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# *Culture, Scarcity, and Maternal Thinking:*

## *Maternal Detachment and Infant Survival in a Brazilian Shantytown*

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*Maternal practices begin in love, a love which for most mothers is as intense, confusing, ambivalent, poignantly sweet as any they will experience.*
Sara Ruddick (1980:344)

This paper is about culture, scarcity, and maternal thinking. It explores maternal beliefs, sentiments, and practices bearing on child treatment and child survival among women of Alto do Cruzeiro, a hillside shantytown of recent rural migrants. It is set in Northeast Brazil, a region dominated by the vestiges of a semifeudal plantation economy which, in its death throes, has spawned a new class: a rural proletariat of unattached and often desperate rural laborers living on the margins of the economy in shantytowns and invasion barrios grafted onto interior market towns. *O Nordeste* is a land of contrasts: cloying fields of sugar cane amidst hunger and disease; a land of au-

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thoritarian landlords and libertarian social bandits; of conservative Afro-Brazilian possession cults, and a radical, politicized Catholicism. In short, the Northeast is the heart of the Third World in Brazil—its mothers and babies heirs to the so-called Brazilian Economic Miracle, a policy of capital accumulation that has increased both the Gross National Product and the Gross National Indifference to a childhood mortality rate that has been steadily rising throughout the nation since the late 1960s.[1]

Approximately 1 million children under the age of 5 die each year in Brazil, largely the result of parasitic infections interacting with infectious disease and chronic undernutrition. Of these, few could be saved (for long) by the miracles of modern medicine. Infant and childhood mortality in the Third World is a problem of *political economy,* not of *medical technology.* Here, however, I will discuss another pair of childhood pathogens—maternal detachment and indifference toward infants and babies judged too weak or too vulnerable to survive the pernicious conditions of shantytown life. The following analysis of the reproductive histories of 72 women of Alto do Cruzeiro explores the links between *economic* and *maternal* deprivation, between material and emotional scarcity. It discusses the social and economic context that shapes the expression of maternal sentiments and the cultural meanings of mother love and child death, and determines the experiences of attachment, separation, and loss. It identifies a unifying metaphor of life as a *luta,* a struggle, between strong and weak, or between weak and weaker still, that is invoked by Alto women to explain the necessity of allowing some—especially their very sick—babies to die *"a mingua,"* that is, without attention, care, or protection. This same metaphor is projected on to body imagery in mothers' perception of their bodies as "wasted" and their breasts as "sucked dry" by the mouths of their infants, producing the disquieting image of hungry women hungrily consumed by their own children.

Finally, it is argued that maternal thinking and practices are *socially produced* rather than determined by a psychobiological script of innate or universal emotions such as has been suggested in the biomedical literature on "maternal bonding" and, more recently, in the new feminist scholarship on maternal sentiments.

## BACKGROUND/CASE STUDIES

Two events, occurring more or less simultaneously, first captured my attention and started me thinking about maternal behavior under particularly adverse conditions. One event was public and idiosyncratic, the other was private and altogether commonplace. One aroused community sentiments of anger and hostility; the other aroused no public sentiments at all. Both concerned the survival of children in similarly unfortunate circumstances.

### Rosa

During a drought in the summer of 1967 while I was then a Peace Corps health and community development worker living in Alto do Cruzeiro in the interior market town of Ladeiras (a pseudonym), I was drawn one day by curiosity to the jail cell of a young woman from an outlying rural district who had just been apprehended for the murder of her infant son and 1-year-old daughter. The infant had been smothered, while the little girl had been hacked with a machete and dashed against a tree trunk. Rosa, the mother, became, for a brief period, a central attraction in Ladeiras as both rich and poor passed her barred window in order to rain down slurs on her head: "beast"; "disgraceful wretch"; "women without shame"; "unnatural creature." Face-to-face with the withdrawn and timid girl, I asked her the obvious, "Why did you do it?" And she replied, as she must have for the hundredth time: "to stop them from crying for milk." After a pause she added (perhaps to her own defense): *"bichinos não sente nada"*—little things have no feelings. Embarrassed, I withdrew quickly, and left the girl (for she was little more than that) alone to ponder her "crime."

### Lourdes and Ze

I lived at that time on the *Alto,* not far from the makeshift lean-to of Lourdes, a young girl of 17, single and pregnant for the second time. Conditions on the Alto do Cruzeiro were then, as now, appalling: contaminated drinking water, food shortages, unchecked infectious disease, lack of sanitation, and crowded living conditions

decimated especially the oldest and youngest residents of the hill. Lourdes's first born, Ze-Ze, was about a year old and severely marasmic (i.e., malnourished)—toothless, hairless, and unable even to sit up, he spent his days curled up in a hammock or lying on a piece of cardboard on the mud floor where he was harassed by stray dogs and goats. I became involved with Zezino after I was called on to help Lourdes with the birth of her second child, a son about whom a great fuss was made because he was both fair *(loiro)* and robust *(forte)*. With Lourdes's limited energy and attention now given over to the newborn, Zezino's condition worsened and I decided to intervene. I carried him off to the cooperative day care nursery *(creche)* I had organized with the more activist women of the hill. My efforts to rescue Ze were laughed at by the other women, and Zezino himself resisted my efforts to save him with a perversity perhaps only equal to my own. He refused to eat and wailed pitifully whenever I approached him. The *creche* mothers advised me to leave Zezino alone. They said they had seen many babies like this one and that "if a baby *wants* to die, it *will* die" and that this one was completely *disanimado,* lifeless, without fight. It was wrong, they cautioned, to fight death. But this was a philosophy alien to me and I continued to do battle with the little boy until finally he succumbed: he ate, gained weight, his hair grew in, and his face filled out. Gradually, too, he developed a strong attachment to me. Long before he could walk he would spring to my back where he would wrap his spindly arms and legs around me. His anger at being loosed from that position could be formidable. He even learned to smile. But along with the other women of the *creche* I wondered whether Ze would ever be "right" again, whether he could develop normally after the traumas he had been through. Worse, there were the traumas yet to come since I had to return him to Lourdes in her miserable conditions. And what of Lourdes—was this fair to her? Lourdes did agree to take Zezino back and she seemed more interested in him now that he looked more human than monkey, while my own investment in the child began to wane. By this time I was well socialized into shantytown culture and I never again put so much effort where the odds were so poor.

I returned to the Alto in the summer of 1982, 18 years later. Among the women of the Alto who formed my research sample was Lourdes, still in desperate straits and still fighting to put together

the semblance of a life for her five living children, the oldest of whom was Ze, now a young man of 20, and filling in as "head" of the household—a slight, quiet, reserved young man with a droll sense of humor. Much was made of the reunion between Zezino and me, and the story was told several times of how I had wisked Zezino off when he was all but given up for dead and had force fed him like a fiesta turkey. Ze laughed the hardest of all, his arm protectively around his mother's shoulders. When I asked Ze later in private the question I asked all my informants—Who has been your greatest friend and ally in life, the one person on whom you could always depend—he took a long drag on his cigarette and replied, "My mother, of course."

I introduce these vignettes as caveats to the following analysis. With respect to the first story, it was to point out that severe child battering leading to death is universally recognized as *criminally deviant* in *Nordestino* society and culture. It is, to this day, so rare as to be almost unthinkable, so abhorrent that the perpetrator is scarcely thought of as human. "Mother love" is a commonsense and richly elaborated motif in Brazilian culture, celebrated in literature, art, and verse, in public ceremonies, in music and folklore, and in the continuing folk Catholic devotion to the Virgin Mother. Nonetheless, selective neglect accompanied by maternal detachment is both widespread among the poorer populations of Ladeiras but "invisible"—generally unrecognized by those outside shantytown culture, even by professionals such as clinic doctors and teachers who come into frequent contact with severely neglected babies and young children. *Within* the shantytown, child death *a mingua* (accompanied by maternal indifference and neglect) is understood as an appropriate maternal response to a deficiency *in* the child. Part of learning how to mother on the Alto includes learning when to "let go."

I also want to point out, with reference to the second vignette, that although the data indicate that Alto mothers do sometimes withdraw care and affection from some of their babies, such behaviors do not invariably lead to death, nor are the distanced maternal emotions irreversible. One of the benefits of returning to the same community where I had previously worked was the chance to observe the positive outcomes of several memorable cases of selective neglect—children, who, like Ze, survived and were later able to win their way inside the domestic circle of protective custody and love.

It is also essential to note that selective neglect is not analogous to what we mean in the United States by "child abuse"; it is not motivated by anger, hate, or aggression toward the child. Such sentiments—part of the "classic" child abuse syndrome identified in the United States (Steele and Pollock 1968; Gill 1970; Bourne and Newberger 1979; Gelles 1973; Kempe and Helfer 1980)—appear altogether lacking among women of the Alto who are far more likely to express *pity for,* than anger against, a dependent child, who are disinclined to strike what is seen as an innocent and irrational creature, and who, to the best of my knowledge, never project images of evil or badness onto a small child.

## THE SAMPLE: THE WOMEN OF O CRUZEIRO

My sample of 72 Alto women was an opportunistic one, comprised of the first women to volunteer for the study following an open meeting I called at the *creche* and social center at the top of the hill. Many more women volunteered over the next several weeks than I could possibly have interviewed during the brief period of my stay (8 weeks). The only criterion for inclusion in the sample was that the woman had been pregnant at least once. All understood that I was studying reproduction and mothering within the context of women's lives on the Alto.

The interviews elicited demographic information, work history, patterns of migration, marital history. This was followed by a discussion of each pregnancy and its outcome. For each live birth the following information was recorded: location of, and assistance with, the delivery; mother's perceptions of the infant's weight, health status, temperament; infant feeding practices; history of early childhood illnesses, how treated, and outcomes, including mortality. Following the reproductive history I asked each mother a series of open-ended, provocative, and evaluative questions, including: Why do so many infants die here? What do infants need most in order to survive the first year of life? What could most improve the situation of mothers and infants here? Who has been your greatest source of comfort and support throughout your adult life? How many children are enough to raise? Do you prefer to raise sons or daughters and why?

As both psychological anthropologist and feminist I was concerned not only with raising questions about *behavior* and *practice* (i.e., *did* some of these women selectively neglect some of their infants and place them at risk) but also with questions of *meaning* and *motivation,* how and why they might do this. I wanted to know what infant death and loss meant to them, and how they explained and interpreted their actions as women and mothers. I wanted to know what were the effects of chronic scarcity and deprivation on women's abilities to nurture, to attend, indeed even to love. And, finally, I wanted to know what were the consequences of continual loss of infants and babies for the world views of Alto mothers, as, at a later stage, I hope to explore the consequences of selective neglect on the personalities, beliefs, and sentiments of those children—like Ze-Ze—who *do* survive in spite of their inauspicious and inhospitable early experiences. What follows here is a discussion of the initial findings from the first and exploratory stage of the research.

I was able to work efficiently during this initial period because I was both known and trusted on the Alto as the *Americana* who had once lived and worked with them. In fact, several of the older women and their adult daughters (now grandmothers and mothers) in my sample were the very same young mothers and toddlers with whom I had worked 20 years ago (1964–1966) in the construction and operation of a cooperative day care center for working mothers. My previous work and association with the midwives of the Alto and my attendance at numerous home births years ago now gave me access to the homes of young women who gave birth during the research period.

The women interviewed ranged in age from 17 to 71; the median age of 39 meant that most were still potentially fertile. A profile of the average woman in my sample could read as follows. She was born on an *engenho* (sugar plantation) where she grew up working "at the foot of the cane." She attended school briefly and while she can do sums with great facility, she cannot read. After marriage she moved several times always in search of better work conditions for her husband or a better life for the children, preferably a *vida na rua* (a life on urban streets) rather than in the *mata,* the rural backwaters. Her husband or present companion is a "good" man, but described as *meio-fraco,* weak-poor, unskilled, unemployed, or worse, sickly and dependent or, perhaps, a *cachazeiro,* a drunkard. They

have been separated from time to time. She works at least part time in the marketplace, as a domestic, or taking in laundry, or even, seasonally, hiring herself out in the fields. The combined weekly household income in 1982, Cr$5000 ($25.00), put the family on the borders between *pobreza* and *pobretão*—poverty and absolute misery. The nuclear family is counted from above and below—including the little dead angels in heaven, and *os desgraçados*, the living but sinful children on earth.

## REPRODUCTIVE HISTORIES

The 72 women reported a staggering *686* pregnancies and 251 childhood deaths (birth to 5 years). The average woman (speaking statistically) experienced 9.5 pregnancies, 1.4 miscarriages, abortions, or stillbirths, and 3.5 deaths of children. She has 4.5 living children. Many infants and toddlers were, however, reported by their mothers to be sick or frail at the time of the interview, and at least some of these could be anticipated to join the mortality statistics in the months and years ahead (see Table 1).

Alto babies are at greatest risk during the first year of life: 70% of the deaths had occurred between birth and 6 months, and 82% by the end of the first year. No doubt contributing to the high mortality in the first year is the erosion of breastfeeding which, the interviews with my older informants reveal, had begun on the plantations long before commercial powdered milk was available. All Alto infants are reared from birth on *mingaus* and *papas*, cereals of rice or manioc flour mixed with milk and sugar. The breast, when offered at all, is

TABLE 1

REPRODUCTIVE HISTORIES SUMMARY

| | | |
|---|---|---|
| Total pregnancies | 686 (9.5/woman) | |
| Total living children | 329 (4.5/woman) | |
| Miscarriages/abortions | 85 | 101 (1.4/woman) |
| Stillbirths | 16 | |
| Childhood deaths (birth–5 yrs.) | 251 (3.5/woman) | |
| Childhood deaths (6–12 yrs.) | 5 | |

N = 72 women; ages 19–71; median age 39.

only a supplement to the staple baby food, *mingau*. Central to the precipitous decline in breastfeeding among Alto mothers[2] is not so much a positive valuation of commercial powdered milk as a pervasive devaluation of breastmilk related to the women's often distorted perceptions of their bodies, and breasts in particular, to be discussed below.

## Sex, Birth Order, and Temperament

I probed the circumstances surrounding each pregnancy, birth, and death, and I elicited infant care practices and mothers' theories of infant development and infant needs. In addition, I probed for patterns of preferential treatment or neglect, and I asked the women to share with me their thoughts and feelings about motherhood, family life, about joy and affliction, about loss and grief. Neither the reproductive histories nor the interviews revealed a strong sex or birth order bias.

The 72 mothers reported a total of 251 deaths of offspring from birth to 5 years: 129 males and 122 females (Table 2). Despite a fairly pervasive ideology of male dominance in Brazilian culture, the women of the Alto expressed no consistent pattern of sex preference, and virtually all agreed that a mother would want to have a balance between sons and daughters. Both sexes were valued in children, although for different reasons. Boys were said by mothers to be

TABLE 2

Sex and Age at Death (Birth–5 Years)

| | *Male* | *Female* | *Total* | | |
|---|---|---|---|---|---|
| Postpartum (1–14 days) | 21 | 12 | 33 | 175 (70%) | 205 (82%) |
| 15 days–7 weeks | 18 | 8 | 26 | | |
| 2 mos.–6 mos. | 57 | 59 | 116 | | |
| 7 mos.–1 year | 13 | 17 | 30 | | |
| 13 mos.–2 years | 12 | 15 | 27 | | |
| 2½ yrs.–5 yrs. | 8 | 11 | 19 | | |
| Totals: | 129 | 122 | 251 | | |

N = 251.

"easy" to care for and were independent from an early age. Sons could be sent out to "forage" in the market and were unashamed to beg or steal, if necessity came to that. Sons were also enjoyed for their skill in street games and sports, an important aspect of community life on the Alto. But daughters were highly valued as well: they were not only useful at home, but were a mother's lifelong friend and intimate. Alto mothers and daughters strive to stay in proximity to each other throughout the life cycle; distance, dissention, and alienation between mothers and daughters occurs, but is considered both tragic and deviant. "Obviously," Alto mothers would conclude, a woman would want to have at least one *casal* (a boy-girl pair) and preferably two pairs, spaced closely together.

With respect to birth order among the subset of completed families, the most "protected" cohorts were those children occupying a middle rank, neither among the first or last born. Although childhood deaths often occurred in runs, this usually reflected external life circumstances of the mother during that period of her reproductive career, and there were no strong correlations between birth order and survivability. However, the *casula,* the last born child to survive infancy, was particularly loved and indulged.

Far more significant with respect to maternal investment was the mother's perception of the baby's constitution and temperament—the infant's qualities of readiness for the uphill struggle that is life. The mothers readily expressed a preference for babies who evidenced early on the physical and psychological characteristics of "fighters" and "survivors." Active, quick, sharp, playful, and developmentally precocious babies were much preferred to quiet, docile, passive, inactive, or developmentally delayed babies. Mothers spoke fondly of those babies who were a little *brabo* (wild), who were *sabido* (wise before their years), and who were *jeitoso* (skillful with objects, words, tasks, people). One young mother explained:

> I prefer a more active baby, because when they are quick and lively they will never be at a loss in life. The worst temperament in a baby is one that is dull and *morto de espirito* [lifeless], a baby so calm it just sits there without any energy. When they grow up they're good for nothing.

The vividly expressed disaffection of Alto mothers for their quieter and slower babies was particularly unfortunate in an area where malnutrition, parasitic infections, and dehydration artificially pro-

duce these symptoms in a great many babies. A particularly lethal form of negative feedback results when some Alto mothers reject and withdraw their affections from their passive and less demanding babies whose disvalued "character traits" are primarily the symptoms of chronic hunger. This pattern is revealed in the mothers' explanations of their children's causes of death.

## PERCEIVED CAUSES OF CHILDHOOD MORTALITY

Although uneducated and, for the most part, illiterate, the shantytown mothers interviewed were all too keenly aware that the primary cause of infant mortality was gastroenteric and other infectious diseases resulting from living in, as they so graphically phrased it, a *porcaria,* a pig sty. When asked why, *in general,* so many babies and young children of O Cruzeiro die, the women were quick to reply: "they die because we are poor, because we are hungry"; "they die because the water we drink is filthy with germs"; "they die because we can't keep them in shoes or away from this human garbage dump we live in"; "they die because we get worthless medical care: 'street medicine,' 'medicine on the run' "; "they die because we have no safe place to leave them when we go off to work."

When asked what it is that infants need most in order to survive the first year of life, the Alto mothers in my sample invariably answered "good food, proper nutrition, milk, vitamins." I soon became bored with its concreteness. The irony, however, was that not a single mother had stated that either a lack of food or insufficient milk was a primary or even a contributing cause of death for any of her *own* children. Perhaps they must exercise this denial because the alternative—the recognition that a child is slowly starving to death—is too painful.

Table 3 offers a condensed rendering of these women's perceptions of the major pathogens affecting the lives of their children. Certainly naturalistic explanations predominated in which biomedical conceptions of contagion and infection blend with aspects of humoral pathology and belief in the etiological significance of teething. While *a vontage de Deus,* God's will, was understood as the ultimate cause of all human events (including the death of one's children), in very few instances did mothers attribute particular deaths to the immediate action or will of God or the saints. Human agency (al-

TABLE 3

CAUSES OF INFANT/CHILDHOOD DEATHS (MOTHERS' EXPLANATIONS)

| | |
|---|---|
| I. *The Natural Realm* (locus of responsibility: natural pathogens) | |
| A. Gastroenteric (various types of diarrhea) | 71 |
| B. Other Infectious, Communicable Diseases | 41 |
| C. Teething *(denticão)* | 13 |
| D. Skin, Liver, Blood Diseases | 13 |
| Total: | 138 |
| II. *Supernatural Realm* (locus of responsibility: God, the saints) | |
| A. *De Repente* (taken suddenly by God, saints) | 9 |
| B. *Castigo* (punishment for sin of the parent) | 3 |
| Total: | 12 |
| III. *The Social Realm* (locus of responsibility: human agency is directly or indirectly implied) | |
| A. Malignant Emotions (envy, shock, fear) | 14 |
| B. *Resguardo Quebrado* (postpartum or illness precautions broken) | 5 |
| C. *Mal Trato* (poor care, including poor medical care) | 6 |
| D. *Doença de Crianca* ("ugly diseases" involving benign neglect) | 39 |
| E. *Fraqueza* (perceived constitutional weakness that involves maternal under-investment) | 37 |
| Total: | 101 |

though not necessarily guilt and responsibility) was imputed to the deaths of 101 of the children. This includes deaths attributed to poor care *(mal trato)*, to uncontrolled pathogenic emotions (such as anger or envy resulting in evil eye, or fear resulting in the folk syndrome *susto* [magical fright]), and to breaking of customary precautions *(resguardas)* surrounding childbirth and the 40 days following, and attached to common childhood ailments. Finally, the interviews revealed a pattern of passive selective neglect expressed in the medium of the folk diagnoses of *doença de crianca* (sickness of the child) and of *fraqueza* (weakness) implying in both cases a will toward death in the child.

Underlying and uniting these etiological notions is a world view in which all of life is conceptualized as a *luta*, a power struggle between strong and weak. Death can be stronger than young life, and so mothers can speak of a baby whose drive toward life was not sufficently strong or well developed, or who had an aversion *(disgosto)* to life. A pregnant woman who is "used up" *(acabado)* from too many

previous pregnancies is said to transfer this weakness to the fetus who is then born frail and skinny, unfit for the *luta* ahead. Conversely, when a mother says that her infant suffered many crises during its first year but *vingou* (triumphed) in any case, she is giving proud testimony to the child's inner vitality, his or her will to live, to *lutar* (to fight). If an infant succumbs to *denticão* (teething) it is understood that she died because the "force of the teeth" overwhelmed the delicate little system. The folk pediatric illness *gasto* is almost always fatal because the infant's alimentary canal is reduced to a sieve: whatever goes into the mouth comes out directly in violent bouts of vomiting and bloody diarrhea. The baby becomes *gasto* (spent, wasted), his or vital fluids and energy gone. Most disquieting, however, is the image mothers convey of those of their babies who were said to have died of thirst, their tongues blackened and hanging out of their mouths because their mothers were too weak, ruined, or diseased to breastfeed them. One young mother said:

> They are born already starving in the womb. They are born bruised and discolored, their tongues swollen in their mouths. If we were to nurse them constantly we would all die of tuberculosis. Weak people can't give much milk.

When I challenged a young and vigorous Alto woman about her inability to breastfeed, she responded angrily, pointing to her breast, "Look. They can suck and suck all they want, but all they will get from me is blood." Once again we have the metaphor of *a luta*—the struggle between weak and weaker over scarce resources. Another reason given by Alto mothers for their failure to breastfeed their babies for more than the first few weeks of life was that their infant had rejected the breast. And why not? For I was told repeatedly by mothers of newborns that their breastmilk was "foul" or "worthless" and for many different reasons. The milk was said to be either "salty" or "bitter" or "watery" or "sour" or "infected" or "dirty" or "diseased." In all, their own milk was rejected as unfit for infants and little more than a vehicle of contamination.

I do not know to what extent mothers' perceptions of breastmilk insufficiency is a function of their nutritional status or of their reliance on supplementary infant feedings of *mingau*, which surely interferes with the mother's own milk production. But I do know that once the breastmilk falters Alto mothers are quick to interpret this as a symptom of their own *fraqueza*, their physical and moral weak-

ness. Similarly, when these young women refer to their breastmilk as scanty, curdled, bitter, or sour, they are also speaking metaphorically to the scarcity and bitterness of their lives as women of the Alto. What has been taken from these women is their faith in their ability to give. As the mothers stated earlier "We have *nothing* to give our children" and "Weak people can't give much milk."

In all, the etiological system and body imagery can be understood as a projection, a microcosm of the hierarchical social order in which strength, force, and power win out. It is a response to, a defense against, and a reflection of the miserable conditions of Alto life. It is these survivor values and perceptions that make Alto mothers reluctant to care for those infants and babies seen as deficient in vital energy, in *animacão*. Multiple births fare poorly on the Alto: few twins and triplets survive infancy. An obstetrical nurse in Ladeiras reported that poor mothers will take the stronger of a set of twins and leave the smaller or frailer for the hospital staff to dispose of as they see fit. All the mothers agreed that it is best if the weak and the disabled die as infants and that they die without a prolonged and wasted struggle. Celia, for example, could speak of her two infants having given her "no trouble" in dying. They just "rolled their eyes to the back of their heads and were still." It is the more gradual, protracted deaths—the deaths of *doença de crianca*—that Alto mothers particularly fear.

## *DOENÇA DE CRIANCA:* ETHNOMEDICAL SELECTIVE NEGLECT

The Alto mothers spoke frequently and covertly of a cluster of childhood illnesses that are both greatly feared and from which they withdraw treatment and care. They used a euphemism, "sickness of the child," in order to avoid discussing the many anxiety-provoking symptoms and conditions subsumed under the term. The women volunteered that a child with a *doença de crianca* was best left to die *a mingua,* meaning a child allowed to slowly wither away without sufficient care, food, love, or attention. It meant, quite simply, a death by neglect. The women did not like talking about this subject, but neither did they deny or conceal their own behavior or their feelings.

*Doença de crianca* was used to refer to any serious childhood condition which, while not necessarily life-threatening, was believed

likely to leave the mother with a permanently disabled, frail, or dependent child. Various paralyses, epilepsy, childhood autism, and developmental disabilities were discussed in this context. The symptoms that mothers particularly feared and which they were likely to label as symptoms of a "sickness of the child" included deliriums from high fevers, fit-like convulsions, extreme passivity and immobility, retarded verbal or motor skills, disinterest in food, play, social interaction, changes in skin color, loss of body liquids and body fat, sunken eyes. The etiology was multicausal; many things caused *doença de crianca* including frights *(pasmo, susto)*, germs and other microbes, evil eye, and complications resulting from otherwise normal childhood illnesses. Measles, diarrhea, even a common cold could, without taking proper precautions, "turn into" *(virar)* a dreaded sickness of the child, thereby marking the child as beyond hope of a normal recovery.

The expansiveness and flexibility of the folk diagnosis allows Alto mothers a great deal of latitude in deciding which of their children are not favored for normal development and from which she may withdraw her attentions. The woman does not hold herself responsible for the death and nor is she blamed by the immediate female community (men seem to have little knowledge of the matter); the cause of death is a perceived deficiency in the child, not a deficiency in the mother. Thirty-nine babies were said to have died of a sickness of the child, but the same behaviors are implied in an additional 37 deaths attributed to *fraqueza* (innate weakness of the child). The following statements of mothers are illustrative:

There are various "qualities" of *doença de crianca*. Some die with rose colored marks all over their body; others die black colored. It's very ugly—with this disease it takes a very long time for them to die. It takes a lot out of the mother. It makes you sad. This sickness we don't treat. If you treat it the child will never be right. Some become crazy. Others are just weak and sickly their whole life.

They die because they have to die. If they were meant to live, it would happen that way as well. I think that if they were always weak, they wouldn't be able to defend themselves in life. So, it is really better to let the weak ones die.

There are two diseases we don't like to talk about because they are the ugliest things in the world. So we just say *doença de crianca* and leave it at that. One of these is what some people call *gotas de serena* [literally "evening mist"] which is a kind of madness, like rabies in a dog. The other is *pasmo*, a terrible paralysis that the child gets from a bad shock. His skin turns black and he just sits there still and dumb in the ham-

mock, really lifeless. We are afraid of these sicknesses of the child. It is best to leave them die.

*(Doença de crianca)* can come from many different things. It can come from a fright the child has, but also from dirty laundry, or from strong germs that enter through the fingernails. Look, we don't like talking about all this. We don't mention its name. We are afraid of calling it up.

It became painfully apparent that Alto mothers were often describing the symptoms of severe malnutrition and gastroenteric illness further complicated by their own selective inattention. Untreated diarrheas and dehydration contributed to the baby's passivity, his or her disinterest in food, and developmental delays. High fevers often produced the fit-like convulsions that mothers feared as harbingers of permanent madness or epilepsy. Because these hungry and dehydrated babies are so passive and uncomplaining, their mothers can easily forget to attend to their needs, and can distance themselves emotionally from what comes to appear as an *unnatural* child, an angel of death that was never meant to live. Many such babies are left alone in their hammocks while their mothers are out working, and not even a sibling or a neighbor woman is within earshot when their feeble cries signal a final crisis, and so they die alone and unattended—*a mingua* as people say. A mother speaks of having "pity" for such a child, but her grief is as attenuated as her attachment to a baby who never demonstrated more than a fragile hold on life. The dead baby is washed and dressed in white satin and covered with sweet-smelling flowers. The coffin is simple: a cardboard or inexpensive wooden box decorated with a lining of purple tissue paper and a silver paper cross. Alto children form the funeral procession. In this way they are socialized to accept as natural and commonplace the burial of siblings and playmates; as later, perhaps they will have to bury their own children and grandchildren.

## BONDING THEORY AND THE BIOLOGICAL BASIS OF MOTHER LOVE

In recent years there has been considerable interest in exploring the biological components of mother-infant attachment. The observations of species specific maternal behavior patterns such as nesting, grooming, and retrieving which have been studied in animal

mothers immediately after birth led a number of ethologists, human biologists, anthropologists, pediatricians, and developmental psychologists to posit the parallel existence of a sequence of largely *innate* behaviors in human mothers' responses to their newborn. Such maternal behaviors as smiling, gazing, cooing, nuzzling, sniffing, fondling, and enfolding the newborn immediately postpartum has been observed, recorded, and quantified in order to demonstrate the existence of a universal psychobiological script referred to as "mother-infant bonding" (Klaus and Kennell 1976).

Maternal bonding (or loving and attentive, if somewhat mindless, attachment to the newborn) is said to be "triggered" in mothers in response to instinctual infant behaviors, especially crying, sucking, clinging and smiling. The automatic "milk let-down" reflex in lactating mothers' responses to hungry infant cries is often cited as evidence of the unlearned and innate components of mothering. Klaus and Kennell and their associates have identified a "critical" or "sensitive" period for maternal bonding that is said to occur immediately postpartum:

> There is a sensitive period in the first *minutes* and hours of life during which it is *necessary* that the mother and father have close contact with the neonate for later development to be optimal. [Klaus and Kennell 1976:14]

If the mother and infant are separated during this time (as is customary in hospital delivery), maternal bonding may be inhibited, suggest Klaus and Kennell, with consequences as serious as maternal indifference toward, or even rejection of, the infant when the two are reunited. Unlike other mammals, however, rarely are these consequences irreversible in *human* mothers:

> The process that takes place during the maternal sensitive period differs from imprinting in that there is not a point beyond which the formation of an attachment is precluded. This is the *optimal* but not the sole period for an attachment to develop. Although the process can occur at a later time, it will be more difficult and take longer to achieve. [Kennell, Trause, and Klaus 1975:88]

Support for the evolutionary genetic basis of human bonding has come from recent studies of hunter-gatherer populations. Research by Draper, Howell, and Konner (see Lee and DeVore 1976) indicates that the relationship between mother and infant in such small, mobile social groups is characterized by: a high degree of physical

skin-on-skin contact (for over 70% of the day and night in the early months of life); continuous and prolonged nursing (up to 4 or 5 years); close, attentive, and seemingly "indulgent" maternal behavior. These behaviors "typical of most primate species living in large groups [and of most] hunter-gatherers known today . . . probably represents the usual social environment for development in our species going back millions of years" (SSRC Committee on Biosocial Science n.d.:2). Maternal bonding, therefore, is thought to be part of our human evolutionary inheritance.

Alice Rossi suggests that while "biologically males have only one innate orientation, a sexual one that draws them to women, women have two such orientations, a sexual one toward men, and a reproductive one toward the young" (1977:5). Human mothering has a strong unlearned component, argues Rossi, because of the precarious timing of human birth. The extremely immature and dependent human neonate requires particularly close attention and care in order to assure its survival. Therefore, it was particularly advantageous for a "maternal instinct" to become genetically encoded in women's evolutionary psychology

The by now extensive maternal-infant bonding literature[3] has had, among other effects, a profound influence upon changes in the obstetrical management of pregnancy, labor, and delivery in this country and elsewhere. Many hospitals now have "birthing rooms" and rooming-in wards in order to enhance early mother-infant interaction and maternal bonding. Unfortunately, however, some of the "disciples" of Klaus and Kennell enlarged the claims made for the significance of early bonding. This lead to the naive belief among some health professionals that if early contact was *necessary* to ensure *optimal* parenting, perhaps this was *all* that was needed to ensure *competent* parenting. A number of hospital-based intervention programs, based on this shaky assumption, were launched during the 1970s when belief in the critical importance of early bonding was at its height (see Lamb 1982b). Some programs identified high-risk populations for "inadequate" parenting (usually this meant the poor, nonwhite teenage or single mothers, mothers of low birthweight infants, previous child abusers) and manipulated the hospital environment in order to "promote" bonding in the high-risk mothers who were sometimes observed against a matched control group. Rarely was there any attention paid to providing a suppor-

tive environment for the mother and child once they left the hospital. Similarly, the child abuse literature is replete with references to abuse and neglect as the consequence of failures in early maternal bonding.[4]

Recently, the scientific basis of bonding theory has been called into question,[5] and several longitudinal studies have not supported claims for any *long-term* effects of early mother-infant interaction (Ali and Lowry 1981; Rutter 1972; Chess and Thomas 1982; Curry 1979; deChateau 1980; deChateau and Wiberg 1977). As the scientific status of maternal bonding has receded, however, a view of womanhood positing the powerful effects of reproduction and mothering on females has arisen among some feminists (Rosaldo and Lamphere 1974; Ortner 1974; Chodorow 1978; Marks and de Courtivron, eds. 1980; Ruddick 1980; Gilligan 1982; Greer 1984). Sara Ruddick, for example, in a widely cited article published in *Feminist Studies* (1980:346–347) posits certain

> features of the mothering experience which are *invariant* and nearly *unchangeable*, and others, which, though changeable, are nearly *universal*. It is therefore possible to identify interests that appear to govern maternal practice throughout the species.

These *interests* concern demands for the *preservation, growth*, and *acceptability* of offspring. Ruddick refers to women's experience of a "social-biological pride in the function of their reproductive processes" (1980:344) and of a "sense of well-being" when their children flourish. Although she acknowledges that some economic and social conditions, such as poverty and isolation "may make [maternal] love frantic" (p. 344), she nonetheless maintains that these "do not kill the love." And she adds, "For whatever reasons, mothers typically find it not only *natural* but compelling to protect and foster the growth of their children" (1980:344). In stating her strong case for a *generalized* mode of "maternal thinking" Ruddick does specify that her model is based on her "knowledge of the institutions of motherhood in middle-class, white, Protestant, capitalist, patriarchal America" (p. 347) and she does call upon others "to correct her interpretations and to translate across cultures."

This is precisely what I shall do for the remainder of this paper in response to both the "bonding" and the "maternal sentiments" literature.

## CULTURE, SCARCITY, AND HUMAN NEEDS

I have seen death without weeping
The destiny of the Northeast is death
Cattle they kill
To the people they do something worse — Traveling *repentista* singer, Brazil

Whenever we social and behavioral scientists involve ourselves in the study of women's lives—most especially thinking and behavor surrounding reproduction and maternity—we frequently come up against psychobiological theories of *human* nature that have been uncritically derived from assumptions and values implicit in the structure of the modern, Western, bourgeois family. Theories of innate maternal scripts such as "bonding," "maternal thinking," or "maternal instincts" are both culture and history bound, the reflection of a very specific and very recent reproductive strategy: to give birth to few babies and to invest heavily in each one. This is a reproductive strategy that was a stranger to most of European history through the early modern period,[6] and it does not reflect the "maternal thinking" of a great many women living in the Third World today where an alternative strategy holds: to give birth to many children, invest selectively based on culturally derived favored characteristics, and hope that a few survive infancy and the early years of life. This reproductive strategy requires a very different conception of maternal thinking, and just as surely elicits different kinds of maternal attachments, feelings, and sentiments—such as, for example, those implicated in the selective neglect of "high-risk" babies on the Alto do Cruzeiro. Since this reproductive strategy is characteristic of much of the world's poorer population today, it would seem that some revision of maternal bonding/maternal thinking as a universal human script is in order.

As might be expected, women whose cumulative experiences lead them to resignation with respect to high fertility *and* to an expectation of frequent failure to rear healthy, living children will respond differently to their newborn than middle-class mothers with both greater control over their fertility *and* a high expectation for the health and viability of their children. Infant life *and* infant death carry different meanings, weight, and significance to Alto women than to the mothers generally studied in "bonding" research. De-

spite the fact that the birth and neonatal environment on Alto do Cruzeiro should be optimal for intense, early bonding to occur, mother-infant attachment is often muted and *protectively distanced.*

The traditional birth environment among Alto women is a home birth attended by a lay midwife and by several supportive female friends or relatives, especially the woman's mother. Virtually all the mothers in my sample over 40 gave birth at home with a traditional *parteira;* half the younger women still prefer home to hospital delivery, although "charity cases" are accepted in the maternity wing of the town hospital. Even those who do give birth in the town *maternidade* stay for less than 2 days and keep their newborns in a small crib next to the hospital bed.

Alto mothers and infants sleep together until the baby is considered old enough to sleep in its own small hammock or cot next to the mother's bed. Co-sleeping lasts from 1 month to 6 months. Breastfeeding, although greatly attenuated, is the norm for the first few weeks (generally 1 month to 6 weeks in this sample). Although Alto infants are not tied to the mother's person in shawl or sling, the infant spends a good many hours of the day in the arms or, when slightly older, balancing on the hip of the mother or any one of a number of convenient mother surrogates: siblings of both sexes, neighbors, visiting anthropologists. There is a great deal of physical affection expressed toward infants who are frequently stroked, tickled, teased, sniffed (kissing is thought inappropriate), and babbled to by all in the household. In short, all the conditions conducive to "bonding," as described in the medical and psychological literature, can be said to obtain in O Cruzeiro.

Nonetheless, Alto mothers protect themselves from strong, emotional attachment to their infants through a form of nurturance that is, from the start, somewhat "impersonal," for lack of a better word. Many Alto babies remain not only unchristened but *unnamed* until they begin to walk or talk *or* until a medical crisis (and the possibility of death) prompts a hurried, emergency baptism. In such cases (and I have been present at several of these) the name given the child is incidental. In some cases I or another casual onlooker was asked to pick a name spontaneously. Often the infant simply inherits the name of the last infant to have died in the family. Unnamed babies are simply called *ne-ne* (baby) or given a Brazilian generic name, Ze

(Joe) or Maria. Adult affection for the *ne-ne* is diffuse and not focused on any particular characteristics of the infant as a little persona.

The circulation of babies through informal adoption or abandonment is commonplace on the Alto. Mothers in dire straits will sometimes ask a current or former employer to take their baby as a foster child or even as a future household servant. Young and unmarried women will sometimes leave a 5- or 6-month-old baby on the doorstep of an Alto woman known to be particularly tender-hearted. This happened to a dear friend and key informant during the summer of my stay in 1982, and brought back poignant memories to us both of the occasions during 1965–1966 when we had to cope with several babies abandoned at the cooperative day care center we had organized on the hill.

Given the extraordinary incidence of infant mortality on the Alto, child funerals are an almost daily occurrence and are dispatched with a quality of *la belle indifferance* that outsiders sometimes find quite shocking (see, for example, Scrimshaw 1978). The infant coffin-maker is a village-level specialist found in every community of Northeast Brazil. He sometimes works in the medium of cardboard, paper maché and scrap material. A brief wake is held in the home when an infant over 6 months dies. Household visitors are expected to admire the sweet angel, but not to grieve. Mothers are scolded by other women if they shed tears for an infant, and few do. There do exist cases of Alto women who refuse to forget the death of a particularly favored baby, but their emotions tend to be dismissed as inappropriate or even as symptomatic of a kind of insanity.

The mundaneness and the high expectancy of infant death is shared by physicians and politicians of the town. In pointing out to the mayor of Ladeiras the rather extraordinary rate of child mortality for the community, he replied that he was aware of the problem and that he had, in fact, fulfilled a campaign promise in that regard: a free baby coffin to all registered voters according to their family's needs.

In all, what is constructed is an environment in which loss is anticipated and bets are hedged. "Mother love" with its attendant emotions of *holding, keeping,* and *preserving* is replaced by an estranged and guarded "watchful waiting." What makes this possible is a cultural conception of the child as human, but significantly less human than the grown child or adult. There is socialized in the Alto mother

an emotion of estrangement toward the infant that is protective to her, but potentially lethal to the child. Maria Piers (1978:37) refers to this state of primitive unconnectedness as "basic strangeness":

> Basic strangeness precedes basic trust. It marks the beginning of life and its end. In the intervening years, however, many situations occur that drive us back partially or wholly into that state. Basic strangeness denotes the opposite of empathy. It is a state in which we "turn off" toward others and are unable to experience them as fellow human beings. Instead, we may value them as inanimate objects.

Piers suggests that the single most frequent cause of such total estrangement is "abject poverty" leading to physical weakness and hopelessness. In such a condition, "even one's own child may appear as a competitor" (1978:39). In human parenting nothing can be taken for granted, least of all that the parent would sacrifice her life and resources for her child. Human mothers who reach the limit of their endurance can and often do become both estranged from and indifferent toward their children. Certainly Piers's concept is worthy of further refinement and investigation.

However, I do not wish to suggest by the foregoing that Alto mothers never suffer the loss of their infants. Indeed, amidst the generally passive and emotionally flat narrations of their lives as women, workers, and mothers, the pain of a particularly unresolved or poignant loss would break through and shatter the equanimity and resignation that is the norm. There would be memories of *particular* babies in whom a mother's hopes for the future *had* been invested, and she would weep in the telling of *that* death of all the deaths and losses she had endured. In the presence of so "deviant" a response I would be at a loss for how to proceed or, indeed, whether to proceed at all. But invariably my Alto assistant, Irene, or another woman would come to the rescue. "No, Dona Maria," she would scold the grieving woman, "of course you will not go mad with grief. You *will* conform. You will go on. You have *your own life* ahead."

The reproductive and life histories of these shantytown women lead me to question the validity of such ill-defined terms as maternal bonding, attachment, maternal thinking, critical period, and separation anxiety that fill the literature on mother-infant interaction. The terms and concepts seem wholly inadequate to convey the experience of mothering under the less than optimum conditions that

prevail throughout much of the world today. The classical maternal bonding model focuses altogether too much attention on too few critical variables and on too brief a period in the mother-child life cycle. The model grossly underestimates the power and significance of social and cultural factors that influence and shape maternal thinking over time: the cultural meanings of sexuality, fertility, death, and survival; mother's assessment of her economic, social support, and psychological resources; family size and composition; characteristics and evaluation of the infant—its strength, beauty, viability, temperament, and "winsomeness."

The bonding model has neither relevance to, nor resonance with, the experiences of the women of O Cruzeiro for whom the life history of attachments follows a torturous path marked by many interruptions, separations, rejections, and losses reflecting the precariousness of their own existence and survival. But it is also important to note that an early lack of attachment, an indifferent commitment, or even a hostile rejection of an infant does not preclude the possibility of an enfolding drama of mother-child attachments later on, as some of the memorable survivors of early and severe selective neglect, like Ze-Ze, would indicate. That there must be a biological basis to human emotions is not disputed. It is argued, however, that the nature of human love and attachments is a complex phenomenon, socially constructed and made meaningful through culture. A more contextualized model of maternal thinking and sentiments is needed.

Finally, in concluding this paper, I wish to make it abundantly clear that there are many conditions on the Alto do Cruzeiro that are hostile to child survival. Most serious are the ones I scarcely mentioned: contaminated water, unchecked infectious disease, food shortages, the absence of day care facilities, and grossly inadequate medical care. I have focused instead on maternal thinking and behaviors that may also contribute to childhood mortality in order to address the indignities and inhumanities forced on poor women who must make choices and decisions that no woman should have to make. In the final analysis, the selective neglect of children must be understood as a direct consequence of the "selective neglect" of their mothers who have been excluded from participating in what was once called the Economic Miracle of modern Brazil.

## NOTES

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[1]See Paim, Netto-Dias, and De Araujo 1980. Also, see Wood 1977. A recent PAHO investigation of childhood mortality in a dozen urban and rural sites in eight Latin American countries found the City of Recife in Pernambuco, Northeast Brazil, to have the highest infant mortality of all urban centers sampled.

[2]See Goldberg, Rodrigues, Thome, and Morris 1982; Grant 1983; Berquo, Cukier, and Spindel 1984. A recent UNICEF report noted that in Brazil the percentage of babies breastfed *for any length of time* has fallen from 96% in 1940 to under 40% in 1974. This same report cites another study which found that among a large sample of children of poor parents in the South of Brazil, bottlefed babies were between three and four times more likely to be seriously malnourished than breastfed babies.

[3]See, for example, Klaus and Kennell 1976, 1982; Kennel, Voos, and Klaus 1979; Klaus, Jerauld, and Kreger 1972; Lozoff, Brittenham, and Trause 1977.

[4]See, for example, Hurd 1975 and Schwarzbeck 1977.

[5]See, for example, Sveja, Campos, and Emede 1980; Lamb 1982a, 1982b, and 1982c; Korsch 1983.

[6]Contemporary historians of European and American family life in the early modern period have described child-rearing practices that were at best harshly pragmatic, and at worst sadistic and passively infanticidal. See, for example, Aries 1962; de Mause 1974; Fox and Quitt 1980; Laslett 1965; Shorter 1975; Stone 1977).

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