Challenges and concerns in assisting indigenous people with suicide attempts

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Abstract

There has been an alarming rise in suicide attempts among indigenous people in Brazil leading to national concerns about the provision of psychosocial care and professional support. In this study, we make an attempt to understand the perspectives of professionals in assisting indigenous people from a specific group, the Iny, and identify the specific challenges of addressing issues through the mental health care system, related specifically to suicide prevention. Using a qualitative approach with participant observation and semi-structured interviews, the research included indigenous and their families assisted by three public institutions, and the professionals that work in the public psychosocial assistance. For this paper we examined the tensions, conflicts and challenges of the health care professionals at one of these institutions, a Psychosocial Care Center in the state of Goiás/Brazil. For the analysis of data, a sociocultural protocol was built to identify dialogical tensions between the different thematic-fields of mental health care. The findings reveal that the theme of suicide was an important concern in the daily work with the community, but there were significant issues related to the assumptions, methodology and meaning of care between the professionals and the community on account of which the objective of the programme to address suicide attempts had not been effective or successful. The discussion of the results raises several critical questions about possible contributions of dialogical cultural psychology in the context of indigenous health, and also has important implications for the global issue of well-being of indigenous people.

Introduction

The present article discusses the dialogical tensions present in the discourse of health professionals about the work process of a public institution for psychossocial care provided to the general population and to the indigenous people who have attempted suicide. To this end, we address the complexity of the meanings of mental health practices, a debate that goes back to the reflections on the advances and limits of the medical and psychological clinic. The debates about ‘mental hygiene’ in the early twentieth century, were, until the anti-asylum struggle movements that have strengthened in recent decades, have implications for the performance of several professions dedicated to health and impacts on the implementation of public policies for psychosocial care, like Psychosocial Care Center (CAPS) in Brazil as presented below in this paper. Additionally, this article will attempt to build linkages with experiences of individuals from other marginalized communities from other parts of the world, like the poor in affluent countries like America and disadvantaged people in countries of the global south like India. In this manner, we hope to develop a more generalized understanding of structural, systemic, social and interpersonal difficulties faced by people living with marginalization, and how that plays an important part in mental health.

For professionals involved in public health policies aimed at indigenous populations, the issue gains new ingredients, since it is necessary to overcome the prevailing problems related to indigenous communities and the services provided to them. For this purpose, more research needs to be directed towards the specific issues that emerge in the conflicts between indigenous people and their movement as well as in

personal and professional training of experts. We need a specific focus on the intervention on psycho-social processes linked to suicide attempts and the need to pay attention to the specific physical, mental, social and spiritual dimensions of the indigenous people and communities in focus (Batista & Zanello, 2016; Zacarias, Santos, Silva & Ramos, 2016). The concern for a better understanding of people living with disadvantages of different kinds is global. For this purpose, we require a multidisciplinary and multicultural approach on why people do self-harm is internationally recognized in different contexts, such as Desmond (2016) Hodgetts, Sonn, Li & Groot (2020); Mullainathan & Shafir (2013); Singh, (2021).

The movements of political and cultural resistance of indigenous communities have been recognized as a necessary dimension for health promotion. Nevertheless, the understanding of health beyond the physical and biological aspects has not achieved full respect for the indigenous cosmo-visions, in all their depth and extent. In this sense, caution should be exercised when using the term mental health when dealing with issues related to indigenous health (Sousa, Gonzalez & Guimarães, 2020). The ontological assumptions of the people being cared for are not necessarily the same as those of the health professionals, considering that modern sciences unfold against the backdrop of the assumptions of a naturalistic ontology. In contemporary anthropology, there has been a movement known as the "ontological turn" which sought precisely to take seriously the indigenous ontological conceptions as categories of knowledge (cf. Graeber, 2015). For Amerindian perspectivism in anthropology, the human condition would not be centered in the soul or in the mind, but in the ability to perspective the world always situated in a specific body, whose constant cultivation is a necessary condition for the maintenance of the human condition itself and of its integral health. This ontological understanding, no nature is given, therefore, we in face of the transformative potential of natures. The body must be constantly cultivated as such for the maintenance of its state, which includes materialities with meanings. Based on these ontological assumptions, it is not possible to think of any notion of illness, or of suicide, without taking into account the complexity of the constitution of the person that involves the relationship with the body understood as a bundle of affections (Castro, 1996; Silva Guimarães, Lima Neto, Soares, Santos & Carvalho, 2019), in the circulation of agencies and in relation to other beings, both human and non-human, who affect each other in coexistence. In this way, suicide cannot understood as an individual, self-inflicted event. For example, the social vulnerabilities faced by communities in the face of the need to survive in the midst of capitalism are related to material conditions that affect the person in their entirety, which includes care in the dimension of spirituality, alongside the categories articulated by the term biopsychosocial. And in the scope of the "social", many beings are included, beyond humans.

The social forces that point tendencies towards suicides and other forms of self-harm in a given society were, for example, classically proposed by Durkheim (ref.), and continue to be unfolded contemporaneously (cf. Singh, 2021). In fact, the very meaning of 'social' departs from the traditional sociological understanding of the world. What 'social' means for the Amerindian communities is different. Such findings have also been observed in other parts of the world. For example, in the Chipko movement in Northern India, the local people treated trees that were to be culled as significant members of society and this led to a community uprising of the tree-huggers. This raises the issue of fundamental epistemological and ontological differences between people, a fact that is critical to the provision and

understanding of mental well-being and health. In the Amerindian context, Vanzolinni (2018) and Sztutman (2018) have proposed the concept of counter-witchcraft, in reference to the sociological concept of "commodity fetish", starting from Amerindian cosmovisions to understand capitalism as a mode of witchcraft that sickens the subjects to the extent that they do not realize they are affected by its influence. Kopenawa and Albert (2015), for example, presents essential dimensions of a deeper Yanomami understanding of health, challenging non-indigenous perspectives and proposing a counter-anthropology. One of his central messages is that indigenous health is not limited to a separate care between body and mind-spirit: "The whites do not understand that by extracting minerals from the earth, they are spreading a poison that will invade the world and eventually kill it. For them, the health of the body-spirit is inextricably linked to the spiritual harmony of the earth. Dialogue with the living spiritual beings of the environment that make up the territory is fundamental to maintaining this harmony. The Yanomami concept unequivocally expresses that all disease epidemics are caused by a profound disharmony brought about by the "peoples of merchandise". Driven by a thirst for power and material goods, they disrespect the guardian spirits of minerals and all that dwells in the depths of the earth, resulting in the widespread diseases we face today. The non-indigenous way of life constantly affects the quality of life of the indigenous communities in Brazil, whether through the construction of technologies that are exported to different countries, or through their non-indigenous way of life that destroys the land without the permission of the great guardian spirits.

In view of the sociocultural specificities, interdisciplinary approaches on suicide are necessary, which take into account the community struggles of resistance to the historical colonial process and persistent coloniality (cf. Quijano Obregón, 2013; Mignolo, 2017; Souza & Ferreira, 2014). Although we use the word colonization in the same way for different countries, there is no doubt that these colonies had very different experiences. In some situations, the colonizers and mixed populations left the country before or soon after independence, but in some places, as in Brazil, they stayed and broke ties with the country of origin. This has had an important impact on the ways in which post-colonialism is experienced. The interpersonal heterogeneity of people in communities (Valsiner, 2017) also takes place, next to the sociocultural specificities. The debates on health within the scope of dialogical cultural psychology emphasize the relevance of paying attention to the socially and culturally marked ways that the person integrates with the environment and the various beings that the Eurocentric view categorizes as natural, cultural or spiritual, considering dimensions of experience that go far beyond the focus on the biological body. The notion of person, which is not identified to the notion of individual (cf. Spink, 2011), is linked to relations of kinship and territoriality, which demand from the health professional a distancing in relation to strictly biomedical and psychologizing perspectives on mental health, which have still been dominant in the care to indigenous communities (4 make reference again to the references in the first paragraph of the text).

The Brazilian Federal Council of Psychology recognizes that psychology has historically been constituted based on Eurocentric traditions, and, therefore, it is necessary that the professional deconstructs positions, actions and behaviors in the care of indigenous people, opening the dialogue with conceptions and care practices of different peoples in the construction of a wellbeing (Conselho Federal de Psicologia

(Brasil), 2022). This proposition was included in the technical references for the performance of psychologists with indigenous peoples, built together with indigenous psychologists, leaders and indigenist psychologists. The research of Karajá (2019) brings some voices of her people about the phenomenon of suicide, coming to the conclusion that for the Inỹ people, suicide is multicausal, and can be attributed to the consumption of alcoholic beverages, other drugs, interpersonal violence, marital conflicts, mental disorders, socioeconomic conditions, depression, low self-esteem, sadness, and witchcraft, as a factor highlighted predominantly among the interviewees. The author, an indigenous woman of the Inỹ people, a nurse linked to the indigenous health subsystem in Brazil, reflects that the estrangement from cultural practices, brings an imbalance between the three levels of the Inỹ world: the celestial, the earthly, and the underwater, guaranteed by the performance of festivals and cyclical rituals. She also points out that the estrangement driven by the changes due to the contact with *Tori* (white) society, implies a series of consequences such as increased interpersonal violence, couple disagreements, mental disorders, hearing commanding voices, physiological illnesses, and suicide.

We argue that suicide is a complex phenomenon of worldwide relevance, about which several perspectives of knowledge are focused and seek to propose possible solutions. Like any human phenomenon, the understanding of its complexity from a single perspective of knowledge opens possibilities, but also has limits. We understand that it is necessary to alternate between different perspectives of knowledge, integrating different layers of complexity involved in the phenomenon. This understanding is at the base of the psychosocial attention model in Brazil, which aims at an integral health action through transdisciplinary teams, for example. But if the understanding of the phenomenon of suicide cannot be done exclusively through the lenses of a single area of knowledge, neither can it be done exclusively through the lenses of the natural or human sciences, whose westernized assumptions also have their limits of understanding and should seek dialogue with indigenous perspectives on the theme.

Background: on the psychosocial attention to the indigenous population in Brazil

Population surveys point to the increase in cases of suicide attempts and suicides in the general population. More than 700,000 people die by suicide every year around the world, which is a serious global public health problem. The reduction of mortality by suicide was included as an indicator in the Sustainable Development Goals of the United Nations and, among the strategies for that is the identification of specific groups at risk of suicide and interventions tailored to the needs of these populations (WHO, 2019). In Brazil, the incidence of suicide in the indigenous population is 4.4 times higher compared to the general population (Secretaria de Vigilância em Saúde, 2021).

Among the Inỹ people "suicides have never been part of their universe", but the first case being recorded in 2002 and, between 2010 and 2016, there were a total of 41 suicides by hanging in this population residing in Bananal Island, Tocantins (Nunes, 2017; Brazil, 2019). We are detailing data from this

population, in specific, because the professionals interviewed in this research predominantly serve the Inỹ population.

They were historically called Karajá by the colonizers, but their original self-denomination is Inỹ, which means "we" in their language (Silva, 2017). The Inỹ people speak the Inyrybé language, which belongs to the Macro-Jê linguistic stem. Their communities are concentrated in the Bananal Island region along the banks of the Araguaia River. The first contacts of the Inỹ date back to the end of the 16th century and the beginning of the 17th century, through the Jesuit missions and the expeditions of the Paulista bandeirantes, a period marked by violence, when many were murdered - including children - or made slaves, exchanged for goods and cattle in the passage of the Anhanguera, the bandeirante Antônio Pires de Campos. More recently, in the 1950s, there was a movement of occupation of the country's interior called "March to the West", promoted by the government of Getúlio Vargas, with the occupation of the bank of the Araguaia River by farms and several cattle ranchers (Nunes, 2017), producing significant impact for the communities.

Circumstances linked to territorial and political conflicts and other impacts on indigenous autonomy to manage their communities according to their traditional ways of life tend to generate feelings of depression, isolation, and discrimination, often accompanied by resentment and distrust in health services, especially if these services are not appropriate to the lifestyles of the communities attended (Achatz, 2022; Souza & Ferreira, 2014). Within the Unified Health System (SUS), considering the need for health care for indigenous peoples based on the articulation and complementarity between culturally appropriate and intercultural health knowledge, the National Policy for Health Care for Indigenous Peoples (PNASPI) (2002) was established, focused on the concept of differentiated care, in which it established the Indigenous Peoples' Health Subsystem (SASI) as a strategy to ensure access to health care for indigenous peoples (Pedrana, Trad, Pereira, Torrenté & Mota, 2018; Mendes, Leite, Langdon & Grisotti, 2018).

With the organizational model of the SASI, the Special Indigenous Health Districts (DSEI) were created. In all, there are 34 in the country, and within these, other instances responsible for health care at different levels, such as the Base Poles, the Basic Health Units (BHUs) and the Casas de Apoio à Saúde Indígena (CASAI). In 2010, the Special Secretariat of Indigenous Health (SESAI) was created within the Ministry of Health, being the body responsible for the management and implementation of health actions and programs, requiring a robust administrative structure (Mendes et al., 2018).

Considering the magnitude of the impact of mental health problems on the Brazilian indigenous populations, which drastically interfere with their well-living and social organization, it is proposed that the DSEI articulate with other services of the Psychosocial Care Network (RAPS), such as the CAPS, the hospital care services and primary care. Each of these points of attention in care aims to offer care to different situations of psychosocial suffering in the communities involving, for example, people with problems due to the harmful use of alcoholic beverages and/or other drugs, situations of violence and

suicides, and other aggravations related to indigenous health (Brazil, 2019; Albuquerque, 2018; Nóbrega, 2016).

The National Mental Health Policy (PNSM) considers the CAPS as strategic services in the organization of a substitute network for the Psychiatric Hospital in the country, with the mission of replacing the anti-asylum logic. A component of the RAPS specialized care, the CAPS is a reference service in the care of people in intense psychological distress, it has a multidisciplinary team specialized in Mental Health care, capable of operating in the daily life of the subject, assisting him in the territory, when or if you are in crisis, and also in the processes of psychosocial rehabilitation (Brazil, 2004).

Method

Type of study and presuppositions

The research was conducted according to a qualitative exploratory-descriptive approach in a dialogical hermeneutic perspective in the field of a cultural dialogical psychology.

The methodological choice is based on the understanding that psychology emerged as a contemporary science in the modern age that in its foundation brings principles of ancient Greek and Latin philosophy renewed by Judeo and Christian traditions as the background of humanistic philosophies. Nevertheless, the ethnic and cultural diversity in the ethos of modern European societies, was confronted with the image of unknown peoples and lands violently explored by Europeans all over the world. New sociocultural combinations opened paths to novel possible individual and collective choices previously non-existent. From its specificities, the meeting of cultures provoked the emergence of new ideas about human nature, universality or relativity of the forms of organization of life, transmission of values in addition to the understanding of people in the world.

Dialogical cultural psychology understands that the ethical commitment to oneself and to the other means that both need to be heard as well as to make their voices heard, it is an effort not to silence the other, nor hide behind his voice. These voices speak from an anticipatory understanding of completeness on the subject of dialogue, an understanding that starts from the cultural traditions in which they were respectively formed. For dialogical cultural psychology the methodological investigation starts from a field of diversity and multiplicity of voices, further expands its diversity, avoiding the psychological dogmatism where only one perspective is dominant or an eclecticism where there is no differentiation between me and the other and where any perspective is worth as an orientation. Local

The study was developed in a CAPS III of reference for the care of indigenous Inỹ people with suicide attempts and their families, in a municipality in the Midwest of Brazil located over a thousand kilometres from the village of the indigenous people assisted. Considering the need for integrated care in a network of attention, this CAPS interacts with the indigenous health teams of the DSEI Araguaia and the CASAI, which is located in the same municipality as the CAPS.

Participants

Eight CAPS professionals with a higher level of education, who had been working in the service for at least one year, present in direct assistance to Iny indigenous people who had attempted suicide or to their families, agreed to be iterviewed. The interviews were conducted by the first author of this paper and main research, who is a psychologist with specific training in indigenous health and with approximation to the field prior to the realization of the research, so that she was known and recognized by health professionals and indigenous leaders for the work already developed in the DSEI, in the villages and in the CAPS in question. Professionals who were away from activities in the institution during the period of data collection were excluded.

Data construction

The notion of data construction emphasizes that the data was not in the environment available to be collected by the researchers, as natural objects. The data in the present qualitative research was actively sought by the researchers who prepared an interview script and constructed to the extent that the interview involved a singular researcher-participant relationship, unrepeatable and dependent on the actions of each interlocutor in the course of the interviews. The recording of the events that gave rise to the data occurred in 2018. The guiding questions were about how the professional perceived the care to indigenous people in CAPS, about what caused the suicide attempt in indigenous people, what activities were developed in CAPS with indigenous people with suicide attempts and what what makes it hard or easy for the professional in the care to indigenous people in CAPS. All interviews were audio recorded and transcribed for further analysis.

Analysis and processing of data

For data analysis, a protocol was built containing the content of the transcribed interviews. However, the content analysis of the semantic referents of each speech is not enough for a dialogical understanding of the events, since the communicative act involves the addressing of the speech-who speaks, to whom is the extraverbal situation, that is, when and where the communicative act takes place, considering that the human action supposes the use of media in a specific sociocultural scenario (Wertsch, 1993). Only with the inclusion of this additional information, it becomes possible for the researchers to produce inferences about the positions, oppositions and affinities expressed by the research participants, as expressive aspects of their speeches.

Ethics and Research Committee response

The project to which this study is linked was developed according to the recommendations proposed by the National Health Council that regulates research involving human beings (Brazil, 2012). This study was approved by the Ethics and Research Committee, according to opinion 3.311.391/2019, and by the National Research Ethics Committee. All participants signed the Informed Consent Form. To ensure confidentiality, the testimonies were coded by the letter P followed by the identification number of the participants by the research team.

Results: utterances from the participants

The results present, in a selective way, a set of views of the participants regarding the actions of care for indigenous people with suicide attempt, promoted by a CAPS. The participants present a number of challenges in the effectiveness of mental health actions focused on suicide in indigenous people in the mental health care network. We have organized the results into four thematic axes, as follows:

1. Challenge in the understanding of cultural issues and suicide in the indigenous context

What was most difficult for me is that I didn't know what suicide was like for them. One day she explained it to me like this: 'Call us. The spirit that has gone calls. But is this good or bad? It seems that it's good and bad. I don't understand, because if it is good to go, in their culture, then dying is natural. To take your own life is natural, because the spirit asked for it. But there it was a question of the conflict of place too, because here in our culture taking one's own life is not right, and there, maybe it is even praiseworthy, you know what I mean? (P1)

One of the things we worked a lot on was the difference between life here and life in the village. What was normal there, which was very divided. The things that leaned towards the side of our culture and another towards the indigenous culture. Some things that were difficult to take on here because there was still a lot of indigenous culture, it was divided. (P1)

I want to be in the city, I want to be in the village', to realize that the city offers some things that the village does not offer, and vice versa, so what I perceived was perhaps this feeling of no place. (P6)

What I found most difficult to understand is how they absorb so many things, for example, religion. In the case of one of them, she spoke of dreams, she spoke of the evangelical church, she spoke of other religious places she had attended. I wondered how she could assimilate so many different things, I couldn't. (P4)

2. Resistance and abandonment of the psychosocial care offered by the institution

For me it is complicated because I want to know why you didn't come, are you not enjoying the care? Do you want to talk about another subject? (P1)

We have a flow here in CAPS. The Indian didn't follow this flow, he went straight to the psychologist. I think he loses with this, and the team also loses with getting to know him better, and including this person, because they are sometimes excluded from society, and then we arrive being different, attending him in a different way. Why does he go straight to the doctor, when others don't do that? 'He's Indian, he's Indian, send him to the doctor. No, it's not like that, I don't agree with it, but the CAPS team also has disagreements. (P4)

3. Lack of training of professionals and the concern with the pathologization of culture

We have no training, no training at all, right, people? And what if there's a boró [popular word used in Brazil to mean problem, confusion or a disquieting situation]*? So, I think that we need to protect ourselves more in this, protect ourselves as technicians, it's not even a technique, it's knowing a little more about the culture, that's all. (P1)*

There are many things that are taboo for them, which are not for us. In my own case, I practically do not know their culture. I try to adapt the interview more by instinct than by having the knowledge to know what I should ask and how I should ask them. (P2)

I think it would be important that we had a perspective of continuing education, that CAPS would perhaps understand that it is part of our public, that the service would not be centered in people, but in the institution as a whole. Perhaps we would think of an internal organization in the service that we would have a more systematized schedule for these individual consultations. This way of organizing. I think that group consultations are a priority. (P6)

4. Distance between the indigenous community and the psychosocial care institution

There are some cases that are not registered as patients from the CAPS municipality in the city hall system, then it gets more complicated because we can't do anything. There is no way the pharmacy can provide medication, and do nothing when he is with data from another city. (P7)

I keep thinking about how to offer these services closer to their places of origin, because suddenly, if I bring this indigenous person to a unit far from his context, what sense does it make? (P6)

No doubt, I think we need a lot and the place. That project that we did there [in CAPS], if there was a kiosk, I'm not talking about a hut. Wow, I think it would be so cozy for them and I think for us! Adapting the

space minimally, I think it would also be very good for us, not only for them, right? I can even visualize it like this. Hammock, mat, right? It would be very good. (P1)

I'm going to speak in theory because I don't know if these things are possible but, for example, making it a rule that on the first consultation someone from the family must come with someone from the family, that would make it much easier, and normally this doesn't happen, so if this were already defined beforehand, it would make it much easier. A difficulty that is inherent to their situation and ours here is the question of distance, we know that the adherence to psychiatric treatment is universally proportional to the distance the patient is from the health service, so the further away they are, the less they will adhere. (P2)

Discussion: dialogical tensions in the discourse of health professionals

The discussion is organized around the four main challenges identified in this project. These are the understanding of cultural issues and suicide in the indigenous context, resistance and abandonment of the psychosocial care offered, training of professionals, the pathologization of culture and distance between the indigenous community and the psychosocial care institution.

We found the concerns present in the assistance to indigenous people in the scope of the challenge of understanding cultural predicates as to the issue of suicide. P1 perceives the difference between cultures, as to the ways of meaning the phenomenon. He talked about a the tension between ways of life and social organization in the production of suicide. There is a suspicion that conflicts related to the overlapping of ways of life can generate difficulties that eventually culminate in suicide. In another moment of the interview, the participant evaluated that mental illness was not a reality for the Inỹ before the contact with white people. Thus, the health teams are situated in an ambiguous position, to the extent that they bring knowledge and practices from the world of whites, which is the source of illnesses, they are also responsible for bringing solutions for health promotion in the community.

P6 brought up the feeling of not belonging concerning the indigenous person who comes to the city, causing discomfort and a sense of non-place. She observed that being in the city to study brings many challenges for an indigenous person, such as loneliness, missing the family and the urban violence in the village, triggered by gender and machismo issues, as reasons for suffering. P6 brings the language issue as another complicating aspect in establishing the psychiatric diagnosis, due to the little information and the lack of knowledge of the indigenous culture in the professionals culture. Shereferred to the "wants" of a supposed indigenous person intermediated by a health professional. However, professionals do not always have consistent information about the patient's condition, disease and life history. The access to the suicide attempts, commonly, occurs via the formal report or by an accompanying professional. Here is evident the relevance of the relationship with indigenous people without meditations by third parties,

which implies, many times, the challenge of speaking the indigenous languages and understanding the expressions and symbolisms brought by each person, which demands spending time together and the construction of interpersonal bonds that allow going beyond stereotypes and generalizations about the indigenous being.

P4 talks about the indigenous patient beliefs and the form of relationship with the sacred, as something different from his own and makes him reflect on the centrality of the various expressions of spirituality in the indigenous trajectories constructing meanings to their experiences. Several works with indigenous people reinforce the importance of the articulation of intermediacy in therapeutic practices, since they include multiple conceptions of health and disease (Melo, Freitas & Apostolico, 2021; Nascimento, Hattori & Terças-Trettel, 2019; Baggio, Nascimento, Terças, Hattori, Atanaka & Lemos, 2018). The lack of preparation of the team to understand the cultural context appears as a challenge for some CAPS professionals, who fear of falling into the error of medicalizing issues related to culture and the context of indigenous life, realizing that cultural issues interfere in communication, making it difficult to listen to what is really being transmitted by the cultural bias, since communication also occurs in a non-verbal way.

P1 presents a discomfort and doubt about the meaning of the indigenous abandonment of the treatment offered by the service. Highlights the challenge of dealing with the unknown as a disturbing experience that generates helplessness. The professional feels impotent and frustrated because of the lack of justification and the patient's inability to answer calls in the situations of abandonment of treatment. In an attempt to fill the gap in relation to the other, who exceeds understanding, professionals tend to elaborate meanings that fall on what can be understood as difficulties peculiar to the indigenous population, the indigenous health network or the professional personal ability.

P4 considers the care of indigenous people in CAPS as a result of an imposition of the municipal administration on CAPS, which would not be prepared to meet the demands of the indigenous population or do not recognize indigenous people as part of the population to be served by CAPS. In some cases, the inclusion of indigenous people in the care in heterogeneous groups ends up not being sensitive to the specificity and indigenous demand. Thus, professionals point to two extremes: serving indigenous people individually without inserting them in the activities of the service, or considering the needs of the indigenous population equal to other users, without paying attention to cultural specificities.

Professional training has been done in a model aimed at homogenization of the population, without considering ethnic-racial, cultural differences and other forms of care. It was possible to observe some stereotyped and prejudiced speeches, which we consider as the persistence of the Eurocentric education, due to coloniality, still present in academic curricula that presents indigenous culture as exotic and does not consider indigenous people as holders of their own knowledge. The health professionals need to be confronted with the ethical and political point of view, seeking new ways and opening the possibility of creative and transforming encounters (Achatz & Guimarães, 2018).

Some professionals do not acknowledge the indigenous population as a responsibility of the CAPS service disregarding the cultural specificities and social vulnerabilities, justifying a homogeneous care for all users of the service. Nevertheless, some participants reflected on the need of adequacy of the municipal regulation system, so that the indigenous population could be really served in a complementary way in the municipal health system, articulated with the work of health teams in the communities. Another necessity for the effectiveness of the care is the priority in the attendance considering other vulnerable non-indigenous populations already foreseen in the politics of health of the SUS. However, the non implementation of these priority actions hinders the access and contributes to the drop-out of the indigenous people.

P4 points to a hardening of the team, whose lack of knowledge of what to do in the care of indigenous people is felt as paralyzing, while at the same time there is an obligation to give answers to the management. There is still the question whether other forms of care and possibilities in relation to this population would not be possible. Sometimes, the prioritization of care is seen as exaggerated, unnecessary, generating resistance and disagreements within the team. The professional's position is ambiguous, revealing the uneasiness of this place of not knowing when facing the new, the different. It also points to the tensions in the team, which has shown difficulty in broadening the discussions about the care for indigenous people and organizing the service in the face of the new, the different. of the need for care brought by the municipal management, causing a demotivation and plastering of assistance.

P1 refers to the lack of training, both in the service and in graduation, to attend indigenous people in CAPS as a hindrance to the service P2 emphasizes the need to be informed, to be able to talk with someone who already has experience in serving the indigenous population. Added to the lack of knowledge, the team's seems afraid that the lack of preparation to understand the cultural context may cause the error of diagnosing issues related to culture and, consequently, they don’t feel safe to follow the assistance procedures, because it may generate more violence instead of promoting care when the indigenous specificity is not considered. The fear of not respecting due to ignorance of the culture, paralyzes and prevents the professionals from venturing into a coexistence with the different. Such attitude reduces the listening, contributes to the silencing, generating the lack of assistance, estrangement and suffering (Achatz & Guimarães, 2018).

In CAPS, the community-based care is advocated in a model of attention in which the territory and the singular care are based on strengthening social ties, inclusion and social participation. Despite this, some professionals still reproduce care practices centered on the figure of the doctor and hospitalization, in which they offer users ready care, removing the focus from the needs of this population. Reinforcing the existence of failures in the training of professionals and psychosocial care (Zeferino, Cartana, Fialho, Huber & Bertoncello, 2016; Onocko-Campos, Costa, Pereira, Ricci, Silva, Janeth, et al., 2017; Trapé, Campos & Costa, 2018).

P6 presents the need for continuing education on indigenous issues and the understanding that there is a public responsibility of the service and not of some professionals, personally, who perceive this need. His

speech also highlights the need for an internal reorganization of the service. Some of the interviewed professionals perceived the lack of continuing education as a hindrance to effective cross-cultural communication with the indigenous population served in CAPS, associated to the lack of dialogue and communication between the points of care, reflecting the difficulties in the implementation of the actions provided for in public policies on mental health, in general, and the indigenous institutionalized health system.

P7 talks about the lack of dialogue between CAPS and the indigenous health secretariat (SESAI) as a hindrance in monitoring the cases. The need for greater knowledge of the functioning of the subsystem and building partnerships between professionals located in different institutions is emphasized, in order to incorporate differentiated care to indigenous people in the health services of the municipality, as CAPS. The indigenous persons who live in the city, for reasons of study and work need access to health services as persons belonging to a indigenous people.

P6 pays attention to the effectiveness of a care so far away from the community for villagers and questions whether it would not be more effective to provide assistance closer to the territory, because in the city it ends up being a one-off service without conditions to maintain a longer treatment as mental health cases require.

P1 reflects that the effectiveness in the accompaniment of indigenous people in CAPS depends on some infrastructural conditions, criticizing the distance of the institution from the indigenous territory, considering that CAPS is more than a thousand kilometers from the village. It is a hindrance to access and a possible reason for discontinuity in treatment. He adds the need for the accompaniment of a family member to better report the patient's history, facilitating the understanding of the patient’s condition.

There are still few studies on the psychosocial care of the indigenous population regarding the access and description of technical-assistance practices in CAPS, but studies in Primary Health Care show that geographical characteristics and infrastructure limitations, such as great distances, natural obstacles, lack of electricity and means of communication hinder the regular provision of care in indigenous villages, either in the ways recommended by the Family Health Strategy or by the PNASPI (Rocha, Pina, Parente, Garnelo & Lacerda, 2021).

It emphasizes the need to understand the ways of life of the populations that inhabit the territories served by the teams in order to reduce the cultural and geographical barriers between vulnerable populations and the health care points in order to facilitate access, in addition to the need for greater articulation of the SASI (Albuquerque, 2018; Rocha et al., 2021). The RAPS, despite considering the regional and cultural specificities, still has a very recent approach to indigenous populations and the paths for the effectiveness of this care are still being built, from initiatives of SESAI together with the State and Municipal Health Secretariats (Albuquerque, 2018).

P2 discusses the issue of continuity of treatment and the (in)effectiveness of occasional care when not linked to a contact with the indigenous health teams. The speech presents uneasiness and ambiguities caused by the unknown, which is a generator of tension, since it takes the professional out of his usual place, forcing him to make new reflections that oscillate between willingness and resistance to care.

Professionals claim that they have not received guidance or training to act in this interethnic context different from their health training, even though it is one of the guidelines of the PNASPI. Despite the challenges presented, it is possible to observe the commitment and interest of many professionals to improve their work and offer quality care to the assisted indigenous . Many have expressed a mixture of interest and fear towards the unknown, verbalizing sometimes contradictory issues, common in such a complex and, for many, new reality.

Therefore, it is necessary to broaden the focus of knowledge of professionals about health and disease, taking into account how to deal with adverse situations to their usual practice of care, making an inter and cross-cultural mediation permeated by inter and transdisciplinary, so that public policies can be built that consider the indigenous specificities and effectively serve these populations (Zacarias et al., 2016; Berni, 2017). The recognition of the unique conditions of people, cultural diversity and territories favors the proposal of Special Therapeutic Projects (STP) more consistent with the indigenous needs.

We understand that the elaboration of STP, as a technology of care, could can further expand psychosocial care as an ethics of care based on autonomy, the guarantee of rights and the concept of well-living. Given that, here, this concept of well-living praises community relations, collective solidarity and common spaces respecting the diversity and these spaces (Kinoshita et al., 2020). However, some professionals tend to propose interventions that do not correspond to the user's needs, requirements, but rather the conveniences of the team and/or health unit, being the PTS thought from a 'menu' of activities that CAPS offers (Silva, Sousa, Nunes, Farinha & Bezerra, 2020).

Thus, it reaffirms the need for qualification of PTS guided by respect and knowledge of indigenous tradition in order to assist and combine knowledge, considering the power of guidance for an expanded clinical practice in CAPS. It is necessary that the professional understands the intercultural challenge in the assistance and seeks the balance between the implication and its cultural reserve, paying attention not to suppress their point of view, offering a lack of assistance and reproducing a paternalistic practice. The bond should be built from the recognition of differences and respect for points of view, seeking to reduce the imposition of interventions that can lead to conflict, wear and loss of the link with the community (Silva et al., 2020; Sousa, 2018; Melo et al., 2021).

In the dialogue between cultures, some experiences prove to be untranslatable and it is precisely on this border of interethnic relations that it promotes, in the health professionals, disturbing and unruly experiences which enable transformations and ruptures of affective-cognitive patterns for those who are willing to live this type of experience. Given this context, The construction of projects in co-authorship requires the internal willingness of professionals to review their notions of time, workspace, methodologies and usual forms of intervention for the experience of affective sharing that enables the

exchanges, the establishment of bond and the production of new knowledge and possibilities (Ranchod & Guimarães, 2021).

We emphasize the importance of ensuring a model of care that relates to the complex network of social and cosmological organization of indigenous peoples, understanding their care practices and based on the mitigation of inequalities in power relations that permeate biomedical and indigenous knowledge. In order to reach a care organization that achieves these results, in addition to sensitized and trained professionals for the promotion of an intercultural dialogue, it is important that the services, besides the willingness to provide care, offer, through the management and adequacy of bureaucratic flows, the paths that allow the production of health (Nóbrega, 2016).

The analysis of the text of the PNASPI in general highlights obstacles to the understanding of differentiated care as a process of interaction mutually constructed, shared and validated between indigenous and non-indigenous peoples. Thus, the demand for intercultural strategies such as the inclusion of traditional specialists in indigenous health care services and an intercultural training for non-indigenous professionals is highlighted (Pedrana et al., 2018; Mendes et al., 2018). The professional needs to be open to the unknown, to learn with the indigenous reflections and way of living, and to co-construct its praxis with the indigenous communities and persons.

Final considerations

This article is a significant step forward in reconciling the reality of indigenous people and the attempts to provide professional assistance and care in the specific instance of escalating suicide rates. Furthermore, it also contributes to the larger knowledge about cultural conflict and the respect and protection of indigenous people around the world that is an urgent need world-wide.

Studies related to the forms of organization and care of indigenous communities' own health systems, considering interculturality, are essential for the development of health care strategies for this population. As was pointed out in the introductory section, the difference between local indigenous perspectives and the perspective of the dominant society can be serious and conflictual. The failure to understand the ideology and culture of local people can result in negative consequences, of which self-harm is one possible outcome, as we have seen in the findings of this study. When there is epistemic violence through the silencing or pathologizing of local culture by the established support system, people from indigenous communities. Instead of receiving care, they have to deal with the health system's inability to provide care or find meaning and relevance of the indigenous place in larger society. In such situations, it is the responsibility of any care system to make sincere attempts to better understand local cultures and use ideas and approaches that create a balance between different communities rather than creating more gaps and conflicts. The theme of suicide in indigenous populations comprises a series of dimensions that makes necessary the interlocution between aspects of social organization and indigenous cosmology with care not to start from explanatory models typical of institutionalized health care on suicide (Nunes, 2017). The health professional should be able to dialogue, in the dialogical sense of the

term, with beliefs, concepts and habits of people and communities diverse from those that were present in the professional education, and that are full of symbolisms, ethical and moral values (Zacarias et al., 2016).

Considering the harmful psychological effects of a hierarchization of knowledge and exclusion of indigenous knowledge, in the reproduction of epistemic violence; we recognize the limits of an action on suicide based only on biopsychosocial knowledge, when the biopsychosocial reality of the indigenous peoples and the spiritual dimension are ignored, as relevant predicates guiding the discourses and practices of people. The theme of suicide and the impact of this event in the lives of people point to the need for support and investment of public management from listening to the population, to deal with this phenomenon. All actors can contribute with their points of view in an attempt to find a more appropriate way to deal with the issue and events linked to the theme.

The challenges for the implementation of an appropriate form of care for indigenous people, which considers the understanding of indigenous well-living and other cultural specificities, especially those related to suicide attempts, are many. The difficulties are related to the unpreparedness of professionals to dialogue with the indigenous population, reflected in the management of services and the daily activities to provide care. Therefore, it is essential to carry out studies and research that address the collective construction of knowledge to promote health care prioritizing the care in the territory, involved with the community life and rescue of rights and citizenship. Adding to these principles the ways of reading and understanding the world, health and well-living from the indigenous traditions , and providing subsidies for the organization of actions related to psychosocial care of these peoples. The challenges reported by the participants are inherent to communicative processes involving people originating from distinct sociocultural contexts, and become intense in the scope of relations in an institution responsible for promoting mental health care.

We summarise the challenges reported pointing the need to understand the cultural predicates about suicide of the people and communities served, which include the role of spirituality in health care; the need to understand the socio-cultural tensions experienced by the people and communities served, considering the indigenous specificities in the sharing of institutional referral flows, the relevance of more appropriate spaces to the indigenous experience for care, the provision of care in places closer to where indigenous people live; and the need to understand the singularity of the life trajectories of the people assisted in relation to their people and community of origin, specially reflecting on issues that generate discomfort of the professionals for the situations where there is abandonment of treatment. The professionals need to feel secure about the processes involved in the dialogue where the indigenous people are the protagonist in the elaboration of the basis for cooperation concerning the psychosocial care aims.

Declarations

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