Community therapy:
A participatory response to psychic misery

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(with reflections from David Denborough and Cheryl White)

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This collection introduces 'community therapy' which has been developed in Brazil to respond to various forms of social suffering and 'psychic misery'. The collection includes an introduction to the history, key tasks, and stages of a community therapy gathering; a description of one example of a community therapy meeting; and a brief exploration of how ideas from narrative therapy have been introduced into community therapy practices.

Keywords: community therapy, local knowledge, outsider witnesses, Brazil, externalising, communitas, narrative therapy

INTRODUCING COMMUNITY THERAPY

Adalberto Barreto

Community therapy involves respecting two different forms of knowledge: academic knowledge and local knowledge. I believe that the exclusion and diminishment of people's local knowledge is a key contributor to psychic misery. When people's local knowledge is devalued, this leads to an interiorisation of misery: misery becomes an internal experience. In some ways, psychic misery becomes a problem of faith. When people no longer have a belief in themselves, or a faith in their own knowledge, this brings psychic misery. And the situation is made worse if they seek assistance from people who only value academic knowledge and do not value local knowledge. One of the key tasks in responding to psychic misery is to enable people to believe in themselves – to assist others to have faith in their own knowledge.

A BRIEF HISTORY OF COMMUNITY THERAPY

My brother is a lawyer who was often consulting people from poor communities in Fortaleza in the north east of Brazil about legal matters. Where there were psychic repercussions, psychological difficulties, related to these legal matters, he would refer them to me as I was working as a psychiatrist in a university hospital. One day, at the university hospital, eight people sent by my brother turned up to see me and my students of psychiatry. I realised on this day that I wasn't going to be able to keep up with the numbers of people who wanted to speak with me so I decided that next time I would take my students of psychiatry and we would go to the favelas (shanty towns). We would see the people in their own context. The next time, however, when I arrived in the favelas with the students, 33 people turned up for the consultation and I didn't know what to do. I didn't have any medicines to give them and so this situation meant I had to start speaking in a different way.

I said, 'Look, I can't come here to cure any disease that you have. Instead, I've come here to cure my own disease'. The people looked at me in a very funny way and then I said, 'Are you happy with the doctors that you see, the doctors who see you?' And they said, 'No. They don't look at us. They don't touch us and they don't stay with us'.

I replied: 'Well, look, I am their teacher. I teach these doctors and these people who come to your community and so I want you to teach me how I can make them more effective. I'm here to cure my disease. I'm here to cure my university alienation. I'm here to cure myself from the idea of that I should know everything. Because when we come here we realise we don't have the medicines to give. We also realise that each one of us has knowledges: there are African knowledges, Indigenous knowledges and experience. I'd like to find a way that we could share our knowledge in this context. I'm no longer coming here to solve your problem, but to solve mine. Perhaps each one of us can solve our own problems, and perhaps the only way we can do this is through a community relationship'.

At this point, we started having a broader public conversation or public consultation. People started to speak about the particular difficulties that they were currently experiencing. One woman said that she was unable to sleep because she was having visions of killing her husband. At first, I tried to prescribe her some sleeping pills, but the woman said, 'Look, you've given me this paper, this prescription, but it's actually no good for us. I don't have the money to buy the medication that you've prescribed. The only good that this prescription could possibly do, would be if I made some tea out of the paper it is written on. That's how useful this prescription is for me'.

At this point I said, 'Okay, that's not so good', and then I asked the group, 'Well, how many of you here have had difficulties with sleeping?', and many different people in the favella at that time said that they had had difficulty sleeping. I started asking them, 'Well, what did you do?'. One person said, 'Look, I had trouble sleeping when my son left the favella and went to Sao Paulo but I used this certain tea to calm me down'. Another one said, 'I used massage'. Another one said, 'I spoke with my friend each night before I tried to sleep'. There were many different ideas, many different expressions of local knowledge, that were shared. I was taking notes and was very impressed.

This was the moment when I realised that solutions could be found within the communities. This was the moment I realised that there was an alternative to imposing my solutions. Why did I have to prescribe? This was the starting point of trying to

think about a systemic form of 'community therapy' – one that would integrate the knowledges developed by community members through their lived experiences. This is where it began. We started to hold regular meetings in the favela. After five years of doing so, we then analysed what we'd been doing and tried to find a theory to explain what had been taking place in these meetings.

KEY TASKS

When we analysed what we had been doing, we realised there are a number of key tasks that we are trying to achieve:

(i)   To move from nurturing dependence to creating autonomy.

(ii) To break from a professional tradition in which information is concentrated and held by the technician or the professional and instead to create a context in which information about healing circulates among the people.

(iii) To rescue and honour knowledge from African and Indigenous Indian ancestors rather than to domesticate and colonise the knowledge from these traditions. We wish to break from western psychoanalytic metaphors and to instead base our work on metaphors that are indigenous to Brazil and to Africa. For instance, the primary metaphor for community therapy is that of the spider web.

(iv) To develop a very efficient approach that can reach many, many people.

(v)   To respond to and prevent suffering. This is a citizen's task. Western psychology and psychiatry has developed as a response to pathology. It is therefore based on concepts of disease, treatment, and hygiene. Treatment is seen to be done by professionals in a private space with fixed chairs and a concern about hygiene. While professionals are trained to respond to disease and to pathology, to respond to suffering is a task beyond professionals. To respond to suffering and to prevent suffering involves responding to the soul. It involves comfort and a communal space. This is a citizens' task. When Western pathological models are used to respond to suffering, this medicalises suffering. We are refusing to medicalise social problems. We return the role of responding to and preventing suffering to citizens.

(vi) To uphold mutual respect between popular knowledge and scientific knowledge. These different forms of knowledge can complement each other. We respect Western medical knowledge in relation to responding to pathology and we respect local knowledge in relation to suffering. This includes linking with traditional healers.

(vii) To create a participatory model for responding to social suffering. Sustaining mental health is a plural dynamic process. We are interested in moving mental health out of a private space into a public citizens' space where each person can become a lead actor in communal and collective health. Within community therapy we are interested in giving renewed value to social participation and to contexts of belonging. We are looking to participatory solutions which enhance solidarity networks.

(viii) To move beyond professionalism. We are moving to end the mania of trying to cure people and we're determined to create an approach in which there's no need for facilitators to have a university background. Community therapists are performing citizen tasks and so there is no need for this to be professionalised.

THE STAGES OF COMMUNITY THERAPY

Community therapy is organised through a public ritual which consists of eight stages. These community therapy rituals or meetings occur in public spaces such as schools, churches, and local community centres. The larger meetings can involve hundreds of people. However many people are involved, the process lasts approximately one-and-a-half hours.

STAGE ONE: WELCOMING AND WARMING UP

The welcoming lasts for about seven minutes and evokes various rituals to build a collective ethos. We might celebrate those people who have had a recent birthday, or acknowledge the

significance of a recent public holiday that represents a particular history in the life of the nation. The welcoming often involves some activity in which people make physical contact with each other because this fits with Brazilian culture which is very tactile culture. The welcome often also involves a song and a clapping and joining of hands. This welcoming process builds a collective ethos.

The facilitator will then introduce the following rules:

- No counselling, judgement, or advice is to be given.

- People will be silent when others are speaking.

- No interpretations or analysis of what people say will be offered. It is only possible to ask other participants questions.

- When people are speaking, they will talk using the 'I'. They will speak from their own experience, things that they have lived already.

- At any time during the meeting, it's okay to propose a song, a story, a poem, a joke, or a proverb if what has been spoken has suddenly brought this to your mind. These offerings are to be short, but if you suddenly remember a song or a proverb or a poem that is linked to what someone is saying, then you can share these folk cultural propositions.

STAGE TWO: SELECTING A THEME

This stage involves choosing the subject of what this community therapy session will focus on. When working with a community of people it's important to acknowledge that different people will relate to life through different mediums of communication. The facilitator will often begin this stage by saying something like: 'Now were going to talk with our mouths but later we'll communicate in other ways'. The facilitator then describes that in order to choose the subject for this meeting, we need to hear some examples of difficulties that people are currently experiencing. Various participants will volunteer to share a short example of a difficulty, a form of suffering, that they are going through. The facilitator is very clear that this is not a forum to disclose secrets. They say something like: 'This is about

routine problems. If you have secrets, well keep them secret. Don't share these at community therapy'. One of the other phrases that facilitator's might use is, 'Do you have any concerns? Is there something that is making you sleepless at the moment?'

After four to six people have given an example of a problem they're facing, the facilitator will then set up a vote. Everyone will vote on which theme that has been mentioned they would like to see the meeting address. Participants also have to justify why they choose this particular theme. Each possible theme is voted on and everyone justifies why they have made a particular choice. People can vote for their own theme.

STAGE THREE: CONTEXTUALISING THE THEME – LINKING SUFFERING

Whoever's theme received the most votes is then asked to speak for about ten minutes to describe in more detail what they've been going through. During this process of contextualisation, anyone in the group can ask this person questions. Participants' questions enquire about the person's feelings and responses to certain situations in ways that make links with other people's experiences (see stage six).

After the theme has been contextualised, it is the facilitator's role to negotiate the theme into a form that will be resonant for others. The theme is turned into a question for the group to respond to. This is a key part of the processes. In stage five, a participant will have described in some detail a personal difficulty that they're going through. Now it's the facilitator's role to negotiate with this person a name for the problem that will be resonant for others. For instance, if the problem was initially called 'sexual abuse' then this might be re-named as a 'violation of rights'. The question for the group might become, 'Who amongst us has experienced a kind of violence in which our rights have been violated? And how have you endured this?' Alternatively, if someone initially said, 'I have AIDS', then in the contextualisation stage they would be asked questions including, 'What do you feel or fear in relation to this experience?' When they answer, 'I have a fear of discrimination', the theme may be problematised as, 'Which of us has been discriminated against for whatever reason? And how have you dealt with this?' Or, if the personal theme

that has been contextualised is about loss, the facilitator might say, 'Who has had a big loss? Who has lost lovely people in their lives? And how do you remember them?' This stage involves negotiating a definition of particular suffering in ways that others will be able to join with. The theme for the meeting is derived from individual, personal experience, but is carefully named in ways that others can then join around.

STAGE FOUR: SHARING OF LOCAL KNOWLEDGE

Once the problem has been named in a way that will be resonant to others, the facilitator puts this out to the group with questions like: 'Who else has lived a similar situation?', 'What have you done to respond or resolve this?', 'Throughout your dealing with this situation, what has not been destroyed?' Participants share stories, local knowledge, and memories for the next 45 minutes.

Within this part of the process, the facilitator has a number of responsibilities. If this sharing ever seems to be focusing on the negatives, then it is the facilitator's responsibility to shift the sharing from the negative to the positive. For instance, if the group is sharing stories about significant losses they have experienced, then halfway through the 45 minutes the facilitator might swap the way they are asking questions. They might start to enquire: 'What's the best story you know about the person who has died? What did the death not destroy in your life? What has not been destroyed by this death? What has carried on?' In this way, the dead are resurrected.

Similarly, if the theme is jealousy, the question posed to the group may be, 'Who else has lived with feelings of jealousy and how have they resolved this?' If the first 20 minutes of sharing has been around experiences of jealousy, then the facilitator may ask 'What have people done in their relationships with friends that have taken the place of jealousy? Or people who have no problem with jealousy, can you share with us what you do in your relationships?' And then people might start to share different sorts of stories. In these sorts of ways, half way through this stage, the facilitator takes some responsibility to move the sharing from more negative aspects of the theme to more positive aspects. Balancing the negative and the positive within the session is one of the facilitator's responsibilities.

Facilitators also take care to ensure that skills or strategies of overcoming are not located in an individual or an expert. Instead, these skills and strategies are located in the collective. Facilitators also speak about how overcoming obstacles is more about 'perspiration than inspiration'.

STAGE FIVE: CLOSING RITUAL

The meeting ends with some sort of cultural ritual of conclusion which emphasises solidarity, the rhythms/cycles of life, or a certain sustaining theme that has emerged during the meeting. Participants are asked to speak about what they will be taking away with them from this particular meeting.

REFLECTIONS

This process isn't group psychotherapy. We're not trying to come up with answers for participants. In fact, through these collective conversations, we're trying to make it possible to doubt certainties. We often have more questions than answers at the end. And these meetings are not looking for consensus. Any search for consensus will destroy what we are trying to build. Instead, this is about a shared space of suffering. We are questioning the idea of the enlightened individual and are working instead from collective inspiration and perspiration. This is a process of offering and sharing strategies of dealing with suffering, so it's not about confidentiality. It's a public space approach which enables participants to become the doctors of their own experience. This is also a process of awakening memory. We are trying to awaken memories, to assist people to remember what they have forgotten.

AN EXAMPLE OF COMMUNITY THERAPY

Described by David Denborough & Cheryl White

The example of community therapy we witnessed occurred one evening. We were gathered together in a church in Salvador, Brazil, and about one hundred people were sitting in large circles. As the welcoming took place in song and ritual, special mention was made of the two Australians! Recent birthdays of participants were celebrated and we were invited to join hands as a song was sung.

A small band was on hand to provide the accompaniment. It was obviously a well-known song as everyone joined in with strong voices.

After the rules were shared, participants were invited to voice the topics they would like to speak about. A number of current sufferings were shared. One person said, 'I have a concern that my dream is not going to become true. Because I cannot find work, I am concerned that my dreams for my life will not come true'. A second person spoke about fights and conflict in the family with her sister. When the facilitator asked, 'How do you feel about this?', she said, 'Depressed. I've done everything I can and the misunderstandings continue'. The facilitator (Dr Adalberto Barreto) then asked, 'So this is about not being understood?', and the woman said, 'Yes, not being understood by my sister'. These first two themes ended up being named as: 'Not to have my dream come true' and 'Not being understood by my sister'. A third person then spoke of 'Feeling rejected and not loved by my mother'. These were the three themes offered by participants.

Before the vote was taken, the facilitator said, 'Look, we're going to vote now to decide which theme we're going to focus on. Whichever theme gets the most votes doesn't mean it's the most important. It just means it's the one most of us can relate to tonight'. As it turned out, the first theme received 24 votes, the second theme six votes and the third one, 'feeling rejected and not loved' received 46 votes. This was the theme that the meeting then focused on. The facilitator took care to say, 'For the two of you who didn't get the votes, I will be available for conversation afterwards'. From what we could gather, however, neither of the people took up this offer.

We now moved into 'contextualising' the theme. Some of the questions that the person was asked included:

- Is this feeling of rejection old or new?
- Is it as old as your life, like from when you were born?
- What have you done to keep going?
- Throughout this time, what did you feel and what did you think?

At one point in this process, a participant mentioned that something in the conversation had reminded them of a particular strong women's song. And so, the facilitator proposed that this song be sung. The band started up and everyone launched into song. This was a powerful moment. It was clear that this song and the collective singing brought solace. But it also provided a powerful way of moving from the individual voice to a collective expression. Throughout the evening, at key moments, the sharing of proverbs, song, jokes, and songs, would transform the meeting. These forms of cultural expression would move the ritual beyond the sharing of individual experience and into an experience of *communitas* (Turner, 1969, p.96). A sense of 'unity in diversity' would be invited in these moments (Freire, 1994, p.157).

When the meeting moved into stage seven, participants were asked to share their experiences of not being understood or being rejected by others, and how they have dealt with this. One man spoke about being rejected by his brothers. He was then asked questions by other participants and by the facilitator:

- What did you do first?
- Did this help?
- What helped you to strengthen yourself?
- Was there a sentence or a thought that you told yourself?

At this point he said, 'When I was feeling most rejected, I would sing to my child the song "I will not let you be hurt again"'. And at this point, everybody started to sing this song about children. This is an inspiring song and it lifted the group's spirits aloft. Towards the end of stage seven, a funny moment occurred when someone said, 'Dear Lord, as I cannot lose weight, please let my friends gain weight!' Everybody burst into laughter.

When the meeting closed in ritual and in song, the atmosphere was one of goodwill and connectedness. As Dr Adalberto Barreto describes, it was as if a public space of shared suffering had been created, local knowledge had indeed been respected and rescued, and memories of sustenance had been awakened and circulated.

What will we be taking away with us from witnessing this community therapy event? A sense

of excitement and hopefulness about what community therapy could contribute in other contexts, other countries. And a sense of intrigue about what elements may need to be adapted, changed, improvised so that the process is resonant in other local cultures.

THE INTRODUCTION OF NARRATIVE IDEAS TO COMMUNITY THERAPY

Marilene Grandesso

Marilene Grandesso is a Brazilian therapist and community therapy facilitator. The largest community therapy event she has facilitated was for 1400 members of the police force. There are many ways in which Marilene is now using ideas and practices from the field of narrative therapy and collective narrative practice as she facilitates community therapy meetings. Here Marilene describes some of these explorations. She can be contacted c/o mgrandesso@uol.com.br

EXPLORING THE EFFECTS OF AN EXTERNALISED PROBLEM

As facilitators, when we're contextualising the theme that is to be focused on, we will ask questions that externalise the problem and that explore the effects that this problem has had on the person's experience. We ask questions that trace the effects of the externalised problem on the person, on their relationships, and on their sense of the future. For instance, we can ask questions such as, 'How has this problem affected your life? How has it affected your relationships? What are the effects of this problem on your sense of your future, on your dreams, and your goals? How does this problem affect your ways of looking at yourself as a woman?' Through these sorts of questions, people can paint a detailed picture of the effects of externalised problems on their lives and relationships.

NOT LOCATING THE PROBLEM IN PEOPLE

During stage six (problematising) we negotiate a shared understanding of the problem, or form of suffering, and pose a reflexive question that is likely to be resonant for many people within the meeting. How the theme or problem is named in stages two (selecting the theme) and three (contextualisation)

is a very important part of the process. It is here that we must take care in relation to the politics of experience. We must also ensure that problems are not located within people. For instance, if someone has named that they 'don't feel loved by their mother', we must take care that the session doesn't get taken up with mother-blame. Similarly, if someone says, 'I would like to talk about a problem with my husband', then we have to ask a few questions in order to try to negotiate a description:

(i) that is more near to her experience, that is more particular,

(ii) that is going to be resonant for others, and

(iii) that is not totalising of the husband, or mother, or of any other person.

The question that is put to the group in stage six is an invitation that will open particular horizons. We must consider what horizons are opened by the question we ask. The definition of the problem needs to be co-constructed in such a way that it will not lead to negative talk about others. This is the responsibility of the facilitator. If a person starts blaming their mother, and others join in a way that could escalate this, then the facilitator must take responsibility to ask questions that open horizons away from mother-blame.

Generating the shared theme is like preparing the earth before putting in a seed. This process involves creating a sense of connection through feeling and meaning. As a part of this, the facilitator takes care to construct the theme and the question in terms of how people have *responded* to the particular problem being discussed, and what skills they have used to do so.

GENERATING RICHER DESCRIPTIONS OF PEOPLE'S SKILLS AND VALUES

As participants then share stories and strategies about ways of responding to the theme that is being considered (stage seven), we ask re-authoring questions to generate richer descriptions of people's skills and knowledge. Originally, community therapy would propose that the facilitator write down the list of strategies that is generated by the group conversation and this was then handed to the person whose theme was being discussed. But this list could sometimes appear as if it was containing advice or suggestions. We are using narrative

practices to improve this process and to remove the hazard of advice-giving. All of the strategies that people speak about consist of implicit skills and values. As facilitators, we can ask questions to place these strategies in context. We can enquire about the social histories of these skills, values, and knowledges. By tracing these skills and values through time and space the process can generate richer stories. And having done so, we are now creating collective narrative documents (Denborough, 2008) that collate the skills and knowledges from the group on any particular theme in the hope that they may be of assistance to others, in different places, who are going through similar suffering. Generating richer descriptions of the skills, values and knowledges that are implicit within strategies that people have used can enrich the community therapy process.

QUESTIONS THAT EVOKE MOVEMENT

As a facilitator, I am conscious of asking questions that evoke movement. For instance, during a community therapy session in which a mother was speaking about her son who had attempted suicide, I asked questions such as:

- 'Can you tell me what happened?'
- 'How was this for you passing through the situation?'
- 'What was the process of moving through this situation?'

These are deliberate questions that evoke movement. We are always asking questions such as, 'How did you pass through this?'

A PERSONAL AND COLLECTIVE LISTENING

Community therapy creates a particular listening context and the power of the word is unpredictable. As people listen to the experiences of others, moments of resonance occur. Good memories are evoked, memories of situations in which they did something special, or acquired some ability. These experiences of resonance and the memories that they spark, open doors to people's values and beliefs. In this way, when people are listening within community therapy, they're put in connection with themselves. People don't speak of the other, and so we're listening to ourselves when others speak. As

the conversations weave in and out between individual and collective considerations, we are listening to others and ourselves.

OUTSIDER-WITNESS PROCESSES

The rituals of community therapy involve many different forms of outsider-witness practice. People's testimonies are told in front of an audience of peers who respond and join in various ways. As narrative community therapists, at certain points in the session we invite some people to come into the centre of the group to speak about what words, expressions and descriptions have captured their attention; what images or metaphors these words or expressions have evoked for them; what these images or metaphors say about what is important to this community; and where these words and expressions have taken them (White, 2007).

At the same time, music and song is one of the most powerful forms of outsider-witness practice in community therapy. We always have singers play a key part. Every time someone in the group describes an evocative experience, we think of a song that relates to this, and we sing it together. This creates connections between people's stories and storylines.

SPEAKING IN THE 'I' IN A COLLECTIVE CONTEXT

There are a number of reasons why we ask people to speak in the 'I', in the first person, during community therapy meetings. It's a paradox in a way, because at the very moment that a person speaks in the 'I' within these community therapy meetings, they are actually a part of creating collective connection around shared themes. This double experience is taking place: people are speaking in the 'I' in relation to their joint experience of a problem, so it's different than speaking in the 'I' in other more individualistic circumstances.

We find that asking people to speak in the first person creates a different relationship to fatalism. People here often 'accept their fate' and inviting people to speak in the 'I' creates different possibilities in relation to this fatalism. Having the opportunity to speak in the 'I' can be an empowering process when done in this collective context.

What is more, people in Brazil like to talk a lot. A further reason why it is good to get people to speak in the 'I' is that if someone stands up and starts pontificating about life and the universe, the facilitator can say, 'Oh, is this true in your life personally? Can you speak about that?', and this means that the person does not continue to speak for hours!

Having said this, there is great diversity within Brazil and so we need to have considerable sensibility to cultural meanings. For instance, speaking in the 'I' will have very different cultural meanings in a favela in the North East of Brazil compared to the context here in São Paulo, which is a huge city in which many people have lost connection to cultural traditions and are living much more isolated lives. Considerations of class and status also make a big difference in how people speak about their lives. Responding to these cultural nuances results in differences in how we facilitate community therapy meetings.

CREATING A SENSE OF SOLIDARITY

Within community therapy, we're interested in creating a sense of solidarity, a sense of compassion, a sense of 'my problem is not the worst', or 'I am not the only one with this problem'. We're also trying to create a public space in which there's no conformist agenda, there's no one way to live life. Significantly, we're trying to create a context in which there is no position of submission to suffering. We wish instead to contribute to a sense of 'I can do …', of not accepting the status quo. This renewed sense of personal agency, a sense of being able to be a protagonist in one's own life, is what we hope participants will carry with them after a community therapy meeting.

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