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Integrative Community Therapy

A Space for Communitarian Resilience

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Abstract

The authors present the Integrative Community Therapy (ICT), an approach regarding community's mental health, which was created in 1987 by Professor Adalberto Barreto, PhD, of the Federal University of Ceará, in the Pirambu Slum, Fortaleza, connected with the Centre for Human Rights. Now, ICT is an integrated network with 42 education centers throughout Brazil and is present in 27 countries worldwide: Latin America, Europe, Africa, and Asia. ICT is a group methodology with the purpose of building solidarity bonds among the participants, improving resilience and self-esteem and educating future citizens within different populations. The ICT session (also known as ronde) promotes an exchange of individual experiences and a way of overcoming suffering; the methodology allows and induces people to make themselves available for this exchange; it provides keys to find personal and community solutions. This methodology presents five theoretical references: the Systemic Approach, the Communication Theory, Paulo Freire's Pedagogy, Cultural Anthropology, and the Resilience's Theory.

Keywords

Integrative Community Therapy · Communitarian resilience · Global mental health · Group methodology · Unmedicalization of suffering · Autonomy · Protagonism

Introduction

The process of the Brazilian psychiatric assistance has evolved in the last 40 years in search of a model based on the appreciation of the autonomy and the resources of the people in psychiatric and psychological suffering, in opposition to the old iatrogenic model, still present today, which considers people as incompetent and neglects the collective suffering. From this perspective, there is a tendency to "medicalize" psychological suffering, excluding the various aspects of human life: mental, emotional, social, cultural, and spiritual.

At the same time, in recent decades, new approaches to care have emerged that have promoted a positive impact on the treatment of mental disorders. Among them, the following stand out: the "Therapeutic Community" of Maxwel Jones and Ronald Laing in England; the Democratic Psychiatry of Franco Basaglia in Italy; and the Psychotherapy of the Oppressed by Alfred Moffatt in Argentina.

The implementation of the Psychiatric Reform, validated by the Declaration of Alma Ata (1978) and the eighth National Health Conference in the mid-1980s, in Brazil, has directed mental health care to open, multidisciplinary and humanized services. With these new principles and technologies aimed at groups and communities, a great step was taken to break with the hegemonic model of "hospital-centered" care, restricted to medicalization and the vertical professional-patient relationship. With the National Policy on Integrative and Complementary Practices (PNPIC), implemented by the Brazilian Ministry

of Health, in 2006, a new culture in health was implemented, including more knowledge and practices built according to the various cultural universes, promoting other ways of taking care of oneself, which took into account physical, mental, emotional, social, and spiritual well-being as determinant factors to health.

In this context of paradigmatic changes in health, Integrative Community Therapy (ICT) is born in Brazil, and its proposal is to face collective suffering in public community spaces accessible to populations in situations of social vulnerability and to rely on local cultural resources and solidarity networks.

From the Hospital to the Slums

In the 1980s, I used to conduct psychiatric consultations in the University Hospital of UFC (Federal University of Ceará) with my medical students, in partnership with the Centre for Human Rights[1] (Ligeon-Ligeonnet and Sampaio 1996). By the rising of the number of the people sent to this Centre, I rethought my practice so as I would assist them in a different way, and I proposed going to their own environment (the slums).

This time using only my psychiatric background, allying my ethno-psychiatric education acquired in France with Prof. Georges Devereux, and the systemic approach. But with the experience in the slum, I expanded my references and principles in the care of people with psychiatric and psychological suffering.

When we arrived there, around 30 persons were waiting for us and most of them requested relaxing medications and antidepressants. On the whole, they presented the same categories of suffering: isolation, material and emotional losses, identity crises, relationship and segregation disorders treated the same way, with drugs. In this first meeting I was questioned by a lady who was talking about her insomnia as a result of her husband's murder. Immediately, I gave her a medical prescription that she refused to take because she could not afford the medicine. She started crying. At this particular moment, another woman offered her a handkerchief to wipe her tears, another one brought her a cup of tea, and another one gave her a foot massage. Others talked about their insomnia and what they had done to sleep better. Immediately, I saw a visible effect: people were creating bonds. . . having conversations.

At the end of the encounter, she was surrounded by people and received what she needed: social support and not my professional help. During this first meeting with all of those people, while listening to them, I realized that it was more about suffering for not getting attention or not being taken care of, than illness or psychiatric disorders that are usually treated with drugs. I realized that I needed to go from the individual clinical model where the problem belongs to the individual and the solutions come from institutions and experts, to solutions that come from the group, to a co-participative model, that considers the individual, the professional, and the patient all as part of the problem and as part of the solution.

The Context of our Action

The migration phenomena in the semi-arid northeast, also known as the *polygon of droughts of Brazil* (Menezes 2012; Neves and Souza 2002), has been frequent and customary. Usually, people who run from hunger and misery migrate to the outskirts of big cities. In this region entire populations were forced to migrate due to various transformations caused by the disorganized national development, globalization, and a predatory economic policy, and all these were aggravated by many recurrent droughts (Cano 2017) (Fig. 1).

Faced with this reality of populations displaced from their lands and cultures with material, emotional, cultural bonds' losses, I asked myself: Wouldn't it be more productive and healthier to invest in rebuilding these bonds and supporting

[1]Created by the lawyer Airton Barreto to welcome the inhabitants of the Pirambu Slum/Fortaleza who had their rights disrespected, migration problems, and psychiatric suffering.

Fig. 1 Favela do Pirambu, Fortaleza, Brazil

one other? Seeking to get an answer to this, I decided to invest in the development of the group's methodology, which was later called Systemic Integrative Community Therapy.

The Slum Is a Place of Social Exclusion

All of our work started in Fortaleza in the Project 4 Sticks Community (4 Varas Project). It is one of the 100 organized communities that make up the great Pirambu Slum[2] (Federation of Entities of Neighborhoods and Favelas of Fortaleza 1982; Singer 1999) with more than 400,000 inhabitants/Fortaleza.[3] The name 4 Sticks Community comes from the legend that says: "an elderly man at the end of his life called his 4 sons. He asked each of them to break a stick and showed that the 4 sticks, bonded together couldn't break." This legend gave me the orientation of my work, which was to join the sticks without excluding any of them. This symbolizes the union between academic knowledge and indigenous, African, European culture, and the participants' life experiences. Then I understood: isolation fragilizes while union protects and takes care (Fig. 2).

These people are marked by institutional abandonment, insecurity, and loss of self-esteem that harms the biggest heritage, which is believing in oneself and in its own resources. This very occurrence creates agents of violence and segregation within the society. The fears and irrational actions result in worsening the tension in an environment of despair and psychological suffering.

The increase of these situations of illness, trauma, and fragility generates a "psychic precariousness syndrome" as Jean Furtos (2009) contends. The person be?comes so incapable to say

[2]This slum started being formed in the drought of 1932, when migrants from the Polygon of Drought arrived constituting a real concentration camp, with cardboard shacks and pieces of wood. So far, this slum has a history of struggle and conquest of its space and of much suffering.

[3]Capital of the State of Ceará with about 3000 million of inhabitants.

Fig. 2 Comunidade 4 Varas, a project created by Prof. Barreto, place of initial development of Integrative Community Therapy. (**b**) Comunidade 4 Varas, a project created by Prof. Barreto, place of initial development of Integrative Community Therapy

no for the unacceptable, for it remains merely to say no to him/herself. For she feels powerless to say no to anyone. This very negation, the lack of recognition of the knowledge and the know-how of these marginalized individuals, amplifies the loss in their self-confidence. Additionally, it creates progressive isolation, an attitude of failure, self-depreciation, and dependence. Lyon's Declaration (2011)[4] reminds us that a person is born incomplete and that it needs others to live. This inner failure, or else called "precariousness sane," which should not be confused with homeless people, unemployed, and poor people, is the main motor agent for the construction of bonds among human beings, familiar and social alike. The so-called precariousness sane reminds us that we have the necessity to be protected from our fragility, embraced by affectivity, having our individuality respected, having our difference recognized by others, being assisted by our actions, and valued for what we are and not for what we do or give to others (Rhizome 2012).

The Psychiatrization of Suffering and the Emergence of ICT

Throughout the numerous Community Therapy sessions/rondes with the inhabitants of the 4 Varas Community, I identified the main problems causing suffering: homelessness, wandering adolescents, anxiety, depression, alcoholism, addictions, elderly people, stress, violence, lack of resources for buying medicines or psychotherapies. Usually, these problems would be psychiatrized and medicalized, not taking the psychosocial issues involved into account (Fig. 3).

[4]Declaration prepared by 45 mental health experts at the 5 continents, Congress in Lyon-Villeurbaine, France, 2011: Psychosocial effects of globalization and its principles and consequences. Goal to promote an ecology of social bond in the context of globalisation. It reaffirms the principles of the Declaration of Alma Ata of 1978 and the Charte d'Ottawa of 1986, as well as the political declaration of Rio de Janeiro of October 21, 2011, on the social determinants of health.

With the sessions and the continuous process of observing/acting/reflecting, I was building the methodology of the Integrative Community Therapy. Since 1987, we proposed weekly meetings to stimulate the sharing of life experiences. These open spaces allowed people to learn from one another, receive social support, and share their suffering and their strategies to overcome everyday challenges.

The ICT is an integrative practice in health and social work community that emerged by these communal encounters. As we carried out the ICT sessions, we realized that we had to protect each other's words and stories avoiding vertical relationships such as imposition of ideas and advices. The space of speech, listening, and bond-building can happen in the horizontalized bias, where everyone provides their experiences, and everyone learns.

Why Systemic Integrative Community Therapy?

Why therapy? The word therapy (θεραπεία) is a word of Greek origin which means to welcome, to be warm, to serve, to assist. Therapist and community welcome and care for one another in a warm and loving way.

Why community? The word community – *common* + *unity* – means what people have in common. For example: sufferings, exclusion, search for solutions, and overcoming difficulties. Slums are organized into communities that seek to respond to the challenges of everyday life. The community becomes a substitute family.

Why Systemic? Systemic thinking tells us that crises and problems can only be understood and solved if we perceive them as integrated parts of a complex network that connect people into a whole. We are a whole, in which each part influences the whole. Therefore, if human suffering is due to the macro socioeconomic and political context, the responses must also be systemic, mobilizing resources of multiculturalism.

Why Integrative? In health promotion the culture is seen as a resource that must be recognized,

Fig. 3 ICT ronde held by Prof. Barreto in the 4 Sticks Community, Fortaleza, Brazil

mobilized, and articulated in a complementary way with another knowledge. Only this way can we add up, multiply our growth potentials and solve our social problems and build a fairer and more democratic society.

Therefore, Integrative Systemic Community Therapy is a community space for sharing life experiences and knowledge in a horizontal and circular way. Each one becomes a therapist of himself, from listening to the life stories that are reported there. Everyone becomes co-responsible in the search for solutions and overcoming the challenges of everyday life, in a warm and welcoming environment. We can summarize by saying that the ICT is a space for words, listening and building bonds.

Open Space

The space where ICT takes place is of great importance. It must be open, welcoming, warm, protected by rules that provide a safe environment and that allows people to engage from the methodology's perspective. This safe and healthy space allows the construction of friendship bonds and belonging and extends to the community just after the session (Cyrulnick 2009).

It needs to be a reception area of the pain of the soul. Furthermore, it has to be a place of socialization of "knowledge" built throughout life; a place to exchange emotions, build relationships, and rethink the relationships and strategies.

Active Listening

In active listening, listening to the other is listening to oneself. The other's speech touches each other's story and makes it possible to clarify it. The other is a mirror that allows identifying the values and weaknesses of those who listen. An illustrative example: on an ICT session, a person complains about her mother and the mistreatment received by her. At *sharing experience*, another

participant thanks the other for making her discover that she had a loving and caring mother. The other becomes a source of knowledge and growth.

Verbalizing

Verbalizing in ICT offers visibility to hidden suffering and thus allows to receive the support it needs from the group. Verbalization allows resignification and meaning to one's own pain and suffering, thus discovering identification with the other components of the group. Moreover, it is in sharing with each other's experiences that the pain and the suffering is relieved and that new ways can be found to overcome the problems.

All this creates a dynamic that Boris Cyrulnik (2017) understands as a promotion of the emergence of empathic links, an interest for the other, a security in the relationship through attachment and also self-knowledge; in meeting the other, in the intersubjectivity.

The Methodology

Community Therapy is not defined as a psychotherapeutic process, but rather as a group therapeutic act that can be performed with any number of people and any socioeconomic level. It is a simple but not simplistic intervention practice, requiring specific training.[5] It is run by facilitators, properly trained, without any requirement of previous academic training. The community therapist in his training learns to deal with the resonances of active listening and ensures compliance with the rules that structure the ICT ronde. As a community therapist, he does not need to act as a specialist who diagnoses, advises, or prescribes medicines (Fig. 4).

The intervention takes place in the various networks that make up the system of human relations, including family, friends, institutions, and the collectivity, supporting vulnerable human groups in crisis situations. The ICT replaces the clinical model with the integrative model of health promotion, solidarity networks, and social inclusion (Barreto 2014; Rangel et al. 2014).

We mention the example of a 28-year-old girl who exposes her feeling of not being loved by her mother on the ICT ronde. At the beginning of therapy her conviction was: "my mother didn't love me; I was the only daughter who wasn't comforted by her during childhood." We asked her what the explanation for the lack of physical contact and the mother was informed that at the time she had tuberculosis and, therefore, avoided contact with her children. The protagonist did not know that tuberculosis was contagious. I then asked her if she had ever thought that her mother did not touch her so as not to contaminate her and this was a gesture of love and not of lovelessness. She then replied, "I had never thought about that." This doubt settled in her conviction and triggered change.

Generally, people arrive on the ICT session as prisoners of their convictions of being victims, and during the sharing of experiences emerge various possible strategies/readings, generating awareness and promoting resignification. Often the theme chosen is the one that touches most of the participants. For example, faced with a situation of insomnia, several members of the group speak of their strategy of overcoming it: physical exercises, medicinal herbs' recipes, massage, etc. It is about sharing their life experience and not only talking about theories. Our experience has shown that the *pains of the soul* can be welcomed and cared for by the community itself. They have problems but they also have solutions. In its co-participatory and horizontalized dynamics, the group encourages people to recognize their own affective and cultural potential. The group shares experiences, reflects, supports, strengthens affective ties, thus consolidating the sociocultural fabric, all of this in an ethical and protected environment (Santos et al. 2014).

ICT Session's Steps

The ICT sessions follow six stages, with an average duration of 60–90 min: 1- welcoming stage,

[5]4 Sticks Community. Available from: http://www.aetci4varas.com and http://www.abratecom.org.br

Fig. 4 Caregiver's Care Group carried out by Prof Barreto in the Community 4 Sticks, Fortaleza, Brazil (an activity that is part of the community therapist's training)

2- choice of theme, 3- contextualization, 4- sharing experience, 5- group closing, 6- evaluation session by team.

Welcoming Stage (10 Min)

In this stage we welcome the people and make a quick presentation of the ICT as a space for sharing life experience. We remember the rules: 1- make silence when the other speaks, 2- speak of himself in the first person, 3- do not give advice, do not judge, do not make speech or interpretations, 4- suggest songs, jokes, poetry, popular sayings, proverbs, which have to do with the topic under discussion.

The rules have a structuring function of the session, as it guarantees respectful listening, avoiding ideological manipulations. Silence is the golden rule, for it enables active listening. Speaking of themselves in the first person allows the individuals to appropriate their experience with uniqueness, generating self-empowerment, reinforcing his personal and cultural identity. As each participant narrates their story to a caring and respectful audience everyone learns and processes their personal transformation.

The insertion of songs or other expressions of their culture has an effect of welcoming the emotions that emerge in the group (Hugon and Camarotti 2013). They allow them to leave the individual suffering for the support of the collective; allowing to metaphorically name emotions and integrate them into consciousness.

At the welcoming stage we propose a moment of celebration of life, birthdays, significant dates, and overcoming. These celebrations, value people and events, favor a welcoming space and networking after the ICT session. Afterwards, a psychophysical warm-up dynamic is performed. It usually uses local culture songs, dances, and body dynamics. The goal is to relax and leave

the participants at ease, to ensure respectful and fraternal dialogue. At ICT, welcoming is the key to successful participation. The warm atmosphere and established rules allow social engagement, sharing and mutual learning.

Choice of Theme (10 Min)

In the stage of choosing the topic, the therapist warns that it is time to choose a concern or problem situation. The experience of ICT has shown that it is very important to express feelings. "What we don't voice our feelings, our body suffers." It is important to reinforce the need to speak up, using the local cultural saying: "When the mouth shuts the organs speak, when the mouth speaks the organs heal."

What to talk about? It is important to talk about what concerns the education of children, conflicts, security, violence, etc. We remind people in the session that they do not have to tell their secrets, because it is a public space. Also, the therapist hosting the session announces: "Whoever wants to speak say your name and your suffering in a nutshell." The therapist should write down the names and concerns of the people who present their problem, should make a short summary of each story, and restore saying "If I understood correctly, you are saying that…" Recapping allows for respect, fidelity, and harmony of what was said and what was understood by the therapist. It is indispensable to build a meaning common to the group, enabling identifications and structuring the sharing of experiences.

When recapping, it is important to focus on emotion and not on the problem: "Did I understand that your suffering is the fear of relapse?" "Impotence in helping your mother?" After we have the confirmation of each theme presented, a vote is proposed and the issue that receives the most votes will be chosen as the theme of the session. The vote for the choice of the theme is a democratic exercise, learning to position oneself, becoming the subject of your personal history. In fact, when choosing the theme proposed by someone, the group chooses its own suffering. Because you only recognize in the other one what you already have in yourself. At the end of this stage, it is addressed to those who have not had their themes chosen, thanks and makes available at the end of the ICT for guidance or referral.

Contextualization (10 Min)

> "A phenomenon becomes incomprehensible as long as the field of observation is not wide enough to include the context in it" (P. Watzlawick)

The theme chosen by the participants will be explained to the group by the person who placed it. During the detailing of the problem situation everyone, therapists and participants, can ask questions. At ICT, ideas are not debated, but feelings are shared. The questions make it possible to contextualize and understand the meaning of the problem for everyone, their relationships, points of view, overcoming prejudices, and perspectives of the future. Still, redefining their experience; changing counseling from guilt to co-responsibility. At the end of the statement, thanking people and asking them to listen to the group they will share their story with.

Sharing Experiences (25 Min)

At this stage the community therapist addresses the group and says for example: "We have heard the restlessness of this lady and it certainly resonated in our own history. The time has come for us to talk about ourselves, what has resonated in my life story." Then, the therapist launches the *motto*[6] to the group and asks: Who ever lived a similar situation and how did you overcome it?

Sometimes, depending on the problem, the *motto* can be more symbolic, for example: "Who has ever suffered the pain of loneliness and what have you done to overcome it?" "Who has ever suffered discrimination and what has helped you overcome it?" "Who has ever experienced a painful separation and what has helped you start your life over?" With the stimulus of the questions, similar situations already experienced, and their respective overcoming strategies emerge. The sharing of

[6]Motto is a key question that allows reflection. The motto is constructed by the therapist from the testimony of the problem explained by the protagonist. Usually this key question brings out similar situations and their overcoming strategies experienced by the various members of the group.

experiences around the problem situation posed gives visibility to suffering and makes it possible to receive support from the group; highlights the sociocultural resources available on the network; and gives rise to solutions, innovative strategies.

Group Closing: Aggregation Rituals (10 Min)

In the last stage of the session, everyone stands up and makes a circle, holding hands or hugging neighbors, forming a great circle of solidarity. The protagonist receives positive connotations from the group and his trust in the group, for opening his heart and allowing the community to reflect about something so important to their lives. They may suggest appropriate music. Asking people to point out what they learned from the person's story or say what they have admired the most about it or about other stories.

In this circle the rituals of aggregation take place, a moment of synthesis where the therapist asks the question: "What am I taking from this *ronde*?" A circle of emotion and knowledge sharing is created in a cozy environment. The words of identification spoken before are now transformed into a body gesture of support and construction of a humanized network.

Evaluation Session by Team

After the therapy, it is up to the team to meet the individual demands of any of the participants and make appropriate referrals, if necessary. Then the team of therapists should make the appreciation of the session/*ronde*. This assessment will be made using the proposal *action-reflection-action* of the pedagogue Paulo Freire (Barreto 2008), an approach to learning and improvement of practice, personal discoveries, professionals, and confirmation of community commitment. We have tokens where information is noted that are used for future evaluations and research of session results.

Network's Construction

The ICT sessions are usually led by community leaders, health, education, social worker professionals, and caregivers, provided they are properly trained. On *rondes*, everyone is an expert in their history and a therapist of themselves, thanks to the resonances derived from the sharing of their life experiences. No one knows more about the person than the person does. After the session, people who demonstrate that they have a psychiatric or clinical problem are referred to the health services. The community therapy welcomes suffering and affective support, and pathologies are referred to health services.

In the ICT session, when we ask "What have you done to overcome your problems?" the most diverse solutions emerge from different cultural expressions present there. Each person speaks of their strategy of overcoming in tune with their ancestry. It is a very rich moment for everyone because one perceives the wealth of possibilities, resources available in the community. For us, health professionals, who were formed to a single model, in a universal scientific explanation (disease), we have difficulty dealing with the cultural plurality (illness) of answers to a problem (Kleinman 1980).

At the end of the ICT session, the search for consensus is avoided, criticizing or excluding some strategies. The exclusion of some solutions presented would trigger the power struggle that would destroy the plurality of the group. We need to accept all strategies and trust the critical sense and ability to choose each one present. That is the only way to make communication possible between the different forms of "popular knowledge," "scientific knowledge," and "political knowledge."

Theoretical Pillars (Axes) of Integrative Community Therapy

To the extent that the methodology was being constructed through practice, we were including the theoretical references that supported the systematics of the sessions, at the same time broadening and deepening the reflection of the results obtained in the process. So, we elected five fundamental pillars: Systemic Approach, the Communication Theory, Paulo Freire's Pedagogy, Cultural Anthropology, and the Resilience Theory.

Systemic Approach

The systemic view of psychological processes indicates that difficulties need to be understood in a complex and integrated network. Within the ICT, therapists and participants contextualize the issues brought to the session, adding them to the context of family, community, and sociocultural relationships.

Communication Theory

When we parameterized the communication theory from P. Warzlavick et al. (1998), we understood that the ICT session was about all behavior having communication value and people being able to verbal and nonverbal or gestural expressions. It also helps us to understand that knowledge of oneself and the other depends on the communication relationship that happens in human groups.

Pedagogy of Paulo Freire

From the point of view of Prof. Paulo Freire (1983, 1989) in the learning/transformation process, it is necessary to respect the knowledge, aesthetics and ethics of the various parties, criticality. In the process of the ICT some values contained in the pedagogy of this renowned professor are fundamental to this practice: critical reflection on practice, recognition of cultural identity, awareness of the incompleteness, respect for autonomy, common sense, joy, hope, and conviction that change is possible.

Cultural Anthropology

Culture is a fundamental referential element in the construction of personal and group identity. It is what gives man the ability to think, evaluate, discern values, and make choices. Integrative Community Therapy was born in the act of respect for the identity of the various ethnic-cultural groups existing in the Community 4 Varas. We believe that the personal and collective recognition of one's own identity generates an inner force that drives the construction of citizenship, disruption with the domination, and acceptance of the existence and rights of the other.

The Theory of Resilience

Taking resilience concept into account for ICT practice, it can be affirmed that in the stages of this methodology, the participants identify with each other, refocusing on the ability to transform suffering into competence – the *oyster wound* into *shining pearl*. In the unfolding of the session, the questions go from personal to group issues. In the end, it is perceived that the group suffered, learned, transformed; and thus, community resilience is formed.

The group is transformative, always greater than the simple sum of its components. In the group, we learned that we are all close in our essences, but different only in our expressions (Camarotti 2013).

Communitarian Resilience/the Resilience Process

Crises, sufferings, victories and overcoming, as they are presented to the group will promote reflection of the person and the group leading to a gradual awareness. They allow the individuals to discover the social and personal implications of the origin of human suffering and misery, as well as a way of overcoming it. Recognizing and praising one's qualities and competences in public is a way to also recognize the importance of the resilience process. Hence, it becomes an instrument of transformation of the individual and of the group alike. The socialization of knowing, the fruit of each person's life experience, initiates a dynamic process between what is told by others, and the resonance within each one of them. This way, the individual is allowed to discover his own path, and produces his own knowledge which can be useful to others.

A caring word or gesture, in the family and/or communities, can make the difference between

those who fail and those who win. Emphasizing these virtues, and values in the group, is a way to recognize the effort of the resilience process and making it an instrument of a transformative force.

Community resilience implies a constant understanding of the vulnerabilities of the groups and also an incorporation of the skills that help them to overcome and resume their autonomy. Let us consider ICT as an approach that helps individual resilience and builds community resilience.

Integrative Community Therapy and Mental Health

Integrative Community Therapy, therefore, takes place within communitarian health and social work practices that are considered by WHO (Artiga and Hinton 2018) to be relevant and "good practices." In collective spaces, it integrates and gives value to the diversity of cultures, know-how and skills, so that everyone feels both a subject and an agent of their own life and of the society they dwell in. This community action proposes, first and foremost, a different perspective on situations of human rights abuse, and implements ways of fighting poverty, isolation, and exclusion in order to understand psycho-social problems differently (Ferreira Filha et al. 2009).

Promotion of mental health, obtained within one's own context and community is one of the major goals of Community Therapy. Taking into account the multiple difficulties of living in the Favela – insecurity, stigmatization, exclusion, intolerance of differences and the precariousness of the infrastructure, the care of psychological suffering and the promotion of resilience through ICT leads to the well-being and balance of each person and their community context. Helping people to overcome their pain individually and in a group, the ICT session contributes to improving the social determinants of health (Carvalho et al. 2013; WHO 2011). Evidence shows that ICT has been gradually inserted into the practice of mental health professionals, with evident improvement in patients' self-esteem, greater security for decision-making, social reintegration, and strengthening of family, friendship, and spiritual bonds (Mourão 2016).

In March 2017, after 30 years of practice, Community Therapy was officially integrated as a public policy within the National Health System (SUS) by the Brazilian Ministry of Health, as part of the so-called PICS – National Policy of Integrative and Complementary Practices in Brazil (Fig. 5).

Currently, ICT is included in various actions of governmental services – health, education, social, and justice –, nongovernmental network, and universities. The Community Therapy is an integrated network with 42 education centers throughout Brazil,[7] and is present in 27 countries worldwide: Latin America, Europe, Africa, and Asia, and nearly 40,000 trained community therapists, including professionals from various fields and therapists on a volunteer basis.

Integrative Community Therapy Values

The Integrative Community Therapy despite defining its layout with a theoretical axis, it is much more an attitude and positioning oneself than a mere application of a technique. Thus, during the training of becoming a community therapist, one works exhaustively with the life stories of each participant. Thus, the future community therapist ought to incorporate these very indispensable values and also emotional and cognitive support, working on ethics and technique itself (Hugon et al. 2020).

In the training of community therapists, we prioritize some values: 1- being welcoming, 2- being simple, 3- investing in the circularity and horizontality of relationships, 4- welcoming human emotions, 5- being creative and daring, 6- making room for uncertainties, 7 - seeing the other as a source of knowledge, 8- accepting unpredictability, and 9- expressing humor as love and care.

[7] In Brazil, all these training centers follow the pedagogical principles of the Brazilian Association of Community Therapy (ABRATECOM).

Fig. 5 Ronde of ICT held in March 2020, with women users of the Psychosocial Care Centre in the city of Itabaianinha, Sergipe, Brazil

Be Welcoming

To be welcoming is to accept the other as he is; open to differences and diversity, opposed to traditional and current values. It also means being attentive to emotions and body language, and that is vital to welcome the participants' life stories and their resonances in the group. This attitude is inherent to care and a substrate for personal growth.

Be Simple

In Integrative Community Therapy it is also important to redeem a linguistic and postural simplicity, and emancipate the individual from the knowledgeable specialist, as well as enabling him to accept learning with the other. Complication is an instrument of power, of domination that wishes to impose its superiority affirming that it is knowing that as much more complex as the other must submit him to it. Thus, simplicity permits each person to redeem what is the essential; to be touched and sensitive to the other, thus opening their heart to accept the suffering of others.

The Circularity in Caring: Giving and Receiving

Prof. Paulo Freire reminds us that learning is a collective construction, and that one cannot really teach without learning something together with the other. Our experience shows us that this very truth happens exactly similarly in caring.

In health services, the vast majority of them are individual and vertical, a professional who has the knowledge and a patient who receives it. In the circular and horizontal view, everyone can absorb the richness of experiences and share the possibilities for solutions.

Welcoming Human Emotions

Empathy and the ability to accept the emotions and suffering of others are fundamental characteristics for the community therapist. Through his sensitivity, the animator of the session will follow the steps of the methodology in an orderly manner and at the same time take care of the participants and the group, integrating everyone in a support and solidarity network. In this way, the therapist has a primary function of transforming the ICT *ronde* into a transdisciplinary group therapy, where the target of care is reversed in *being a group*.

Be Creative and Daring

The community therapist is challenged to overcome conventional barriers, frontiers, and classical concepts, meaning becoming creative and overcoming unpredictability. He needs to be audacious and above all to allow himself to self-knowledge, in some moments shows his emotions, and this way allow the other to do the same.

The responsibility of the animator/facilitator is to create a welcoming environment, which leaves

people's needs run freely to allow them to dare, unveiling what has been silenced. Also, he needs to be the guardian of the rules during the entire time the ICT session takes place, to guarantee an environment of trust and security, enabling them to talk without being judged. To dare obtaining and using one's own way of animation, follow one's intuition, giving them the right of creating, innovating, and positively overcoming, being ingeniously creative, without changing the ICT's proposition.

Making Room for Uncertainties

The improvement of the practice as a community therapist happens through permanent reflection. Every certainty is a prison. Everybody that comes to the ICT sessions was imprisoned within one specific perception. He thinks of him as a victim or guilty of something. Questions open perspectives of different options to confront reality. One point of view is merely a view of one point. There is always something to learn, to read, to hear, to live, and above all to work at. But one only learns when reviewing and reconsidering his own certainties (Moran 2007).

We need to value the critical awareness. The community therapist must try to be an expert in asking questions that create doubts, within an environment of confidence and serenity. The best question is that it invites us to think, to doubt, to generate a reaction or a doubt at the person. The sharing of life experiences and the cultural resources of the participants help to reconsider our own vision of the world.

To See the Other as a Source of Knowledge

Although each one could benefit from the other resources, the therapist needs to leave room for silence, valuing the participants presence. It is important to welcome the differences as presents and alterity as a mirror that rises resonances, which favor the self-awareness. The encounter with the other is a journey to discover an unknown continent. The other, according to his singularity/individuality and differences is a factor of change, of growth, and resilience.

Accept Unpredictability

The community work is based in unpredictability that demands flexibility and a big capability in being adapted in contextual demands. It is the conscience of the essential, and that of the possible, as a dynamic process, which we all need to accompany. One needs to be at the service of the process and not the contrary. Accepting the unpredictability and the changes means creating from the difficulties that community work imposes.

Expressing Mood with Land Care

Humor is a cultural resource, which is indispensable in working with a group. It stimulates the integration between emotion and rational understanding, thus facilitating the resignification and transformation of what was tragic into playful. Someone laughs only if he has understood, or thought.

In the ICT *rondes*, the presence of songs, jokes, and popular sayings are sources of wealth and good humor. When listening to a symbolic and playful language, people integrate the emotions felt in symbols as a way to reframe the traumatic or sad experience.

Effectiveness of ICT: Reducing Demand for Specialized Services

In the last decades, through the University of Ceará (UFC) and national public agencies, we have developed implementation projects associated with research to evaluate the results of community therapies carried out on a large scale. We will cite two examples below:

1-. SENAD (2006) conducted in partnership with the UFC a survey involving 12,000 people in several Brazilian states, that has showed that "88.5% of the participants in the 'listening and speaking space' (ICT) found a solution to their problems and hardly 11.5% needed specialized treatment," as seen below in Diagram 1. Furthermore, building networks of social care makes the individual and the community alike

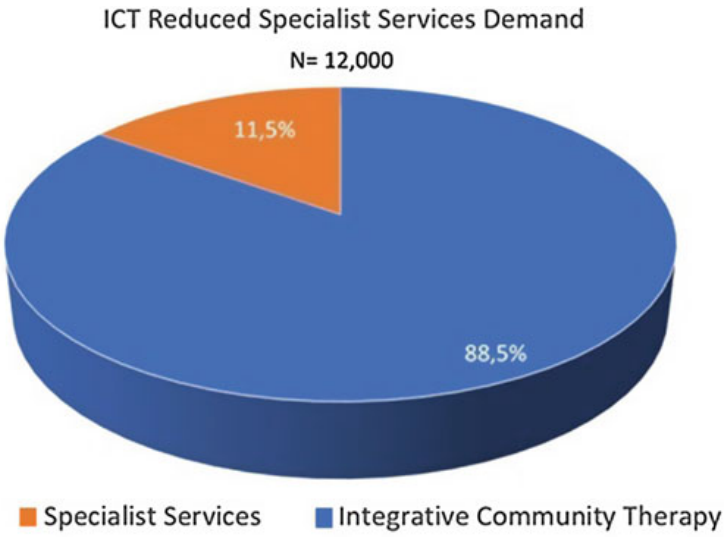

Diagram 1 Referrals from the ICT sessions

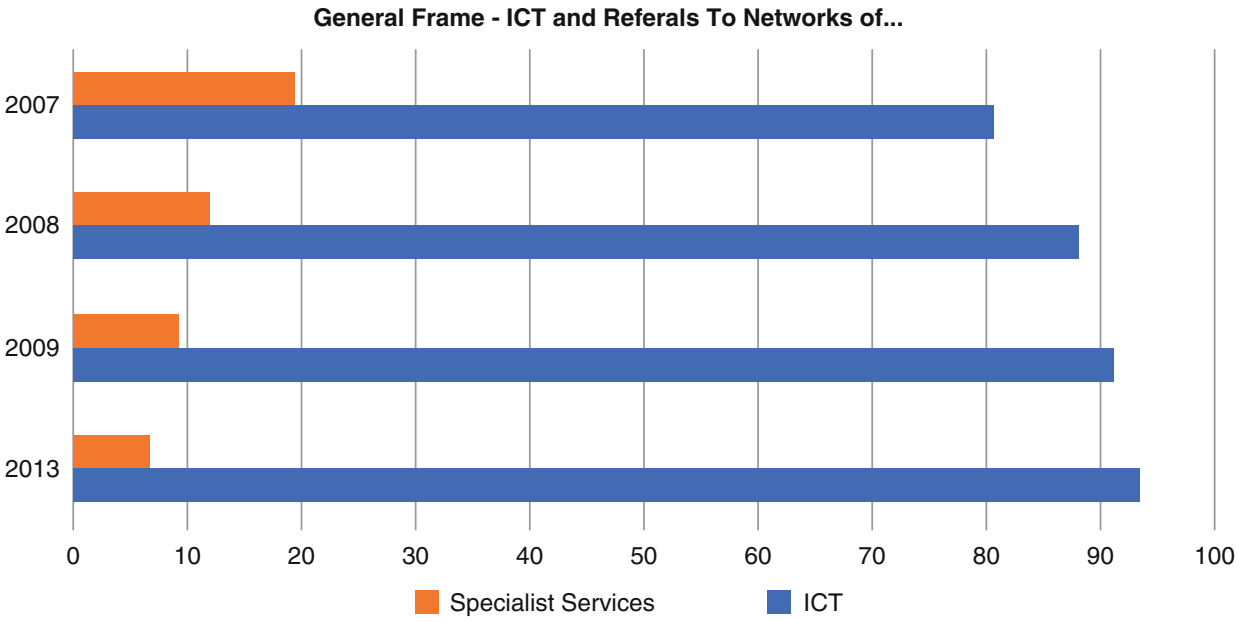

Diagram 2 Referrals to specialized services and to network in 2007, 2008, 2009, and 2013

more autonomous, and less dependent on specialists' professionals and institutions.

2-. During the research of the following two Conventions in 2007 and 2008, the date of the first research conducted was confirmed in 2006. In 2007 in a sample of N = 4272 participants, and in 2008 N = 5203, respectively, reinforced the original percentage regarding the ICT's efficacy, in addition to the two more recent Conventions of 2009 and 2013 (see Diagram 2 below), which brought the overall average in 88.1% of ICT usage and efficiency (Barreto et al. 2011, 2013).

Comments

The aforementioned data demonstrate that ICT is a space for caring the everyday suffering, which can contribute to reducing assistance in

specialized health services and medicalization. The ICT practice has a noncompetitive action, but rather complementary one, becoming able to show of what is possible to be cared by it or to be referred to other specialists.

ICT direct impact upon three Health Determinants: stress, social support, and social exclusion.

Stress. Prolonged periods of stress, vulnerability feeling, one's own possible opinion, absence of friends on whom one could count on, all these have nefarious effects on physical and mental health.

Social support. Belonging to a network of support, having access at affective resources, and of the mutual assistance toward to the community create a feeling of being recognized, loved, and appreciated, which produces a particular protective effect regarding health.

Social exclusion. Developing actions that favor a feeling of belonging, participation, and valorization of the individual, is the most propitious toward health, of those who feel excluded, ignored, explored, and live in context of exclusion.

The possibility to intervene on the social determinants of mental health promotes an improvement in health. It enables the construction of social networks using their own self-acquired resources and promoting citizenship.

According to the first research conducted by the Convention of 2004, there were noted seven main themes reported more frequently, which in the four consecutive researches of the Conventions of 2007, 2008, 2009, and 2013 were also noted. The first was stress due to: anxiety, fear, insomnia, nervousness, etc. Secondly, family problems: conflicts, divorces, cheating, and jealousy. The third was depression and violence: against women, children and elders, robbery, homicide, gangs, and sexual violence. Then, the fourth was alcohol and drugs. The fifth theme was work: unemployment, insecurity, financial problems, and lack of recognition. The sixth was breaking social bonds due to: abandonment, homelessness, solitude, and enforced migration among many. The seventh was conflict: interpersonal, between neighbors, land disputes. The last one was a variety of independent problems, stated as *others* (see below at the follow Diagram 3).

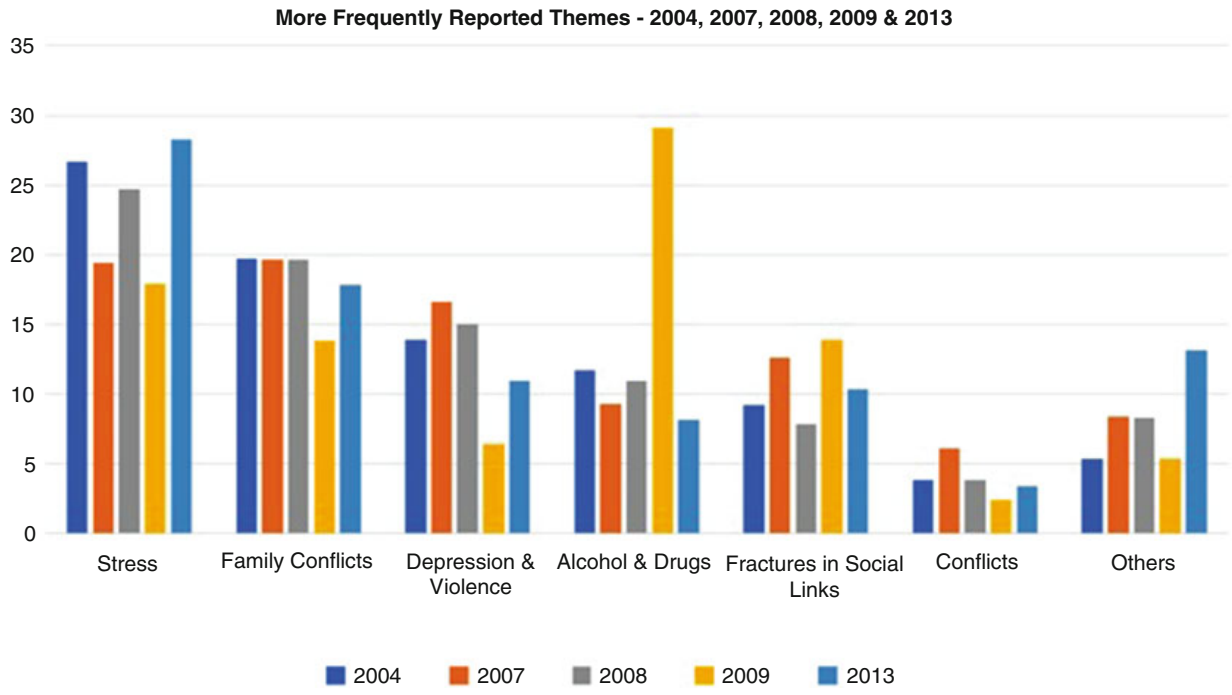

Diagram 3 More frequent reported themes

Conclusion

The experience of 33 years creating and developing the Integrative Community Therapy made me realize that we have great challenges ahead: investing in social, community, and transcultural psychiatry, thus complementing the knowledge of the clinical and psychological aspects already used in mental health services. The paradigm shift must be stimulated and safeguarded by society's own stakeholders, or by the strategies and resources of the participants and practitioners, in relation to their cultural capital that would lead to a mutual benefit for the mental health. Cultural diversity is good for everyone, and a true source of wealth for one people and one nation. In addition to academic knowledge, it seems particularly necessary to rely on the "mutualization" of the wisdom of each culture, the know-how implementation, and the knowledge gained from life experience.

We need to create new paradigms, where each discipline, and each specialization is part of a broader construction. It is necessary that without losing its identity and like the pieces of a puzzle, each cognizance that each knowledge can be integrated in a more extensive knowledge, with multiple colors and facets, where the notion of health can also be perceived in all its relational and interactive dimension. So far, any caring relationship was quite often constructed, according to the asymmetrical model of an expert who gives to an individual who receives, a unilateral model that is equivalent to totally depriving itself of the extraordinary wealth of knowledge acquired by any person from his life experience, even those in great difficulty. Paulo Freire reminds us that there is no longer a teacher who knows everything and teaches the student, and a student who knows nothing and has to learn everything from scratch.

This whole experience allowed us to take advantage of the combination of academic and cultural knowledge and then expand solidarity networks. To do so, we need to accept the fact that we experts do not know everything and that we need each other. Being humble is being aware of one's competences and limits, by accepting the competences of others as complementary. This is only possible if we give up the position of the expert who knows, to learn from each other. Nevertheless, it goes without saying that it is essential to include in our *Vade Mecum* the contributions of the sociocultural psychiatry.

We propose a paradigm articulating clinical models with solidarity models in a complementary and noncompetitive perspective, to treat pathologies but also promote health.

Migrating from a model that generates dependency toward one that promotes co-responsibility, from a model centered on individual toward a model focused on collectivity. Seeking a model where practitioners and patients are together part of the problem and part of the solution.

All this know-how acquired progressively represents fundamentally a paradigm shift, a change of "lenses" which invites us, firstly, to go beyond the individual and to touch the collective. Also, it enables us to look beyond shortages and deficiencies, to rely on the skills acquired through life experience, and to bring out the potential of those who suffer. Moreover, one is brought to get out of the verticality of relations, and to breathe horizontality, as well as to deconstruct an attitude of mistrust toward the other and believe more in the capacities of that other. Furthermore, one is invited to break with the isolation of both scientific knowledge and traditional knowledge and moves from the solution that comes from the outside to the solution is inside the person, the family, and the community. And finally, one is invited to break from a clientele model and promote a critical one.

An Extension of Vision: From a model where together practitioners and patients are part of the problem and part of the solution

From a model based on: ⟷	To a model based on:
Clinical/individual model ⟷	Solidary model
Scientific knowledge only ⟷	Scientific knowledge integrated with the sharing of experience
Generating dependency ⟷	Promoting co-responsibility
Top down solutions ⟷	Bottom up solutions and social support

(continued)

An Extension of Vision: From a model where together practitioners and patients are part of the problem and part of the solution (continued)

Individual model ⟷	Collectivity model
Treating pathology ⟷	Promoting health

I believe that the development of community therapy has promoted important changes for the participants, for the communities and for the community therapists involved. I understand that it is necessary to carry out several researches to consolidate our observations and also to evaluate from the controlled studies the impact of this methodology on people's lives.

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