must use historical judgment to restore the morbid episode in the individual biography of the patient, and the patient's biography must give a certain historical-cultural context.¹ For De Martino the distinction between health and illness is a based on a historically and culturally specific judgment. Individuals become ill inside of a particular cultural horizon, and every culture is engaged in developing methods for dealing with the risks of psychopathological crises.

Responding to attempts by phenomenological psychopathologists (for example, Binswanger, 1957; Minkowski, 1927) to reconstruct the characteristic modes of existence in severe mental disorders, De Martino critically poses the question of

whether it is legitimate to talk about a “world” in the case of the mentally ill. De Martino, who is sometimes rather critical of phenomenological psychiatry, specifies that the concept of “world” can be extended to psychoses only by the most general acceptance of the connection between meanings and relationships in which man lives and is “at home.” In this sense, it is always possible to trace a world that is implicit in behavior without recourse to the unified consciousness that one has of it (De Martino, 1977, p. 42). Nevertheless, the “world,” in the true sense meant by De Martino, is made up of intersubjective values, and “normality” requires that actions fit into a socially and culturally conditioned framework. Moreover, in De Martino’s view, if a world loses its historicity, that is, if it loses a good proportion between the “private” and the “public” dimensions of existence, it loses its “normality” (De Martino, 1977, p. 50). While the diagnostic categories of human mental disorders list the ways in which people lose contact with a common world and with historicity, it is cultural institutions that enable us to face such critical moments in the world. The struggle against this risk identifies man as the founder of cultural life (De Martino, 1977, p. 75).

For De Martino, schizophrenia confronts us with the extreme risk to which human existence is exposed: the collapse of the ethos of transcendence. For this reason, schizophrenia is the most “philosophical” of the diseases (De Martino, 1977, p. 75). For the schizophrenic person, the loss of the power to transcend his own situation is directly proportionate to the loss of the ability to situate herself in a world of shared values; he passes from acting to being acted upon.

Being-in-the-world, for De Martino, is identified with cultural life itself. As such, the worlds of mental pathologies can only be understood as the risk of being unable to be in any possible world shared with other persons. These psychopathological worlds shed light on the immanent risk to the cultural order itself and foreground the sense in which culture is a being-in-the-world made up of individuals’ choices with an eye to participation in a socially shared world (De Martino, 1977, p. 169).

Psychopathological “worlds” in phenomenological psychopathology

De Martino identifies a valuable clinical tool for entering into contact with the culture of the other, putting us on our guard, however, by reminding us that the nature of the being-in-the-world of people afflicted with mental disturbances is not really *cultural*. This prudence comes from a consideration of the risks involved for a correct anthropological analysis, but it fails to adequately consider the potential implications of the stigmatization it produces. From our point of view, it is legitimate to speak of “culture” and “world” even in reference to the most serious mental pathologies, as is the case of schizophrenia.

Although well aware of the caution required in using these terms in discourse on mental pathology, we maintain that there can be a series of risks—both on the ethical and the clinical levels—in not considering the various forms of mental

illness as so many worlds and, therefore, cultures. Let's take the example of schizophrenia. On the one hand, failing to perceive the peculiar "difference" of the schizophrenic experience, in comparison with other mental disorders (personality disturbances or neurosis, for example) means denying that persons with schizophrenia live in a *sui generis* life-world, similar to that described by phenomenological psychopathology (Binswanger, 1957; Blankenburg, 1971; Fuchs, 2000, 2010; Jaspers, 1913; Minkowski, 1927; Parnas et al., 2005; Ratcliffe, 2008; Sass, 1992; Stanghellini, 2008; Wyrsh, 1949). On the other hand, refusing to recognize that the schizophrenic condition has the character of a culture leads to a series of repercussions in both the clinical and social encounter. On an ethical level, it results in delegitimizing the other values demonstrated by people with schizophrenia. Moreover, by not considering the other as a bearer of values in the clinical setting, we preclude the possibility of reciprocity and communication.

In the case of schizophrenia, the schizophrenic patient has an *idios kosmos* (a private world) that is, nevertheless, real culture. Although private, this world nevertheless demonstrates certain typical elements that make it resemble the worlds of other people with schizophrenia (Stanghellini, 2008). It can be considered a *culture* insofar as it is made up of certain values (Stanghellini & Ballerini, 2007a), a distinctive experience of the other and a particular concept of sociality (Stanghellini & Ballerini, 2011a, 2011b). An accurate characterization of the schizophrenic person's value-structure can be found in early phenomenological literature (Berze & Gruhle, 1929; Binswanger, 1956; Blankenburg, 1969, 1971; Kretschmer, 1921; Minkowski, 1927) where all agree that the basic principles guiding individuals with schizophrenia include: (a) every force coming from without the self is feared as an attack on one's own individuality and a danger for one's sense of selfhood; (b) autonomy, i.e., self-determination, as well as faithfulness to oneself and to one's own exceptionality are proclaimed as the most important values; (c) abstract or "philosophical" principles to govern one's life are actively searched for; and (d) feelings of intuitive attunement to the present concrete situation, and skills to shape knowledge in a contextually relevant manner, are disparaged.

The clinical application of the ethnographic encounter

De Martino demonstrates how the problem of method in liberating oneself from the natural ethnocentric attitude, implicit in the evaluations that Western science gives of non-Western cultures, assumes a particular significance in transcultural psychiatry (on cultural aspects of the psychiatric interview see Bäärnhielm & Scarpinati Rosso, 2009; Kirmayer, 2007; Krause, 2006; Mezzich, Caracci, Fabrega, & Kirmayer, 2009; Tseng, 2003). Critical ethnocentrism can contribute to clarifying the distinction between normal and abnormal, the determination of an anthropological criteria of psychic "risk" in any culture and the culturally conditioned forms that this risk assumes (De Martino, 1977, pp. 171–172). Transcultural psychiatry has as its objective the coordination of the concept of culture with the conceptual pair "normality–abnormality" (Devereux, 1970).

In De Martino's view, we cannot assume as the theme of our research the behavior of a person belonging to another culture without in parallel thematizing the behavior prescribed by our culture in an analogous situation. This self-reflective practice necessarily requires a comparison with the other. Regarding these two terms alongside one another leads to a refusal to see one or the other as the sole criteria of normality; the two terms must reciprocally illuminate each other (Kilani, 1992). *Ethnography, then, is a fitting metaphor for the clinical situation* (Hocoy, 2005).

The following are some of the parallels between the ethnographic and clinical encounters:

- Like the ethnologist, the cultural orientation of the clinician comes into play in the selection of symptoms that are clinically relevant. This occurs prior to the attribution of meaning to certain signs and symptoms and the formulation of a diagnosis.
- Like the ethnologist, the clinician cannot refrain from applying labels, without which he would be unable to transmit and translate into practice the knowledge that he has accumulated (Stanghellini, 2009).
- Like the ethnologist, the clinician can “improve—*by measuring*—the very units of measurement and the very tools for measuring” (De Martino, 1977, p. 273) that he has at his disposal, and by readjusting his own categories of evaluation through a systematic comparison of that which he knows and lives with the knowledge and lived experience of the other (Stanghellini, 2004).
- Like the ethnologist, the clinician needs to be aware of the difference between his own perspective on a given phenomenon and the other's perspective. If, and only if, there is awareness of difference (rather than analogy) of perspectives, it is possible to validate the other's vision, and to avoid labeling the other while he goes on along his own logical-emotional path.
- Finally, establishing an analogy between the ethnographic and the clinical encounter prevents us from uncritically accepting the view that the other has of reality and in which he feels entrapped.

Transcultural psychiatry has done much to understand both the cultural shaping of mental illness and the ways in which the culturally specific assumptions of the clinician or researcher may shape her understanding of pathologies in a different cultural setting. An example of noncritical ethnocentrism is the prejudice shown by Western psychiatry in evaluating depression in African cultures (as described by Beneduce, 2004, p. 29). An implicit anthropological model that dominates practice in much Western psychotherapy tends to consider the mentalization (verbalization and “psychologization”) of emotions as the expression of mature internal awareness, in comparison with a more archaic elaboration, which preferred prevalent somatic codes. When this hierarchy between psychological register and bodily register is established, African populations are considered too immature to express their discomfort in Western terms of depression. An outstanding counterexample

of this typical Western prejudice is Kleinman's influential work in the field of medical anthropology (Kleinman, 1980) as well as his study identifying Chinese "neurasthenia" as depression (Kleinman, 1986).

From critical ethnocentrism to clinical hermeneutics

Cultural prejudice is indubitably less evident when we observe people who belong to the same culture as us, but it is, nonetheless, at work here too. The application of critical ethnocentrism in the clinical setting includes the following:

- Focusing on the patient's subjective experience (rather than mere behavior) as the point of departure of any clinical encounter.
- Encouraging the other to reflect upon his experiences, express them in a narrative format and identify a core-meaning, or meaning-organizer, around which his narrative can become meaningful *for him*.
- Supporting the other in making explicit his personal horizon of meaning (values and beliefs, i.e., "culture"), within which his narrative is set.
- The clinician's making explicit to the other his own understanding of the other's narrative (assumptions, personal experiences, beliefs) as if it were his own.
- Through this process, the clinician also makes his own set of theoretical assumptions, personal experiences, values and beliefs, explicit.
- The clinician promotes a reciprocal exchange of perspectives with his patient, as well as the co-construction of a new meaningful narrative which includes and, if possible, integrates contributions from both the original perspectives.
- The clinician tolerates diversity and potential conflicts of values and beliefs.
- Finally, the clinician facilitates coexistence, when it is not possible to establish consensus.

An excellent example of this approach in the field of psychopathological research can be found in the volume *Schizophrenia, Culture, and Subjectivity* edited by Jenkins and Barrett (2004), which is described as a "systematic effort to advance a cultural approach to the study of schizophrenia that takes the complex phenomenal reality of subjective experience as a starting point" (Jenkins & Barrett, 2004, p. 2). The agenda proposed by Jenkins and Barrett overlaps at many points with our version of critical ethnocentrism as the philosophical framework for clinical hermeneutics, including: the idea that experience is always embedded in intersubjective realms of meaning that are historically and culturally constituted; the primacy of lived experience over categories imposed by any sort of theory; the active engagement of all subjects involved in the process of knowledge construction, and the attempt to create "experience-near" concepts (pp. 7–8).

Sharing the idea that schizophrenia is a particular type of human existence situated at the margins of intersubjectivity and at the very edge of shared meaningfulness (Jenkins & Barrett, 2004, p. 5), Stanghellini and Lysaker (2007) have explored the implications of this view for understanding the workings and potential

of individual psychotherapy for persons with schizophrenia. We see difficulties with intersubjectivity as a core feature of schizophrenia—not as an epiphenomenon, as seen for instance, in standard cognitive approaches. Standard cognitive approaches tend to see positive symptoms (e.g., delusions or hallucinations) and negative ones (e.g., apathy) as examples of inaccurate or dysfunctional perceptions, which lead to social dysfunction, that is, misunderstanding between people and withdrawal (Fowler, Garety, & Kuipers, 1995). In contrast, we (Stanghellini & Ballerini, 2002, 2004, 2007b, 2011a, 2011b) see schizophrenia as a *disorder of the situated self*. We construe schizophrenia as a disorder of common sense (Blankenburg, 1971), that is, as a condition in which the emotional capability to view others as people like ourselves, to feel engaged in a world shared with other people, to establish interpersonal relations with them intuitively and spontaneously, the ability to communicate according to common codes, the capacity to see the social world as horizon of one's own initiatives and one's own plans for life, undergoes a grotesque and paradoxical distortion. Persons with schizophrenia may also lack easy access to the second-person perspective, which enables people to share with others a view of themselves, a perspective necessary for intersubjectivity. As a consequence, we suggest that the therapeutic encounter with persons with schizophrenia may be conceptualized as a “dialogical prosthesis” that helps them move towards recovery by providing a dialogical space. In this space, closer connections between these persons and their emotions, and between these persons' emotions and the interpersonal situations in which emotions take place, can be established. If the basic disorder in schizophrenia is the failure to establish a prereflexive sense of a *situated self*, then conceptualizing the clinical encounter as a dialogical prosthesis promotes the construction of narratives focused on real-world situations (especially You-and-I situations) which explicitly help reconstruct a verbal, narrative-based sense of the situated self.

Highlighting disturbances of intersubjectivity, aiming at achieving a shared partnership, focusing on the here-and-now, You-and-I relationship, and pointing to shared meaningfulness are, in this framework, the main steps of the therapeutic process. The process of therapeutic action is embedded in “moments of meeting” taking place in the intersubjective matrix (Stern, 2004). The process takes place in the liminal space that lies between the therapist and the patient. The rapport between them is one of copresence. In this context, understanding means acknowledging differences as well as similarities, and if possible negotiating a cross-subjective construct connecting two different horizons of meanings. Intersubjectivity is seen as the problem addressed by therapy, not something that improves when other problems are addressed and solved. The benchmark of this intersubjective process is its capacity to enhance the patient's ability to acknowledge the other's point of view, and by doing so, improve the capacity to sense one's experiences as one's own, and reflect upon them, and take an intentional stance on them.

Following De Martino's principle of critical ethnocentrism, we have suggested that the crucial step of the psychotherapeutic process is offering the “You” or second-person perspective (Stanghellini & Lysaker, 2007). If the therapist patiently

keeps offering a second-person view, the patient may evolve a first-person account, assuming an intentional stance over his own experience. This may help the patient begin to recover a sense of subjectivity (first-person perspective over one's experiences and actions) and intersubjectivity (second-person perspective over others).

Conclusion

This paper attempts to reformulate De Martino's concept of "critical ethnocentrism" and establish its relevance for psychiatry, especially in regard to the clinical treatment of schizophrenia. The basic feature of this approach is focusing on the other's *subjectivity* and thinking of the other in relation to his world; that is, understanding his behaviors, experiences, emotions, beliefs, and values as parts of his *lifeworld*. This means connecting him to a horizon of meaning within which his acts become intentional and meaningful, and therefore, comprehensible and open to communication.

According to our version of critical ethnocentrism, this construction of the meanings of another person's acts and lifeworld, is accomplished in the encounter between two subjects, and their respective frames of reference. In this way, we can speak of critical ethnocentrism as the basis for clinical hermeneutics. Hermeneutics is a general theory of comprehension and interpretation of that which is human—in the sense of a philosophical discipline that concentrates on the processes and modes for assigning meaning in the human world (Ricoeur, 1965). Hermeneutics casts light on the fact that understanding is connected to context and has a dialogic structure. It is a path that disentangles itself in the play between precomprehension (determined by psychological structure and cultural factors) and interpretation (Dilthey, 1900). Precomprehension is at work from the very beginning, in the collection and selection of that which is brought by the other. However, through retroactive interpretation, precomprehension can be modified through the introduction of something new and different in the pre-orientation that follows. Interpretation, in as much as it is the actualization of the discourse of the other inside ourselves is, therefore, the meeting point of two subjectivities.

Interpretation is never the product of a scientific or objective method, but rather of our historically and culturally rooted prejudices, that, from the very beginning, influence the meaning of the object that is to be interpreted (Gadamer, 1960). These prejudices, we argue, provide a necessary anchor to our "cultural homeland" (De Martino, 1977, p. 478) conserving within them the traditions and the works of those who have preceded us.

The clinician cannot, and should not, free himself from his precomprehensions, which are tied to his history and to the history of the culture to which he belongs. However, the clinician can put his prejudices to the test in the encounter with the other. In fact, it is often difficult to be aware of one's own prejudices if one does not enter into contact with various possibilities of being-in-the-world. De Martino points out how encounters with other cultures show us ways of being human

that are different from the ones that we ourselves occupy, revealing to us what it means to be human in our own culture. In order to achieve this fusion of horizons, however, it is necessary that we begin with a critical consciousness of the limits that circumscribe our own cultural world. This critical consciousness does not arise from a simple act of self-reflection carried out in the solitude of one's deepest self, but involves instead a "double thematization" of one's own world and that of the other (De Martino, 1977, p. 391). The prerequisites for this comparison are a simultaneous awareness of both fundamental differences and shared belonging to a common humanity. The patient's "culture" and that of the clinician are not irreconcilable. The hermeneutic dialogue implies, in fact, a tension between radical alterity, or incommensurability, and identity. In this way, and only in this way, the clinician may become a "You" for his patient, since if the *interpretandum* were completely incommensurable, the hermeneutic enterprise would be condemned to a checkmate. If it were completely identical, there would be no sense to making an effort at interpretation. Being a "You" means to acknowledge the other's perspective, and to be open to a reciprocal exchange of perspectives without requiring either party to renounce their rootedness in a world and culture. This "opening" is based on the presupposition that neither clinician nor patient has an advantage of truth over the other. Considering the perspective of the other as meaningful—that is, considering him as a spokesperson for his own *culture*—and, therefore, being willing to call one's own assumptions into question, is the prerequisite for authentically entering into relations in every type of human interaction, including everyday life. In so doing, we help the other to recover and develop a sense of subjectivity and intersubjectivity.

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Note

1. On "culture and psychiatry" as meaningful conjunction for debate and research see also Lucas and Barrett (1995).

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