CHAPTER 7

Community in Conversation

Generating Collaborative and Dialogic Conversations in Community Contexts

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The History of Integrative Community Therapy (ICT)

Integrative Community Therapy (ICT) can be understood as a social and political practice that aims to strengthen bonds and to promote an exchange of experiences and knowledge. As a conversational practice, ICT favors social transformation since it is sustained by values of inclusion, respect for differences, and legitimation of different voices (Freire, 1983; McNamee & Gergen, 1998; Pakman, 2018). This approach is informed by the principles of dialogue, social construction, and legitimation of collaborative actions (Anderson, 1997; Seikkula & Arnkil, 2006; Grandesso, 2015). It is presented as a simple methodology and may be performed in any space in which people live or visit where they can be listened to respectfully and have eye-to-eye contact. For us, ICT expresses the assumptions of collaborative-dialogic (C-D) practices.

ICT was born in the Pirambu slum, in the city of Fortaleza, Ceará, in Northeast Brazil in the mid-1980s. This practice was generated by Adalberto Barreto in response to the suffering of the people of this community who lived in extreme social, economic, and housing vulnerability, far away from mental health centers with long waiting lists. The dialogic space generated by ICT proved an extraordinary resource to the overwhelming needs of great numbers

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of people living in the community. This chapter provides an overview of ICT process, its evolution, and its applicability to other parts of Brazil and the world.

In the ICT context, participants are invited as "experts" on their lived experiences. They can be listened to and responded to by a large audience – sharing experiences, finding ways to go on, and strengthening social networks. In addition to be trained in psychiatry, Barreto specialized in family therapy, anthropology, theology and ethnopsychiatry. He started working at the Federal University of Ceará, where he was in charge of an internship program for medical residents in community social psychiatry and where he and his team saw patients on an outpatient basis. His brother, Ayrton Barreto, a lawyer, worked in the Pirambu slum and responded to the queries of the inhabitants of this community, advising them from a human rights perspective. Witnessing the difficulties of people from that community in accessing mental health services in general hospitals, he agreed to refer these people to Barreto's office in the university. Shortly afterwards, due to the rapidly increasing number of referrals, Barreto and his students went directly to the slums and organized an assistance and follow-up program in order to respond to all those who were in need. From the first day, on which 30 people were waiting for them, the number of people increased on every consultation day, making it impossible to offer them individual help. They felt the urge to respond to everyone present though, and so invited them to gather and have conversations in a group round in the open air under a cashew tree. People agreed and, once there, they began to share the sufferings in their lives. The responses of the people in the group who listened to the words of the one speaking were characterized by compassion, affection, and solidarity, offering company and comfort. The speakers were revitalized and encouraged by the responses of the others in the group and continued to freely share their plights. The social response seemed to be more healing than the specialist's presence. For example, a desperate mother faced the problematic drug addiction of her child, another person did not have a job or enough money to eat, another witnessed the murder of a loved one. They shared sufferings from the pain of their souls, for which there was no medicine that could relieve it, nor a psychopathological category by which it could be classified.

In addition to the scientific-academic knowledge acquired at the university, Barreto was also acquainted with the mystical religious beliefs of his cultural community of origin, Canindé. During his childhood he witnessed the constant movement of the pilgrims looking for Saint Padre Cícero's miracles (the Canindé's city protector) as solutions for their diseases and problems. Therefore, he decided to combine his scientific and cultural knowledge as he invited dialogue with members of the community. He then organized a community

health program in which scientific, cultural, and popular knowledge of the community members helped them overcome conflicts and build supportive social networks for people in crisis.

This practice helps the individual to consider their suffering in its human dimension and as contextually situated, fostering the activation of the therapeutic ability of the group itself. The history of ICT bears witnesses of a practice in action, based on the creator's training as a physician (Barreto, 2008) and his ability to move away from the medical model that offers medicines for social suffering due to contexts of economic, educational, health, and housing inequality. Thus, he created an approach that values and uses the cultural resources and knowledge of the community, and the experiences of individuals and families. In his words, he democratized their knowledge. He was not working from a top-down position, bringing in external professional expertise, but rather was contributing his knowledge and, at the same time, respecting and integrating the expertise of the community members. A peculiarity of ICT is that, first, the practice arose, and later, its methodology and theoretical explanation was developed.

Conceptual Foundations and Objectives

ICT was born as a practice in action, in response to a demand from a community. As the practice evolved, Barreto (2008, 2013) conceptualized it with five theoretical pillars: systemic thinking, theory of human communication, Paulo Freire's dialogical methodology, cultural anthropology, and resilience. To expand:

- The new paradigmatic *systemic thinking*, which considers the community as a complex system and invites the community facilitator to deal with the complexity, uncertainty, and the intersubjectivity in the construction of meaning (Grandesso, 2000; Esteves de Vasconcelos, 2002).
- The *theory of human communication*, focusing on the universe of relationships.
- *Paulo Freire's dialogical* proposal of action and reflection (Freire, 1983, 1986), emphasizing co-authorship among those involved in a process of learning and transformation.
- *Cultural anthropology*, which values local knowledge, ancestral wisdom, and the multiculturality of life contexts.
- [*Resilience perspective*] that views humans as capable of transforming their existence by expanding their consciousness and assuming authorship of their stories, which promotes creative ways of dealing

> with adversities by not only coping with them but also growing and developing from them. (Anderson, 1997; Grandesso, 2014, 2020).

The authors integrated the assumptions of narrative approach (Grandesso, 2011) and C-D practices' stance (Grandesso, 2015) in order to enrich conversational possibilities in which new meanings could be generated.

ICT takes three perspectives into account:

Individual: Support and strengthen the confidence of the individual in their ability to evolve and develop as an autonomous, independent person, and as part of their community, enabling the recognition of their values and their potentials.

Family: Value family and its social networks as resources for strengthening individual development.

Community: Recognize and support each person, family, and social group, and the feeling of union and identification with their cultural values; favor the generation or restoration of solidarity bonds and the valuing of traditional cultural institutions and practices that strengthen cultural identity and are the holders of the "know-hows"; stimulate group participation to promote initiatives that lead the groups' members to be agents of their own transformation through dialogue and reflection that, in turn, promotes and reinforces the ability to act together.

Stages of an ICT Meeting

The ICT rounds have been characterized traditionally as a face-to-face meeting space in which communities come together to listen and welcome their life experiences. In 2020, in times of the COVID-19 pandemic, when physical isolation became a necessary measure of health care, we started to hold the rounds online. Each ICT meeting, whether in person or online, lasts around an hour and a half and weaves a collective narrative, which is built along five stages that support the dialogue and collaboration between community participants, like a backbone: 1) welcome; 2) choice of the topic; 3) contextualization; 4) problematization; and 5) closing. These stages, which allow us to privilege the uniqueness of each shared story and develop a purposeful conversation with the community, will be described in more detail in the following sections. The ICT methodology has proven to be useful with small groups of five to ten people, and up to large groups of 250, 450, and even 1400 people, according to one of the authors' experiences (Grandesso & Cerveny, 2007).

1. Welcoming and Establishing the Format: Reception of the Community

Before receiving the community, the community therapist (CT) organizes the space to facilitate and maximize the opportunity for members to have eye contact and listen to everyone. In order to situate the participants, the therapist presents the ICT as a space for welcoming their word, inviting generous listening, and sharing both the sufferings that people have endured and the resources and coping strategies they have discovered and constructed throughout their lives. The aim of an ICT is not to solve problems but to welcome people's voices, to share sufferings, and to legitimize local knowledge. It is not defined as a psychotherapy but as a space and process that promotes the possibility for well-being and empowerment. Therefore, some *conversational agreements* are introduced to organize the conversation and to give voice and time for all participants.

- Speak in the first person, using the pronoun "I". Each person is an expert in their own experience. This encourages authorship – a sense of creating and owning one's story.
- Be silent in order to listen to each other in a respectful and attentive way and to listen to yourself—to your internal dialogue. This way of listening to the other helps and supports participants to share and express their experiences.
- Avoid giving advice, judging, and interpreting the other's experience. These agreements help invite and promote horizontal, non-hierarchical relationships.
- If anyone present remembers a song, poem, proverb, popular saying, or joke, which has a connection with what is being said, they can present it to everyone.

Afterwards, the facilitator(s) opens space for celebration of an event or accomplishment for people who want to share. This practice characterizes a kind of definitional celebration ceremony (White 2004, 2007; Grandesso, 2011), a ritual of recognition and legitimation of identities, giving visibility to something that would otherwise remain invisible. People generally refer to a date they want to celebrate, such as a birthday or anniversary, or an important achievement they have accomplished. For example, in a community with drug and alcohol abusers, a participant wanted to celebrate "staying clean" – not using crack for six months. Each time someone speaks we ask them to say their name, favoring more personal relationships. The celebration ends with a song chosen by those present.

Once this ritual is completed, the facilitator(s) organizes an activity or a game that can be played for a short time, in order to achieve a more relaxed atmosphere before beginning the next stage.

2. Choosing a Subject for the Day's Conversation

Inspired by Freire's methodology (Freire, 1983, 1986), the CT encourages those present to bring forth an issue of their interest, something that they would like to share with the other participants that is causing some kind of suffering or uneasiness. Those who speak are asked to say their name and to express in a few words what they want to talk about, for instance, their worry, suffering, or something from everyday life that is causing them discomfort. At this point, the therapist writes down on a sheet of paper for themselves the topic proposals and the names of the people proposing them. Once four to five alternatives have been gathered, the therapist reminds those present of the suggested topics and asks some of the attendees to say which one had the greatest resonance on them and why. This identification makes it possible to know which concerns had the strongest impact on those present and prepares the community to vote. To choose the topics, the therapist presents the proposed topics one by one and invites each person to vote for only one of them. The therapist highlights that the choice is made by personal resonance, since all topics are equally important. People who have not had their topics chosen are thanked by the therapist, who makes a space for any necessary conversation at the end of the round if the participant does not feel comfortable. In 18 years of practice (MG), this has not happened once.

As an example, the following are five topics of an online ICT round that we conducted in May 2020, which was jointly sponsored by our organizations INTERFACI and Federal University of São Paulo (UNIFESP) during COVID-19.

1. The sadness and discouragement of the people due to negligence regarding health measures to take care of themselves and others.
2. Distress and tiredness for having to reinvent oneself each day, with the stress of so many things to do at the same time.
3. Living in confinement: the difficulty in dealing with mixed situations—with no separation between work and home.
4. Suffering and impotence regarding the suffering of the least favored and, therefore, the most vulnerable.
5. Feelings of uncertainty towards the future.

3. Contextualization of the Chosen Subject

At this stage, the therapist invites the person whose topic has been chosen to talk more about it in order to understand the meaning of his/hers experience

and the emotions involved in it. Anyone can ask questions to understand how this situation is affecting him or her and how the person is dealing with it. We usually try to ask questions that can help the person acknowledge their feelings. The focus on feelings allows community members to identify and emotionally resonate with them.

It is not a long stage—a maximum of ten minutes has been shown to be enough to listen to the story and to be in touch with the person's feelings. This dialogical process opens possibilities for the whole community to be emotionally connected around the shared meanings:

> Putting their accomplishments into language in front of a community influences how the presenter views and understands their story. For instance, each person can transform the commonplace into exotic. This also allows language to construct an astonishing reality which otherwise would have no visibility. Such practice contributes to new versions of participants as competent in addition to favoring an ontology of hope.
>
> (Grandesso, 2015, p. 128)

As the CT listens to the person who narrates their story, he or she formulates a potentially reflective question, born from his/her listening, which Barreto (2008) calls *motto*. Motto usually refers to a word, phrase, or sentence that tells the principle, belief, or purpose that captures the essence of something. This question opens space for the next stage, which will mobilize the entire community. Some examples will be given in the next stage.

4. Problematization: Sharing Local Knowledge

At this stage the conversation is triggered by the *motto* question, which is made by the therapist at the end of the previous stage. This question aims to invite those present to share their knowledge and their learning, as well as the coping strategies they have developed to deal with similar lived circumstances. For example: *"Who has experienced a similar situation to the one presented by the person whose topic was chosen? What have you done to deal with it? What have you learned? or What has helped you?"* For example, in an ICT held by me (MG), the subject chosen was the feeling of distress and impotence regarding the least favored who had no means of protecting themselves in social isolation during the COVID-19 pandemic. The *motto* question proposed was: *"How have you been dealing with the discomfort facing the suffering of the least favored in terms of resources to take care of themselves?"* A more symbolic or even metaphoric *motto* question could have been presented, such as: *"How have you been able to keep on believing in light at the end of the tunnel?"* Whether more textual

or more metaphorical, what matters is that it is a question that invites the sharing of coping strategies in relation to the contextualized dilemma.

This stage has a longer duration than the previous ones, in order to favor a plentiful harvest of resources and coping strategies from the community. In this ICT round, in which the motto question was *"How have you been dealing with the discomfort facing the suffering of the least favored in terms of resources to take care of themselves?"*, the people present shared a series of social actions to help the ones most in need, which in turn helped themselves not fall into immobility in the face of the perverse social inequality in which we live in my (MG) country. These social actions included:

- Not losing the capacity of feeling indignant in the face of social inequality
- Developing solidarity actions
- Listening to those who need to be heard
- Welcoming those who seek help
- Making explicit the rights that everyone has, which can be forgotten in conditions of poverty and misery.

The sharing of coping resources in a community context such as ICT has made it possible to legitimize those who speak and to awaken possible alternatives of authorship for those who listen.

Closing Ritual

In this last stage, the CT invites those present to think about the impact that the ICT round has had for each of them. Inspired by Freire's dialogical and reflective methodology (1983, 1986), this is yet another moment of sharing. This time, the focus is on what each person is taking with him or herself from this therapy round. It is also another moment to honor the shared stories. Starting with the therapist's reflection, each person who wants can thank and emphasize the importance of what they have learned directly to the person to whom they are grateful. For example, a person could say: "Thank you José for helping me see that there are many things I can do to collaborate with those in need, and the importance of keeping indignation alive in the face of perverse social inequality". This stage also promotes the construction of new bonds between the participants, as they connect through shared experiences. To conclude, those present can sing a farewell song or one related to some special meaning of the conversation during the ICT.

ICT Online

Regarding ICT online, we would like to highlight that this modality was developed, encouraged, and practiced during the need for physical isolation due to

COVID-19. Brazilian culture, the cradle of ICT, and Latin America in general, cultivate affectionate relationships in which physical contact, hugs, and closeness are predominant. In view of the intense suffering of people in isolation, the possibility of carrying out ICTs online offered a context of extreme relevance in which to welcome people in distress and promote the sharing of resources and solidarity actions. The stages of ICT *online* are exactly the same as the five we practice within the face-to-face rounds. We have observed that these ICT rounds have had an immense reach that we would not have had in face-to-face ones. In the online rounds, participants have accessed from distant provinces as well as from other countries around the world, promoting dialogue and the exchange of collaborative experiences without borders. In addition, the access platforms allow us to place up to 100 people together, and many of our ICT rounds reach this audience. Online ICTs have fulfilled a therapeutic and health-generating role according to the testimonies we have received from the participants.[1] These virtual ICT rounds offered to the general public were intended to strengthen bonds and build support networks, minimize the stigma and prejudice of infected people, and provide a place for listening to health professionals who expose their lives at the front lines in the fight against COVID-19 (Barreto, Ferreira Filha, & Silva, in press).

Between March and the 31st of July 2020, 424 *online* rounds were carried out in Brazil, with the participation of more than 3579 people. From March until 12th July 2020, the Latin American ICT network (Argentina, Bolivia, Colombia, Chile, Dominican Republic, Ecuador, Mexico, Paraguay, Peru, and Uruguay) carried out 379 rounds: 370 in Spanish, 5 in Guarani, and 4 in English.

With the online rounds we witnessed the community present in an online ICT entering into the privacy of people's homes when they were in physical isolation and their work, and even in public spaces, as in one of our ICTs (MG), we had a participant who was traveling in the municipal subway in the city of São Paulo. Distant cities, immigrants who live far away from their country, and indigenous populations in multicultural encounters have been able to strengthen hope by sharing experiences and knowledge acquired through this global challenge imposed by the coronavirus. ICT has proven to be a powerful tool for empowering people and promoting solidarity actions.

Becoming a Community Therapist

The CT's training provides a basic theoretical unit but, above all, carries out an experiential and bodily process of self-knowledge that allows them to maintain a stance of active listening, emotional resonance, and flexibility in face of the uncertainty that occurs in each round, to which an unforeseen number of people can arrive, with different crisis situations and different imponderable types. We have witnessed that this personal transformation extends beyond the ICT's context (McNamee, 2018). This was the example shared by a psychiatrist[2] and

CT from Paraguay: In the context of the coronavirus pandemic, a CT facilitator who was on hospital call was asked to see a patient infected by COVID-19 in the ICU. Upon arrival, she observed that the patient was coughing unceasingly, he was highly anxious and fearful and he was obviously in severe respiratory distress and likely did not have long to live. He was having difficulty articulating words. She saw him through a plastic protection screen and talked to him through a cell phone in loud-speaker mode. She wanted to decrease his agitation, anxiety, and fear. The CT talked to him in his Guarani language:

CT: "Close your eyes, calm down, concentrate on the oxygen, on the lung of your soul. Would you like to see someone?"
P: "My wife."
CT: "And what would you like to say to her?"
P: (He answered as if she was his wife)
"Forgive me for the flowers I did not give you, the kisses I did not give you, the infidelities I gave you. I thank you for the children, grandchildren, and great-grandchildren. I ask you for forgiveness for not being the companion I was, *mami*."

The CT felt he was saying farewell to his wife through her. She indulged in this dialogue flow and continued to answer him without looking at the vital signs monitor next to her.

P: "Forgive me."
CT: "Here I am, papa."
P: "I see the light."
CT: "Follow it."

The CT observed that the face that previously manifested great suffering transformed into a face that communicated peace. The monitor went flat. He had passed away.

Reflecting upon this strong experience, the CT stated that in the ICT course we work with fears and uncertainties, we are made of flesh, we are human beings, we are siblings in life, it is an instant and we must take advantage of it. She thinks that this training opens many possibilities, including being able to accompany this man in his last minutes of life.

Facilitating conversations in ICT implies sustaining a horizontal position, the same as the participants of the round, by being a welcoming host, using a simple language that is in accordance with the language of the community, being respectful of the cultural values and the diversity, valuing the emotions that unite us as human beings, and generating connection among the participants (García & Guevara, 2007; Grandesso, 2015, 2020). In addition, flexibility

is required in order to be ready to respond to what each round presents as to the number of people and the problems brought by the participants.

The CT, starting from a stance of genuine curiosity, *has to be able* to ask conversational questions that challenge the certainties and opens a space for people to share their experiences. Based in a "*withness thinking*" dialogical stance (Shotter, 2004), the CT favors reflective interactions, in such a way that each participant, including the CT, can be in touch with one another through their body expressions in addition to their words. When someone express themselves through words, movements, and emotions (Andersen, 2001), those who listen acknowledge what the person is expressing. This active listening allows the listener to connect with what he or she is hearing in such a way that, at the same time, the person can listen to oneself too. Speaking, acknowledging, and being listened to grants legitimacy to what is being said (García & Guevara, 2007). In the open ICT meetings where many people can attend, the whole community legitimates what the speaker is saying. The words and stories become valuable witnesses in the form of a cultural ritual that consolidates the social network.

The CT helps to recognize the resources generated throughout life, the inherited ones from the ancestors, and the effort made when facing difficulties. The focus is on the process and never the result. The CT sustains a stance that enables the elaboration of the interpersonal relationships rather than an intervention technique from an expert's position. The community members are experts in their lives and the CT is an expert in questioning. The CT is responsible for generating the context of community conversation. An ICT offers the extraordinary alternative of generating dialogues in community and can be considered a collaborative and dialogic practice. This implies a familiarity with the process proposed by the methodology of community therapy and with C-D practices in order to invite dialogue and collaboration. The CT believes in the resources of the other and creates a culture of respect by adopting an attitude of not-knowing. To paraphrase Tom Andersen (2005), being a therapist is, above all, being with others, and it is difficult to be with others when both they and I feel uncomfortable being together.

Final Considerations

Understood as a C-D practice, ICT offers an innovative possibility for facilitating conversations in a variety of contexts and with groups of different sizes and compositions. We have witnessed the transformative power of people in conversation in community spaces, in a variety of contexts. When the person shares their own life dilemmas out loud, those listening will have their own inner dialogue about what they are hearing. This process allows all present to be transformed by the rhizomatic effect of language. As we have witnessed, ICT

enters spaces that public policies do not consider or respond to in an inclusive and meaningful way.

The ICT bears an ethical stance of curiosity, inquiry, respect, active listening, and humility, generating horizontal relationships between the participants. It is a democratic community space, where everyone has an equal voice and learns from each other—including CTs—and from the resources developed to overcome the sufferings that occur over the course of life. Therefore, promoting solidarity values and bonds, autonomy, and responsibility of our lives strengthens the practice of citizenship, renewing hope in the present and in the future.

Contemporary society has widened the economic gap between those who have more and those who have less; this includes access to health care, education, and justice. Those who live in countries with higher rates of poverty and/or violence seek to migrate to countries where they think they will live better, and upon arrival, in many cases, some are crowded into groups of refugees and others are left on the road. According to predictions, this situation will increase post pandemic.

ICT offers the possibility of strengthening people and their human networks by responding to the suffering of countless people in a short time – about 90 minutes – with one or two facilitators. Its reach goes further than the present community once solidarity has been promoted. It favors citizen action to include differences. We have found this attitude and action especially useful in countries with huge and perverse social inequality; practices that honor and respect the differences open space for collaboration and democracy – more human ways of life.

Notes

1 The technical support and promotion of these online rounds has been given by the joint action of the Brazilian Association of Community Therapy (ABRATECOM), the Brazilian Association of Social Psychiatry (www.apsbra.com.br), the Latin American ICT Network, and the European ICT Association (www.aetci-a4v.eu/aetci-paca). The realization of the rounds has been the responsibility of training institutes for community therapists in Brazil and Latin America.

2 The psychiatrist was Olga Marsollier from Paraguay.

References

Andersen, T. (2001). Ver y oír. Ser visto y ser oído. In S. Friedman (Ed), *El nuevo lenguaje del cambio* (pp. 201–224). Gedisa Ed.

Anderson, H. (1997). *Conversation, language and possibilities: A postmodern approach to therapy*. Basic Books.

Andersen, T. (2005). Procesos de reflexión: Actos informativos y formativos. In S. Friedman (Ed), *Terapia familiar con equipo de reflexión. Una práctica de colaboración* (pp. 39–69). Amorrortu Editores.

Barreto, A., de P. (2008). *Terapia comunitária passo a passo* (2nd ed). LCR.

Barreto, A., de P. (2013). *Terapia comunitaria integrativa paso a paso*. Ed. en español Ecuador, p. 42.

Barreto, A.P., Ferreira Filha, M.O., Silva, M.Z., & Nicola, V. (2020). Integrative community therapy in the time of the new coronavirus pandemic in Brazil and Latin America. *World Soc Psychiatry*, 2: 103–105.

Esteves de Vasconcelos, M.J. (2002). *Pensamento sistemico: o novo paradigma da ciência*. Papirus.

Freire, P. (1983). *Pedagogia do oprimido*. Paze Terra.

Freire, P. (1986). *Pedagogia da autonomia: Saberes necessários à prática educativa*. Paz e Terra.

García, A. & Guevara, L. (2007). Voicing voices. In A. Anderson & P. Jensen (Eds), *Innovations in the reflecting process* (pp. 58–73). Karnac.

Grandesso, M.A. (2000). *Sobre a reconstrução do significado: Uma análise epistemológica e hermenêutica da prática clínica*. Casa do Psicólogo.

Grandesso, M.A. (2011). Terapia comunitária integrativa e terapia narrativa. In M.H. Camarotti, T.C.G.P. Freire, & A.P. Barreto (Eds), *Terapia comunitária integrativa sem fronteiras: compreendendo suas interfaces e aplicações* (pp. 196–195). MISMEC-DF Publications.

Grandesso, M.A. (2014). Terapia comunitária como prática coletiva de conversação: Construindo possibilidades de trabalho com sistemas amplos. In C. Guanaes-Lorenzi, M.S. Moscheta, C. Corradi-Webster, & L. Vilela e Souza (Eds), *Construcionismo social: discurso, prática e produção de conhecimento* (pp. 171–185). Instituto NOOS.

Grandesso, M.A. (2015). Integrative community therapy: A collective space of dialogical conversation and collaborative exchanges. In E.F. Rasera (Ed), *Social perspective on group work* (pp. 123–133). Taos Institute Publications.

Grandesso, M.A. (2020). Integrative community therapy: Creating a communitarian context of generative and transformative conversations. In S. McNamee, M.M. Gergen, C. Camargo-Borges, & EF. Rasera (Eds), *The Sage handbook of social constructionist practice* (pp. 183–192). Sage Publications.

Grandesso, M.A. & Cerveny, C. (2007). Da multidão ao sistema: Reflexões sobre particularidades da Terapia comunitária com grandes grupos. In M.A. Grandesso & M.R. Barreto (Eds), *Terapia comunitária – Tecendo redes para a transformação social: saúde, educação e políticas públicas*. Casa do Psicólogo.

McNamee, S. (2018). Profissionais como pessoas: Encontros dialógicos para transformação. In M.A. Grandesso (Ed), *Colaboração e diálogo: aportes teóricos e possibilidades práticas* (pp. 75–95). Curitiba: CRV.

Mcnamee, S. & Gergen, K.J. (1998). *Relational responsibility: Resources for sustainable dialogue*. Sage Publications.

Pakman, M. (2018). *El sentido de lo justo: Para una ética del cambio, el cuerpo y la presencia*. Gedisa.

Seikkula, J. & Arnkil, T. E. (2006). *Dialogical meetings in social networks*. Karnac Books.

Shotter, J. (2004). *On the edge of social constructionism: "Withness-thinking" versus "aboutness-thinking."* KCC Foundation Publications.

White, M. (2004). Folk Psychology and Narrative Practices. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research*. (pp. 15–51). Sage Publications, Inc.

White, M. (2007). *Maps of narrative practice*. W W Norton & Co.