Exile is a painful condition common, in different degrees, to every human being. The author's vast clinical and trans-cultural experience could teach the reader how to learn from exile. He worked in Argentina, Israel and Canada with children, adolescents, families and couples. Along the lines that describe the evolution of the author's thinking trough his articles and the life circumstances surrounding them, the reader will learn about the possibility of benefiting from the basic dialectic of **being out-in**, typical of the exile experience. To be able of being **out** of allegiances to theoretical models and professional accepted roles allows us to be **in** touch with the need of patients and communities that always present us with new changing clinical realities. Exile has the possibility of making us more efficient in dealing with novelties. As exile could also be, at least partially, a self decided event, emigrants have to learn to accept the novelty of the new place that is neither better nor worse than the old one but a complete different game.

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Learning from Exile

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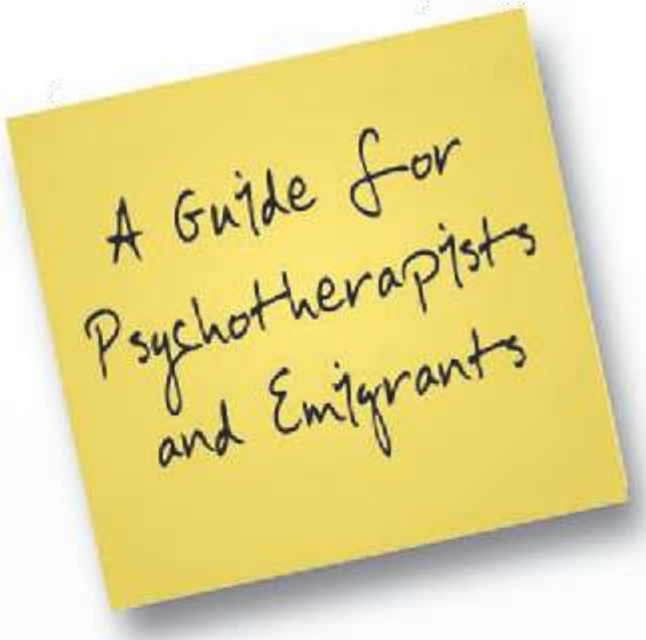

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LEARNING FROM EXILE:

A GUIDE FOR PSYCHOTHERAPISTS AND EMIGRANTS

By José Stelzer

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INTRODUCTION

It is for man to arrange his feelings.
—Proverbs 16:1

"Unhappiness is much less difficult to experience. We are threatened with suffering from three directions: from our own body, which is doomed to decay and dissolution and which cannot do even without pain and anxiety as warning signals; from the external world, which may rage against us with overwhelming and merciless forces of destruction; and finally from our relations to other men. The suffering that comes from this last source is perhaps more painful to us than any other. We tend to regard it as a kind of gratuitous addition, although it cannot be any less fatefully inevitable than the suffering which comes from elsewhere."

Freud's quote could be considered an attempt to taxonomize the mental health profession, a way of classifying its professional activities according to the origins of the suffering it examines. Psychotherapy would be the activity related to the third kind of suffering mentioned by Freud. It could be defined as a professional activity leading to the understanding and alleviation of the human suffering caused by human interaction.

Gordon Lawrence explains us how mankind, mainly after WWI entered into a process of denying tragedy. He says: "To anticipate my argument: tragedy, ranging from disappointment through loss to death, is constructed by people as an intrusion in their lives; an impertinence of fate. Tragedy, we have come to believe, is not supposed to happen and is to be wished away. Life should be trouble free. We

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1 Freud, S. Civilization and its discontents.SE, Strachey J. London The Hogarth Press and the Institute of Psychoanalysis p 77.

have come to believe in the pleasure principle even though we know within ourselves that it is false."[2]

Today, we have reached the point where a cultural denying of tragedy and of expecting immediacy in getting happiness has caused an epidemic of depression and drug abuse, especially among the adolescents with whom I work.

This book will not be like other current books that promise readers some kind of happiness or fast help with solving their problems. On the contrary, it will look closely at suffering and the denial of tragedy. This book also deals with my experiences of learning through my own suffering during my work at different academic and clinical institutions in different medical cultures. Looking back, I can now see the advantage of not writing about my experiences then. I may have lost some actuality over the ensuring time-space passage, but the advantage of waiting these many years is that the writings are less influenced by anger and despair. They are based more in realizing my ignorance of the institutional rules of the places in which I worked, and I feel more able to transmit my experiences and newfound understanding of them to others.

When I talk about suffering I include traumatic situations. The writings compiled here are the result of trying to make sense of all kinds of traumatic experiences I suffered both during my training and work and through emigrating. To my way of thinking, traumas are like cognitive-emotional cold showers: they surprise us. We are not prepared for dealing with something new, unexpected, frightening, shameful, etc. Trauma is the concept of crisis: suffering but with an opportunity to learn (sometimes a lot) from it.

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2 Lawrence, G. Tragedy: Private trouble or public issue. Psychoanalysis and the Public Sphere Conference, November 18, 1995.

From this perspective, I like to say, “Poor the people who have not experienced trauma in their lives.”

My desire to share what I had to learn makes me think that according to some General Plan I was supposed to be a journalist, reporting to a general audience my understanding as to how medical institutions operates. As if I infiltrated the medical profession – as a physician, psychiatrist and psychotherapist – so that now, almost forty years later, I can spread the news about its problems.

On the Book’s Structure: Drawings and Frames

This book has two parts. The first part consists of my already published articles, most of them written during my moments of suffering and as an attempt to understand what was going on in my professional life at that time. The second part consists of a recounting of personal events surrounding the writing of the professional articles. Even though my professional articles are written in a non-scientific way, they lack a connection with my life events then coinciding with them.

Once I had the opportunity to know an important Canadian painter, and he allowed me see his art. Then, the drawings and paintings I was looking at were unframed, but by listening to him and being with him we “framed” the pictures inside his life experiences. He used to feel very lonely, as if abandoned by colleagues and friends who did not support him in his getting his work exhibited. The main thing they wanted from him was that he be sober, “normal”. Shortly after his death, I was invited to a posthumous exhibition of his works, where I finally saw them framed; someone had paid for the

frames. When I looked at his paintings and drawings, now framed, I felt not only that the painter was dead, but that his work was also dead. Instead of the "frame" of a living history surrounding the drawings and paintings, I saw pieces of well-finished wood and metal.

This anecdote serves as a metaphor for what I want to do with this book: I want to frame my professional articles with both my working and interpersonal life experiences that surrounded them. In this book, I flesh out the skeleton of my already published articles with my institutional and interpersonal experiences of many working years. Knowing the author's personal circumstances surrounding the creation of his/her writing has always helped me understand them.

On the Book's Content

In addition, I want to transmit a few ideas on how to improve mental health practice and, maybe, hopefully, the general practice of medicine. My desire is based on the experiences of more than forty years trying to solve clinical problems faced in three different countries in which I worked (Argentina, Israel and Canada).

Most of the institutions in these countries are structured in ways that don't foster either efficiency or the highest of ethical values. The methodologies used to solve human problems are based on old epistemologies that are in need of urgent change. Nevertheless, I live with the hope that acquiring wider knowledge of the need for change by young professionals, and even laypersons, may produce needed changes. What's needed are a different kind of therapeutic attitude and a different therapeutic role, both to be based on a conception of clinical activities, as a cultural build-up between patients and professionals.

Two other aspects of the book should be taken note of. One is the institutional aspect of the mental health practice I observed in the three countries in which I worked: in Argentina during the 1960s and part of the 1970s, in Israel from the late 1970s until now, and in Canada from the mid-1980s to the present. I am a living example of what Arthur Kleinman would consider an experiment on his ideas of health cultures: how combinations of patients and professionals produce different pictures in different places and times. The second aspect is the description of some new therapeutic attitudes and models that I developed with the objective of solving clinical problems in those different national settings. New clinical problems required new solutions, and, when they were experienced we needed different listening attitudes and new therapeutic roles. Likely these two other aspects are related.

The image I want to convey is that of a road with obstacles that need to be removed in order to allow for beneficial change. The first step is gaining an awareness of the existence and nature of the obstacles. To the known epistemological obstacles for solving problems, we must add the administrative and emotional ones. All of them go together in a kind of structured pattern. Also, clinical problems are structured in patterns of cultural arrangement among patients, professionals, training institutes and national characteristics.

We professionals will have to think about how to articulate all this. We will have to imagine a new way of working, training, and relating to human problems. The ideal situation I have for my book is that it will enter the mass media and help bring about new people with new personalities joining the health field.

The very fact that health, and even its theoretical models, can be merchandised should caution us about allowing perverse

personalities in perverse institutional settings jeopardize effective new ways.

Who Will Benefit from this Book?

I tell the story of my professional life, and this story may be useful for psychotherapists and for anybody else interested in institutions
related to medicine.

My younger colleagues may find my observations and recommendations useful, particularly those professionals who, because of either a lack of experience or because they live in underdeveloped places, idealize famous and prestigious teaching hospitals, universities and training institutes. These readers could, through my papers, follow my development and discover new ways of thinking and technical attitudes to help solve new clinical realities. The latter point in itself could justify the entire book, because learning through prior experience is, unfortunately, too seldom followed. To the contrary, each therapeutic method usually attempts to keep the same so-called “tried and true”, even if it the approach has not solved any problems. The book should also be useful to those who want to solve patient and community problems and who understand that there is always a continuously changing reality that lies beyond theoretical established models and professional allegiances.

The book may also be of benefit to new or prospective emigrants. Sometimes people emigrate to save their lives. Others, as semi-elective decisions, move because of a real or perceived lack of opportunity. In the latter instance, idealizations and misconceptions about the new place are almost always present. By sharing my own experience as an emigrant, I hope to help people understand that emigration

involves a total change of structures, and that the new place is neither better nor worse than the previous one - it is simply different, a completely different situation.