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SCIENTIFIC ARTICLE - CASE REPORT

ETHNIC SUICIDE: AN AVOIDABLE PHENOMENON AMONG INDIGENOUS CHILDREN OF THE BRAZILIAN AMAZON

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ABSTRACT

The indigenous population is particularly vulnerable to psychiatric disorders and suicide, as recorded worldwide among various ethnic groups and ancestral peoples. We present a case report to illustrate the psychopathological phenomenon of psychotic depression with suicidal behavior in a Karajá indigenous child, documenting the possibility of successful medical intervention to prevent suicide, despite the obstacles posed by the Brazilian government that hinders the treatment of this vulnerable and at-risk population, clearly revealing the neglect of psychiatric care for Brazilian indigenous children. Indigenous children seem especially vulnerable to psychiatric disorders and suicide, even though they are culturally more isolated than adults and have had less exposure to non-indigenous culture. This serious situation and public health problem among indigenous people are still interpreted in a romanticized, inappropriate manner, with a strong sociological bias, to the detriment of modern approaches to mental health based on Neurosciences. Denying children access to treatment, regardless of or because of their ethnicity, especially when their lives are at risk, may constitute a crime according to the standards regulating humanitarian treatment that our civilization has achieved.

Keywords: Indigenous, Amazon, Mental health, Psychiatric disorders, Suicide, Karajá Ethnicity.

INTRODUCTION

The native indigenous communities of Brazilian territory total approximately 817,000 people, distributed across 305 ethnic groups.[1] The Karajá people represent one of the most traditional and preserved ancestral communities, with a rich culture of collectors, fishermen, and hunters, living in a manner very similar to our ancestors from 10,000 years ago, in a pre-agriculture period. The Karajá people traditionally survive through fishing, hunting, and gathering fruits and roots from the Cerrado.

Art and ceramics are important cultural expressions for this ethnic group. They are known for their skill in creating decorative ceramics, which are used in rituals and ceremonies. The pieces are adorned with colored graphic designs (geometric drawings) and represent animals and human figures.[2,3]

This ethnic group belongs to the Macro-Jê language family and uses the native language Iny rybè, in addition to Portuguese. They have a social division in which men play roles such as hunting, fishing, defending the territory, political leadership, and building the villages. Women are responsible for the care and upbringing of children, performing domestic tasks, artistic work such as painting for ritual ceremonies, and making ceramic dolls, as well as preparing food for festivals.[2]

The Karajá people primarily inhabit the Araguaia River basin, occupying lands in the states of Mato Grosso, Tocantins, and Goiás, in a transition area from the Cerrado to the Legal Amazon[2] (figura 1). (Figure 1). The ethnic group has a population of 4,326 people. Each village establishes a specific territory, demarcating internal cultural spaces for their ritual practices, fishing, and hunting.[1]

The indigenous population is particularly vulnerable to psychiatric disorders and suicide, as recorded worldwide among various indigenous peoples and ancestral ethnic groups. The study and approach to psychiatric disorders and suicide among Brazilian indigenous people have been neglected for centuries and continue to be so to this day, with very little scientific literature on this topic and the absence of clear and effective public health policies. Since the 1990s, with the epidemic of alcohol and drug use and the announcement of alarming suicide rates among indigenous people, academic and media interest in this and other phenomena related to indigenous mental health has emerged.[4,5,6]

We present a case report to illustrate the psychopathological phenomenon of psychotic depression with suicidal behavior in a Karajá indigenous child, documenting the possibility of successful medical intervention to prevent suicide, despite the obstacles posed by the Brazilian government that hinders the treatment of this vulnerable and at-risk population, clearly revealing the neglect of psychiatric care for Brazilian indigenous children.

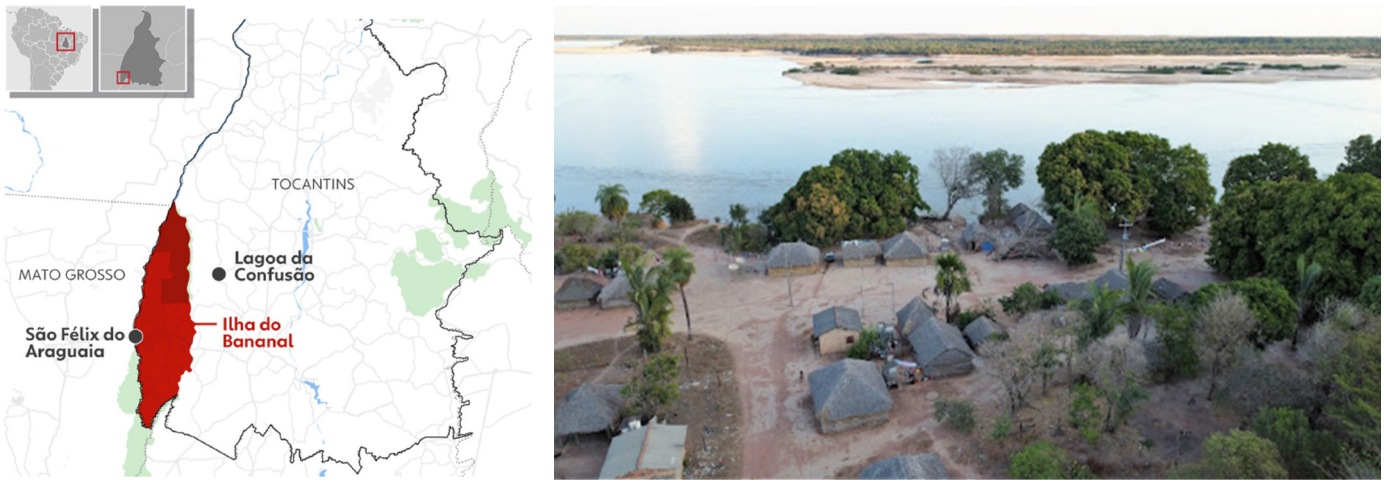

Figure 1 – Geographic location of Bananal Island (above) and Karajá village (right side).

CLINICAL CASE

Ibòò marãdu (fictitious name), 10 years old, male, indigenous child from the Karajá ethnic group, lives in a relatively isolated village on the largest river island in the world: Bananal Island, on the banks of the Araguaia River (Figure 1). Ibòò marãdu has very little contact with non-indigenous people, living with his community of nearly 3,500 individuals. Ibòò marãdu began a two-month history of a typically depressive syndrome (depressed mood, easy crying, irritability, anxiety, distress, loss of appetite and consequent weight loss, insomnia, anhedonia, social withdrawal), with evident functional and social impairment (he abandoned school and stopped playing with other children), along with indicators of severity: episodes of self-mutilation (slapping his face), shouting, and running away into the forest adjacent to the village, seemingly with psychotic symptoms (paranoid delusions) that he would be captured by forest ghosts.

The mother reports that the child had a previously normal mood, interacted well with other children and at the indigenous school. He was born at term, through a normal home birth without complications, and was breastfed until 18 months of age. He shows normal neuropsychomotor development and has received complete vaccinations. There is no history of personal trauma, head trauma, CNS infections, epileptic seizures, or any other systemic medical issues. The mother used to abuse alcohol when she was young and reports having had episodes of major depression. The father abuses alcohol and cigarettes, uses illicit substances (gasoline mixed with toothpaste), and has an unstable, irritable mood and sometimes physically assaults the mother. Several of his relatives also have issues related to alcohol and cigarettes, as well as reports of mood disorders.

The anthropologists from FUNAI responsible for the community denied medical treatment for weeks, justifying that it was a "cultural problem" and, as such, should be resolved within the community itself. In Western terms, we could translate this as: "left to fend for himself." However, the psychiatric condition worsened even further, and the child attempted to drown himself in the river, but fortunately, he was stopped by another boy who witnessed the scene. The mother, going against FUNAI's decision, asked for help from a niece who knew us previously and brought the child for treatment. We received the family and, based on the transcultural phenomenological psychopathological examination, diagnosed psychotic depression. Given the family history suggestive of bipolarity, we started atypical antipsychotic medication (quetiapine 25 mg/day, titrated to 50 mg/day after 14 days) and provided psychotherapeutic support to both the child and the mother. After six days of treatment and follow-up, the child was no longer suicidal, and after three weeks, he was in a euthymic state, with no residual symptoms of psychotic depression and without any undesirable side effects. The family was instructed on the importance of continuing the treatment, including forming a therapeutic alliance with the tribal shaman responsible for the tribe, with the goal of joint treatment while respecting the community's ancestral traditions. However, after three months, the treatment was interrupted due to the difficulties in transportation imposed by those in charge of the community's health services, and we lost contact with the family, despite persistent requests made to local authorities to prevent the treatment from being discontinued.

DISCUSSION

Combining the data from the anamnesis with the psychopathological examination and considering the psychiatric history of both parents of the indigenous child reported here, the most likely diagnosis is a severe depressive episode with psychotic symptoms in the context of bipolar disorder type.[1] This illness is recognized as a major imitator, capable of mimicking several diagnoses in Child Psychiatry,

which makes its diagnosis complex and difficult, posing a challenge for non-specialists. It is one of the diseases associated with high suicide rates, requiring rapid diagnosis and intervention. The family history of mood disorders is rich, as it is a disease with a strong genetic basis and linked to a very high heritability pattern.[7]

Sociogenic theories attempting to explain the etiology of mental disorders were prevalent in the 19th century8 and, unfortunately, are still used today in a pseudoscientific manner to justify psychiatric illnesses in various settings, particularly in the context of ancestral communities exposed to Western culture9. In this regard, some anthropologists – like those mentioned in our case report – often interpret mental illness among indigenous people as a process associated with the harms brought about by contact with non-indigenous people and the increasing process of acculturation9. Our group has been debunking these false interpretations with empirical data from studies on indigenous children and adolescents, demonstrating that psychiatric illnesses, which are brain diseases, affect these ancestral communities as they do any other human group, regardless of their level of isolation.[10,11,12]

Suicide rates among Brazilian indigenous people are higher in areas where communities are more isolated, namely in the Central-West (35.6/100,000 inhabitants) and North (24.1/100,000 inhabitants) regions, with lower rates in communities located in regions with higher levels of acculturation, such as the Northeast, Southeast, and South (3.8, 4.1, and 9.7/100,000 inhabitants, respectively).[13] On the other hand, suicides predominantly occur in the gender most exposed to the acculturation process, among men. Other demographic characteristics of indigenous suicides include: they mostly occur in the 15-29 age group, among singles, with low educational levels, and predominantly by hanging.[13] It is striking that among indigenous children, the suicide rate observed is 11/100,000 inhabitants, meaning it is 18.5 times higher than that observed among non-indigenous children (0.6/100,000 inhabitants)[14,4], an alarming statistic that highlights the lack of official government intervention on a Brazilian indigenous public health issue that jeopardizes this ethnic group and its ancestral communities.

Prejudice against the diagnosis of depression, even in cultures very different from our own, and the lack of preparation to deal with these transcultural occurrences, can lead to terrible outcomes. Fortunately, a healthy encounter between asymmetric cultures, when guided by respect for their origins and ancestral values, can translate into benefits for the community, by providing access to advancements in medicine without it representing the subjugation or kidnapping of that people's cosmological essence.[15]

CONCLUSION

Indigenous children seem especially vulnerable to psychiatric disorders and suicide, even though they are more culturally isolated than adults and have less exposure to non-Indigenous culture. This serious situation and public health problem among Indigenous people are still interpreted in a romanticized, inadequate way, with a strong sociological bias, to the detriment of modern approaches to mental health based on Neurosciences.

Denying children access to treatment, regardless of or because of their ethnicity, especially when there is a threat to life, could be considered a crime under the regulations that govern the humanitarian treatment our civilization has achieved.

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