Becoming a (Neuro)Migrant
Attachment, Early Stimulation, and the Government of the Future of Chile
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Introduction

Since 2010 encounters between health institutions, practitioners, and Haitian and Dominican communities have triggered frictions and conflicts in the Chilean public health system, especially in maternal and child health. The gradual arrival of Caribbean migrants to the neighborhoods of the north of Santiago led practitioners to question health programs and their own practices in this matter. At a Family Health Center (Centro de Salud Familiar, CESFAM), psychologists, social workers, physicians, nurses, and midwives often talked about the “great difficulties” they experience when working with “afro-descendant women.” They used to tell me that Dominican and Haitian mothers “don’t prioritize attachment with their babies” and “don’t stimulate children.” Some of them reported, especially during informal talks at lunchtime or after leaving the center in the afternoon, that Haitian women had “strange practices” related to Haitian-Creole medicine and Vodou. Several workshops on “cultural competencies” organized by the local Health Department provided them with a cultural frame for reflecting critically on what they called “cultural practices.” Yet the training materials tended to promote a culturalist approach, leading some health workers to attribute practices related to gestation, labor, and childrearing to Haitian or Dominican “customs.” At the same time, some migrant women felt conflicted after clinical, psychosocial, and educational interventions in maternal and child health. In their everyday life spaces, women told me that “gestation” and “childrearing” were a “natural thing,” and they took care of their children like their grandmothers and mothers did in the past.

These frictions and conflicts challenged one of the most successful Chilean public policies: the Chile Crece Contigo (ChCC) program (Richter, Daelmans, Lombardi, et al. 2017). This program gives children access to health and social services and benefits in different state levels from gestation to age nine. The program’s premise is that children build the foundations of learning, language, physical health, mental health, and socio-emotional

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development during their first year of life (ChCC 2015). As in similar childhood-oriented programs and initiatives (e.g., Uruguay Crece Contigo; Zero-to-Three, First Thousand Days), developmental sciences play a crucial role. The program fosters comprehensive childhood development through multiple evidence-based psychosocial interventions within “windows of opportunity”—sensitive periods in the life of infants, toddlers, and children (ChCC 2006; 2012). The ChCC program is based on a 2006 interdisciplinary report emphasizing that the effects of poverty in childhood persist into adulthood. It also encouraged the Chilean State to address the country’s socioeconomic inequalities, giving children more opportunities from their early years (ChCC 2015; Torres, Lopez Boo, and Parra 2017). The report titled “The future of children is always today” (“El Futuro de Los Niños es Siempre Hoy”) was prepared and launched during the first Michelle Bachelet’s government of 2006-10.

In this article, I explore the interactions between health institutions, “psy” technologies (Rose 1996; Rose and Abi-Rached 2013), and afro-descendant women registered with the ChCC program. I document how these interactions affect women’s subjectivity and everyday life. Following Michel Foucault’s technologies of power, I talk about psy technologies to group practices involving psychotherapies, techniques of psychological evaluation, and psychopharmacology treatments. Rather than focus exclusively on biopower and the governmentality aspects (Foucault 2003) of maternal and child health policies and interventions, I foreground migrants’ heterogeneous processes of subjectivation and potentialities (Béhague, Kanhonou, Filippi, et al. 2008; Biehl and Locke 2010). In other words, I emphasize how migrants assimilate, resist or refuse individually and collectively (McGranaham 2016; Benjamin 2016) technologies for childrearing and child development promoted through the ChCC program.

I argue that, in the ChCC program, entanglements between attachment theory, neurosciences, and epigenetics gained authority for health practitioners, and shaped migrants’ representations of motherhood and childrearing anchored in neurobiology (Rose and Abi-Rached 2013; Vidal and Ortega 2017). Although health institutions have encouraged staff to improve their cultural competence in the new multicultural context, practitioners’ interventions have tended to promote a neurobiological understanding of attachment and early stimulation, neglecting moral and contextual dimensions of migrants’ parenting practices. These interventions have delineated representations of “normal” and “abnormal”
motherhood and childhood (Béhague and Lézé 2015), thus forming ideals of children’s development and a migrant citizenship project for the future of Chile. I also argue that by raising concerns about migrant children’s neurobiological development and social vulnerability, the ChCC program is an instance of what some researchers call the “neuroscience of poverty” (Wax 2017). That is, the validation of neuroscientific evidence that supports the relationships between poverty, vulnerability, neuroplasticity, and their effects in adulthood (Pitts-Taylor 2019).

This article is based on a multi-sited ethnography (Marcus 1995) conducted over 14 months between 2018 and 2019. I carried out observation sessions at the CESFAM and in different migrants’ daily spaces (e.g., neighborhoods, social organizations, etc.). In the context of the ChCC program, I participated in health practitioners’ meetings, workshops, clinical consultations, and home visits. I also conducted 45 semi-structured interviews with ChCC health practitioners, Dominican and Haitian women, family members, experts, and policymakers and gathered ChCC documents. Although different health practitioners’ and migrant women’s voices and documents converge in this work, I organize the central argument around the experiences of Lucy—a 30-year-old Dominican woman. I focus on Lucy’s case for two reasons. First, unlike other migrant women, Lucy participated in most of ChCC clinical, psychosocial, and educational interventions. And second, Lucy’s case reveals how migrant women engaged in a complex and heterogenous way with interventions. ChCC practitioners assessed Lucy as a “successful case.” Although she seemed to adopt “new” parenting practices, she and a few women revealed a certain degree of skepticism about the underlying mechanisms involved in attachment and early stimulation. Her case highlights how women integrated and hybridized parenting practices in different forms and to varying degrees.

I begin by describing how ChCC interventions promoted liberal values that paradoxically led some afro-descendant migrant women to internalize feelings of disempowerment and inhibition resulting from potential normative transgressions. Occasionally, ChCC practitioners evaluated these feelings as “passivity” or “laziness.” Then, I describe how attachment theory has delineated an ideal of motherhood based on a biological conceptualization of parent–child bonding, delimiting and validating some parenting practices over others. I then move on to explain how interventions (based on
attachment theory, neurosciences, and epigenetics) turned childrearing into a perfectible practice. I also document interventions that seem to shape afro-descendant migrant women’s representations of motherhood and childrearing around neurobiology. Toward the end of the paper, I describe how, for the ChCC program, afro-descendant children have become a potential risk that must be managed from early childhood. Here, I stress how the intersections between expert knowledge, racialized representations, and national ideals are crucial in shaping migrants’ otherness. Finally, I show that migrant parents face an “intensive parenting” ideology that leads them to put children’s needs first and pay attention to experts in children’s development.

**Responsibility and liberal values**

Lucy arrived in Chile in September 2015. Until then, she lived with her two children (12 and 8 years old) at her mother’s house in a shantytown marked by drug trafficking and crime in Santo Domingo, the Dominican Republic. She moved there after suffering from domestic violence for a couple of years. Although Lucy reported her former partner to the police, he constantly transgressed the restraining orders dictated by the court. The severe harassment and death threats led her to experience anxiety, depressive moods, and suicidal thoughts. Lucy’s father convinced her to emigrate to Chile, arguing that nobody, neither he nor the police, could provide protection. In Lucy’s words, her father considered Chile a “safe” and “prosperous” place.\(^{11}\) In Chile, Lucy found some stability. She got a job that allowed her to send monthly remittances to support her children. She also engaged in an intimate relationship with a Dominican man and fell pregnant in early 2017.

Lucy arrived at the CESFAM when she was 20 weeks pregnant. Following ChCC guidelines, one of the CESFAM midwives registered her in the ChCC program, which was standard practice for all pregnant women in the public health system. Midwives aimed to register women before 14 weeks pregnant. For this reason, the practitioner promptly introduced Lucy to a structured plan of medical controls, workshops, and informational materials about gestation and childrearing. The same midwife pointed out: “we are receiving migrant women in the program after week 14, and this is a problem for women’s health and also for our program’s statistics.” In parallel, Lucy said, as many other migrant women
interviewed for this research, that she did not contact practitioners earlier because she did not feel “any complication with the pregnancy during the first weeks.” In these situations, practitioners usually highlighted the “relevance of prevention for mother’s and baby’s health,” thus promoting the “women’s responsibility in the process from the beginning.”

During her monthly check-ups at CESFAM, practitioners noted that Lucy began expressing mental health issues after receiving some news from the Dominican Republic. A very close friend warned her about her son and daughter’s the living conditions, saying: “your mother has been spending the money that you send them from Chile betting with friends...your children sometimes did not even have enough to eat, and the neighbors often gave them a plate of food.” Lucy felt that her mother did not recognize the great efforts she made in Chile: “nobody understands that here in Chile nobody gives you a plate of food...here if you do not have a job, you die of hunger.” Anxiety and sadness became prominent in her everyday life. Facing this, the midwife decided to refer Lucy for a psychological evaluation to monitor psychosocial risks that could affect her pregnancy. In September 2017, Daniela, a psychologist at the CESFAM, started seeing Lucy every three or four weeks. Additionally, a social worker visited Lucy’s home monthly. Because of the high demand for services and the precarity of the public health system, mental health practitioners offered two monthly clinical sessions. In an interview in 2018, Daniela reflected critically on the extent of the support she could provide:

Unlike biomedical practitioners [mainly midwives and nurses] who sometimes follow ChCC guidelines like soldiers in an army, we [psychologists and social workers] understand we have to work in the best possible way considering patients’ reality and our resources...we don’t have more clinical hours.... We try to do our best, but we just monitor the case, and depending on the severity, we can refer the patient to a specialized mental health center.

Practitioners tended to encourage “responsibility” and impart liberal values such as autonomy and freedom of decision in check-ups, workshops, and private sessions. Daniela and her team used to discuss how the therapeutic plan should help Lucy to: “set limits to end the toxic aspects of her relationship with her mother;” “foster a healthy relationship with her current partner in Chile;” as well as “promote a representation of herself as an independent woman who can plan a life with her child and bring her two children to Chile.
shortly.” According to Daniela, these “gender-oriented interventions” led women to adopt a “more autonomous position in their lives,” helping them to “make decisions on their own in different dimensions of their lives...not only as mothers but also as wives, workers, etc.”

Yet promoting responsibility and the imposition of liberal values from a gender perspective triggered conflicts in most of the Haitian and Dominican women I interviewed for this research. They tended to internalize feelings of disempowerment and inhibition resulting from potential normative transgressions at personal, couple, family, and community levels. Lucy, for example, expressed some contradictions regarding the interventions or what she sometimes called “tasks” (“tareas”). She pointed out:

I understand when Daniela says I must set limits with my mom and bring my children to Chile.... But she is my mom! And she has taken care of my children, and that is a fact regardless of the problem of gambling.... Children also love her.... I don't want a bad relationship with my mom or to break my family.

Lucy felt constrained for being in between mental health practitioners’ expectations and her moral framework. For Lucy, changes in the relationship with her family and children could damage “family unity.” She favored a “gradual change” for her life or a “change in the future.” Once, while talking at her home, Lucy said: “I want to bring my children and have a new family here...first, they should want to come, and then my partner should accept them...I need more time for dealing with this.” Regarding Daniela’s therapeutic expectations, like other Dominican women I met, Lucy said that interventions sometimes were “for another kind of women” or “for Chilean women.” She added, “Chilean women are self-oriented” and more “concerned about work and education.” She highlighted “the lack of family and community networks” in Santiago. She said:

They [Chilean women] are alone, without family. Their mothers or friends don't help or care for their children.... I know this because I have worked in houses, caring for children here in Santiago.... Women here must deal with the burden of everything... with work, the house, the supermarket.... I believe that families can deal with problems and solve them.... That is the reason why we have families (laughing).
I observed similar dynamics between practitioners’ therapeutic expectations and Haitian women. For example, cultural facilitators usually insisted to practitioners that women “did not respond” to interventions because of “traditional gender roles” within their families and communities. In a clinical meeting, a facilitator said to them:

If you told a Haitian woman that she must find a job or report her husband for domestic violence, it would be hard for her to do that.... In Haiti, women are at home, and the violence is normalized. Nobody goes to report it at the police station.... If you do that, you expose your husband. People will not support you.... Some women came here [CESFAM] and felt they could not fulfill the practitioner’s tasks.... They felt guilt or shame, and then she did not come again.

Health practitioners used to translate those feelings of disempowerment and inhibition as a “lack of motivation for change.” This translation reproduced and reinforced racialized stereotypes of Haitian and Dominican women as “lazy,” and “passive” group—stereotypes about black women documented in different contexts (Abarca-Brown 2018; De Souza 2013; Nash 2018; Roberts 2017). Influenced by training workshops in “health and interculturality,” practitioners usually applied culturalist explanations for this “afro-descendant women’s attitude.” In a clinical meeting, a midwife said:

Chilean and other migrant women [South American women] don’t show a lack of motivation for change or an indifferent attitude with their babies.... Our interventions don’t make sense to them [Haitian and Dominican women] ...I believe that motherhood is a cultural thing, and they have other practices, they get involved in the process when the baby is born.... only few women engaged with the program’s activities from the beginning.

The alleged “lack of motivation for change” seemed to respond to gender-oriented interventions in clinical settings rather than to “cultural” aspects mentioned by some practitioners. According to Daniela, adopting “the gender perspective” was “one of the most relevant milestones in public health in Chile.” However, she added that “working with Dominican and Haitian women is hard because they value other things like family and traditions... from our perspective, they are more conservative than us.” Indeed, although gender mainstreaming in public policies has reduced inequalities between men and women
in Chile (Gideon 2006), debates about gender and health have recently included reflections on “culture” and “context” due to Chile’s new multicultural reality. Like in different countries (Browne 2001; Culley 2006; De Souza 2013; Puzan 2003), those debates have led practitioners to interrogate representations of women, motherhood, and family, and the scope and role of feminist/gender-oriented interventions in health.

**The “benefits” of attachment and early stimulation**

According to ChCC practitioners, Lucy needed “therapeutic support” and to “engage with the interventions” due to her family conflicts and lack of social network in Chile. After delivery, Lucy continued attending ChCC workshops and psychological consultations monthly. Workshops were crucial for many Latin American and Caribbean women, becoming a space to familiarize themselves with different gestation and children development matters. For some practitioners, Afro-descendant women had the chance to learn something new about “the effects of motherhood” on children’s physical and emotional development. For Lucy, workshops were an exciting space. After one of them, she pointed out: “I had never heard something like this [related to attachment], neither with my first son nor with my second one... I have taken care of my children as my mother did with me, as we take care of babies in the Dominican Republic (giggling).” Lucy and other Dominican women usually said that some workshops were “slower” and “boring” because of practitioners focused on working with “neglectful” or “bad Haitian mothers,” reproducing racialized stereotypes of Haitians common in the Dominican Republic. They said Haitians “raise their children as animals” and “use witchcraft in their upbringing.” Lucy added, “Haitians sometimes do not bathe their babies, or have strange beliefs about feeding.”

The “attachment workshop” (“Taller de apego”) played a central role in program interventions oriented to the child’s first year of age (ChCC 2012; MINSAL 2008). It aimed to inform parents of six-month-old children about the positive effects of prioritizing attachment in parent–child bonding. Practitioners highlighted the relevance of this workshop, arguing that women could acquire tools that allow them to develop a better bond with their babies. They also insisted on the participation of other family members, especially fathers. However, only on rare occasions did parents participate in the workshops. Mothers usually said that
fathers could not for work reasons. For Jessica, the psychologist in charge of the workshop at the CESFAM, this space allowed migrant women to “reevaluate” the “natural relationship with their cubs,” becoming thus “better moms” (“mejores mamitas”). Once a fortnight, Jessica explained the “benefits of attachment” as a salesperson trying to describe the multiple qualities of a product or new technology. For more than half an hour, she spoke about children’s mental development, centering on the relevance of attachment in cognitive, emotional, and behavioral dimensions, and “therefore in the type of person that your children will be in the future.” Jessica added, “a person who can deal with their emotions, impulsivity and have healthy relationships... preventing psychological problems such as depression, drugs use and even social problems such as delinquency.”

In workshops on attachment, psychologists and social workers used metaphors and comparisons with animals and vegetables to illustrate child development. Cubs, butterflies, seeds, plants, and flowers were some of the main characters in their analogies. For practitioners, attachment and early stimulation provided by the environment ensured these characters to overcome critical moments and reach a state of maturity. Thus, practitioners used these analogies as if each developmental milestone could be delimited to a “natural” or “biological” order, adopting a biological, essentialist, and normative perspective that tended to neglect the sociocultural and material aspects involved in human development.

Attachment was the basis for early stimulation. Practitioners followed this assumption based on the “new Chile Crece Contigo’s concept of stimulation” (ChCC 2012, 2015):

The actions aim to foster children’s gradual domain of cognitive, motor, social-emotional and communicational skills through strategies that allow them to autonomously explore an enriched environment, where they find appropriate stimuli to deploy and consolidate their capacities according to their developmental rhythm and individual characteristics.

Jessica, for example, suggested to mothers that through “secure attachment,” they could stimulate their children, especially during “windows of opportunity” or sensitive periods in the first years of life (ChCC 2012). To do this, she strongly recommended using toys and materials provided by the program for early stimulation in different stages of development.
For children older than four months, for example, practitioners suggested toys such as finger puppets, colorful sound balls, animal cards, among others.

ChCC practitioners, especially younger midwives and nurses at the CESFAM, legitimated and valued attachment theory and early stimulation. They referred that the theory broadened their range of professional actions, moving from a “biomedical to a psychosocial approach.” Some recognized that although they did not learn about attachment theory during their university studies, they became familiar with it while working in the ChCC program. In an interview, a midwife pointed out: “I studied at a faculty of medicine, but we had modules on developmental psychology…. We learned how important our role is to improve the quality of childrearing practices for the future of children.” Still, some of these younger practitioners questioned the program design after facing different frictions and conflicts with Haitian and Dominican women in clinical settings. In an interview, a nurse said: “I think that experts who designed the program did not imagine this new multicultural scenario...they did not take into account that some neighborhoods today have 25 or 30 percent of migrant people.”

Attachment theory has become prominent and gained authority (Jordan 1993) in the design and delivery of social and health policies, in neoliberal, post-dictatorial Chile (1990 to the present).vi “New social protection policies” (Larragaña 2010) have addressed socioeconomic inequalities through interventions focused on children at different levels: family, community, and school. Unlike economic-oriented policies that target adults, these social policies have situated families as responsible for reducing younger generations’ social and economic gaps (Castillo 2015). For this reason, public policy focused on early childhood, particularly the ChCC program, have promoted the concept of attachmentvii because it allows operationalizing the “quality” of the child-parent bonding and its effects.

ChCC practitioners presented attachment as part of pediatric or developmental sciences rather than a psychoanalytical theory. Yet attachment theory was initially formulated by John Bowlby, a British psychoanalyst, and Mary Ainsworth, a US psychologist, toward the end of World War Two (Bretherton 1992).viii Bowlby’s work became highly influential after presenting a WHO report entitled: “Maternal care and mental health: a report prepared on behalf of the World Health Organization as a contribution to the United Nations program for the welfare of homeless children” in 1951. His work gained influence in
academic and health practitioners’ spheres, especially in the US and Europe. Nevertheless, attachment theory rapidly became controversial in conceptual and political terms\textsuperscript{x} (Carter, Ahnert, Grossmann, et al. 2015; Keller and Bard 2017; Ladd-Taylor and Umansky 1998; LeVine and Miller 1990; Otto and Keller 2014; Quinn and Mageo 2013). Some researchers have criticized the ethnocentrism and universalism embedded in attachment theory (Keller and Bard 2017; Quinn and Mageo 2013), noting its bias toward Western modern middle-class families and the role of caregivers and mothers, while neglecting cultural and contextual aspects such as different types of families and childrearing practices, the presence of multiple caregivers, or various objectives of raising a child (Gaskins 2013; Crittenden and Marlowe 2013; Meehan and Hawks 2013; Johow and Voland 2014; Keller and Chaudhary 2017). Scholars have questioned labels such as “secure attachment” (Mageo 2013) and the consequences of a specific style of mothering over the life course (Quinn 2013).

Attachment theory has spread in Chile during the last three decades. Through academic and research programs in health and psychology in universities, researchers have situated attachment theory within developmental sciences. This partly allowed for attachment theory to become intertwined with contemporary developments in epigenetics and neuroscience—far beyond psychoanalytical spaces—in a context that was marked by the prominence of biological psychiatry in public health since the 1980s. In parallel, maternal and child health policies have followed mainstream attachment models, to the detriment of those that integrate evolutionary and cross-cultural aspects (Carter, Ahnert, Grossmann, et al. 2015; Keller and Bard 2017). This approach highlights children’s needs, portrays attachment as the mother’s exclusive responsibility, and neglects different types of interaction between parents and children.\textsuperscript{x}

Practitioners approached Haitian and Dominican women’s motherhood using a deficit discourse, with attachment models as the baseline that migrant women fell short from. Deficit discourse represents some people or groups in terms of deficiency, absence, lack, or failure (Fogarty, Lovell, Langenberg, et al. 2018). By reproducing this discourse, practitioners tended to divide women between those who prioritize attachment (Chilean women) and those who do not (afro-descendant women). Daniela, in an interview, pointed out: “I believe that the problem of attachment and early stimulation is the worst problem
right now for the program...afro-descendant mothers don’t adopt an active attitude with their babies, and they lose the chance of stimulating them during the first years of life.”

**Governing motherhood: neurosciences and epigenetics**

In workshops, practitioners highlighted the “positive effects” of early stimulation on the children’s “brain structure” and “neural connections.” Following evidence provided by ChCC guidelines, they encouraged women’s actions from gestation. In a workshop, Jessica elaborated saying that the relationship between maternal practices and neurobiological processes starts in the womb: “some scientific studies show that when a woman is pregnant and suffers stress, the level of cortisol goes up, affecting the fetus’s neuronal development...that is the reason why it is important to be relaxed.” This kind of interventions promote early stimulation, as well as mothers’ self-management and self-control. Gradually, women embodied the responsibility for the following generations' healthy development.

ChCC interventions turned motherhood into a perfectible practice for many afro-descendant migrant women. In fact, after a workshop, Lucy said:

> These things [attachment, neuroplasticity, and genes–environment relation] are interesting because one can learn about motherhood...and that is the reason why everything here [in Chile] is more complicated, even taking care of a child.... Here everything is like a professional thing.... One can help children from the beginning of their lives.

For Lucy, workshops became a space to learn about different parenting practices and interrogate motherhood. Unlike other migrant women, she got involved in ChCC activities and used to ask practitioners about various aspects of motherhood. Yet for Lucy and at least a few other women, the underlying mechanisms of practitioners’ interventions seemed more like an act of faith than a verifiable reality. Lucy jokingly said: “This is like an investment. We will see if this helps my daughter’s brain. Who knows? Maybe she will be smarter than her mother (laughing).” Lucy’s words revealed a degree of skepticism about the program’s interventions. This attitude situates her in somewhat of a paradox: on the one hand, she embodied “control” of the childrearing process by integrating parenting practices promoted
by the program; on the other, she seemed uncertain about the effectiveness of the childrearing practices.

Interventions shaped afro-descendant migrant women’s representations of motherhood and childrearing around neurobiology. Like Lucy, other women developed their maternal practices “to stimulate the brain,” changing how they represented the relationship with their babies and the children’s development. Lucy said after a workshop, “it is a new way of understanding the relationship with my daughter…one can think that the baby is quiet, and she is well, so in the meanwhile one is resting…. But you can use that time for stimulation, which is good for her future.”

Only some women who attended workshops adopted childrearing practices promoted by the program. ChCC practitioners reported that women who had their first children in Haiti and the Dominican Republic tended to refuse “new practices.” In an interview, Jessica said:

They maintain their practices, they learned how to be mothers, and it works for them....
Women got their second or third child here in Chile, and for that reason, they have experience as mothers, so they usually don’t listen to us.... It is hard to introduce new practices.

Practitioners linked the no integration of practices promoted by the program with living in extreme social conditions such as “poverty,” “discrimination,” and “social exclusion.” Jessica said, “I think that women, especially Haitians, live in precarious conditions…and they are not really concerned about a workshop about attachment or early stimulation here at the CESFAM...they came because they feel forced to do it.”

However, rather than social conditions, the level of participation in the ChCC interventions played a crucial role in how women engaged with new childrearing practices. Women who were most involved, attending workshops and regular check-ups, tended to integrate neuroscientific knowledge and transform their practices. Usually, they were women who worked at home or had time flexibility to attend the CESFAM. Lucy is an example of this group of women. She participated in most ChCC interventions, even though
she did not have her first children in Chile. She took up childrearing practices recommended on the program and hybridized them with her own existing way of mothering.

Over the last three decades, Chilean childhood policies have progressively integrated evidence from psy disciplines and neurosciences, framing the interactions between parenting practices and subjectivity. In the case of the ChCC program specifically, this evidence supports the idea that better childrearing reduces future socioeconomic inequalities (Bedregal, Torres, Carvallo 2014; Molina Milman, Castillo, Torres Sansotta, et al. 2018; Richter, Daelmans, Lombardi, et al. 2017). These concerns about disparities, poverty and children’s development comprise what some researchers call the “neuroscience of poverty” (Wax 2017). That is the field through which it is possible to address the mutual relationships between socioeconomic status and neuroplasticity (Pitts-Taylor 2019). In other terms, although the ChCC program has encouraged comprehensive children’s development through multiple health and social services and benefits, it delegates the responsibility for socioeconomic inequalities to the family space. Some Chilean researchers have critically argued that the program mainly burdens mothers (Caro 2009) and delineates a woman-object of pedagogically oriented interventions for the governmental purposes of maternal and child health policies (Calquín Donoso, Guerra, Vasquez et al. 2019).

Overall, the ChCC program held at least three promises for afro-descendant migrant women: personal recognition for their maternal work based on the program’s criteria; the healthy future of their children; and finally, their integration into the new country. In other words, the program offers a normative framework through which Haitian and Dominican women can integrate into Chilean society as “good mothers” and “good migrants.”

The management of risk and representation of a nation

The interventions not only pointed to Lucy’s relationship with the newborn but also to transnational maternity practices. ChCC practitioners suggested Lucy rule her children by setting limits or boundaries (“poner límites”); otherwise, they could experience “adaptation problems” after the eventual “family reunification” in Chile. In a clinical meeting, practitioners raised some concerns about the participation of Lucy’s son in gangs and the “distant” and “cold” attitude of her daughter. As a physician said in that space:
They [children] were not raised with their mother, and if they are showing disruptive behaviors against their mother, this could be exacerbated in adolescence here in Chile…. We have already seen this, adolescents who leave school and sometimes join criminal gangs.

The practitioner’s words revealed two assumptions about children’s development. First, that given the lack of early stimulation due to “maternal absence,” the presence of certain social conditions would trigger mental health disorders and psychosocial issues. And second, that adolescence is a critical period in which young people may develop disruptive behaviors.

Although the ChCC program targeted parents and children regardless of their nationality, practitioners’ concerns focused on the afro-descendant community—particularly on two aspects. First, they paid close attention to parents’ childrearing practices. Some practitioners reproduced racialized representations by linking afro-descendant migrants’ “habits” and “customs,” such as “the inclination for parties and drugs,” to children’s development issues. And second, they centered on children’s “disruptive behaviors.” Both concerns converged on a feared psychosocial issue: juvenile offending. Although some practitioners opposed this stereotype and argued that juvenile offending results from “social conditions,” those concerns became more robust in a context marked by constant criminalization of afro-descendant migrants in the media in Chile since 2016 (El Mostrador 2017; La Tercera 2016). Indeed, the same physician pointed out in an interview,

Migrant children sometimes live with violence and affective deficiencies [carencias afectivas], and when they do not have opportunities in the host country, they commit crimes. Look what happens, for example, in France with young African migrants…. They are young people with families in precarious conditions, and they reproduce the habits of their communities.

Children thus become a risk that must be managed from early childhood to prevent “likely” disruptive behaviors in the future. The ChCC program configured a “psychopolitics of otherness,” that is, a “technology that normalizes through psychiatry and psychology those who are constructed and governed as radical others” (Fassin 2011, 225). Developmental sciences, influenced mainly by attachment theory, neurosciences, and epigenetics, situated afro-descendant children of being “at risk”, or reducing young people to their alleged psychological and neurobiological susceptibility to engage in disruptive
behavior (Rose 2000; 2007). In other words, a biopolitical operation (Foucault 1977; Rose 2007) that co-opt migrant children as subjects who will potentially embody a place of abnormality (e.g., mental disorders, juvenile offending).

By contrast, this psychopolitics also shapes an antagonistic migrant-otherness. According to some ChCC practitioners, interventions would lead migrant children to achieve a “healthy development” in a country where “they [children] can develop their potentialities.” For instance, a midwife said in an interview:

> Here [in Chile], they [migrant children] can go to the university and find a job. They can do whatever they want. Even if they could become athletes, who know, they could contribute with an Olympic medal (laughing).

Her words show how the program sets the conditions for a biopolitical optimization (Rabinow and Rose 2006) in which practitioners’ racialized representations of children’s development and migrant-otherness play a crucial role. Practitioners sought to foster afro-descendant children’s capacities at higher levels (e.g., as skilled workers or professional athletes), which in turn delineated normative values of integration anchored on national ideals. Those ideals reveal, firstly, an idea of nation shaped during the colonial history and the formation of the Chilean nation-state (Larraín 2011), which excluded afro-descendant people (Cussen 2016). Secondly, these comments imply a measure of economic racism, where neoliberal market rationality delineates an ideal image of the migrant as an individual who “should contribute” to the nation. Through this, the ChCC program shapes future Chilean-migrant citizens.

On parental acculturation and the intensive parenting ideology

Afro-descendant migrants engaged in multiple ways with parental acculturation processes—through which institutions and agents of the host country transmit successful parenting and childrearing models, leading migrants to compare, negotiate and eventually modify their parenting practices (Bornstein and Bohr 2011; Faircloth, Hoffman and Layne 2013). Although some migrant parents have refused parenting models transmitted by the
ChCC program, most have assimilated or negotiated childrearing practices, shaping hybrid forms of parenting. For instance, concerning Lucy’s case, a social worker pointed out:

I visited Lucy’s home and saw her with other Dominican women and their babies in the central courtyard. They were her neighbors…. And then I realized that those women take care of Lucy’s baby some days when she is working (...). They have been neighbors just for the past three or four months…. The exciting thing is that all children there were playing with toys from the ChCC program…. I told Lucy, “you are using the ChCC toys,” and she answered laughing: “I am teaching them about attachment and stimulation.”

The social worker highlighted how Dominican women spoke about attachment and early stimulation and used ChCC resources. His words also revealed a feeling of success associated with the usefulness and legitimation of expert knowledge and practices and achieving the program’s sanitary goals. Nevertheless, at the same time, he seemed not to acknowledge different Dominican women’s mothering styles—for example, the collective practices of caring for babies as a group.

The ChCC program reproduced an “intensive parenting” ideology with Afro-descendant migrants. That is, an ensemble of institutions, knowledge, practices, values, and practitioners lead migrant parents to put children’s needs first and pay attention to experts in children’s development (Hays 1996). As research has shown for different communities and contexts (Quinn and Mageo 2013), practitioners believed that their Western models of motherhood and development were better for Dominican and Haitian women. They also seemed not to recognize how psy technologies impact women’s representations of themselves as mothers, and of children’s development.

Researchers have documented the effects of intensive parenting ideology for indigenous communities in Chile, specifically how maternal and child health policies have affected Mapuche people’s childrearing traditions (Murray, Bowen, Segura, et al. 2015). Mapuche parenting practices encourage children to explore, learn, and socialize with others. One of the greatest fears of Mapuche mothers is that their children become a “mamón,” a colloquial expression used in Chile to describe children who are too dependent and attached to their mothers. However, due to the introduction of new forms of parenting promoted by public policies, Mapuche mothers sometimes negotiate their parenting strategies, feeling
pressured to incorporate early stimulation actions to become “good mothers” (Richards 2007).

Chile’s maternal and child health policies need to focus on migrant women’s and parents’ acculturation processes during pregnancy and early childrearing. Although a significant amount of literature has shed light on the relationships between the migration process and motherhood (Alcalde 2015; Parrado 2011), little is known about the subjective struggles that migrant women embody during pregnancy and the first years of mothering in the context of this kind of programs. In part, this paucity of interest in migrant women’s subjectivity follows in a long tradition of women being invisible in migration studies before the mid-1970s (Kofman 1999), the construction of migrant women’s image as deficient, passive, and without agency (Arisaka 2000), as well as static and Eurocentric conceptions of motherhood (Dağdelen 2018; Collins 1998; De Souza 2004). Feminist and decolonial perspectives are certain to enhance research about south–south migration in Latin America and the Caribbean.

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This article is based on broader research that examined how new discourses relating to migration, multiculturalism, and mental health have taken shape in Chile from 1990 to the present. It explored how, through the introduction of health reforms since the 1990s and the subsequent global mental health (GMH) agenda (Patel, Garrison, de Jesus, et al. 2008), psy technologies (Rose 2007; Rose and Abi-Rached 2013) have shaped afro-descendant migrants’ subjectivities and everyday life. This research was approved by the Ethics Committee of King’s College London (Ethics Ref: HR-17/18-5319) and was authorized by the local Health Department.

Lucy and other names in this work are pseudonyms.

Nation-wide population statistics in Chile record a total of 281 Dominicans in 2002 (INE 2003). By 2018, there were 17,959 (INE/DEM 2019). Most of them arrived in Chile as tourists before implementing the consular visa in 2012 during the first Sebastian Piñera’s government (2010-2014). In fact, in 2016, the government estimated that the immigration status of about half of the Dominican community in Chile was irregular.

In 2017, the local Health Department hired Haitian cultural facilitators for translation and meditation in clinical and community settings. Each CESFAM of the neighborhood had at least one cultural facilitator.

The original words in Spanish were: “crian a sus niños como animales”; “utilizan la brujería en la crianza”; and “los haitianos a veces no bañan a sus bebés o tienen creencias extrañas sobre la alimentación”. In part these stereotypes are based on Dominicans’ unfamiliarity with Haitian parenting practices anchored in Haitian-Creole medicine and Vodou.

I base this on Brigitte Jordan’s concept of “authoritative knowledge” (1993). By this concept, Jordan means the rules that “explain the state of the world better for the purposes at hand (“efficacy”) or because they are associated with a stronger power base (“structural superiority”), and usually both” (Jordan 1993, 152).


It is essential to highlight that Bowlby’s work was strongly influenced by ethnologists such as Niko Tinbergen, Konrad Lorenz, and especially Robert Hinde (Van der Horst, Van der Veer, and Van Ijzendoorn 2007).

Some psychoanalysts argued against the centrality of the maternal role, child–mother bonding (Rutter 1995), and the lack of relevance attributed to sexual aspects of psychoanalytic theory, particularly to sexual drive (Gullestad 2001). According to some feminist scholars, the theory represents a conservative research program, which could discourage women from leaving children in daycare (Duschinsky, Greco, and Solomon 2015).

For example, researchers have shown how US children pay attention to the knowledge that adults indicate as important, suggesting that social invitation directs learning (Butler and Markman 2012). Maya children instead participate as community members by learning through collaborative interactions (Rogoff 2011).