doi: http://dx.doi.org/10.11606/issn.1679-9836.v99i3p305-318 Rev Med (São Paulo). 2020 May-June;99(3):305-18.

# The perception of suicide as an inseparable way of violence according to young indigenous population: a study made with the Dourados Indigenous Reserve

## *A percepção do suicídio como inseparável das outras formas de violência segundo os/as jovens indígenas: um estudo de caso da Reserva Indígena de Dourados**

**Maria de Lourdes Beldi de Alcantara[1], Walter Moure[2], Zelik Trajber[3], Indiana Ramires Machado[4], Equipe de Jovens da Ação dos Jovens Indígenas de Dourados-MS[5]**

Alcanatara MLB, Moure W, Trajber Z, Machado IR, Equipe de Jovens da Ação dos Jovens Indígenas de Dourados-MS. The perception of suicide as an inseparable way of violence according to young indigenous population: a study made with the Dourados indigenous reserve / *A percepção do suicídio como inseparável das outras formas de violência segundo os/as jovens indígenas: ume studo de caso da Reserva Indígena de Dourados*. Rev Med (São Paulo). 2020 May-June;99(3):305-18.

**ABSTRACT:** This essay is focused to study and analyze the consequences of attempted implementation, through the Sistema Único de Saúde-SUS (Health Unique System), of the mental health protocol - DC-10 – among the indigenous population. In this specific case, based on a qualitative research, applying an intercultural action/participation methodology, this essay has been made in the Dourados Indigenous Reserve (Reserva Indigena de Dourados – RID), with the young people and their leaders into the Young Indigenous Population Actions - Ação dos Jovens Indígenas – AJI, acting as an informal school into the RID (Dourados Indigenous Reserve). The necessity of presenting the young indigenous people perception about their suffering, does not only brief a biomedical interpretation, but also the trauma effect they had and still have that we may define as colonial, *post traumatic cultural illness*. Whatever the name we use, they are young and already carry a silent pain which cannot be reduced as a biomedical hegemonic vision, which brings the necessity to measure how this vision may cause them traumatic experience. This situation is based on an interdisciplinary and polyphonic vision upon the phenomenology and for this reason it consists in a think/make condition.

**Keywords:** Indigenous people/psychology; Embarrassment; Ethnic violence/psychology; Suicide/psychology; Mental health in ethnic groups; Health of indigenous people; Child; Adolescent.

**RESUMO:** Esse trabalho foca estudar e analisar as consequências da tentativa de implementar, via Sistema Único de Saúde - SUS, o protocolo de saúde mental DC-10 na população indígena. Nesse caso, esse estudo, baseado numa pesquisa qualitativa com metodologia de pesquisa ação/participação/intercultural, foi e está sendo realizado na Reserva Indígena de Dourados - RID, e conta com a participação dos jovens e das lideranças jovens da Ação dos Jovens Indígenas – AJI, a qual atua como uma escola não formal dentro da RID. A necessidade de apresentar a percepção dos/as jovens indígenas sobre o sofrimento que carregam não se resume numa interpretação biomédica, mas sim, efeito dos traumas que sofreram e sofrem que se pode nomear de colonial, *post traumatic cultural illness*. Seja qual for o nome, são jovens que carregam um sofrimento silenciado e que não pode ser reduzido à visão hegemônica biomédica, o que leva à necessidade de avaliar em que medida essa visão lhes acrescenta experiências traumáticas. Essa discussão se pauta numa visão interdisciplinar e polifônica baseada na fenomenologia e, por isso, constitui-se num pensar/fazer.

**Descritores:** Povos indígenas/psicologia; Constrangimento; Violência étnica/etnologia; Violência étnica/psicologia; Suicídio/etnologia; Saúde mental em grupos étnicos; Saúde de populações

* This essay will not inform the participants names. It was a result f a free, previous, and informed consulting.

1. Professor of Medical Anthropology, FMUSP. Coordinator of the Guarani Indigenous Youth Support Group -GAPK. IWGIA Consultant. ORCID: https://orcid.org/0000-0002-3842-8307. E-mail: loubeldi@usp.br.
2. Clinical Psychologist, Institute of Psychology - USP. Coordinator of Indigenous Youth Action – AJI. ORCID: http://orcid.org/0000-0002-1999-6106 E-mail: waltermoure@yahoo.com.br.
3. Pediatrician. Works since 1999 in Mato Grosso do Sul with the indigenous population, providing services to SESAI. ORCID: https://orcid.org/0000-0001-7592-5188 E-mail: trajberz@gmail.com.
4. Kaiowá indigenous nurse works at SESAI and is a graduate student at FMUSP. ORCID: http://orcid.org/0000-0001-6182-5418. E-mail: indy.ramires@gmail.com.
5. Ação dos Jovens Indígenas da Reserva Indígena de Dourados – RID. Acts as a non-formal school in the village of Bororó. www.jovensindigenas.org.br.
**Corresponding Author:** Prof. Dra. Maria de Lourdes Beldi de Alcantara. Av. Dr. Arnaldo, 455, sala 1215, CEP 01246-903. E-mail: loubeldi@usp.br.

indígenas; Criança; Adolescente.

**Introduction**

The main objective of this essay is to make an intercultural analysis about the lack of dialogue between the mental health protocols adopted by the Sistema Único de Saúde – SUS (Health Unique System) and its implementation into the indigenous communities. Such dialogue does not occur between the health team, mainly with local health agents, causing a total unequal health knowledge and practices, where the hegemonic biomedical system prevails, with consequences that also involve other ways of violence inside of indigenous communities.

The indigenous population has the right of using the SUS (Health Unique System), according to the Brazilian Constitution of 1988[1,2], the Indigenous Health Care Subsystem - Subsistema de Atenção à Saúde Indígena (SASI-SUS) and the National Policy of Indigenous People Care Health - Política Nacional de Atenção à Saúde dos Povos Indígenas (PNASPI) that establishes:

> "the health issues aimed at the indigenous population must consider their local reality and their cultural specificity, taking a different and integrated approach and having the SUS (Health Unique System) as rearward and reference system, for this achieve some changes should occur in the services structure and organization in order to provide integration and the necessary attendance with no discrimination. (...) it is necessary that the attention to health issues are in a distinguished way, considering cultural, epidemiological and operational specificities of these population"[3].

The Ministry of Health publishes in 2007 the Ordinance 2,759, Article 1st, that stablishes the General Guidelines of Indigenous Population[4], featuring as a boundary for these people, as well as a support and respect to the capacity of several ethnicities and indigenous communities, with their values, economic systems, technologies, organization, expression and growth production. From this perspective, the psychosocial approach turns to be reasoned and consensual along with the indigenous communities. Therefore, it is also taken in consideration the traditional medical knowledge communities, with viable alternatives and consensual mechanism to approach the health problems of these communities. Not less important, according to Ordinance 2,759, the mental health problems solutions must be complied with basic attention level, and with the potentiation of the Psychosocial Care Center - *Centro de Atenção Psicossocial* – CAPS – in the corporate construction of actions in indigenous territories, especially in areas with large concentration of communities. The singular treatment of mental health in indigenous population is a progress, having scope in the deep of the specificities in a way of not imposing cultural aspects of "non indigenous people" for their psychosocial treatment, once most knowledge "psi" were set up based in other ways of cultural production and occidental interpretations. Mainly the action that goes ahead "to that involving the bond problems and the quality of encounters around the world, the people, the institutions, etc."[5,6].

However, the reality of indigenous people is the total applicability of the biomedical protocols, making the cultural diversity presented as a footnote. It turns out that the free, previous, informed appointment is not applicable in relation to the protocol viability. In other words, there is no intercultural dialogue and consequently the interculturality is not applied in relation to health protocols. The necessity of creating protocols as results of intercultural dialogue between the biomedicine and the traditional knowledge would be essential both for exercise of rights and for resignation of an intercultural practice.

This essay is based on a work done with indigenous children and young population from the Dourados Indigenous Reserve - *Reserva Indígena de Dourados* - RID, result of 20 years living together. We basically worked with issues bought by children and young people. The issues did not change during this period. Most of them refers to rejection they feel from their families, the intergenerational conflict, the lack of perspective from the future, unemployment, the prejudgment they suffer into and outside the RID. All of this reverberates in any relationship they try to have. They become unable to keep bond. Mostly it ends in violence situation. The violence is pretty much present in this social communication, both in terms of families, friends and loving relationships. The ephemerality is a standard. We believe it happens due to the lack of future perspective. It all comes down to here and now. Living in liminality, they risk everything to be able to belong to some group/place with the intention of having a more stable bond[7]. This process also includes the evangelic churches[8]. The high level of violence, and suicide as a kind of violence, are consequences of illness*. The age of this group goes from 11 to 18 years old. Few studies

* Kleimann[50] and Seppilli[51], sustain that in the western culture there is a distance or dissociation between the experience the patient has with suffering and the pain related to the disease and with the ones treated by the doctors. Frequently, in the biomedical conception, the whole world of personal and cultural experience is neglected during the treatment process. Such constant pains and suffering are responsible for the experience of *illness*. In English we have the term *disease* to nominate sickness and disorders both empirically cataloged, and the term *illness* which is considered more sensitive to suffering experience from the point of patient view and its culture, reason why these authors revalue the term *illness,* in order to be able to map the anthropological narratives and explore the disease without separate them from their culture. In the Portuguese language, although there are the words *enfermidade* and *doença*, in the imaginary environment they are mistakenly used as for the shown meanings. We may be more closely when the meaning of the words nfermidade/*doença* e *sofrimento* are properly distinguished.

analyze the causes of indigenous suicide between the young population, and those who do the studies assign the causes the consequence of having no lands and the loss of their tradition[9–12]. However, these studies do not consider the narratives of these indigenous children and young people about the perception they have about their "being in the world", their soul pains, their expectations, frustration, and the prejudice they suffer. According to Alcantara et al.[13], there is not only one cause to suicide, but several reasons that depend on the conjuncture of each historic moment[13].

### *Brief historic: laws that assure health to indigenous population*

The indigenous population, that represents 0,42% of the Brazilian population, guaranteed by the Federal Constitution in the Article 231 that recognized its social organization, behavior, language, belief and tradition, and the rights from the land this population live traditionally[2]. Besides the international agreements affirmed by Brazil: Convention 169 of International Labor Organization - da *Organização Internacional do Trabalho* (OIT)[14], about indigenous and tribal population, United Nation Declaration about Indigenous Population Rights - *Declaração das Nações Unidas sobre os Direitos dos Povos Indígenas*[15]. Summing up, the indigenous population has autonomy to choose its way of development, education, and health care, according to its behavior and tradition. In Brazil, the indigenous population is accounted for 817,963, organized in 305 native ethnic speakers of 274 languages[16]. Each ethnic knows about the body and health, as well as its own practices to promote health and disease treatment. Such practices, besides promoting health and preventing diseases into the community, they are also fundamental in the updating process of ethnic identity and the gender of Brazilian indigenous population.

### *Mental health – suicide as one of indigenous violence ways*

According to World Health Organization (WHO) data, around 800,000 people die by suicide every year. For each suicide, there are much more people that try to commit suicide[17]. The previous attempt is the most important risk factor for suicide into population in general. Being considered the second main death cause between young people around 15 and 29 years old. 79% of suicides in the world occur in countries of low or medium income. Pesticides ingestion, hanging and firearms are among the most usual methods of suicide in a global level. In Brazil, the rate of suicide in each 100 thousand inhabitants raised 7%, unlike the world rate that dropped to 9.8%, according to data from WHO. Until 2012 the rate was 4.2%, according to Health Ministry, mentioning the main causes are depression, schizophrenia, and the use of illicit drugs. Such causes could be treated and avoided in 90% of the cases, according to the *Associação Brasileira de Psiquiatria* (Brazilian Psychiatric Association)[18,19].

Regarding to indigenous population in the world, which is 300 million, we do not have a wider analysis, except the regional data which depend on the countries. This silencing situation is considered very meaningful, since it shows how this population is despised in almost entire world. Many countries do not have a census procedure focused directly to indigenous population, making a larger analysis more difficult to be done**. In this note we include Canada[20,21] that has together with Australia[22–24], more deeply studies about suicide into the indigenous population. These studies emphasize the colonial issue, the post-colonial trauma and the injustice these people suffer as cause for the high level of alcoholism, violence and suicide. Several intercultural protocols were developed to prevent suicide, alcoholism, and other drugs by constant dialogues with the indigenous young population, leaders, teachers, and health care groups. Regarding to the Americas initiatives, we find other historical facts like the creation of indigenous population autonomy facing the still "colonialism situation" made by developmentalist modern states, such as: Zapatista autonomy: "...along with creating ways of self-government, there was progress in justice and cultural, health and education collective actions allowing improvement in the communities life conditions"[25]. In Peru there are several autonomous indigenous territory models which established an intercultural protocol since the Kukama, that is remarkably like RID (Dourados Indigenous Reserve), even the Wampi population declared itself a nation[26–30]. Resulting the progress of indigenous movement against the developmentalist capitalism that threat the indigenous population survival in South America.

In Brazil, this behavior does not seem to be the one that prevails, especially in the RID (Dourados Indigenous Reserve). The mental health protocols were inserted from a biomedical vision. The health care groups implemented these protocols into the indigenous communities in 2008, with the intention to be able to avoid suicide, alcoholism, domestic violence, mainly against women and the domestic violence. According to Batista and Zanello[31], currently the practice on giving attention to mental health has assistance

**According to Pollock et al.[52], previous reviews of suicide epidemiology among Indigenous populations have tended to be less comprehensive or not systematic, and have often focused on subpopulations such as youth, high-income countries, or regions such as Oceania or the Arctic. Given that approximately 80% of the world's more than 300 million Indigenous people live in Asia, Latin America, and Africa, a comprehensive study of global suicide rates that includes low - and middle - income countries are needed.

from a technical area at SESAI, formed with psychologists, social assistants, and anthropologists, among other members that all together created a multi-professional team. They plan interdisciplinary actions in mental health, both in their secretary and at DSEIs, using different methodologies based on each demand. According to SESAI published at Health Ministry portal, suicide is the most important issue, including the launch in 2014 of Suicide Prevention Guideline in the Indigenous Population, directed to teams[32]. Generally, prevention and promotion strategies in health are recommended, with the progress of support social networks and cultural identity of the community. Therefore, there is a development of support groups, Local Therapeutic Project, Discussion Groups, among others, including the participation of Multidisciplinary Groups of Health Indigenous Population, in partnership with psychologist and/or social assistant[33].

Other line care is under FUNAI and Health Ministry (SESAI and Secretary of Attention to Health – SAS) responsibility, acting through the Intersectoral Teamwork about Mental Health and Indigenous Population (Grupo de Trabalho Intersetorial – GTI). Since 2013, the group has been analyzing the priorities and creating strategies to be applied in the territories. The GTI (Intersectoral Teamwork) approaches the psychic suffering and the use of alcohol and drugs, bringing up discussions to understand how these situations occur into the communities. As a result, the 1st Workshop about Indigenous population and the Arising Needs of Alcohol Abuse: Care, Rights and Management happened in 2016. The workshop presented as a result the recognition of the indigenous protagonist need about health, searching for an integral therapeutic Project[34].

The National Policy of Mental Health is an action from the Federal Government, coordinated by the Health Ministry that comprises the strategies and guidelines adopted to organize the assistance to people with psych suffering, including preventive and healing care of mental disorder and chemical addiction. This policy is organized in a Psychosocial Care Group (Rede de Atenção Psicossocial – RAPS), that offers plural and integral attendance, in different levels of complexity with a behavior based on scientific evidences. The CAPS (Psychosocial Care Center - Centro de Atenção Psicossocial) may be considered the main strategic point of care. Until then, the policy goes towards to strengthen the autonomy, protagonist, and the social participation[35].

In 2017, the Ordinance 2,663 was published defining suitability criteria in agreement to the indigenous movement claims[36]. CAPS (Psychosocial Care Center - Centro de Atenção Psicossocial)[3] is among the establishments observed to the care qualification.

The IAE-PI manual, launched in 2018, mentions that the financing resources to CAPS (Psychosocial Care Center - Centro de Atenção Psicossocial) comes from the recognition of this population access difficulties to RAPS (Psychosocial Care Group - Rede de Atenção Psicossocial), that are configured by the distance: geographic – between the communities and the specialized services - sociocultural – between the ways of dealing with the psych suffering[3]. It is worth mentioning that since the institution of RAPS (Rede de Atenção Psicossocial - Psychosocial Care Group) in 2011, through the Ordinance 3,088, the indigenous population was already considered priority[3,37]. The manual aims to guide the articulation between the RAPS and the DSEIs, which requires approach in technical and management levels. For this reason, an intersectoral work is extremely important, with the participation of managers and professional people from DSEIs in the agreement forums of the RAPS, besides the FUNAI and other institutions involvement. The Ordinance 2,633 aims that the CAPS be supported by the Secretaria de Saúde Estadual ou Municipal (State and Municipal Health Secretary) and determines the territory reference DSEI as the main guiding of cultural singularity of each ethnicity and the understanding of psych suffering and care[3,36].

Between this original plan and the reality there is a large empty space. The money for the CAPS implementation, as above described, comes from the federal government and from the county. However, as known, most counties are broken, and this reflects directly on the CAPS implementation, lack of specialized staff and of all resources. If the results are not so good in cities where everything was well planned, it is easy to imagine the results in the indigenous population: without specialized staff and without specific training about indigenous culture. We have the impression that it was already born to be useless. We can affirm it concerning the CAPS service made in the RID (Dourados Indigenous Reserve). According to a statement of a doctor that works for SESAI: "... applicability is impossible, it is difficult to understand the focus, the resource is not enough, it is not possible to work the health into the county, much less to reach the tribe, to know and work properly with the population" (Statement of a doctor from SESAI, 2020). Expectations and demands, that did not exist since then, are created between the indigenous population, such as, the psychologist and psychiatrist status and their biomedical skills about mental disorder, that constitute an imaginary situation that keeps nominally changing, the illness, such as depression instead of sadness, or even expression like "that person is bipolar". A new vocabulary has been recreated!

***Mato Grosso do Sul and the mental health implementation***

The Indigenous Health Special Secretary (Secretaria Especial de Saúde Indígena – SESAI), a department from Health Ministry (Ministério da Saúde - MS) was created in 2010 to assure basic attention to indigenous population health from National Policy of Indigenous Population Health Care (Política Nacional de Atenção à Saúde dos

Povos Indígenas - PNASPI). The proposal is to build a different model of health care, based on acting strategy applied in 34 Indigenous Special Sanitary Districts (Distritos Sanitários Especiais Indígenas - DSEI), as a way of assuring the rights recommended by the Unique Health System (Sistema Único de Saúde - SUS). These universal and integral health rights comply with the community needs and involve the indigenous population in all process steps of planning, execution, and evaluation of all health actions. The SESAI highlighted assignments are developing actions of integral care of indigenous health and education, in line with policies and SUS programs, observing indigenous traditional health practices; and performing actions of indigenous health sanitation and buildings. The SESAI acting scope embraces a population of 765,600 people living in 5,614 tribes with 360 Base Polo and 68 Indigenous Health Care Centers (Casas de Saúde Indígenas - CASAI).

According to DSEI, the states with higher suicide levels are Alto Solimões: 172 cases (32.11%), and Mato Grosso do Sul: 152 cases (23.05%), 13 cases (1.8%) were caused by exogenous intoxication of an indeterminate intention (CID Y14 a Y19) and also by hanging.

Referring to the Dourados Indigenous Reserve, we have the following suicide and violence data, according to SESAI: The reported violence situations, on below table, the violence acts rates seem to be very curious, such as: bicycle and wagon accidents, running over, suspected fracture, burning. According to SESAI, in Dourados, these rates are made when there is a suspicious of another person participation. They are not protocols, but registered data based on complaints of indigenous population that looks for service. Example: the bicycle fall caused an abortion, so this is considered a violence situation, in other words, this seems to be a purposeful act.

### *Suicide Data*

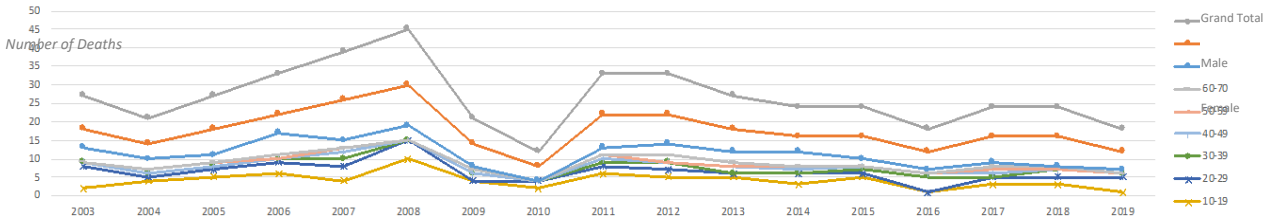


**Gráfico 1:** Suicide Mortality by Gender. Data informed by SESAI-MS

**Gráfico 2:** Mortality Comparison by Suicide and Aggression in Dourados Reserve (MS). Data informed by SESAI-MS

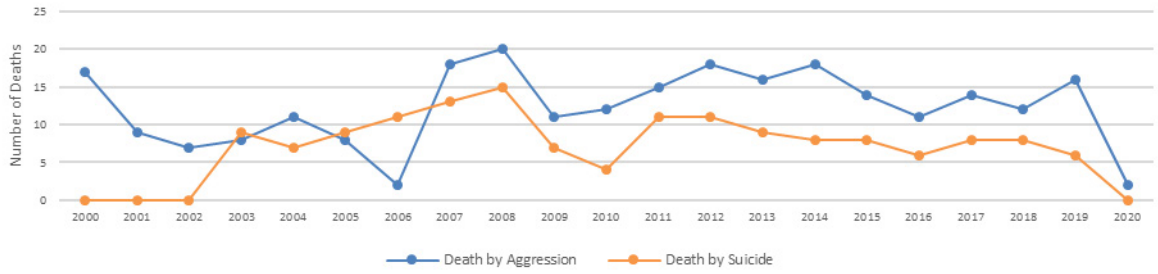


**Gráfico 3:** Annual Total of Aggression in Dourados Reserve (MS). Data informed by SESAI-MS

It is clearly noted that the violence data overtake both the suicide ones and age rates. In 2008 there was an increase on death numbers caused by suicide and domestic violence. However, the situation where there is no death is really scared as we may see in the above table. One of the reasons we may consider is that at this moment a change has occurred in structural terms at RID (Dourados Indigenous Reserve), since the RID implementation, the indigenous "Capitan" was chosen by the Head of SPI/ Funai Post, acting as the main "character", essential for social and political issues. Such "character" was formally removed due to a decree from the Funai President in 2008. Levi[10] argued that even with this decree, the "character" keeps existing on most kaiowá and guarani reserves, but it does not have anything that matches a bureaucratic and administrative tools, not even defined laws or a legislative staff to whom it can appeal. It frequently suffers legitimacy attack, facing the opposition that inevitable position themselves out of the political composition the "character" articulated to take the position of "Capitan" and acquires privilege in the services administration. By the character dismissal of the "Capitan" and the weakening of the Funai Head role, an organizing empty space was created into the reserves, creating a favorable environment creating conflict expressions and unpunished offense situation. We may consider that a repercussion of a program implemented in 2005 about a great innutrition complaint that was occurring in RID (Dourados Indigenous Reserve), made the federal government elaborate multidisciplinary policies aiming the attempt of decreasing the suicide rates between the young indigenous population and its unhealthy work, such as cutting sugar cane on farms around. All these situations appeared from top to bottom, reflecting a huge breakdown into the social context of RID (Dourados Indigenous Reserve).

## METHOD

Starting from research/action/participant which has, as main premise, the "diving" of the researcher in its labor camp. Only by living together, it can create a kind of complicity with the purpose of stablishing a dialogue that tends to harmony. At this point, there is no more study object but the interlocutor. The result of this kind of methodology is building an intercultural dialogue with a view of post-colonial school[38–42], since it refers to polysemic and polyphonic interacting with dialogues that results in a hybrid narrative. Knowledge that always creates a border causing new narratives, places, and subjects. As mentioned by Guimarães Rosa[43]: "*Look and aim; the most important and beautiful, in the world, is to see that people are not always the same, they are not finished – but they are constantly changing*". Or as conceived by Bakhtin[44]: "*The half of a word belongs to me, the other part belongs to its interlocutor*", resulting in ontological and epistemological processes.

Therefore, this research result is mostly qualitative. Since without it we cannot analyze the statistics that show the violence rate, including suicide.

There were several conversation groups with young people of Indigenous Young Population Action (Ação dos Jovens Indígenas), health agents and indigenous nurses. All voices presented had previous informed free permission.

The themes for each conversation group were frequently brought by the indigenous young people and agents.

The themes mostly referred to daily/events that caused a huge unwell situation.

### *Brief history: indigenous population in Mato Grosso do Sul*

This indigenous population condition in Mato Grosso do Sul is extremely vulnerable. It is the second state with the largest indigenous population in Brazil, 80,459 inhabitants, located in 29 counties. Mato Grosso do Sul is represented by 08 ethnicities: guarani, kaiowá, terena, kadwéu, kinikinaw, atikun, ofaié e guató[45]. They live in the most fertile lands in the country, one of the birthplaces of agribusiness. The territorial disputes mark one of the most disparate conflicts against the indigenous population. Many communities live on the side of roads with no resources. The reserves that were legalized in beginning of 20th Century live nowadays in extremely poverty. One of the most critical reserve is the Dourados-RID, considered the most populous in Brazil, around 18,000 people living in 3,560 acres, most of which are children and young people. Dourados Reserve is considered the most violent and presents one of the higher rates of suicide and domestic violence.

The Dourados Indigenous Reserve (RID) is inhabited by two ethnic groups, the guarani and aruak: the ñandeva and kaiowá guarani, and the terena aruak. Most guarani population keeps the native language, unlike the terena. There is between them a "progress" classification: "the most of terena population is white, the ñandeva population is between, but the kaiowa…". It also shows the economic situation of the Dourados Indigenous Reserve - RID. Obviously it does not correspond to reality, but it sure reflects the result of civilizing process imposed by the Brazilian governments since the beginning 20th Century and of all civilizing process that depicted the indigenous policy, since the Indigenous Protection Service (Serviço de Proteção ao Índio – SPI) until current days by the Indigenous People National Foundation (Fundação Nacional do Índio – FUNAI).

The continuous circulation and traffic feature the Dourados Indigenous Reserve - RDI. The RDI population lives within 5 km from the second larger city in Mato Grosso do Sul-MS, 100 Km far from the border with

Paraguay. All and any kind of consume and services are made in Dourados. The lack of work and lands make the young population to find jobs out of the reserve. The public sector is the unique that offers job: indigenous schools, Special Secretary of Indigenous Care Health (Secretaria Especial de Saúde Indígena - SESAI), Indigenous National Foundation (Fundação Nacional do Índio – FUNAI). Until 2015 most of the young indigenous people worked in cutting sugar cane, but with the use of machines in this planting type, they started working in the apple harvest in Paraná and Santa Catarina, resulting a long time spent far from the families.

There is no food production, besides small subsistence planting, most of food and clothes are gotten in stores in Dourados.

It demonstrates a deep social-economic, political, and cultural change[8]. This change becomes a standard of how the discrimination, social exclusion creates a completely asymmetric dialogue on which the indigenous population appears as a second category citizen.

***Suicide symptoms***

The suicide has not only one cause, but many of them, as already studied by Alcântara (2008), it depends on the historic moment and the relation the indigenous people have with such situation. The main symptoms are sadness, social isolation, abandon, vision, callings, fears[8].

Most of the time, the symptoms or manifestations of a probable suicide are seen by the families, but they see themselves powerless for taking any decision. First because the indigenous young people refuse themselves to see a blessing or to go to the Pentecostal church. Second, because the distances of these indigenous young people from their family members is necessary, since they are bewitched.

The sadness is a symptom that brings more than occidental etiology. It is at the same time a state of mind sent by the witchcraft. It comes from outside. Who is affected has no control. The "bewitched" person acts as if she/he was out of his/her mind and he/she is not responsible by his/her acts. The symptoms of this illness are the silence, the social distance and the visions of friends who committed suicide.

> "*They become different, keep themselves away from the others, put in their minds they are excluded from the family or they don't even talk ... just keep for themselves due to a lack of thrust to confess about what is happening, so they end up dying quietly*" (Statement of a health agent, July/2018)

> "*We realize when they are going to commit suicide, in some cases. They even comment that they hear voices and sometimes see friends that had already committed suicide in certain places*" (Statement of a teacher, December/2017)

> "*Only sometimes we realize when they can kill themselves. They seem to be so unhappy, do not talk to anybody, do not eat. Then they start to drink alcohol, to smoke and then he/she will commit…the family is who suffers*" (Statement of a health agent, November/2017)

> "*By what I have seen, the sadness and the distance from living with others are the most usual symptom*" (Statement of a teacher, January/2019)

Suicide causes have intimate relationship with other ways of violence: the indigenous young people polysemy.

***Witchcraft***

It is caused by envy, jealous, revenge. Usually when the body is weak, in other words, detached from the soul.

According to Csordas[46] the approach of corporeality comes from the methodological premise that the body is not an object to be studied in relation to culture, but it is the culture subject; in other words, the culture existential base. Complementing Mauss[47] the body is simultaneously the original object which culture working is developed and the original tool with the work is made. It is, at once, a technique object, a mean of technique and subjective origin of the technique.

Therefore, the body is the culture activity, it must be in its full well-being. When the witchcraft "takes" the body it represents not only the unwell of the person, but also the unwell of the community, putting it in great risk. The body operates at the same time the sensory modalities, social interaction, and the meaning attribution. The witchcraft is an unwell manifestation of the activities between person/subject and the community. All indigenous people take the risk of bewitched and it scares the whole community. Especially when the community suffers "an eternal" post-colonial trauma, Post Traumatic Cultural Illness - PSTCI, including the genocide and the socio-cultural body disarticulation.

There are several witchcraft classifications, those which are made to kill, like suicide, those which are made to cause disease, etc. The witchcraft is always ordered by someone who has somebody that represents certain disarrangement into the community/family.

***Family incomprehension***

The reasons why the indigenous young population commit suicide are usual in our conversation circles of "tereré" (cold drink made with water and mate herb served in a bowl), the family problem is the biggest reason. They fell themselves misunderstood and not accepted by the parents:

> "*everything we do or say... we are cursed, they say that we are no good, that we don't help, we only pay for badness and the words keep in our minds, when I hear all*

*these cursing words I wish to die*" (Statement of a young indigenous girl, April/2019).

On the other hand, the parents do not also understand the children and much less accept their behavior. The complains are frequently:

"*Our children don't help, they only think about hanging out, drinking and listening to music very loud, they don't want to work and study, they live on the road, when we need them, they are never here to help us, what are they for?*" (Conversation with mothers in Bororó, January/2017).

Without a place to talk, the violence becomes the ordinary language:

"*Today's young people do not have a nice environment in their houses and families, their families don't want to accept the today's young people as they want to be, the way of dressing and even the music they like, such as rap, funk, dance, they already think that the music and the clothes are marijuana stuffs, without showing interest to know why they are wearing such clothes or listening these kind of music*". (Statement of a health agent. July/2018)

"*Most of parents make use of alcoholic drinks causing conflicts between father and mother, and domestic violence*" (Statement of a health agent, July/2018)

"*My son only gives me attention if I hit him" ... "my daughter is lost; she only thinks of hanging out and I never know if she will return...*" (Statement of a health agent, July/2018).

The financial conditions are always pointed out, since the parents cannot fulfill the children wishes. The consume appeals bring to parents and children scorn and degradation feelings, make the parents feel like depreciated for being unable to buy a cell phone, for example, it becomes an exclusion problem and it also affects all self-esteem scopes and it is an obstacle in the subjectivation process.

"*sometimes the suicide starts when there are many problems, not enough money, no structure to have a decent life*"
(Statement of a health agent, July/2018).

"*For not having affection from the Family, there is no condition to have clothes or shoes to go to school, he/she is not baptized by the shaman (pajé), or he/she is bewitched*" (Statement of a health agent, July/ 2018).

***Out of place***

The out of place feeling reaches all parts of these young indigenous people life, since they are not accepted by the family, they began to create/attend the "gangs" which are features for being ephemeral, these "gangs" are formed by affinity, not by age. They are violent between themselves. Fights are constant in their lives:

"*Just drink a little that starts to talk nonsense to each other and then a big fight begins that almost ends in stab*". (Statement of a young girl of AJI, January/2018).

"*(...) we think everybody is friend, but when we drink one starts to attack the other, we are no longer friend...*" (Statement of a young girl of AJI, December/2019).

"*(...) usually when we drink or smoke the girls start to offer themselves to men, they start to fight for the girls, sometimes it ends to death.*" (Statement of an indigenous young girl, November/2019)

The lack of alternative life necessarily takes them to the use of drugs and alcoholism. Even those who work in the apple harvest in north of Parana and Santa Catarina also make use of drugs. In many statements of these young indigenous people, they mention the work is strenuous and they miss their families and friends very much, so they need drugs and alcohol to forget these feelings.

With not soon possibility, they live day by day, never using a verb in a future tense, since the past brings a present/past full of difficulties, impediments, and trauma, leaving no choice with no hope.

In these almost always permanent present/past and no future situations, they search for answers that most of the time comes as witchcraft, as consequence of envy and revenge.

"*I am sure that she made a witchcraft for me, I tried to kill myself several times, I was really bad, I saw no future and then suddenly I was hanging myself. If my mother had not arrived. She wanted my boyfriend. I know she stayed with him...*" (Statement of a 14 years old indigenous young girl, July/2018).

"*(...) I thought many times to kill myself, nobody loves me, I have no friends, family, I am alone, I am sure nobody will miss me, nobody likes me, I think there is a witchcraft on me!*" (Statement of a 12 years old indigenous young girl, November/2018).

"*(...) people here are very envious, when they see us with a new clothe, they start to say we are bad people, they talk all kind of bad things, they cast witchcraft, we start being sad and sometimes we don't even know why, and then…think about the rope!*" (Statement of a 17 years old indigenous young girl, January/2018).

"*It is difficult to live here, I wish I could leave, but to where? I have no relatives in any other place. We are not away from witchcraft here, they do anything, and I have no money to pay, right now I am sad, I only think about*

*that…it is the witchcraft!*" (Statement of a 15 years old indigenous young girl, March/2017).

The health agents and teachers hear the same speech, at the same time they assume that the suicide is the result of family breakdown, lack of economic resources, however the witchcraft is the main cause.

"*Some families say that it is the witchcraft, they say that other person harmed another, some of them dance and pray for not bring another witchcraft*" (Statement of a health agent from Bororo, July/2018).

"*Most of the time as a witchcraft. The traditional indigenous people make sympathies and witchcraft in their bodies*". (Statement of a teacher, December/2017).

"*Most people say that it is "macumba", the young boy/ girl was cursed and killed himself/herself*". (Statement of a health agent, July/2018).

"*He/She thinks it is good to die; when he/she is attacked by a witchcraft, he/she wants to die*" (Statement of a health agent, July/2018).

The lack of authority and the disrespect to the leaders and shaman (pajés) cause the community breakdown and the evangelical churches take place as leaders. Nowadays there are around 80 evangelical churches in Dourados Indigenous Reserve (RID).

"*There is no more shaman (pajé) with wisdom as before*." (Statement of a health agent, July/2017).

"*The Captain does nothing; it only disturbs because we ask for help and it does nothing. I think it should talk to us*." (Statement of a health agent, July/2017).

"*(...) the old shaman (pajé) does not exist anymore and the ones we have here do nothing. The Captain resolves nothing*" (Statement of a health agent, July/2017).

"*The Captain has no action, only makes data survey with the police*" (Statement of a health agent, July/2017).

*"(...) the today's young people do not trust in the shaman (pajé), much less in the Captain, they mock the shaman (pajé), even the shaman children need to see the psychologist*" (Statement of a health agent. July/2017).

*"(...) only the church can help, see this/that person... he/she was lost and now he/she is not…he/she goes to church and changed. He or She helps the parents, he/she is not on the roads anymore ...*" (Statement of a health agent. July/2017).

"*(...) in the church we star to respect each other...it is truth. Only the church can remove the witchcraft…*" (Statement of a health agent. July/2017).

"*(...) the pastor knows everything, even who made the witchcraft...he reveals...I am afraid of him.*" (Statement of a health agent. July/2017).

***Drugs***

The use of drugs, which is exceptionally large in the Dourados Indigenous Reserve (RID), is apparently associated to the lack of work and recreation, since the young people have no activity besides dancing in other cities. But it is overly complex. For many of them it is a way of earning money by becoming the person who traffics drugs, like "mules". The statements show the drug has a significant role at the every day life for them: search for self-esteem, belonging, courage, economic chance, etc.

By the opinion of some agents and teachers:

"*The use of drugs is a way of recreation for them, or they believe that just try once it will be cool*" (Statement of a health agent, July/2017).

"*Drugs are good in the beginning, but then they become addicted, they lose control and start stealing*" (Statement of a health agent, July/2017).

"*The drugs are a very usual subjects in the Community, most of the young people see drugs as something that turns things better than the depressing situation, others see as the profit generation and others consider them as something really terrible*" (Statement of a teacher, July/2018).

"*Drugs are like escape. In all possible ways.*" (Statement of a teacher, July/2018).

"*Drugs are something that do not bring danger to your life, that won't even harm your behavior in the Community and family*" (Statement of a teacher, July/2018).

To the young people:

"*When I drink or smoke, I know I can do anything, you don't know what is good, I could stay drunk or drugged all the time*" (Statement of a 13 years old girl, September/2018).

"*When I smoke, I feel myself very brave, even beautiful, I start feeling no fears, that is good.*" (Statement of a 17 years old girl, September/2018).

"*When I drink, I feel no pain... no sadness, there are lot of people by my side, I like that.*" (Statement of a 15 years old girl, September/2018).

"*I like smoking and drinking because I forget everything: hunger, lack of money, I don't care what people say.*" (Statement of a 17 years old girl, September/2018).

"*We are nothing, but when I drink and smoke, I am*

*everything, people begin to be afraid of me, it is good!*" (Statement of a 13 years old girl, September/2018).

***Solutions brought by health agent and teacher narratives***

Most interlocutors realize the young people are abandoned, they have no place in the Community, so the suicide for them is a mixture of several factors: lack of economic perspective, continuous obstacle in life process, and the witchcraft, most of the time is the causer of all social and economic failures.

The solution in the conjugation of welcome, affection and at the same time to offer a real-life opportunity with education and work.

"*People never know when somebody will commit suicide. But I believe in dialogue. To show that living is so good for people who think in take their own lives*" (Statement of a teacher, July/2018).

"*Seeking approximation, getting trust, guiding the person for solving the problem, according to lived context.*" (Statement of a teacher, July/2018).

"*There must be dialogue, understanding, talking, affection.*" (Statement of a health agent, September/2018).

"*I believe in a spiritual vision it is the only that wins. With many churches and Christians are blessing the tribe expelling the bad spirits. Ina psychological view it is important to work in a way the teenagers and adults may express their problems to work, specifically the self-esteem*" (Statement of a teacher, July/2018).

We noted on the above speech there is a huge ambiguity between the solutions at the same time the socio-economic causes are also mentioned. They come together with the traditional and biomedical speeches. With the presence of psychologist in the Dourados Indigenous Reserve (RID), the agents and teachers start to work with the social role of the psychologists. It may help, but they know it will not be the solution, since the problem is communitarian discomfort, and only the spiritual healing will have success. There is a conflict between the biomedical language and the spiritual practices, the evangelic ritual, the "macumba" ritual, and at last the shaman (pajé) by his lack of symbolic effectiveness. The accession of evangelic churches comes mainly by the fact of being the place where the witchcraft reveal happens and probably who made the witchcraft. The mental health team is mentioned and even visited, however there is no treatment support.

Even for the young population the mental health team action is not truly clear, they do not understand, and the fact these young people visiting the team, means they are problem for the community. There is no communitarian acknowledgement that this young boy/girl will not be inserted again in the social context. The gossip has an important role in this context, since as it may introduce or not these young people, it becomes a networking that keeps the situation of continuous social structure. Gossip as protection net in the community, may also be like this between the health agents, although these agents know the secret is an (occidental) ethical duty, they have an extremely importance role to protect through "gossip" who may threaten social and biologically the community.

***Intercultural discussion: bonder narratives***

The suicide[8] has always been seen, for most of Amerindian people, as result of a great witchcraft. The tupi-guarani population was the first to be reported by the Jesuits, in the 23rd Century, for the practice of suicide besides anthropophagy. However, if these practices were a kind of epidemic, as affirmed by the biomedicine and mental health studies, these ethnicities had already disappeared. Nevertheless, what happens is the opposite, the tupi-guarani population was the first to be contacted by Portuguese and Spanish people, and among the countless exterminated population, these native people stayed alive. Therefore, the question remains: Are these native population marked by suicide?

Our study is more focused in the indigenous young population that attend the AJI. They are children and young people considered highly vulnerable, since they are largely the result of broken marriage, becoming them "guachos" (adopted children), toxic-dependent and/or with high consume of alcoholic drinks. Most of them study in RID schools and have their "gangs", according the way they nominate, which are no longer formed by age group but by affinity.

These young people bring with them an emotional weakness/vulnerability. The violence define the relationship for these group.

There are several situations without any reference point, not even in the family, in extensive or nuclear fragment, in the leaders, teachers and health agents.

There is no intergenerational dialogue, the oldest people are no longer respected by the fact they are not give considered examples. The meaning of a community that structures the indigenous culture is passing by a huge individualization process. Mostly as a result of evangelical churches that bring the protestant ethics as a synonym of individualization[48]. But these churches carry a great contradiction - while having this purpose, they are also the attempt for meeting the large family. Most of evangelical churches are frequented only by families, resulting a great number in the Dourados Indigenous Reserve (RID), making the family to have a great prestige in the community. Inside this dynamic that the evangelical church provides, it resignify the protestant ethic.

However, during the last 5 years the Pentecostal churches have had a great influence that wanders the

attempt of the large family congregation, and from this point that the main leaderships come from, both within the RID and health staff, schools and centers linked to city hall. These churches are showing a hegemonic status in the dialogue with the non-indigenous people, assuring political command posts. A young boy mentions that he frequently suffers with pursuit from leaders, people involved with these churches and for having some relatives who are traditional religious leaders - Pajes". "... I have been pursued and threatened...people say I have the demon inside me, they say terrible things of my prayer relatives...I am really scared. Me and my mother's house were robbed, I am afraid of be outside home".

These reports demonstrate a new RID status. If there was a tense situation between these churches and traditional leaderships, now they face persecution and an open dispute. It worries a lot since these churches have a very repressive attitude in relation to young people, condemning and exposing them.

***Domestic violence: an answer for suicide?***

The domestic violence was always presented and was justified by alcoholism or by drug use, as the person was possessed by another and being not responsible for the committed acts. However, this position has been replaced by diagnoses of biomedicine implanted by the biomedical health system.

When we speak about violence between young population, it brings other characteristics: indiscriminate use of drugs made them empower themselves, with no fear, becoming "a real warrior, a real Indian" as people use to say, "we don't take outrage home, we don't accept being cursed and discriminated".

The access to many types of drugs they have since they live on Paraguay and Bolivia bonders, make their use be early and constant. The most used drug is the "baptized crack" – Why is it baptized? "because the drugs from White people are weak".

The addicted people baptize the drugs with substances that make them more powerful. They always use the drugs in affinity groups, compounded by boys and girls. These groups have very fragile ties of belonging, any insult, any insinuation regarding the girlfriend of one of them, or vice versa, generates fights which usually ends in death.

The dancing parties that happen in RID usually ends the same way, fights between young people of "gangs" and inside these gangs, being the partners dispute the most common. The introduction of funk like a suburb culture make them feel at these groups because of the marginalization of the such situation changed these young people habits regarding to body conception and the relationship with their partners, creating deep family, social political and religious leader conflicts. The social exclusion of these young people generates more conflicts and violence.

**Final considerations about suicide as an inseparable way from other ways of violence in RID**

The suicide has no cause, but a set of causes which is the results of its historic moment. It is considered a worldwide worry, nevertheless, related to indigenous population, suicide must be analyzed into this population sociocultural context.

Although, as known, we still have few reliable data about what happens with young people which have little difference between genders. Indigenous population is the most vulnerable in the world, representing the highest index of poverty, education with few work opportunities out of their communities, little access to health and sanitary systems, according to reports from Indigenous Issues Forum from United Nation Organization.

In relation to Brazil, the indigenous population has equal rights to all citizens, however, they suffer a deep social and economic discrimination. Causing a constant uneasiness, mainly between Young indigenous people.

The indigenous people suicide rate in Brazil has become a public health concern since 2006. A mental health protocol is made based on the International Statistical Classification of Diseases and Related Health Problems, which means a posture totally biomedical in relation to mental health.

In Dourados the suicide is a result of many factors: the weakness of political and religious leadership together with the changes on social relations, such as: from extensive family to nuclear family, the change on women and young people social role, the economic changes that depend exclusively on work opportunities into and outside the Dourados Indigenous Reserve, the frequent traffic with the city, changing the imaginary/expectation/impediments of young indigenous people. Not to mention the issue of constant confinement and expulsion they suffer related to their traditional territory. Their territories are highly disputed by agribusiness which is supported by developmentalist policies applied by Brazilian state, being strongly represented by the ruralism group in the congress.

Although, the indigenous young people do not have a complete narrative of such constant expulsion that brings an extreme violence to the indigenous population, they report pieces of this narrative that are seen by some activities, mainly drawing, that are made in AJI[49]. The loss of someone in the family by violence, neglect and death is very frequently. We may confirm they suffer of a colonial trauma that they silently carry with them.

During these last years, the dialogue with the non-indigenous people is marked by the proximity of the city, the high use of crack, the social rejection into and outside of RID, building an empty space of ephemeral belongings. The friendship and dating ties are extremely fragile, being

one of the most common cause of suicide.

On the other hand, the high consume of drugs brings a significant change into the relation between these indigenous young people, by the fact they feel empowered, make them feel well, encouraged, resulting in a high level of violence between them.

As a consequence, there is an increase of the Guardian Council (Conselho Tutelar) intervention, an occidental institution which is defendant by the community to solve its own internal problems, and the ineffectiveness of the community to solve such problems, creating many other problems.

The same happens with the *ipses litteris* implementation of health programs from SUS, without the previous, free, and informed consultation, resulting in demands/needs that bring biomedical classifications about suffering phenomenon that have still been resonated by the indigenous population. This new demand comes accompanied with a "new" expectation of the soul pain may be solved, nevertheless, it creates frustration and damages in relation to white people culture. There is no qualified attention and the medication is indiscriminately given. The diagnostics based on CID 10 are not appropriate and consequently the medications. The conclusion is that there is poor treatment adherence, since the antidepressants cause malaise for not having a specialize support, and on the other hand the indigenous people want to be heard and understood and not only medicated.

The implemented health policy has an effect of violence against the indigenous population that can never be neglected when all kinds of violence that occur into the Reserve are evaluated. It may be reflected by the massive inclusion of non-indigenous institutional departments acting into the Reserve. Due to the lack of an indigenous policy defined by the self determination of them, favoring the acting of non-indigenous institutions with protocols that are not made based on inter-ethic reality.

This situation comes totally against the health conception of a strategy plan from OPS-2014/19. "To make stronger the capacity of the health sector to approach the social determinants, through the adoption pf a health strategy in all policies."

## RETERENCES


1. Teixeira CC. Fundação Nacional de Saúde: a política brasileira de saúde indígena vista através de um museu. Etnografica. 2008;12(2):323-51. Disponível em: http://journals.openedition.org/etnografica/1733.
2. Brasil. Presidência da República, Casa Civil. Constituição da República Federativa do Brasil de 1988. Brasiilia, DF; 1988. Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm.
3. Incentivo à atenção especializada aos povos indígenas (IAE-PI): manual de orientação. Disponível em: https://portalarquivos2.saude.gov.br/images/pdf/2018/marco/21/20180206-Manual-IAE-PI.pdf
4. Brasil. Ministério da Saúde. Portaria nº 2.759, de 25 de outubro de 2007. Brasil; 2007. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2007/prt2759_25_10_2007.html
5. Saúde Mental dos Povos Indígenas do Brasil. 2015. Disponível em: http://redehumanizasus.net/90072-saude-mental-dos-povos-indigenas-do-brasil/.
6. Stock BS. Os povos indígenas e a política de saúde mental no Brasil: composição simétrica de saberes para a construção do presente. Cad IHU Ideias (UNISINOS). 2011;9(145).
7. Turner VW. The ritual process: structure and anti-structure. Chicago: Aldine Publishing Co.; 1969.
8. Alcântara MLB. Jovens indígenas e lugares de pertencimento. São paulo: EDUSP; 2008.
9. Brand AJ. O impacto da perda da terra sobre a tradição Kaiowá/Guarani: os difíceis caminhos da palavra [tese]. Porto Alegre: Pontifícia Universidade Católica do Rio Grande do Sul; 1997.
10. Pereira LM. Expropriação dos territórios kaiowá e guarani: Implicações nos processos de reprodução social e sentidos atribuídos às ações para reaver territórios-tekoharã. Rev Antropol UFSCar. 2012;4(2):124-33. Disponível em: http://www.rau.ufscar.br/wp-content/uploads/2015/05/vol4no2_07.LEVI_.pdf.
11. Chamorro G. Imagens espaciais utópicas. Símbolos de liberdade e desterro nos povos guarani. Indiana. 2010;27:79-108. Disponível em: https://www.iai.spk-berlin.de/fileadmin/dokumentenbibliothek/Indiana/Indiana_27/IND_27_2010_79-107_Chamorro.pdf.
12. Melià B. Un extranjero en su tierra : el Avá-Guaraní. In: Una nación, dos culturas. CEPAG; 1997. p. 23–8.
13. Alcântara MLB. Suicídio adolescente em povos indígenas: 3 estudos. IWGIA/UNICEF; 2014.
14. Brasil. Decreto nº 5.051, de 19 de abril de 2004. 2004. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2004-2006/2004/decreto/d5051.htm.
15. Nações Unidas. Declaração das Nações Unidas sobre os Direitos dos Povos Indígenas. Rio de Janeiro; 2008. Disponível em: http://www.funai.gov.br/arquivos/conteudo/cogedi/pdf/LEGISLACAO_INDIGENISTA/Legislacao-Fundamental/ONU-13-09-2007.pdf.
16. Instituto Brasileiro de Geografia e Estatística - IBGE. Censo Demográfico 2010. Características da população e dos domicílios. Disponível em: https://biblioteca.ibge.gov.br/visualizacao/periodicos/93/cd_2010_caracteristicas_populacao_domicilios.pdf
17. Organização Mundial de Saúde. Relatório mundial da saúde. Saúde mental: nova concepção, nova esperança. Genebra;

2001. Disponível em: https://www.who.int/whr/2001/en/whr01_po.pdf?ua=1

18. Setembro Amarelo: taxa de suicídio aumenta 7% no Brasil em seis anos. 2019. Disponível em: https://pebmed.com.br/setembro-amarelo-taxa-de-suicidio-aumenta-7-no-brasil-em-seis-anos/.

19. Brasil. Ministério da Saúde. Reforma psiquiátrica e política de saúde mental no Brasil. Conferência Regional de Reforma dos Serviços de Saúde Mental: 15 anos depois de Caracas. Brasília; 2005. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/Relatorio15_anos_Caracas.pdf.

20. Macintosh C. Indigenous mental health: Imagining a future where action follows obligations and promises. Alta Law Rev. 2017;54(3):589-610. doi: https://doi.org/10.29173/alr763.

21. Rhodes P, Langtiw C. Why clinical psychology needs to engage in community-based approaches to mental health. Aust Psychol. 2018;53(5):377-82. http://doi.wiley.com/10.1111/ap.12347.

22. McDonald H. East Kimberley concepts of health and illness: a contribution to Intercultural Health Programs in Northern Australia. Aust Aborig Stud. 2006;(2):86-97. Available from: https://search.informit.com.au/documentSummary;dn=429992484938647;res=IELAPA

23. Shand FL, Ridani R, Tighe J, Christensen H. The effectiveness of a suicide prevention app for indigenous Australian youths: study protocol for a randomized controlled trial. Trials. 2013;14(1):396. https://doi.org/10.1186/1745-6215-14-396.

24. Silburn S, Glaskin B, Henry D, Drew N. Preventing suicide among indigenous Australians. In: Purdie N, Dudgeon P, Walker R, editors. Working together: aboriginal and torres strait islander mental health and wellbeing principles and practice. Australia: Commonwealth of Australia; 2014 p.91-104. Disponível em: https://core.ac.uk/download/pdf/36780809.pdf#page=125.

25. Diez J. Os múltiplos processos de construção da autonomia do movimento zapatista. Ciên Sociais Unisinos. 2012;48(3):215-24. Disponível em: http://revistas.unisinos.br/index.php/ciencias_sociais/article/view/2648.

26. Coordinadora Regional de los Pueblos Indígenas de San Lorenzo (CORPI), Grupo de Trabajo Racimos de Ungurahui, Grupo Internacional de Trabajo sobre Asuntos Indígenas (IWGIA), Hierro PG, Tirado AC, Calonge AS, editores. Una historia para el futuro: territorios y pueblos indígenas en Alto Amazonas. Santa Cruz de la Sierra: Ed. CORPI; 2002. Disponível em: https://www.iwgia.org/images/publications/0345_Una_Historia_para_el_Futuro.pdf.

27. Chirif A. ¿Cuál es la situación de los territorios indígenas en la coyuntura actual? SERVINDI; 2015. Disponível em: https://www.servindi.org/actualidad/134946.

28. Chirif A, Hierro PG. Marcando territorio: progresos y limitaciones de la titulación de territorios indígenas en la Amazonia. IWGIA; 2007. Disponível em: https://www.iwgia.org/es/recursos/publicaciones/317-libros/2825-marcando-territorio-progresos-y-limitaciones-de-la-titulacin-de-territorios-indgenas-en-la-amazonia.html.

29. Chirif A, Hierro PG, Smith RC. El indígena y su territorio son uno solo. Estrategias para la defensa de los pueblos y territorio indígenas en la cuenca amazónica. Lima: OXFAM América, Coordinadora de las Organizaciones Indígenas de la Cuenca Amazónica (COICA); 1991.

30. Pueblo Wampis conforma primer gobierno autónomo indígena del Perú. Peru: SERVINDI; 2015. Disponível em: https://www.servindi.org/actualidad/144577.

31. Batista MQ, Zanello V. Saúde mental em contextos indígenas: escassez de pesquisas brasileiras, invisibilidade das diferenças. Estud Psicol. 2016;21(4):403-14. https://doi.org/10.5935/1678-4669.20160039.

32. Brasil. Ministério da Saúde. Setembro Amarelo Ministério da Saúde lança Agenda Estratégica de Prevenção do Suicídio. Brasília; 2017. Disponível em: https://www.cvv.org.br/wp-content/uploads/2017/09/Boletim_suicidio_MS_set17.pdf.

33. Brasil. Ministério da Saúde. Secretaria Especial de Saúde Indígena. Relatório de gestão do exercício de 2016. Brasília; 2016. Disponível em: https://www.saude.gov.br/images/pdf/2017/abril/26/RG-SESAI-2016-Versao-Final.pdf.

34. Fundação Nacional do Índio, Ministério da Saúde, Secretaria Especial de Saúde Indígena; Secretaria de Atenção à Saúde, Fundação Oswaldo Cruz. I Oficina sobre Povos Indígenas e Necessidades Decorrentes do Uso do Álcool: Cuidado, Direitos e Gestão. Relatório executivo. Brasília: Funai, MS, Sesai, SAS, Fiocruz; 2018. http://www.funai.gov.br/arquivos/conteudo/cogedi/pdf/Outras_Publicacoes/Relatorio_Execuvito_Oficina_Povos_Indigenas_Alcool/Relatorio_Executivo_Oficina_Povos_Indigenas_Alcool.pdf

35. Brasil. Ministério da Saúde. Cadernos de atenção básica: saúde mental. Brasília: Ministério da Saúde; 2013.

36. Brasil. Ministério da Saúde. Portaria Nº 2.663, DE 9 DE OUTUBRO DE 2019. 2019. Disponível em: http://www.in.gov.br/web/dou/-/portaria-n-2.663-de-9-de-outubro-de-2019-221313223

37. Brasil. Ministério da Saúde. Portaria nº 3.088, de 23 de dezembro de 2011. BrASÍLIA; 2011. Disponível em: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt3088_23_12_2011_rep.html.

38. Said EW. Orientalism. New York: Pantheon Books; 1978.

39. George C. Book review: Gayatri Chakravorty Spivak, In Other Worlds: Essays in Cultural Politics. New York: Methuen; 1987. Millenn J Int Stud. 1988;17(3):590-1. https://doi.org/10.1177/03058298880170030522.

40. Bhabha HK, editor. Nation and narration. London: Routledge; 1990.

41. DelVecchio Good M-J, Gadmer NM, Ruopp P, Lakoma M, Sullivan AM, Redinbaugh E, et al. Narrative nuances on good and bad deaths: internists' tales from high-technology work places. Soc Sci Med. 2004;58(5):939-53. Available from: https://linkinghub.elsevier.com/retrieve/pii/S0277953603005823.

42. Fischer MMJ. Anthropological futures. Durham, NC: Duke University Press; 2009.

43. Rosa JG. Grande sertão: veredas. Rio de Janeiro: José Olympio; 1956.

44. Bakhtin M. Estética da criação verbal. São Paulo: WMF Martins Fontes; 2011.

45. Governo do Estado de Mato Grosso do Sul. Subsecretaria Especial de Cidadania (SECID/MS). Comunidades Indígenas. Campo Grande, MS; 2019. Disponível em: http://www.secid.ms.gov.br/comunidades-indigenas-2/

46. Csordas TJ. A corporeidade como um paradigma para a antropologia. In: Corpo/Significado/Cura. Porto Alegre: UFRGS; 2008. p.101-46. Disponível em: https://edisciplinas.usp.br/pluginfile.php/2018635/mod_resource/content/1/A Corporeidade Como Um Paradigma Para a Antropologia.pdf

47. Mauss M. Sociologia e antropologia. São paulo: Cosac & Naify; 1950.

48. Weber M. A Ética protestante e o espírito do capitalismo. São Paulo: Companhia das Letras; 2004.

49. Conselho Indigenista Missionário (Cimi). Relatório: Violência contra os povos indígenas no Brasil. Dados de 2018. Disponível em: https://cimi.org.br/wp-content/uploads/2019/09/relatorio-violencia-contra-os-povos-indigenas-brasil-2018.pdf.

50. Kleinman A. The illness narratives: suffering, healing, and the human condition. New York: Basic Books; 1988.

51. Seppilli T. Saúde e antropologia: contribuições à interpretação da condição humana em ciências da saúde. Interface - Comun Saúde, Educ. 2011;15(38):903-14. https://doi.org/10.1590/S1414-32832011000300022.

52. Pollock NJ, Naicker K, Loro A, Mulay S, Colman I. Global incidence of suicide among Indigenous peoples: a systematic review. BMC Med. 2018;16(1):145. doi: https://doi.org/10.1186/s12916-018-1115-6.