# Healing Efficacy and Subjectivity among Long-Term Residents in a Spiritist Asylum

SABRINA MELO DEL SARTO & ESTHER JEAN LANGDON

**Abstract** The article presents an ethnography of the social life of permanent residents interned in a Spiritist psychiatric hospital in the interior of the State of São Paulo (Brazil), focussing their participation in a "healing ritual" known as *passe*. It describes the ways of living and sociabilities that emerge in a compulsory daily routine, in order to identify agency and expressions of subjectivities and desires. Although they are in a hospital wing composed of individual residences, institutionalisation is a major characteristic of their lives, such that their histories often intertwine with a life in institutions. Their residential life is marked by a compulsory religious and medical routine that imposes a moral order on their actions. Through ethnographic research, we seek to understand their social practices that diverge from the normative order imposed by the hospital routine of enforced medications and participation in the Spiritist healing ritual of the *passe*. Rather than engaging in the ritual performance, these long-term residents resist through the enactment of alternative goals and desires. Long-term institutional experience and excessive medication contribute to other subjectivities and goals within the walls of the institution and its mandatory rituals.

**Key Words** mental affliction, institutional order, therapeutic practices, subjectivity, spiritism.

## Introduction

Consideration of the status of "mental illness," "madness" or "insanity" in the contemporary world demands that we recognise Western civilisations' long history of imposed norms and marginalisation. As João Biehl (2005) has demonstrated in the case history of Catarina,[1] internment in a psychiatric institution is less influenced by medical diagnosis than by other factors, including life histories and social and economic resources. This article examines the social life of long-term patients interned in a Spiritist psychiatric hospital in Brazil who occupy a special residential annex called "Sheltered Home," a situation different in many respects from that of total abandonment described by João Biehl. However, like Catarina, they have been institutionalised for many years, some since childhood, for behaviour and/or social situations identified as abnormal. We are not examining in this article their expression of suffering or mental affliction, but rather how they, as subjects, engage in social action, constructing their lives within the limits of the institutional order. As part of the daily routine, patients are required to attend the Kardecist spiritual healing ceremony known as the *passe*, a ritual performance that is designed to heal the spiritual causes of their afflictions. Based upon ethnographic research of participant observation with the residents of Sheltered Home, we discuss the question of therapeutic efficacy as it relates to their life conditions and engagement in the ritual process.

The long-standing relation between Spiritism and health in Brazil has been examined by a variety of authors and several have examined the close historical relation between Spiritist doctrine, medicine and health seeking behaviour (Cavalcante 1983; Montero 1985). The relation is so much a part of Brazilian culture that the Spiritist healing practice known as the "hands-on healing" (Kurz 2017) or *passe* was officially authorised for use in primary health care by the *National Policy for Integrative and Complementary Health Practices* in 2006 (Nascimento *et al.* 2019). Sidney Greenfield's (1989, 1991, 2008) research examined the

healing efficacy of Spiritist surgeries, speculating that the success of such practices lies in the relation between Brazilian culture and the power of imagination, trance and suggestion. More recently, Helmar Kurz (2015, 2017, 2018a,b) has built upon anthropological models of healing and neuroscience, in order to examine the Spiritist *passe* as a component of the healing process of mental patients. Although he attributes part of the *passe*'s efficacy to the impact of the aesthetics of the performance on Brazilians, his research among Germans suggests that the *passe* sets in motion internal processes of healing independent of specific cultural frames. The aesthetics of healing stimulate internal processes ("interoception") that involve transformation and change in habits by drawing upon the patient's personal resources and engagement in the ritual process (Kurz 2017). His model of healing will be the focus of our discussion, given that he has conducted research among private patients of the same hospital as well as other comparable institutions in Brazil and Germany. However, our research points to different conclusions about the possibilities of the healing efficacy of the *passe* among long-term patients that are subject to the conditions of the public wards.

Recognising the social character related to long-term internments and the coercive aspects of institutionalisation (Goffman 1961; Foucault 1997), we examine the sociability and subjectivity of permanent residents of the psychiatric hospital in order to understand how their daily participation in the *passe* is lived and perceived. In order to examine their lived experience, we follow João Biehl (2007: 422) and his notion of subjectivity. For him, subjectivity is both an empirical reality as well as an analytical category that suggests a contrast with objectivity and connotes creativity, fluidity and the possibility of adopting a distinct symbolic relation with the world. Experience, as Arthur and Joan Kleinman (1995) observe, is that which mediates and transforms the relation between the context and the person. Through intensive ethnographic research, we found that long-term patients' experience and interpretation of the ritual diverge in several ways from both Spiritist explanations as well as anthropological models of healing efficacy.

## Spiritism, Psychiatry and Institutionalization in Brazil

In Brazil, institutions for the internment of the "mentally ill" emerged with the industrial expansion during the final decades of the 19th century, and urban sprawl was a determining factor for the construction of what were called "hospices" at the time. Since the origin of Brazilian *alienism*, the country has remained attuned to European methods of treatment. Psychiatric institutions and treatments were introduced, and the principle focus of sanitary concern was on those subjects destabilized by rapid urbanization—the working class, the unemployed, freed slaves and foreign immigrants (Bastos 1997). During this period, hygienic or mental medicine of a scientific character gradually constructed the dominant discourse over all aspects of life, penetrating personal relations and moulding them to an idea of order and discipline (Cunha 1986). Following the *Proclamation of the Republic* (1889), those governing the country strove to create an educated society and to eradicate the "promiscuous places" that harboured disease and criminality; the "crazy" were included as examples of the diseased and criminal. Asylum institutions were thus created primarily as a public health intervention to cleanse society. They were conceived of as a necessity of society, and the pathological nature attributed to states of "madness" justified the exclusion of those considered "mentally ill" (Bastos 1997).

According to Angélica Aparecida Silva de Almeida (2007), psychiatry and Spiritism consolidated during the same period, both seeking social, scientific and institutional legitimation. For Spiritists, most mental illnesses have causes other than or in addition to the causes identified by psychiatry. Based on the idea that souls evolve over the course of many lives, many problems are attributed to spiritual debts accrued in previous incarnations. Insanity can be motivated by two factors: by unconscious feelings of guilt due to errors committed in past lives and by "obsession," or mental perturbation, in which one is tormented by an "unevolved spirit" (Ribero 2013: 119). Thus, Kardecist Spiritists founded psychiatric hospitals where they combined biomedical treatments with religious practices. Many of their practices are carried out by volunteers, since caring for the

ill is considered an act of charity, an important practice according to the Spiritist doctrine. Charity contributes to one's spiritual evolution, and thus these hospitals can always count on volunteers for fulfilling many of the tasks as well as on financial contributions from Spiritist followers.

The movement against internment of mental patients, known as the *Psychiatric Reform,* began in the late 1970s as health professionals and patients' relatives mobilized for the defence of human rights and restoration of citizenship for the interned (Delgado 1992). As a de-institutionalization process, it was based on the ideology of community psychiatry critical of psychiatric science and treatment administered in asylums (Camargo 2017). The movement proposed to decentralization treatment, substituting psychiatric hospitals with therapeutic communities. Concerned with the issue of human rights for the victims of the psychiatric violence of the autocratic state, it was part of the return to democracy and movement against the Brazilian dictatorship. It influenced the elaboration of public policies in health and other sectors, including culture, justice, human rights, work and social security. (Amarante & Nunes 2018)

Critical analyses of the *Brazilian Psychiatric Reform* proposal and its developments (Andrade 2010; Maluf & Andrade 2014) generally argue that the reform movement was responsible for the progressive attempts to extinguish psychiatric hospitals, which were overcrowded and costly institutions for the state. Psychiatric hospitals gradually saw a decrease in the number of beds: from 80,000 in 1970 to 25,988 in 2014 (Amarante & Nunes 2018: 2072). At the same time, pharmacological treatment expanded, spearheaded by the pharmaceutical industry that influenced the entire psychiatric community (Conrad 1992 *apud.* Camargo 2017). With the reform, psychiatry moved beyond the limits of the asylum model and into the public sphere of ambulatory care (Maluf 2010). The traditional model of hospital treatment was slowly substituted by the community care model and the rise of therapeutic communities, such as the "Psycho-Social Care Centres" (CAPS - *Centro de Atenção Psicossocial*) and "Psycho-Social Assistance Groups" (NAPS - *Núcleo de Assistência Psicossocial*).

Within this context, some psychiatric institutions closed down and others transformed in order to continue to exist. Some institutions altered their structures in order to become general hospitals with specialization in psychiatry and others became retirement homes. For a variety of reasons, certain psychiatric institutions did not fully comply with the process of de-institutionalization and continued with permanent residents. These institutions received additional patients who were coercively transferred from those that had been forced to close.

Those who have been interned in psychiatric hospitals for decades are labelled "chronic inhabitants." They reside permanently in institutions, regardless of the manifestation of symptoms of serious mental illness. They are those who have become estranged from interaction with social groups outside the institutional walls and are confined to relations maintained within the psychiatric hospital (Carneiro & Rocha 2004; Biehl 2005).

Psychiatric hospitals are usually subdivided into medical units or wards, and, in some of them, there is a specific residential unit that houses "chronic patients." According to Michelle Alcantara Camargo (2017), these wards, called "shelters" (abrigo), were designed to conform to the 1994 Ordinance (Portaria/SNAS nº 224 de 29/01/1994) that required the reformulation of the asylum policy and physical space in order to change the environment for long-term resident patients. These units are supported by the "Unified Health System" (*Sistema Único de Saúde,* SUS) and are composed of houses built within the hos-

**Photo I:** Sheltered Home Residences

pital walls, in order that the residents can live in a less asylum-like environment.

### Sheltered Home: Institutional Routine

The *Spiritist Light Hospital* is one of these Brazilian institutions that, even with the process of psychiatric reform, has continued to maintain long-term residents in treatment. Beginning in 2015, the first author began research on the daily life of this hospital and its chronic inhabitants, hoping to comprehend the dynamics that transcend the coerciveness imposed by the institutional world. Initially she visited the institution staying with the residents for the day and participating in their activities (Del Sarto 2018). Then in 2019, she conducted intensive ethnographic field work for three months, sharing all moments of the daily institutional routine of the chronic inhabitants (Del Sarto 2020). Semi-structured interviews were conducted with the hospital staff. The issues raised in this article are primarily derived from this experience.

The hospital is situated in a city of 230.000 inhabitants located in the interior of the State of São Paulo. It is a Spiritist, psychiatric and asylum institution, created in the 1940s to provide care for people diagnosed with psychiatric disorders, and it houses both permanent and temporary patients from all parts of Brazil. In the 1990s, the hospital had 330 beds, 260 of which were commissioned by the *Unified Health System* and 40 for patients with private health plans. There were also 30 beds for underage patients with chemical dependence. The hospital has undergone significant changes in its composition and the treatments offered. It no longer accepts underage addicts; public beds were reduced to 142, and private beds for patients with superior economic resources or private health insurance were increased to 60. In spite of these changes, the Spiritist tradition of the hospital has been maintained and patients continue to be treated as biopsychosocial-spiritual beings. Treatment is carried out by a multidisciplinary team. Spiritists also are found among the administration staff and medical professionals, and they are present as volunteers who attend to the spiritual aspect of the patients through rituals and visits to the private wards.

It is important to recognize that the public wards, supported by the *Unified Health System* and donations, differ substantially from the private wards, resulting in very different patient experiences. The public wards are more crowded, with more patients per room. Private patients reside alone or share a room with only one other person. They have greater access to leisure areas and in general the environment of the private wards reflects more modern, well-cared conditions, in comparison with the visible deterioration of the public wards with structural problems and old furnishings. Private patients eat separately in their own dining hall, receiving meals of better quality and greater diversity. Finally, institutionalization for private patients is not as marked by the regimentation and coercive aspects that characterize the public wards. Internment is for the most part voluntary, and they are able to voice their complaints, have greater freedom of choice and benefit from a greater variety of psychotherapeutic treatments.

There are four public wards. These include a collective unit called the *patião* ("large yard") that houses in one large room the male patients without financial resources and who are incapacitated by critical states of mental or physical health. It was inhabited by both male and female permanent residents until 2018, when women were transferred to the female public ward that houses short term temporary patients. A third ward houses short term male patients for up to thirty days. Because of poor funding by SUS, the conditions of these wards and the situation of the long-term patients reflect abandonment and despair. The patients who live there have no contact with the external world and are considered incapable of returning to a social life.

The fourth public ward is the Sheltered Home annex, designed to conform to the 1994 ordinance calling for the humanization of psychiatric environments for chronic inhabitants. Although also supported by the *Unified Health System*, it contrasts in appearance and intention with the deplorable condition of the collective wards for long-term patients. It houses patients who have sufficient autonomy to care for themselves without the need for a full-time caretaker and has the appearance of a small village found within the walls of the institution. It consists of six separate residences with

a collective yard with cement seats. Although it has a capacity for a total of thirty-three people, at present there are only 21 residents, seven men and fourteen women. Four houses are exclusively for women, and two for men.

Each house has a living room, kitchen, bathroom and from two to three bedrooms. Kitchen facilities are strictly regulated; stoves are forbidden as well as knives and any other pointed objects. Behind each house there is a service area for washing clothes. Normally two to three people share a bedroom, and they decorate their houses according to their particular tastes, with pictures (mainly of Catholic saints), clocks and personal objects. Several residents own televisions and radios that can be heard throughout the day.

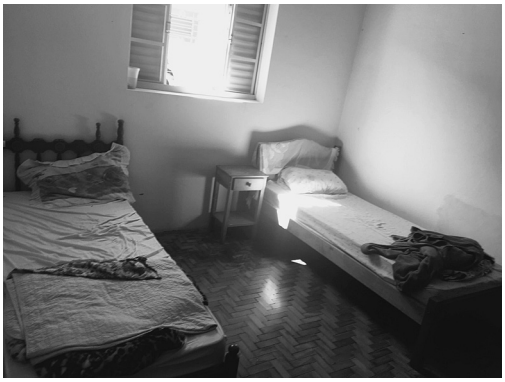

**Photo II:** Sheltered Home bedroom

The average age of the 21 residents is 66 years with an average of 22 years spent in institutional settings. Fourteen patients came directly from other institutions, where they had been interned as orphans or had no family support. All remain institutionalised because they are judged incapable of surviving independently and lack social support or resources outside the hospital to take responsibility for them. Because of their long-term institutional internment, their life histories intertwine with that of the hospital and other institutions where they have resided. Many have no clear understanding of why they are there or under what circumstances they would be able to leave. There is a running joke among them that the only way to leave is in a coffin.

The residents' lives are organised according to a daily routine established by the hospital. They awaken at 7 a.m. to a loud speaker barking out orders. After dressing, they go to the public canteen for breakfast. Immediately following, they file into a large hall located in the rear of the hospital where they participate in the "hour of the *passe"* consisting of a lecture on the Kardecist doctrine and the hands-on healing treatment (cf. Kurz 2018b). Following the *passe*, they return to the sheltered home and are administered the first medication of the day. Lunch is served at 11:30 in the canteen and immediately after they receive their second medication. There is a third medication at 2:30 p.m. and a mid-afternoon coffee. Dinner is served at 5 p.m. and the last medication of the day is administered at 8:30 p.m. Finally, a small snack is served at 9 p.m.

The loud-speaker installed in the hospital yard broadcasts orders and calls for assistance to the hospital staff throughout the day. Its presence not only coordinates the residents' activities but also is a constant reminder that they reside in an institution. Between the hours of the routine activities, the residents often gather in the collective yard to pass the time. Others sleep in their houses or listen to the radio or television. The female residents have the responsibility of cleaning their houses. Three of them also clean the men's residences and receive a monthly payment for their work. Nine of the patients are allowed to leave when authorized and can circulate in the neighbourhood around the hospital. Judged as incapacitated, the Federal government sends their disability payments directly to the hospital. Part of the payment is retained for the ward's maintenance, and each patient receives 60 Brazilian Reais (approximately $US 15.00) each week. This amount is controlled by the social worker who distributes it or saves it for the patients**.** Some go to the local shops by themselves, while others need someone to accompany them or must ask someone to make their purchases. Normally they spend their weekly allowance in the local food market, buying snacks and drinks that are not part of the Hospital's plain diet. In some cases, they save their money for weeks to buy clothing and other personal items or more expensive objects for their homes.


**Photo III:** Sheltered Home external area.

The *patião* and Sheltered Home are in constant relation. The resident of the Sheltered Home who demonstrates aggressive behaviour or fails to comply with the institutional regulations, will be sent to the *patião* (or female public ward) and remains there until the hospital psychiatrist authorises a return. Normally he or she spends two weeks interned in this ward but the period can extend to several weeks in case of more serious breaches of behaviour. Residents sent to the *patião* or female public ward do not receive their weekly allowance nor can they leave the hospital for short excursions. In addition, they are not allowed to have personal clothing or accessories. The probability of internment in these public wards is continually present in the daily institutional life in the form of threats from the hospital staff when they refuse to take their medicines or disobey in other ways. Also, these public wards are the destiny for residents who become permanently incapacitated because of age or health and no longer can care for themselves.

The hospital staff affirms that the sheltered home aims to progressively re-socialize and demedicalize patients. The therapeutic routine involves a complimentary relation between religious and pharmacological treatment. Both are obligatory - the hour of the *passe* as well as the daily medication. Four times a day at "medicine" time, they line up before the entrance of the nursing station to receive their pills. Each resident receives the pills with a small cup of water. Following that, they must open their mouths for the nurse in order to prove that they swallowed all the pills. They express resistance and dissatisfaction with the obligatory medication, complaining of the collateral effects and at times attempting not to swallow the pills (cf. Del Sarto 2020: 130). The only psychotherapeutic counselling that exists takes the form of a brief weekly visit from a psychologist who asks them how they are as she passes through the ward.[3]

The residents receive an average of 17 pills a day. A large part of them are antipsychotics and antidepressants; others are administered to counter the collateral effects of the first group. Most are familiar with the medications they take four times a day but dislike the heavy medication, associating it with punishment and control rather than with therapeutic goals. Medication is not seen as a cure for their problems, but rather as a cause of unwanted corporal or mental reactions and a manifestation of the coercive institutional force in their daily lives. Celia, a 50-year-old resident interned for 23 years, stated in March 2019:

> "We argue, and they administer remedies to punish us. Look at my mouth, it is always foaming. These remedies for depression do this to me. It's a remedy for the 'head.' Look at Marlene (another resident), she has a good head and we both have to take them. In order to lose weight, I drink green tea; for the head, Risperidone; I take Akineton for my deviated eyes caused by Risperidona. [...] There are times that my eye turns outward because of the remedy, and then I take another one to counter it. [...] If I had a house, I would want to live there just so not to take so much psychiatric medication. Here they fill me up. My mouth always foams. [...] I have to take medicine for the head, for depression. [...] At night I take two Amplictil of 25, Risperidone, green tea and Dogmatil. They give medicine to punish us."

Celia diagnoses her problem as one of the "head," a semantic category used among the group to speak of mental affliction. Although they dis-

tinguish between different degrees of affliction, problems of the "head" are not a central issue in the daily interaction between them. Many acknowledge that they were interned because of being "bad in the head," but they attribute their long-term permanence to social abandonment by their families or relatives.

Within the conditions and limits of the institution, the residents interact in ways that express their personal desires and capacities for sociability. They exchange reciprocal forms of assistance and small gifts and form special friendships and romantic relations.

Along with the threat of the *patião* and forced medication, they regard participation in the hour of the *passe* as another form of coercion by the hospital, although the Kardicist Spiritists consider it to be a necessary complement to the pharmacological treatment. Sheltered Home residents are the only patients in the hospital required to attend the *passe,* which occurs after breakfast Monday through Friday, although interested patients from other wards are present. It occurs in a large hall that is also used for other kinds of performances or events in the hospital. Rows of chairs are lined up in the hall before an elevated stage where the Spiritists leading the reunion are located. The volunteer Spiritists who perform the healing touch sit among the patients. Normally the men sit on the left side of a central corridor with the women on the right. The hall seats approximately 200 people, but generally only 40 to 50 patients are present, given that participation is not obligatory for those of other wards. Lighting in the hall is dimmed and soft instrumental music plays in the background during the entire ritual. The hour of the *passe* is divided into two parts. First, Sheltered Home residents, together with the other patients attending, receive a lecture on the Kardecist spiritual doctrine. The lecture is followed by the *passe,* described as a type of blessing and energetic healing which transfuses positive energy (Kurz 2017). During the performance of the *passe*, the patients sit with their eyes closed, and the Spiritist volunteers silently go before each individual, placing their hands above their heads without touching them. The volunteer stands with closed eyes, open chest and head lifted to the heavens while he or she briefly transmits the energies from the invisible realm.

### The *passe*: Multiple Discourses and Ritual Goals

Different explanatory models of disease and healing circulate in the hospital, the most obvious of which are biomedical and Spiritist, although other religious perspectives are present in both the caretakers and patients. As in other Spiritist medical institutions in Brazil (cf. Ciello 2019; Aureliano 2013), treatments representing these perspectives co-exist and can be seen as complementary, in spite of differing explanatory models of disease and cure. In the Spiritist Light Hospital, medical treatment for mental illness is primarily guided by the biomedical paradigm, with emphasis on the use of medicines. In the case of Sheltered Home residents, psychotropic substances predominate as biomedical therapy, given that psychotherapy sessions are basically non-existent. In their case, rather than psychotherapy, biomedical treatment is complemented by obligatory participation in the *passe* ritual that seeks to restore spiritual as well as physical health.

At the end of the 19th century, both Spiritism and psychiatry in Brazil sought social and institutional legitimization for their concepts and treatment of mental illness. Both biomedicine and Kardecist Spiritism were seeking to be recognized as "scientific" at the time, and Spiritism was successfully expanding its therapeutic practices based on the writings of Allan Kardec (cf. Aubrée & Laplantine 1990). Based on its perspective that all illness, including madness, is be a result of both physical and spiritual problems, Kardecist Spiritism developed a complementary association with biomedicine in various medical institutions, particularly in those of mental health. Spiritist medical professionals and administrators work alongside those who do not hold the same beliefs. All Spiritist medical institutions also have a corresponding spiritual counsel in the invisible dimension that cares for patients.

Along with the Spiritist Light Hospital, other institutions are run by philanthropic Spiritist foundations in the State of São Paulo (Camargo, 2017) as well as many other parts of Brazil (for Paraná see Ciello 2019, for Santa Catarina see Aureliano 2013). According to Hannes Stubbe (1987 *apud.* Kurz 2017), the Brazilian health system does not provide sufficient therapeutic resources for the population, particularly for psychological

and psychiatric afflictions. The healing practices provided by the Kardecists, which are viewed as acts of charity, have come to replace those of the official health sector on some occasions and offer free treatment to the population (Kurz 2017: 197). As in the case of *Spiritual Light Hospital*, several receive funds from the national *Unified Health System* to care for patients who do not have private health insurance, but as recognised by Helmar Kurz (2017), resources received from the government are insufficient for adequate patient treatment.

As Waleska de Araujo Aureliano (2013) has demonstrated in her study of the therapeutic-religious institution, the Center for Cancer Patient Support (CAPC), Spiritist therapeutic institutions in many ways organizationally and symbolically mimic those of biomedicine, while addressing the spiritual dimension of the patient's affliction. However, Spiritist treatment goals are more comprehensive than those of biomedicine and encompass a broader concept of *healing*, rather than the more limited biomedical concept of curing, which aims at the elimination of observed symptoms (Langdon 2013; Frank 1961).

According to Spiritism, illness is caused by acts performed by the person in his or her present life which compromised the balance between body, mind and spirit, or they may be caused by disembodied spirits, motivated by karmic debt, which act on the embodied subject causing disequilibrium a spiritual and mental order. In other cases, karmic disease may also occur because of choices made by the spirit itself during reincarnation (Aureliano 2013).

The objective of the *passe* is to extend beyond the material physical body connecting to a network of social actors who are both material and immaterial participants in a "religious field" for the care of illness. Maria Laura Viveiros de Castro Cavalcanti's (1983) pioneer study of the cosmology and ritual of Kardecist Spiritism describes the *passe* as an important ritual practice that has the double objective of treating the body and spirit. Through the *passe,* energy flows from the invisible world (that of the spirits) to that of the visible, the world of humans, through a medium. Even in cases of karmic illnesses that do not have a cure, it aims to restore the spiritual dimension of the patient through the transmission of energy (Cavalcanti 1983: 75). The efficacy of the *passe* depends upon the presence of a superior spirit, the ritual preparation of the medium and the capacity of the patient to absorb the energy through an attitude of good will.

The *passe* is not the only Spiritist ritual performed in the Hospital, but it is the only one of which they are aware. Disobsession rituals, as described by Fernando Ciello (2019) in his thesis on Spiritist therapy for mental patients in the state of Paraná, are also performed at the *Spiritist Light Hospital*, but without the patients' awareness. However, as mentioned, only the residents of Sheltered Home ward are obligated to attend the *passe* and see it as one of the coercive measures they are subjected to. This is in contrast to the Spiritist volunteers' explanatory model about the purpose and efficacy of the ritual. The volunteers who perform the *passe* are trained as mediums and their perspective as to its purpose and efficacy follows that of the group's doctrine - the healing touch is important because mental illness results from the acts of disembodied spirits that influence the mental functions of embodied individuals. The performance of the healing touch is an act of charity that addresses the spiritual aspect of madness.

Carol, a 66 year-old volunteer at the Hospital, explained:

> "My responsibility is to organize the *passe,* because there used to be a lot of talking, walking about [...] and little by little I started to discipline things, precisely for this, to transmit trust to them so that when they are in there, they feel that we're all there to help them. They sit and wait to receive the healing touch, and we raise our thoughts and ask God for this energy to come so that we can be a faucet that will pass this energy on to them. With the patients, there are *perispirits* from other beings that are already disembodied, that are ignorant. They aren't evil - they don't know good, and they suck energy from the patients. Okay, they have very refined techniques for this. Those obsessing spirits that suck them are called "spiritual vampires" and they suck the energy of patients. But you can't disregard the biological aspect, because there are people who have the genetics for schizophrenia, the genetics to be addicted to alcohol, they have their fathers' metabolism for that. This is something that has been proven; there's no doubt about it. So the patient can overcome a good share of it, and then what happens is she dis-

> embodies, loses that connection with the obsessing spirits, because the good spirits will help and improve her, she's born again, sometimes with an easier test, and she starts to overcome it. That's the aim. The treatment needs to be together, the biological and the spiritual, so that it has an effect. If you only do the physical, it will take really long, with only the spiritual sometimes you won't even solve anything."

Marcia, a 71 year-old volunteer, made a similar statement:

> "The *passe* is this, you're physically ill, lacking energy, you go to the hospital and they take blood ok? That's the physical part. When you're psychically ill, you're psychically in disharmony, you can receive the *passe*. As you go, spiritually speaking, elevating your thoughts, the range of your vibrations, you start to connect to spiritual mentors who are entities that have left their physical bodies but exist and are up there, but we don't see them. They are pure energy, and you contact them and start to become an instrument for transmitting these energies."

According to the volunteers, the aesthetics of the environment of the *passe* is also fundamental to this process, and the atmosphere created in the hall where the meetings take place is a rupture from the daily noise and activity of a psychiatric hospital. In the words of Rosângela, a 68 year-old volunteer:

> "The preparation of the environment for the transmutation of cosmic energy for the benefit of those who receive it is very important, so, it can't occur in any environment, if there's noise, if it's dirty [...] you know this, I don't need to say it, the environment of the Earth that is not conducive only produces bad things... Now, when the environment is good, prepared, you go in and straight away you notice that there's something different there. You've seen that I cry? I'm so tuned in that emotion comes just like that, you feel that good sensation, you know, as if you were in an air conditioner, as if it were a cloud [...] that's a fantastic moment, the more you harmonize with an environment, the more you'll help someone."

However, the residents of Sheltered Home do not express the same sensations or expectations when participating in this daily ritual. They are not motivated to attend and often attempt to escape participation. Few say that the healing touch makes them feel good. Valdir, a resident who has been institutionalized for over thirty years, expresses this sentiment, "For me the *passe* is like an obligation. It's part of the rules for living here, but to be honest, if I could, I wouldn't go." Some say that when they go to the *passe*, they feel bad, their vision darkens, and they feel a kind of dizziness. Others also say that they do not understand what the speakers are saying, and that the dark ambience makes them sleepy.

Rosana, a 64 year-old resident who has been institutionalized for 17 years, described the healing touch as follows:

> "It's [located] beside the *patião*. I go there every day, but it didn't happen today because of the rains. [...] we go there to the yard, you enter via the *patião*, follow the path, there's a room full of benches,... chairs, you go in there, sit down. There are men and women who talk about a pile of things. At times I fall asleep and don't even understand what they're talking about. I look and I see nothing, because it's sort of dark and with my eyesight I can't see. I only hear the voices. [...] You have to go to the *passe*, you know, it's good to take away the evils of the body."

Conscious of their denials or resistance to the healing touch, the volunteers seem to think that both the residents and entities causing the disease, the spirits obsessing them, should be treated like children who must be taught to behave appropriately. They thus claim that even when residents deny that they understand or do not want to participate in the ritual, it is crucial that they go, because the *passe* will not only treat the patient, but also the obsessing spirits that surround him or her. As far as the volunteers are concerned, it does not matter if the patients rationally understand the healing touch, since its efficacy does not depend on understanding, but on the gradual transformation of the patient and the obsessing spirits. This transformation of the patient and of the obsessing spirits can occur in the current life span or in future lives. Therefore, an irrational misunderstanding of the healing touch does not inhibit evolution in another carnal life. In that environment, illness – particularly chronic and degenerative diseases – are seen to be a part of the individual, and thus cannot effectively be "cured."

In spite of the fact that the residents do not perceive the possible therapeutic value of the ritual and hold no expectations regarding healing, participation in the ritual allows them to expand their field of social interaction for both affective or economic reasons. It is one of the few chances that they have during the day to interact with patients that reside in other wards of the hospital as well as with outsiders who are not part of the medical team, such as the volunteers who perform the *passe*. These encounters make possible the creation of networks beyond the limits of their ward and different forms of relations emerge. For example, one resident maintains a romantic relation with a patient she met when sent temporarily to the collective ward (*patião*). Since returning to her residence in Sheltered Home, the couple meets only during the *passe*, when they talk and exchange small gifts, such as fruit, trinkets or clothing. The *passe* is also a chance for the residents to find out about their friends who were sent to the *patião*. During my research, they always sought to find out about a former resident of Sheltered Home who, because of health problems, was sent permanently to the collective ward. Not only are expressions of friendship and affection witnessed between patients of other wards, but also they demonstrate fondness with some of the volunteers. One volunteer who is particularly expressive and affectionate with the residents is surrounded by them during the *passe*. They fill the row of seats beside her, touching and holding hands during the lecture.

The extended network also fosters economic exchanges during the hour of the *passe*. Because of a recently established smoking prohibition in their ward, the residents take certain objects to the *passe* in order to exchange them for cigarettes. One resident told us that in the public collective ward there was a lack of soap, so that he was able to exchange soap for cigarettes.

Although it is the intention of the Spiritist volunteers to create a special sacramental space during the "hour of the *passe*" in which the ritual performance results in transformation of the spiritual condition of the patients, we found that the ceremony addresses other needs and objectives of the permanent residents. For them, the *passe* helps to reorganize the institutional order, permitting the expansion of social and economic relations beyond the small group of 21 people that inhabit their small community. It provides the opportunity for new manners of living a permanently institutionalized life. Thus, the *passe* gives the opportunity for expanding the residents' experience. Although in the eyes of the residents, it does not strengthen or contribute to a spiritual network, it contributes to the satisfaction of their material and emotional desires and needs.

## Healing Efficacy and Consciousness of the Patient

Discussions of ritual efficacy have long been a focus in anthropology. Early analyses, such as those of Claude Levi-Strauss (1975), Clifford Geertz (1966) and Victor Turner (1964), concerned symbolic action and the dynamics of the ritual process resulting in modifications of the inner state or perspective of the patient (Langdon 2013). Subsequently, with the performative turn in anthropology, theorists began to suggest that ritual efficacy lay not in semantic manipulation, but in the heightened aesthetic and sensorial experience created by performance that engages participants in dynamic interaction in specific contexts to bring about the creation of reality and the reordering of experience (Laderman & Roseman 1996; Langdon 2013; Schieffelin 1985). Through the concept of embodiment, Thomas J. Csordas (1990) has focussed on the work of culture and ritual upon the body. More recently and building upon these theories, Mark Nichter (2008) has suggested that sensorial anthropology should also be considered in order to understand how sensations are experienced phenomenologically, interpreted culturally, and responded to socially in ritual healing.[4]

Drawing upon these discussions, Helmar Kurz (2015, 2017, 2018a, b) has investigated the efficacy of Kardecist Spiritist rituals in mental health institutions in Brazil, including the *Spiritist Light Hospital*, and has endeavoured to explain how the *passe* works sensorially within Brazilian culture to bring about personal transformation and reintegration in mental health patients. Based on narrative interviews made with patients who were temporary residents of the private ward of the hospital and with mediums and patients in other parts of Brazil, he presents case studies of

those who have had successful outcomes through participation in the Spiritist *passe* and have moved from patients suffering from mental afflictions to Spiritist mediums who participate in the *passe* in order to help others. Helmar Kurz is concerned with the relationship between corporeal engagement and sensation that result in healing experiences conceived of as self-transformation by learning and changing habits: "Patients integrate into a stable and caring group, learn to act self-responsibly and experience self-empowerment by developing capacities of healing self and others" (Kurz 2017: 203). For him, Spiritism de-stigmatises mental illness, promoting strategies in which the person learns how to love and forgive oneself and others and to live an ethical life.

For Helmar Kurz, the "work with the senses" in Kardecist ritual concerns an ongoing process of self-awareness brought about by a rupture in habitual sensorial environment. During the *passe* there is a reduction of stimuli to acoustic sensations in order to stimulate the practice of listening. This is in contrast to the noisy and highly interactive environment that characterises Brazilian culture and social relations. The reduction to few acoustic stimuli evokes sensitisation of (self) perception as attention focusses on hearing voices and results in a shift of self-perception. The silent sensory experience of the healing touch intensifies this experience and through repetition, a new form of self-experience will be learned. For Helmar Kurz, the silence and aesthetics of the *passe* establish a meditative environment that marks a rupture from everyday interaction and attentive listening for the voices contributes to inducing trance, the shifting of consciousness and stimulating inner processes. He adopts the neuroscientific concept of interoception (Dox 2016; Farb *et al.* 2015) to refer to these inner processes, and suggests that the concept forms the bridge between anthropological interest in processes of embodiment and neuroscience's focus on related inner processes: "While anthropologists develop a growing interest in processes of embodiment in terms of how social and cultural factors influence state, behaviour, and experience of the human body, neuroscience focuses related processes within the body" (Seligman & Brown 2009 *apud.* Kurz 2017: 203).

Helmar Kurz's investigations in Brazil demonstrate the complementary relation between local religious and psychiatric explanatory models that result in mutual inspiration and practices of cooperation. His research on the success of Kardecist Spiritist practices that have been transferred to Germany highlight the potential for their healing efficacy in other cultural settings, concluding that illness explanatory models and healing practices are not necessarily reducible and exclusively linked to social and cultural frames or contexts, but also entail personal expectations, individual resources and emotional aspects (Kurz 2018: 37) that are related to the quest for explanations, coping strategies, and solutions for human conditions and experiences.

In spite of Helmar Kurz's valuable contribution of an analytical model that contributes to the understanding of the role of the senses in Spiritist healing, our study did not yield similar results with regard to the healing efficacy for the chronic inhabitants of Sheltered Home. This does not represent a failure in his model that joins anthropological concerns with those of neuroscience in order to understand the process of healing, but due to the different life conditions and personal resources of the patients interviewed by Helmar Kurz and those whose daily lives were followed in this residential ward. The patients interviewed by him were temporary residents treated in the private ward and received various modalities of psychotherapy and spiritual counselling. Their personal narratives expressed consciousness of their affliction and a desire to reduce medication and restore their emotional and mental wellbeing. They were engaged in their healing processes.

Those of the sheltered home have experienced very different life conditions. Institutionalization is perhaps the single most important condition of their lives, since it has shaped, in fatal ways, the diagnosis of mental illness and incapacity to live in the outside world. Obviously one reason is the condition of having spent the greater part of their lives in coercive institutions, with little or no contact with the outside world and with little potential of perceiving other possibilities in life. A second, and one that most probably limits personal resources for consciousness of their afflictions or engagement in a healing process is the forced ingestion over decades of psychotropic medica-

tions that cloud thinking and create sluggish somnambulist or highly agitated responses. For them, there is no apparent reason for why they are there nor do they envision any possibility of leaving the hospital. They do not tell narratives about their afflictions, nor do they perceive mental illness as a determining factor in their lives.

They are wards of the state; they have the status of minors with limited rights in a public psychiatric hospital in which the possibility or hope of being released is almost non-existent. As chronic inhabitants of the institution, they remake their lives within its limits, creating micro political movements through social interaction. These movements, or forms of resistance, emerge as strategies of survival of living subjects whose subjective experience is constructed within the confines of the social reality of the hospital. During the *passe*, the residents comply with the daily obligation to attend the spiritual treatment and yet resist engagement with the ritual performance, finding other ways of experiencing the moment, be it in the expression of affection, small economic exchanges or simply sleeping through parts of the ritual.

## Final Consideration

In this article we have followed the institutional life of "Sheltered Home" to examine the coercive mechanisms exercised upon the residents and their relation with one specific obligation: the ritual of the *passe*. As residents inserted within a structure of institutional power, their experience and interpretation of this ritual process differs from the interpretations and intentions of the Spiritist volunteers who administer the healing touch or *passe*. Given that they are individuals abandoned by the social logic, they are part of a system that determines the routines to which they should live. Failure to comply or acts of disobedience are met with punitive measures. One such measure is increased confinement through banishment to other public wards, such as the *patião*, where they lose the few rights that they have, including the right to personal clothing or participation in brief trips outside the hospital. Heavy medication is another form of coercion, one that can be further increased in certain cases of unapproved behaviour. Among the obligations and rules that they must obey is the required participation in the daily ritual of the *passe*, intended by the hospital to heal the spiritual causes of their mental afflictions. Negation to attend the *passe* can result in punitive measures.

In spite of their expressed resistance to the *passe*, the residents attend the ritual, appropriating the event for their own purposes and desires. In this sense, they do not engage in the ritual process, seeking a therapeutic resolution that would liberate them from affliction. Rather, the hour of the *passe* represents an opportunity to explore other possibilities and desires in their institutional lives. They are able to increase the social field, relating to persons who reside outside the walls of the hospital, such as the volunteers, or communicating and trading objects with patients from other wards and from whom they are separated during other periods of the day. Generally limited to the confines of the sheltered home, they remake their social world during the *passe*, by resisting engagement with the ritual and expressing their personal desires and affections.

By emphasising their capacity to express other objectives through participation in the obligatory ritual hour, we do not seek to minimize their objective situation as chronic inhabitants of a psychiatric institution. In turn, we seek to respect them as humans with volition and resilience, valuing their subjectivities and experiences. Our study has shown what João Biehl (2016: 418) affirms as

> "[...] how people struggle, make and live their lives in spite of, by means of, or along with macrostructural forces [...] recognising the real effects of these forces on the lives of people: violence, inequality, limits, possibilities or opportunities."

The residents of Sheltered Home find different ways or means to remake their lives within the limits of the institutional order.

Although the ruptures in social relations caused by long years of internment have left marks on the lives of the residents of *Spiritual Light Hospital*, their resilience has enabled them to reconfigure these ruptures, generating the subjectivity of belonging to the social group with which they live (cf. Camargo 2017). This capacity to generate social networks contributes to the restoration of some of the forms lost through prolonged institutional life. Although they do not engage in the ritual hour seeking relief from or healing of men-

tal affliction, the *passe* offers opportunities for the enactment of agency, subjectivity and desire that permits them to construct ways of living beyond the institutional moral order.

## Notes

**1** In his well-known monograph *Vita: Life in a Zone of Social Abandonment*, João Biehl (2005) analyses the total abandonment of Catarina, a woman who has been interned in mental institutions for much of her life due to misdiagnosis and total lack of family support. Years of institutional treatment have left her speechless and crippled.
**2** All are from the State of São Paulo, but only one is from the city where the hospital is located.
**3** Approximately every three months there is an "assembly" in which the medical professionals meet with the group of residents to discuss the living experience and any problems in the ward.
**4** Although Sidney Greenfield's (1999, 2008) studies of Spiritist healing in Brazil did not work specifically with the sensorial concepts suggested by Mark Nichter, his works argue that Brazilian culture has a role in the individual's readiness to respond and be affected by Spiritist rituals.

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**SABRINA MELO DEL SARTO** studied Social Sciences at the Universidade Estadual Paulista (UNESP) between 2014 and 2017. In 2018 she entered the Graduate Program of Social Anthropology of the Universidade Federal de Santa Catarina (UFSC). She obtained a Master's degree in 2020 and is currently studying for her doctorate with emphasis on Mental Health, Institutionalization and Hospital Ethnography. Her research is funded by CAPES.

INCT Brasil Plural/UFSC
C.P. 5178
Florianópolis, SC 88040-970
e-mail: sabrinadelsarto@hotmail.com

**ESTHER JEAN LANGDON** (Ph.D. Tulane University 1974) is a CNPq researcher and coordinator of the National Institute of Research: Brazil Plural – IBP (CNPq/INCT). She retired as full professor from the Graduate Program in Social Anthropology of the Federal University of Santa Catarina in 2014 and continues as advisor and voluntary professor. Her primary research themes are shamanism, anthropology of health, oral literature and performance. She has published throughout the Americas and Europe; the most recent books include Cosmopolitics among the SIona: Shamanism, Medicine and Family on the Putumayo River; Saúde Indígena e Políticas Comparadas na América Latina (with M. D. Cardoso); and Políticas públicas: reflexões antropológicas (with M. Grisotti). Her curriculum is registered with CNPQ https://wwws.cnpq.br/curriculoweb/pkg_menu.menu?f_cod=94F11130168720DB71ABA8AC99C5B986.

INCT Brasil Plural/UFSC
C.P. 5178
Florianópolis, SC 88040-970
e-mail: jean.langdon@ufsc.br