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THEMATIC ARTICLE

Mental health in the Tupinambá community of Serra do Padeiro, southern Bahia, Brazil: community and struggle as sources of health

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Abstract *This work presents concepts and practices linked to mental health in the Tupinambá Indigenous community of Serra do Padeiro in southern Bahia, Brazil. This qualitative cartographic research mapped existing processes and relationships in the Tupinambá territory. Data production techniques were participant observation, semi-structured interviews, field diary, and bibliographic studies. Shared responsibility characterizes how Indigenous medicine care is organized in the territory. The factors that produce psychosocial distress, care practices, and conflict coping are understood from the interactions between Indigenous and non-Indigenous ways of care. The inseparability between psychic and social is combined with territorial dimensions, reinforcing the link between mental health and daily community life. The struggle for territory enables the reconstruction of a subjective ethos that refuses servitude, moving from previous conditions of precariousness and subalternity, with expulsion from the territory to other more autonomous and collective subjectivation processes. The example of Serra do Padeiro highlights that the struggle offers the most significant health.*
Key words *Mental Health, Indigenous Populations, Ethnic Violence, Social Cohesion*

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Introduction

Suppose the visibility of mental health problems has spread in Brazil, driven by the advent of the pandemic, wars, and environmental, economic, political, and social disasters. In that case, the same is true for the problems of Indigenous peoples[1]. The slowness of demarcation of Indigenous lands, the Temporal Framework, conflicts over territorial rights, the illegal exploitation of natural resources, and various forms of state and civil violence generate problems that function as "factors that directly contribute to the fragility of Indigenous territories and are responsible for the escalating land conflicts in the country"[2], producing diverse distress levels in these populations.

The relationships between mental health, interethnic violence, and climate crises are increasingly emerging as analytical issues. Conflicts linked to Indigenous lands and development projects are part of this problematic outlook. The impacts on the lives of Indigenous peoples include changes in the traditional ways of life, the production and consumption methods, and habits; harm to the comprehensive and safe development of children; weakening of the elderly population, the primary guardians of Indigenous knowledge; harmful use of illicit and licit drugs (including psychotropic medications); increased cases of suicide and other forms of violence[3]. The health-disease process among Indigenous peoples considers, among its socioeconomic and cultural determinants, the dimension of the right to land, its preservation and permanence, associated with these social groups' political and health self-determination. The relationship with the land, natural environments, and spiritual beings underlie the collective construction of their organizations, which is also intrinsically linked to physical and psychological balance[4]. The systems of knowledge and practices of Indigenous medicine and the relationship with non-human beings are components of their cosmologies, founding and organizing their ways of life.

This paper presents a map of the concepts and practices related to mental health in the Tupinambá community of Serra do Padeiro in southern Bahia. It presents some concepts of psychosocial distress, different care practices, and coping strategies in a territory of land conflicts. Given its importance for this community, the interaction between Indigenous and non-Indigenous care methods is an aspect to be observed. The ways of conceiving and caring for psychosocial distress, the influence of the struggle for territory and community organization on recovery and prevention of diseases – are guiding aspects of this work.

The results of this study present specific conceptions of the mental health of a cultural group, an articulation between its meanings and practices, and the Tupinambá People's ways of life and resistance. They dialogue with the transcultural perspective in the document that guides psychosocial care in the health policy of Indigenous peoples, in which "mental or psychosocial health or well-being refers to something more than simply the lack of distress or illness, but rather to individual, family and social/community well-being or good living"[3]. The low number of studies on mental health in Indigenous contexts in the Brazilian northeast (even less so on the Tupinambás) is a gap that is being addressed. The analysis of the confluence between struggle, community, and mental health is where this study stands out, where the problems studied are centered on the indicated policy markers.

Tupinambá da Serra do Padeiro

The Tupinambá de Olivença Indigenous Land (IL) covers approximately forty-seven thousand hectares, stretching from the coast to the mountains and encompassing more than 20 Indigenous locations. Located between the municipalities of Buerarema, Ilhéus, São José da Vitória, and Una, in the southern region of the state of Bahia, Serra do Padeiro is one of the communities in the IL. The Brazilian government recognized the Tupinambá ethnic identity in 2002. The procedures for identifying and delimiting the IL started in 2004. The ratification of the territory to the Tupinambá people has faced several obstacles from the Brazilian government and is currently stagnant.

The unsatisfactory progress of the Tupinambá demarcation process required the beginning of land recovery in 2004, in which traditionally occupied areas under the possession of non-Indigenous are recovered through Tupinambás' direct action[5], which has led to continued reactions from rural landowners, public agents, and local businesses. Assassinations, monitoring the movements of leaders, arrests, torture, ambushes, media defamation, and ethnic racism are some of the actions taken. "Given the incomplete land regularization process, the Tupinambás have guaranteed through direct action effective ownership, if not of the entire territory, of a good part of it"[2]. Conquering it requires the community to

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organize itself, improve its strategies for struggle and survival, and address the effects of conflicts and good living.

The community has notable support within Indigenous and indigenist movements, and from national and international bodies. It has a historical leadership in fighting for Indigenous rights regarding land, health, education, culture, and ancestry. Centuries of coexistence with non-Indigenous people have led to the need to articulate the knowledge of the "white man's world" to strengthen the fight[6]. They gain recognition through community organization. One example is the Tupinambá Cloak[7], where research and production of cloaks used ancestrally by Tupinambás has enhanced ethnic and community reconstruction, environmental protection, and Indigenous arts and sciences.

The 2019 Special Secretariat for Indigenous Health (SESAI) data indicated that the Indigenous population in the IL was 5,038[2]. A 2016 census in Serra do Padeiro revealed 483 Indigenous people in the community[2]. The Indigenous Health Policy is implemented through the Multidisciplinary Indigenous Health Team (EMSI) linked to the Ilhéus Base Center, a technical assistance unit linked to the Special Indigenous Health District of Bahia (DSEI-Bahia), a SESAI decentralizing body.

Mental health in an Indigenous context

The psychosocial distress concept addresses distress-producing situations experienced in everyday life. A complex set of elements underpin (individual, family, political, institutional, labor, economic, religious, environmental, cultural, aesthetic) and interfere with daily life. The psychic dimension and social field inseparability reinforces the connection in mental health between daily life and its underlying plots, the active bonds, and their effects on subjectivity. In the Amerindian context, the psychic-social inseparability is combined with the territorial dimension. The importance of land for Indigenous nations should be considered not an end but a principle. To this end, they must improve and reinvent their practices of environmental protection, production, consumption, agency, and ritualization amid conflicts. Such practices, seen as care actions, help to rethink non-Indigenous mental health, generally based on biologicist and individualizing notions that favor health medicalization in Indigenous populations[4]. These consist of defining and treating non-medical problems as medical ones, translating into diseases[8]. Medicalization reduces autonomy, devalues the impacts of the context on health, depoliticizes social problems, and simplifies distressing experiences.

The relationships between social and cultural issues and mental health among Indigenous peoples are expressed in aspects such as diet, physicality, curative and preventive actions, rituals, baptisms, natural remedies, respect for older adults, religiosity, native language, respect for knowledge, and the very Indigenous struggle[9], which is a repertoire highlighted as ways of promoting health. The colonialist process intervenes in these aspects and directly affects the production of mental distress and illness among peoples, given the difficulties in living the "Indigenous ethos". "To be entangled in mental distress is to have problems related to internalities and white people's affairs"[10]. The historical struggle of these nations "is not a choice, but a way to keep or create favorable conditions for promoting health, above all, for its permanence"[9]. Fighting and resisting is a health-producing vector and, at the same time, its attestation. Struggle and health feed off each other.

Methods

We employed cartography, a qualitative intervention research method, to build knowledge of processes and relationships linked to certain territories. We aimed to monitor processes, outline the network of forces linked to the event under study, investigate their permanent movements and modulations, and capture dynamics and events in a health-producing territory[11].

The first author entered the field after contacting community leaders for prior authorization through ethical procedures and planning the period for conducting the research. There were no difficulties in this authorization, given the cooperation, connection, and coexistence relationships established since 2017 with the community. The techniques used were participant observation, semi-structured interviews, field diary, and bibliographic studies. The field period lasted three weeks, followed by remote monitoring of community processes based on contacts and news. Observations occurred in ordinary community spaces, celebrations, collective work, and the community association's monthly meeting. At this meeting, an agenda was requested for presentation, evaluation, collective authorization, and delimitation of participation criteria.

The people to be interviewed were chosen by mutual agreement between the community, the first author, and some of the people interviewed. Fifteen interviews were conducted and audio recorded. One person belongs to the Pataxó Hã-Hã-Hãe ethnic group, and the others are Tupinambá. Nine women and six men were interviewed. Four women are older adults; the others are over thirty. One man is an older adult, and the others are 30 to 55. Three people work on the health team; two are nursing technicians, and the other is an Indigenous Health Worker. One technician coordinates the health sector. The interviews were held during home visits and in private spaces to maintain confidentiality. The Informed Consent Form for participation in the research was presented and signed in all interviews.

The interviews were processed by listening to and transcribing the recordings. The questions in the interview roadmap helped to structure the thematic axes but did not define them. The grouping of transcribed excerpts into thematic axes allowed us to analyze the variety of discourses and elaborations on the same theme, such as expressions used, events and memories, and affections and feelings during the speaking experience.

Data were analyzed by composing thematic axes and collecting excerpts to assess the themes' convergence (and divergences). When applicable, the most significant keywords in the list of expressions of the axes guided the establishment of analytical categories. Keywords aimed to transform the participants' modes of expression into analytical categories, concepts to explain mental health, and the struggle for land. Field diary use and bibliographic review complemented the research results.

Adopting pseudonyms was due to two symbolic aspects provided by the community. Parenthood with plants, especially trees, is naming plant species, fruitful or not, with the names of relatives. Then, there is the identity with birds[12].

This work was approved by the National Research Ethics Commission (CONEP) and the Research Ethics Committee, responding to both requests and forming part of the first author's master's dissertation[13].

Results and discussion

Mental health concepts

The mental health concepts expressed by Tupinambá interlocutors alternate between the following dimensions: genetic-hereditary, family, interpersonal within and outside the community (including with non-Indigenous people), life events, territorial conflicts, and spirituality. The theme of madness is generally mentioned when discussing mental health. The spiritual dimension was cited as a determining factor in situations and cases considered mental health problems. Biriba, a leader and elder in the community, defines it as "Some people are born with problems. Others, due to life, have depression (or what people call depression) and are affected by something. Others experience a spiritual event, embody a spirit, something incorporated into the person". *Crazy (or going crazy), mad (or going mad), depression, stress, nerve pain, disorder, mental illness, sound mind, head problem, mongoloid, day-to-day well-being, mental illness, psychology of the mind or brain, talk doesn't make sense, forgetful, talks too much, takes medication*, were some of the terms used to refer to the topic.

The term *crazy* is the most commonly used term to refer to someone with a mental problem. It is generally used in a derogatory, humorous, or more generic way or with some evaluative criterion. "*There is the complete crazy person [entirely, completely], who runs and throws rocks, and the crazy person who lives with us, but is not quite right in his mind, he/she is somewhat crazy*", points out Biriba. This concept has concrete consequences, such as the need to use medication. They claim that some do not need medication, others do and can "control" themselves with it, and others who, even using it, cannot control themselves. In keeping with Biriba's caution in differentiating craziness levels so as not to lump everything together, Guará, a middle-aged adult and leader, does so. Between mockery and seriousness, he points out elements to understand a Tupinambá principle.

We, Tupinambá, are baffled. First, we think everyone is crazy [laughs]. We have a principle that everyone is crazy. We need to respect the individuality of others. The individuality of others is very different from mine. [...] we understand that often what someone calls crazy is that they want someone to sit down and spend the whole day talking and the other person listening. What they want is to be heard. At the point where everyone is worried and doesn't stop to listen, they are treated like

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crazy because they get nervous, stressed, and start cursing because no one stopped to listen. Some other cases include people who are angry with life because they want to be alone in a corner without looking at anyone (Guará).

The understanding of the topic changes with schooling and interaction with non-Indigenous people, directly affecting how to understand and deal with the topic. Lavandeira, a leader in education and culture, addresses this change. From the viewpoint of the disease as incurable and crisis containment practices – reports from the community's elders – he moves to an understanding based on the dialogical resource of words and less linked to the use of medications, prioritizing inclusive actions in community life.

It's about understanding this very place of mental health. We used to understand that everything was an illness. You had to be admitted to a mental hospital, or else there would be no cure. You could get better and receive palliative care. You had to take medication: you had to be medicated. With this understanding of mental health, there is another way to deal with and treat it, which would not necessarily involve medication (Lavandeira).

Such changes influence the distinction between original and Western perspectives on mental health[14]. They present a process of reviewing current concepts of asylums – also colonial legacies – corroborating that unifying an understanding of mental health is unfeasible[3]. At the same time, they speak of an interethnic outlook of secular contact, where the notion of mental health (and another Western knowledge) is found. Although each Indigenous society understands mental health differently, the effects of Western medicalization in the territories bring complex domains to its understanding. The varied health practices outlined from the interaction between Indigenous and Western knowledge speak of an ongoing construction of movements of negotiation, exchanges, and agencies rather than homogeneous stabilizations[15]. Herein lies the first task for any interethnic action[3-11,13,14,16].

The fight for land is often seen as a source of distress. "*One thing that the elders here say is that many people also went crazy about territory, of belonging to the place. Because everyone lived here, and suddenly the fence arrived*", recalls Lavandeira. The continued experience of emotions such as fear, apprehension, and anger, with the undefined territorial situation and the existing conflict, incites illnesses that range from depression to madness. Jenipapo, an Indigenous Health Worker involved in the reoccupations since he was eleven years old, believes that "going crazy" results from "overthinking and being afraid" due to the "wars", their confusion, and overload. "Fear of one thing and thinking about that", referring to the constant concerns of territorial disputes.

In order to have our mental health and not this variation, the territory, the land, and nature need to be well. Because we have this responsibility, this connection with the land. We are not displaced, and people try to cut this umbilical cord (Lavandeira).

Conflicts also compromise people's comings and goings and the establishment of external and even internal bonds. Forced migration from the territory was listed as a source of disorientation and distress. In some cases, the difficulty in forming relationships can lead to loneliness, referred to as a source of distress, especially depression. "*Some relatives leave, and they become disoriented until they return*", says Pintassilgo, a middle-aged adult, referring to family cases and perhaps to himself, who was once a migrant, noting the influence of territory and community on well-being. These are compulsory territorialities in the face of the hardships of non-demarcation that shape distressful processes affecting mental health[17].

Care

There are different ways of naming and referencing care actions. "Traditional" care, Indigenous medicine – "*because it is medicine*", says Biriba – is widely referred to in the use of baths with native or cultivated plants, herbs, teas, home-made medications, prayers (praying over the head), natural baths in stone caves, water springs, and walks. These actions strengthen the spirit and promote care for afflictions, distress, and illnesses. Difficulty sleeping, problems with alcohol use, physical weakness, mental disorders such as hearing voices, seeing figures, physical and mental discomfort, motor and psychological agitation, depression, and melancholy are some of the ailments mentioned.

The elderly population is an essential group in the provision of mental health care. They are sought out in times of anguish, distress, doubts, and conflicts or to obtain a blessing, prayer, material help, care for children, medical recommendations, and reconciliation between couples and family members. This work is not limited to the shaman's work but extends to other older adults in the community. The custom of visiting people's homes is a resource in the repertoire of care and the local therapeutic itinerary. According to Pin-

tassilgo, who witnessed elderly care concerning his grandfather, a prayer and former shaman, "*these older adults knew how to talk to people*". The way they talk can solve many things. Jenipapo talks about the shaman's work: "*I'm sure [that] he keeps these things away, from people going crazy. With his prayers and baths, he keeps bad things away, from people going crazy*".

Decentralization and shared responsibility for traditional care are attributes of how Indigenous medicine care is organized in the territory. With the participation of different stakeholders, it can occur independently in homes and nearby areas, or referrals to a shaman can occur when the problem persists. The shaman's assessment can lead to developments, such as an assessment by the health team. In many cases, therapy can use both medicines. This flow can derive from the health center, which guides the search for the shaman while they continue monitoring.

Health activities are monitored assiduously by leaders and the community as part of the local association's planning, making up one of the six departments. It occurs due to the lack of supplies, fuel for health vehicles, road maintenance, and driver payments, among other problems. In the 2019-2023 Planning Report, a five-year community plan, the health item, the first item addresses "Monitoring mental health with SESAI", presenting the relevance given to the issue[16]. In this note, when citing the precarious situation of Indigenous health, they add:

It is no different with the Tupinambás. Many problems need to be solved, especially in the quality of care, which is currently visibly precarious. One of the particularities of the Tupinambás is mental health, which is currently far from providing the support they need. AITSP works to meet the needs that the State cannot[16] (p.14).

The health team and treatments with non-Indigenous medicine are frequently referred to and inserted as a resource for mental health care in the community. Specialized assistance occurs mainly at the Psychosocial Care Center in Una and the psychiatric hospital in Ilhéus. The association's funds cover private appointments with psychiatrists in Itabuna. There is a unanimous report of difficulty accessing services in Una, the least used route. Distances, unmaintained roads, scheduling and transportation hardships are barriers to access, which also point to possible difficulties for the DSEI and the Base Center to coordinate services. Thus, the agencies that the community builds with its health team often manage to face problems with their resources.

In the past, there was no medicine to help. [...] That was where we had to take care of ourselves. However, today, thank God, we have the spiritual and medical sides, which is also very good and helps. Medication is obtained there [at the health center], and people calm down. That is a blessing. It is even better when a doctor is not an unbeliever and does not reject our medicine. [...] We can drink whatever medicine we want, but it is useless if we don't bathe or sip a cup of tea (Biriba).

Indigenous sciences are components of mental health promotion in communities. They are part of differentiated care[3], with different obstacles to implementation since biomedical knowledge is often not worked on from a complementary perspective. The agencies with beings from the territory, rituals, and diets appear as resources for coping with distress linked to territorial conflicts and other conflicts linked to daily life[9,14,17]. In Serra do Padeiro, the intercultural dialogue between Indigenous caregivers, leaders, and the community with the Indigenous Health Policy (team and management) points to an interethnic and differentiated action based on the leadership of the community and its agents in the territory.

Territory and spirituality

The recovery of part of the ancestral territories is a structuring axis of community life[5,6] that enables rebuilding a subjective ethos of refusal of servitude for more autonomous subjectivation processes. It shifts the conditions and experiences of deprivation, precariousness, and subordination previously imposed with the territory's dispossession. The resumption of production and organization activities through community associations and cooperatives leads to better living conditions, rebuilding community bonds, and strengthening the ability to address interactive problems and external threats. It is combined with strengthening identity, connecting sociocultural and territorial ties.

The reorganization of occupied lands promotes environmental recovery, the maintenance of which is the responsibility of the Tupinambás under the guidance of the Enchanted Ones. Non-human or "extra-human" entities that can acquire human form through incorporation, the Enchanted Ones make up the spiritual, cosmological, and cosmopolitical system of the Tupinambá and many Indigenous ethnic groups in the Brazilian Northeast[18]. Their caring and protective role is fundamental to the Serra do Padeiro.

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The links between the Tupinambás, the Enchanted Ones, and the territory underpin the community's existence and ethnic identity. The Enchanted Ones appear mainly through incorporations and in dreams. In the first case, mainly in rituals called *Toré/Poranci*. They act directly in the fight for the territory, health care, school management, the protection of the inhabitants and community life, the care of internal and external ties, the environmental, cultural, and ethnic recovery[2-6]. In health, they provide guidance, care, and follow-up in accidents, distress, and illness. In mental health, their work includes ecological and cosmic influences in the biopsychosocial sphere. Spirituality establishes close connections with mental health. Hearing voices is an experience commonly attributed to spirituality, whose interpretation requires caution in any intercultural translation.

White people say that schizophrenia exists. People hear voices. Indigenous people have always talked to spirits and always dialogued with them. However, in the white world, they call it schizophrenia to take away the gift of others to talk about something that cannot be seen. Many Indigenous people are on edge and hearing more and more. Even those in the city who did not know they were Indigenous have begun to wake up and hear voices and see things that others cannot see[12].

In the experience of producing the Tupinambá Cloak, Silva[7] reports his experience, which approaches the theme of hearing voices, madness, and spirituality.

I see that the Cloak really spoke to me; it is not my fantasy. Because I thought, "Am I delirious, am I crazy?" But no, the Cloak spoke to me, and these images came to fruition in reality[7] (p.331).

The intimate relationship between perceptive experiences (hearing voices) and spirituality is understood here based on the actions of the enchanted ones. Hearing voices is not a symptom of a possible disorder or illness. An attribute of the Indigenous being is the connection with the territory's beings. Hearing and imagining, outside of the capture of hallucinations and delusions, can connect with spiritual and even artistic experiences. The advent of "talking to something that cannot be seen" can also produce disturbances that lead to experiences of madness. We should underscore how non-Indigenous knowledge and practices' expropriation and colonial epistemological procedure generally operate in subjectivity, reducing such experiences to symptoms and diagnoses[19]. In the present case, hearing voices can offer practical indications for treating and healing certain illnesses since the experience of madness and deviation is incorporated as an element of subjectivity. However, due to prolonged interethnic contact, madness can also be seen as deviation, reinforcing interpretative prudence.

Collectivity, culture, and work

Cultural life in Serra do Padeiro has a distinctive place in its organization. Generally animated by the youth group, the school and religious events, festivities and rituals renew and strengthen the action of the Enchanted Ones and community ties, besides expanding and consolidating political articulations with external stakeholders and organizations. It is another component of the diversity of the community project's activities.

A current and relevant aspect is the impact of the Tupinambá Cloak. Present in different spheres of knowledge production and arts, it has definitively placed Serra do Padeiro on the map of Indigenous art and education[7]. This adds to its good practices in production, subsistence, and spiritual care. More than an external repercussion, the Tupinambá Cloak demarcates a territory of internal strengthening of the community and its leaders.

Biriba summarizes the intersections between culture and health. It gathers two striking aspects of Tupinambá: food and eating. It is a synthesis of their philosophy, science, and medicine. It is a source of life support. Aphoristically, it says that *joy stems from the guts!*

Here are two things that Tupinambá like: eating pepper and working hard, and solving all their problems. It can be the worst of problems. It's funny: we just smile. No matter how angry we are, we'll only be found smiling and happy. Joy stems from the guts. If you're hungry, there's no certain joy. If you're crazy, eat. If you're healthy, eat. [...] That's what life is (Biriba).

Regarding work, one aspect stands out in the reports: doing what you like. This is often the defining criterion for choices and definitions in the division of labor. Pintassilgo, an area coordinator, brings the perception of what "others like to do" to his activity. "*Everyone has a gift for doing something*". Working is another form of individual and collective care. It may be connected to the forgetting strategy, "*working instead of thinking about the worst*", because staying that way "*gives you an extra blow*", he warns. It also appears as a resource to face the restrictions on movement imposed due to threats, as in the case of leaders.

It is common in groups that one problem wants to override another. This requires a key

theme, a guide to follow, even in the turbulence of quarrels. "*Sometimes we see the quarrel, some other times we see the territory, and trample on any quarrel*", says Guará. "*Is an Indigenous getting drunk a territory matter? An Indigenous woman to marry a drug addict, an Indigenous stealing, or other types of issues, are not reasons not to fight for the territory!*" he adds, aware of typical rhetoric on the subject. A priority theme that reshapes the problems and directs the forces and tensions of the struggle, the territory is where the community is woven.

"*Here, many people are united; they gather for anything. Everyone takes care of their lives, but, when necessary, they are united, together*", observes Amescla, highlighting the workspaces such as the manioc flour processes and the association meetings, when together strengthening the feeling of unity and its effects on health. The community is a unique element in confronting psychosocial problems. A tool for problematizing care, it favors work arrangements centered on the community and interactions between individuals and external agents, including the health team. It is a necessary path to avoid and deconstruct tutelary and medicalizing modalities[4]. The formation of solidarity support networks and collective production methods support health and education policies, exercising active social control. This organization continually articulates different spheres of life, favoring understanding the Tupinambá ways of addressing biopsychosocial distress.

Learning and coordinating knowledge to live well and fight better is relevant. Economic empowerment, the formation of alliances, the strengthening of political action, inclusion in higher education institutions, and the ongoing training of young people and adults in the Indigenous movement are some of the lines of action identified. More than a consolidated achievement, sovereignty, and autonomy remain on the agenda and demand diverse work. As a component of subjective production, a historical Tupinambá refusal links the way of conceiving health in Serra do Padeiro to the warrior condition. Here, we present a unique trait of the Tupinambá attitude towards violence against Indigenous peoples and their impacts on health. Making the fight an inevitable flag to solve their problems, they find in it their permanent source of care and health, where death is no reason to retreat. This is what Guará says: "*We, Tupinambá, will never accept being vassals because we are an Indigenous people, autonomous and masters of ourselves. We die fighting, but we never serve*".

Conclusion

The different aspects of community life in Serra do Padeiro encompass the stage reached by this Indigenous group in its struggle for an autonomous and sovereign project. They contrast with the imaginary and stereotypes of impoverishment and distress attributed to Indigenous nations. Their conceptions of mental health encompass several ways of understanding and practicing care for psychosocial distress. In dealing with the colonial process, they learned to articulate traditional and Western knowledge to promote their health by fighting for rights. Territory, spirituality, community, work, and culture are closely linked. The centrality of the struggle for land emerges as an axis that produces distress and care in the search for health, which is only possible from the territory. The land repossessions are a historical milestone in reorganizing territories and communities. They work in and through the territory, protecting their place, bodies, bonds, and ancestors. They operate their agencies to defend it, prosper it, and share their achievements. In the meantime, a comprehensive concept of health is produced.

A brief outline of the process that runs through the several events that generate distress to the collective zeal movement strongly linked to the action of the Enchanted Ones and the very territory can be made. Engagement in the struggle and its fruits (land recovery, community relationships, social rights, subsistence conditions, and cultural and religious life) promotes access to experiences of abundant material, social, political, subjective, cultural, and spiritual resources. Health needs to be considered in terms of the elements mentioned above and others. The example of Serra do Padeiro helps to show that the most significant health comes from struggle.

This paper outlined strategies for analyzing mental health from a community perspective. This emphasis differs from the markers of the Indigenous Health Policy, which focus on delimited health indicators and problems. We attempted to provide reflections to qualify differentiated care, offering clues that guide related practices and research. The challenge of producing increasingly participatory methodologies is present.

In Serra do Padeiro, we find experiences that question pillars of the health culture, such as hierarchy between services, professionals, and clients; power struggles and disarticulation of social control; prejudice and violence against differences; and individualization and medicalization of so-

cial issues. Including the experience of Serra do Padeiro in the debate on differentiated care also qualifies the anti-asylum struggle. When addressing community-based practices, we can see the potential of culture and sociability to problematize Public Health. Before vertically implementing programs and models – as is customary – it is urgent to note that there is much to be learned from Indigenous nations, including when the subject is community, struggle, and health.

Collaborations

LJA Mendes: conception, design, analysis and interpretation of data. LJA Mendes, ID Varga and MON Torrenté: writing or critical review.

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