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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

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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

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