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* Original Article

'Here I suffer too much': notes from a survey conducted at a Custody and Treatment Hospital

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Abstract
The present study introduces particular methodological aspects encountered during fieldwork conducted by a social science study in progress, which aims to understand the diseases, crimes and hospitalization rates associated with a custody and treatment hospital in Brazil . Our study consists of qualitative research that adopts a perspective of symbolic interactionism, with methodological features from grounded theory. Initially, we present some of the institutional ambivalences that aroused our interest and describe the general characteristics of the object of the study. We clearly show that the ' interned' are individuals who experience the daily life of the institution. These people are categorized as *interned-patients* and *interned-staff*. Then, the technical procedures adopted while both obtaining and analyzing the data are presented. Subsequently, we discuss the issues arising from the investigator's background and familiarity with the research subject, the accumulation of roles and the difficulties of distinguishing them in the field, and the relationship between the native (or near-native) investigator and the research universe as well as the benefits and difficulties arising from this relationship. While discussing these issues, we describe some of the interactions with the various social actors who compose the field. The present work aims to at least contribute to the methodological construction of other similar studies and to encourage some reflection on this field.

Keywords: Psychosis; Crime; Hospitalization

Introduction

While discussing the methodological aspects and the progress of a study involving a custody and treatment hospital (CTH), we must also discuss its main substantive issues, which are often unavoidable in daily fieldwork. Because this work is the product of an unprecedented[1] research study and because of limited space, this text will focus on exposing some of the findings and methodological aspects of a study with multi- and interdisciplinary characteristics that was performed using social sciences techniques . It is understood that the CTHs in our country are rich fields of research that are waiting for studies to unveil their mysteries, meanings, directions and motives. The *sui generis* culture and characteristics of CTHs form an almost autonomous world, establishing boundaries that go beyond the physical barriers between the "normal" and the "crazy and dangerous" society.

There has always been a gap between the idealized CTH and the actual CTH in Brazil. What we find striking is the ambiguity arising from an institution that, in practice, punishes and is unable to adequately treat the mental illnesses of its patients. On a daily basis, these institutions handle undesirable human beings without clearly understanding whether they should be punished or treated. This ambiguity was the springboard for this research endeavor. Through the experiences of the patients and staff members, can we glimpse the aspects of an institution that should treat patients but that in reality serves as a means of punishment?

It should be noted that research on CTHs necessarily mobilizes aspects of different knowledge fields. In this challenge, we had several opportunities to construct questions based on references to the sociology of crime, prison studies and studies from the fields of mental health and forensic psychiatry. Based on our clinical experience with psychotic patients, we believe that it is important to construct meaning from the subjects' experiences and how they address meaning in their daily lives. The present study sought to study psychosis, crime and detention from the experiences recounted by

psychotic patients and criminals who have committed homicide. Additionally, we relied on direct observations of the field. The goal was to understand how these individuals think and how they represent their diseases, crimes and admissions of their crimes to the CTH. How do these patients understand their place within this institution? How do they build their social networks with the other patients and the staff members that work there? How do they understand their crimes and the means by which they are being punished?

T he phrase "Here I suffer too much" is common among both the patients and staff members. The fieldwork also immediately highlights the similarities between the difficulties experienced by both the patients and staff members. It was easy to notice that all who are interned in this hospital (i.e., patients and staff) belong to the same symbolic universe of sociability and interaction. The staff defines and handles the crimes. They spend a significant part of their lives in the CTH and therefore absorb the culture and difficulties of the institution. For this reason, we adopted the designations *interned-patients* (IPs) and *interned-staff* (IS) while considering both groups as interned. We also analyzed the IS experiences as well as the personal impacts of their work and the institutional culture.

Custody and Treatment Hospitals

According to Carrara (1998), criminal mental asylums emerged concurrently in several countries in the late nineteenth/ early twentieth century. These institutions emerged when the courts noticed that neither asylums n or prisons could adequately segregate criminals who were classified as mentally unstable. In Brazil, decree 1132 from 1903 instituted the practice of providing legal and medical assistance to these individuals. This decree also proposed building criminal mental asylums for the criminally insane (i.e., judicial asylums). As they were being built, annexes in public asylums were built to house these mental patients.

In the twentieth century, semi - asylums or semi-prisons housed mentally ill criminals. Despite the 1903 law , "criminal mental asylums" appeared almost 20 years later. In 1921, the Federal District Judicial Asylum was created. This institution was followed by the São Paulo Asylum in 1923 and the Barbacena Asylum in 1929. Subsequently, other asylums were created in other states. According to the directive, psychiatry should be the dominant factor, but in practice, psychiatry became subordinated to juridical power (JACOBINA, 2001, 110-111 pp). The trajectory from the judicial asylums to the custody and treatment hospitals was marked by ups and downs in a path that went from punishment to attempted treatment.

Today, if a crime is a symptom of a disease, the offending person is considered untouchable by the law. Given this imputability, the individual is then referred to the judicial asylum. However, mental asylum treatments have not been successful throughout history, and mentally ill offenders are given no benefits under criminal reformation laws (CTH INSPECTION REPORT, 2003). According to Foucault (2001), following the psychiatric evaluation, the judge does not punish the crime or offense. However, the judge examines the defendant's irregular conduct as the origin of the crime . The crime is then assessed from a psychomoral point of view, where the disease is no longer a disease but a moral defect. The psychiatric evaluation must establish boundaries between disease and responsibility, between pathological causation and free will, between treatment and punishment and between hospital and prison. If the issue is proven to be pathological, the medical institution shall (or should[2]) take the place of the penal institution (FOUCALT, 2001).

In Brazil, there are currently 33 CTHs with 3,370 patients confined for security reasons (INFOPEN, 2010). Few studies have discussed CTHs, and most of these studies only address the laws or institutional issues. Examples of scientific works that have analyzed CTHs, the target of our study, include Correia (2007): "Advances and impasses in ensuring the human rights of mentally ill individuals who committed crime"; Peres (1997): "Disease and Crime," which examines the relationship between psychiatry and the judiciary; and Lorenzo (2006): "The treatment of mental patients at the Custody and Treatment Hospital."

With regard to Brazil , we found historical works, such as the thesis of Jacobina (2001): "Psychiatric Practice in Bahia (1874-1947): Historical Study of the Asylum São João de Deus/Juliano Moreira Hospital" and the thesis of Kummer (2010): "Forensic Psychiatry and the Judicial Asylum of Rio Grande do Sul: 1925-1941." We found articles such as those written by Sá (1985): "The Judicial Asylum, Health or Justice?" This article addresses how the Judicial Asylum is subordinated to the Secretary of Justice instead of the Secretary of Health. We also examined the article by Moscatello (2001): "Criminal relapse in 100 inmates from the Judicial Asylum Franco da Rocha," which addresses criminal behavior; the article by Adams (2009): "Quality of life of schizophrenic patients in Custody Hospitals;" and the article by Bravo (2007): "Prisons of madness, the madness of prisons." However,

only the article by Cordioli (2006) "Custody Hospital : the rights advocated by Psychiatric Reform and the reality of patients" addresses the experiences of the inmates of these institutions. We found no work that specifically addresses the experiences of psychotic inmates in Brazil's CTHs.

The institution examined in this study[3] has an official capacity of 280 beds. However, the National Health Surveillance Agency (NHSA) recently determined that the institution has a maximum occupancy of 140 beds: 20 for females and 120 for males. The majority of the *interned-patients* are male, and homicides outnumber all of the other crimes.

Upon arriving at the CTH, the visitor encounters a tall white wall and a large blue iron gate. There is an old building that houses the patients; a nearby building consisting of the cafeteria, kitchen, laundry, linen and occupational therapy rooms; a newer building that houses the administration; and an annex besides the outdoor patio for the security team. The courtyard surrounding the main building is large and has benches, trees, a soccer field and a parking lot. In the administrative building, there are the Director's and administrative offices, the Head of Security's office, the Public Defender's office, the archives, the pharmacy, the personnel department's offices, a meeting room, bathrooms for staff members and visitors, the eating room and the offices of the departments of psychology, social work and occupational therapy.

In the building intended to house the patients, there are two classrooms, the nurse's room and the cleaning room. In the wards, besides the infirmaries with the beds, there is the nursing station, the attendance room and a collective restroom. In wards "E" and "A," there is a solitary room that houses the *interned-patients* who try to escape or become aggressive. The *interned-patients* suffer from a lack of privacy; the bathrooms and toilets in the patients' wards have no doors, the dormitories are collective and there is no place to store personal belongings.

In the building of the CTH that houses the patients, the physical structure is old and deteriorated, the stairs are narrow, the walls are damp and the building suffers from low light and ventilation, which adds to the typical odor of old asylums. The beds and restrooms are in poor condition, and hygiene is generally deficient. There is a locked gate separating the nursing station from the hall of the ward. Entry to all of the wards is barred, as are all of the windows. The appearance of the building more closely resembles a prison than a hospital.

Method and data collection techniques: stages and procedures

This research is inspired by symbolic interactionism, which has been widely used in the fields of mental health and social sciences (ANDRADE; TANAKA, 2000). The interactionist school of thought assumes that human behavior and experiences are mediated by interpretation. Meaning is assigned to the relationships among individuals through their interactions. Thus, a social phenomenon must be understood through the experiences of the participants and the meanings assigned by the participants and the participants' interactions (CHARON, 1989). Interaction occurs at any time that a group of individuals is in the immediate presence of other people (GOFFMAN, 2007).

It is important to clarify that the present research examines the views of reality presented by the people targeted in this study. That is, we observe the views of the *interned-patients* and the *interned-staff*. I n line with Becker's (2008) study on deviants, we observe the interactions of these views. As part of the interactionist approach, we borrow from a methodology known as grounded theory, which was developed by the sociologists Barney Glaser and Anselm Strauss in the 1960s. According to grounded theory, a theory is derived from the data collected and analyzed through the research process (GLASER; STRAUSS, 1967).

This methodology is widely used in health research on subjects ranging from nursing to psychology (MOREIRA; DUPAS, 2006; PAULI; BOUSSO, 2003). This range is possible because this methodology allows for great flexibility in building knowledge on the issues that often constitute an intersection of disciplines. G rounded theory aims to describe the subject of a study and the cognition and actions of the portrayed actors. Additionally, grounded theory organizes and occasionally classifies data according to their properties. Finally, grounded theory allows researchers to form theories based on the collected data (STRAUSS; CORBIN, 2008).

For our research strategy, we observed the participants and conducted semi-open interviews. The fieldwork was divided into two stages: A) a stage of exploration and adaptation to the fieldwork, where we formed general observations of the institution and its routines, familiarized ourselves with its operations and with those who lived or worked there and engaged in informal conversations with the *interned- patients* and *interned-staff*; and B) the fieldwork, which was conducted semi-open interviews with the interned individuals selected for our core research sample. Clinical and criminal

records as well as a narrative written by an informant were integrated with the research as part of the complementary resources. We used a field diary to record the observations and the contents of the conversations and interviews. This multiplicity of sources and techniques for obtaining information ensured that we would obtain a greater number of and better references to not only aid our understanding but also enhance the quality of our findings (FLICK, 2009).

According to Minayo (2007), when observing participants, the observer is in a direct relationship with the interlocutors. That is, the observer lives in the social space being examined by the research and participates as much as possible in the participants' social lives to gather data and understand the context. The researchers are part of the context that they observe and are capable of not only modifying it but also being modified by it.

The fieldwork started with trips to the CTH on different days and at different times. We acquired a 'familiarity' with the *interned-patients* and *interned- staff* by monitoring the routines of the institution and by observing the participants during key moments, such as meals, medication times, family visits, free time in the courtyard and*lockdown time*[4]. During our informal conversations with some of the *interned-patients*, we always conducted brief presentations and succinctly explained the nature of our research. Whenever an investigator was in the courtyard, a ward or the cafeteria, some *interned -patients* would approach, gather into small groups and make requests and complaints that expressed their needs and exposed some of the privations that they suffered in the institution. During the day, we noticed much movement in the wards, the courtyard and the administration. Depending on the time, there were many*interned- patients* in the courtyard, all of whom wore yellow uniforms. At approximately 5:00 pm, after the patients had entered the wards, the courtyard was occupied by pigeons, stray dogs, janitorial *interned-staff* (who cleaned the institution) and prison guards who sat on benches or chairs. The breeze was pleasant and improved as darkness approached. There was a silence in the air and a certain apparent tranquility. Sitting there sometimes felt as if we were sitting on a bench in a square while waiting for the time to pass.

Usually, the requests would arise as the starting point of a conversation. They would ask for money, '*pacaia*'[5],and permission to call their families. They would ask us to intercede on their behalf with the judge, the director, the attorneys or the Social Services. They would also ask for personal items. For example, an *interned-patient* named Saturnino always asked for shoes and sometimes even asked Arquimedes, "I want a job when I leave this place. How can I get one?"

The participants usually complained about the meals. "The food is very bad. The chicken is just bones and is sometimes raw. The food is always the same," Rochester told us . "The food is terrible. You should taste it to confirm," complained Saturnino. " There are people here who do not like soy or eggs. I do not eat," said Onorino. "My Measure[6] is expired. I'm waiting to do the report," said Lorisvaldo. "I received no answer from the judge. If you want to convict me, do it already. Otherwise, throw me back on the street," said Ferdinand.

A few moments after the initial contact, we would ask some general questions in simple language. What do you think about the CTH? Is it a hospital or a prison? What are the advantages and disadvantages of this place (CTH)? How do you feel being here? What brought you here? Do you consider yourself sick? If so, what is your illness? What else do you want to talk about? It is noteworthy that much of the information was collected in the presence of others. For the *interned-patients*, public disclosures did not seem to make much of a difference because most of the patients did not hide their crimes, their life histories or their psychopathological symptoms.

Some *interned-patients* with psychotic characteristics and who committed homicides publicly recounted their crimes in detail without any apparent reservations. Some said it felt good to talk and get some relief, whereas others said that talking about their homicidal acts created anguish, although they would still discuss these acts. We observed that for the patients, these moments of free conversation generally allowed them to not only express their identities and their beliefs but also to describe their main demands and problems. Ferdinando told me: "I came here because I killed my parents." "I came here because of murder, armed robbery, kidnapping, drug trafficking and weapon possession ," said Aurino.

As with the IPs, we conducted conversations with the prison guards and the other employees (i.e., the so-called *interned -staff*). We used the same questions that we posed to the *interned-patients*. However, we asked two additional questions: how do you feel working here? What do you think about the *interned-patients*?

We began to approach the *interned-staff* after our first observations of and conversations with the *interned-patients*. Alone, in pairs or in groups, their speeches, conversations and discussions

provided useful data. The conversations in pairs and in groups provided a wealth of information through debates, discussions, controversies and memories that were complemented by their partners . The conversations usually occurred at each worker's area or at the work room, but they also occurred in the courtyard when it was not occupied by the *interned-patients*.

Although group discussions have particular characteristics, they also have advantages that can be obtained through a technique called*discussion groups* (BOHNSACK; WELLER, 2006). According to Weller , " group opinions (*Gruppenmeinungen*) are not formulated but only updated at the time of the interview. In other words, the views generated by the group cannot be observed as an attempt at manipulation or as a result of mutual influence at the time of the interview. Above all, these positions reflect the collective orientations or world views of the social group to which the respondent belongs" (WELLER, 2006, 245, p).

As an example of the above , on an early evening in February 2011, I had a fruitful conversation with a group of prison guards in the courtyard of the HCT. Ribas said, "This is how patients talk to us : that guy hit me and is abusing me. Then what do we do? The abuser cannot know about what the patient said, or there will be retaliation. Then we find a way to get the abused out of the ward, but we do not punish the rapist ." Antonina stated the following:

> *"In my opinion, the patient here receives what is provided by the law. There are patients here who want to do whatever they want. I call for lunch, and they don't come. They must have discipline and order and follow rules. Patients must obey; they swear, knock on the nursing station's door and want water and juice. They think this is a hotel. I don't give them anything but also don't want anything from them".*

Ribas argued, "Do you think that patients who did not accept the law outside will accept it in here? Many come from the countryside. They don't even know that they are coming here. They think they are coming for a medical exam. When they arrive and find out they are here to be admitted, they go crazy ."

Field dynamic and research analysis

We chose not to use the recorder during any stage of the fieldwork because we considered it an instrument that could arouse unrest or even feelings of persecution in some of the *interned-patients*. This decision proved to be correct when, at the beginning of an interview with an *interned-patient*, I placed my mobile phone on silent mode and was asked if the interview would be recorded. I clarified that the interview would be transcribed but not recorded. The patient then said, "Ok, that's good ." Up to that point, there had been no resistance on the part of the informants regarding the recordings of the interviews. We manually recorded our observations of, conversations with, discussions with and interviews with the informants. The professional habit of listening to the patients' long stories[7] and registering them on medical records demanded that we listen to the informants' narratives. We took notes as they spoke. Then, on the same day, we organized our notes and filled in the gaps by relying on mnemonic devices.

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In compliance with the ethical requirements of Resolution 196/96 (BRASIL 1996), we asked the research participants to read and to sign the Informed Consent (IC) form, which outlined the research objectives.

Because of the pathological nature of the participants, we had to be careful when applying the IC. Some *interned-patients* signed the form with ease, whereas others were more fearful or persecutory. One of the first interviewees promptly signed the IC as soon as we had finished reading it: "Give it to me, I'll sign it," he said. One patient refused to sign for fear that it would affect the legal process because this individual was at the CTH to be evaluated in an attempt to modify the sentence.

It was necessary to carefully evaluate the timing of the IC for each specific situation. With one *interned-patient* who had a high level of mental confusion and psychotic episodes, it was prudent to wait for an improvement in his condition and a moment of greater clarity before asking him to sign the IC. In every situation, it was beneficial to wait for the necessary time to establish a greater bond of trust between the researcher and the informant. The only exception was the first *interned-patient*, as we had already established a relationship with this patient from another psychiatric unit of Bahia. Before signing the IC form, the second member of the sample said, "If this is the work, I will collaborate and sign the paper. You guarantee that it will not cause any problems for me or the others?" After confirming that participation would not cause any problems, the patient stood up, put his hand on his head, closed his eyes, clasped his hands near the chest, thought a little longer and then said, "I will sign now, I've already decided!"

The profiles of the *interned-patients*, most of whom had little education, have indicated the need for a simple explanation of the content of the IC form and the need to obtain verbal confirmation that the patients understood the form before signing it. On these occasions, it is always stressed that there will be no advantages whatsoever for those who participate in the study. Despite this clarification, some *interned-patients* showed their expectations of the research being conducted. Their statements included the following: "I hope that you will end this research soon and can help us improve something here. These are the saddest hours, the lockdown time. Now we can only leave tomorrow." " Will this research help me to get out of here?" " Can you help me to retire ?" We perceived that the *interned-patients* had a need for attention. The general suffering caused by the institution wa s also evident and clearly expressed by the patients. "Here everything is bad," said one of the patients. However, in the most remarkable expression regarding this effect, a patient stated, "I victimized someone , but I am a victim here, as I suffer too much."

When group conversations were conducted with the IPs, they told their stories. Sometimes, they joked about their own disgraceful states to soften the weight of the discussed subjects. An *interned-patient* said, "It is good to have you come and talk to us. It distracts us, and you don't seem to be afraid of crazy people." Many noticed my familiarity with the field, and our conversations ended up being somehow therapeutic. Some of the discussions reflected this experience: "Talking about the case after it has passed is good. It relieves us." On another occasion, a patient told us, "Doctor, can you talk to me? I need to get something off my shoulders. I have asked the agent to take me to the psychologist. They don't take me." The fact that they were always calling me doctor leads me to think that most of the time, they were more inclined to regard me as a psychiatrist[8] than a researcher.

The *interned-staff* members who we approached for conversations were generally available, responsive and helpful. A nursing technician took advantage of my presence a nd interviewed me on the subject of depression for a college assignment. There was initial resistance on the part of a university level *interned-staff* member. This resistance promptly disappeared after the staff member learned of my profession. In another case, a staff member showed resistance precisely because of my profession. As with the *interned-patients*, we perceived a therapeutic effect of our conversations with the *interned- staff*. Once, at the end of an interview with a group of agents, a prison agent said, "You should stay for the night shift so we can talk. It was very good to talk, to exchange ideas and to get some relief ."

There is a tension among the *interned-staff* members from different sectors as well as between the medical and security staff. A prison guard described the following situation:

> *In the prison system, the cervical spine is the agent. Not here. The medical staff is in control here. When a patient is placed in a particular ward, the staff does not look at the security side. They only look at the clinical side. When there is a problem, they call the agent. Now, the only resource that we have for containment is medication. We cannot isolate. We can only use mechanical restraint if the doctor asks for it. There was a case in which a contained patient was killed at night. With the containment, the doctor took away the patient's ability to defend himself. If it had been the agent's decision, we would have transferred the patient from the ward or placed him in isolation, but the doctor did not listen to the agent.*

In the dynamics of fieldwork, it has always been crucial to be an attentive listener. According to Lemgruber (1999), the researcher must be trained to listen more and ask less. The initial responses help the researcher almost naturally formulate his or her follow-up questions. As an additional checking mechanism, when preparing certain field interpretations, the researchers must go back to the interviewees and ask whether the interpretations make sense. If problems with the interpretation are noted, the researcher should ask the interviewees to explain the subject matter again. By itself,

the consent of the respondents does not validate the findings, but this checking mechanism effectively contributes to the correct understanding of the meaning, which is known as communicative validation in this research field (FLICK, 2009).

The analysis of the collected information occurs parallel to the course of fieldwork and not just at the end (STRAUSS; CORBIN, 2008). Under this assumption, as a result of the fieldwork, we produced two articles based on the apparent confusion of the *interned-patients* due to the combination of two institutions into a third, highly ambivalent institution that was sometimes ambiguous and at other times paradoxical . This finding agrees with the results of Goffman's (1999) studies: "The Paradox of the fusion between Asylum and Prison" and "Paradox or Ambivalence? Asylum and prison - the case of the Custody and Treatment Hospital ."

As the fieldwork progressed, writing about our observations and reflecting on the subject helped us to organize our thoughts regarding the possible bases of our work and the issues to be explored. The fieldwork pointed to the most important problem, which is the problem of defining how the research would be delineated. In addition to the two previous articles, the present study highlighted particular methodological issues encountered during the fieldwork. These issues resulted from the researcher's profession, the profile of the target clientele and the institutional culture.

Based on Minayo's (2007) guidelines for data analysis in qualitative research, we observed the commonalities and singularities arising from the experience of each participant. We sought to identify the diversity of views and meanings in seemingly similar experiences and relate them to aspects pertinent to the history of each individual and to the culture, with special attention paid to the aspects related to the collective representation of madness and the culture of segregation. We accurately described the respondents' narratives. The terms used by the interviewees were quoted without correcting for their grammar, as it is understood that their manner of speech gives information about the individuals.

The present study found an additional challenge in that we had to integrate the knowledge of mental health and forensic psychiatry with the sociology of crime and the prison system. For Minayo (2007), the methodology includes the approach theory (method), the instruments of knowledge operationalization (techniques) and the researcher's creativity (experience, sensitivity, personal capacity and background). There is a tension point, as I had to detach myself from my identity as a psychiatrist to adopt the anthropological view and prevent prior tendencies and beliefs of the field from distorting the data.

The background: technique and field research

Researchers who adopt qualitative techniques do not fear their own perceptions when they start analyzing the data. It is through their experiences that researchers often filter reality, decode it and give it meaning. However, these experiences should not override field observations. Fieldwork should always be considered a priority (STRAUSS; CORBIN, 2008). Following Geertz's (1989) lesson, we seek to interpret the meaning that the subject gives to his or her experience to perform a "reading of the reading." This study takes advantage of all of the experience and knowledge gained by the author in the field of mental health and her familiarity with total institutions.

Although I have practiced psychiatry for over 26 years and have extensive work experience in psychiatric hospitals in Salvador, I searched for an institution that was previously unknown. Thus, I first visited CTH institution in 2009 with the intention of preparing a research project for a Master's degree in Social Sciences. I agree with Julita Lemgruber's (1999) statement that it is impossible to go through prison and leave with no marks or wounds. I was struck from the first moment by old and familiar images as well as new, unusual ones. I noted from the first few visits that in addition to all of the degradations common to asylums , there was something more in this institution. Perhaps this phenomenon was caused by the combination of two social ills, asylum and prison, into a single institution. Even with the intention of better understanding a new universe, I was surprised to find many characteristics of an asylum (a universe that is better understood by the author) in addition to the characteristics of a correctional facility in this institution. According to Lemgruber, (1999) "prisons will be always the same, no matter the time or the place."

To enter the CTH, I used my medical license and psychiatrist title, which allowed me to freely explore the institution at any time of the day[9]. Additionally, I was given access to medical and criminal records. With respect to these two points in particular, it is important to remember that in addition to the training and title of "doctor," I also used the relationships that I had established with the staff and the director of the institution. These relationships proved to be valuable and effective throughout the research. However, I tried to distance myself from the role of psychiatrist and mainly assumed

the role of researcher as much as possible.

After the field trips, we felt the need to establish joint arguments and discuss our perspectives. We sought to focus and fine-tune this debate both between the mentor and mentee and using the differences between two foundations and perceptions of the same reality. It is clear that there is a need to leave the psychiatric view, which diagnoses and prescribes to find strange characteristics, and to try to view reality through the eyes of the patient, who is often called or self-proclaimed to be "crazy," "dangerous" and a "murderer ." Sometimes, doing so has not been possible. With its particularities, the field has naturally prompted the use of the façade that I assume during my interactions with the psychiatric patients. In accordance with Goffman (2011), this facade is approved by the patients .

In the situation described above, I recalled the anthropologist Fernanda Eugenio's (2003) experience in a school for blind childrenand forced myself to be more passive than I wanted to be (EUGENIO, 2003). Two moments were notable. When talking to the patients in an infirmary, one patient who knew that I was a psychiatrist pressed his hands against his head and said, "I'm hearing voices. I can't stand it anymore. It is my sister's voice. She says she is going to kill me ." Realizing the patient's anguish, I asked the nurse technician in the ward to call the doctor on duty to medicate the patient and forced myself to avoid prescribing him medication.

On another occasion , a state ambulance left a patient to be admitted to the institution but did so without a court order. The mother was distraught. She did not know what to do after the doctor on duty had told her that she could not stay with the patient. At that moment, I suggested possible solutions to my colleague. Right then, I realized that I was occupying a different role, which was based on my past experience in the administration of a public psychiatric unit. In these situations, it was almost impossible not to combine the roles of researcher, psychiatric unit manager and medical psychiatrist because the institutional demands eventually led to a conflict and subjective needs to find a plausible solution to a problematic situation.

Based on another point of view, Gilberto Velho (2003) stresses that a Brazilian researcher must often draw upon his or her network of pre-existing relationships. It must be noted that there was a previous relationship between the researcher and the CTH director because we had worked together for several years in a psychiatric hospital. This pre-established relationship allowed us to maneuver more easily while conducting our fieldwork. Despite the fear that the institutional problems would be exposed to the public - as highlighted by Lemgruber (1999) in his study of a female prison - no restrictions were imposed by the director of the CTH. I was given free access to the CTH, and the key staff members were told to address all of my requests. According to Goffman (2007), in a place limited by established perception barriers, where a particular type of activity is regularly performed (i.e., a social establishment), the audience is prevented from seeing behind the scenes, and outsiders are not allowed to participate in a representation that is not addressed to them. For the aforementioned reasons, I was less constrained by these limitations.

My training and professional experience as a medical psychiatrist were unavoidable aspects of this research. Nonetheless, I did not consider myself to be a 'native' or an insider. Almeida (2011) discusses the advantages and disadvantages of being a 'native' or an insider when conducting research in a prison environment. The advantages consist of greater access to information and subjects that would never be accessible to a researcher; the difficulties arise when the researcher tries to obtain a less naturalized view (i.e., the view of a researcher) in an environment to which a staff member is so accustomed (ALMEIDA , 2011).

In general , Merton (1972) defines insiders and outsiders as follows: insiders are members of specific groups and collectivities or occupants of a particular social status, whereas outsiders are non-members. Using this strict definition, I am a CTH outsider because I am not part of the interned group (i.e., a patient or a staff member). However, I am partly an insider; as a member of the psychiatrist subgroup, I am naturally placed in this context. Although I have never been in this CTH, I still felt immediately familiar with the institution. From the first day, I had a feeling of belonging that is common to individuals familiar with the asylum system. According to Merton (1972), it is important to remember that the outsider will never be socialized or engaged in the experiences of the social group to which he or she does not belong.

To better understand the social nature of the CTH, we turn to the contribution of Goffman (2011). According to the author, the social intercourse involves a constant dialectic between presentation and avoidance rituals. Deference is a symbolic means by which an individual's appreciation for another individual is expressed (through either avoidance or presentation rituals). It seems to me that the *interned-patients* exhibited deference because they were always calling me doctor and acknowledging my authority over them. Thus, the patients partly legitimized my feelings of belonging

to the institution.

The *interned-staff* members also legitimized my place and allowed me a certain level of access within the fieldwork as a result. One afternoon, I was in the service room searching for the medical records of an IP when an IS from that sector (who I did not know) told me:

> - You came here, said good afternoon, told me who you were and asked for a medical record. If we were somewhere else, you would have to say immediately that you are a psychiatrist. Otherwise, you would not get any patient's record. There is an employee here who will give you problems to stop you from getting what you want .
> - In the archives? (He nodded.) I never had trouble getting medical records from the archives.
> - Then she knows you, or you were recommended by someone else .
> - Yeah, maybe.

According to Becker (2008), there is insufficient research on the experiences of deviants and what they do or think about themselves, society and its activities. One reason for this lack of research is that it is not easy to study deviants. Deviation scholars must convince their respondents that there will be no danger to them and that they will not suffer as a result of their testimonies. Those who commit deviant acts protect themselves in various ways against nosy outsiders. According to Goffman (2011), interactions with individuals must preserve the individuals' privacy and avoid questions that are likely to be interpreted as an invasion of the self. However, for certain people of a certain status, these rules change.

In the CTH, my status as a psychiatrist gave me permission to ask personal questions without risking embarrassment to myself or to the interviewed *interned-patient* and without violating the respondent's boundaries. Because of my hybrid position in the field (i.e., neither a complete insider nor an outsider), I needed less time to obtain the trust of my subjects and to become familiar with the field. Because I already had knowledge of the psychiatric asylum culture and could apply this experience to the CTH field, I was able to skip some stages.

An aforementioned *interned- patient* was unwilling to be a part of the central research sample because he feared that the legal process would be harmed in some way. In our first two conversations, he told me that there were things he would rather not talk about and situations that he would only divulge on the evaluation day. However, in our third conversation, he told me in detail a delirious plot that justified his strong anguish. I asked him if this plot was the issue that he could not tell me about. He said, "Yes it was. I don't know why I said it. I only told this to a doctor at the POC[10] and to a doctor here at the CTH. But I was brief. I did not tell them everything like I did today." One day in the courtyard, I asked a group of *interned-patients* if they would have talked to me without reservations had I not been a psychiatrist. One of them told me:

> *"No. We tell you everything because you are a doctor, understand things and help us. That day that I was not well, you talked to me and helped me. I did not even need medicine. You were like a psychologist."*

Another *interned -patient* told me, "We talk because you help us and solve things." These narratives indicate that what the *interned-patients* say has a direct relation to 'whom they say it to', as Goffman suggested (2011). In this regard, because the researcher is also a psychiatrist, the participants mentioned certain issues that would not have been brought up had the researcher been a member of a different profession. Thus, the fieldwork raised issues that were deemed important to be revealed to a psychiatrist. Perhaps another researcher could raise different issues.

We rely on Anselm Strauss and Juliet Corbin (2008) when they say that professional experience is a potential source of sensibility: it can block perception, but it can also allow researchers to move more quickly to a familiar area.

It is not possible to predict the outcomes of the present research endeavor. However, we know that the field shows us the paths to follow. Whether we follow them depends on our ability to prioritize the field's interpretations of our own. We understand that adequate interpretations are widespread within the field . However, growth depends on fruitful interactions between the field and the researcher . We know that there are questions to be raised, questions that will not be answered and narratives that will make us silent.

We conclude with an excerpt from a narrative of an IP, Arquimedes. This story highlights the aspects of victimization in the trajectories of mentally ill criminals. These people are untouchable but somehow still punished by society:

- I was in a crisis. I ended up taking the life of my own mother [...] after the fact, I went to work. Then the cops arrived. They were afraid, and they shot me three times, saying that I confronted them all, but it is not true [...]. I was not within my normal conscience. I was not taking my medication properly. I thought it was normal [...] what I did was not because I wanted to. My plan was to buy a house for my mother. Everything happened backwards. I victimized someone , but I am a victim. Here I suffer too much [...].

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Notes

1 This work was developed from an ongoing study on a custody and treatment hospital located in Brazil. That study aims to provide information for Marcia Cristina Maciel de Aguiar's Master's dissertation in the Social Sciences Graduate Program of the Federal University of Bahia under the guidance of Professor Luiz Claudio Lourenço. This task is also integrated with other studies conducted by the research group LASSOS - FUB on the prison system in the State of Bahia.

2 This is our observation.

3 To avoid exposing the patients and staff members working in this institution, we use pseudonyms and avoid mentioning other data that could identify the interviewees.

4 During the day, we noticed much movement in the wards, the courtyard and the administration. Depending on the time, there were many interned-patients in the courtyard, all of whom wore yellow uniforms. At approximately 5:00 pm, after the patients had entered the wards, the courtyard was occupied by pigeons, stray dogs, janitorial interned-staff (who cleaned the institution) and prison guards who sat on benches or chairs. The breeze was pleasant and improved as darkness approached. There was a silence in the air and a certain apparent tranquility. Sitting there sometimes felt as if we were sitting on a bench in a square while waiting for the time to pass.

5 Handmade cigarettes.

6 Security measure.

7 Marcia Cristina Maciel de Aguiar is a psychiatrist who has been working for over 26 years in public and private psychiatric institutions while performing clinical and/or administrative functions. Currently, the researcher chairs the Association for Research and Comprehensive Assistance, is the clinical and technical director of the Inacio Ferreira Center for Psychic Health and is also Assistant Professor at the Department of Mental Health and Neurosciences, School of Medicine of Bahia – UFBA.

8 This particular aspect will be addressed later in this text.

9 At the beginning of the fieldwork, we could talk to some interned-patients in the ward without the direct presence of a prison agent and/or a nurse technician. Doing so would not be possible without the medical psychiatrist title.

10 Penal Observation Center.