Spring 2010

"Tem um Doido no CAPS / Que diz que Louco é Gente/Que diz que Louco Sabe/Que diz que Louco Sente" Failures and Successes in Brazilian Mental Health Reform: A Case Study of CAPS – Quixadá

Zachary Fuhrer
SIT Study Abroad

“Tem um doido no CAPS /
Que diz que louco é gente/Que diz que louco sabe/Que diz que louco sente”

Failures and successes in Brazilian mental health reform

A case study of CAPS – Quixadá

Zachary Fuhrer
Spring 2010
Adviser: José Perúcio Torres da Silva – Pedagogo/Arteterapeuta, CAPS – Quixadá
School for International Training - CSA Brazil- Northeast

To Perúcio, the team of CAPS – Quixadá and SIT: Fortaleza
This project would have been impossible without your help

Table of Contents

****

RESEARCH AND ANALYSIS

Abstract

In 1987, as public health decentralized and O *Movimento da Luta Antimanicomial* challenged the internment of *loucuras* in asylums, Brazil hosted its first National Conference of Mental Health. While the fight for mental health reform and the dehospitalization of the mentally ill in psychiatric hospitals began to take form in the 1970s with the *Rede de Alternativas Psi* and *O Movimento dos Trabalhadores de Saúde Mental*, Brazil has battled with questions of *saúde loucura* (treatment of the mad) since the country's colonial era and the reception of the epileptic and mentally ill family of Dom João VI. The Brazilian state of Ceará's mental healthcare history begins closer to the attainment of Brazilian independence, with the creation of the *Asilo de Alienados* in Parangaba, Fortaleza in 1886. The asylum aimed to take the insane and indigent from cramped city centers and far-off interiors and place them in controlled detention centers, attending to patients with the often cruel therapies and psychiatric treatments of the day. Throughout the 20th century, with no access to mental healthcare in interior municipalities, those deemed psychotic were transported, generally involuntarily, to psychiatric hospitals in Fortaleza for indefinite internments, away from family members and with no seen benefit for the patients.

With the rise of a democratic Brazil, came the beginnings of political responsiveness to outcries for human rights for those with “deficiencies” and accessible healthcare in the country's vast interior regions. The push for a reassessment of mental health treatment came directly from the militant groups of students and healthcare professionals behind NAPS/CAPS (The Nucleus for Psychosocial Attention and the Center for Psychosocial Attention), which began as municipality-funded projects for local mental healthcare. My research focuses on the work of Ceará's third CAPS, founded in 1993 in the municipality of Quixadá.

This thesis asks if political policy instituted following the decentralization of public healthcare in Ceará succeeds in dealing with the necessities of the long-mistreated and ignored populations suffering from mental illnesses in the state's interior. The introduction of this work

displays a brief history of Quixadá and the treatment of those deemed *loucuras* from the late 18th century up until the movements for *antimanicomial* reform (anti-institutionalization of the insane) and human rights in the late 20th century in Ceará, with a focus on the *sertão* (the state's semi-arid interior). I then examine the creation and physical and theoretical development of CAPS in Quixadá and its efforts to change the culture of mental health treatment both through clinical treatment and political activism during the 1990s up until the current day. In this examination, I highlight the uniqueness of the municipality's organization and the connections between its mental healthcare and local realities. In the following chapters, I argue that the CAPS – Quixadá approach – under the initial leadership of Raimundo Severo, coordinator Dr. Carlos Magno Cordeiro Barroso, supervisor Dr. José Jackson Coelho Sampaio, Secretary of Health and Social Assistance, Dr. Ivonete Dutra and a team of multi-professional militants from various reform movements in Brazil – illustrates the potential of mental healthcare reform in Brazil, while highlighting the shortcomings of the SUS (System for Unified Healthcare) and the Ministério da Saúde (Ministry of Health). I emphasize the capability of the CAPS – Quixadá team to force the citizens of its city to rethink prejudices against the mentally ill in conventional methods of treatment through the reintroduction of the *loucura* into regular, community life, demonstrating the strength of family consultations and art-based therapies. In conclusion, I argue the need for a nationally-implemented *mapeamento* (detailed survey) of mental health conditions in all Brazilian municipalities, a reassessment of the preconditions for the creation of a CAPS facility, additional federal resources for CAPS and a questioning of the inefficiencies of government legislation meant to improve the rights of those in need of mental healthcare from 1989 until the present day.

Resumo

Em 1987, quando a saúde pública estava iniciando seu processo de descentralização e *O Movimento da Luta Antimanicomial* estava desafiando o uso de asilos para colocar e tratar as *loucuras*, O Brasil criou sua primeira Conferência Nacional de Saúde Mental. Quando a luta de saúde mental e a reformante antimanicomial começou na década setenta com a *Rede de Alternativas Psi* e o *Movimento dos Trabalhadores de Saúde Mental*, o Brasil já combatia questões de s*aúde loucura* quando ainda era uma colonia de Portugal e recebia a família imperial de Dom João VI com problemas da loucura e epilepsia. A história da saúde mental no Ceará é mais nova, começando com a criação do Asilo de Alienados de Parangaba, Fortaleza em 1886. O asilo prentendia tirar os loucos e indigentes dos centros urbanos e interiores e colocá-los num espaço de controle e detenção, atendendo aos pacientes com tratamentos e terapias da época. Durante o século XX, sem acesso a saúde mental no interior, os "psicóticos" em crises eram transportados (geralmente involuntariamente) para os hospitais psiquiatricos em Fortaleza, onde eles ficavam vivendo como moradores desse lugar, longe das famílias e sem "cura."

Com o processo de democratização no Brasil, o país começa a pensar e implementar políticas públicas de saúde mais humanizadas, contemplando direitos humanos de "deficientes" e doentes e uma saúde acessivel nos interiores. Foi a pressão de grupos militantes estudantes e profissionais de saúde dos projetos NAPS/CAPS (Nucleu de Atenção Psicossocial/Centro de Atenção Psicossocial) que levou a uma avaliaçao mais criteriosa da saúde mental no Brasil. Minha pesquisa foca o trabalho da terceira unidade de CAPS no Ceará, que foi criado em 1993 no município de Quixadá.

Eu pergunto se as políticas públicas depois da descentralização de saúde pública no Ceará têm conseguido trabalhar com as necessidades das populações carentes que sofrem de doenças mentais no interior do Estado. A introdução desse trabalho mostra um pouco da história de Quixadá e o tratamento das doenças mentais do final do século XVIII até os movimentos de reforma

antimanicomial, e direitos humanos no final do século XX no Ceará, focando no sertão. Eu examino a formação e o desenvolvimento teórico e fisico do CAPS em Quixadá e seu trabalho para mudar a cultura da saúde mental através de tratamento clinico e a ação política governamental iniciada nos 1990. Nessa pesquisa, eu mostro as qualidades éspicificas do CAPS – Quixadá e as ligações entre seu atendimento e as realidades locais. Nos capítulos seguintes, eu argumento que o trabalho do CAPS – Quixadá – com a liderança inicial do Raimundo Severo, o coordenador Dr. Carlos Magno Cordeiro Barroso, a supervisão do Dr. José Jackson Coelho Sampaio, a Secretaria de Saúde e Assistencia Social do municipio na época, Dra. Ivonete Dutra e um equipe de multiprofissionais militantes dos movimentos de reformas no Brasil – mostram o potencial de saúde mental no Brasil, enquanto focando a problematização do sistema dentro do programa do SUS e o Ministério da Saúde. Eu analiso a capacidade da equipe do CAPS – Quixadá para fazer seus cidadãos repensarem sobre os prejuisos causados contra doentes mentais em tratamentos convencionais. Eu mostro as novas formas propostas de tratamento com a reintrodução do doente mental em sua familia e na sociedade, illustrando o sucesso das visitas aos famíliares e as experiencias com a arte enquanto recurso terapeutico. Por fim, eu mostro a necessidade de um mapeamento nacional de saúde mental para todos os municípios do Brasil, uma analise dos criterios de implementacao do servico dos CAPS, recursos federais e a questão da ineficiencia das leis para assegurar os direitos dos usuarios da saúde mental desde 1989 até os dias de hoje.

Location of Research: Background on Quixadá

Vendo as rebatas em ambição — *Seeing ambition bounce back*
Nos raros serenos que molham o cheio — *In the rare serene moments filled with water*
Sinto o cheiro bom de terra sofrida — *I smell the fair scent of suffered land*
Alberto Porfírio – Poeta Quixadense (Quixadense Poet)

É mono o leito — *It is the single bed*
Do céu, o seu, do cedro — *From the sky, yours, of cedar*
E são monólitos — *And are monoliths*
No cheiro, no gosto — *In smell, in taste*
As pedras — *The rocks*
Quebram o terço — *Break the chaplet*
Mas deixam o credo — *But leave the creed*
Num cruzeiro — *In a cruzeiro*
Digno de Fedra — *Worthy of Phaedra*
Perúcio Torres – Arte-terapeuta/Pedagogo (Art-Therapist/Pedagogue), CAPS – Quixadá

Location: Quixadá, Ceará, Brazil

Annual Rainfall: 500-700 mm

Characterized by: Drought, large rock formations known as *monólitos* (monoliths), one of the first government projects in Brazil to combat drought (Açude do Cedro), the diverse flora and fauna of the *Caatinga* region, folk healers, rain prophets, improvisational folk singers, extreme sports, UFO sightings and the recent development of a PetroBras BioDiesel plant, mountaintop Roman Catholic sanctuary, Catholic college and local branch of a federal university.

Population: ~80,000, ranging from wealthy doctors, store owners and entrepreneurs with sprawling patios and private pools to impoverished rural dwellers who get by on government benefits in mud and stick houses on long-abandoned farms.

Organization Studied: CAPS – Quixadá (est. 1993), the third Center for Psychosocial Attention developed in the state of Ceará, focuses on accessible mental healthcare for the poorest of the mentally ill, while reforming the culture and treatment of those suffering from mental illness on the footsteps of developing healthcare reform and decentralization in Brazil. Public Institution with 16 employees, receives R$39.127,50 each month from SUS/Ministry of Health – enough to treat ~220 of the organization's 6,324 active patients.

Adviser: Perúcio Torres – Arte-terapeuta/Pedagogo, CAPS – Quixadá. Perúcio has played a leading role in the creation of six organizations for mental health treatment, special education and extracurricular programming in Quixadá, deciding to push for mental health reform in his hometown after spending eight years traveling the entirety of Brazil by foot and hitch-hiked truck.

Overview of Quixadá

The municipality of Quixadá sits approximately 167 km from Fortaleza, the capital of the Northeastern Brazilian state of Ceará. Located in the semi-arid *Caatinga* (white wilderness) in the

interior of the state, Quixadá presents itself as a city of monoliths, brooding rock formations that feature region-specific flora and fauna. In short, "Man reached the Caatinga 12,000 years ago."[1] Settled initially by the Cariri Indians along the Jaguaribe, Banabuiú and Sitía rivers, the Portuguese occupied the region during the 16th century, expelling the indigenous populations in favor of cattle raising and later cotton farming.[2] Quixadá, formerly a part of Quixeramobim, did not exist as an independent municipality until 1870, first establishing its status as a burgeoning city with the construction of the Açude do Cedro (Cedar Reservoir), a project commenced by Dom Pedro II to combat drought in the Caatinga after the natural disaster killed thousands in Ceará during the late 1870s.[3] The drought continued throughout the 20th century, serving as a popular political platform that hardly took the form of sustainable public policy and action, leaving *sertanejos* (residents of the semi-arid sertão interior) to abandon local rain prophets and pray to the congressmen for the implementation of long-held promises of irrigation reform, stretching from the nearby São Francisco river.[4][5]

On its current town symbol, the municipal government represents Quixadá as the land of the rooster-shaped monolith, "Galinha Choca," extreme sports, diverse flora and an ambiguous man with his hands thrown in the air. While the names of the cultural figures Rachel de Queiroz (author of *O Quinze,* the sertão masterpiece about the 1915 drought) and Cego Alderado (Famous repentista/local improvisational musician, known for his folk songs about *sertanejo* life and struggles) appear on plaques, buildings and statues all over the city's center, the history of the municipality as a breeding ground for militancy and social activism, folklore and drought seems lost on the current youth generation occupying the town square.[6] 140 years after its independence from Quixeramobim, Quixadá stands in the middle of vast commercial development, recently

1 Miguel Von Behr, *Quixada: A Terra dos Monólitos*, (São Paulo: Somos Editora, 2007), 117.
2 *ibid.*
3 *ibid.*
4 Nicholas Gabriel Arons, *Waiting for Rain: The Politics and Poetry of Drought in Northeast Brazil*, (Tucson: The University of Arizona Press, 2004), 17.
5 Interview: José Perúcio Torres da Silva, page 16, ISP Field Journal.
6 *ibid.*

becoming a site for eco-tourism and BioDiesel energy reform at the helm of the national petroleum company, PetroBras, and religious tourism at the turn-of-the-century immigration of an Italian Bishop, who built a giant sanctuary at the top of a monolith.[78] The *repentista's* song may confuse the "urbanized" local children and neighboring teens cluttering the town square while studying at the town's private and public colleges, but the hardships of drought and the songs that evoked them remain on the minds of the rural inhabitants with no private wells and cars beside their stick and mud houses.

Opened in 1993, the organization CAPS – Quixadá, a government-funded Center for Psychosocial Attention, formally sits at the center of the city. The heart of CAPS' work, however, takes place in city landmarks and far out in the unpaved *sertão*, where the center's team of internists, therapists, psychologists and psychiatrists interact with the families and town citizens that shape their patients lives more than any illness or medication. The ideology of CAPS – Quixadá stresses that the reemergence of the mentally ill into daily community life offers a stronger catalyst for public policy reform and a reassessment of prejudices against the mentally ill than the isolated consultations made in the psychiatry, infirmary care and psychology consultation rooms of the cramped CAPS building. As a testament to the traditional Quixadense citizenship of the CAPS patient, Perúcio Torres' patients are often seen at the foot of the *Açude do Cedro*, belting the lines of Humberto Tereira and Luis Gonzaga's drought-stricken "Asa Branca" (White Wing), while staring at the bright, white *passaros* (birds) mating by the famous dam.

Quando o verde dos teus olhos
Se espalhar na plantação
Eu te asseguro nãochore não, viu!
Que eu voltarei, viu
Pro meu sertão

When the green of your eyes
Spreads itself on the plantation
I assure you, don't cry now, see!
That I'll return, see
To my sertão

From "Asa Branca"
Humberto Tereira/Luiz Gonzaga

7 *ibid.*
8 Miguel Von Behr, *Quixada: A Terra dos Monólitos*, (São Paulo: Somos Editora, 2007).

Background on Federal Laws and Legislation for Mental Health Rights

In order to better understand the current legal status of the mentally-disabled in Brazil, it is important to observe both the laws for citizens with "deficiencies" and those displaying signs of mental disorder. Below, I have summarized relevant pieces of legislation for the reader.

From *Direitos dos Usuários dos Serviços e das Ações de Saúde no Brasil: Legislação Compilada – 1973 a 2006*
(A compilation of the rights of those using healthcare services in Brazil, from 1973-2006)

Direitos de Portadores de Deficiência (Rights of the Disabled)
Lei n° 7.405, de 12 de novembro de 1985: Largely concerned with the physically disabled, this law simply made it an obligation for all locations and services to place the "International Symbol of Access" on spaces capable of being used by the disabled. The "International Symbol of Access" is a wheelchair, illustrating the law's disregard of those with auditory, visual and mental disabilities.

Lei n° 7.853, de 24 de outubro de 1989: Declares basic rights and the need for social integration of the disabled and the eradication of discrimination. Declares the right to education for all disabled individuals, without setting up the proper infrastructure for public, accessible special education. Promotes the development of family planning and preventative care establishments, while beginning to question the treatment of the mentally disabled outside of their communities. Mentions there will be questions in the census of 1990 and subsequent censuses regarding the disabled, discovering the "exact number of disabled citizens in the country." In 2010, surveys of those in need of mental healthcare in the country are still lacking, with no questions about mental illness or conditions for the mentally ill in this year's census.[9][10]

Decreto n° 3.298, de 20 de dezembro de 1999: Regulates the law from 1989, focusing on classifying the individual needs and extremes of disabilities. Divides classification first into "deficiency," "permanent deficiency" and "incapacity," then into the categories, "physical deficiency," "auditive deficiency," "visual deficiency" and "mental deficiency." Important to note is that the classification of mental deficiency covers only those displaying signs of medical illness before the age of 18 years, discrediting those with work-related mental disabilities acquired in adulthood. Reinforces ideas of social integration of those with disabilities, launching organizations through the Ministry of Justice called CONADE and CORDE to monitor the respect of these human rights. Expands upon basic rights to education, work, culture, tourism, leisure and rehabilitation, placing the responsibility on the shoulders of CORDE, CONADE, the Ministry of Work and Employment, the Secretary of State for Social Assistance, the Ministry for Social Assistance, the Ministry for Education, the Ministry for Transportation, the Institute for Applied Economic Research and INSS to secure these rights and assist in the law's application.

Lei n° 10.098, de 19 de dezembro de 2000: Almost entirely concerned with the accessibility of buildings, healthcare and transportation systems for those with physical disabilities.

Decreto n° 5.296, de 2 de dezembro de 2004: Regulates the Lei n° 10.098 by focusing more specifically on general norms and criteria for increasing accessibility to buildings, public services and transportation for the disabled. Clarifies that the mentally disabled have a right to prioritized

9 Censo 2010 – Questionário Básico. http://www.censo2010.ibge.gov.br/censo2010_amostra.pdf
10 Censo 2010 – Questionário da Amostra. http://www.censo2010.ibge.gov.br/censo2010_amostra.pdf

attention from public services and financial businesses.

Decreto Legislativo n° 198, de 13 de junho de 2001: Declares an end to all discrimination against those with disabilities in all of the Americas.

Decreto n° 3.956, de 8 de outubro de 2001: A reiteration of the decree from June 13, 2001, working off of the discussions held at the Interamerican Conference to Eliminate All Forms of Discrimination.

Direitos de Portadores de Transtornos Mentais (Patients Displaying Mental Illnesses)
Lei n° 7.853, de 24 de outubro de 1989: Discussed Above.

Decreto n° 3.298, de 20 de dezembro de 1999: Discussed Above.

Lei Decreto n° 10.215, de 6 de abril de 2001: Displays the protection of the rights of the mentally ill and redirects the model of assistance in mental healthcare. The golden law of mental healthcare reform and rights of the mentally ill, this law protects the mentally ill against involuntary hospitalization, abusive and torturous treatment in and outside of hospital care, while stressing the importance of reintroducing the psychiatric patient back into his/her own environment. The law pushes for the dehospitalization of the mentally ill in psychiatric hospitals and asylums, supporting the development of extra-hospital treatment centers. This law displays a preference for clinics like CAPS over psychiatric hospitals. Far from dehospitalization, psychiatric hospitals still treat thousands of mentally ill patients in city centers and typically receive significantly more funding than extra-hospital clinics.

Lei n° 10.708, de 31 de julho de 2003: Perhaps recognizing the difficulty of reinserting back into everyday society those patients interned in psychiatric hospitals and asylums, this law provides for a benefit of R$240,00 for "resocialization." Benefits of this sort are hard to obtain, according to CAPS staff, and rarely last more than one year.[11]

11 Interview: José Perúcio Torres da Silva, Page 73, ISP Field Journal.

Personal/Professional Motives for Research

This study along with future research in and out of Brazil will set the foundation for my undergraduate senior thesis and potential graduate studies of alternative hierarchies and community organizations that existed in Northeastern Brazil during the late colonial period through the 20th and 21st centuries. My research in Ceará may be expanded to study the impact of the epileptic and mentally ill family of Dom João VI on the development of mental health asylums and medical colleges during the 19th century or perhaps the legacy of the *repentista* and the impact of drought and giant rock formations in Quixadá on the psyche of the municipality's citizens. On the footsteps of this research project, I am already in the process of working with my project adviser in Quixadá to plan a return trip to Ceará to visit and research the historically albino locality known as As Almas in the literal north of Camocim, Ceará. This analysis of the rarely discussed racial discrimination of albinos, would provide an alternative angle to the discussion of Brazil as a nation entirely of mixed colors, while studying the affects of consanguinity on the mental health in this community and projecting them onto the historical inbreeding that occurred and continues to occur in the deep sertão.

****

My initial motivation to research the history of mental health treatment and current *antimanicomial* and human rights movement for the mentally ill came after weeks of people-watching on bus rides passing through Papicu Terminal in Fortaleza. The term “deficientes,” a simple way of classifying the disabled, appears on public buses, beside the obese, the aged, the pregnant and the young, as worthy of reserving special seating at the front of the bus. While the term should represent those with mental disabilities, I never witnessed a front seat offered to a child or teenager displaying signs of down syndrome or another mental illness. In the terminal, people laughed at a woman speaking to herself and asking if anyone had a cell phone or a nickel. As she passed, mothers grabbed their children and those waiting for buses murmured to strangers, “A

mulher é louca!" "Que doida!" ("The woman's crazy!" "What a nut!")

These fairly common incidents encouraged me to begin studying the history of mental health treatment in Ceará and the locations and organizations that provide art and education programming alongside medical attention for the mentally ill. While researching at the public library in Fortaleza, I came across dissertations and old newspaper clips about the development of the first mental asylum in the state, the Asilo de Alienados do Parangaba. Further research indicated the presence of large public and private hospitals exclusively for psychiatric care in Fortaleza, the capital of Ceará. But as I made my way through the Brazilian federal Law n° 10.216 – guaranteeing human rights, accessible treatment and education for citizens displaying mental illnesses, while demanding an end to involuntary internment of psychiatric patients in hospitals and a preference for mental health treatment outside of brooding, urban asylums and psychiatric hospitals – I noticed the youth of the movement for mental health reform and became curious about mental healthcare in Ceará's vast interior.

Before coming to Quixadá, I only knew of the municipality through articles about its rock formations, droughts, UFO sightings, mental health conferences, Center for Psychosocial Attention (CAPS) and the pride it took in practically eliminating the need to send "psychotic" patients to Fortaleza for internment in psychiatric hospitals. With a massive preference for the interior of Ceará over the capital city, I decided to pursue a research project in the "City of Monoliths" under the direction of an art-therapist and pedagogue at CAPS – Quixadá. The diversity of the city's population, militancy of the CAPS team and richness of local culture and scenery kept me motivated, if not overwhelmed with passion, for this project and future related research endeavors.

Social Relevance

This examination of the successes and failures of Brazil's decentralized mental healthcare system, using the city of Quixadá, Ceará as a model, illustrates many federal and local reforms that need immediate implementation. The lack of data about the mentally ill populations in Brazil's municipalities and federal applications of legislation protecting human rights leads to cases of human beings with mental illnesses living in iron cages built by their families and the inaccessibility to work and education for those with special needs. While the decentralization of public healthcare and the development of municipality-based mental healthcare models helped to enable the growth of inventive, community treatments that changed the local culture of mental health treatment in cities like Quixadá, the Ministry of Health and SUS (System for Unified Healthcare) need to question the flexibility given to municipal governments to determine if the mentally ill are worth fighting for. This study will hopefully demonstrate immediate changes that can occur on a city, state and national level.

Methodology

In order to acquire a comprehensive understanding of the historical treatment and classification of the mentally disabled in Quixadá and the entire state of Ceará, I reviewed literature on psychiatric hospitals, beginning with the Asilo de Alienados do Parangaba in 1886. This literature review ranged from texts explaining changes in the architecture of mental health clinics and mental health reform movements in the 20th century, to local case studies of mental health treatments in Quixadá and the current fight against the rehospitalization of the mentally ill and misappropriation of government funding for mental healthcare. The review also covered federal legislation regarding *deficientes* (the disabled) and *portadores de transtornos mentais* (the mentally ill) beginning in October of 1989 with the enactment of Lei n° 7.853, de 24 de outubro de 1989, which displayed support for the social integration of the disabled in Brazil. Lastly, the review covered organizational texts, case studies, records of art therapy sessions and news clippings acquired from the team of CAPS – Quixadá, most meaningful of which were patients' *repentes* (improvised verses) recorded in writing and an unpublished article written by my adviser about his use of the *repente* as a form of art therapy.

At CAPS, I spent three weeks shadowing doctors, coordinators, therapists, motorists and patients, closely analyzing the organization and programming in and outside of the CAPS – Quixadá clinic. I also conducted interviews in and out of the building to better understand the history of the organization, its interaction with *Quixadense* culture and community life, development of alternative therapies, perspectives on mental healthcare reform, funding structure and desired areas of improvement. Every day served as a never-ending interview, as I spent nearly all of my waking hours with my incredibly involved and militant adviser, Perúcio Torres. With his help, I took the foundational information I received from my literature review and interviews with CAPS professionals and stepped out into the field to speak at great length with a former CAPS – Quixadá coordinator and politically-charged psychiatrist, the town's Secretary of Health, patients in

their home settings and adolescents and adults with mental illnesses, currently imprisoned in their own homes because of their parents' fear and a lack of accessible mental healthcare. With these formal and informal conversations came group discussions with the CAPS team and participation in group therapy sessions in various locations throughout the city.

Near the end of my time with CAPS, I spoke with various members of the team about my observations of the successes and failures of the organization and government mental health reform at the request of the organization's coordinator, Luisa Nara da Silva. Upon my return to Quixadá on June 9th, I will present my monograph and suggestions to the entire CAPS – Quixadá staff and likely the Secretary of Health, Dr. Ivonete Dutra.

I generally recorded interviews by hand, using an audio recorder only in appropriate situations or formal conversations. I also documented many sites and individuals photographically.

Definition of Terms

Açude do Cedro: Cedar Reservoir/Dam; one of the first major works by the Brazilian government to combat drought. Project began under Portuguese imperial rule but was completed during the Brazilian republic.
Alienado: Alienated
Antimanicomial: Anti-asylum
Arte-Terapia: Art Therapy
Asilo: Asylum
Bangelo:A slang word for a man missing many of his front teeth
Berimbau: A string instrument used in Brazilian capoeira
Benzodiapínicos: Diazepan addicts. Diazepan is a tranquilizer used as a sedative, muscle relaxant and anticonvulsant and commonly used to treat anxiety and tension
Caatinga: A semi-arid ecoregion in Northeastern Brazil
Cearense: A resident of the state of Ceará, Brazil
Cidadania: Citizenship
Doenças Mentais: Mental Illness
Doido: Crazy or Nutjob
Hospital Geral: General Hospital
Jornada: Day, Meant to describe the conferences held in Quixadá on Mental Health and Citizenship
A Loucura: The crazy
Louco: Crazy
Monólitos: Monoliths
Pandeiro: Tambourine
Portaria: Ordinance
Prefeito: Mayor of a Municipality
Prefeitura: Prefecture/Municipal Government
Quixadense: Resident of Quixadá, Ceará, Brazil
Saúde Mental: Mental Health or Mental Healthcare
Sertanejo: A resident of the sertão
Sertão: The semi-arid region of Northeastern Brazil, also meaning backlands
Repente: A form of improvised poetry and song common in the sertão
Repentista: A performer of repentes
Retirante: A migrant, generally associated with one leaving the interior for the city
Zabumba:A large bass drum, traditionally used in forró music

Chapter 1: A Brief History of Mental Health Treatment in Ceará, Brazil

"The Emperor has gone mad; if somebody comes to tell me that he walks throwing stones in the streets, it would not be a surprise to me"

Dr. Casanova, doctor of the family of Dom Pedro I's second wife, expressed to José Bonifácio[12]

The initial concepts of mental healthcare in Ceará stem largely from a royal family and a natural disaster. In 1807, when the family of Emperor Dom João VI fled Napoleon's armies to Brazil, they brought with them a rich history of epilepsy, psychosis and rumors of hyper-sexuality.[13] When the Portuguese crown officially moved to Brazil, the medical needs of the royal family began to weigh heavily on the decision making of the emperor. After the death of Dom Pedro I in 1831 – officially caused by tuberculosis, though the ruler's health was in constant shambles as a result of his epilepsy – Dom Pedro II took the throne symbolically, though a regency government controlled the first nine years of his rein, until the boy king took power in 1840.[14]

Suffering from epilepsy as well, Dom Pedro II grew up surrounded by doctors.[15] The influence of a large medical team surrounding the regency during the 1830s clearly influenced the government's decision to place medical education and treatment as major priorities for Brazil, focusing on reforming the medical school system through the advent of the Schools of Medicine in Rio de Janeiro and Bahia and patient care with the Hospice Dom Pedro II.[16] When the regency ended, the empire took an even greater stake in the organization of medical treatment in Brazil, commencing what *Cearense* psychiatrists Drs. Carlos Magno Cordeiro Barroso and José Jackson Coelho Sampaio refer to as the "Golden Age of Asylums" in the 1850s.[17]

> In the spirit of French hygiene from the medicine of the cities, imperial Brazil ordained spaces for slaves (*senzala*), the dead (public cemeteries), those with contagious infectious

12 Marleide de Mota Gomes and Miguel Chalub, "Dom Pedro I of Brazil and IV of Portugal epilepsy and peculiar behavior," *Arquivo Neuro-Psiquitr.*, São Paulo, September 2007.
13 *ibid.*
14 Marleide de Mota Gomes and Lucia M.C. Fontenelle, "The emperor Dom Pedro II: His convulsive seizures when a child," *Arquivo Neuro-Psiquitr.*, São Paulo, December 2007.
15 *ibid.*
16 *ibid.*
17 José Jackson Coelho Sampaio and Carlos Magno Cordeiro Barroso, "Manual de Organização do Centro de Atenção Psicossocial de Quixadá," 1994.

> diseases (sanitation facilities for people infected with leprosy and tuberculosis) and the crazy (hospices/asylums). The objective is preventative: isolate the city by the separation of the unproductive.[18]

As discussed with Dr. Carlos Magno, the push for the separation of the *loucura* in Ceará did not begin formally until the introduction of the *Asilo de Alienados do Parangaba* in 1886.[19] Far from the medical schools and hospitals of southeastern Brazil, Ceará's asylum grew out of its capital's only public health center, the church-run *Santa Casa de Misericórdia de Fortaleza*, which overflowed with patients of all types during the 1870s.[20]

The incidence of drought in the interior of Ceará adds a key proponent to this medical history. In the early 1870s, recognizing the need to ease the transportation of agricultural goods from the state's interior to Fortaleza, the provincial government commenced the project referred to as the *Estrada de Ferro de Baturité* (Iron Road from the interior, mountain-region of Baturité, Ceará), connecting the capital to even the southernmost regions of the state by the mid-1870s.[21] According to Quixadá, Ceará art-therapist and pedagogue José Perúcio Torres da Silva, this development brought undesirable *retirantes* (migrants from the interior) to Fortaleza along with agricultural goods.[22] Movements from the interior of Ceará to Fortaleza swelled during the great drought of 1877-1880, bringing starving and thirsty *sertanejos* to crowd around the Santa Casa facility, begging with the city's poor for food, water and medical attention.[23] Wandering orphans, prostitutes and indigents entered the asylum in the late-1880s, where doctors followed Brazilian psychiatric procedures of the time, namely the isolation and torture of the *loucura*.

This theme of community segregation based on hardly scientific epidemiology and efforts to control those escaping nearly predictable periods of drought in the semi-arid regions of the Ceará

18 *ibid.* (Translated from Portuguese).
19 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
20 Cláudia Freitas de Oliveira and Carlos Alberto Cunha Miranha, "Asilo de Alienados São Vicente de Paula, no Ceará do Século XIX: entre Fontes e Teoria," *O Publico e o Privado,* January/June, 2009.
21 B.G. Ferreira, *A Estrada de Ferro de Baturité: 1870 -1930. Projeto História do Ceará, política, indústria e trabalho 1930-1964,* (Fortaleza, Edições Universidade federal do Ceará/Stylus Comunicações, 1989), 33.
22 Interview: José Perúcio Torres da Silva, Page 26, ISP Field Journal.
23 Cláudia Freitas de Oliveira and Carlos Alberto Cunha Miranha, "Asilo de Alienados São Vicente de Paula, no Ceará do Século XIX: entre Fontes e Teoria," *O Publico e o Privado,* January/June, 2009.

interior stood at the forefront of the treatment of the *loucura* well into the 20th century. While the national models of psychiatric isolation changed from asylums to workers' colonies in 1890, state hospitals in 1940 and private hospitals in 1960, the conglomeration of masses of those deemed psychotic in units separated from normal societal activity stayed constant, with the number of beds in psychiatric hospitals increasing "sixteen times more rapidly than the Brazilian population" from 1964-1982.[24] In Ceará, after the asylum in Parangaba came the 1935 creation of the now-closed private psychiatric hospital, Casa de São Gerardo, followed by the creation of the public, state-funded Mental Health Hospital in Messejana, Fortaleza.[25] With the solution remaining alienation and sedation of the *loucura*, "evolution" of mental health treatment proved as stagnant and uninformed as state and federal government efforts to control drought in the state. As politicians continue to place issues of irrigation and water accessibility in the sertão as centerpieces of political platforms and outcries for ill-conceived World Bank loans, mentally ill *sertanejos* continue to be interned for months at a time in towering psychiatric hospitals in Fortaleza.[26]

Organized mental healthcare in the interior of Ceará simply did not exist until the 1990s. While efforts to reform clinical and social treatment of the mentally ill in and outside of city psychiatric hospitals and improve psychiatric training of general doctors in the interiors began in 1979 with the *Plano Integrado de Saúde Mental* (Integrated Plan for Mental Healthcare), Ceará's *loucura* of the sertão continued to be removed from interior life involuntarily, locked away in asylums.[27] In 1992, when Dr. Carlos Magno began his residency in a Fortaleza psychiatric hospital, he jumped at the sight of patients lining up for mass shock treatments, overly sedated and far from any "cure" or likely exit from the generously state-funded facility.[28] The patients he met came from

24 José Jackson Coelho Sampaio and Carlos Magno Cordeiro Barroso, "Manual de Organização do Centro de Atenção Psicossocial de Quixadá," 1994.

25 José Jackson Coelho Sampaio and Carlos Magno Cordeiro Barroso, "Centros de Atenção Psicossocial e Equipes de Saúde Da Família: Experiências no Ceará."

26 Nicholas Gabriel Arons, "A Political History of Drought in Northeast Brazil," *North American Congress on Latin America.*

27 José Jackson Coelho Sampaio and Carlos Magno Cordeiro Barroso, "Centros de Atenção Psicossocial e Equipes de Saúde Da Família: Experiências no Ceará."

28 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.

all over the state, creating a microcosm of Ceará in white gowns and hospital beds, while exchanging skin diseases and conceiving children within the hospital's walls.[29] At the time, a grassroots organization for mental healthcare reform surged up the eastern coast from São Paulo, working off the foundation set by initial efforts by the loosely defined, *Movimento Brasileiro de Reforma Psiquiátrica* (Brazilian Movement for Psychiatric Reform) of the 1970s and 1980s.

This organization, NAPS (Nucleus for Psychosocial Attention) and later CAPS (Center for Psychosocial Attention), developed in São Paulo in the late 1980s with the goals of localizing mental healthcare in interior cities, developing alternative methods of psychiatric treatment, pushing mental health issues to the forefront of local and federal politics and changing the culture of *loucura* through the re-entrance of the mentally ill into regular society life.[30] In 1990, with the federal implementation of SUS (The System for Unified Healthcare) as a national model for decentralizing medical treatment to better serve municipalities far from urban state capitals, the CAPS model began to move north along the eastern coast of Brazil, bringing with it the militancy of burgeoning *antimanicomial* movements.[31] The federal government integrated CAPS into federal legislation in the early 1990s, refining the definition of the psychosocial attention centers on January 29, 1992 with Portaria n° 224, stating that CAPS, "attends to the intermediate care in between ambulatory care and hospital internment."[32] The Portaria lays out the role of CAPS as a center for individual attention (medication, psychotherapy), group attention (psychotherapy, group activities), home visits, family attention and assistance, community activities focusing on the integration of the mentally ill in the community and their social insertion and refreshments for those clients that frequent the service for at least four hours.[33][34]

In 1993, Dr. Carlos Magno arrived in Quixadá, Ceará, called to help treat psychiatric

29 *ibid.*
30 José Jackson Coelho Sampaio and Carlos Magno Cordeiro Barroso, "Manual de Organização do Centro de Atenção Psicossocial de Quixadá," 1994.
31 Júlio Cesar Ischiara, "Saúde Mental: a modernização de um conceito e o atraso de uma concepção."
32 Portaria n° 224 de 29 de Janeiro de 1992, Ministério da Saúde, Brazil.
33 *ibid.*
34 Júlio Cesar Ischiara, "Saúde Mental: a modernização de um conceito e o atraso de uma concepção."

patients in the semi-arid municipality, while developing a CAPS facility to address issues surrounding the treatment and human rights of the mentally ill in the city. Before CAPS, Quixadá lacked any outlet for mental healthcare, forced to send over 100 patients in crisis to Fortaleza for treatment each year.[35] Like many other cities in the interior, Quixadá struggled to acquire technically trained staff and had little information about the mentally ill population, due in part to a nationwide issue of documenting healthcare needs, presence of mental illness and living conditions. Forced to confront a community where the solution for psychotic patients had long been forced internment in Fortaleza, alienation and persecution by community members and/or home incarceration by helpless and fearful parents, the multi-professional team that started CAPS – Quixadá realized that they could not merely prescribe a pharmacological remedy to correct years of improper treatment of the mentally ill.[3637] Unsatisfied with his residency in Fortaleza, Dr. Carlos Magno practiced exclusively at CAPS – Quixadá, earning his title through a five-year residency at the extra-hospital facility and leading the organization's direction as its longtime coordinator after CAPS – Quixadá founder, Raimundo Severo, moved to other locations.[38]

Staring out at Dom Pedro II's landmark *Açude do Cedro* (Cedar Reservoir), minutes from the CAPS building, visitors are reminded of the municipality's ties to the former Brazilian royal family and the epic battle Quixadá continues to face with drought. Turned back toward the CAPS building, visitors encounter patients with epilepsy and psychosis with no team of royal doctors to cater to their needs and no luxurious beds and baths to rest in. Still the devoted team of psychiatrists and therapists from CAPS finds ways to trek out to the patients' mud and stick houses in the deep and hard-to-reach areas of the sertão, attending to patients not only with a great understanding of mental healthcare, but a knowledge of their culture and thirst.

35 "O Centro de Atenção Psicossocial de Quixadá: CAPS/Quixadá: Uma Política Cidadã de Saúde Mental," 2006.
36 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
37 Interview: Ivonete Dutra, Page 63, ISP Field Journal.
38 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.

Chapter 2: The Foundation and Infrastructure of CAPS – Quixadá

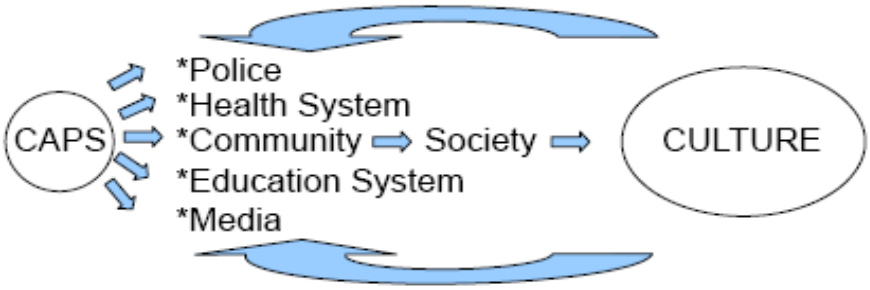
"When members from the Ministry of Health came to visit CAPS, they kept asking 'Where is the patients' lunch? Where do they eat here?' I told them they should come with me to the patients' houses if they wanted to see."

Dr. Carlos Magno Cordeiro Barroso – Former CAPS – Quixadá Psychiatrist and Coordinator[39]

CAPS – Quixadá occupies a small, salmon-colored building with an outdoor, flowered patio that functions as a waiting room, four consultation rooms (psychiatry, infirmary care, psychology, occupational therapy/pedagogy), a kitchen, a coordinator's office and a makeshift conference room consisting of a round table surrounded by file cabinets filled with patient records. Patients wander in and out of the building, conversing on benches, while awaiting their examinations. No LCD Televisions or Magazine racks entertain receptionists and patients, while necessary building upgrades and repairs peek out from every dripping sink. The building, located in Quixadá's commercial center, only represents a slim part of the organization's work. According to former CAPS – Quixadá coordinator and psychiatrist, Dr. Carlos Magno Cordeiro Barroso, "The first priority of CAPS – Quixadá is to provide a great clinic. But we want our patients to leave, to reenter their communities."[40]

Established in 1993, CAPS – Quixadá became the third CAPS in Ceará, after Iguatú and Canindé.[41] In part the result of state laws geared toward mental healthcare reform, the creation of CAPS – Quixadá came largely as a result of the militancy of student groups and multi-professionals that pushed the town government to reconsider the treatment of the mentally ill in the municipality.[42] With initial funding from the *prefeitura* (municipal government), CAPS – Quixadá opened with the following multi-disciplinary structure.

39 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
40 Interview: Carlos Magno Cordeiro Barroso, Page 48, ISP Field Journal.
41 "O Centro de Atenção Psicossocial de Quixadá: CAPS/Quixadá: Uma Política Cidadã de Saúde Mental," 2006.
42 Interview: Ivonete Dutra, Page 63, ISP Field Journal.



This approximated diagram of one presented by Dr. Carlos Magno illustrates the ideal goal of CAPS to play a strong role in the treatment of the mentally ill in and out of the clinic.

Not demonstrated in this diagram are two key institutional relationships, that of CAPS and the *Programa de Saúde da Família* (Program for Family Healthcare) and CAPS and the *Hospital Geral* (General Hospital). With this organization, CAPS – Quixadá developed as a group looking to first and foremost change the culture of mental illness and mental healthcare by illustrating its importance in every facet of *Quixadense* society.

During my stay in Quixadá, I witnessed the current manifestation of this system, beginning first with the CAPS treatment structure. According to current CAPS – Quixadá coordinator and social assistance representative, Luisa Nara da Silva, the clinic's medical care exists in the form of psychiatry, psychology, infirmary care and therapy consultations on site, while working off-site in the form of family visits, home consultations, off-campus art therapy sessions and interactions with local state universities and general healthcare posts.[43][44] From Monday through Wednesday, lines curl around the CAPS front patio as the employees enter promptly at 8 a.m. Approximately fifty of these patients per day seek consultations, evaluations and discussions with psychiatrist Dr. Nestor Mainreri da Cunha Pinto.[45] Nestor's popularity reflects not only the pharmacological need of many of the patients frequenting CAPS, but also the needs of those looking to obtain documentation of

43 *ibid.*
44 Interview: Luisa Nara da Silva, Page 19, ISP Field Journal.
45 Observations: Page 66, ISP Field Journal.

their illnesses for government benefits.[4647] Having served as a psychiatrist at a the now closed *Casa de São Gerardo* in Fortaleza prior to beginning work at CAPS – Quixadá, Nestor emphasizes that doses of medication at CAPS are significantly lower than those prepared at the state capital's hospitals, with patients commenting that the decreased medication enables them to function in a much more conscious state than that experienced when interned at asylums and hospitals in Fortaleza.[4849] Yet one cannot ignore the prevalence of drug treatments offered at CAPS, nor their popularity amongst frequenters of the site. On Thursdays and Fridays, or when Nestor calls in sick, the lines of patients often disperse, recognizing that without the psychiatrist an easy remedy cannot be obtained.[50] In order to consider the pharmacological treatments at CAPS – Quixadá, it is important to separate those patients with severe mental illnesses in need of medication to prevent the onset of physical pain and crisis from the throngs of Quixadenses with common mental disorders (anxiety, neurosis) attempting to procure Diazepan through the facility.

The weekly routine at CAPS involves scheduled consultations with all of the medical specialists and organized physical therapy, art therapy and occupational therapy groups in a malleable structure, meant to accommodate what the team refers to as daily demand fluctuation.[51] Certain items – hours of operation, monthly supervision, staff meetings – stay fixed week to week, but the staff enters each day with little expectation of the amount and type of work that will meet them at the building.[52] Organized consultations at the building can unfold with staff members often forced to make home visits to patients in crisis 30 km into the *sertão*, find room for therapy sessions in public spaces and redraft programming due to fluctuations in heat and precipitation.[53]

The theoretical model of CAPS, interacting with every facet of *Quixadense* society, extends into the practical world, but hardly in as organized a fashion as Dr. Carlos Magno's flow charts.

46 Interview: Nestor Mainreri da Cunha Pinto, Page 81, ISP Field Journal.
47 Interview: José Perucio Torres da Silva, Page 73-74, ISP Field Journal.
48 Interview: Dairton, Page 68, ISP Field Journal.
49 Interview: Nestor Mainreri da Cunha Pinto, Page 82, ISP Field Journal.
50 Observations: Page 66, ISP Field Journal.
51 Interview: José Perúcio Torres da Silva, Page 73, ISP Field Journal.
52 *ibid.*
53 *ibid.*

Luisa Nara da Silva reflected the importance of this organized disorganization in our first meeting, remarking that the staff never treats a case in a one cause/one cure matter, emphasizing an understanding of patients within the context of their environments.[54] Yet when forced with an overwhelming demand of psychiatric care or a situation in which a family lacks the patience for alternative treatments and therapies, drugs often provide the most immediate treatment.[55]

Generally, overwhelming rigidity in the CAPS model stems from guidelines set by the Ministry of Health and SUS (System for Unified Healthcare), rather than the CAPS – Quixadá team. First receiving benefits from the federal government in 1996, according to Dr. Carlos Magno, CAPS – Quixadá lives from day-to-day off of underwhelming public funding that leaves some staff members desiring the privatization of the organization.[5657] In an article on the the history of mental healthcare in Ceará, CAPS – Quixadá psychologist Júlio Cesar Ischiara lays out the national criteria for implementing a CAPS – Center for Psychosocial Attention and the allotted funding for the five types of CAPS facilities. The three most common CAPS facilities – CAPS I, CAPS II and CAPS III – are associated solely with different population sizes. In order to set up a CAPS I, a municipality must have 20,000 residents; CAPS II requires 70,000; and CAPS III, 200,000, providing the potential for 76 municipalities in Ceará to create a CAPS I facility, 7 to create a CAPS II and 2 to create a CAPS III, while ignoring the 97 municipalities with fewer than 20,000 inhabitants.[58] Auxiliary CAPS facilities exist in large cities to better attend to children and patients with drug addictions.[59] This classification does not take into account the specific mental health needs of the individual municipality, nor does the system's allotted funding connect to any statistical information regarding the municipality's mentally ill population.

The enactment of *Portaria n° 189 da Secretaria de Assistência à Saúde do Ministério da Saúde de 20 de março de 2002* (Ordinance of the Secretary of Healthcare and Assistance and the

54 Interview: Luisa Nara da Silva, Page 19, ISP Field Journal.
55 Observations: Page 76-77, ISP Field Journal.
56 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
57 Interview: José Perúcio Torres da Silva, Page 74, ISP Field Journal.
58 Júlio Cesar Ischiara, "Saúde Mental: a modernização de um conceito e o atraso de uma concepção."
59 *ibid.*

Ministry of Health) defined the CAPS classification system alongside an additional set of requirements to receive funding through the body *Procedimentos Ambulatoriais de Alta Complexidade/Custo* – APAC (Ambulatory Procedures of High Complexity/Cost).[60] APAC and the Ministry of Health, by virtue of the *Portaria*, expect CAPS II and III facilities to treat every type of intensive and semi-intensive case, implement preventative measures to decrease the incidence of mental health disorders in CAPS' communities and spend sufficient time attending to patients outside of the CAPS facility.[6162] Meanwhile, the amount of funding a CAPS facility receives from the state does not cover the numbers of patients requesting care under the jurisdiction of the recent federal laws declaring access to mental healthcare.

As illustrated by the *Portaria*, CAPS I can receive a maximum of R$24.862,00 per month, CAPS II a maximum of R$39.127,50 per month and CAPS III a maximum of R$51.004,50 per month.

TIPO	TRAT. INTENSIVO	SEMI-INTENSIVO	NÃO INTENSIVO	Nº MENSAL CLIENTES	VALOR TOTAL POSSÍVEL
CAPS I	25	50	90	165	R$ 24.862,00
CAPS II	45	75	100	220	R$ 39.127,50
CAPS III	60	90	150	300	R$ 51.004,50
Procedimentos/mês/paciente	25	12	3	–	–

CAPS – Quixadá files under the CAPS II classification, with a population of around 80,000, not including the additional 170,000 *Cearenses* the organization must consider in neighboring municipalities that lack mental healthcare facilities.[63] While a general care CAPS, CAPS – Quixadá

60 Portaria n° 189 da Secretaria de Assistência à Saúde do Ministério da Saúde de 20 de março de 2002, Ministério da Saúde, Brazil.

61 Júlio Cesar Ischiara, "Saúde Mental: a modernização de um conceito e o atraso de uma concepção."

62 Interview: Júlio Cesar Ischiara, Page 20, ISP Field Journal.

63 Interview: José Perúcio Torres da Silva, Page 58, ISP Field Journal.

found ways to aid the creation of alternative facilities for the treatment of children and patients with "syndromes" in response to overwhelming numbers of *Quixadenses* seeking care and on-site conflicts between children and adults.[64] Upon my last investigation of the CAPS records, the facility holds 6,324 active patient records.[65] Yet, only receiving enough funding to treat, at most, 220 patients per month, the team must find ways to deal with patients' needs, currently contemplating the ability for the staff's psychologists to treat patients in group, rather than individual, hour-long sessions.[6667]

While the support of the Ministry of Health gave immense weight to the *antimanicomial* movement that enabled CAPS facilities to spread in the past two decades, the rigid funding and treatment protocol administered by the state often interferes with the community-specific needs and individualized organization structures of each CAPS. The gaps left by the federal government fall on the shoulders of individual municipal governments, often without the funds or motivation to support campaigns for the rights of the mentally ill and open access to mental healthcare. Unsatisfied with its status as a public institution, CAPS – Canindé currently operates with the support of the church and other local organizations, recognizing that reaching out to private philanthropic organizations made more sense from a fund raising standpoint.[68] Meanwhile, CAPS – Quixadá must interact with a community that now seems to look to the organization's services as a gateway to government benefits and drugs, rather than a militant organization working toward changing the popular conception of the mentally ill and questioning pharmacological treatment methods. Focusing on the history of the *loucura*, deemed psychotic patients, overlooks the history of the treatment of non-psychotic patients in Quixadá and other interior municipalities. While formal mental healthcare facilities did not reach Quixadá until CAPS' creation, the impact of major drug companies stormed the interior by way of providing easy solutions for general medical

64 Interview: José Perúcio Torres da Silva, Page 74-75, ISP Field Journal.
65 Observations: Page 75, ISP Field Journal.
66 Júlio Cesar Ischiara, "Saúde Mental: a modernização de um conceito e o atraso de uma concepção."
67 Observations: Page 73, ISP Field Journal.
68 Interview: José Perúcio Torres da Silva, Page 74, ISP Field Journal.

professionals dealing with patients with psychological problems.[69]

The treatment of the mentally ill in Quixadá certainly improved with the implementation of CAPS, both from a psychosocial and cultural perspective, but the culture of pharmacological solutions for issues of depression and anxiety requires a consistent fight and militancy of each CAPS team. Regardless of funding and patient obstacles, the structure of CAPS – Quixadá must continue to aspire to Dr. Carlos Magno's flow charts and diagrams. For if the group's desire to effect change on *Quixadense* culture halts in regards to mental health treatment and human rights for the mentally ill, CAPS – Quixadá could only fulfill one aspect of its multifaceted role in the community – to exist as a "good clinic."

69 *ibid.*

Chapter 3: Changing the Culture of Mental Health Treatment and Prejudice

"He's only well after three months in the hospital" "The doctor said he will always be this way. Leaves one hospital and enters soon in another, for the rest of his life." "Doctor, he breaks everything in the house." "He wants to kill me, he has to be interned." "If I stay with him in the house, what will the neighbors say?" "Doctor, intern her because she's crazy."

José Jackson Coelho Sampaio and Carlos Magno Cordeiro Barroso demonstrate common remarks made by family members of mentally ill patients during home visits[70]

Dairton, a 51-year-old patient suffering from bipolar disorder and a slew of physical health issues, frequents CAPS – Quixadá on a near daily basis. His mental health history spanning nearly every psychiatric hospital in Fortaleza, Dairton can practically write an encyclopedia on mental healthcare treatment ethics of the past forty years in Ceará. In the afternoon on May 24, 2010, Dairton sat on the back patio of CAPS, rolling a cigarette and grabbing his bloated stomach, which he mentioned began to hurt because of medications he needed to take for his heart problems.[71] Happy to have someone to talk to, Dairton opened up about his past internments in psychiatric hospitals, focusing on the *Asilo de Alienados do Parangaba*. "Both times the police brought me there," Dairton said, referring to the involuntary two-month internments he faced at ages 14 and 29.[72] Regarding his treatments at the psychiatric hospitals in Fortaleza, Dairton remarked, "They lined us up, gave us shocks, drugs."[73]

When CAPS entered Quixadá, its first responsibility was to illustrate that internments in asylums and psychiatric hospitals did not suffice for the treatment of the mentally ill. The organization's team stressed that a child with down syndrome or adult with schizophrenia still belonged to a family that needed to provide care. CAPS' initial community outreach worked off of a comprehensive town mental health map created by a team of multi-professional militants, working with families and the *PSF* (Program for Family Healthcare) to alter preconceptions of the mentally

70 José Jackson Coelho Sampaio and Carlos Magno Cordeiro Barroso,"PSF e Atenção às Pessoas com Transtornos Caracterizados Como Psicose," 1997. (Translated from Portuguese).
71 Interview: Dairton, Page 68, ISP Field Journal.
72 *ibid.*
73 *ibid.*

ill as harmful beings, incapable of working and needing isolation treatment far from family homes.[74] Upon first surveying the town of Quixadá, current CAPS art therapist and pedagogue, Perúcio Torres, encountered mentally ill children and adults locked in hand cuffs and kept in rooms fit for animals, beaten to silence crises and attacks.[75] Far from any mental health facility, many of these parents lacked an understanding of available treatment for the children, viewing them as embarrassments that needed to be hidden behind closed doors.[76]

The importance of the home visit in the CAPS model proved paramount to the success of parental education, with regards to the treatment of mentally ill children. When Carlos Magno encountered parents shouting, "He needs to be locked up for three months," echoing the traditional methods of interning the *loucura* in asylums, he responded, "What if I return tomorrow and everyday for the next week to help with your child's crisis."[77] Families generally responded positively in this regard, seeing the ability of CAPS to substitute, with greater efficacy, three months of psychiatric treatment in Fortaleza with five days of treatment in Quixadá, either through the general hospital, CAPS or home visits.[78]

Enforcing the concept of reintroducing the mentally ill into daily life required more than family visits, but a demonstration of the potential of the *loucura* to accomplish more than take up space and food or pose a threat to family and neighbors. Commencing with the traditional family model in Quixadá – marked by the regularity of grandparents, cousins, siblings and parents living on the same street – CAPS sought to humanize its patients by exposing them to the community alongside family members. In the late 1990s, under the guidance of Perúcio Torres, CAPS developed two music groups, not specifically for the mentally disabled, but for the entire community to take part in.[79] Perúcio presents one of the groups, Pão e Lata, as the "first alternative percussion group in the state of Ceará," creating drums out of plastic bottles, lids of garbage cans

74 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
75 Interview: José Perúcio Torres da Silva, page 82, ISP Field Journal.
76 *ibid.*
77 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
78 *ibid.*
79 Interview: José Perúcio Torres da Silva, page 78, ISP Field Journal.

and any other imaginative item able to be hit with a hand or drum stick.[80] This group merged children with adults and *loucura* with sane, reaching high levels of success within the state of Ceará, while touring four states in the Northeast in the beginning of the 21st century.[81]

These groups garnered a great deal of media attention for CAPS and Quixadá, enchanting the *prefeito* (mayor), while swelling to include 70 community members banging on plastic drums. The second music group, CAPS Samba, consisted predominantly of adolescents with drug problems, without families and/or with aggression issues. Perúcio Torres reflects with a wide smile and nostalgia-filled eyes when discussing two children that rose through the program.[82] One, Pedro Malavelha, was taken in by Perúcio after losing his parents and guardians at age 12.[83] After several years performing with *Pão e Lata*, Pedro branched out into the music world with Perúcio's help, achieving massive attention for his abilities as a percussionist, enabling him to lead a successful life in Fortaleza under the stage name, Riquermo.[84] A second Pedro, Perúcio's other favorite student musician, grew up incarcerated by his family, which beat the child out of fear of his mental illness.[85] With the help of the CAPS social assistant, Perúcio worked to change the family's treatment and trained Pedro on the *berimbau* (the string instrument used to accompany Brazilian *capoeira* (martial art/dance fighting)).[86]

When CAPS – Quixadá stopped treating children in 2008 – creating alternative spaces for recreation, rehabilitation and treatment through such as PETI (Program for the Eradication of Infant Labor), CRISCA and APAPEQ (Friends and Parents of People with Special Needs in Quixadá) – many of the music and physical therapy programs transferred locations. While the decentralization of mental healthcare on a local level agrees with the CAPS model, the redirection of recreational and cultural programming to NGOs working with children left a void in organized activities

80 *ibid.*
81 *ibid.*
82 *ibid.*
83 *ibid.*
84 *ibid.*
85 *ibid.*
86 *ibid.*

accessible for the adults treated at CAPS.

Referring back to Carlos Magno's flow chart, changing local notions of mental health treatment must include interaction with the Secretary of Education and the Police.[87] While Brazil's laws guarantee access to education for the mentally disabled and protect against involuntary internment, they do not create schools with special education programs nor enforce police brutality if stopping a violent patient in crisis.[88] Recognizing the limitations of the written word, CAPS – Quixadá took the initiative to create the first special education program in the municipality, declaring NGO status with no desired assistance from the state government.[8990] In order to better prepare teachers to lead special education classes, CAPS – Quixadá pressured UECE (State University of Ceará – Quixadá Campus) to make special education a mandatory concentration within the pedagogy curriculum.[91] And to combat the police brutality against and unnecessary internment of patients in crisis, CAPS holds information sessions and workshops with state police officers, illustrating ways to recognize a CAPS patient and non-violent forms of controlling their often violent and unruly mental trials.[92]

To attract regular media attention to the local healthcare situation in Quixadá, the first CAPS team installed mandatory annual *Jornadas de Saúde Mental e Cidadania* (Mental Health and Citizenship Conferences/Days), featuring two days of lectures, performances and round table discussions with local physicians, politicians, therapists and patients, often hosting speakers from all over the country.[93] Through these conferences, Quixadá became the center of mental healthcare reform in the state of Ceará, gaining national attention for its mental healthcare system and capturing the interest of psychologists and doctoral students as far away as France, who continue to frequent the site for research and observation.[94] Only recently have *Cearense* mental healthcare

87 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
88 Lei n° 7.853, de 24 de outubro de 1989. Brazilian federal Legislation.
89 Interview: José Perúcio Torres da Silva, Page 34, ISP Field Journal.
90 Observations: Page 33, ISP Field Journal.
91 Interview: José Perúcio Torres da Silva, Page 74, ISP Field Journal.
92 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
93Programs from CAPS – Quixadá Annual Jornadas
94 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.

professionals focused state-wide conferences in Fortaleza, where 14 CAPS facilities are located.[95]

With these focal points – family/society, education, police and media – the CAPS team humanized the *loucura*, while setting the foundation for their reentry into regular family and community life. Yet the organization constantly must adapt to changing cultural markers in Quixadá, disagreeable reactions from family members of the mentally ill and prominent issues with non-psychotic patients that frequent mental healthcare facilities in attempts to procure quick fixes for common mental disorders.

This other field of mental health treatment must be considered in a different light than the *antimanicomial* and human rights movements that worked to socially integrate those with mental illnesses that alienated them from their communities and families. Before CAPS arrived in Quixadá in 1993, general health posts controlled local mental healthcare.[96] Lacking psychiatrists and psychologists, existing medical professionals reacted to the presence of mental disorders and illnesses in Quixadá by prescribing the medication Diazepan. CAPS arrived to a population of *Quixadenses* demanding 1,500 prescriptions of Diazepan per month, for every issue ranging from minor cases of insomnia to schizophrenia.[97] Around the CAPS office, staff members occasionally joke about the ease with which *Quixadenses* could acquire the drug, remarking that a bar and a street corner could be a pharmacy.[98] Thus, issues with drug addiction, dealt with at CAPS and in the Quixadá community, step beyond modern conceptions of the crazy, poor, crack addict or the clown of an alcoholic. The community must also confront addictions of the lower and middle classes to freely prescribed pharmaceuticals, previously used as a solution for problems curable through therapy and exercise.

Though Dr. Carlos Magno stresses the link between the 1960s anti-psychiatry movement in England and CAPS – Quixadá's efforts to change the conception of mental healthcare as a

95 Interview: Luisa Nara da Silva, Page 19-20, ISP Field Journal.
96 Observations: Page 72-73, ISP Field Journal.
97 *ibid.*
98 *ibid.*

pharmacological daydream, the current CAPS team, along with the PSF, still struggles to figure out the best way to combat the abundant *benzodiapínicos* (Diazepan addicts) that frequent the facility on psychiatric consultation and prescription distribution days. Two months ago, the CAPS team decided to decrease the amount of days during which patients could acquire prescriptions and place a limit on the amount of prescriptions administered in a day.[99] Now, no more than 240 patients can potentially acquire Diazepan per month at the CAPS facilities, however, the strength of the drug addiction often causes confrontations between patients denied a prescription and the staff doctors looking to help them end their drug dependence.[100] While this complicates the methods by which the *benzodiapínicos* must acquire their medicine, with a little effort, patients can still pressure private clinicians and doctors at general health posts and hospitals to provide prescriptions.[101] The development of organized therapy sessions geared toward the treatment of this particular drug addiction warrants increased focus in a community now struggling with the psychological problems of the modern poor. The working classes of Quixadá view beautiful consumer goods on televisions, learn to dream of owning fancy motorcycles instead of feeding families and often forget about the rich historical identity of Quixadá in favor of American pop music and clothing.[102] As such, CAPS must now adjust to common mental disorders stemming from work-related pressures and far-off materialistic ideals, questioning whether to administer a prescription to allow a woman to sleep, necessitating a drug because of her addiction, or force her to confront unrealistic and truthfully undesirable dreams.

On the back patio of CAPS, after smoking his hand-rolled cigarette and reflecting on his extensive history of painful psychiatric treatments and physical health problems, Dairton looked up, smiled and gave me a one-armed hug.[103] Despite his continued struggle with physical and mental strife and difficult relationships with family and community members, Dairton showed a brief

99 Interview: José Perúcio Torres da Silva, Page 82, ISP Field Journal.
100*ibid.*
101*ibid.*
102Observations: Page 14, ISP Field Journal.
103 Interview: Dairton, Page 68, ISP Field Journal.

appreciation for CAPS by demonstrating greater ownership over his well-being through his treatment at the facility. “Eu moro e vivo em Quixadá” (“I live in Quixadá”) he remarked.[104]

104 *ibid.*

Chapter 4: Quixadense Tradition in Art-Therapy
The Repentista and The Town Singer

"What we are doing with art therapy in Quixadá is attempting to rescue the creative potential of patients at the precise moment of their complaint, using their pain to better express their feelings."

José Perúcio Torres da Silva[105]

On May 10, 2010, after undergoing a brief program orientation with CAPS – Quixadá coordinator, Luisa Nara da Silva, I wandered to the back patio of the facility, following the sound of a tambourine, triangle, guitar and voice. There, Perúcio Torres sat strumming a guitar and trading verses with Amauri, a built, tan and big-eared who suffers from multiple neurological disorders.[106] Strutting a toothy grin, Perúcio sang of unattractive love, his squinting eyes nearly meeting his shaggy hair. The free-flowing rhyming lyrics, called *repentes* because of their improvised nature, accompany forró and samba rhythms, realized on any arrangement of tambourine, guitar, triangle and zabumba (a large bass drum). The *repentista* (improvisational singer) is the poet of the *sertão*, singing about activities common to the *sertanejo* (inhabitant of the sertão) romantically and comically.[107]

With a great deal of CAPS – Quixadá's patients coming from the large *sertão* surrounding the city's commercial center, the adults frequenting the facility know the *repente* just as well as the drought. The incorporation of the art form into CAPS therapy started in a rather improvised fashion, with Perúcio trying to calm Amauri, who historically suffered through violent crises that led to physical fights with neighbors and tendencies to break any item he encountered.[108] In a recent, unpublished article by Perúcio, the art therapist remarks, "[I] delivered to Amauri a musical instrument called a *pandeiro* (tamborine), asking the patient to beat the instrument instead of beating the CAPS table and challenging him to make a repente saying what he felt in relation to the problem he had with his neighbor."[109] Banging the tambourine in a clean, forró rhythm, Amauri

105 José Perúcio Torres da Silva, "A arteteapia na saúde mental em Quixadá." (Translated from Portuguese).
106 Observations: Page 17-18, ISP Field Journal.
107 José Perúcio Torres da Silva, "A arteteapia na saúde mental em Quixadá."
108 Observations: Page 17-18, ISP Field Journal.
109 *ibid.*

improvised:

Dei um soco no meu vizinho safado	I punched my *safado* (bastard) neighbor
Que a cabeça subiu fez pirueta	That his head soared, making pirouettes
E passando por todos os planetas	And passing by all of the planets
Foi parar no reinado dos profetas	Was stopped in the kingdom of the prophets
Isso um anjo que viu, ficou pateta	This, an angel saw and became goofy, like a clown
A cabeça do diabo estava um facho	The devil's head was torched
Uma alma gritou, "Oh, velho macho"	A soul cried, "Oh, old man"
E uma outra indagou – "O que é isso?"	And another injected – "What is that?"
Disse um anjo que tava junto a cristo	Said an angel that together with Christ
e Amauri brigando lá embaixo	And Amauri fighting down below[110]

A single observation of the verses illustrate an incredible ability of Amauri to verbalize his emotions in clear, poetic stanzas. The *repente* incorporates humor, universal transportation and religion into a demonstration of what the singer wanted to do to his neighbor. After several more songs, improvised and non-improvised, Amauri relaxed, displaying no violent urges or need for police intervention to calm him.[111] Recognizing the success of this interaction, Perúcio instructed Amauri to come back to CAPS whenever he felt the need to fight a neighbor or confront a community member and sing about his rage, while beating a tambourine.[112]

Perúcio develops experimental therapies regularly, understanding the individuality of each patient's case and trying to use models of self-expression and local traditions to give patients control over their emotions, rather than placing all psychosocial rehabilitation efforts in pill form. The *repentista* treatment is a prime example of the CAPS team gathering a community marker, that of the *sertanejo*, and twisting it in a way to best serve its patients, demonstrating a connection between *Quixadense* culture and mental health treatment. Amauri continues to return to CAPS to sing *repentes* when aggressive and when in good health, which generally results in verses about "women, artists on television and politicians that he likes and dislikes."[113]

Soon CAPS – Quixadá gathered an informal band of singers and musicians comprised of

110 *ibid.*
111 *ibid.*
112 *ibid.*
113 *ibid.*

patients, family members, students, drivers and staff members, continuing to perform on the back patio during busy days at the building and transporting patients to public landmarks to sing and improvise with community members amidst the beautiful, monoliths that line the city.[114]

The performing follows a fairly uniform structure, yet the improvised lyrics of the CAPS patients illustrate not only the therapeutic nature of the art form, but also patients' individual issues, which in many instances overlap in their analysis of mental health treatment and preconceptions about the *loucura*. On May 26, 2010, a new patient from the neighboring municipality of Choró came to CAPS – Quixadá, since his town lacks a CAPS facility.[115] While waiting in the never-ending Wednesday line to meet with psychiatrist, Dr. Nestor Mainreri da Cunha Pinto, the patient overheard singing out on the back patio of CAPS, as Amauri, Dairton and Perúcio improvised songs and belted *sertão* standards.[116] Joining the music circle, the new patient recited the following verses, which Perúcio quickly scratched onto pen and scrap paper:

Passo a noite acordado vendo marmota	I pass the night awake, seeing ugly, disturbing things
Vejo sombras e vultos esquisitos	I see strange, frightening shadows and shapes
Abafo com as mãos meu próprio grito	Smother my mouth with my hands to silence my screams
Afogando a solidão atrás da porta	Drowning my loneliness behind my door
Vou ao CAPS pra ver se alguém se importa	I go to CAPS to see if somebody cares
E encontro filas inumeráveis	And encounter innumerable lines
Composta por loucos, mães e miseráveis	Composed of *loucos* (crazies), mothers and the miserable
Gente feia, gente magra, gente torta	Ugly people, starved people, crippled people
Mas escuto uma música que vem do pátio interno	But I hear a song coming from courtyard
Da vontade de entrar e escutar	On my own will I enter and listen
Cantar bem alto pros males espantar	Singing loud, to send my evils flying
E esquecer que a vida é esse inferno	And forgetting that life is hell[117]

The lyrics not only capture the mental pain experienced by the patient, but take the listener through the trip that landed him at CAPS and the ability of music to make him forget his afflictions for a brief moment. His commentary on the scene at CAPS criticizes the masses waiting for psychiatric consultants, musing that a more powerful cure can be found with the group singing on

114 Observations: Page 33, ISP Field Journal.
115 Observations: Page 71, ISP Field Journal.
116 *ibid.*
117 *ibid.*

the patio.

For those patients who struggle to form *repentes*, Perúcio leads renditions of popular music common to the *sertão*. While the two organized music groups Perúcio created, *Pão e Lata* and CAPS Samba, dissolved with the removal of pediatric treatment at CAPS – Quixadá in 2008, the art therapist maintains a steady group of musicians, whom he performs with sporadically in and out of CAPS. Zé Alberto, a twenty-something with a buzz cut, permanent grin and extended hand, struts perhaps the most famous face of the CAPS music scene.[118] In 1993, Zé lived in a difficult family situation, with parents unwilling to let him leave the house, embarrassed by his advanced mental retardation.[119] Perúcio took the boy from his parent's house with their permission and quickly learned of Zé's love for and knowledge of the music of Northeastern Brazil.

Sitting at the base of the *Açude do Cedro* with a group of patients, Perúcio, me and town motorist, Hermes, on May 13, 2010, Zé belted songs about drought, birds from the *Caatinga* and the sertão, rocking his hands to the strum of Perúcio's guitar as if shaking an imaginary egg beater or maraca.[120] At the 2nd Annual CAPS *Jornada* of Mental Health and Citizenship, Dr. Carlos Magno and the first CAPS team gave Zé the ability to sing with the popular band, Banda SKA.[121] According to Dr. Carlos Magno, this performance and following ones at conferences and around the city radically changed Quixadenses' perspectives on Zé, gaining him a fair amount of notoriety in Quixadá.[122]

Yet Zé still suffers from an overly dismissive family that occasionally abuses him, according to Perúcio.[123] The family gladly allows Perúcio and other members of the CAPS team to take Zé from the house and keep him at the CAPS facility for hours at a time, obscuring the parents' responsibility to care for their son by placing all therapeutic expectations on CAPS. Zé's ability to step out into the community and sing with Perúcio and wishful cantors that pass illustrates a

118 Observations: Page 33, ISP Field Journal.
119 *ibid.*
120 *ibid.*
121 Program from the second annual Jornada for Mental Health and Citizenship in Quixadá.
122 Interview: Carlos Magno Cordeiro Barroso, Page 62, ISP Field Journal.
123 Observations: Page 33, ISP Field Journal.

humanized form of mental health treatment that links the patient to every other community member with a comprehensive knowledge of the songs of the *sertanejo*. His lack of freedom inside his own house, however, displays a need for additional social assistance in family interaction that can reinforce the network of care between family, doctor, therapist and patient.

Perúcio's wide-array of cultural experiences, highlighted by eight years of writing, traveling on foot and hitch-hiking through all of Brazil, give him the ability to connect to every *Quixadense* he encounters, patient or not. He illustrates his proclamations that those deemed psychotic deserve to take part in daily, community life, through all-inclusive music groups and near confrontations with parents that lock up their children. The *repentistas* at CAPS fail to overlook Perúcio's compassion for the therapies he thinks up for the *loucos* he asserts are people. As Dairton waxed in a recent improvised song:

Tem um doido no CAPS	There's a nut job at CAPS
Entrando e saindo as pressas	Entering and exiting rapidly
Fechando e abrindo as portas	Closing and opening doors
Cantando quase contente	Singing, almost happy
Parece um vento pensante	Like a thinking wind
Passando dentro da gente	Passing inside of us
Soprando dentro do CAPS	Blowing inside of CAPS
Um sorriso diferente	A different smile
E diz que eu não sou doente	And says that I'm not ill
Sussurra no meu ouvido	Whispering in my ear
E olha que eu não duvido	And sees that I don't doubt
Que ele sabe, que ele sente	What he knows, what he feels
Que lá se faz diferente	That *there* lies the difference
Sorrindo dentro da gente	Smiling inside of us
Tem um doido no CAPS	There's a nut job at CAPS
Que diz que louco é gente	Who says that *loucos* are people
Que diz que louco sabe	Who says that the *louco* knows
Que diz que louco sente	Who says that the *louco* feels[124]

These four verses represent the potential of Perúcio and the team of CAPS – Quixadá to break down lines dividing the ambiguous *loucura* and the sane, not just in the content of Dairton's words, but in the manner that he expressed them. In beautiful, rhyming forms, Dairton sang loud,

124 José Perúcio Torres da Silva, "A arteteapia na saúde mental em Quixadá."

sending his maladies flying, as legendary Quixadá *repentista* Cego Alderado would do. Dairton expresses that he does not doubt what Perúcio says and feels, as the therapist's squinty-eyed smile sitting on top of a vibrating guitar chord resonates within the patient, showing that when they sing together, crazy and sane are arbitrary classifications.

Chapter 5: Continued Challenges Facing CAPS - Quixadá and its Neighbors

When Quixadá's Secretary of Health and Social Assistance, Ivonete Dutra, speaks about the ability of CAPS to change the culture of mental healthcare and illness in the municipality, she does not speak about SUS (The System for Unified Healthcare) or the Ministry of Health.[125] She simply praises the CAPS team's ability to make mental healthcare a community issue that the local government needs to address, regardless of the consistent lack of resources and physical assistance the federal government wishes to provide.[126] No CAPS employee will say that the system in place for local mental healthcare weakened with the decentralization of public healthcare in Brazil, if only because no other system existed in the interior before CAPS and the Ministry of Health began their testy relationship. But the challenges of this system from a support standpoint manifest themselves in the four case studies that follow.

Case I: Inaccessibility to the periphery of the municipality[127]

With the requirements of an organization rooted in home visits and family interactions should come a functioning transportation system. Yet the federal government's payment of R$39.127,50 each month to CAPS – Quixadá does not take into account the organization's need for a full-time driver and mini-bus capable of driving on the rough, dirt roads of the *sertão.* The most consistent CAPS – Quixadá driver – the charming, albeit incomprehensible *bangelo* (toothless man), Hermes – works for the town government, often needing to make cross-state trips midweek for politicians in the dying van that the CAPS team purchased with years of saving and staff help. The van, a white Fiat 7-seater with 200,000 km, three broken doors and four working seat-belts, shakes and growls as Hermes maneuvers around the broken or non-existing paved roads in Quixadá. The preparation for every trip not only necessitates extensive communication with the

125 Interview: Ivonete Dutra, Page 64, ISP Field Journal.
126 i*bid.*
127 *The entirety of this case study is chronicled in the Observations and Interviews sections of the ISP Field Journal.* Page 76-77, ISP Field Journal.

town government to procure the van and driver, but a ten-minute process of assisting every passenger through the two possible entrances, sneaking behind the driver's seat or climbing through the trunk.

After two days of waiting for a van and driver able to make the trip, Hermes, Perúcio, Eunice (a staff infirmary care specialist), Carmezo (an older CAPS patient) and I took off on May 28, 2010 to the Quixadá locality of Juá, 30 km from the CAPS facility. In Juá, a patient, here referred to as C, came out of her family's house just as we parked the car. C, who suffers from schizophrenia and a neurological disorder that causes extreme headaches when unmediated, suffered through a violent crisis, after not taking her medication for ten days. C thought Eunice and I came to inject her with a high dose of medication, which often is Eunice's responsibility when patients suffer through crises, and responded by cursing us, pacing angrily on the street, yelling and swatting trees.

In this situation, C's family must administer her daily medication, which they often fail to do when she feels in good health. According to Perúcio, C more-or-less grew up in psychiatric hospitals, with her parents more willing to cut off any communication with their child, than try to help her in the home. On the porch, the family tried to convince Perúcio that C needed to be sent to an asylum because she posed a threat to everyone in the neighborhood. A mere two weeks before, however, Perúcio took a completely peaceful C to the center of Quixadá to go shopping and walk around. Eunice and Perúcio's believe the family allows C to fall into crisis with the hope of the police or the CAPS team deciding to intern her permanently in a psychiatric hospital. According to Perúcio, during C's violent attacks, the patient's brother locks her in a room and occasionally abuses her.

Regardless of the family situation, the CAPS – Quixadá staff must do its best to be a constant outlet for the patient, while enabling her to take part in normal community life. The social assistance representative needs to work with C's parents to review the process of administering her

medication in pill form, the patient must make monthly trips to the CAPS facility and, ideally, should take part in therapy sessions with Perúcio, who displays an ability to calm and communicate with C at all times. While the process of working with the family requires complex training, conversation and intervention, the question of accessibility has an overwhelmingly simple solution – a large, able vehicle and a full-time motorist. Without easy access to C and available transportation for the patient to the CAPS facility, CAPS cannot assist C or her family with psychosocial treatment.

The following three case studies took place on May 29, 2010 in the neighboring municipality of Bana-Buiú, a locality of Quixadá until 1989. Despite the municipality's right to develop a basic CAPS I, given its population in excess of 20,000, the lack of a supportive town government and team capable of implementing a mental healthcare facility forces the team of CAPS – Quixadá to treat those known to have mental illnesses in the town. Unwilling to pay for any form of mental healthcare, the Bana-Buiú municipal government canceled its contract with CAPS – Quixadá psychiatrist, Dr. Nestor Mainreri da Cunha Pinto, which provided the city with one day of psychiatric consultations per month.[128] *Three major problems affect the mentally ill population of Bana-Buiú because of its current lack of any feasible mental healthcare options: families lack any understanding of how to treat their mentally ill children; those previously treated by Nestor solely can acquire medications, lacking any access to alternative therapies; no comprehensive mental health survey of the town exists.*

While CAPS – Quixadá only receives the funding of a CAPS II facility (for municipalities ranging in size from 70,000 – 200,000 citizens), the facility assumes a population of more than 250,000 given its need to offer care to surrounding municipalities that lack mental healthcare facilities.[129] *In cases like the ones witnessed on the independent visit Perúcio and I made to Bana-*

128 Interview: Nestor Mainreri da Cunha Pinto, Page 82, ISP Field Journal.
129 Interview: José Perúcio Torres da Silva, Page 58, ISP Field Journal.

Buiú, catalyzed by a conversation I had with local teacher and social activist, Maria Silvia Cler Saraiva, on May 15, 2010, social assistance is needed immediately and deserves more than the brief psychiatric consultations that Dr. Nestor Mainreri used to conduct.[130] *In these instances, I have included pictures at the end of this chapter to display the clear violations of human rights that currently go untreated in Bana-Buiú.*

Case II: Undiagnosed Mental Illness and Developed *Loucura*[131]

With few leisure activities to pursue in Bana-Buiú, save for drinking and bathing, families often pass their time gossiping. One of Perúcio's childhood friends, here referred to as O, grew up in Bana-Buiú alongside 70 or more relatives. Due to the clustering of families on isolated properties in the *sertão* and a lack of education about the consequences of certain sexual practices, consanguinity is common and perhaps a cause of the high incidences of mental disorders Dr. Nestor Mainreri witnessed while making visits in Bana-Buiú. O's 15-year-old brother, Z, currently is in a relationship with his first cousin, Perúcio remarking that cousins marry cousins and uncles marry nieces in O's family. Accompanying Perúcio and I on our visit in Bana-Buiú, O asked if we wanted to meet his mentally ill uncle.

After turning off the main throughway in the town and driving on sand and dirt roads for a few miles, we found the house of O's uncle. A small, one-room, brick building sits to the right of large green house that houses O's aunt and cousins. The building features no furniture, a locked, iron gate, a food bowl, an old, rolled-up hammock and a tarp that family members can toss over the gate if they do not want to stare inside. Inside what could barely suffice as a cage for an animal, stands a man in dirty clothes, soaked in sweat. With the approval of one of O's aunts, who greeted us at the door, Perúcio and I held a conversation with the caged man, here referred to as Seb. The conversation was calm, with the three of us speaking about soccer, the heat and how Seb was feeling. Due to the presence of his friend, whose feelings about this case Perúcio and I did not

130 Interview: Maria Silvia Cler Saraiva, Page 39-40, ISP Field Journal.
131 *The following three case studies are chronicled in the ISP Field Journal.* Page 79-82, ISP Field Journal.

know, the two of us did not linger, but took a few photographs with the family and Seb's consent.

The visit followed with a conversation with Seb's family on the porch of the main house, with Perúcio introducing himself as a representative from CAPS – Quixadá investigating issues facing families with mentally ill members. The family mentioned that Dr. Nestor Mainreri used to visit once a month, providing a prescription for a medication that the family now purchases at a local pharmacy. These visits were clearly brief and strictly drug-focused, as the psychiatrist needed to meet with every widely known case of mental illness in the municipality in one day and provide quick assistance for parents discussing the aggressive nature of their children.[132] The case of Seb causes alarm because of the cruel and inhumane treatment he suffers at the hands of his family and the undiagnosed nature of his mental illness by a medical professional. In trying to remember Seb's record, Dr. Nestor Mainreri suspected that he suffered from schizophrenia.[133] Meanwhile, Seb's family asserted that Seb acquired his mental illness in his mid-20s.

The story of Seb's illness and treatment, cross-referenced through many discussions with Seb's family in Bana-Buiú and Quixadá that produced the same account, follows as such: In his adolescent and young adult years, Seb worked and lived in São Paulo, completely functional and not displaying any sign of mental illness. When he returned to Bana-Buiú from São Paulo, the family states, Seb attempted to rape a woman. Treating this as a sign of incredible mental illness, the family took the liberty of arresting Seb and separating him from his family's house. The family remarked that Seb is incredibly aggressive with family members and if let out of his cage will "likely injure or kill another person, if they do not kill him first."[134] Perúcio remarked later that aggressiveness must occur as a reaction to the internal pain Seb deals with as a result of his family's treatment.

Without proper platforms for social assistance in Bana-Buiú or any willingness to obtain a mental healthcare provider, Seb will likely never leave his cage. Perúcio, struggling to figure out the

132 Interview: Nestor Mainreri da Cunha Pinto, Page 82, ISP Field Journal.
133 *ibid.*
134 Observations: Page 80, ISP Field Journal.

fastest way to improve the situation, remarked to the family, "I will return and speak immediately with Dr. Nestor about making sure [Seb's] medication is free."[135] As CAPS – Quixadá and the mental healthcare reform and *antimanicomial* movements insist that patient treatment must incorporate a strong family support system and a proper living situation for the patient within a family home, CAPS' staff must always approach parents of the mentally ill in a non-confrontational manner focused on joint assistance. Perúcio and the CAPS – Quixadá team must then think how to become involved in Bana-Buiú without funding from the local or federal government and with over 6,000 patients to care for already in and around Quixadá.

Case III: Anticipated Mental Illness and the Impact of a Doctor Attempting to be a Psychic

The second case in Bana-Buiú involves a family that never gave their child an opportunity to grow or interact as a normal human being, because of the prediction of a doctor claiming to have psychic powers. The child, 28-year-old "Fabi," currently lives in an isolated room at the center of his family's large four-bedroom house, with a locked iron gate and iron window providing family members to observe him at all times. When Perúcio and I arrived, Fabi's mother kept us outside for nearly fifteen minutes, while his room was cleaned, clothes stripped and hammock switched. Our visit seemed to cause the family to decide to clean the room, not wanting us to see the conditions before preparing the space.

Fabi's parents displayed a great sense of appreciation for our visit, as they lack any guidance in regards to medical treatment and live in constant fear of their child and what would happen if he left the house. While Fabi did not show signs of illness or aggressiveness until he turned 15, according to his mother and father, the family began preparing for his treatment while Fabi's mother was pregnant. During pregnancy, the mother was bitten by a cobra and went to a local doctor for an examination to determine if the incident would affect the health of the mother or her baby. The doctor stated that if the baby did not die by the age of 18 months, he would suffer from serious

135 *ibid.*

mental problems.

While the child came out completely normal, the family never treated him as such. He never experienced any form of education or therapy and could never leave the house, leading to his pale complexion in comparison to his parents' *moreno* skin. Well before Fabi's 10th birthday, the boy moved into locked-in quarters, the family anticipating the serious mental problems that the doctor predicted.[136] When we entered his room, located directly off of his parent's room, Fabi sat nude in his hammock, fingering the gums beneath his missing front teeth. He barely spoke, but occasionally shot out frantic curse words, before smiling and squatting in the corners of his room. Fabi's parents allowed us to enter the room and take a picture of the three of them smiling together, before the father displayed scars on his arms from Fabi's bites and scratches.

The family's treatment of the child does not come off as strictly the result of a fear or hatred of their child, as they proudly displays photographs of him as a child in their front living room. With no mental health outlets nearby, the parents must create their own treatment, mirroring the traditional asylum model by locking their son in a home prison and separating him from the rest of society. If and when the family receives social assistance, the mental healthcare team must know how to balance the family's religious beliefs and trust of an unorthodox doctor. The team must convince the parents that their son can leave the house for therapy sessions, despite the mother's claims that this would be impossible, given that any effort to take Fabi out of the house sparks additional physical aggression geared toward his parents.

Case IV: Mother with Access to Drugs and Nothing More

Perúcio and I visited the house of 18-year-old "Raph" and his mother, Lourdes, for a brief conversation after encouraged to meet with her by a local high school teacher. Right before we arrived, Raph had taken his medication, which left him sound asleep in his hammock. Like the other two cases, Raph's living quarters features an iron gate with a lock, however, the mother claims

136 Interview: José Perúcio Torres da Silva, Page 82, ISP Field Journal.

to only lock the gate at night. Before we entered Raph's unlocked room, which doubles as a storage room, Lourdes took a few minutes to point out framed pictures of her son throughout the house, before presenting her sleeping son.

In this case, the mother can easily access medication from the general healthcare post for her son, who displayed signs of mental retardation and neurological disorder from a very young age, according to Lourdes. Lourdes pointed out her son's muscular build, remarking that Raph's recently developed aggressiveness necessitates the locked gate at night. Receptive to Perúcio's proclamation of coming assistance, Lourdes hopes to figure out a way to assist her son, as Dr. Nestor Mainreri lacks the time and financial incentive to arrange visits without the support of the Bana-Buiú mayor.

These four cases, three in Bana-Buiú and one in Quixadá, illustrate the extreme challenges faced in municipalities with governments that wish to assist the mentally ill and continued transportation issues facing CAPS – Quixadá. While every municipality with a population of 20,000 has a right to create a CAPS, the application of mental healthcare and human rights principles guaranteed by Brazilian federal law rests entirely upon the shoulders of municipal governments. When a municipality fails to care for the mentally ill, the responsibility to offer social assistance falls on the shoulders of neighboring municipalities, who must then turn their facilities, designed for the care of a single city, into a regional operation. While the decentralization of healthcare can provide easier assistance to psychosocial attention in the ideal municipality, access to a life lived outside of a cage is a federal responsibility, strong local government or not.

Bana-Buiú Case Photographs:

SEB
According to family, attempted to rape a woman upon his return from São Paulo. Considered mentally ill, Seb was imprisoned by his family in the room below in his mid-20s.

FABI

The photograph below shows Fabi in his room with his mother and father. The iron gate and window are not displayed in the shot, but the viewer should take note of the discrepancy in skin color between the child and his parents caused by a life lived indoors.

RAPH

Mother, Lourdes, claims to only lock the gate to Raph's room at night. Raph is pictured sleeping in his room, shortly after taking his medication. The photograph was taken without flash, as to not wake Raph, explaining its blurry nature. The opened gate can be seen at the right of the photograph.

Chapter 6: Conclusions and Suggestions

Upon meeting Perúcio Torres in Quixadá on May 8, 2010, I described my research project as an analysis of the history of mental health treatment in Ceará and the connections between *Quixadense* culture and the practices of CAPS as an illustration of the success and failures of the decentralized, public healthcare system. After three weeks of observations, interviews, family visits and bar conversations, the project focused in on three elements of the CAPS – Quixadá model: CAPS as a political movement and treatment facility capable of catalyzing local reforms in the social and clinical treatment of the mentally ill; the ability of art therapy practices to use *Quixadense* music tradition in mental health treatment; and the continued struggles with local and federal politics and family culture, manifested in the inhumane treatment of four patients on the periphery of Quixadá and in the municipality of Bana-Buiú. The question of cultural connections between the community and mental healthcare facility became a three-part study of the facility's affect on local culture, the affect of local culture on the treatments at the facility and a spotlight on current logistical and cultural challenges facing CAPS – Quixadá. At the request of the CAPS – Quixadá team, I prepared a set of suggestions for the organization and questions that need to be raised on a federal level, which I will present for the CAPS team between June 9, 2010 – June 13, 2010.

Suggestions for CAPS – Quixadá

From the psychologists to the receptionists, the CAPS – Quixadá staff frequently discusses the funding limitations that impact the capability of the facility to treat its patients and offer additional services to the community of Quixadá. Looking at the organizational success of CAPS – Canindé, described by Dr. Nestor Mainreri as primarily funded by local church organizations, CAPS – Quixadá must begin to deeply consider the benefits of privatization, while maintaining the CAPS name as a marker of the mental health reform movement.[137] Given the relative ease with which local NGOs founded by CAPS – Quixadá professionals acquired private sponsorship and the

137 Interview: Nestor Mainreri da Cunha Pinto, Page 82, ISP Field Journal.

recognized importance of the CAPS facility to the community of Quixadá, privatizing CAPS – Quixadá would almost certainly result in an increased budget and the subsequent ability to make necessary improvements to the organization.[138]

While this question of the organization's underlying funding model takes chief importance in my suggestions, CAPS – Quixadá must also discuss what it could do to adapt its initial model of local cultural intervention to fit a city struggling with mental health problems resulting from unattainable expectations of material success and a mentally ill population slowly disappearing from local popular culture. I developed two specific solutions, based on several conversations held with the CAPS – Quixadá staff.

First, the CAPS – Quixadá must expand its annual *Jornada* on Mental Health and Citizenship to incorporate a written record of staff and non-staff articles related to the year's theme, while encouraging all members of the CAPS – Quixadá team to write with greater frequency about treatment advances and developing local mental health issues. The unpublished articles written by Perúcio Torres and Júlio Cesar Ischiara illustrate the militancy and ingenuity of the CAPS – Quixadá staff in a format that, if published, can be accessed by a much wider viewership and result in a resurgence of media coverage on the mental health reform movement in Quixadá.

Perúcio and CAPS – Quixadá coordinator, Luisa Nara da Silva, adored the concept of launching a movement to incorporate more athletic programming into mental health treatments, beginning with a local Olympics to demonstrate the physical potential of the local mentally ill population. The merger of adult and children competitors in this Olympics and the planning of music performances, dances and public speakers in connection with the event would illustrate the progressive nature of CAPS – Quixadá, given the lack of sports activities made available to the mentally ill. The Olympics event, according to Perúcio, would also reinforce the importance of organized art and physical therapy programs for the adult mentally ill population commonly overlooked by local and state politicians by virtue of the population's insignificant pull in political

138 Interview: José Perúcio Torres da Silva, Page 78, ISP Field Journal.

elections.[139]

The last suggestion for the CAPS – Quixadá staff regards the all-too-common state-wide CAPS issue with the digitization of patient records.[140] The current model of disorganized and hard-to-read physical patient records must be improved by virtue of an online, computer program chronicling individual patient histories. Due to the cost of most "Patient Keeper"-type programs, I have offered to translate the few free digital patient record-keeping programs, which are only available in English. This reform in record organization would require a computer for the CAPS – Quixadá receptionist, who currently must organize and assemble patient records after updated by staff therapists, psychologists and psychiatrists.

What the federal and State Governments Need to Do

If the federal government desires to apply the beautiful laws developed recently for the mentally ill, it needs to learn more about the mentally ill population and its current mental health and social treatment. The responsibility to fund and administer local maps of these populations on a municipality level should not rest on the shoulders of individual social activists in each Brazilian city, but become a necessary element of the national census or a new federally-standardized program for demonstrating the mental healthcare needs of the entire country and each of its localities.

With a greater understanding of each municipality's mentally ill populations and available mental healthcare through the survey, the Ministry of Health will need to reassess its process of determining the guidelines for creating a CAPS facility and available funding for each facility. Using Quixadá as a model, the federal government fails to take into account CAPS – Quixadá's responsibilities to surrounding municipalities without mental health programs and the differences between the city's mentally ill population and others in the country. This illustrates a great flaw in

139 *ibid.*
140 Interview: Luisa Nara da Silva, Page 68, ISP Field Journal.

the current system of federal support for decentralized mental healthcare reform in that the concept of SUS as a nationally-unified system of localized healthcare puts too much responsibility in the hands of municipality governments to develop mental health platforms, while failing to appreciate that a population of 80,000 in Quixadá will require a completely different funding and organizational model for its CAPS facility than a population of 80,000 in a *Cearense* municipality not located in the semi-arid *Caatinga* region.

The lack of information about the various human rights offenses being inflicted upon the mentally ill due to a lack of enforcement of federal laws guaranteeing basic rights to all Brazilians and an inaccessibility to mental healthcare treatment and information necessitates an immediate government response. In a few hours traveling through one municipality out of the hundreds in Ceará, I encountered three cases of individuals with known and unknown mental illnesses, forced to live in prison cells and animal cages. This treatment is unacceptable and should never be considered a solution for any physical or mental illness. A lack of government action will only result in the normalization of these prison sentences for the mentally ill, giving more support to the current movement of urban medical professionals to re-segregate the sane from the *loucura* in asylums and psychiatric hospitals in state capitals. No human being deserves to be locked behind an iron gate by virtue of an inherited or developed health problem.

Bibliography

Books

Arons, Nicholas Gabriel. *Waiting for Rain: The Politics and Poetry of Drought in Northeast Brazil*, Tucson: The University of Arizona Press, 2004.

Queiroz, Rachel de. *O quinze.* 66th ed. São Paulo: Editora Siciliano, 1999.

Ferreira, B.G. *A Estrada de Ferro de Baturité: 1870 -1930. Projeto História do Ceará, política, indústria e trabalho 1930-1964.* Fortaleza, Edições Universidade Federal do Ceará/Stylus Comunicações, 1989.

Von Behr, Miguel. *Quixada: A Terra dos Monólitos.* São Paulo: Somos Editora, 2007.

Articles

Arons, Nicholas Gabriel. "A Political History of Drought in Northeast Brazil." *North American Congress on Latin America.*

Freitas de Oliveira, Cláudia and Alberto Cunha Miranha, Carlos. "Asilo de Alienados São Vicente de Paula, no Ceará do Século XIX: entre Fontes e Teoria." *O Publico e o Privado.* January/June, 2009.

Ischiara, Júlio Cesar. "Saúde Mental: a modernização de um conceito e o atraso de uma concepção." Unpublished.

Mota Gome, Marleide de and Chalub, Miguel. "Dom Pedro I of Brazil and IV of Portugal epilepsy and peculiar behavior," *Arquivo Neuro-Psiquitr.*, São Paulo, *v. 65, n. 3a, Sept. 2007. Available from <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0004-282X2007000400033&lng=en&nrm=iso>*

Mota Gomes, Marleide de and Fontenelle, Lucia M.C. "The emperor Dom Pedro II: His convulsive seizures when a child," *Arquivo Neuro-Psiquitr.*, São Paulo, v. 65, n. 4b, Dec. 2007. Available from <http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0004-282X2007000700034&lng=en&nrm=iso>.

Sampaio, José Jackson Coelho and Barroso, Carlos Magno Cordeiro. "Centros de Atenção Psicossocial e Equipes de Saúde Da Família: Experiências no Ceará."

Sampaio, José Jackson Coelho and Barroso, Carlos Magno Cordeiro. "PSF e Atenção às Pessoas com Transtornos Caracterizados Como Psicose." 1997.

Sampaio, José Jackson Coelho and Barroso, Carlos Magno Cordeiro. "Manual de Organização do Centro de Atenção Psicossocial de Quixadá." 1994.

Torres da Silva, José Perúcio. "A arteteapia na saúde mental em Quixadá." Unpublished, 2010.

"O Centro de Atenção Psicossocial de Quixadá: CAPS/Quixadá: Uma Política Cidadã de Saúde Mental," 2006.

Censo 2010 – Questionário da Amostra. http://www.censo2010.ibge.gov.br/censo2010_amostra.pdf

Censo 2010 – Questionário Básico. http://www.censo2010.ibge.gov.br/censo2010_amostra.pdf

Interviews
Torres da Silva, José Perúcio. Multiple dates.

Cesar Ischiara, Júlio. 05/10/2010.

Barroso, Dr. Carlos Magno Cordeiro. 05/18/2010 and 05/23/2010.

Nara da Silva, Luisa . 05/10/2010 and 05/24/2010.

Dutra, Dr. Ivonete. 05/23/2010.

Mainreri da Cunha Pinto, Dr. Nestor . 05/11/2010 and 05/29/2010.

Appendix

1. Could you have done this project in the USA? What data or sources were unique to the culture in which you did the project?

   This project would have been impossible to complete in the USA, because it is focused on a Brazilian municipality and Brazilian mental healthcare reform. All interviews, observations in the city of Quixadá and neighboring cities need to be considered in relation to local and national culture. The monoliths, rain prophets and *repentistas* in Quixadá do not exist in the USA and neither does my adviser Perúcio Torres.

2. Could you have done any part of it in the USA? Would the results have been different? How?

   This research approach can be adapted to study local mental healthcare models in the USA, yet the vast cultural differences would create a completely different project. The only activities that I could potentially pursue in the USA with regards to this research project are revisions of the monograph and a restructuring of the field journal and bibliography to enhance the final product.

3. Did the process of doing the ISP modify your learning style? How was this different from your previous style and approaches to learning?

   The ISP provided a completely different learning experience than I've ever encountered. From a language development standpoint, to a field research and writing standpoint, the ISP differed from all other research I've produced.

4. How much of the final monograph is primary data? How much is from secondary sources?

   The final monograph is around 60-70% primary data, with most literary support coming from primary sources (ex. federal legislation, local poetry).

5. What criteria did you use to evaluate your data for inclusion in the final monograph? Or how did you decide to exclude certain data?

   I crafted an abstract with the assistance of my adviser and focused my initial thesis, analyzing the affects of the decentralization of public healthcare on the interaction of local culture with local mental healthcare into a three-part study with a historical introduction on mental health treatment in Ceará.

6. How did the "drop-offs" or field exercises contribute to the process and completion of the ISP?

   The drop-offs only helped with my ability to confidently ask questions, but the lack of a need to ask for directions in town made most of the drop-off exercise useless to my research project. The field exercise assisted me in better organizing my field journal and monograph.

7. What part of the MTFSS most significantly influenced the ISP process?

   The field journal and community participation most significantly influenced the ISP process.

8. What were the principal problems you encountered while doing the ISP? Were you able to resolve these and how?

   The only problems I encountered were a lack of time to complete every visit and interview I wanted to accomplish and have enough time to write. I resolved this by revising my schedule to include more visits outside of the CAPS facility rather than observations on-site during the day followed by auxiliary programming after the work day ended.

9. Did you experience any time constraints? How could these have been resolved?

   Students should be given more time to write their ISP monographs to give them the opportunity to best represent their three weeks of research. Beginning to write the paper, while researching causes a conflict in the ability to consider the monograph from a complete observational perspective and takes away from time that could be spent organizing notes from the field. The schedule for students upon returning from their ISPs seems arbitrary, with a sense of urgency that was hardly reflected during the first 11 weeks of the SIT program.

10. Did your original topic change and evolved as you discovered or did not discover new and different resources? Did the resources available modify or determine the topic?

    My original topic focused to accommodate the cases I observed and interviews I conducted. I only had a vague understanding of the CAPS – Quixadá model and the local culture in Quixadá before arriving in the city and therefore needed to focus my problem statement accordingly. The resources did not determine the topic, but modified the open thesis of addressing connections between local culture, municipality-based mental healthcare and the history of mental healthcare in Ceará to analyze specific structural models of the CAPS – Quixadá organization, art therapy treatments and major human rights offenses encountered by citizens of local and neighboring municipalities.

11. How did you go about finding resources: institutions, interviewees, publications, etc.?

    I lived with my adviser and discussed with him any potential question or desire regarding locating institutions, interviewees and publications. In the interviews, I often asked interviewees suggestions for additional reading material and performed complementary resource research on the internet.

12. What method(s) did you use? How did you decide to use such method(s)?

    I lived as a member of the Quixadá community, becoming part of a family and a temporary member of the CAPS – Quixadá team. I would not ascribe this to any method, but just a sense of open-mindedness and flexibility in approaching independent research.

13. Comment on your relations with your adviser: indispensable? Occasionally helpful? Not very helpful? At what point was he/she most helpful? Were there cultural differences, which influenced your relationship? A different understanding of educational processes and goals? Was working with the adviser instructional?

    Words cannot describe how thankful I am to Perúcio. His help was constant, instructional

and inspirational. I could not have completed this project in the manner I desired without his assistance and friendship.

14. Did you reach any dead ends? Hypotheses which turned out to be not useful? Interviews or visits that had no application?

    Some interviews and experiences cannot be used for this particular paper, but I do not feel as though I reached any dead ends.

15. What insights did you gain into the culture as a result of doing the ISP, which you might not otherwise have gained?

    I realized once again how different it is to read about an issue than be confronted by it. No picture or article can describe the affects of drought and the Quixadá monoliths as well as the view from the top of the Pedra do Cruzeiro on the 20th day without precipitation during the rainy season.

16. Did the ISP process assist your adjustment to the culture? Integration?

    Living in Quixadá with Perúcio and his family assisted my adjustment to the local culture and integration into community life.

17. What were the principal lessons you learned from the ISP process?

    Always be prepared to experience things that will challenge your worldly perceptions and emotionally overwhelm you. I will never forget Amauri and Dairton's *repentes* or the hell that Seb, Fabi and Raph are living through locked in home prison cells in Bana-Buiú.

18. If you met a future student who wanted to do this same project, what would be your recommendations to him/her?

    Conduct initial site visits in Fortaleza to get a better idea of the current treatments at mental health hospitals in the state capital, but definitely do the project in a municipality in the interior.

19. Given what you know now, would you undertake this, or a similar project again?

    Absolutely.

65