Cumbered Cries

Contextual Constraints on Maternal Grief in Northeast Brazil

by Marilyn Nations, Joseph Corlis, and Jéssica I. D. Feitosa

In the past 30 years, debate has raged over maternal influence on infant death in Northeast Brazil. Scheper-Hughes, in two acclaimed articles and a book, sparked the controversy by alleging that *nordestina* mothers disinvest disfavored children of resources, thereby contributing to their deaths. We propose an interpretation of maternal investment through retrospective contextualization of a three-tiered series of factors. Between 2011 and 2013, we analyzed 316 ethnographic interviews about childhood death collected in the interior of Ceará. Our subsample comprises 58 death narratives from grieving mothers whose children died during the 12 months preceding the interview between 1979 and 1989; follow-up studies of 13 of those grieving mothers were conducted in 2011. Our sample closely resembles that of Scheper-Hughes, and from its stories we identify seven contexts—historical, political, economic, ecological, biological, social, and spiritual—that constrict how mothers grieve. Each context interrelates with the others, forming a cultural niche that regulates accepted emotionality, modes of suffering, roles of authority figures, and so on. We explore these contexts, offering alternatives to Scheper-Hughes's theory, and conclude that a community-wide tendency to neglect never existed.

In recent years, anthropologists have seen a surge of allegations that many societies tolerate and conceivably generate parental tendencies to disassociate mothers from offspring, ultimately contributing to children's deaths. This wave seizes upon the concept that parents and guardians living in communities with scant economic resources allocate their limited possessions to themselves and preferred children at the expense of other dependents. In Niger, "vulnerable children become 'victims of non-discrimination' through a form of benign neglect engendered by pervasive poverty" (Hampshire et al. 2009:758); rural India may bolster "selective neglect of children with certain sex and birth-order combinations" (Pande 2003:395), while the southern Indian state of Tamil Nadu, in particular, may harbor rampant female infanticide (Diamond-Smith, Luke, and McGarvey 2008); in Nigeria, caretakers watch their children die while collecting government subsidies to sustain the rest of their large families (Osifo and Oku 2009:316); and families may neglect female siblings in rural Peru (Larme 1997). The conclusions are unmistakably comparable and alarming: in areas where political and/or economic empowerment appear unattainable, children grow ill and die because of an insipid microlevel plague—throngs of negligent parents who arrogate to themselves food, water, and medicine from the mouths of their own children. While we cannot speak to the cultural variability of maternal investment, we are sure that mothers alone are not responsible for the survival of children (Millard 1994).

Pinto explains why infant death necessitates debate:

> Birth's potentiality of action and the child's ability to embody the future mean that in loss . . . with a slight tweak, a modest tuning out, it is easy to hear ignorance and laziness. But retune, and it is not so uncanny that the only thing to say is . . . "everything is in the hands of God." (Pinto 2008: 200)

Rightly, the ethnographer Scheper-Hughes explains how research, lacking contextualization of motherhood and childcare practices, contributes to victim blaming (Scheper-Hughes 1984:536). Nevertheless, in her research on Northeast Brazil, Scheper-Hughes pioneered the maternal selective neglect theory, which postulates that mothers in marginalized and underdeveloped communities shield their meager assets—material, emotional, and otherwise—by "devis[ing] 'ethnoeugenic' childrearing strategies that prejudice the life chances of those judged 'less fit' for survival" (Scheper-Hughes 1984: 535). Those strategies include "a pair of childhood patho-

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gens—maternal detachment and indifference toward infants and babies judged too weak or too vulnerable to survive the pernicious conditions of shantytown life" (Scheper-Hughes 1985:292). She concludes, "In human parenting nothing can be taken for granted, least of all that the parent would sacrifice her life and resources for her child" (Scheper-Hughes 1985:313). As the theory's name suggests, the women selectively "reject and withdraw their affections from their passive and less demanding babies" (Scheper-Hughes 1985:301), but the "mothers Scheper-Hughes describes do successfully bond with *some* of their offspring, and provide these children with sufficient care to insure survival," so she cannot be said to describe depression or shock among her informant mothers, since such psychological explanations would likely produce more generalized effects (Finerman 1995:6).

In essence, the anthropologist recasts the classic, albeit controversial image of limited good in underdeveloped societies: "A mother's ability to love her children is viewed as limited by the amount of love she possesses" (Foster 1965:298). Nevertheless, Finerman (1995:7) explains that "while such studies present compelling data on relationships between parental behavior and child survival, the *interpretation* of these data is highly problematic, and poses far-reaching problems for research and application."

Nations and Rebhun (1988) first rebutted Scheper-Hughes on the basis of ethnographic data from a similar *nordestina* community collected during the same time period. The authors contend that maternal grief reactions can be understood only if situated within the realm of folk-Catholicism and that structural violence impedes poor Brazilians from accessing needed medical attention. Subsequently, Rebhun (1994:175) delves into health-related experiences in Pernambuco state—where Scheper-Hughes's study occurred—and unveils that women affirm, "There's always room for another child in our heart" when informally adopting children.

As this research was commencing, however, Brazil was in flux. Economic policies of the day were heralded as miraculous, and the total income of the richest 5% of the country increased by 72%; nearly 75% of the population, however, experienced no change (Moreira et al. 1978). Migrants from rural communities found themselves "testing their luck" in an exodus of more than 27 million from the poor countryside into overcrowded tenements in unprepared city centers, especially in the country's Northeast (Ponte and Nascimento 2010:184). And since this debate began, two interesting occurrences have transpired.

First, the infant mortality rate in Northeast Brazil has plummeted by 76.3%—from 97.1 infant deaths per 1,000 in 1980 to 23 per 1,000 in 2010 (Instituto Brasileiro de Geografia e Estatísticas 2013). Selective maternal neglect, however, is not mentioned in the report. If the twin factors of maternal underinvestment and indifference toward sick and dying babies were relevant to Brazil's high infant death rates, as Scheper-Hughes (1984, 1985) avers, the drastic decline in death rates would likely depend as much on lessening numbers of neglectful mothers as on increased economic empowerment. However, we know of no behavioral health interventions regarding maternal attitudes throughout the Northeast during this time period. To the contrary, programs in the late 1980s—such as the highly acclaimed oral rehydration intervention—enabled poor women and traditional healers to treat deadly diarrhea at home, at once dealing with proximate and ultimate causes of child death by bypassing the hospital hegemony and halting the effects of disease (Millard, Ferguson, and Khailia 1990; Nations and Rebhun 1988; Nations et al. 1988).

Second, the debate on selective maternal neglect in Brazil has continued to rankle both nationally and abroad. A study from Ceará determines that out of 127 infant deaths studied, "27 cases (21.1%) of mothers reported that their infants were 'doomed'" and mothers refused to intern their children for hospital care (Terra de Souza et al. 2000:1684). However, an in-depth qualitative study of 16 grieving mothers in Belo Horizonte, Minas Gerais, Brazil, found no evidence of fatalistic acceptance of child death (Goulart, Somarriba, and Xavier 2005). Nations (2008) reports that mothers from Ceará blame poor medical care (24.1%), lacking public health services (7.5%), political and economic woes (13.8%)—all macrolevel, ultimate tier causes of infant mortality—and disease (37.9%)—the proximate tier—for their children's deaths, but none blame negligence; she then accuses Scheper-Hughes of "downplaying these deadly, *emically*-defined determinants" for writing, "I soon became bored with [the] concreteness [of the mothers' answers]," thereby supplanting the women's own explanations of infant death with an etic-laced foreign theory of selective maternal neglect as the most relevant cause of high infant mortality in this drought-stricken region (Nations 2008:2245; Scheper-Hughes 1984:539). Likewise, in an article on infant death trauma and maternal depression, grieving mothers transfigure the images of their children's corpses, imbuing them with symbolism that defies feelings of helplessness, hopelessness, definitive loss, and personal guilt (Nations 2013).

This article is another attempt to reorient the debate on whether maternal neglect has ever occurred in Northeast Brazil by juxtaposing Scheper-Hughes's support for her theory with our own ethnographic evidence. We find our inspiration in Geertz (1973:29), who asserts that ethnography is "essentially contestable," that it is "less marked by perfection of consensus and more by the refinement of the debate." Moreover, he argues, ethnographic monologues are "of little value, since there are no conclusions to be reported, but, a discussion to be sustained" (Geertz 1973:29).

To that end, we unveil maternal emotional investment in sick and dying infants through a retrospective exploration of local grief reactions. Ours is a question of how grieving occurs and what that reveals vis-à-vis *nordestina* maternal investment in infants, both living and deceased. Scheper-Hughes's articles depict how infant death represents a foreseeable aspect of general life:

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> 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* [sic] that outsiders sometimes find quite shocking. 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 [sic] 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. (Scheper-Hughes 1985:312)

In 2012, Vailati explained that, throughout history, foreign visitors who witness infant funeral practices in Brazil "often oscillated in their reactions from admiration to indignation" (Vailati 2012:263). One such historical account comes from two British visitors in colonial times:

> When a child dies, the parents are so certain of its felicity, according to the dogmas taught to them by the Church, that they put on no mourning habiliments, but act as if it were a festival: sometimes the parish bells are rung, as if for joy, and their friends pour in congratulations. The remains of the deceased child are decked out to represent an angel; the coffin is profusely adorned; the hearse is an open canopy, supported by pillars, painted and gilded; the driver of the hearse with a footman behind and several outriders are all dressed in scarlet; and the whole cortège, when viewed from a distance, looks like a hunting party. . . . Custom forbids women from attending funerals in Brazil . . . the immediate relatives remain at home for eight days, during the first of which they remain in perfect silence. (Chandler and Burgess 1853:44–45)

For Scheper-Hughes (1985:295), "selective neglect accompanied by maternal detachment is both widespread . . . but 'invisible.'" When she suggests, "mothers who reach the limit of their endurance can, and often do, become both estranged from and indifferent toward their children," she is right insofar as the possibility exists, especially among mothers suffering with mental illness (Scheper-Hughes 1985:313). But where is that limit? The causal model of child mortality

> holds especially true for households that pool income from farming and remunerated work, including wage labour, vending, and handicraft production. The model also applies to poor urban people not involved in farming but drawing income from various unsteady and insufficient sources. Economic hardship sustains sources of cheap labour and also contributes to high rates of child mortality. Poverty on the tier of ultimate causes may underlie culture-specific patterns of child care on the tier of intermediate causes that predispose children to malnutrition, thus increasing the probability of death. (Millard, Ferguson, and Khailia 1990:290)

Precisely because selective maternal neglect is one possible "culture-specific [pattern] of child care" in the resource-poor areas of Northeast Brazil, we seek to prove that a gross misinterpretation of the reality led Scheper-Hughes (and other scholars who continue to claim such tendencies exist) to arrive at the conclusion that "child death *a mingua* (accompanied by maternal indifference and neglect) is understood as an appropriate maternal response to a deficiency *in* the child" (Millard, Ferguson, and Khailia 1990:290; Scheper-Hughes 1985:295). We contend that the selective maternal neglect theory fails to peel away each of the contextual constraints of the ultimate and intermediate tiers of causes of infant death to unmask the stifled bereavement that our informants claim to abide daily[1] (Millard, Ferguson, and Khailia 1990). And while we take care throughout this article not to idealize these women as sterling archetypes of pure motherly love incapable of neglect or disassociation, our sample explains that their mourning is for all—not selected—deceased children.

That Scheper-Hughes found mothers' recounting of memories to be poignant during her interviews is not surprising (Scheper-Hughes 1985:313). Our informants' stories likewise gripped us. Nonetheless, we avouch that the mention of only select stories reveals not a lack of investment in other babies' lives but a glimpse into the absence, trauma, and heartbreak that each infant death represents. We posit that while the existence of maternal neglect is possible in any population, our mothers' stories epitomize the fruits of real maternal investment in each of their children.

Our Studies

Between 2011 and 2013, we organized and analyzed 316 ethnographic interviews of women regarding infant death, maternal suffering, and bereavement. The interviews were conducted in two phases. First, between 1979–1989, the senior author went to three rural communities (Pacatuba, Guaiuba, and Itapebussú), a housing resettlement project (Conjunto Palmeiras), an urban shantytown (Gonçalves Dias), and a fishing village (Pecém). All of these areas lie within a 2-hour bus ride from Fortaleza, the capital of Ceará state in Northeast Brazil. Most women of the sample were married, although some lived in divided homes because drought and mechanized agriculture drove many rural farmers (men) to cities, which overloaded shantytowns with underpaid construction and manufacturing labor. The women too worked—in budding cashew factories or at home in the Sertão (the arid noncoastal area of the *Nordeste* infamous for its long droughts) producing handicrafts and farming. Class divisions often mar-

1. For more on proximate causes of infant death in Northeast Brazil, we suggest Nations (1988).

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ginalized the high concentrations of indigenous Tupi and mixed-heritage (Portuguese, Dutch, Tupi, African) inhabitants. Nearly the entire sample was illiterate and resided in precarious homes devoid of clean water and adequate sanitation; some neighborhoods in Pacatuba, for example, had an average of 15,000 fecal coliforms per deciliter of water in their local drinking sources (Nations 1982). In 2011, 13 of the original informants from Pacatuba and Guaiuba were reinterviewed.

Of the 58 interviews from the two interview periods that constitute our subsample, 51 mothers collectively bore 103 deaths of children under the age of five, 71% of whom died before their first birthday. The chosen informants were biological mothers (90%), grandmothers (6%), and adoptive caregivers (4%), and we refer to them broadly as mothers throughout this paper. Every interview explored the mother's understanding of and reaction to the fatal disease episode and death of one of her children. About half (49%) of the mothers described a single death experience, whereas 45% spoke of two to six children's deaths, which included two pairs of twins. The most recent death occurring within the previous 12 months was considered.

The senior author elicited death narratives in the privacy of the women's sleeping quarters. Multiple sessions were necessary to reconstruct each mother's experiences before, during, and following the infant death. All narratives were tape recorded and transcribed manually. Field observations of events related to infant death helped to shape the contextualizations and were quickly etched into a notebook to be expanded into descriptive texts each evening. Through transcript analysis, seven distinct cultural contexts along the three-tiered model for infant mortality surfaced: biological, ecological, economic, historical, political, sociocultural, and spiritual. The fatal disease episodes of all 103 children were reexamined following the contextualized semantics approach of Bibeau and Corin (1995) to interpret mothers' reported signs, meanings, and actions. Situating mothers within the seven defining contexts—which determine maternal recourse, composure, and coping—provides significance to the process surrounding the infant illness, death, and postmortem events. Throughout these interviews and analyses, the informants' anonymity has remained intact.

Thus, the time period, cultural region, and methodology of our study are comparable to Scheper-Hughes's (1984, 1985). Perhaps one of the few differences between Scheper-Hughes's sample and ours is that the mothers of her study participated heavily in sugarcane production, "working 'at the foot of the cane,'" as she says, whereas our informants farmed mostly cashews, cattle, and fruit (Scheper-Hughes 1985:297).

Our Findings

Despite any reported dearth of economic investment in children's recoveries or of tears after their deaths, we recognize that our interviewees did and do have grief responses. Yet these responses can only be properly comprehended when embedded in each of the seven facets defining rural Cearense mothers' niche in the 1980s—her local moral world (Kleinman 2006). As in all things, each person and each experience is unique; thus, our mothers report varying sentiments. We have, nonetheless, pinpointed commonalities between them. Each of the seven contexts—positioned within the intermediate and ultimate tiers of infant death causality—may "unintentionally predispose children to malnutrition and disease," according to Millard, Ferguson, and Khailia (1990:288), but they also sculpt maternal grief responses in important ways. Thus, we situate our scope on precisely the same aspects of Brazilian life that could have given rise to "the necessity of allowing some—especially their very sick—babies to die '*a mingua*,' that is, without attention, care, or protection" (Scheper-Hughes 1985:292).

The historical context provides us insights into Brazil's storied postmortem rituals. Politics in the rural Northeast generated a system of bargaining that drained and dominated mothers following children's deaths. Economic and ecological facets of informants' experiences directly affected decisions of how to deal with a child's remains. Society muted mothers' expression of grief, yet interviewees expose a deep-brewing sadness. Too, informants' biological make-up, they claim, can inflict lasting *distúrbios* (mental disturbances) in bereaving mothers. Finally, spirituality provides some mothers with an outlet that borders on acceptance while leaving others feeling bitter and isolated.

The agglomeration of these different aspects of society and grief produces a vision of power dynamics in infant death experiences for Northeast Brazil. In retrospect, either our mothers focused on their place as equal players in the decisions and impacts that eventually culminated in the many losses of life, or they lamented their experiences as subjugated and feckless onlookers who endured extraordinary pain witnessing their children succumb. Our interviews undermine the notion of selective maternal neglect espoused by Scheper-Hughes (1984, 1985, 1992) because discourse reveals the ambit of maternal investment within each grief reaction.

"In That Era"

The 1970s and 1980s in Brazil was a time of restriction, especially medically. Scheper-Hughes (1984:536) describes the era's roots as "extend[ing] back to the earliest days of colonization when the patterns of *latifundia*, *monocultura* and *paternalismo* were first established." Our informants recall how the time period looked in light of their health struggles. Pipiu, a health agent from Guaiuba, recalls "a municipality that was extremely poor, you know, in dire need of every kind of assistance." For mothers who survived their children, class precedence and history shaped the grief response.

Scheper-Hughes declares, "Children form the funeral procession. In this way they are socialized to accept as natural and commonplace the burial of siblings and playmates" (Scheper-Hughes 1985:306). Our informants tell a different story. Chil-

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dren under 7 years of age—"innocent ones who have not yet sinned"—participate in funeral processions to symbolize the deceased child's purity. Grieving families celebrate the love they felt and continue feeling for the dead child and desire for its eternal well-being, hoping to one day reunite in paradise with family members from past and future. Raquel explains, "We pray to benefit the *anjinho* [little angel], but it's not like we do with [deaths of] adults where we have a whole mass to celebrate." During our interviews, however, informants enthusiastically presented photographs of deceased children, and we recognize that this tradition of taking and preserving photos stems from one of many grief response traditions.

Images have long been featured in Brazilian funerary cultures, portraying deceased children as dolls and "ascended angels," as Raquel labels them. Figure 1 presents an example of a dolled up dead infant from among the earliest photographed instances in Brazil. This figure, not shown to us by any of our interviewees but exhibited in a national museum, represents the epitome of how communities across Brazil sought to commit lost children, although *dona* Antônia laments, "My husband asked them to take the photo of our girl, but I wanted my living daughter, not the version wrapped in paper."

From our sample, informants offered us their versions of an *anjinho*. Figure 2 depicts the beginning of a *nordestina* funeral procession, a wake of twins in the family's home. Francisca explains the scene: "We light candles and place the children on a table. We watch over them the whole night before taking them out to bury the next day." Despite the poverty that necessitated that the twins lay in the same cardboard coffin, the family endeavored to honor its loss in light of the baby doll standard.

In figure 3, we see the second stage of rural *nordestino* burials. Most in the funeral procession wear white—for purity and peace—as the *caixinha* is transported to the burial site. The assembly publicly displays affection for the deceased child, sniffing the scented child—inhaling its vital essence—to show fondness.

Our informants stress that interments are a man's domain. Because of the gender divide, funeral processions snake through the community's streets to show everyone the baby, "the little doll," as *dona* Fiinha describes, on the way to the grave, where the men pronounced their final good-byes and "tossed dirt directly onto the angel's face," according to Antônia Morena. The absence of a coffin lid symbolizes the *anjinho*'s readiness to ascend to heaven. For reasons we explore later in this essay, mothers like *dona* Rosa Tema iterate, "I did not go to my baby's funeral." According to her, a woman's role is to protect keepsakes and cope: "Our armoires were soap boxes, but I washed and ironed all of my babies' clothes to keep. I never mixed their clothes with the grown ups'."

Only in cases of the folk illness *doença de criança*—the child's disease—does the elaborate procession not occur (Nations 1992). As *dona* Binha explains, "We are afraid of contaminating more children . . . none under 7 years old can attend the funeral, and we bury all of the dead child's possessions because they pass on the sickness." Even Scheper-Hughes's informants lived in fear of "calling [the disease] up," as if simply speaking its name could conjure it again (Scheper-Hughes 1984:541).

Figure 1. Deceased Olga Marcondes de Matos. 1895. Photograph by De Nicola. Museu Paulista da Universidade de São Paulo Archives. A color version of this figure is available online.

Scheper-Hughes (1985) mentions the prominence of coffin makers, but she fails to note another common profession, the local photographer who snaps pictures of the departed. Our interviewees explain that these photographs enshrine the child, keeping his or her position in the family hierarchy. Negligent mothers, gradually eliminating "one newborn or toddler from the circle of protective custody," would not bother with keepsakes—such as photographs, documents, and favored clothes—from the departed child (Scheper-Hughes 1984:536). Our informants report safeguarding such reminders for each child that passed away.

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Figure 2. Pair of twins together in a single *caixinha de papelão* (little cardboard box) fitted with paper decorations of light blue to symbolize *O Céu*, heaven. The *caixinha* appears here atop the death table for viewing (Alto São João 1979). A color version of this figure is available online.

This historical perspective situates the women's role in caring for the deceased child within the greater communal reaction to the loss. Mothers inherit this role, like many other norms, from history. For mothers to recast their part in this procession or refuse other such functions would be untenable and, as we see via later contextualizations, justify the dead child's ultimate rejection from heaven.

A Favor for a Favor

One way mothers tried to circumvent the formidable and long-standing odds against them, which Scheper-Hughes characterizes as "hostile to child survival," was to garner special treatment from local politicians (Scheper-Hughes 1985:314). Northeast Brazil hosted a rampant *clientelismo*, defined by Maria de Lúcia as "trading my vote for my baby's death certificate." Our informants explain how they found themselves captive in a system of favor swapping. Parents would finagle medical assistance through bribes, services, and pledges to vote, lest they remain incapable of providing food, medicine, or burial rites. Scheper-Hughes herself (1985:312) reports that a mayor in Northeast Brazil boasted of fulfilling his pledge of "a free baby coffin to all registered voters according to their family's needs." She theorizes that "the 'selective neglect' of [the] mothers who have been excluded from participating in what was once called the Economic Miracle of modern Brazil" is responsible for "indignities and inhumanities forced on poor women who must make choices and decisions that no woman should have to make" (Scheper-Hughes 1985:314). We concur that rural *nordestinas* in that time knew little of the political and economic success their country enjoyed. Scheper-Hughes overstates, however, by conflating matriarchs who have little to offer with mothers who willfully withhold. By comprehending this *clientelismo*, we perceive the binds that encumber mothers' grief and, thus, the investments that burgeon in spite of beleaguering power dynamics.

Dona Antônia Morena recalls her family's powerlessness: "As a hearse drove past our funeral procession, the driver mocked, 'Looks like the living have died, huh?'" She cursed his cold indifference as the car hastened past. What is a mother with only one vote to barter when her fourth child dies?

In Cearense politics, without collateral, no favors were given. Mothers who used state hospitals in Fortaleza faced a hospital hegemony composed of "murderers and not doctors," claims community leader *dona* Vilauba. Indeed, public opinion of doctors was so low that "people thought that if we hospitalized our child it was because we wanted to rid ourselves of the work a sick baby requires at home," according to Francisca Tânia from Conjunto Palmeiras (a resettlement community next to the municipal dump site). This contradicts Scheper-Hughes's argument that mothers do not check the young into hospitals because they forget their babies who are perishing in hammocks (Scheper-Hughes 1985:306). Hospital staff wielded power as though the consent from the poor scarcely mattered, as in Fatima's case:

> Fatima, a 27-year-old mother from Pacatuba, searched for a *rezadeira* [folk-Catholic healer] who could cure her 10-month-old daughter, but she quickly realized the child needed special assistance. Married to an unemployed hus-

Figure 3. Photograph of a photograph, 2011. The original image was taken by the senior author (Nations 1982) and has remained on the entryway wall of *dona* Antônia's home along with religious symbols and photographs of other family members. A color version of this figure is available online.

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> band and pregnant with another child, Fatima was barely able to scrape together enough money for the bus ride to Fortaleza. Her money spent on the trip into town, she slept standing in the hospital halls near her baby's room. One day, a doctor barred Fatima from visiting her baby, sternly warning her that given her physical exhaustion, mounting stress and pending delivery, she was at high risk of suffering an emotional breakdown. So the doctor transferred her daughter to an isolation ward, only visible to Fatima through a tiny window. Weeks later, the infant seemed to be recovering. She was sitting up again and "playing." Doctors agreed she was much better and would be discharged, but when the optimistic parents arrived at the hospital to take their healthy girl back home, they were stunned to see a stream of blood oozing out of her nose. The nurse coolly informed the distraught couple that the doctor had ordered an "intestinal cleansing" without their previous knowledge or written consent. Tragically, a nasogastric catheter had been poorly inserted, puncturing the girl's intestines. Shortly thereafter, Fatima's daughter died of an internal hemorrhage. Fatima's husband berated the hospital staff as *burros* [dumb jackasses] for "killing his daughter." The mother remained silent, trudging home with her girl's lifeless corpse once her husband's rage subsided.

Cases such as Fatima's expose how hospitals violated people's rights and sensibilities "in that era." Her silence, however, does not detract from her pain. It does not negate the investments she made in her daughter's recovery. Her silence, rather, is her reaction given her family role, dictated by a society that defines poor mothers by their powerlessness.

Scheper-Hughes (1984:540) writes that "weaker and smaller [children] may be left behind for the hospital staff to dispose of as they see fit." On the basis of our data, this sounds unlikely. First, according to our sample, mothers desired to take their children home, even if only to dispose of their remains. *Dona* Rosa Tema remembers, "I left my boy at the hospital. My husband had to pick him up . . . I wanted my boy alive, but God didn't let me have him." Hospitals, however, often refused to allow the babies to receive their final rites, and so mothers wept, pleaded, and grieved without closure from washing and dressing the dead. The out-of-pocket costs and bureaucratic red tape grieving parents faced to secure a child's corpse from the hospital morgue, obtain an official death certificate, and transport the body back to the village to bury were near insurmountable (Nations and Amaral 1991). Such barriers necessitated heartrending scenes—poor fathers pleading with night watchmen at an infectious disease hospital in Fortaleza to ignore institutional norms, a lone guard releasing a child's lifeless corpse over the hospital wall into the father's keeping under the cover of night—which the senior author observed.

Furthermore, if the entire region were rife with women competing with their children, why would the culture of adoptive mothering and caring for the most indigent of children have been as common as *dona* Liduina mentions? She states:

> I remember my daughter especially on her birthday because another boy was born on the same day at the same hour. His mother didn't have *conditions* [to pay for the necessities of life such as adequate food, water, housing, and medical care] but I did. . . . I wasn't able to save my sick daughter, but I could bear her loss better when I adopted that boy.

Adoption appears to occur between families who view themselves not necessarily as socioeconomic equals but as peers within an overarching power hierarchy. Instead of protecting their limited good, our informants seek to rear as many children as possible in what appears a social support system and a ready coping mechanism for grieving mothers. As Mayblin (2012:242) states, "As casual adoption and child fostering are common practices, motherhood, in local parlance, is not necessarily synonymous with biology. What it must equate with, however, is that long, drawn-out process of love and care."

Economically Poor, Symbolically Rich

Scheper-Hughes's explanation of mothers hoarding resources for self-preservation was never evident in our research. On the contrary, her acknowledgment that, "[i]f there is one raw and vital nerve among impoverished *Nordestinos*, it is the horror of drought . . . and of thirst" seems more applicable (Scheper-Hughes 1984:544). Pipiu states, "People were needy. There was no treated water, nothing potable at that time. People got water from rivers, dams, wells . . . this is why we had so many children that lacked good food and got infections and diarrhea so easily." Scheper-Hughes's description that "virtually all family income was spent on the weekly marketing for food" reverberates throughout our interviews (Scheper-Hughes 1984:538). Nevertheless, between 1978 and 1980, about 34% of the population of Pacatuba endured chronic malnutrition, "comparable to [levels] seen in all but the very poorest parts of the developing world" (Leslie and de Souza 1996:285).

Alimentation was not the only scarcity. According to our sample, what is common is a father selling the bicycle he rode to work and a mother auctioning the sewing machine she used to earn a living in order to buy medicines for their sickly children. Considering the arduous tasks overcome in financing hospitalization and then trekking to a distant facility, the simple logistics of interment usually stretched these families too far. Raquel, a mother from Guaiuba, gripes, "So many people have already spent everything just to see if their babies will make it, and then they have to pay more for funerals?"

Children's births and deaths went unregistered, even if born in hospitals. Raquel explains, "You need a birth certificate to receive a death registry, but to pay Cr$8,000.00 (US$40.00) for a birth certificate and then Cr$5,000.00

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(US$25.00) for a death certificate when the baby has just died, my God. . . . That's almost Cr$15,000.00 (US$75.00). No poor father is going to register that death. Only people with *conditions* [to survive the area's grinding poverty] will pay."

Indeed, many mothers report spending so much money on treatment and food that their babies could only be buried in paper caskets. These mothers used anything that might hold a child: shoe boxes, cardboard, and so on. While Scheper-Hughes (1985:312) states, "Household visitors are expected to admire the sweet angel, but not to grieve [at the wake or funeral]," our informants reveal that these paper caskets—seen in figures 2 and 3 above—hold enormous symbolic wealth and attachment. *Dona* Liduina reports having "loaded the *caixinha* with a mountain of rose periwinkles." *Dona* Antônia details the paper box in which she interred her daughter—"white and fitted with bows, flowers, and other embellishments"—in our interview some 2 decades after the funeral. "We couldn't put anything red," she adds. Other mothers placed photographs, pacifiers, pillows, and potpourri to comfort the departed. Though Scheper-Hughes (1985:312) insists that "affection for the *ne-ne* is diffuse and not focused on any particular characteristics of the infant as a little persona," the *caixinha* decorations seem to individualize the child, relating him or her to tangible preferences and lasting memories.

Francisca refers, as does 14% of our interviewed mothers, to another facet of the burial. Because society considers the emotional pain too great for a grieving mother to withstand, the child's *madrinha de vela* (candle godmother), who is not a member of the nuclear family, places a candle in the child's clasped hands to light the way from this life to the next, something the informants call *vela na mão*.

While 29% of the interviewees disclose that they "did not have *conditions*" to provide all they wish they could for their children, this context shows us that mothers refused to believe that they could no longer nurture their children. The rich symbolism of the burial envelops deceased children in emotional riches, forming an indelible image that enables mothers to recall the infant's death and burial in interviews decades later.

At the Crossroads of Life and Death

The symbolism permeating infant postmortem treatment extends to the location of interment. Once again, our informants report how their hands were forced in making decisions regarding the burials. Children lacking birth and death certificates were disallowed burials in common cemeteries.

Almost all who perished before 7 years of age were inhumed at the crossroads of two streets. "If a child died in the 1970s," explains *dona* Vilauba, "the bishop proclaimed that a baptized baby was Mary or Emanuel, and so we would put that baby in a *caixinha*, take it to a crossroads, furrow a grave seven hands deep and bury the child." Children were interred at busy crossroads so that passersby could baptize them along their journeys. *Anjinhos* were also buried in the corral, together with livestock, in ostensible holy soil—Jesus's birthplace. Local dogma affirms that the lost infants weep from their graves 7 days, 7 months, and 7 years after burial. As *dona* Antônia describes, "When the anniversary date comes, October 11, I always reminisce of my daughter. I keep her birth certificate, vaccination registry, hammock, and crocheted hat, and I remember her always." Yet, while even the shape of two crossing roads factors into the significance, newly paved roads attest to the powerlessness of bemoaning mothers who believe cries from the graves became muffled once communities implemented infrastructural improvements without affording mothers an opportunity to voice their concerns.

Conversely, infants not baptized before dying were buried by families behind the cemetery walls, in clandestine plots, or in the corral. Although this may seem to galvanize Scheper-Hughes's assertion that "mothers protect themselves from strong, emotional attachment to their infants through a form of nurturance that is, from the start, somewhat 'impersonal,'" the context of such situations must again be scrutinized delicately (Scheper-Hughes 1985:311). While the hearty significance of baptism as a parental investment is discussed later in this article, the timing of baptisms is the question here. Simply put, death came too quickly for some babies. Just more than 70% of deaths in our sample occurred within the first month after birth; mothers were still recovering from the delivery during the *resguardo* (postpartum period). Families had not yet made arrangements for baptism ceremonies. Nevertheless, our mothers do not devalue their children because of the location of the funeral, claiming to fulfill the same rites, with *caixinhas* and decorations, for their departed unbaptized neonates as they imparted upon baptized infants; only the freedom to choose the milieu is limited. As *dona* Antonia Morena states, "I can bear the wake ceremony because my baby is still in my home, but outside, when he is lowered into the ground and the dirt falls on top of his face, the pain is *medonha* [egregious]."

We point out, as well, that such burials are no longer legal in Brazil and do not often factor into other studies of selective maternal neglect. These rites remain particular to the period of Nations's and Scheper-Hughes's studies. *Dona* Vilauba expounds, "Previously, infants were buried at the crossroads, but then a law was passed, in 1983 I believe, that if a child was buried by the road, the government would come and remove him." While true that macrosystemic constraints create the niche in which local psychocultural traditions form, these traditions do not then reflect a microlevel strategy to favor certain children, as Scheper-Hughes claims (1984:535). The interred are still family members with all affection and remembrance conferred on them, as even Scheper-Hughes (1985:298) asserts: "The nuclear family is counted from above and below—including little dead angels in heaven." The ecological context of burial rites reveals how mothers faced infant death before the 1990s, ritualizing interment norms by vying to save their children via burials in quasi-sacred locations un-

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der the pretense that the dearly departed could be blessed forever.

Orthodoxy of Public Tearlessness

Particular to Northeast Brazil, wails over loss or even complaints about the mundane must remain concealed, and in cumbering their cries, poor mothers carry out their local customs, which embody thought (Nations 2013; Rosaldo 1980). As *dona* Antônia claims, "Crying is good to relieve the pressure, but people have to control themselves." After all, as *dona* Fátima from Guaiuba explains, "We place ourselves in the situation of the person and imagine how she must suffer. The loss of a child could happen to any of us."

As the commonplace division of labor during the time of the interviews held mothers inside the house in the company of no-longer-necessary baby blankets and toys, the interviewees relate how they wept alone. Often with distant expressions and tones, these mothers also describe the burden of separation from healing social atmospheres: "Husbands go to work, pass the day in the pasture, and the wife stays inside bearing the loss of the child," posits *dona* Juracir. Whereas Scheper-Hughes claims, "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," each of our mothers shows grief (Scheper-Hughes 1985:306).

Wanting to lessen the burden our informants faced, their communities mount extraordinary pressure for the mothers to remove reminders of the infant's death. "The doctor even told me to grab all of the baby's blankets and throw them out, burn them. But I didn't have the courage to burn them, so I put them in a little box and I put it out in the yard," remembers *dona* Maria de Fátima. She continues, "Would you believe that every day I went to sniff those blankets and cried?"

Communities likewise strongly discourage mothers from attending the funerals of their lost infants. "They say it isn't good for parents to inter their child. We would remain jarred, you know, burying a son," recalls *dona* Antônia. While these safeguards aim to prevent mothers from perpetuating their grief, mothers like *dona* Maria de Fátima cling to the memory of their deceased babies in discreet moments away from communal processions, even from family members. While all (100%) mothers in our sample admit to sobbing immediately upon receiving notification that their children had died, a truly negligent nonpareil would not have shed a single tear throughout the entire terminal infant experience. Maria de Lúcia says, "Mother Mary, I almost went mad. Even today I cry when I recall that my baby spoke, even in her final hour she spoke!" When queried as to whether mothers should cry aloud, she responds, "There are many who say a mother should not lament the loss of a baby, but a mother never copes. . . . Only God tried to console me after my girl died." Such moments epitomize the maternal grief response that Scheper-Hughes (1985) defies *nordestina* mothers to exhibit—interminable anguish. While this may reflect local cultural differences between Ceará and Pernambuco, more likely it originates within a closed personal space that allows grieving without the risk of pejorative descriptions—such as "insane," "broken," "damaged," and so on—branding these mothers.

Local belief trusts that women are spared suffering as long as they do not display symbols of their loss. Scheper-Hughes (1985:313) recounts how, during interviews, her native assistant "would scold the grieving [women]," reinforcing the cultural pressure to suppress grief. More likely, communities spare themselves from braving the depressing battle these mothers withstand daily.

Many informants report gradually acquiescing to the custom of crying inside, meaning, as *dona* Liduina explains, "I want to weep but the tears fall internally. Here with you [in the interview], I have wanted to cry twice already, but I hold back the tears." This form of crying aligns closely with the awe conferred upon the archetypal Our Lady of Sorrows, whose heart is depicted as having endured seven daggers—symbols of religious tragedies—yet only a single tear trickles down her cheek. Mayblin (2012:243) reminds that "the virtue of the good mother is closely analogous to the virtue of the *Santa Maria Mãe de Deus* (Holy Mary, Mother of God), who is worshipped daily through rosary recital and with special intensity throughout the month of May."

Nevertheless, Scheper-Hughes makes clear the inference, not that women are hiding emotions, but that women typically remain undisturbed by their losses by elaborating:

> 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. . . . There would be memories of *particular* babies . . . and she would weep in telling of *that* death of all the deaths and losses she had endured. (Scheper-Hughes 1985:313)

Still, according to Pipiu, these women no longer venture outside of their homes: "The joy of life vanishes, lost with the passing of a child. Someone who used to be social one day now locks herself away from the world." "They say we should have another baby to become happy again for happiness is being a mother," explains *dona* Mercedes from São João. This, no doubt, ties into the system of informal adoption detailed above.

The adages *dona* Mercedes heard are similar to advice many other mothers report. In fact, 57% of the informants report having heard that "people say a mother attending her child's funeral is inappropriate." *Dona* Liduina illustrates how even symbols of mourning were spurned: "I used to light a candle in my house for my daughter, but 'they' say that it does harm to her for me to light a candle in the home." A ubiquitous "they" relegate openly grieving mothers to a realm outside the accepted norm. Our mothers conceal their sor-

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row rather than face ostracism in order not to splinter other relationships.

"Angels with Wet Wings"

Maria de Fátima elucidates another reason why mothers withhold tears in grief: "They say that it does the baby harm to cry because the tears saturate the wings of the baby-angel and the little creature cannot save itself." To each mother in our sample, the spiritual health of a child is integral to its survival, not only in this life but throughout all eternity. Says *dona* Cleidir, "I saw it written that a mother cried and cried, and her child encountered Our Lord Jesus and Our Lady Mary very late because the mother's tears dampened the child's wings, and he could not ascend to heaven on time." According to our informants, sobbing endangers the well-being of the lost child after death; nonetheless, many remain unable to constrain their cries, as the case of *dona* Socorro exemplifies.

> *Dona* Socorro recalls her first child, a daughter, born after a full-term pregnancy delivered with a doctor's help. She had dreamt of this daughter for months: "I dreamed I had a little girl, almost like a preview; she would be born healthy, big, blonde." Tragically, *dona* Socorro "passed 9 months hoping and waiting only to have the euphoria obliterated." Her daughter died so suddenly that even the doctor was "unprepared to say anything, only blurting, just like this, 'She died.'" The child perished unbaptized. *Dona* Socorro did not even hold her newborn. Still in her *resguardo* period, *dona* Socorro stayed at home and wept. The sound of babies crying became her trigger. "I grew nervous that I might hear a baby wail. My neighbor Jane had a newborn at that time as well, and she would allow the boy to cry. I don't know why. I would pine, 'Why did God snatch my daughter, who was my firstborn?' I would never have left her to cry alone so." Her feelings of being bilked did not dissipate. Around this time *dona* Socorro began having different dreams. "I dreamt that I was going to a funeral procession, which I hadn't done with my girl, you know? I'm always so afraid of the open eyes of the child." She continues, "In my dream I went to the funeral for a child, and two angels appeared, like those in the Catholic churches with the little vests. I halted in front of them instead of going along with the procession. Then the angels extinguished the child's *vela na mão*, and the baby disappeared." She had this dream sporadically, but it always unfolded in the same fashion. She says that she has yet to understand her procession dream or to discern the spiritual fate of her unbaptized firstborn.

For these mothers, the spiritual well-being of the children remains the only part of the deceased children's health they can continue to nurture. Mothers rush frantically to baptize their offspring in hopes of nourishing the infant spiritually as well as physically, preventing any "medical crisis" (Scheper-Hughes 1985:311). Antônia Vieira recalls, "My daughter grew ill on a Sunday, and my mother said, 'Honey, this baby will not grow old. Why don't you go baptize her right away?'" According to Maria Nazaré, "A baptism can stop diseases," but should an infant die without a Catholic baptism, the spiritual world may remain forever elusive, for as *dona* Cleidir posits, "It's a terrible sin, for the mother and the baby, when a child dies unbaptized!" Viewpoints regarding baptism and tears directly affect how some mothers grieve for their deceased infants—in hopes that the dead rest in a better place or, conversely, in woe that the dead are destined to remain outcasts from heaven forever.

The significance of spirituality in the understanding of infant mortality in Northeast Brazil also extends into surviving mothers' dreams, as *dona* Socorro's case above illustrates. Many parents report gaining closure from their dreams. Maria de Lourdes remembers, "It was 5 months after my son died that I dreamt of him. . . . He told me not to cry anymore." She retells that she only dreamt of her departed son once, but "seeing him helped so much in withstanding the loss." Still, some mothers are guarded against such dreams. Maria Jandira from Conjunto Palmeiras expounds, "It is terrible for us to remember our children in dreams. There we stay, traumatized again by our *saudade* [yearning]." Such mothers claim to linger in a depressed state after waking, feeling robbed once more of their children. To legitimize the unquenchable longing, *dona* Maria de Fátima reminds us, "There are ex-husbands, ex-in-laws, ex-everybody, except ex-children. Those don't exist."

Nevertheless, most of our interviewees—similar to those in Scheper-Hughes's study—declare that the knowledge their children are in heaven helps the mothers bear the burden of their loss (Scheper-Hughes 1984:543). Maria Jandira explains, "According to all that our church teaches in the books that we read—the entire Catechism—everything indicates that the babies go to heaven." In contrast, Scheper-Hughes (1984:539) cites that "some of the women were quite explicit that their last born children had been a particular burden to them and that it was a 'blessing' that God decided to take them in their infancy." Clearly, to Scheper-Hughes, such views indicated strong maternal undervaluing of children, even referring to them as burdens. To us, however, the possibility that a child may now be in heaven seems to reinforce the socioreligious beliefs of our sample: paradise proves an idyllic alternative to poor Brazilian life. Thus, we cannot confound the mothers' relief that a child may be in heaven with any withdrawal from the child's physical existence. Seeking reassurance that God's will transcends infant loss and bestows triumphant infant redemption represents one of the enduring mechanisms mothers possess, even if the solace comes from community beliefs and one-on-one dream sequences (Nations 2013).

Heartbreak Brings Breakdowns

While having and raising children stress all parents to some extent, bereavement can break a mother, according to our sample. During the initial 30–40 days immediately follow-

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ing labor, new *nordestina* mothers are greatly limited in their undertakings. "A mother's sole obligation in this delicate time is to breastfeed her baby and rest," clarifies Maria de Lúcia. The tranquility aims to distance the mother, exhausted from performing labor, from disruptions in her recuperation. Our informants collectively refer to this time period after delivery as *resguardo*, the postpartum period, and Maria das Mercedes explains that it can "restart if anything goes awry during those 30–40 days, such as accidentally taking a cold shower." Indeed, during *resguardo*, mothers seem to possess the very characteristics (e.g., "quiet, docile, passive, inactive, or slow") that Scheper-Hughes (1984:539) claims children who are unfit for survival evidence.

The consequences of "breaking *resguardo*" are many. Maria de Mercedes from São Bento explains, "I couldn't turn my head . . . a darkness clouded my view, and I went blind for a while." She continues, "I couldn't eat. I couldn't drink . . . I almost buried myself." Still, these symptoms are regarded as exceptionally negative manifestations that afflict mothers not properly rested during the month-long period. Many times our mothers did not enjoy the entire 30–40 days since their children required care during *resguardo*.

As Scheper-Hughes (1985) notes, *nordestina* mothers consider *resguardo* a possible cause of infant death. In our study, *dona* Fiinha opines that when her efforts to save her child during *resguardo* were unsuccessful, "the disbelief and despair welled up so much that I wanted to fight God." Yet, even as their babies perished, the mothers report clinging to their caregiving responsibilities, refusing to believe they could no longer serve their children. "Even though I was in my *resguardo* period, we decided not to call anyone because the people who prepare the room for the dead simply create commotion, and I didn't want that in my house. Instead, we got the papers to make a *caixinha* ourselves, and we buried our child," recounts *dona* Binha. Francisca Tânia articulates:

> I became so completely insane that I began having migraines because the loss was overwhelming. I couldn't stay at home. I couldn't carry on a conversation anymore. I wasn't a normal person anymore. They had to take *me* to the hospital. My husband told the doctor I was "uncontrollable."

Thus, instead of waiting for the *resguardo* period to elapse in order to focus on their own health, these mothers experienced painful postpartum dealings that included rage, loss of memory, seclusion from loved ones, wandering aimlessly in the streets, and feeling detached from their own bodies.

Resguardo, however, is not the only biological consideration for these mothers. Although daily life essentially returns to normal after safe completion of the *resguardo* period, mothers from our study found themselves uniquely burdened by an infant's illness, almost always serving as lone caretakers for their children while their spouses or boyfriends found money to support the family, sometimes by going 2 hours away to Fortaleza for work. For this reason, mothers typically cared for ill children until the very moment before the disease claimed the child's life. In that last moment, a family member, *rezadeira*, or close friend interceded to remove the dying child from the mother's care because, as *dona* Juracir enlightens, "The pain of having your own baby die in your arms is too much." Scheper-Hughes's theory claims that mothers, in an effort to ensure their own survival, may even leave their babies to perish unattended. Our study examines the other side of the coin. No *nordestina* mother believes she can mentally withstand the shock of holding her child as it breathes its last breath. Raquel recalls a remarkable moment:

> A baby girl lay dying in her mother's arms when the biological father with his new wife stopped by. Upon seeing the state of the child, the father said, "Hurry! Give her to me," and he handed the dying infant to his new wife, who was of no relation to the child. It was the new wife who put the *vela na mão*.

This, according to the mother, was a kind gesture that spared her the torment of her child dying in her arms as she rocked in her chair.

"Morrer no Meu Poder"

While each of the contexts molds the maternal grief response of our informants, the summation of the contexts leads these mothers to carry a specific idea of how people should live and die. Mothers, such as Fatima, refer to this notion as *morrer no meu poder*, to die under my own power, which is to say that the mothers have created a context in which they believe they have control over end-of-life situations. Seventeen of our mothers (33%) mention this paradigm that serves as the litmus test by which the community views the loss of life as either a good death or a death by suffering. Among other things, this perception shapes the manner in which survivors grieve.

Because of a lack of autonomy in their lives, the mothers explain that *morrer no meu poder* is their measure of control. To die a *boa morte*, a good death, entails dying in a way that reflects the comforts, affection, and respect due during life. *Morte sofrida*, or death by suffering, is a death that lacks one or more of these qualities. The mothers explicate that this difference affects not only their children but also their own coping after the children's deaths as well. The existence of such a concept is not a facet of Scheper-Hughes's (1985:295) conclusion that "part of learning how to mother . . . includes learning when to 'let go.'" Instead, *morrer no meu poder* serves as the capital example of the high-stakes *luta* (fight) in which these mothers battle for their children's survival.

Because good deaths comprise aspects of desired outcomes for children in life, they provide fewer elements of the infant death episode that the mothers might deny or revolt against. Baptism, for example, is a fixture. "I don't like any child of mine to live unbaptized," pronounces *dona* Binha. "All of my children are baptized. I even had a daughter who died baptized while I was still in *resguardo*," she continues.

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Baptism is one of the aspects that infants require, whether ill or well, for a good life; so, too, it is in death. Similarly, the necessity of contact between mother and child does not wane in times of sickness. Maria de Fatima voices the sentiment that "I needed to be allowed to stay with my daughter. I interned her in the hospital, but I wouldn't leave her alone. The social worker there said that if I took her back home, she would die for sure. I told her, 'No, my daughter stays with me.'" The mothers had heard stories of terrible treatment for isolated infants—like *dona* Izabel's case: "When my boy died, the hospital wouldn't let me take him home to bury. They wouldn't give me back my son!"

Furthermore, mothers look poorly upon crying during or following the death episode, even though that requires them to subdue their own emotions. "What happens when a mother cries is she puts all of her pain outside for everyone to see," explains Fátima Maria. But this *boa morte* standard substantiates the mothers' desire to invest in their children. The case of *dona* Elenice distinguishes what it means to have a *boa morte*.

> *Dona* Elenice, a devout woman, has faith that baptisms protect believers from sickness. In total, she has given birth to 13 children, including a set of twins who both died when they were 2 months old. *Dona* Elenice remembers the twins' deaths as excruciating to bear. She explains that they both fell ill at the same time, and so she took them, by herself, to the nearest hospital. During treatment, her first daughter, Roseane, died. In light of the loss, the conditions of Roseane's death, and the grim prognosis for the second twin, *dona* Elenice withdrew the living twin, Rosilene, from the hospital. *Dona* Elenice knew that she was not better equipped than doctors to save her daughter, but she also knew that Roseane passed away in a place of tears, suffering, fear, discomfort, and "chaos." *Dona* Elenice took Rosilene home where she delivered the remedies she could, cradling the child in all the comfort she could summon. *Dona* Elenice believes she gave Rosilene a good death, even though she admits to sobbing over the losses equally.

Viewing health as more than simply the absence of sickness, our informants focused on providing positive lives and, for lack of a better term, good deaths for their children.

On the other hand, according to our interviewees, a bad death for an infant is any death that seems deficient of the care or sensitivity in which the mothers report trying to shroud their children. To cry at a child's funeral is to bring a bad death upon the child "because the child cannot save his soul," says Fátima Maria. To die in a hospital bed away from home is a wretched way to pass into eternity because "hospital staff *judiam as crianças* [torture our children as if the babies were Jews of the Bible]," according to Francisca Tânia. To die unbaptized is a *morte sofrida* because of the belief that "an unbaptized child may be condemned to wander outside of heaven," as *dona* Liduina explains. We consider the case of Maria de Lurdes:

> Maria de Lurdes never hesitated to take her children to the rehydration center near her home. She and her husband frequently fought about that. They fought about everything, in fact. Maria says the couple separated because of the children. When she was pregnant with her last child, her *sábio* [wise before his age] son became gravely ill. Maria resolved to take him to the hospital, which required her husband's help, and together they set out to catch the two connecting buses to go to the nearest hospital. Upon entering bus turnstiles, Maria's son began convulsing, having a seizure in her arms. Maria remembers a whirlwind of commotion and then the silent sense her son was dead. She requested the bus driver let her off so that she could make her way home, but he refused. He drove the bus straight to the hospital without stopping for other passengers to board, and when Maria and her husband arrived with their son, the attending nurse reassured them that the boy was still alive. Quickly the hospital staff snatched the child from the couple and whisked him into a partitioned room. Shortly thereafter, a doctor returned to explain that the child had indeed died. When asked if she wanted to see her son, Maria responded no, but clarified that she wished to take him home to be buried. The doctor then pronounced that the hospital ordered an autopsy to ascertain the cause of death and Maria's husband would need to return to the hospital days later to secure the child's remains. Twelve days after her son's death, Maria gave birth to a baby girl prematurely.

This *morte sofrida* that Maria de Lurdes recalls is hardly indicative of any selective maternal neglect. But *dona* Santina explains, "The mother fixates. She relives the most traumatic pieces again and again." Often, the interviews with these mothers correlate a *morte sofrida* experience with a more prolonged sense of blame, anger, mistrust, or loneliness. Francisca Tânia states, "When a child dies, it's as if the whole world dies."

Mothers in a Vacuum

As Robbins (2013:450) explains, "Over the last twenty years or so . . . it has often been the suffering subject who has replaced the savage one as a privileged object of our [anthropological] attention." It is no secret that the women of Brazil's *Nordeste* have and continue to suffer, but they are not alone. This study has focused on women and maternal neglect simply to refute more clearly the theory Scheper-Hughes postulates; however, it behooves us to feature the numerous roles that fathers, grandparents, boyfriends, neighbors, adoptive parents, fictive kin, and even random fellow Brazilians play in child welfare. Fatima recalls that it was her husband at the hospital with the child because the doctor prohibited her to enter. Juracir says, "The baby's grandfather took her to the city. The child had diarrhea and fever, vomit too. We went to the doctor, the baby's grandpa, the father

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and I. The grandfather was still praying, and then we went to pray more with the *rezadeira*, *dona* Anesia." Maria de Lurdes relates:

> The boy got home from the doctor's and died. His father, Chico, drank so much—so much—and cried because his boy died. Chico lived going to the bodega. Then he dreamed of his son 3 days in a row—the boy begging his father to stop crying so that he could go to heaven. So the father said, "Look, I dreamt of my son, and he will get what he asked for. If he had to lose himself or lose something good because of me, now he's going to receive it. He won't lose another thing because of me." And just like that, the man quit drinking, quit crying. Everyone agreed it was a good thing.

Our informants have countless other examples, but without considering men, the notion of selective maternal neglect inherently denies half of society of its impact as active participants in infant life. To say that "poor women . . . must make choices and decisions that no woman should have to make" at once implies that women alone create the cultural norms surrounding infant life as well as refuses men a voice in the debate on what causes infant death (Scheper-Hughes 1985:314). Finerman explains how "depictions of parents as either incompetent or negligent slaves to a 'culture of poverty,' or to other cultural norms and values encourage a view of parents as obstacles (rather than keys) to program success" (1995:7). She adds that "such inflammatory phrasing stereotypes parenting and shapes perceptions of liability and control," especially among researchers and health policy makers (Finerman 1995:7).

In this debate about culture-wide infant health practices, we welcome further interpretations but, like Kleinman, "wish a return of human dignity to these mothers who are burdened by the imposition of a heavy and unjust, yet sadly comfortable—at least to the world's elite—stereotype" (Nations 2009:19).

Further Reflections

Our paper illustrates how mothers in Northeast Brazil react to infant death within their local moral world. We refute any and all categorical suggestions that the women of Northeast Brazil may be complicit in newborn deaths. We focused on grief responses to explore just how *nordestina* mothers reconcile their loss(es) within the spheres of influence that guide their lives.

The term "local moral world," however, can prove complex. As Kleinman writes,

> In its broader meaning, the word *moral* refers to values. Life, in this sense, is inevitably moral, because for each and every one of us, life is about the things that matter most to us. . . . In its more focused meaning, *moral* refers to our sense of right and wrong. . . . We expect that other people in very different locales would agree that [our] acts are moral in this second sense. (Kleinman 2006:2–3)

A local moral world, therefore, is the reinforcement of values and ethics by a society that holds geographic as well as sociocultural proximity. The extent to which people from varied locales agree that any given activity is moral correlates directly to the closeness of situations, values, and senses of right and wrong the differing locales share. For ethnographers, "the objective is to describe lives and meanings in the manner that they are experienced," says Kleinman in the preface of Nations's book (Nations 2009:9). At the core of our research lies the realization that any significance of the information these *nordestina* mothers confer depends largely on moral contexts, which are bound by time, environment, attitude, and religion. In fact, the local moral world of our sample most resembles that of the mothers in Scheper-Hughes's study (Scheper-Hughes 1984, 1985). While the debate over selective maternal neglect in Brazil continues, our question is whether such neglect ever existed in the first place; was it simply misconstrued? We can never know for sure, but in this article, we have taken Kleinman's words to heart: "context, context, context" (Nations 2009:9).

As we learn from Obeyesekere (1990), culture exists in response to situations, a natural process wholly focused on confronting reality. And culture shapes the many possible expressions of grief (Nordanger 2007). No doubt the *nordestina* mothers braved a bitter reality in the 1980s, yet we find that a selective maternal neglect theory fails to encompass all of the maternal responses to infant sickness and loss. We infer that, for our informants, child death constitutes lived experiences that have led to "social suffering," drawing from and spilling into each of the contexts discussed above (Kleinman, Das, and Lock 1997:315). The image of the *anjinho*, for example, situates grief in the moral-religious locus encompassed by the ultimate and intermediate tiers of the causes of infant mortality. A religious symbol to control symbolically what cannot be controlled physically emerged from the classic reasons for theodicy: "loss, suffering, and threat" (Kleinman et al. 2011:273; Malinowski 2002 [1944]). The existence of this theodicy alone could imply that these mothers are no more neglectful of their young than any other community.

One possible reason that Scheper-Hughes may have attributed infant death to local maternal attitudes could arise from the notion that "because of the universal qualities of trauma, we as observers and witnesses are secure in our abilities to know it when we see it and to feel empathy with those who suffer it in 'a sort of communion in trauma'" (Robbins 2013:453; quoted in Fassin and Rechtman 2009:18). The maternal attitudes Scheper-Hughes blames, however, are not the universal "communion." Maternal activities, beliefs, and feelings are predicated upon local experiences of trauma—which includes poverty, marginalization, thirst, and so on—and we contend that maternal rationalities did and

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do necessitate contexts in order to be identified and understood.

We find that the divided self approach conveys a great deal regarding local moral worlds (Kleinman et al. 2011). In the mid to late twentieth century, Brazil itself fragmented in sometimes contradictory ways (Ponte and Nascimento 2010). Likewise, the ways in which our informants reconcile their divergent moral obligations reflect a deeply divided self. On the basis of our study, maternal grief responses may be internal and/or external, hidden and/or exposed, and at times seem to conflict. Our mothers reported crying inside but refused to attend funerals, yet all the while "infant death is part of a basic topography" on nearly every street corner (Pinto 2008:193).

Grief can also persist for different amounts of time, swelling or remitting at different moments. In fact, we find quite incredible the Western biomedical notion that any bereavement lasting longer than 6 months may constitute prolonged grief disorder, even though our mothers believe that any grief for less than 7 years shows a lack of investment (Pringerson et al. 2009). For Robbins (2013:452), research among devoutly Christian groups outside of Brazil has shown "the feeling that one is a moral failure destined never to see heaven can even become something verging on a permanent condition." Indeed, the temporal context of investment and grief seems a noteworthy aspect for future study in this debate. Obeyesekere (1981:10) notes, "There is no terminal point to my interviews, since the lives of my informants haven't ended."

Because our informants live whole experiences, we must juxtapose any divided selves with the notion of *morrer no meu poder* to arrive at an understanding of maternal grief responses in order to comprehend whether these mothers neglect any children. As Levinas writes,

> The language through which meaning is produced in being is a language spoken by incarnate minds. The incarnation of thought is not an accident. . . . The body is the fact that thought is immersed in the world that it thinks about and, consequently, expresses this world while it thinks it (Peperzak, Critchley, and Bernasconi 1996:40).

That is, according to the explanations given by our sample about their lived experiences—their thoughts, actions, and expressions of those thoughts and actions—selective maternal neglect is not the cause of infant death.

Nevertheless, Geertz (1973) famously admits that anthropology strings together theories and debates predicated upon arrays of interpretations. Adds Kleinman in his preface to Nations (2009:19), "The engagement of Brazilian academics in this debate through publications in Portuguese could result in even further cultural interpretations which clarify our understanding of the motives, emotions, and reactions that mothers have in the face of a child's death." We concur.

We have attempted here to highlight the importance of contextualization in the loss of infant life. Such contextualization could exculpate communities where selective maternal neglect conjecture tempts theorists.

Conclusions

To be clear, death always portends moral interpretation. In several poor communities in Northeast Brazil, a region where Scheper-Hughes sought to substantiate a selective maternal neglect theory, we found an elaborate local moral world that sculpts the maternal responses to child illness and death. And according to one of our interviewees, Pipiu, "The scar of an infant death remains etched into the face of each grieving mother."

Acknowledgments

M. Nations thanks the Brazilian National Council of Scientific Development and Technology (CNPq) for its support through Scientific Productivity in Research Awards (from 2009–2012 and 2012–2015). J. Corlis and J. I. D. Feitosa would like to thank the Brazilian Coordination for the Enhancement of Higher Education Personnel (CAPES) and CNPq, respectively, for their fellowships that have enabled their research. Additionally, we thank Kenneth Martin for his contributions to the proofreading process.

Comments

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Beyond Neglect

The article by Marilyn Nations, Joseph Corlis, and Jéssica I. D. Feitosa once again takes up a debate that had developed in the 1980s around maternal influence on infant mortality in Northeast Brazil. In particular, it has once more presented the vast ethnographic materials collected by American anthropologists Nancy Scheper-Hughes and Marilyn Nations in connection with a similar research subject: infant mortality in Northeast Brazil. The first study was carried out by Nancy Scheper-Hughes in four fieldwork sessions (1963, 1984, 1985, 1992) in the towns of Alto do Cruzeiro and Timbaúba in the Pernambuco State. The second study was carried out by Marilyn Nations at different times between 1979 and 1989 in six different localities in the State of Ceará. As the authors themselves have indicated, the article aims at refocusing the debate on the notion of "maternal neglect," asking "whether maternal neglect has ever occurred in Northeast Brazil."

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It is to be expected that the ethnographic research will provide not only a vast corpus of materials that attempt to describe and understand the implications and experiences of the groups studied but also, as far as possible, the development of technical knowledge made up not only of thoughts and ideas but also of feelings and emotions. In it, the symbolic component can be perceived in the dimension of meaning (Bibeau 1992).

In the 1960s, when Nancy Scheper-Hughes was working as a volunteer, she used to visit households to check on the health of small children and newborn babies. She realized that children at risk of dying due to diarrhea could be saved using rehydration solutions. At times, however, it was difficult to save children when their mothers considered them ill-fated (Scheper-Hughes 1992). She herself later described this "ethnoeugenic" model as selective neglect "childrearing strategies" (Scheper-Hughes 1984). These unfortunate and shocking words caused offense, like an attack on cultural relativism or failure on the part of these mothers to bond with their children.

Nancy Scheper-Hughes's rich, well-documented, and well-presented research material contrasts with the unfortunate theoretical considerations on selective eugenic theory, on the negligence theory, that over time had generated reactions of bewilderment and discord in Brazil and elsewhere.

I wonder whether a more careful reading of Bowlby's theories might not have helped understand better the different forms of loss and bonding in an environment so deeply characterized by structural violence and by the deep inequalities caused by poverty and social exclusion.

A second consideration refers to the two areas that, though similar, also present significant historic and cultural differences. An important role in the history of Pernambuco, admirably described by Gilberto Freire, was played by sugar plantations where slave labour was very widely used (Freire 1992). The Afro-Brazilian population still has a strong influence on the State's social and economic composition. Ceará, instead, was colonized through an expansion of agricultural activities and livestock breeding on the part of populations of European origin that involved enslavement and extermination of the indigenous populations (Garcia Filho and Sampaio 2014). The extent to which these historical-cultural differences may cause mothers to give different interpretations to infant mortality in the two different contexts is today hard to establish.

A third point worth considering and inspired by the article is the fact that there has been a significant drop in the infant mortality rate throughout Northeast Brazil over the past 30 years. This has been brought about both by improvements in primary care (Aquino 2009) and the recent establishment of a neonatal intensive care network (Silva et al. 2014) and by a reduction in inequalities and an improvement in living conditions among the poorest populations (Rasella et al. 2013). The Brazilian cash transfer program has substantially improved the lives of many poor families in the Northeast, and they nowadays can send their children to school and enjoy greater dignity in their lives (Rego and Pinzani 2013). However, this has not been accompanied by a substantial improvement in the humanization of hospital care: over the years, the harsh treatment experienced in hospital by the population, well documented in the article, has been denounced by a number of authors who have highlighted institutional violence against patients under hospital care (Deslandes 2004; Gomes et al. 2008). Sadly, medical science is still today unprepared to address many of the cases described in this work humanely and with dignity.

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Among the definitions with implicit ethnocentric assumptions universally applied by Western feminists and social scientists are those of motherhood, marriage, and the family (Amadiume 1987:6), often at the expense of the multiple voices and social roles of women of color. In the late twentieth century, Western feminist writing about Third World women produced these women as a single category defined by their victim status and subjugation to their patriarchal cultures (Weedon 1997:179). Because the Third World woman was produced as a subject of history, differences among these women—along with acts of resistance, conflict, and change, that is, their agency—were ignored (Mohanty 1997:179; Oyewùmí 1997). Similarly, Nations, Corlis, and Feitosa point to a growing number of studies that allege that many societies, especially poor communities in the developing world, "tolerate and conceivably generate parental tendencies to disassociate mothers from offspring, ultimately contributing to children's deaths." While their article is largely a plea for alternate interpretations of maternal roles in child death, it is more importantly a note of caution on how easily scholarship on the maternal failures of poor women of color is spread and reproduced as absolute truth.

In their article, Nations, Corlis, and Feitosa revisit some of the most important and controversial conclusions of *Death without Weeping*, rechallenging through retrospective contextualization 30 years of debate over maternal influence on infant death in Northeast Brazil. Using a sample of 58 death narratives from grieving mothers, similar to those studied by Scheper-Hughes, the authors turn their focus from maternal neglect—a form of disinvestment, emotional and material, in the survival of a child that was not expected to live—to one of maternal investment. Here the authors argue that in fact there are several cultural contexts that shape how women grieve: historical, political, economic, ecological, biological,

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and spiritual. Moreover, these cultural contexts also shape and determine the social expectations for investing emotional and material resources, even if limited, toward dying and deceased children.

Nancy Scheper-Hughes provides one of the best-known anthropological studies of how socioeconomic condition shapes maternal sentiment. She largely depends on a political and economic model for interpreting the emotions of mothers, concluding that "overwhelming economic and cultural constraints" as well as high expectancy of child death produce patterns of nurturing called "maternal indifference and mortal neglect." On the other hand, Nations, Corlis, and Feitosa, finding the same socioeconomic and political structural constraints, found that in fact mothers and other family members—including fathers, grandparents, and extended family—demonstrated a great deal of grief and suffering when children died. Although the grief manifested itself in different ways, from mothers sinking back in a somber silence at the unexpected news of her child's death, to uncontrollable tears, and even "crying from within," there seemed to be a consensus that the grief, or emotional investment, was social and communal; everyone in a community felt and mourned the death of a child. In my own research in rural, black, quilombola communities in Bahia, spaces that share some of the same socioeconomic and structural development constraints of the urban favelas, I have also found that in discussing the social roles of women in these communities, it is most appropriate to consider their relationships in terms of the community or group—communities in which men and women combine domestic and extradomestic responsibilities in order to maintain the household (Sudarkasa 1996:166).

Scheper-Hughes depicts desperately poor, urban women as trapped by their situation—a representation that borders on structural determinism, or what Finerman (1995:7) calls "a depiction of parents as . . . slaves to a 'culture of poverty,'" a representation that all too often gets attributed to poor women of color in Brazil and abroad. Here Nations, Corlis, and Feitosa highlight an understanding of not only how "culture shapes the many possible expressions of grief" but also the ways in which Western dominant forms of knowledge production have denied agency and, most importantly, multiplicity and complexity to the voices and lives of poor women of color, historically constructed as powerless and subjugated.

As a scholar and Chicana born in a working class, Mexican family that has struggled within the segregated, xenophobic, and racist social and cultural structures of the United States, I appreciate the painstakingly detailed attention that Nations, Corlis, and Feitosa have given to the grief narratives, both spoken and silent, of *nordestina* women. It is worth creating a more inclusive image of the Northeast—to move beyond the violent labels of maternal indifference and mortal neglect—in order to attempt to uncover the embodied narratives of pain, grief, and silent survival that these women experience.

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First of all, I would like to start by highlighting the concept that "a local moral world, therefore, is the reinforcement of values and ethics by a society that holds geographic as well as sociocultural proximity. . . . Any significance of the information these *nordestina* mothers confer depends largely on moral contexts, which are bound by time, environment, attitude, and religion." In addition, Rebhun and Nations (1988) contend that "maternal grief reactions can be understood only if situated within the realm of folk-Catholicism and that structural violence impedes poor Brazilians from accessing needed medical attention." In doing so, Nations, Corlis, and Feitosa propose seven contexts that it influenced on maternal mother behaviors: historical, political, economic, biologic, social, and spiritual. These facets define the rural Cearense mother's niche in 1980 as her local moral world.

However, I want to focus in my comment on two important points that helped change the whole scenario in Brazil. First, Nations, Corlis, and Feitosa explain about the political context in Northeast Brazil and other poor areas in Brazil that have the same problem, that is, the *clientelismo*, or as Nations states, "a favor for a favor." Unfortunately, this means people trading their vote for things. Of course, it is a crime, and in the last election, some politicians were sued and some mayors lost their posts. My grandmother once told me an old Brazilian story about a politician who used to give one foot of a boot pair before the elections and the other after his election. The poor communities without political and economic power are more susceptible to such behavior, and it is understandable.

In fact, the political context influences and keeps the economic context and vice versa. In light of this, the 2010 Census highlights that 37.3% of women are heads of households (Instituto Brasileiro de Geografia e Estatística 2012), and these women are young, separate, black, poor, and with low schooling, and they are in the informal market and on poor working conditions and wages (Mendes 2002). Brazil occupies the seventy-fourth position in the gender gap index of the World Economic Forum in a ranking of 128 countries (Madalozzo 2008). The worst poverty situation can be observed in many households headed by women who live without economic and political power.

In spite of these women's situation, the infant mortality rate has plummeted not only in Northeast Brazil but also in the entire country. The postneonatal mortality infant rate was responsible for this important decline, which is related to changes that have occurred in environmental causes (Ferrari 2012). Nations, Corlis, and Feitosa put a good argument as to what was said by Scheper-Hughes, "If the twin factors of maternal underinvestment and indifference toward sick and

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dying babies were relevant to Brazil's high infant death rates, as Scheper-Hughes (1984, 1985) avers, the drastic decline in death rates would likely depend as much on lessening numbers of neglectful mothers as on increased economic empowerment." In the face of this, it is necessary to understand what has happened in Brazil in this past 30 years. Brazil changed its Constitution in 1988, which brought democratic elections and put down the cold years of military government. After that, in 1992 a Unified Health System (Sistema Único de Saúde) was created, which has reorganized the public health net and developed programs focused on preventing diseases. Brazil also created a social assistance system, and as in some other countries, it has launched a conditional cash transfer (CCT) program as a strategy to reduce poverty and inequality of millions of miserable families.

Therefore, Rasella (2013) studied the CCT program created in Brazil, named Bolsa Família Program, which happened at the same period of the Family Health Program by the Health Ministry. The study by Rasella (2013:9) observed "an increase in the health service utilization and a general positive impact on final health outcomes, as child undernutrition, health, and survival, even if in some cases the effects are mixed. These results provide evidence that a multisectorial approach, that combines a solid cash transfer program with an effective primary care, can significantly reduce child mortality, especially for poverty-related causes, in a country with large inequalities such as Brazil." An Institute of Economic Research and Strategy of Ceará study shows without a doubt that the Family Health Program (Programa Saúde da Família) has been key to reducing child mortality in the state (Diário do Nordeste 2010).

In summary, I strongly believe—as do Nations, Corlis, and Feitosa—that maternal selective neglect has never been an issue in Brazil but just an extreme poverty situation. The improvement in economic conditions along with the assurance of access to health care and social assistance resulted in mortality infant rate plummet in Brazil. This fight is not over because there is still poverty in Brazil, but it is a very good start.

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26 V 15

Toward an Anthropology of Grief and Bereavement

In this article, Nations, Corlis, and Feitosa make an important contribution to the anthropology of grief and bereavement and also correct a misrepresentation of these practices as they occur in Northeastern Brazil. The authors argue against the view that mothers in Brazil are numb and do not feel grief—even neglect certain children in an allocation of resources. The authors detail how jumping to such an assumption is a kind of interpretive violence (see also Nations 2008), an error of decontextualization (Hinton and Good 2015): considering the absence of crying as indicating a numbing and a sort of lack of maternal concern when, in fact, the display of that affect results from a complex local ethnopsychology and ethnospirituality—and a very different semiotized affect lies just below.

Nations, Corlis, and Feitosa have written an important article that accomplishes multiple types of contextualization of the local grieving practices for small children in Northeastern Brazil: historical, political, economic, ecological, biological, social, and spiritual. The authors also highlight the local work of culture, the local therapeutics that help those aggrieved to overcome distress. In this sense, their article is also a study of the local work of culture and of local therapeutic process (Hinton and Kirmayer 2013).

Various cultural ideas shape the display of grieving in Northeastern Brazil. Outward grieving is not condoned, and tears are said to make wet the wings of the newly deceased child and prevent the angel from reaching heaven. Enduring suffering with minimal outward display is said to do as Virgin Mary upon her loss—she is represented in a famous image as having a heart pierced with seven blades and allowing herself but one tear.

As Nations outlines with her coauthors here, and as she does in other publications (Nations 2013), grieving mothers in Northeastern Brazil transfigure their children's corpses, imbuing them with symbolism that transmutes feelings of helplessness, hopelessness, definitive loss, and personal guilt to a sense of active participation in the positive transformation of the deceased. This is accomplished through multiple local practices. The child becomes an angel, an event often celebrated in a photograph of the dead child kept in the home—an image of the child garbed as if an angel surrounded by the bounty of heaven.

The article also suggests future avenues of research, other perspectives to study grief and bereavement in Northeastern Brazil, and more generally. For one, what are local ideas about the spiritual status of the deceased child within the broader set of practices regarding the dead—the local ideas about the cult of the dead and encounters with the dead, the nature of the family shrine and associated practices? Where in this pantheon are the dead who have become angels, and what of those who died at a later age? How do other local religious traditions, like candomblé, figure in the grieving process and ideas of transformation? Second, it would also be intriguing to examine more broadly and in more detail how the dead are experienced: in sleep paralysis, in hypnagogic or hypnopompic states, in dream. The authors suggest

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that dreams in which the deceased are seen as angels are a key part of grief recovery. Finally, it would be of interest to determine the frequency of disordered prolonged pathological bereavement in this population and compare with other cultural contexts.

To give another cultural example, Cambodian refugees often have dreams of dead relatives and use those dreams to determine the spiritual status of the dead. Certain holidays are devoted to making merit for the deceased so that they are reborn (Hinton et al. 2013). A deceased relative may ask the living to go with him or her in a dream, which causes great fright—the dreamer's soul may be displaced from the body. If a relative is no longer seen in dream, it indicates that he or she has been reborn; still seeing the relative in dreams indicates the deceased to not be reborn and to be in a difficult spiritual state. The dead are often seen as shadows in the home or detected as an incense-like smell and may be experienced as a descending shadow-like form in sleep paralysis.

To conclude, Nations et al. in this work and in other publications (Nations 2013) have created an important line of research, important contributions to an anthropology of grief and bereavement that includes an examination of local means and paths of recovery. The authors' contextualization of these processes reveals the dangers of interpretative violence, and the article corrects previous misrepresentations. It is the key task of anthropology to explore semiotics, practices, and practicalities in local social and meaning worlds, highlighting local difficulties and paths to recovery, as this article does.

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In this riposte to Scheper-Hughes, our authors set the ethnographic record straight. Their careful reinterpretation of some of the central evidence used by Scheper-Hughes to construct her maternal neglect theory is long overdue, particularly in relation to manifestations of grief and practices surrounding death. Whereas Scheper-Hughes interprets a lack of tears as an absence of grief, our authors rightfully point to the northeast Brazilian cultural aesthetic circumscribing expressions of grief, wherein an excess of tears—in public at least—is proscribed. They make the valuable point that an absence of women from funeral processions and interments is normal; thus, Scheper-Hughes was clearly mistaken in interpreting the raggle-taggle children carrying the infant coffin as a lack of a mother's emotional investment.

But are such misinterpretations enough to discredit her argument entirely? If there is a temptation here, it is surely to view this article as part of an ongoing debate about the basic nature of motherhood and the quality of the bond between a mother and her child. Embedded in this anthropological debate is the supposition that there can be only one winner. Either it is proved that disenfranchised resource-impoverished mothers are unwittingly complicit in their children's deaths, or it is proved that they are not. My instinct, however, is that we should avoid an agonistic reading of these two works and look for their overlaps. Each work contributes its own textures and layers of ethnographic complexity to an expansive question that no single anthropological study can ever definitively answer. In part, because the data and methodologies employed by the two works are not entirely equivalent. But also because *Death without Weeping* and "Cumbered Cries" in fact share an approach, belonging to the kind of anthropological address that Robbins describes as the anthropology of suffering. Both these works—in different ways—offer accounts of suffering and violence that "confront you in your humanity," raising issues that "you cannot help but feel are beyond culture" (Robbins 2013:455). The issues raised are emotive to their core. On the one hand, we are asking questions about the rightness of benign neglect; on the other hand, we are asking questions about the right of cultural outsiders to pass judgment on different forms of parenting. That as humans we feel compelled to ask such questions is interesting in itself. Nurturing children the world over is a hard task. Because it is hard (there is so much that can go wrong), there is always some sort of ethical work to be done. By ethical work I mean reflective work, the work we do when we gossip or speculate about who does it right and who does it wrong. I am inclined to see Nations, Corlis, and Feitosa's attempt to exculpate poor northeasterners from ethically imposed culture of poverty theories as part of this ongoing work within social science. Their desire for a public argument with Scheper-Hughes suggests as much about their own (unacknowledged) cultural constructions of mothers as it does about Northeast Brazilian motherhood per se. This in itself is not wrong; the point, I believe, is that this work goes on in some form or other in all societies, and our authors' failure to signal the philosophical and existential complexity that attaches to any discussion of motherhood rather flattens the debate. That is, both Scheper-Hughes and our authors perpetuate a kind of anthropology in which the suffering poor must continually be defended, morally and intellectually, from outwith. The suffering poor, for their part, are too busy merely reacting to the tough parenting conditions they find themselves in. Sometimes those reactions are morally reprehensible (witholding resources), sometimes they are morally correct (sharing resources, even if what is shared is not in itself enough to save a life); all the same, reflection on those reactions remains the preserve of a scholarly elite who debate among themselves the rights and wrongs of poor people's behavior. I find this strange, because motherhood is not just something poor northeastern women do; it constitutes a complex native philosophy and an exalted so-

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cial office in which religious, politicoeconomic, and ecological pressures meet. Neglectful mothers are a source of fascination and moral debate within northeast Brazilian culture itself (Mayblin 2012). What counts as failure here is set and policed as much from within such communities as it is from without. That is, social scientists are not the only ones debating what it means to nurture and grieve, to be a parent, and to give enough without giving too much. There is ongoing work being done in all these debates, for raising children is hard, wherever one lives. We have to attend to such metacultural elaborations if we seek to present parenting in other cultures as more than knee-jerk reactions of love or benign neglect.

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Ethical Commitment in Anthropological Research

The research of Marilyn Nations, on which this article under discussion is based, monitors social development, investment in primary healthcare programs, and the decline in infant mortality in the State of Ceará (Brazil) since the 1980s. In that decade, for every 1,000 children born in the state, 111.5 died before 1 year of age. In 2013, the rate dropped to 16.6%, a reduction of 94.9% in 23 years, the most impressive reduction when compared with all states of the federation. This indicator was 69.1% for the country in 1980 and is now 14% (Instituto Brasileiro de Geografia e Estatística 2015).

Among other factors, the rapid changes are due to the improvement in economic and social conditions, though, above all, to the universalization of health as a universal right and duty of the state, as enshrined in the Constitution of 1988. The creation of the Unified Health System (SUS) and its universalization—despite the organizational, management, and human resources difficulties it still faces—was fundamental for improving a plethora of health indicators.

Ceará pioneered some experiments related to universalization of primary health care and now reaps the fruits of its efforts. Notably, there was the creation of the Program of Community Health Agents (PACS) that began home visits to the poorest people and residents of remote rural areas or poor areas of cities, performing simple services, among which was teaching homemade oral rehydration techniques to mothers. On behalf of the United Nations Children's Fund (UNICEF), I coordinated a team of researchers who conducted the first qualitative evaluation of this experiment in 1990 (Minayo et al. 1990), seeking to understand the significance and the results of this intervention for local people and for professionals and health workers. This assessment, preceded by an epidemiological survey on the magnitude of the impact of the program on infant mortality, revealed what was effectively working as well as the limits of action. It especially indicated the environmental, economic, and cultural barriers, such as the effects of drought in much of the year. There are also the lack of water or brackish water and the severe levels of poverty, accompanied by highly peculiar ways of perceiving the world, life, death, and the future. The evaluation of PACS showed its importance, particularly in reducing infant mortality, making it the benchmark, first for the Brazilian Northeast and subsequently for the whole country and, according to UNICEF, for several similar international contexts.

Since the late 1980s, Nations (2009) has led anthropological studies on infant mortality in Ceará and contributes to enhanced human understanding of this problem. In her works, there is an acute sensitivity to the network of relationships that is established and involves children, families, the local community, and health services. Her professional tenacity leads to increasingly in-depth knowledge of the phenomenon. For this reason, her research has a much broader scope than its microsocial focus. It touches on sensitive points of ethnography, comprehensive processes, and possibilities of interpretation, making them comparable and generalizable to similar situations in Brazil.

This socioanthropological commitment present in the studies of Nations and her collaborators entitles her to the forcefulness of her criticism of Nancy Scheper-Hughes's work on maternal selective neglect (Scheper-Hughes 1985). This is an interpretive category created by Scheper-Hughes to refer to the behavior of poor mothers of Recife who, according to her interpretation, allowed sick and weak children to die, focusing on stronger and healthy children instead because of personal impotence and the lack of social and health support to care for all. Scheper-Hughes's research was conducted in a shantytown in Recife, where infant mortality rates in the 1980s were similar to those of Ceará. However, her interpretation of this drama for families shifted the blame onto the mothers, albeit stressing the situation of structural violence in which they lived. The works of Scheper-Hughes, seen as a benchmark in various parts of the world, including Brazil, are now being cited as examples of ethically questionable ethnographic studies.

This article of Nations and her collaborators, based on the in-depth ethnography of infant mortality in Ceará, refutes the superficial and ethnocentric interpretations of Scheper-Hughes. The authors show other possible interpretations of the facts and everything involved. As the masters of anthropology teach us, reality is polysemic, and there is no last word on any subject. But if there is greater willingness to act intersubjectively and contextualize the facts, it is possible to get closer to understanding the reality.

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22 V 15

In "Mourning and Melancholia," Freud wrote that "although grief involves grave departures from the normal attitude to life, it never occurs to us to regard it as a morbid condition" (1963:165). The pathology of melancholia rings loudest in Freud's essay, but there is also the message, if understated, that grief, too, is always a departure from the normal, quirky in its strangeness and variability.

In their moving contribution to decades-long debates about maternal investment, resulting from the publication of Nancy Scheper-Hughes's *Death without Weeping*, Marilyn Nations, Joseph Corlis, and Jéssica Feitosa offer a significant measure of evidence to challenge the idea that "maternal neglect has ever occurred in Northeast Brazil." Inspired by Geertzian emphasis on layered interpretation, they nonetheless offer plain evidence, in the form of narratives and cultural explanation, relocating *nordestina* mothers in the anthropological imagination and, more importantly, enriching understandings of life and loss in Brazil.

Nations, Corlis, and Feitosa do not need to invoke Freud's economic vision of the psyche to rebut Scheper-Hughes. But at issue in their challenge to connections between structural violence and maternal disinvestment are questions about the forms grief might take and the meanings we make of those forms. What pieces of a life, what fragments of expression, what ways of inhabiting loss are taken as evidence, and evidence of what?

In the years since the publication of *Death without Weeping*, anthropology's interest in the ways systems of power conform complex ways of bearing loss into acceptable forms of evidence has developed into a method for understanding relationships between institutional demands and the subjects who must live up to them. In the turn from psychologically oriented accounts seeking more basic variations in human experience toward the intricacies of institutional recognition, pluralistic (and noninstitutional) modes of recognition—of feeling and allowing for the feelings of others—has been underexplored.

Where children are concerned, it can be difficult to parse contradictory ways of feeling and knowing feeling. The idea of the child, let alone her existence, is loaded with affect, symbolism, and meaning, creating complexes of emotion that are far from straightforward. Children mean in a multitude of ways. Their loss is thus likely to refract in a million directions, toward other relationships, group identities, time, the future, and the far reaches of moral codes. Their presence and absence resonate beyond the parent-child binary. So, too, the relationship between parents and children means in ways that make child death different from the loss of a spouse, parent, sibling, friend, foe. In the same way, a suicide is different from slow illness, a good death from a bad death, death in childbirth to death from old age. To grieve a child is a special kind of thing, but all grief is special and strange.

Across the narrative accounts of child death offered in this essay, I felt a growing restlessness, one threatening to erupt through the careful, if also impassioned, presentation of women's words. This restlessness should not be read as a rebuttal of the argument those words help build. But it demands that we ask what words are and do in the work of grief, how those instabilities remain in the work grief is made to do as evidence. In what ways is the weirdness of grief never disengaged from processes of being a person through the intersubjectivities of telling?

The protective quality of emotional detachment is often invoked by anthropologists to emphasize the effects of vulnerability. This move shifts the locus of scrutiny from the soul of the sufferer to the world that creates suffering. It is not unlike the move in *Death without Weeping* from scrutiny of women's emotions and actions to the conditions that generate them (though in chapter sequence the shift is the reverse). Though I find this move essential to the moral work of anthropology, a certain liberal subject can be found in invocations of context. Conversations are delimited by this subject making, zooming out to discourse analysis or in to the accuracy of the component parts.

This is at once in evidence and destabilized in a telling moment in this piece, in which a woman tells of her child's father taking the child from its mother and giving it to his new wife, in whose arms the child dies. "This, according to the mother, was a kind gesture that spared her the torment of her child dying in her arms." The account is unsettling in many ways, and in the shift from the woman's words to those of the anthropologists, the "according to" should unsettle us further. It invites other possibilities for emotion and explanation, those that may remain unspoken, even unremembered. And it raises the possibility that morally loaded differences in how we understand grief may be matters of knowing where to stop the explanatory engine. Yet, it also suggests that there is a point at which analysis must end.

In a more basic way, in the interpretive work of ethnographic explanation, we might ask if a mother's actions toward her (still living) child is the same kind of sign as her account of seeking treatment. Ontology aside, it is in the latter that I find this paper to be most powerfully disruptive. Just as women I met in India told detailed accounts of failed medical systems—contra overwhelming stereotypes that rural, poor women did not seek care for sick infants—the women in this study detail horrors of medical, not maternal, neglect and abuse. Amid such radical failings, it is striking that it remains beholden on anthropologists (myself included) to make explanation—of behavior, words, culture—our critical apparatus, to joust with interpretations.

This is not to suggest that thinking about the emotions of others is wrong; our sense of human possibility is only enhanced by the effort. But it is to wonder, as do Nations, Corlis, and Feitosa, what goes into each act of intimate in-

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terpretation. We do not need to suggest that a woman feeling ambivalence about a child, living or dead, sick or well, is deficient when we acknowledge the vagaries of emotions as messy and burdened by context as parental feeling. But the question remains as to what conditions of normality guide the way we collaborate mourning with signs of humanity, what we forget about the ways grief departs from normal attitudes to life. What may be at stake in conversations about maternal affect is not only what we (must) make of the emotions of others but also what qualities of humanity we endow in the effort. Not all actions should require translation to be deemed okay.

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Nations, Corlis, and Feitosa offer a welcome update to previous publications on the issue of mother-child emotional relationships among the urban poor in Northeast Brazil. As they point out, Brazil has undergone currency stabilization, transition to civilian government, and accompanying fluctuations in infant mortality rate since the 1980s. Their longitudinal view helps place both their and Scheper-Hughes's data within a historical context rather than presenting the data as static (Nations and Rebhun 1988; Scheper-Hughes 1992). Within their long-term model, they identify seven contexts in which women grieve lost children, showing both complexity and a continuing emotional connection and reiterating Nations's explanations of maternal conduct sometimes identified, incorrectly, as evidence of lack of caring.

A simple focus on mother love ignores socioeconomic constraints on caretaker agency. Child caretakers include fathers, grandmothers, older sisters, and so on, all of whom face similar barriers. Another context includes the circumstances of pregnancy. The experience of a woman pregnant by rape, or a woman whose family considers her pregnancy scandalous, or a pregnant woman without financial means to raise the child differs from that of a woman joyfully pregnant by her beloved. The experience of a teenager thrown out of her home for disgrace differs from that of an older woman, a single woman from that of a coupled one, a first pregnancy from the latest of many. Most poor women face multiple problems: un- and underemployment, hunger, sickness, family violence, loneliness, and the many stresses of trying to survive and raise children under difficult circumstances. In addition, a woman's attitude toward her children may differ over time because of the shifting contexts in which her life unfolds.

A focus on the multiple barriers facing poor women as they seek care for sick children provides more explanatory power than relying on the putative presence or absence of a romanticized vision of mother love. Whether all poor mothers do or do not love their infants in some uniform way is irrelevant to understanding a complex situation that connects this article to a growing literature on barriers to health care in a variety of settings, which has both greater explanatory power and also proves more fruitful for designing interventions to drop infant mortality rates, as Brazil has successfully done.

Today's theoretical models emphasize contingency, examining complex interactions among multiple factors that shape social interactions. Nations, Corlis, and Feitosa's update provides a more modern view not only in the temporal updating of data from decades ago but also in their more nuanced view of how child caretakers negotiate the many difficulties of poverty, circumstance, and exclusion as they try to raise their children to survive.

Reply

The anthropologist's task of unveiling cultural interpretations is difficult, given their multiple, even antagonistic, significances. We agree wholeheartedly with Cecilia Minayo's comment that "reality is polysemic, and there is no last word on any subject. But if there is greater willingness to act intersubjectively and contextualize the facts, it is possible to get closer to understanding the reality." Indeed, the father of interpretive anthropology, Clifford Geertz (1973:29), reminds us that ethnography is contestable—being "less marked by perfection of consensus and more by the refinement of the debate." Our scholarship aims to add still more voices to the debate and not a last word.

With that in mind, we appreciated all of the commentators' thoughtful remarks regarding our article, and we thank *Current Anthropology* for the opportunity to contribute to the ongoing discussion on maternal grief reactions to infant death in Northeast Brazil. If we have indeed "set the ethnographic record straight," as Maya Maybin states, reorienting misrepresentations of Nancy Scheper-Hughes's ethnocentric and superficial account, or if we "enrich[ed] understandings of life and loss in Brazil," as Sarah Pinto claims, then we achieved what we envisioned with this article. But we, especially the senior author, feel compelled to go further in setting the historical record straight. Here we refer to Andrea Caprara's dating and sequencing of Scheper-Hughes's and Marilyn Nations's original research and contributions—some long overdue academic housekeeping, so to speak. Nations defended her PhD dissertation on the topic in May 1982 in the Department of Anthropology, University of California Berkeley—the same institution where Scheper-Hughes had recently joined the faculty (Nations 1982).

While Caprara claims that this debate began in 1963, we draw attention to the fact that Scheper-Hughes served as a Peace Corps volunteer "in the construction and operation of

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a cooperative day nursery for working mothers" during the 1960s (Scheper-Hughes 1984:536). She was not a trained anthropologist then, nor did she publish findings in the anthropological literature at that time, thereby making them available to scholars. And while Scheper-Hughes's volunteer experience certainly introduced her to Northeast Brazil—which she revisited 20 years later—it was not anthropological fieldwork. It was work. And it is quite possible that Scheper-Hughes's own sense of memory had an effect on the descriptions of her first experiences in the country included in her book on infant death published 3 decades later.

Be that as it may, Nations's and Scheper-Hughes's actual fieldwork have produced data that have provided anthropology with an unprecedented case-control study of sorts. In ethnographic history, it is rare to find two studies that are more or less contemporaneous, address the same topic, use similar methodologies, and occur in proximate locations. With the Scheper-Hughes and Nations data, we have a chance to glimpse the *nordestina* reality from two different perspectives, playing into the ephemeral, dialectic processes of debate that define ethnographic data verification. Indeed, our article is merely our interpretation.

Nevertheless, we disagree with Mayblin's comment dismissing the two differing accounts as being neither right nor wrong; anthropologists need not engage in judgment of good or bad, but we should actively attempt to expose whatever we can as false. As Karl Popper (1963:180) warns, "A theory will be considered the more it resists the confrontation of experience and of rival theories." Scientific theories simply cannot be flexibilized to embrace anomalies or cases not predicted. For instance, Scheper-Hughes's original microlevel cognitive explanation of maternal neglect due to the "internalization and projection of a psychology of want and deprivation" cannot be shifted in later works to macrolevel determinants without falsifying the first theory (Scheper-Hughes 1984:544). Thus, fretting over discrepancies—by entering into the minutiae; by scrutinizing ethnographic evidence; and by calling into question every researcher's subjective, theoretical, and methodological biases—is necessary in order to judge the scientific merits of interpretive accounts. As Pinto says, whether grief is okay or not is not our business. Validating or refuting the explanatory power of selective maternal neglect as a relevant—or as a preconceived or imposed—facet of the debate about causes of infant mortality in Northeast Brazil is. To be sure, selective maternal neglect is not an emergent emic category, as Minayo correctly points out. Since Scheper-Hughes's first article on this subject, she seems to have incorporated the unfortunate, as Caprara puts it, etically conceived theory into her own research questions—a grave error in anthropological research, we believe (Scheper-Hughes 1984:536).

We could not agree more with Mayblin that interpretations must be set and policed as much from within as from without. In their 1988 article, Nations and Rebhun argue that it is necessary to consider the ethnoethical or popular rationality that guides mothers' decisions about death. Linda Anne Rebhun asserts in her review of this article, "Whether all poor mothers do or do not love their infants in some uniform way is irrelevant." We concur; we conducted our study knowing full well the possibility that all mothers may not love their children. The ethnoeugenic neglect of children that Scheper-Hughes alleges, however, would absolutely be relevant to public health interventionists. Thus, we set about to consider the maternal grief response in order to avoid what Elizabeth Farfan-Santos pinpoints as the perpetuation of "applied by Western feminists and social scientists . . . often at the expense of the multiple voices and social roles of women of color."

Of course, Caprara is correct in noting that historical and contextual differences exist between Ceará and Pernumbuco, and we too pointed out several. Nonetheless, the bulk of the ethnographic evidence Scheper-Hughes presents is, in its essence, similar to our own. What differ radically are the interpretations of maternal grief reactions that have historically been drawn from this evidence. Let there be no doubt that Farfan-Santos is absolutely correct; this article "is largely a plea for alternate interpretations of maternal roles in child death . . . a note of caution on how easily scholarship on the maternal failures of poor women of color is spread and reproduced as absolute truth."

What does it look like when Western academia stigmatizes different cultures? According to Scheper-Hughes's own accounts, which are unequivocally capturing, "a glimpse into *nordestina* society entails a descent into a Brazilian heart of darkness" where "profound" and "radical" maternal indifference results in unnecessary infant death (1992:xii–xiii, 355, 354). The vocabulary and imagery she employs are meant to reflect "some of our worst fears and unconscious dreads about 'human nature,' and about mothers and infants in particular" (Scheper-Hughes 1992:xiii).

That Scheper-Hughes's study, as well as our own, broaches the topics of death and grief, which Pinto reminds us are mysterious departures from normalcy, makes the importance of contextualization all the more relevant. As Mayblin highlights, "The issues raised are emotive to their core." And in this emotive, surreal space where death and grief and children and angels converge, it is entirely possible that selective maternal neglect, too, could occur. But did it? No. We debunk the myth of selective maternal neglect as false because contextualization of the mothers' emotive and surreal experiences provides us with a framework for understanding "crying inside" and the many other depictions of maternal investment in Northeast Brazil.

Linda-Anne Rebhun raises an additional context for considering maternal grief: the circumstances of pregnancy. Indeed, our sample of mothers consistently shares the message that they are still mothers, will always be mothers. To them, motherhood is not an act but an existence, just as Mayblin echoes. And the senior author has touched on the topic of motherhood in other articles as well (Nations 1988, 2013).

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Still, the situations in which these women become and live as mothers matter greatly to how they react to losing the very children that made them mothers in the first place. This facet of the local moral world is essential to consider in any future discussion of maternal roles, challenges, and grief.

The grief that our mothers allude to is just one of the many experiences of being a mother in Northeast Brazil. The mothers explain that this experience changes them, remains etched on their faces, and they report a myriad of feelings about their own abilities to endure human loss. Devon Hinton asks a pertinent question regarding being a mother in the face of such loss: What does the contextualization of local difficulties, practices, and meanings tell us about a path to recovery? Our mothers say that they continue to grieve. The complexities of their emotions are far from straightforward, and the loss of a child can catalyze millions of nuanced effects. As Pinto reminds us, anthropology allows us to scratch below the affective surface, to reveal the silences, pauses, repressed tear drops, and even pierced bleeding hearts that lie underneath. We concur with Hinton's comment that it is an interpretive violence—an "error of decontextualization"—to assume that because a grieving *nordestina* mother may not weep outwardly, she does not cry inside. We reveal here and in other articles (Nations 2013; Nations and Rebhun 1988) that "a very different semiotized affect lies just below," as Hinton alerts. Yes, the Virgin Mary with seven blades piercing her heart allows but one teardrop. Not only do grieving mothers imitate the Mother of all Mothers, they embody her, a fascinating topic of a forthcoming article by the senior author.

Hinton asks: What path(s) to recovery do *nordestina* mothers have? What agency to recover? We do not yet fully have those answers. In this article, we aimed to establish that grief exists.

Recently, the senior author published an article on dream visions of deceased children by mothers in Northeast Brazil (Nations 2013). A forthcoming article by the same author probes into the ways memory saves and reframes remnants of grief, appearing to serve as one such pathway to move beyond postmortem depression and the stigma of selective maternal neglect in local therapeutic responses. These articles will serve as building blocks for the dialectic discussion of grief and recovery in Northeast Brazil moving forward.

Additionally, a forthcoming article by Corlis and Nations deals with shifting familial roles—of mothers, fathers, grandparents, neighbors, and so on—in Ceará, and we are researching the implications of such culturally constructed roles for the radical engagement of low-class men in childbirth at public hospitals in the state in order to determine whether family-focused childbirth decreases violence. Both of these studies stem from the socioeconomic, environmental, and political landscapes of Brazil's Northeast, which continues to evolve, at once affecting already grieving families as well as those who may experience loss in the future. These studies also remove mothers from the vacuum that a selective maternal neglect theory requires, returning mothers and children to the families and kinships that underpin Brazilian societies (Carvalho and Almeida 2003; Ribeiro 1995).

Minayo, Caprara, and Salime Hadid all note that the significant decrease in infant and child mortality since the time period of Nations's and Scheper-Hughes's initial studies is due in large part because of democracy, national healthcare programs, economic empowerment, and public health outreach programs—like the prayers and oral rehydration therapy (*rezas e soro*) intervention that the senior author designed and helped implement in Ceará (Nations et al. 1982; Nations and Rebhun 1988). Because socioeconomic and political factors remain in flux in Brazil, future studies of health outcomes and their potential causes must embed ethnographic interpretations of child caretakers—their sentiments, actions, and even grief responses—squarely within the local moral world in order to fully comprehend the lived experiences of diverse peoples.

—Marilyn Nations, Joseph Corlis, and Jéssica I. D. Feitosa

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