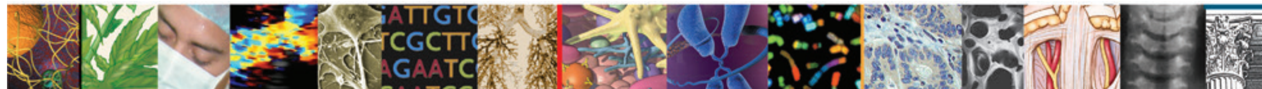

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Perspective
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CASE STUDIES IN SOCIAL MEDICINE

Dialogic Praxis — A 16-Year-Old Boy with Anxiety in Southern Brazil

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J., a 16-year-old boy, presented to a public outpatient clinic for evaluation and treatment for anxiety, learning disabilities, and behavioral problems. J. lived in a shantytown in a medium-sized city in southern Brazil and was referred by his school's psychologist for evaluation by Dr. M., a psychiatrist at a community clinic.[1] According to his mother, J. had a history of "aggressive behavior," which intensified first after he failed 2 years of school when he was 13 and 14 years old and then when he was violently assaulted when he was 15. J.'s mother reported that shortly after the assault, J. began using drugs and alcohol, spending more time on the streets, missing school, and withdrawing socially.

J. attended a crowded public school where there was much student–teacher and peer-to-peer conflict and violence. Though he'd been referred several times to his school psychologist, he had not consented to continued treatment. The psychologist had offered behavior-modification suggestions, including anger-management strategies, but J. did not find these useful. He explained that although he felt anxious and got into too many fights, he felt frustrated by his teachers' negative attitudes toward him and by the school psychologist's emphasis on his "agitation" and "inability to focus." J. claimed that students from the shantytown were more likely to be sent to the school psychologist simply because they "looked poor."

J. explained that he had agreed to visit Dr. M. not because "there was anything wrong with" him,

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but to air his complaints. He expected that Dr. M. would "tell me what was wrong with me and how to change my behaviors," as the school psychologist had done. J. also wondered whether the doctor might prescribe medications for attention deficit or depression, as had been the case for several of his classmates.

Instead, Dr. M. used open-ended questions to encourage J. to talk in an unstructured way about his everyday life and social relations in school, at home, and with friends. Early in their first session, Dr. M. communicated the exploratory and nonformulaic nature of his approach. J.'s initial hesitance to trust Dr. M. began to change when the psychiatrist humbly admitted to "having no idea" what it was like to live J.'s life.

Sessions with Dr. M. led to a shift in perspective on J.'s difficulties. His mother, teachers, and school psychologist had focused on his learning difficulties, behavior, and possible drug addiction. But what came to occupy most of J.'s own attention, in therapy and in general, were the conflicts and judgments he experienced as a "poor person" and his resulting feelings of anger and hopelessness. When he began to understand that these feelings originated from something other than his own psychological characteristics or biologic deficiencies, he felt more optimistic and had the "energy," as he put it, "to battle through [his] struggles." The clinic provided him with a safer environment in which to begin these battles. J. and Dr. M. often had different perspectives, but J. said he appreciated that Dr. M. was the first adult from the "upper-middle class" with whom he could interact with growing confidence, assertiveness, and equality.

J. began attending school regularly and eventually became active in the student council, where he advocated for better teacher–student relations and worked alongside school staff who ran initiatives to foster student participation and democratic teaching practices. Through his council participation, which took place outside the demands and stresses of the classroom, he and school staff interacted in ways that increased mutual understanding.

After a year of intermittent therapy, J. explained how therapy had amplified his "consciência," or consciousness — a word he used to refer to awareness, self-worth, and ability to act in the world. He summed up the most significant change in his life by declaring, "I feel more like a person with value now."[2]

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Social Analysis Concept: Dialogic Praxis

Dr. M. was educated in the 1990s in an interdisciplinary curriculum encompassing medicine, social sciences, and psychodynamic principles. This approach encourages clinicians and patients to analyze symptoms such as anger, agitation, or anxiety not solely as internal problems but also as meaningful responses to external stressors. Therapeutic strategies encourage patients to explore their symptoms' significance, which requires in-depth knowledge of their relationships and social environments. Clinicians sometimes work in schools, with families, and with community organizations to facilitate problem solving and learn more about their patients' environments. Clinicians with further training in social epidemiology and social medicine — specialties that, in Brazil, emphasize structural determinants of health — consider stressors associated with socioeconomic inequity and social conflict to be key.

"Dialogic praxis" is a process drawn from Freirean educational theory in which clinicians and patients engage in bidirectional critical analysis and learning. Dialogic approaches can be therapeutically beneficial because they help identify new problem-solving knowledge and are aimed at altering specific features of a patient's social world.

The social theories underpinning clinicians' training emphasize the importance of "dialogic praxis," a theory of learning and social change developed by Brazilian educator and philosopher Paulo Freire (see box). Freire decried what he called "banking" forms of pedagogy, in which students are treated like banks and teachers deposit knowledge for passive learning and later withdrawals. Dialogic pedagogy, by contrast, raises students' and teachers' critical awareness by creating conditions for learning through open, democratic dialogue. According to Freire, dialogic approaches must be praxis-oriented: students and teachers must act on their environments in order to produce new understandings of their social and personal realities, and they must transform those realities by means of further action and reflection.[3]

In the clinic, dialogic praxis reframes the therapeutic relationship as a bidirectional educational experience that centers on a definition of "insight" different from that used in conventional psychiatry. Whereas insight usually refers to patients' awareness of their internal psychological processes, dialogic praxis emphasizes the clinician's learning process and, rather like what J. called *consciência*, encourages patients to become important sources of knowledge about the situational causes of their distress and ways of modifying them. The theory behind dialogic praxis suggests that patients' actions to change their social environments can themselves be therapeutic, though this process can also generate additional intermittent challenges. For J., for instance, involvement in school government was a way to change the structure of student–teacher relationships, and it made him feel worthy, empowered, and motivated, even if it sometimes exposed him to social conflict, which made him anxious. In this sense, dialogic praxis helped J. appreciate that his conflicted emotions were a fundamental part of his learning about, and burgeoning commitment to, social change.

Clinical Implications

In the clinic, dialogic praxis encourages providers and patients to work together equitably in a process of discovery that considers various social and individual reasons for mental distress. This process depends on asking patients to attempt to change, in small increments, the environments that cause them distress, which can lead to new health-promoting knowledge. This iterative process hinges on three key components.

1. *Clinicians can develop practices to encourage bidirectional and knowledge-generating relations with their patients.* Clinicians can begin by explicitly recognizing the importance of learning about the lives and troubles of their patients, especially patients facing acute social marginalization. The frank recognition of power imbalances in the clinic can reframe patients as coexperts, create opportunities for bidirectional learning, and reduce patients' sense of powerlessness. The U.K. National Health Service, for instance, funds projects in which patients and providers "coproduce" research for the design, delivery, and evalua-

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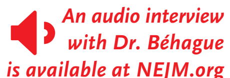
tion of services; in one such initiative, providers shifted from using an illness model centered on patients' deficits to an asset model amplifying patients' strengths.[4] For example, instead of focusing on managing symptoms — anger, anxiety, frustration — in isolation, Dr. M. encouraged J. to become socially and politically active in school to change the conditions causing him frustration. Though doing so initially increased his anxiety, over time it gave him a sense of purpose, legitimacy, and composure.

2. *Clinicians and health researchers can critically assess behavior-change approaches in medicine.* In public health, impact studies have drawn attention to the limitations of individual-level behavior-change interventions, underscoring instead the potential long-term benefits of "complex social interventions."[5] In mental health, behaviorist approaches may be experienced by patients as compounding blame and stigma, since they center on individual-level characteristics, put the onus of responsibility on the patient, and may seem to ignore social challenges such as classism, racism, violence, and institutionalized forms of exclusion (see the Supplementary Appendix for additional references). Dialogic approaches can permit experimentation with actions that engage the environmental forces that patients deem important. Such engagement, in turn, may mitigate the limitations of behaviorist approaches more effectively than individual clinician characteristics such as rapport and empathy.

3. *Clinicians and patients can promote dialogic praxis through community-based activities.* Health institutions can support clinicians and patients in using dialogic approaches and case-study methods to analyze and build on small-scale individual, social, and environmental changes already occurring within communities. Integrating community activities as a component of long-term mental health services can enable providers to respond more efficiently to patients' unique and context-specific needs, as well as amplify therapeutic options. For patients, the agency of community-based action may sustain therapeutic benefits over time, even if some symptoms, such as anxiety, continue to ebb and flow in the process.

Case Follow-up

By his early 20s, J. had graduated from secondary school, built a close circle of friends, and found a stable job. He explained that his continued search for life improvement required not just introspection or self-improvement, but also an interactive way of life and small-scale activism in solidarity with peers to improve conditions in his school, shantytown, and workplace. Such activism often meant becoming the target of social tensions and outright discrimination, and he sometimes sought support from a therapist in facing these struggles. Even so, J. explained that difficult emotions tied to these experiences were an integral part of his life and that merely reducing symptoms was not the main goal of his therapy.



An audio interview with Dr. Béhague is available at NEJM.org

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1. Victora CG, Barros FC, Lima RC, et al. The Pelotas birth cohort study, Rio Grande do Sul, Brazil, 1982-2001. Cad Saude Publica 2003;18:1241-56.
2. Béhague DP. Psychiatry and politics in Pelotas, Brazil: the equivocal quality of conduct disorder and related diagnoses. Med Anthropol Q 2009;23:455-82.
3. Freire P. Pedagogy of the oppressed. 30th ed. New York: Bloomsbury, 2000.
4. Filipe A, Renedo A, Marston C. The co-production of what? Knowledge, values, and social relations in health care. PLoS Biol 2017;15(5):e2001403.
5. Fletcher A, Jamal F, Moore G, Evans RE, Murphy S, Bonell C. Realist complex intervention science: applying realist principles across all phases of the Medical Research Council framework for developing and evaluating complex interventions. Evaluation (Lond) 2016;22:286-303.

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