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EXPERIENCE REPORT ARTICLE

INTEGRATED PRACTICES IN HEALTH: A COMMUNITY THERAPY EXPERIENCE IN BASIC CARE

PRÁTICAS INTEGRATIVAS EM SAÚDE: UMA EXPERIÊNCIA DA TERAPIA COMUNITÁRIA NA ATENÇÃO BÁSICA

PRÁCTICAS INTEGRADORAS EN SALUD: UNA EXPERIENCIA DE LA TERAPIA COMUNITARIA EN LA ATENCIÓN BÁSICA

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ABSTRACT

Objective: to discuss the proposal of the community therapy as an integrative practice in primary health care. ***Method:*** it is an experience report, from a university extension project, whose actions were developed with users of a Basic Health Unit of the family, through the following steps: raising awareness of the work team; participatory community diagnosis; Community Therapy workshop with students, teachers and health professionals; community mobilization for the participation in Community Therapy; and implementation of support groups in Basic Health Unit of the family. ***Results:*** in the course of the meetings of the community Therapy, participants shared impressions about some psychosocial conflicts experienced, expressed from thematic related to the adversities of everyday that led to expressions of psychosocial distress and various forms of illness. Concurrently, there were reports of health problems that varied from specific complaints, proven to be diagnosed as organic, to unspecific problems, characterized as diffuse suffering. ***Conclusion:*** according to what was exposed above, community therapy is inserted in this context as an intervention that enabled the dialogue of the professionals with the singularity that the illness process acquires for users that demand health attention. In this way, participation and co-responsibility amongst participants were encouraged, searching for new alternatives of cure and prevention, aiming at receptiveness, the formation of linkages and empowerment. ***Descriptors:*** group practice; complementary therapies; community medicine.

RESUMO

Objetivo: discutir a proposta da Terapia Comunitária como prática integrativa na atenção básica em saúde. ***Método:*** relato de experiência, a partir de um projeto de extensão universitária, cujas ações foram desenvolvidas com os usuários de uma Unidade Básica de Saúde da Família, mediante as seguintes etapas: sensibilização da equipe de trabalho; diagnóstico comunitário participativo; oficina de Terapia Comunitária, com discentes, docentes e profissionais de saúde; mobilização da comunidade para a participação na Terapia Comunitária; e implantação dos grupos de apoio na Unidade Básica de Saúde da Família. ***Resultados:*** no decorrer dos encontros de Terapia Comunitária, os participantes produziram sentidos sobre alguns conflitos psicossociais vivenciados, manifestados a partir de temáticas relacionadas às adversidades do cotidiano, situações estas que determinaram expressões de sofrimento psicossocial e diversas formas de adoecimento. Concomitantemente, foram narrados problemas de saúde que compreendiam desde as queixas específicas, comprovadamente diagnosticadas como problemas de ordem orgânica, até as queixas inespecíficas, caracterizadas como sofrimento difuso. ***Conclusão:*** a Terapia Comunitária inseriu-se como intervenção que possibilitou o diálogo dos profissionais com os saberes e a singularidade que o processo de adoecimento adquire para os usuários que demandam atenção em saúde. Desse modo, estimulou-se a participação e a corresponsabilidade dos participantes na busca por novas alternativas de cura e prevenção, com vistas ao acolhimento, a formação de vínculos e o empoderamento. ***Descritores:*** prática de grupo; terapias complementares; medicina comunitária.

RESUMEN

Objetivo: discutir la Terapia Comunitaria como una práctica integradora en la Atención Básica. ***Método:*** se trata de relatar una experiencia, que fue desarrollada en el marco de un proyecto de extensión universitaria con los pacientes de una Unidad Básica de Salud de la Familia. Las acciones fueron sistematizadas en cinco etapas: sensibilización del equipo de trabajo; diagnóstico comunitario participativo; oficina de Terapia Comunitaria, con alumnos, profesores y profesionales de la salud; movilización comunitaria para la participación en la Terapia Comunitaria; e implantación de los grupos de apoyo en la Unidad Básica de Salud de la Familia. ***Resultados:*** los participantes de la Terapia Comunitaria comenzaron a producir sentidos sobre los conflictos psicosociales vivenciados, a partir de discursos relacionados a las adversidades que enfrentan cotidianamente, situaciones que determinan el sufrimiento psicosocial y diversas formas de adolecer. Simultáneamente, fueron narrados problemas de salud que comprendían desde las quejas específicas, diagnosticadas como problemas de orden orgánico, hasta las quejas inespecíficas, caracterizadas como sufrimiento difuso. ***Conclusión:*** en virtud de lo puede considerarse la Terapia Comunitaria como una intervención que posibilitó el diálogo entre los profesionales, sobre la relación entre sus propios saberes y la singularidad que el proceso de adolecer adquiere para los pacientes que buscan atención para la salud. De ese modo fue estimulada la contribución y la co-responsabilisación de los participantes en la búsqueda de nuevas alternativas de cura y prevención, en la perspectiva del acogimiento, la formación de los vínculos y el empoderamiento. ***Descriptores:*** práctica de grupo; terapias complementarias; medicina comunitaria.

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INTRODUCTION

The current policy of education for acting in the context of health invest in building pedagogical projects forming workers with skills and expertise to undertake actions that are consistent with the ideals of the *Sistema Único de Saúde*. Hence, we can to say that there is a consensus on advances and reformulations in training in the health field and, consequently, in the posture of the professionals in their relationship with users.

It should be noted, however, that the hegemonic mode of production of care, often neglects the principle of completeness and humanization in health. Therefore, it highlights the need for reorganization of attention based on a model of care that dialogue with the singularity, with the subjective experiences and cultural knowledge of the subjects that require health care.

Throughout human history, it identifies forms of health care, present in several times, so it is understandable that people have always looked for different ways to cure their diseases and restore their state of health. Gradually, as result of the advances and changes of knowledge, discourses about health and disease is scientifically organized and came to represent legitimate knowledge, and therefore, official, and to disregard the knowledge originated from popular culture. Thus, in the name of the superiority of systematic knowledge, produced and seized in academia, the health professional, and only it, would have the power and authority to decide what is normal and what is pathological. So, even without passing through the officials spaces of knowledge, the common people have continued to find ways to prevent and deal with disease processes, from their experiences and contact with nature.

Among the reasons that explain the status and influence of health professionals in society, it identifies the progressive advent of knowledge produced about medicine on the body, their diseases and modes of intervention, whose objective was to prevent, relieve and provide better health conditions.

• The Medical practice identified with scientific practice

The practice was identified with scientific practice and the doctors became the keepers of a knowledge that can be verified "scientifically." Thus, these professionals had strengthened their power in society, causing a disqualification of other types of knowledge and traditional healing practices, as the popular wisdom, when identify it as "unscientific" and therefore ineffective.[1]

It is important to note the process of structuring of scientific medicine had a significant economic support, being responsible for the task of recovering and maintaining the staff at work, even though the conditions and determinants of illnesses were the conditions of life and work. As a result, it was proposed to decrease the social stresses and brought about, at the same time, the reproduction of capitalist relations.

Capitalism, being developed in the late of 18th and early 19th century, socialized a first object that was the body as a force of production, labour force. The control of society over individuals does not operate simply by conscience or ideology, but begins in the body, with the body. It was in the biological, the somatic, and the body that, above all, the capitalist society invested. The body is a biopolitical reality. The medicine is a biopolitical strategy.[2]

It is noted that the scientific knowledge of medicine, coupled with economic interests and the need to accumulate capital, produced a form of health care which took as its starting point the model of consumption, from the excessive use of medical check-ups until the indiscriminate use of procedures, medications and specialized hospital care. The medical power, in turn, began to regulate people's lives and society and led to the authoritarian medicalization of culture, bodies and diseases, and obviously the loss of autonomy.[2]

This autonomy does not only refer to the way people are treated, nor to the determinations and conditions of the way of life. Autonomy is understood here not in the Kantian sense of moral responsibility, of elite over those accused of not following the rule or reason, but in the Spinoza's sense of an assumption about ourselves of body and soul, with respect to the present reality of each one.[3]

The supremacy of medicine, like a type of knowledge which exercises power and influence the ways of life in society, is very clearly expressed in the routine health services. Just watch the recurrent search of people for a customer service that, often, they own complain of a general malaise, whose symptoms do not fit in a traditional nosography. This type of manifestation of disease can be named as "diffuse suffering", it

is a term used to refer to unspecified problems and complaints related to important psychosocial issues such as lack of social support networks, problems that relate to family relationships, labour, social and economic of users of health services.[4-5]In general, it is observed that health professionals classify people with diffuse suffering as grumbler patients, psychosomatic, functional, psycho-functional, hysterical, neurotics.[6]

The designation "diffuse problem" originated from the ascertainment that this type of complaint is one of the largest health care demands, in the popular classes, and without responses from the service, given that a significant number of professionals are not prepared to accept perceptibly this demand, because focus their attention on individualization of this problem.

As proposition for a new practice of health care, it should be stimulated the conception of focused intervention no longer on the object-disease, but the object existence-suffering, in its connection with the sociocultural and subjective processes of people, since, during the course of development of the disease, signs of discomfort are transformed into symptoms of distress, imbued with meaning.[7-8]

It shall be presumed that the discourse is a construction, a posteriori, of concrete social situations experienced by social actors, which, of course, highlights the need to understand the existential and inter-subjective roots underlying discourses on the disease. In this sense, the body, such as space of disease, becomes a text open to different readings in search of meaning for the patient in the process of triggering symptoms. The body can be taken, then, support of signs, generator of meaning and sense.[9]

However, it is necessary understood that, in the relationship between health worker and patient, the construction of meanings and senses is made by the articulation and confrontation of diverse knowledge and recognition of the life history of the user, its social status, culture, beliefs, values, feelings, etc. Reflecting on the work processes in health care, it is conceived the care as an event pervaded by multiple technological suitcases, which represent the knowledge and its tangible and intangible development.[10]

• The health care, its challenges and possibilities of reconstruction of practices

When thinking about health care, its challenges and possibilities of rebuilding practices, through the image of suitcases, to illustrate the boxes of technological tools in the health worker-patient relationship, it is believed that the health workers in their actions, uses three types of suitcases:1) hand bag, which are present instruments like the stethoscope, pen, paper etc., called hard technologies; 2) bag of the head, which contain the structured knowledge, technical expertise, guided by soft or hard technologies; 3) bag of relations, as a soft technology, present in the health worker-user relational space in which it realizes the construction of a health care practice concerned with the formation of bonds, acceptance and accountability.[11]

Thus, a resolute clinical practice requires the availability of health workers to integrate the various technological tools and, therefore, the different models of care, resulting in a more focused practice not only focused on procedures, but beware to the users. Nevertheless, it is noteworthy that the suitcase is the health worker-user relational space that, ultimately, allows one of the most singular moments of the work process in health as a producer of care.[11]

In this context, complementary and integrative practices appear as a possibility of guarantee to completeness health, in a dialogical perspective, emancipatory, participatory and creative, combining knowledge, practices, experiences and health spaces. Therefore, “they are presented as an adjunctive intervention that works, often, with other forms of conventional accompaniments performed by health teams, according to the needs of users".[12:0]

In order to encourage the propose of collective action that dialogue with the knowledge, the uniqueness and the multiple social forces present in the context of illness, through university extension activities, set itself the challenge of implementing the methodology of Community Therapy in primary health care, in order to institute it as a space for integral care and complementary intervention of care in Family Health Strategy – *Estratégia de Saúde da Família*(ESF).

The Community Therapy was systematized by Ceará’s Psychiatrist Adalberto Barreto, in the 80s, as an intervention strategy in groups that aims to stimulate the construction of solidarity networks of care between people and strengthen individual and collective skills, through socialization of experiences. It is composed of a large group of people who belong to multiple cultural universes, this

intervention is to provide the community a space for listening, in order to promote the circularity of the word and raise the emergence of multiple voices not heard or expressed in everyday services health.[13-14]In this sense, the Community Therapy is emerging as a technology of care used by the Family Health Teams, in the daily services and in the community, to build supportive social networks and reduce the emotional suffering of the population arising from problems related to poverty, migration, abandonment, insecurity and low self-esteem.[15-7]

The Community Therapy is organized based on five thematic axes: systemic theory, theory of communication, cultural anthropology, popular education and resilience.

In the Community Therapy, systemic theory aims to understand the behavior of people in their multifaceted context. This theoretical axis enables the understanding that each individual is a whole and each part influences and interferes in the other.[18-9]. It means that in the search for solutions to personal problems, family, community and social, you must understand the whole in which people and groups are inserted, without losing sight of the relationship between the parts of the set to which they belong. In this approach, the subject perceives himself in relation to their family interactions, social, and also in relation to their values and beliefs, a greater understanding of himself, in favor of its transformation.[20]

In the context of Community Therapy, the theory of human communication contributes to the understanding that all behavior is communication, so we communicate not just with words, but with all the actions and practices. Based on the axioms of communication, it should be presumed that all behavior is communication, and that every act, verbal or not, individual or group, has a value of communication, allowing the emergence of multiple meanings and senses in the group, in an awareness of communicative relationship with the other being.[21]

Cultural anthropology is the theoretical basis of Community Therapy that calls attention to the culture as a great set of achievements of a civilization or social groups. "The culture is directly related to the production and exchange of meanings among members of a society or group".[22:76]Likewise, it is from cultural reference of a community that each member takes his ability to explain, to discern values and make their choices in its daily life. It appears, thus, that the culture is the framework of the identity which contributes to each participant, from its cultural references, to produce the meanings on the world and life.

Popular education, based on the dialogic relationship, is fundamental practice in Community Therapy. To put the dialogue into practice, the community therapist, who is consistent with the figure of the popular educator, must not put itself in the position of those who naively intend to be holder of all knowledge. In this sense, a key element is that of taking as a starting point of the pedagogical process, the previous knowledge of popular classes.[23]It starts from the assumption that in work, social life and the struggle for survival and transformation of reality, people gain an understanding of its role in society and nature[23-4]In addition, in the Community Therapy there are not those who teach and those who learn, but a joint and mutual confrontation of knowledge, in a permanent and dialectical manner.

The last theoretical axis of Community Therapy is resilience. It is based on the premise that people have the capacity to generate force and power of acting, from their own suffering, and, because it, arouses learning and competence to mobilize coping strategies of health and psychosocial problems.

In methodological terms, the Community Therapy is operationalized from steps called: host choose the theme, background, questioning or watchword, closure or positive connotation and, finally, the evaluation.

The stage of the host is regard to the reception and adjustment of the participants, in the perspective that they feel comfortably accommodated and included in the group. Preferably, this activity should be performed in a circle, so that all may be visible through various tools such as music, dynamics, plays, dances or any other resources that are in line with local and cultural identity of people in the community. Among the aspects to remember in moment of host, it should be noted: the rule of keeping silence in the group; guiding the participants to talk about their own problems, and remind participants that the space of Community Therapy is for exchange of experiences and not to give or receive advice.

When people are welcomed and included in the group, it follows to the stage of choice of theme, whose objective is to negotiate a generator theme to the meeting. At this time, participants may express different themes. However, it is necessary create a process of

choice for catch only one problematic issue. It is recommended that participants verbalize their experiences briefly, because this moment is marked by the choice of theme and not for exploring it. In general, the choice is made by people's opinion, that, spontaneously, they express why chose a particular theme to be explored.

The third stage of Community Therapy is the background (context). After the theme is chosen, the participant, who had their problems addressed, verbalizes its situation-problem, so that the context is understood. All group members can participate and develop questions that contribute to global understanding and context of the theme to be developed.

After setting the context, throw up the hand step called for questioning or watchword. In this sense, community therapist, through a key question, linked to the problem explored in the earlier context, seeks to promote the exchange of experiences among participants. The facilitator must not only raise the exchange of information about experiences, but to instigate ways to overcome the problems experienced.

The penultimate phase of the Community Therapy is the closure or positive connotation, which should allow individuals to rethink the problems more broadly and go beyond the immediate effects to give a deeper meaning to the individual or group crisis. It should be stimulated a greater awareness of participants about their personal and collective resources to solve problems.

Finally, the evaluation is performed by persons responsible for conduct of Community Therapy and comprises three stages, namely: filling out a form of group activities, impact assessment of Community Therapy and the conduct of the group process, in order to discuss the main potential and weaknesses of each meeting.

That said, the article presented here aims to discuss on the experience of university extension project "The Community Therapy as a Strategy for Intervention in Primary Health Care", linked to the *Universidade Federal Campina Grande*, whose objective consisted in the implementation of the methodology of Community Therapy in Family Health Strategy, as a integrative practice of care and amplification tool of medical clinical and completeness in health.

The extension activities, integrated with teaching and research, occurred during 2011 and were developed with users (male and female) of a Basic Unit for Family Health and other people of the community, from a municipality in the state of Paraíba/ Brazil. The project was attended by a nurse, a doctor and six community health agents, and also with teachers and students of medicine and psychology courses from *Universidade Federal de Campina Grande* / UFCG.

METHOD

It is an experience report, of qualitative and reflective nature. In terms of methodological and theoretical conception, the principles that have guided and supported this study are guided by the possibility of raising action as dialogical educational processes, the ability to promote creative capacity, critical and reflective of the subjects. At the same time, we stimulated the co-responsibility, and empowering of people in finding alternatives for psychosocial and health problems, with a view to raise the power of acting before the life circumstances.

Generally, the meetings of Community Therapy comprised of an average of about 30 people. Though the group was diverse in terms of gender, the participants of the activities, most of them were women, users of health services mentioned above, as well as other people in the community, with diffuse complaints of disease, with ages ranging from 20 and 70 years, and an education characterized predominantly by illiteracy, followed by incomplete high school. With regard to the productive occupation, 70% of people survive with per capita incomes average of one minimum wage, coming from retirements, provision of services to others and social programs.

In search of achieving the proposed objectives, the actions of the project took place from five steps: community diagnosis, awareness of staff, training workshop on Community Therapy, community mobilization and implementation of Community Therapy in Basic Unit for Family Health.

With a view to further know about the community, and the group in which the project was inserted, we developed a participatory community diagnosis. For this purpose, through family visits, we applied a script in order to collect socioeconomic and demographic information from families, and then, we performed a meeting aimed at identifying how people lived, the main potential and weaknesses, health complaints and strategy to overcome the problems faced by the community.

Parallel to the application of the diagnosis with the community, there was also an awareness activity with the work team, which consisted of a meeting to clarify the importance of collective and coordinated actions between the health service staff, community and University, as well as to plan the execution of the project with the entire staff of the Family Health Unit, community leaders and other stakeholders.

In a third moment, we organized a training workshop on health care practices, which aimed to trigger, throughout the project and continuously, a process of qualification in Community Therapy and other participatory methodologies for professional of health services, students and community leaders involved in the project.

As there was no structured group in the Basic Unit for Family Health, we needed to carry out a community mobilization in order to encourage people in the community to participate in meetings of Community Therapy. For this purpose, together with the community health agents and leaders, the whole team had a wide dissemination of project activities through home visits, meetings and involvement with other social agents accessible to the community.

Finally, we began the process of implementing the Community Therapy, which culminated in the structuring of a permanent group at the Health Unit, aiming at building solidarity networks of care and health care. The meetings were held on, fortnightly, lasting about 1h30m, according to the methodology of Community Therapy, namely: host, choose the theme, background, or questioning or watchword, closure or positive connotation and evaluation.

With regard to monitoring and evaluation of the project in the community, over its execution, we adopted the strategy of evaluation called 360º, in which all stakeholders are positioned with respect to the work process, their strengths, weaknesses and possibilities of solutions to the problems presented. The assessments were made continuously from weekly meetings with students and professionals of the health team, and in the meetings of Community Therapy, in which participants positioned themselves as to the progress of actions. In addition, meetings were evaluated at each occasion, through a field journal of group activities, aimed at describing and analyzing how the group process occurred and the senses that the participants produced about the thematic explored.

In addition to the methodology of Community Therapy, other tools were used in order to streamline the group activities, especially, in times of reception of the participants, such as circle dances, group dynamics, stall to tell histories, psychodrama, and songs sung and taken into the sound of a guitar, among other.

RESULTS AND DISCUSSION

The data presented in this session consider, initially, the impact of the project actions to the community, for users (male and female) and the health service. Subsequently, we shall describe some results about the meanings of Community Therapy for people who participated in that activity, the most recurrent themes and meanings produced from them. Finally, we shall present some strategies adopted by the participants of the meetings for coping with psychosocial and health problems.

Actually, in terms of impact of actions, it is noted as one of the main results of the project, the Basic Unit for Family Health, the structure of a group of Community Therapy, which operates, fortnightly, as a complementary strategy of care in primary care.

Thus, the Basic Health Unit now has a permanent group space for mutual support and help to the community, where people could socialize experiences of illness and ways of overcoming it, as well as rescue social and affective bonds and sense of belonging. With the establishment of a group of Community Therapy as a legitimate space for conversations, we identified a reduction in the search for clinic visits, and, concomitant, in use of medicaments.

By participating in a group, people began to build a network of social support in the community, which provided a collective awareness of the problems, once unknown. Certainly, the participants began to feel welcomed even facing the illness experience, since they have been heard in their uniqueness, unlike many medical consultations, which, on behalf of a speed, allow the tests “speak by themselves”, in the name of people.

During the Community Therapies, various themes were listed by the participants, over 12 meetings. As mentioned previously, in order to systematize some data about the group, we adopted a form of monitoring activities, for each meeting, in which were recorded all the information about the theme

discussed, the meaning that people produced from each theme, and also how was built the exchange of experiences among participants.

With this purpose, we observed all the themes generated in the group process, organizing them into categories and placing them in the context of the speech from participants. This feature allowed a better view of each problem, while it provided an understanding of how people described and argued about the main themes that emerged in the group.

Although the project has developed a Basic Unit Family for Health, people who participated in the meetings, most of them were users (male and female) of this service; the topics discussed were not restricted to health complaints. Indeed, among the most recurrent problems in the group of Community Therapy, we can classify them into two macro-categories: the psychosocial problems and health problems.

In the category of psychosocial problems, according to table 1, are located all topics related to general situations of adversity in everyday life, as well as those that express the situation of social fragility, economic, identity, cultural and denial of goods and services that are submitted group participants.

Table 1. Recurrent themes in the meetings of Community Therapy. Campina Grande, 2011.

Psychosocial Problems Category		
Themes	n	%
Family Conflicts	11	37
Unempolyment	07	23,3
Lack of solidariry bonds	06	20
Sense of loss	02	6,7
Relationship problems in the workplace	02	6,7
Child sexual abuse	01	3,3
Gender relations	01	3,3
Total	30	100

The data presented in table 1, dealing with psychosocial problems most frequently raised in Community Therapy, illustrate that, among 30 participants in the group, 37% reported thematic related to family problems, followed by 23.3% for the unemployment, and 20% claimed the absence of solidarity bonds.

In terms of analysis of the meanings people produced about family problems, characterized as an expression of disagreement among family members, difficulty in dealing with the education of children and youth, and also situations of domestic violence.

Regarding thematic related to unemployment, the speeches showed situations of social exclusion and lack of productive jobs. The reports showed that the impossibility of integration and full participation in social and economic life, which generate negative effects on people's self-image and how they deal with the problems, determining expressions of psychosocial distress and illness in the modes of subjectivity of individuals and groups.

Although on the thematic axis of psychosocial problems, the third most discussed problematic in the group was the absence of solidarity bonds. The narratives revealed the fragility of the social and emotional bonds, experienced in contemporary society, which extends to the communities, and therefore undermines the prevention of health problems, through solidarity and mutual support.

The category of health problems, according to table 2, immediately after, shows that 33.3% of people who participated in the Community Therapies faced questions related to heart disease and hypertension, 27% suffered from diffuse health problems, and 20% reported experiencing situations of depression.

Table 2. Recurrent themes in the meetings of Community Therapy. Campina Grande, 2011.

Health Problems Category		
Themes	n	%
Heart diseases and hypertension	10	33,3
Diffuse health problems	08	27
Depression	06	20
Mental Health(disturbs)	02	6,7
Difficulties in dealing with TDAH	02	6,7
Difficulties to access the SUS	02	6,7
Total	30	100

Table 2 reflects, therefore, all themes depicting the various manifestations of disease, since the specific complaints, properly diagnosed as problems of organic nature, even the unspecific complaints characterized as diffuse suffering.

More specifically about the problems of the thematic axis of health, it was observed that people were seeking the Basic Unit for Family Health with the expression of complaints located in the body, with an understanding that every disease has an organic or biological origin, in line with the hegemonic ideology of medical discourse. Probably, these built explanations are nothing more than the attempt of social recognition of illness, so that by placing pain just in the body, the disease begins to gain more visibility.[25]

Moreover, throughout the Community Therapies, gradually, people related pain in the body with the adversities of everyday life. Due to the exchange group experience, it was allowed access to a personal and symbolic language, which is outside the body, and, therefore, we could visualized the mechanisms of identification and mutual support between the community members, before the redefinition of the psychosocial and health problems.

By telling stories and sharing experiences, from the questioning, one of the main stages of Community Therapy, which is to raise the exchange of experiences, people have developed and reported coping strategies for health and psychosocial problems. It was observed that the personal and family history as well as the crises and sufferings produce a sense of resilience and knowledge that enables to each participant triggers overcoming features that were previously unknown. Hence, we can see the importance of the multiplicity of voices heard and possibilities of redefinition of the experiments, because of what all people go through the same problems, but elaborate sentences and provide different overcoming resources, each one. Among the main coping strategies of psychosocial and health problems, we identified: participation in social support groups and mutual help, spirituality and community bonds.

According to reports from people, when participate in a social support group or mutual help, which pass through the same problems, or living situations that affect the well-being and health, sets up an exchange of experience which is beneficial both for those who help as for one who is benefited from the experience of other participants. It should be produced, thus, a feeling of equality, social utility and individual and group competence, so that the support provided by certain groups or social organizations can contribute towards providing protective factors against the emergence of diseases.

A second strategy for coping with the psychosocial and health problems, pointed out in the Community Therapy, was the spirituality. In meetings performed in the Basic Health Unit, the stimulus to the exercise of spirituality, regardless of religion, was one of the resources significantly raised by the participants, with a view to overcoming the psychosocial and health problems. This does not mean that religion "solves" the situations of adversity and health problems, but the speeches of the participants pointed out that faith provides a sense of symbolic support. As facilitators of Community Therapy, we fell the task of contributing to the redefinition of problems and, at times, to demystify the idea that the solutions are fatalistic or divine works, but that all people are part of the problem and solution.

Still among the most elucidated overcoming resources in the group, the community bonds, by inserting in networks of formal and informal support, such as churches, community associations, work places, conversations with neighbours, among others, are placed as possibility of social support and affective bond, as they promote a solidarity attitude of care and mutual support, so that may contribute to decrease susceptibility to illness.

The moment of questioning, aimed at socialization of experiences in the group, was propitious to decentralize the problems reported of a unitary focus, individual,

transferring it to the collective experience, in which people express different ways of overcoming. It should be presumed that, when retell their stories, all people have the human capacity to produce meanings, constructed dialogically in relation to the other being.

FINAL CONSIDERATIONS

At a time when health professionals are urged to redirect their actions and articulate different conceptions about the health-disease process, complementary and integrative practices are presented as tools that provide the restoration of completeness in health, through which the people and social groups bring about a greater control over their lives.

From the standpoint of the need to transform the rationality of the biomedical model, which should occur in the daily practice and the field of academic training, the integrative practices start of pedagogical relations that foster experiences and learning that tell on the world where people are circumscribed, and, therefore, on their individual and collective subjectivities.

In light of this above mentioned, when placing the integrative practices as complementary references for health professionals, the proposal of Community Therapy, in primary health care, was implemented with a view to encouraging a dialogical relation of production of care that would take like starting point the subject's experience and not only their diseases. So, we tried to promote a space for expression of psychosocial and health distress, from a collective and mutual approaching.

Comprised of a large group of people who belong to multiple cultural universes, in the Community Therapy the word circulates in a fluid manner and raises multiple voices not heard or expressed in everyday health care. In this space, each one tells their count, their history and builds new meaning to the lived experiences. In the movement to construct and reconstruct their narratives, they are all, at the same time, participants and builders of reality, a process of collaborative creation and recreation. Group interventions of this nature assume a psychosocial function, as people share problems, social roles and produce common identifying bonds with each other, which, in turn, contribute to the prevention and restoring health.

Finally, we can infer that many of the traditional health practices have limits on the perception of the demands and needs for attention and resolution of the interventions, which calls on health professionals, generally, to reflect on the rationality of their practices and question what, in fact, they stipulate. The adoption of integrative practices highlights the need for acquisition of other knowledge that is committed to the redefinition of the hegemonic practices of health care.

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