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ORIGINAL PAPER

The Search for a Politically Reflective Clinical-Community Approach

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Abstract The following paper explores how working in Venezuela, a country that has gone through 20 years of economic and political problems, has highlighted the gap between clinical and community approaches in dealing with the sufferings of our consultants. Our efforts to develop theoretical and practical tools that can address the historical and political dimensions of people's lives are reviewed. These efforts illustrate how the community paradigm can help expand clinical perspectives, thus allowing a practise which can address the needs of people who have neither the time nor the economic means to engage in a traditional therapeutic relationship. The shift in perspective, the revision of our "therapeutic" stance and the use of de-naturalisation and problematization are illustrated.

Keywords Clinical-community approach · Paradigm · Problematization · De-naturalisation

The Gap Between Clinical and Community Psychology

A gap between clinical psychological and community approaches has long been signalled and criticised by many authors (Sarason 1981; Espín 1993). This gap is made constantly apparent when working in contexts that differ from the developed and economically stable circumstances where many of the available approaches are originally proposed. In the words of Cowen:

> Because mental health services had developed within a predominantly white middle-class tradition, they were for the most part packaged in the frills and ribbons of that tradition, including fixed, prescheduled, 50-minute sessions held in well-appointed offices staffed by efficient, verbally facile reception personnel. Unfortunately, since such trappings are unnatural or even alien to major segments of society, they turned many people off prospective services before those services could ever take hold. (Cowen 1983, p. 637)

Work as clinical-community psychologists (Llorens 2003; Rodríguez 2003; Romero 1999) with impoverished and underprivileged sectors in Caracas, Venezuela, evidences numerous limitations of the traditional clinical approaches rooted in modernist premises such as psychoanalitic or cognitive-behavioural therapy. The intense social and political crisis our country has faced in the last 20 years has also underlined the importance of working with contextualised approaches. Traditional clinical psychology, developed out of the medical model and modernist science, has long aspired to a neutral political and social stance, afar from social conflict and difficulties. Post-modern approaches, specifically social constructionist perspectives (Gergen and Warhus 2003; Gergen and McNamee 1996; Holzman and Morss 2000), have been useful to us in developing ways to deal with many of the social dilemas our work continually faces us with.

Venezuela has had severe economic difficulties beginning in the mid eighties. These difficulties accentuated the economic inequalities of our society, with the percentage of people living in poverty increasing to around 60% (Proyecto Pobreza 1999). Expressions of what various sociologists called the "culture of urgency"

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emerged (Pedrazzini and Sánchez 1992), with a rapid increase of people living on the streets and huge increase of crime rates, specially murder (Briceño-León 2005). All this contributed to political instability that led to two military coup attempts in 1992 and the election in 1999 of one of the coup leaders: Hugo Chávez. Chávez leadership has further polarised the country, with speeches in which one of the mayor themes that have been passionately presented is that of class struggle. The expressions of this social unrest are continually present in our work as psychologists, but at many times we have found ourselves struggling to find ways to develop interventions that can focus on these matters, since little of our psychological theories and techniques have been developed to attend these types of human difficulties. The chance to address economic and political hardships and differences has been a common challenge shared by many of my Venezuelan colleagues. And the fact that psychologists in Venezuela have in general a professional and middle class social status has also generated a dilemma highlighting some of our limitations in developing ways to help and work with impoverished sectors. In many discussions we have heard psychologists time and again taking the option of avoiding economic, political and cultural themes. It is common to hear the professionals at workshops, training programs and clinical interventions stating that political topics are not allowed in the discussions so as to protect the space. Even though we do not discard this option, in this paper we will try to examine our search to find ways to deal and not just avoid these themes.

Bridging the Gap

We have found that clinicians in other parts of the world, who have had to go through politically unstable periods, have become painfully aware of the limitations of the clinical models, and the reluctance of these models to face the political dimensions of the human difficulties we work with. In our work we have drawn from a heterogeneous group of psychiatrists and psychologists who have discussed clinical theories lack of social and political awareness. In this group we find a wide array of perspectives, such as the antipsychiatric movement (Laing 1964; Obiols and Basaglia 1973), feminist revisions of psychological theory (Bruin and Meler 2000; Kristeva 1997; Kristeva 2001; Velásquez 2003); a number of psychoanalysts with marxist and existentialist influence (Fromm 1980; Laing and Cooper 1964; May 1974; May et al. 1967); clinicians who work with trauma, specially those that have worked with political and family violence (Barudy 2000; Corsi 2003; Corsi et al. 1995, 2003; Herman 1997; Masson 1984); postmodern approaches to therapy (Anderson 1997; Coderch 2001; Gergen and McNamee 1996; Holzman and Morss 2000; White 1995) and the readings of social community psychology (Martín-Baró 1984/1993; Montero 2004, 2006). Even though there are many differences in these authors, they share the belief that clinical approaches inevitably carry along a political dimension and that intervention must include it. They have written amply about traditional medical and postivist clinical approaches lack of comprehension and capacity to act on the social and political dimensions.

Marie Langer is one example. Having gone through the Nazi occupation of Austria while training as a student to become a psychoanalyst, she experienced first hand, the dilemas her teachers and colleagues encountered when their intrapsychic formulations were challenged by the rapidly changing political circumstances of the 1930s. In particular she chronicled Freud's difficulties acknowledging the political and contextual dimensions of the human experience. The letter written in 1933 to Marie Bonaparte in which he commends her on her "luck" of being able to attend only to her work, and not have to "hear about all the horrible things that occur in the world" (Langer 1971, p. 259), is a wonderful example of many clinician's feelings towards the political dimension. In that same letter Freud comments on many colleagues who have warned him of the risks of staying in Austria, and replies saying that such risks are "absurd". In 1934, his works, as we now know, were banned and burned in Germany, and in 1938 he finally had to go into exile in England.

Meanwhile Langer went into exile in Argentina where she became a leading psychoanalyst. Her origins made her acutely dismayed by the rise of the military regimes that took power in Argentina in the 1970s. Thence, her work went on to challenge the psychoanalytic community to take a stand on the political abuses happening at that time. Particularly she challenged many of her colleague's intents to take a "neutral" stance in the political arena. She wrote: "we believe that to isolate yourself and try to disregard the social historical process, far from being a neutral attitude is an active way of taking sides" (Langer 1971, p. 265), and added: "the psychoanalytic interpretation can complement our sociological and political understanding, but it looses its meaning when used in isolation, instead of locating it in a social structure." (Langer 1971, p. 20).

Many clinicians working with victims of trauma have also begun to see the political dimensions implicit in the relationships that produce trauma (Barudy 2000; Herman 1997). Judith Herman's work with political and domestic victims of abuse clearly highlights the importance of acknowledging and addressing the historical and political dimensions to be able to make effective interventions. She writes:

> The systematic study of psychological trauma therefore depends on the support of a political movement. Indeed, whether such study can be pursued or discussed in public is itself a political question. The study of war trauma becomes legitimate only in a context that challenges the sacrifice of young men in war. The study of trauma in sexual and domestic life becomes legitimate only in a context that challenges the subordination of women and children. Advances in the field occur only when they are supported by a political movement powerful enough to legitimate an alliance between investigators and patients and to counteract the ordinary social processes of silencing and denial. In the absence of strong political movements for human rights, the active process of bearing witness inevitabley gives way to the active process of forgetting. Repression, dissociation, and denial are phenomena of social as well as individual consciousness. (Herman, 1997, p. 9)

Also a growing number of psychologists have been critical of clinical psychology's incapacity to attend, adapt to and comprehend circumstances that are not set in occidental, politically stable, middle class, educated environments (Anthony et al. 1990; Cowen 1983; Waldgrave 1990; White 1995). Work with the communities that have been impacted by the social and political crisis of our country has driven us to develop approaches that try to integrate clinical and community perspectives. Similar conclusions have been reached by many psychologists working with excluded, impoverished communities. For example, Waldgrave, in Aotearoa/New Zealand writes:

> …we realised that the problems these families were bringing to us were not the symptoms of family disfunction, but the symptoms of broader structural issues like poverty, patriarchy, and racism. We, like most other therapists, were treating their symptomatic behaviour as though it were a family problem, and then sending them back into the structures that created their problems in the first place. (Waldgrave 1990, p. 6)

Just as clinical psychologist have had difficulties addressing the historical and political dimensions of human experience, social and community psychologists with whom we started collaborating closely reported difficulties comprehending emotional and irrational aspects of their work, as some literature also points out (Hogget and Miller 2000). So these circumstances drove us to begin rethinking our paradigmatic, theoretical and practical approaches, to try and develop integrated, dialogical and contextualized understandings that could help us. In John Shotter's words: "be more at 'home' in human life at large in ways that can continually extend as I actively engage myself in elaborating yet further the 'calls' I receive from my surroundings" (Shotter 2000, p. 125).

Integrating Clinical and Social Perspectives: Rebuilding Community

In the case of the team of psychologists with which I work trying to develop a clinical-community approach (Llorens 2003; Rodríguez 2003; Romero 1999) in Venezuela, our reflections have derived mainly from our work with impoverished and excluded sectors of Caracas, the country's capital city. The community centre (Parque Social "Padre Manuel Aguirre, S. J.") where we work, attends the lower income communities in the southwest sector of the city, where a large number of poor neighbourhoods are. At the centre we work with the population that seeks help for diverse psychological sufferings, but we also target specific populations that are in especially vulnerable psycho-social situations as is the case of children who have lived on the streets of the city, victims of family violence and Colombian refugees who have fled from the dangers of their bellicose confrontations.

Work with these populations has underlined the importance of taking into consideration the political, economic and cultural dimensions of their lives. For example, the world and life of the children who have lived in Caracas's streets, dramatically illustrates the limitations of our traditional world views, psychological theories and practises. At the same time, our work with children who have lived on the streets of Caracas and with the non-government organizations (NGOs) that attend them has dramatically evidenced how our understandings of emotional, intimate and interpersonal issues can be helpful in the development of more reflexive intervention projects. These understandings have helped to consolidate and protect these efforts.

We believe then that our challenge is to develop comprehensions and actions that can take advantage of the contributions that clinical and social-community psychology have made, at the same time adapting them to our specific local needs. We decided to develop this integration from our experience, developing our perspective directly from hands-on work and then reflecting upon it through research that could help to organise our impressions (Alvarado and Morales 2000; Arévalo and Hernández 1998; Hernández 2000; Hernández and Llorens 2002; Llorens 1999; Romero 2001; Sapene and Tommasino 2001; Souto and Jaramillo 2002).

Our challenge is to try to expand our psychotherapeutic understandings and tools to see if they can effectively address not only the individual and emotional aspects of life, but also the social and political dimensions of the

circumstances of the people we are working with; dimensions that desperately are calling for our attention. As Totton, who has extensively reviewed historical threads between psychoterapy and politics, states: "Reinserting therapy into its historical context implies re-embedding it in its political context, from which it has so carefully separated itself" (Totton 2000, p. 12).

This reinsertion is facilitated by the challenges and shifts that community psychology has demanded traditional psychology to make. We believe that the paradigmatic, theoretical and methodological challenges and resources that community psychology makes on traditional approaches like psychoanalysis and systemic theory offers clinical psychology the opportunity to develop more contextualised and effective understandings and interventions.

One of the interesting aspects of our journey is that we have found that the process of building community and the possibility of working through emotional scars and conflicts become intertwined. It is through the community building process that these emotional issues are made evident, confronted and reflected. At the same time, the "psychoterapeutic" process (if we can call it that) becomes in itself the process of making visible the ruptures with the community that many of the people we work with have had to suffer in their lives. It also creates a holding environment where these losses can be acknowledged, reflected upon and worked through. Finally the mourning of loss is parallel to the possibility of reestablishing and restoring a new sense of community and its possibilities.

Much of the clinical and psychotherapeutical literature seems too distant to the specific needs and challenges of working with youths raised in poverty and in the violence of the streets of Caracas. Nevertheless, we have also been happily surprised to find that there are also a number of valuable works that have begun to intertwine individual, interpersonal and social contexts in the psychological theory and practise (Gergen and Warhus 2003; Prilleltensky 1997, 1999; Waldgrave 1990; White 1995). The work of Hardy and Laszloffy (2005) is one of such examples. Their four factor model for the understanding of adolescent violence includes "disruption of community" as one of the main factors that youngsters who later turn to violence have suffered. Their view of community has been useful in our work with the shelters. It is one that:

> emphasises both its physical, tangible dimensions and its emotional, psychological and spiritual ones. In short we believe community is a 'place' where adolescents feel a sense of belonging and connection with others in a special way. It's a place where they learn about who they are. It's where they begin to develop a sense of identity and a vision of how the 'fit' in the world around them… It is a place where adolescents find comfort when they are overcome with despair, a place they feel accepted. It is a community that provides adolescents with a sense of safety, security, and meaningful relatedness with others. (Hardy and Laszloffy 2005, p. 63)

I believe this view is a fine example of how clinical and community perspectives can be integrated. It not only points towards the community aspects of the work but also highlights the emotional dimension of these processes. When working with youth who have been systematically excluded from society and that have had to suffer the perils, not only of material and emotional deprivation, but also of cultural disconnection with the rest of the world, it becomes evident that the process of rebuilding a sense of community is a profound intervention that has the possibility of impacting their lives on all these levels.

So how can we rethink our theories and practises, to take us closer to developing psychological tools that can integrate social, interpersonal and individual dimensions in our work? I will try to describe what I believe is one of the main shifts our clinical perspective needs to be able to achieve, in order to become fruitful in the work in this area, as well as some of the specific contributions this shift offers to expand our traditional therapeutic approaches.

Shift in Perspective

I believe that in order for clinical perspectives to be able to contribute to the building of community, as for example, in the case of the work developed with children in socially deprived circumstances, a paradigmatic shift has to be undertaken. This shift, allows us to include contextual comprehensions and collaborative methodologies, not just as a complement to the clinical tradition, but as an inseparable aspect of our approach. These ideas help shape the relationships we establish with the people we are working with. These shifts have been previously explored by narrative and social constructionist oriented authors to whom we are indebted (Gergen and Warhus 2003; Phillips 1995; Pakman 1997; Pocock 1995; White 1993, 1995).

A paradigmatic shift (rooted in postmodern approaches, specifically in social construccionist theory) opens the door for alternative interpretations that allow for different emphasis, either on more individually focused or on socially focused readings of the processes we are working with. The methatheoretical and theoretical contributions of social construccionism have been especially useful in the rethinking of our clinical formation (Niemeyer 1993; Gergen and Warhus 2003; Mitchell 1993; Pakman 1997; Schafer 1992).

The work of Martín-Baró (1984/1993) regarding research, community and mental health approaches in his practise, in El Salvador, has also been an important guide in this shift of perspective. In his words:

> It is important to underline that we do not pretend to simplify a problem as complex as mental health by rejecting its personal roots and, while trying to avoid an individual reductionism, fall into a social reductionism. In the end we always have to answer to the question of why this happened to this person and not the other. But we want to emphasise how illuminating it can be to change perspectives and to look at health or mental disorder not from inside out, but from outside in; not as the emanation of an internal individual functioning, but as the materialisation in a person or group of the humanizing or alienating nature of their historic relationships. (Martín-Baró 1984/1993, p. 28)

Martín-Baro's words invite us to adopt a flexible perspective that can look at the human phenomenon both through individually focused comprehensions at one moment and a more socially focused approach at another. This is our first major shift. The possibility of working simultaneously with more than one reference point, and more than one set of "possible truths". In clinical theory, the opportunity to construct alternative approaches in our work was opened up by the contribution of Kelly (1955), whose 'constructive alternativism' seems to be hand in hand with Martín-Baro's recommendation:

> We take the stand that there are always some alternative constructions available to choose amongst in dealing with the world. No one needs to paint himself into a corner; no one needs to be completely hemed in by circumstances; no one needs to be a victim of his biography. (Kelly 1955, p. 15)

This shift encourages us to work with simultaneous, varied, and even conflicting interpretations. Social constuctionism adds the need to strive for collaborative interventions and dialogically arrived at comprehensions. This allows and invites us to work with different types of practitioners, with different biographical and cultural backgrounds, in the process of sharing our views and abilities. It also encourages us to understand our role in the intervention as that of a positioned perspective, in which we bring along our own biography, cultural background, professional preparation, political inclinations and world views. This is the second mayor shift in comparison with modernist approaches. This challenges our traditional conceptions of expertise and stresses the importance of negotiating meanings and actively engaging in the production of dialogues that reflect upon our work. This is, in the end, an approach that intends to make visible and negotiable our place in the distribution of power in the working relationships we establish. In the words of Lynn Hoffman, who writes the prologue to Anderson's marvelous rendering of a postmodern approach to therapy: "A therapist voice that restrains its impulse to control, avoids the imposition of superior understanding, and allows mutually arrived-at solutions to emerge seems to me highly political in nature" (Anderson 1997, p. xv).

An example of taking a relatively simple step in this direction is expressed in our efforts to build work groups that include different types of professionals and cultural perspectives. In our case, in the discussions and group supervisions our team actively seeks to include not only clinicians, but also social psychologists, developmental psychologists, school psychologists, doctors, lawyers, teachers, social workers, philosophers and different members of the communities we work with (Llorens 2003). This search for conversations with a varied group of views forces the team to search outside the professional jargon to make opinions comprehensible to others, while at the same time, these other viewpoints feed the reflective process. Even though professional teams may initially be hesitant to express their thoughts in front of other perspectives because of the communication difficulties and contrasting opinions that tend to appear, if these groups are conducted respectfully, the discussion tends to increase the professional's efforts to detail the sources of his or her opinions and the efforts to actively listen to others. Although this suggestion seems an almost obvious strategy, it is a lot more common to find that the professional groups that work with communities are composed and controlled by a particular set of professional perspectives (for example, different schools of thought have their own associations and rarely do we see, say, psychoanalysts sharing discussion with systemic oriented professionals, and in different settings we see group discussions controlled by doctors or psychologists or teachers, depending on where they take place).

Most importantly, this shift seeks to include the personal views and abilities of the people we are working with, their biographies and their cultural backgrounds. This means, as in the case of children who have had experience living on the streets, an emphasis on establishing a relationship with their street culture and allowing us to learn from the wisdom and abilities they have acquired form these experiences. In many of the economic and political tensions we have faced, we are making an active attempt to construct work groups where people from different social origins can participate. We actively seek to create a network between schools of different economic status, institutions that are located in different parts of the city (where an east–west division that resembles economic

groupings is present) and government institutions and institutions that have directly criticised the government. All of these efforts reflect what some authors like Strong (2002), borrowing from Lyotard, call the creation of "borderzones", or spaces where the conversational territory does not belong to any one group.

As a result these shifts also follow Montero's (2004) proposals for the definition of a community paradigm which includes an ethical and political stance. This stance helps shape the type of relationships we are trying to build. The psychologist's place is no longer one of a neutral, apolitical, ethical standpoint, but one of a biographically, politically and ethically placed human perspective, that seeks to respectfully include his abilities and knowledges in the process of building community with the children and the adults that work with them. From this stance we can focus on building relationships that allow us to integrate clinical and social perspectives, as well as the perspectives of those we are working with.

Clinical Community Tools in Psychotherapy

Our work is interested not only in reframing our perspective, but also on the development of specific tools that can allow us to work with how the political, economic and cultural dimensions are interwoven into the dilemas of everyday life. Sometimes our proposals have been understood as offering traditional psychotherapeutic services on one hand and developing community projects on the other. Or as a team of psychotherapists who happen to be political activists or vice-versa. But that is not how we understand our approach. Rather we believe a clinical-community stance is present in all of the activities we develop, even in individual psychotherapeutic activities. So it has been necessary to transform our approach into specific strategies that allow us to include and work with the contextual dimensions of life in the consulting room.

To do this, the first and possibly the most controversial change in this psychotherapeutic approach are the considerations related to the therapist's position. In traditional therapeutic approaches the striving for a "neutral" stance has been stressed by many different theoretical schools. This "neutral" standpoint, inherited by modernist conceptualizations of science, intended for the therapist to be able to stand afar from political and ethical positions that threatened to "contaminate" the process. We understand that this ideal was a well meaning intent to respect the consultants own world views and avoid turning therapy into indoctrination, but as many authors have pointed out (Coderch 2001; Gergen and Warhus 2003; Guba and Lincoln 1990; Mahrer 2000; Totton 2000), this intended neutrality has contributed to make the therapist's theoretical and practical positions invisible and therefore unexaminable and unnegotiable. The stance of the "neutral", "objective" expert carries the risk, as we now know, of imposing our own world view, of making it unchallengable. In the end it winds up doing what it precisely wanted to avoid. In the words of Mahrer:

> In the field of psychoterapeutic theory, research and practise, foundational beliefs have been and continue to be essentially hidden, taken for granted, unexplicated, unspecified, camouflaged, and thereby immunized against careful study, analysis, examination, scrutiny, explication, constructive challenge, improvement, change and advancement. (Mahrer 2000, p. 1118)

Community psychology perspectives have actively challenged the assumption of a neutral standpoint and offered options of more reflective and collaborative approaches. The work of Prilleltensky (1997) has been specially useful in pointing out how psychotherapy has avoided reflecting on its ethical agendas as well as ways to ammend this:

> The idea of discussing morality may elicit a negative reaction from psychologists who are afraid of dogmatism, fanaticism and authoritarianism (Fowers and Richardson 1996; Kane 1994). After all, previous claims to morality based on ethnocentric and androcentric models resulted in discrimination and oppression of powerless groups (Prilleltensky and Gonick 1994; Sampson 1993). But my aim here is not to claim an imperious version of what is right and wrong. Instead, my aim is to claim the very idea of morality, that we are bound to pursue the moral act, with all the limitations imposed on such act by time, place and subjectivity. I argue for the aspiration to be ethical and for the search of justifiable values. There is a big difference between searching for the best moral option under a particular set of circumstances and the pursuit of a dogmatic set of rules (Fowers and Richardson 1996; Kekes 1993; MacIntyre 1984). To be sure, we have had many authoritarian moral frameworks, but the ghost of a dogmatic past need not scare us out of making moral commitments in the present. We should resist the temptation to reject any type of values "to ward off fanaticism and authoritarianism" (Kane 1994, p. 9). Giving up the search for justifiable moral values to protect us from new forms of dogmatism would be "a case of throwing the baby out with the bath water". (Prilleltensky, p. 18)

Or following Totton's suggestions, which emphasise the political dimensions:

> Instead of trying hopelessly to eliminate power struggle form the therapeutic relationship, we place it dead centre: we highlight the battle between the therapist and client over the definition of reality, bare it to the naked gaze and make it a core theme of our work. This is one style of working with transference and countertransference. It means that, faced with conflicting demands, we do what is best done in every such situation: we negotiate. This negotiation of realities, I would argue, constitutes an authentic and viable psycho-political practise. (Totton 2000, p. 147)

A therapist that is positioned and that is sensible to social and political themes, will then strive to open conversation on these topics and arrive to dialogically developed comprehensions. Specific tools borrowed from community psychology's bag have been especially useful for this purpose. Taking from Montero (2004), de-naturalisation and problematization can be two useful conceptual tools in developing strategies to speak with our clients. Montero defines *problematization* as:

> The process of critical analysis of the circumstances of life and the role that the person performs in it that challenges the ordinary explanations and considerations of these circumstances. (Montero 2004, p. 293)

And *de-naturalisation* as:

> The critical examination of the notions, beliefs and procedures that support the ways of comprehending and of living in everyday life, so that that which was considered natural is deprived of its naturality and shown to be constructed. It consists of the problematization of the essential and natural qualities attributed to certain facts and relations, revealing its contradictions, and its ties to social or political interests. (Montero 2004, p. 287)

Labels and Identity

These tools help us call into question the categories, concepts and strategies we use to attend many of the problems we face. For example, reflecting on and discarding the label "street children" was one of the first consequences of the approach we have been developing, when working with youngsters in dire circumstances. This label has appeared as the main category used when working with children in extreme circumstances in Venezuela (Pedrazzini and Sánchez 1992; UNESCO 1995). But its political consequences have been rarely reflected upon (Gigengack 1994). On one hand the label is vague and carries with it a number of unspecific connotations. On the other it is rejected by many of the kids we have worked with. When we have developed conversations on how they feel about that label many have shared with us the feeling that it is demeaning. The problematization of the label "street children" has allowed us to examine the implicit notions that we as a society assume of what is "normal" childhood and what it should look like. And, following the work of the psychoanalyst Phillips (2000), we have been able to reflect upon the fact that: "Not being permitted one's own version of oneself–as a person, or as a group- is a fundamental form of oppresion" (p. 145). This is a clear example of the imposition of an identity carrying with it an enormous amount of connotations, by a dominant group, on another more socially vulnerable group. A politically reflective clinical approach helps us to deal with these, not only difficult, and significant, but also potentially painful uses of language.

As an option, the use of the expression "children with life experience on the street" is a rather long phrase to use as an alternative, it also isn't free from other possible stigmatizations, but it has the advantage of including many children who are not currently living on the street, but have had considerable experience on it. Moreover, it also seeks to open up the possibility of interpreting life on the street as an experience and not as an essential condition.

Another practical example of how these ideas influence our approach to the work with children with experience of life on the streets arose when I was developing an intervention in one of the "rehabilitation" centres Venezuelan governments have built for adolescents with criminal records. The director had banned rap music from the centre alledging that it was a way of putting limits on the street culture many of the kids had been brought up in.

Not only can I conceive few scenarios more oppressive as one where people are not even allowed to sing, but from our perspective, banning rap music robs us of precisely the opportunity we are looking for in our search to develop ways to explore and share the values, ideals, feelings, hopes and dreads that are expressed through their songs. From our perspective, our work as clinicians and social psychologists is not so much about "eliminating" or "curing" the values, beliefs and experiences that have been obtained on the street (if that were a possibility), but about building bridges and strengthening relationships where they can reflect on these experiences and envision, try out, alternative versions of life. We offer secure relationships and activities where their doubts, fears, rage, convictions can be explored and examined, but only they can decide how to integrate these explorations into their lives.

In the rap songs we have registered in our work with the children we have discovered many of the ideals, values, preferred identity claims cultivated on the street. In our convesations with them we have also discovered that these ideals are not free from conflict, doubt and contradiction. Our clinical training can help us to illuminate some of the

psychological processes expressed in these songs and also to build conversations that can reflect with empathy on these processes.

For example, Omar had shown the interviewer a rap song he had written filled with violence and bravado. He sang: "Crazy, demented, psychopath, impatient/they call me the man/I don't believe in anyone/all my friends are my enemies/let's toast with champagne and wine/I'm a bomb that boom explodes/I'm the black man Sendan Krotas Krotas".[1] In a later conversation we asked him about the song:

> Interviewer: When did you write that song?
> Omar: I don't like it too much, I wrote that a long time ago.
> Interviewer: Does it mean anything special?
> Omar: That's like…when I was on the street. That's why I don't like it. It's too criminal.
> Interviewer: And the name you say is Sendan Kortas?
> Omar: No man, Sendan Krotas, that's,—what you call it?—a nickname, or something like that. That's a name I saw in a graffiti and it seemed really cool, so no, so what,—what's your name?—, and I'd say 'Sendan Krotas' nice to meet you man. (Llorens et al. 2005)

The song reflects some of the values and identity claims that Omar considered while living on the street and the conversation reflects how some of those themes enter into conflict with what he imagines the adults that are working with him expect. The importance of being cool, of being dangerous, of being defiant, is all expressed in the song. It provided us with an excellent opportunity to open a conversation with Omar on these topics as well as the relationship he established with us, how he imagines we view him, how he would like to be considered and the conflicts these different possibilities imply in his life.

As can be seen, identity formation is a particularly relevant process that our interventions seek to illuminate, share, explore, reflect and talk about. Our clinical experience joined by our social-community shift leads us to try to build a space of trust where conversations on these topics, which respect and actively seek to include the children's voices, can be developed. Instead of looking for the ultimate meaning derived from our theories about the processes we are working with, we include our psychological voice to expand reflection and explore what feelings these different possible identity claims stir, what possible consequences does each one have, what kind of life may they possibly lead to,[2] what would they say about the different ways the children and we have envisioned our lives and how can we continue to live together even in the midst of some irreconcilable differences.

The exchanges in the consulting room have also highlighted how therapy is transformed when we include contextualized comprehensions that take into account the economic, political and cultural dimensions of life. It is amazing how little clinical psychology has dealt with the theme of poverty and exclusion and how uncomfortable therapists can be when speaking with clients of these matters. In a recent supervised session, the members of a family in extreme poverty shared, with anxiety, their preocupation with the many acting-out behaviours that their eleven year old boy and their 8 year old girl were presenting. In a family ridden by economic and drug problems, along with violence, the dangerous behaviours (staying out all night, skipping school, defiant attitudes) the children were presenting seemed to be too much to handle for the adults, who seemed desperate. The parent's desperation eventually led to beatings, and to locking the kids in a small room for hours at a time. A psychiatrist, who was accompanying the therapeutic team trying to explore options for developing spaces for more positive exchanges between the adults and the children, suggested that maybe they needed more space sharing other activities besides work and duties and survival, "maybe going to the public park on weekends for example". This seemingly innocent enough question was received with a prolongued silence and finally by a shrug by the mother who said: "yes I think we need to share more spaces like that".

What our psychiatrist was missing out was that this family was in a situation of extreme poverty. They could not even afford to pay the public transportation fee to come once a week to our centre, many times there was literally no food to eat. A trip to the park, under these circumstances is a lot more expensive and far-fetched than anyone who has been raised in an economic stable environment can ever fathom. The therapist did not consider including the exploration of the economic circumstances of the family in her evaluation. This made this aspect of their lives invisible. A contextual view derived from the suggested shifts in perspective offers at least two options. First of all, it emphazises the need to develop a comprehension of the family′s functioning that include socio-economic

[1] In spanish: "Loco, demente psicópata, impaciente/me dicen pana mío/no le creo a la gente/todos mis amigos son mis enemigos/vamos a brindar con champaña y vino/yo soy una bomba que ¡bum! Explota/yo soy el negro Senda Krotas Krotas.".

[2] For example, a problematizing question that has been useful when working with the personnel of some shelters has been to ask: 'What kind of future life do you think a street kid will have? What kind of life do you think a child who has had life experiences on the streets will have?' After exchanging views on these questions we ask: 'What differences do you find? Does giving the children one name or the other change the way you imagine them? Might this influence the way you relate yourself to them?

considerations. Instruments that guide the therapist in this detection have been developed by our team (Rodríguez 2006). But it also invites the therapist to reflect on his o her world views including the role that political, economic and cultural variables have played on his or her family and personal history.

What stands out for me though is that the mother of the above mentioned family, under these terribly desperate circumstances, found a way to ask for help and convince all the family members to come regularly to therapy. Not only that, but faced with a suggestion that is close to preposterous under the circumstances, because it is economically unreachable, just shrugged and went along with it. She in no way communicated her despair, or explained how difficult something that seemed as simple as a trip to the park was for the family. She received the suggestion as a well intentioned remark from a professional. Once and again we find that the people in socially deprived situations coming for help do not talk about their poverty, living accommodations, violence in their community, feelings of exclusion, unemployment, etc. unless the therapists make an active attempt to include these themes in the work. Many of them do not mention these issues because in the end they feel ashamed to be in these circumstances.

A politically reflective clinical approach complements traditional clinical strategies with at least three tools: The first one is the active exploration of these themes in the life of the people we work with; the second one is the search for a contextualized comprehension that makes visible the strengths and resources families use to struggle with their extremely difficult life circumstances; and the third one is the problematization that helps to make visible to the family members the economic and political dimensions of their lives, which in turn helps to reexamine many of the internalising attributions of their sufferings that have contributed to many of the feelings of unworthyness, helplessness and despair.

A clinical-community approach that seeks to develop individual and social comprehensions of the lives of the people who consult us helps to actively incorporate the weight of poverty in these families experience. Using problematizing questions we can begin to critically reflect upon the meanings attributed to poverty, we can talk about the shame this mother feels about these circumstances, and how it ultimately was related to constructions of self-worth and failure that tend to blame the victim of poverty as the architect of his own sufferings. It also helps to make visible the circumstances that go unnoticed and unaddressed by the professional that work with the families, as for example the therapists, doctors and school teachers. We can begin to deal with the number of losses and frustrations that the experience of poverty has represented in the life of this family. These reflections, which take us on an intense emotional trip, also help to start seeing the immense strength that going to therapy sessions, every week, entails. How this mother began the day before reminding her own mother, her sister, her son and daughter and her niece, that they would be going to therapy tomorrow. How she picked out the best looking clothes for her family and saved just enough, or asked for a ride, to be able to make it. These interventions help us to "locate" this family's experience and arrive at a new perspective of their strengths as well as the weight of inequality and poverty in their lives. In Waldgrave's words, in his work with unemployed populations:

> The new thread of meaning removes blame by introducing a more informed analysis of why a person is unemployed. Meanings of self-failure recede, and praise and recognition for the survival strength of the victims are encouraged… Political concepts and clinical concepts are thus drawn together. The problems and "sickness" become identified as the symptoms of unemployment, poverty and injustice. New meanings that address the clinical factors in a political context emerge. The new understanding strengthens feelings of self-worth and subdues the failure-centred meaning pattern. (Waldgrave 1990, p. 24)

We believe therefore that traditional clinical theory and practise can continue to offer tools to explore, indentify, express, share and heal emotional difficulties in our lives. But we also believe that if we are able to reflect upon it and reshape it, it also has the potential of offering contributions to community building and reflecting on our political dilemas. In the consulting room the contributions of clinical-community approaches promise to add to therapy the possibility of reflecting upon the cultural patterns that bind us; and reflect, analyse and act upon social circumstances that produce suffering, giving voice to the silent, as well as offering refuge for people in oppresive cicumstances. Therapy, seen from this perspective, has an enormous empowering potential that we have yet to develop.

Conclusion

A brief account of the search to integrate community and clinical perspectives, and how this helps to bring the social and political dimensions into clinical practise in our work in the social and economic conditions of Venezuela, has been presented. The need to transform our clinical perspective, shifting our paradigmatic location of our tradition, and the translation of our clinical theory into the daily activities of intervention programs, with special mention of low income communities has been discussed.

I believe there is the possibility of using our clinical experience in the realm of social problems if we, clinical

psychologists with a community oriented practise, are able to rethink and restate our notions of truth and expertise. This, from my point of view, is the most potent result of working hand in hand with community approaches.

The writings of Vaclav Havel have been of great value in our search for meaningful approaches to the personal and intimate dimensions in building community. From our standpoint, attention to private and intimate issues is also a profoundly political act. It has to do with the organisation and development of social movements that attend to the specific and concrete human dilemas that unravel in day to day situations. In Havel's words in the essay 'Politics and Conscience' (1984/1992):

> …politics [seen] as one of the ways of seeking and achieving meaningful lives, of protecting and serving them. I favour politics as practical morality, as service to truth, as essentially human and humanly measured care for our fellow humans. (p. 269)

And in *The Power of the Powerless* (1978) Havel adds:

> the central concern of political thought is no longer abstract visions of a self-redeeming, 'positive' model but rather the people who have so far merely been enslaved by those models and their practises (p. 181)

I believe (and hope) that a renewed clinical psychology, has much to contribute to this vision.

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References

Alvarado, C., & Morales, A. (2000). *Estudio de la relación entre la dinámica de las relaciones objetales y la violencia juvenil*. Caracas, Venezuela: Universidad Católica Andrés Bello, B.A. Dissertation.

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

Anthony, W., Cohen, M., & Kennard, W. (1990). Understanding current facts and principles of mental health systems planning. *American Psychologist, 45*, 1249–1252.

Arévalo, K., & Hernández, S. (1998). *Estudio comparativo sobre la percepción de la dinámica familiar entre tres grupos de niños de la calle, en la calle y con familia*. Caracas, Venezuela: Universidad Católica Andrés Bello, B.A. Dissertation.

Barudy, J. (2000). Violencia agresiva y violencia ideológica en la fenomenología humana. In O. Vilches (Ed.), *Violencia en la Cultura: Riesgos y estrategias de intervención*. Santiago, Chile: Sociedad Chilena de Psicología Clínica.

Briceño-León, R. (2005). Dos décadas de violencia en Venezuela. In Violencia (Ed.), *Criminalidad y Terrorismo* (pp. 108–127). Caracas, Venezuela: Fundación Venezuela Positiva.

Bruin, M., & Meler, M. (2000). *Varones: Género y subjetividad masculina*. Buenos Aires, Argentina: Paidós.

Coderch, J. (2001). *La Relación Paciente-Terapeuta: El campo del psicoanálisis y la psicoterapia psicoanalítica*. Barcelona, Spain: Paidós.

Corsi, J. (2003). *Maltrato y Abuso en el Ámbito Doméstico: Fundamentos teóricos para el estudio de la violencia en las relaciones familiares*. Buenos Aires, Argentina: Paidós.

Corsi, J., Dohmen, M., Sotés, M., & Bonino, L. (1995). *Violencia Masculina en la Pareja: Una aproximación al diagnóstico y a los modelos de intervención*. Buenos Aires, Argentina: Paidós.

Cowen, E. (1983). Clinical methods in psychology. In I. Weiner (Ed.), *Community mental health and primary prevention* (pp. 634–696). New York: Wiley.

Espín, O. (1993). Giving voice to silence: The psychologist as witness. *American Psychologist, 48*, 408–414.

Fromm, E. (1980). *El Miedo a la Libertad*. Barcelona: Paidós.

Gergen, K., & McNamee, S. (1996). *La Terapia Como Construcción Social*. Barcelona, Spain: Paidós.

Gergen, K., & Warhus, L. (2003). La terapia como una construcción social: Dimensiones, deliberaciones y divergencias. *Revista Venezolana de Psicología Clínica Comunitaria, 3*, 3–44.

Gigengack, R. (1994). Social practises of juvenile survival and mortality: Child care arrangements in México City. *Community Development Journal, 29*, 380–393.

Guba, E., & Lincoln, I. (1990). *Fourth generation evaluation*. London: Sage.

Hardy, K., & Laszloffy, T. (2005). *Teens who hurt: clinical interventions to break the cycle of adolescent violence*. New York: The Guilford Press.

Havel, V. (1978). The power of the powerless. In P. Wilson (Ed.), *Open letters: selected writings, 1965–1990* (pp. 125–214). New York: Vintage Books.

Havel, V. (1984). Politics and conscience. In P. Wilson (Ed.), *Open letters. Selected writings, 1965–1990* (pp. 249–271). New York: Vintage Books.

Herman, J. (1997). *Trauma and recovery: the aftermath of violence-form domestic abuse to political terror*. New York: Basic Books.

Hernández, N. (2000). *Muchachos entre la calle y la casa: Un encuentro con la vida cotidiana de la Casa Don Bosco de Caracas*. Caracas, Venezuela: Universidad Simón Bolívar: M.Sc. Thesis.

Hernández, N., & Llorens, M. (2002, June). *Presencia y significado del trauma en niños con experiencia de vida en la calle*. Caracas, Venezuela: Paper presented at the Second Congress of Behavioural Medicine and Health Psychology.

Holzman, L., & Morss, J. (2000). *Postmodern psychologies, societal practise and political life*. New York: Routledge.

Hogget, P., & Miller, C. (2000). Working with emotions in community organizations. *Community Development Journal, 35*(4), 352–364.

Kelly, G. (1955). *The Psychology of personal constructs*. New York: Norton.

Kristeva, J. (1997). *Sol Negro: Depresión y Melancoliá*. Caracas, Venezuela: Monte Ávila Editores.

Kristeva, J. (2001). *El Genio Femenino: 2. Melanie Klein*. Buenos Aires, Argentina: Paidós.

Laing, R. (1964). *El Yo Dividido*. México, D.F.: Fondo de Cultura Económica.

Laing, R., & Cooper, D. (1964). *Reason and violence*. London: Tavistock Publications.

Langer, M. (1971). *Cuestionamos*. Buenos Aires, Argetnina: Granica.

Llorens, M. (1999). *Nosotros los Sujetos: Características psicológicas de los niños de y en la calle y los procesos emocionales*

generados en el personal que trabaja con ellos. Caracas, Venezuela: Universidad Católica Andrés Bello, Research report.

Llorens, M. (2003). Buscando conversación: Nuevas maneras de construir conversaciones terapéuticas en nuestras comunidades. *Revista Venezolana de Psicología Clínica Comunitaria, 3*, 141–176.

Llorens, M., Alvarado, C., Hernández, N., Jaramillo, U., & Souto, J. (2005). *Niños con Experiencia de Vida en la Calle: Una aproximación psicológica*. Buenos Aires, Argentina: Paidós.

Mahrer, A. (2000). Philosophy of science and the foundations of psychotherapy. *American Psychologist, 5*, 190–200.

Martín-Baró, I. (1984). Guerra y salud mental. *Papeles del Psicólogo, 56*, 27–33.

Masson, J. (1984). *The assault on truth: Freud's suppression of the seduction theory*. New York: Farrar, Straus & Giroux.

May, R., Angel, E., & Ellenberg, H. (1967). *Existencia: Una nueva dimensión en psiquiatría y psicología*. Madrid, Spain: Gredos.

May, R. (1974). *Fuentes de la Violencia*. Buenos Aires, Argentina: Emecé Editores.

Mitchell, S. (1993). *Hope and dread in psychoanalysis*. New York: Basic Books.

Montero, M. (2004). *Introducción a la Psicología Comunitaria: Desarrollo, conceptos y procesos*. Buenos Aires, Argentina: Paidós.

Montero, M. (2006). *Hacer para Transformar: El método en la psicología comunitaria*. Buenos Aires, Argentina: Paidós.

Niemeyer, R. (1993). An appraisal of constructivist psychotherapies. *Journal of Consulting and Clinical Psychology, 61*, 221–234.

Obiols, J., & Basaglia, F. (1973). *Psiquiatría y Antipsiquiatría*. Barcelona: Salvat Editores.

Pakman, M. (1997). *Construcciones de la Experiencia Humana Volumen II*. Barcelona, Spain: Gedisa.

Pedrazzini, Y., & Sánchez, M. (1992). *Malandros, Bandas y Niños de la Calle: Cultura de urgencia en la metrópoli latinoamericana*. Caracas, Venezuela: Vadell Hermanos.

Phillips, A. (1995). *Terrors and Experts*. Cambridge: Harvard University Press.

Phillips, A. (2000). *Promises, Promises*. London: Faber and Faber.

Pocock, D. (1995). Searching for a better story: Harnessing modern and post-modern positions in family therapy. *Journal of Family Therapy., 17*, 149–173.

Prilleltensky, I. (1997). Values, assumptions, and practises: Assessing the moral implications of psychological discourse and action. *American Psychologist, 47*, 517–535.

Prilleltensky, I. (1999). La Psicología al fin del Siglo. *Critical Psychology Praxis* (pp. 279–304). Caracas, Venezuela: Universidad Simón Bolívar-Sociedad Interamericana de Psicología-Fundación Polar.

Pobreza, Proyecto. (1999). *Un Mal Posible de Superar. Volumen I*. Caracas, Venezuela: Universidad Católica Andrés Bello.

Rodríguez, P. (2003). Apuntes para la definición tentativa de la psicología clínica comunitaria. *Revista Venezolana de Psicología Clínica Comunitaria, 3*, 195–211.

Rodríguez, P. (2006). Entrevista semi-estructurada de información socioeconómica y subjetiva. Caracas, Venezuela: Universidad Católica Andrés Bello. Research report.

Romero, J. (1999). Un lustro en la comunidad. *Revista Venezolana de Psicología Clínica Comunitaria, 1*, 97–115.

Romero, M. (2001). *Aproximación a la historia de vida de dos jóvenes con experiencia de vida en la calle*. Caracas, Venezuela: Universidad Católica Andrés Bello. B.A. Dissertation.

Sapene, A. & Tommasino, A. (2001). *Influencia del afrontamiento, el apoyo social y el género en el desarrollo de burnout en personal que trabaja con niños de la calle e institucionalizados*. Caracas, Venezuela: Universidad Católica Andrés Bello, B.A. Dissertation.

Sarason, S. (1981). An asocial psychology and a misdirected clinical psychology. *American Psychologist, 38*, 827–836.

Schafer, R. (1992). *Retelling a Life: Narration and dialogue in psychoanalysis*. New York: Basic Books.

Shotter, J. (2000). From within our lives together: Wittgenstein, Bakhtin, Voloshinov and the shift to a participatory stance in understanding understanding. In L. Holzman & J. Morse (Eds.), *Postmodern psychologies, societal practise and political life* (pp. 100–129). New York: Routledge.

Souto, J. & Jaramillo, U. (2002). *Aproximación a la historia de vida de cuatro jóvenes con experiencia de vida en la calle*. Caracas, Venezuela: Universidad Católica Andrés Bello. B.A.Dissertation.

Strong, T. (2002). Dialogue in therapy's "Borderzones". *Journal of Constructivist Psychology, 15*, 245–262.

Totton, N. (2000). *Psychotherapy and politics*. London: Sage.

UNESCO. (1995). *En la Calle con los Niños: Programas de reinserción de los niños de la calle*. París, Francia: Editoriales UNESCO.

Velásquez, S. (2003). *Violencias Cotidianas, Violencia de Género*. Buenos Aires, Argentina: Paidós.

Waldgrave, C. (1990). Just Therapy. *Dulwich Center Newsletter, 1*, 5–46.

White, M. (1993). Deconstruction and therapy. In Gilligan & Price (Eds.), *Therapeutic Conversations* (pp. 22–61). New York: W W Norton and Company.

White, M. (1995). *Reescribir la Vida: Entrevistas y ensayos*. Barcelona, Spain: Gedisa.