Becoming a (neuro)migrant
culture, race, class and gender in Santiago, Chile

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Awarding institution:
King's College London

Becoming a (neuro)migrant

Culture, race, class and gender in Santiago, Chile

A thesis submitted for the degree of Doctor of Philosophy

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ERRATA CORRIGE

Page	Line	Note	ERRATA	CORRIGE
2	5		“Based on a multi-site ethnography”	“Based on a multi-sited ethnography”
20	20		“ethnography conducted over 14 months during 2017 and 2018”	“ethnography conducted over 14 months during 2018 and 2019”
101	9		"Dumit, 2000, 20004”	“Dumit, 2000, 2004"

Date May 20th, 2021

Signed by

Abstract

The arrival of Haitian and Dominican migrants to Chile has led to a series of frictions, conflicts and challenges both within the public health system, as well as in other key social organisations that seek to assist migrants, most notably churches and non-governmental organisations. Based on a multi-site ethnography carried out over 14 months in a borough of north Santiago, I seek to interrogate how new discourses relating to migration, multiculturalism and mental health have taken shape in a post-dictatorship neoliberal Chile from 1990 to the present. Specifically, I explore how, through the introduction of health reforms since the 1990s and the subsequent global mental health (GMH) agenda, biomedicine and psy/neuro technologies have impacted and shaped afro-descendant migrants' subjectivities and everyday lives. Bringing together contributions from anthropology, sociology, science and technology studies, psychoanalysis and feminist theory, I argue that there are multiple forms of becoming a (neuro)migrant in a post-dictatorship neoliberal Chile. Through the negotiation, assimilation, resistance, and refusal of biomedical and psychiatric interventions, migrants engage in heterogeneous subjectivation processes that both affirm and challenge normative values of integration into Chilean society. Thus, these subjectivation processes reveal that psy/neuro technologies challenge migrants' representations of themselves, their malaise and suffering, as well as their mental health. Besides, these processes also reveal how Haitians and Dominicans develop individual, family and community coping strategies to address their afflictions in spaces such as neighbourhoods and churches mainly. I also show that although local initiatives in multiculturalism have encouraged health practitioners to reconsider their practices and values reflexively, they have tended to racialise the notion of "cultural difference" and abnormality/madness. Practitioners have usually reduced migrants' malaise and suffering to a neurobiological level, neglecting the ethnic and contextual aspects involved. Through this, they reproduce and reinforce a conception of afflictions based on a biosocial determinism framed in what some researchers have called neuroscience of poverty.

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Acknowledgments

This thesis would not have been possible without the support of many people and institutions that allowed me to develop this research project.

First and foremost, I have to thank to the Haitian and Dominican community for sharing with me their migration experiences and everyday lives in Chile. Mercedes, Laura, Ramón, Lucy, Pierre, Rose and Renaud[1], I hope I have given an account of your lives, hopes and dreams in this thesis. I have to also thank the health practitioners, health programmes' coordinators, experts, policy makers, pastors and borough's neighbours for sharing their everyday lives and work. Yolanda, Miriam, Viviana, Daniela and Jessica[2], thank you for showing me the multiple challenges that the healthcare system faces in the new Chilean intercultural context. Pastors Juan, James and Choy[3], thank you for accepting me in the church and letting me learn about the evangelical community in Chile.

I would also like to show gratitude to my supervisors Dominique Béhague, Anne Pollock and Francisco Ortega. Dominique, thank you for your constant support and commitment from the beginning of this project, as well as for encouraging me to develop an interdisciplinary and decolonial approach. Anne, thank you for your support and for introducing me to conceptual discussions about race, feminism, and STS studies. Francisco, thank you for the constant clarification around "neuro" debates, as well as for sharing your academic experience. I am also grateful to you for receiving me as a Visiting Researcher at the Social Medicine Institute at the Rio de Janeiro State University in 2017 and 2018. I would like also to thank to Orkideh Behrouzan and Pierre-Henri Castel who helped me during the first stages of this project.

[1] Pseudonyms.
[2] Pseudonyms.
[3] Pseudonyms.

I must express my very profound gratitude to academic and administrative staff of the Department of Global Health and Social Medicine (GHSM) at King's College London. I would like to thank specially the stimulating debates in the context of the Culture, Medicine and Power (CMP) and Mental Health and Society (MHS) research groups. I am grateful to Carlo Caduff, Hanna Kienzler, Nicholas Manning, Ursula Read, David Reubi, and Nikolas Rose for their support and encouragement during this process. I take this opportunity to express gratitude to John Abraham, Carlo Caduff, and Amy Hinterberger for allowing me to work with them as a Graduate Teaching Assistant at the GHSM Department. I am also grateful to my friends and colleagues Thomas Abin, Zeina Amro, Sofia Bowen, Giulia Cavalieri, Fatima Elfitouri, Guntars Ermarsons, James Fletcher, Sebastián Fonseca, Stephanie Goley, Sally King, Victoria Lozano, Tara Mahfoud, Leoni Mol, Fabiola Moretta, Penelope Quinton, Sebastián Rojas Navarro, Edgar Ruiz, Lawrence Sacco, Rosie Sims, Cameron Spence, Craig Ward, Katherine Wheaterburn, Jiawei Wu, Emma Wynne Bannister, and Shuting Zhang, for their constructive comments during writing retreats, research groups workshops, and informal discussions in different moments of this project.

I thank my friends and colleagues of the Platform for Social Research on Mental Health in Latin America (PLASMA) for creating a stimulant workspace. Thanks to Sofia Bowen, Elaine Flores, Álvaro Jiménez-Molina, Claudio Maino, Cristián Montenegro, Felipe Szabzon, and Norha Vera. I will keep in my memories our workshops on Global Mental Health and "the Social Question" in Latin America held in Paris and London in 2017 and 2018, respectively.

I am grateful to all of those with whom I have had the pleasure to discuss this research project in Chile. I would like to express special thanks to my friends and colleagues from the Department of Psychology and the Faculty of Medical Sciences at University of Santiago, as well as the Transdisciplinary Laboratory in Social Practices and Subjectivity (LaPSoS) and the research group on Gender, Sexuality and Psychoanalysis at the University of Chile, for their support and insightful comments related to my research. Thanks to Marianella Abarzúa, Roberto Aceituno, Diego Aguirre, Svenska

Arensburg, Felipe Bernal, Francisca Burgos, Pablo Cabrera, Mauricio Carreño, Isis Castañeda, Jorge Castillo-Sepúlveda, Ángela Cifuentes, Margarita Cortés, Pablo Cottet, Javiera Díaz-Valdés, Cristian Ferreira, Antonia Lara, Patricio Labra, Antonio Letelier, Ximena Montero, Esteban Radiszcz, Pablo Reyes, Danilo Sanhueza, Hugo Sir, Pía Uribe, Katherinne Valenzuela, Cristián Vásquez, Rodolfo Vásquez, Andrea Vera, and María Inés Winkler. I am also deeply grateful to Andrea Polanco; she worked as a research assistant on this project and provided me with new materials and perspectives for analyses.

None of this could have happened without my family and friends. Thank you for your constant support, encouragement and inspiration from the beginning.

Most importantly, I am deeply grateful to Teresa. Thank you for your love and support during these last years.

Finally, I would like to thank BecasChile Scolarship (ANID-Chile) for supporting this process, as well as the PhD Small-Grants Scheme of the GHSM Department for helping me to carry out this project.

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Introduction

In a clinical meeting carried out at the beginning of 2018, Daniela, one of the psychologists at the Family Healthcare Centre (CESFAM[4]) placed in a borough of north Santiago, said: "what we know about psychology or psychiatry does not work with afro-descendant patients. It does not work here [CESFAM], and it does not work in the Psychiatric Hospital. They [migrants] either do not come here or they leave their pharmacological treatments". After similar comments from some of her colleagues, Daniela concluded: "It is true when some people say that psychologists are the new priests. Priests and healers are more valuable to migrants than us. They prefer to go to the church to solve ("resolver") their afflictions". Daniela and her colleagues revealed how several intercultural frictions, conflicts and challenges have arisen in the borough mainly since the arrival of Haitian and Dominican communities in 2010. These intercultural issues have led to the development of different coping strategies for migrants' afflictions within the public health system, as well as within other social organisations that seek to assist migrants, most notably churches and non-governmental organisations.

In this thesis, I seek to interrogate how new discourses relating to migration, multiculturalism and mental health have taken shape in a post-dictatorship neoliberal Chile from 1990 to the present. Specifically, I explore how, through the introduction of health reforms since the 1990s and the subsequent Global Mental Health (GMH) agenda (Patel, Garrison, de Jesus, et al., 2008), biomedicine and psy/neuro technologies[5] (Rose, 2007; Rose and Abi-Rached, 2013) have impacted and shaped afro-descendant migrants' subjectivities and everyday lives. Thus, I address questions such as what discourses and practices have emerged that bring with them the ideals of interculturality in healthcare centres as well as in other social organisations? How are health institutions, social organisations, and expert knowledge and practices

[4] Across the thesis, I conserve the Spanish acronym "CESFAM" (Centro de Salud Familiar)

[5] By psy/neuro technologies, I refer mainly to the introduction of several evidence-based psychotherapies, psychopharmacology treatments and neuroimaging techniques in the public health system in Chile.

entwined with representations of the mental afflictions of afro-descendant migrants? How are the sets of strategies, technologies and practices composing the government of the afro-descendants' afflictions? How are health policies and centres, and biomedical and psychiatric practices "making up" afro-descendant patients/subjects? And finally, how are afro-descendant migrants engaging in subjectivation processes in their relationships with different health and social organisations?

Bringing together contributions from anthropology, sociology, science and technology studies, psychoanalysis and feminist theory, I argue that there are multiple forms of becoming a (neuro)migrant in a post-dictatorship neoliberal Chile. Through the negotiation, assimilation, resistance, and refusal of biomedical and psychiatric interventions, afro-descendant migrants engage in heterogeneous subjectivation processes that both affirm and challenge normative values of integration into Chilean society. Thus, these subjectivation processes reveal that psy/neuro technologies challenge migrants' representations of themselves, their malaise and suffering, as well as their mental health. Besides, these processes also reveal how Haitians and Dominicans develop individual, family and community coping strategies to address their afflictions in spaces such as neighbourhoods and churches mainly.

Although local initiatives in multiculturalism have encouraged health practitioners to reconsider their practices and values reflexively, they have also tended to racialise both the notions of "cultural difference" (Fassin, 2009a; Jenks, 2010; Sargent and Larchanché, 2009) and abnormality/madness (Metzl, 2010). Notably, as some studies have shown in different contexts (Ehrenberg, 2018; Rose and Abi-Rached, 2013; Rose, 2018, Vidal and Ortega, 2017), mental health practitioners have usually reduced migrants' malaise and suffering to a neurobiological level, neglecting the ethnic and contextual aspects involved. Through this, they reproduce and reinforce a conception of afflictions based on a "biosocial determinism" (Pitts-Taylor, 2019) framed in what some researchers have called "neuroscience of poverty" (Farah, 2018; Farah, Noble, and Hurt, 2006). According to

Victoria Pitts-Taylor (2019: 672), this kind of determinism "elevates biological explanations for social problems even while attributing biological conditions to social causes"[6]. Thus, through the causal linking of neurological, cognitive, biographical, vulnerability and poverty aspects, mental health practitioners mask structural conditions associated with afflictions.

Rather than focus exclusively on biopower and governmentality aspects (Foucault, 2003 [1976]; 2010 [1978]) associated with biomedical and psychiatric strategies and practices, I revitalise subjectivities and potentialities (Béhague, Kanhonou, Filippi et al., 2008; Biehl and Locke, 2010; McGranaham, 2016; Simpson, 2007) of migrants and communities. Far from a psychological approach, I understand subjectivity as a complex and dynamic space through which historical, social, economic, political and material forces can be examined (Biehl, Good and Kleinman, 2007; Blackman et al., 2008). Thus, although this ethnography falls in line with recent contributions in anthropology (Duncan, 2015; Giordano, 2014; Jenkins, 2015; Ticktin, 2011), it focuses on the impacts of psy/neuro technologies on migrants' subjectivities and everyday lives. For this, it builds up an exploration inspired in both Foucauldian and Lacanian psychoanalytic traditions on subjectivity, subjection, resistance and resignification (Butler, 1997). Therefore, I emphasise how migrants carry out a heterogenous engagement with biomedicine, psychiatry, magic and religion, revealing different subjective destinies in the Chilean neoliberal context.

This thesis contributes to both local and global contemporary debates on global mental health (GMH), anthropology, social medicine and public health (Béhague and MacLeish, 2020; Lovell, Read, and Lang, 2019; White, Jain, Orr, et al. 2017). Firstly, it promotes decolonial discussions in GMH on the interactions of psy/neuro technologies, religion and magic in the context of South-South migration in Latin America. Rather than reproduce initial debates around global-local,

[6] According to Pitts-Taylor (2019: 672) "unlike purely biological determinism, which understands human behaviour as controlled by biological factors, biosocial determinism allows for two-way influence such that experience also shapes biology".

universalistic-culturalist, emic-etic perspectives (Bemme and D'souza, 2014; Bemme and Kirmayer, 2020), this thesis seeks a more collaborative discussion (Bemme and Kirmayer, 2020) around the epistemic differences that emerge in migrants' mental health/illness trajectories. Thus, it emphasises how Haitian and Dominican migrants engage in heterogenous subjectivation processes not only in healthcare spaces, but also in neighbourhoods and churches.

Secondly, this thesis contributes current debates on transnational migration studies (Arriagada and Moreno, 2012; Stefoni, 2011; 2014; Tijoux, 2016; Tijoux and Díaz, 2014; Stang and Stefoni, 2016), as well as race and racialisation theory in Latin America and in Chile mainly (Tijoux and Palominos, 2015; Viveros, 2009; Wade, 2010; 2015; Wade, García Deister; Kent, et al. 2014). Particularly, it sheds light on debates on the uses of race (Koenig, Lee and Richardson, 2008; Whitmarsh and Jones, 2010), highlighting how mental health practitioners tend to reduce mental afflictions to a genetic predisposition of the afro-descendant population. Finally, it fosters a conceptual and methodological reflection around multi-sited ethnography (Marcus, 1995). This methodological approach does not only allow focusing on different "spaces" (e.g. sites such as CESFAM and churches), but also interrogating the concept of "site" itself. Thus, this approach enables ethnographic engagements with other large-scale and dynamic "entities"[7] such as, for instance, transnational migration, GMH, and religion, among others.

Historical Context: The arrival of the "new migration"

Migrant communities living in Chile have grown exponentially since 1990 when the end of the civil-military dictatorship commanded by Augusto Pinochet occurred. While foreigners represented 0.8% of the population in 1992[8], this quota

[7] Adriana Petryna (2002) developed similar arguments on large-scale entities (e.g. "bioethics") in her book "Life Exposed: Biological Citizens After Chernobyl" (Petryna, 2002).
[8] Equivalent to 105,070 people (INE, 1992).

had reached 7.9% by 2019[9]. Economic stability and the public security have been two of the main factors that explain the so-called "new migration" (Stefoni and Fernández, 2012; Martínez, 2003). That is, Latin American and Caribbean migrants who arrived in Chile following what some Latin American newspapers called the "Chilean dream"[10] (El Colombiano, 2015; El País, 2017a; Clarín, 2017). These new migrants tend to work in manufacturing, construction and domestic service roles. In many cases, they take on work that has been refused by Chilean people, occupying generally low-skilled, risky and underpaid jobs (Tijoux, 2011). Nowadays, the most representative groups are Venezuelans (30.5%)[11], Peruvians (15.8%), Haitians (12.5%), Colombians (10.8%), and Bolivians (8%) (INE/DEM, 2020). The largest number of migrants reside in the Metropolitan region (64%)[12], which adversely affects the perception of some Chileans about the number of migrants actually living in Chile. Moreover, in some low-middle income boroughs[13] of Santiago, such as the area where this study was conducted, migrants represent between 20-25% of the population[14], causing an overdemand in both health and education services.

This new migration has found a completely different context than that found by the European migrants who settled in the late 19th and early 20th centuries. In a historical moment marked by the proliferation of European racial discourses and theories framed in scientific racism (Erickson and Murphy, 2017), the Chilean State enacted the "Selective Immigration Law" of 1845. Through this regulation, the State invited Europeans to colonise outermost regions of the national territory, to promote an industrialisation process in the country, as well as "to improve the race" ("mejorar

[9] Equivalent to 1,492,522 people (INE/DEM, 2020).
[10] Inspired on the European migratory flows towards the USA in the early 20th century, some newspapers pointed out that South American and Caribbean migrants follow the "Chilean dream".
[11] The increase of Venezuelan migrant numbers started in 2018 after a social, political and economic crisis in Venezuela.
[12] Other regions with highest number of migrants are Tarapacá (16.9%), Antofagasta (13,6%), and Arica y Parinacota (10.4%). (INE/DEM, 2019).
[13] In this thesis, I translate the word "comuna" as "borough". A "comuna" is the smallest administrative subdivision in Chile. Santiago province has 32 boroughs. The Santiago north area is composed of seven boroughs. Each "comuna" has its own "Municipality" ("Municipalidad").
[14] This rate is higher than other OCDE countries known as being host countries (Thayer, 2019).

la raza") (Tijoux, 2016). The State encouraged them with promises of receiving some benefits such as land or cattle (Cano, Soffia and Martínez, 2009; Durán and Thayer, 2017). In contrast, the new migration has found the "Immigration Law" (1975), passed during the civic-military dictatorship (1973-1989) in the context of the international Cold War. According to different institutions and researchers (Centro de Derechos Humanos-Universidad de Chile, 2016; Stang, 2016), this law promotes a perception of the "immigrant" as "dangerous" and the "internal enemy", and its procedures do little to guarantee migrants' rights. Despite a return to democracy in 1990, this regulation has not undergone any substantial changes (Arriagada, Cubides and Bartolotto, 2016; Stefoni, 2011).

The increasing arrivals of Haitians[15] and Dominicans[16] since 2010 has been the result of various factors. Chile's economic stability seemed to stand out even more in a global context marked by the subprime mortgage crisis of 2007-08. Besides this, Chile emerged as a potential host country due to its lesser migratory restrictions than other countries such as the USA or the European Union (Riedemann and Stefoni, 2015)[17]. These factors gained particular traction through the deployment of the United Nations Stabilisation Mission in Haiti (MINUSTAH) after the earthquake that hit the country in 2010. The Chilean army had been working on the island for 13 years (2004-2017), contributing to its institutional reorganisation and pacification. Although soldiers worked in Haiti, they tended to take holidays in the Dominican Republic's tourist resorts. Here, they also familiarised Dominicans with social, economic and political aspects of everyday life in Chile. Following a transnational approach in migratory studies (Glick Schiller, Basch, Blanc-Szanton, 1992), in this thesis I point out that the process of becoming a migrant starts in the home country when they imagine

[15] While 651 Haitians arrived during 2000, 253,033 got residence between 2010 and 2019 (INE/2020, 2020).

[16] While there were only 281 in 2002 (INE, 2003), by 2018 there were 17,959 (INE, 2019). In 2016, the government estimated that around 50% of the Dominican population were there on an irregular basis because they had entered the country as tourists, prior to the establishment of the consular visa in 2012.

[17] Unlike the traditional "South-North" migration, some researchers have referred to this as "South-South" migration (Rojas Pedemonte, Amode and Vásquez, 2017; Cabieses, Tunstall, Picket, et al. 2013).

and plan their travel to Chile. However, I also highlight how imagination and planification sometimes did not foresee both legal (e.g. consular visa) and non-legal/arbitrary (e.g. false regulations) migratory restrictions (Thayer, 2019).

Similarly to the other recent presidential elections that have taken place in the USA, Brazil, and Italy, among others, as well as in the Brexit referendum in the UK, the presidential elections in 2017 were marked by divisive discussions around migratory issues. The right-wing sector, heir to a conservative moral position and liberal economic policies promoted by the Chicago Boys[18] in the 1970s and 80s, intensified political campaigns that linked migration to delinquency, drug trafficking and cheap labour (La Tercera, 2016, 2017b; El País, 2017b; El Mostrador, 2017a). Using the slogan "tidy up the house" ("ordenar la casa"), Sebastián Piñera, the election's winner in 2017, carried out several actions designed to restrict and manage migration through, for instance, the implementation of consular visas and the "Plan of Orderly Humanitarian Return" ("Plan de Retorno Humanitario Ordenado"). The plan, focused only on Haitian migrants, sought to "transfer to their country of origin foreigners who are in Chile on a regular or irregular basis and who decide to return voluntarily, individually or as a family group" (DEM, 2018: 1). Some social organisations, scholars and politicians criticised these actions, arguing that this plan constituted racism and xenophobia against not necessarily all migrants but certainly towards "poor migrants" (La Tercera; 2018a; El Desconcierto, 2019). These new restrictions created conditions for the reinforcement of an illegal market related to migration (e.g. "illegal travel agencies", "coyotes", among others).

The reproduction of racialisation practices towards afro-descendant communities have reinforced an ensemble of representations and ideals associated with an alleged "Chilean race" anchored in the colonial epoch and the conformation of the Chilean nation-state in the early 19th century. The Chilean race would be the result of the miscegenation ("metizaje") between Spaniards and indigenous people

[18] Chicago Boys were a group of Chilean economists trained by Milton Friedman and Harnold Haberger at the University of Chicago during the decades of 1970s and 80s.

(Larraín, 2001; Subercaseaux, 2007). This idea is fixed in what Balibar and Wallerstein (1991) have called "fictional ethnicity". That is, a fiction that, through historical and institutional effects, produces the naturalisation of belongingness. Thus, this fiction grounds the image of the Chilean nation-state and promotes the belongingness to the "Chilean race", as well as excludes afro-descendant people from the nation (Cussen, 2016). Although there are few studies centred on afro-descendant migrant communities in the country (Tijoux, 2014, 2016; Tijoux and Palominos, 2015), they have shown how racialisation and sexualisation practices have placed migrants on a "visible" position during recent years. For example, these practices have subordinated them to categories such as "infected people" (e.g. HIV, leprosy), "delinquency", "drug trafficking", "commercial sex work", "laziness", "bad mothers", "hypersexualisation", among others (Abarca-Brown, 2018; Carrère and Carrère, 2015; INDH, 2017; Liberona, 2012; Tijoux, 2014, 2016).

In this thesis, I focus on the interplay between these discourses on race, migration, and afro-descendant migrants' afflictions. Although migrants have embodied these oppressive forces diversely, revealing individual and collective resilience and potentialities, they have tended to engage with subjectivation processes that usually leave them in subordinate positions. Primarily, as some recent studies have shown in Chile (Cabieses, 2019; Liberona, 2012; Tijoux, 2014; 2016), these processes have had various psychosocial impacts on migrants, leading to the emergence of expressions of malaise and suffering. Particularly, migrant adults have tended to express anxiety, stress and a depressive mood in their migratory process. For their part, migrant children have experienced family breakdown, loss of referents, devaluation of one's own image, high levels of depression, emotional difficulties and behavioural problems.

Most Haitians and Dominicans seemed not to have found enough relief for their afflictions in healthcare centres. As some researchers have argued during the last year (Alvarado, 2008; Cabieses, 2019), migrants have faced administrative, language and cultural barriers in healthcare centres in Chile. These barriers have led

to the emergence of several issues related to access, ineffective treatments, and the growth of discriminatory and racist behaviours in clinical settings. Although "cultural pertinence" ("pertinencia cultural")[19] is one of the foundations of the Family and Community Health Model implemented in primary healthcare centres (MINSAL, 2018a), health practitioners tended to stress intercultural training needs.

These needs have partially emerged due to the absence of intercultural health policies until the 1990s. According to some researchers, these policies have shaped a "neoliberal multiculturalism" in Chile (Boccara, 2004, 2007; Boccara and Bolados, 2010; Bolados, 2010; Bolados García, 2012; Richards, 2016). That is to say, a kind of multiculturalism that operates primarily at the level of the recognition of the Otherness in ethnic terms (e.g. Mapuche, Ayamará, among others indigenous people), but that does not integrate political and economic redistribution that tackles structural change. Within this context, the arrival of afro-descendant communities has led policymakers and local health coordinators to promote several initiatives designed to engage health programmes and practitioners in intercultural aims. However, although these initiatives have improved access and also challenged discriminatory and racist behaviours in healthcare centres, practitioners identify several intercultural issues mainly in clinical settings.

The implementation of several health initiatives after the end of the civil-military dictatorship and the subsequent introduction of the GMH agenda have had a significant influence in mental health practitioners' approaches, as well as in patients' representations and practices around mental illness/health. Since the 1990s, the Chilean state has carried out what some psychiatry and public health researchers have

[19] According to the Law nº 20.584 (2012), healthcare services must incorporate a cultural pertinence approach. Focused exclusively on indigenous populations, the law states: "the right of people belonging to indigenous peoples to receive health care with cultural pertinence, which will be expressed in the application of an intercultural health model validated before indigenous communities. The model must contain, at least, the recognition, protection and strengthening of the knowledge and practices of indigenous peoples' healing systems; the existence of intercultural facilitators and signage in the Spanish language and of the native people corresponding to the territory, and the right to receive religious assistance specific to their culture" (Ley nº 20.584, 2012)

called a “silent revolution” (Araya, Alvarado, Minoletti, 2009:596). That is, a set of policies, strategies, and technologies designed to improve mental health indicators[20] even before the call to scale up mental health programmes in low/middle-income countries (Patel, Garrison, de Jesus, et al., 2008). According to some social sciences researchers, this “silent revolution” has promoted the medicalisation of social issues (Aceituno, Miranda and Jiménez, 2012; Mayol, 2012) and it has shaped the management of “biological citizens” in Chile (Cuthbertson, 2015). Specifically, social researchers have highlighted underlying social issues such as the modernisation process, social and economic inequalities, reduction of the social protection system, crisis of social cohesion, and a lack of confidence in public institutions (PNUD, 1998, Mayol, 2012). Thus, medicalisation processes have co-opted individual and collective forms of affliction making “mental disorders” central in Chileans’ everyday lives.

Psy/neuro technologies have masked traditional magic-religious practices related to mental afflictions, shaping a hierarchical coexistence between different health models (Bensa and Fassin, 2008; Campos Navarro, 2016; Fassin, 2009b; Fernández Juárez 2004, 2006; Follér, 2004; Green, 1998; Menéndez, 1992; 2016). In the 1980s and the early 1990s, the reproduction of magic-religious practices was a typical coping strategy for afflictions in the country. For example, health trajectories of low-middle income boroughs' patients revealed a mixture of biomedical and magic-religious representations and practices (Grebe and Segura, 1988; Prado, 1989; Winkler, 1999). People carried out practices of popular Catholicism, divinatory practices, and practices of black and white magic as a way of afflictions' relief (Winkler, 1999). However, since the 1990s, the mentioned “silent revolution” has placed gradually biomedical and psy/neuro technologies on the foreground. In this scenario, the arrival of migrant communities, particularly Haitians, has marked the

[20] For example, the implementation of the Chilean Health reform, specifically, the Regime of Explicit Health Guarantees (AUGE) in 2004. This programme offers financial cover for 56 diseases. Among them, the programme provides treatment for conditions such as depression, schizophrenia, bipolar disorder, drugs and alcohol addiction, and Alzheimer and other types of dementia. Besides, the implementation of the National Depression Treatment Programme in primary healthcare in 2001. This programme was the first of its kind in a low/middle-income country (Araya, Alvaro, Minoletti, 2009).

"return" of magical-religious aspects to the debate around mental health. As various studies have revealed (Auguste and Rasmussen, 2019; Pierre, Minn, Sterlin, et al., 2010), religions play a central role in Haitians' everyday lives, particularly Haitian Vodou[21] (Damus and Vonarx, 2019; Vonarx, 2012; WHO, 2010).

Beyond healthcare centres, afro-descendant migrants tended to manage their malaise and suffering in family and community contexts. This thesis emphasises the centrality of family and community for Haitians and Dominicans in managing afflictions, as well as the differences between healthcare centres and migrant communities in terms of the representations, knowledge and practices around emotional and behavioural problems. Thus, spaces such as homes, neighbourhoods, hairdressers, churches, and NGOs become central places where migrants find relief from their afflictions. These spaces have become political spaces where institutional (e.g. churches) and migrant communities' interests converge. Besides this, these spaces have turned into ethnic-national spaces that have led migrants to the development of individual and collective potentialities.

Methodological approach

As a social researcher, this thesis is a return to the migration and health issues that I witnessed during 2011 and 2012 when practising as a clinical psychologist with psychoanalytic training at a Family Health Centre (CESFAM) situated in one of the boroughs of north Santiago. Unlike countries such as the US and UK, among others, psychoanalytic training and practice in Chile, as in other Latin American countries, tends to be characterised by a constant dialogue with social sciences, as well as by political commitment to social justice in health contexts. As Patricia Gherovici and Christopher Christian (2019)[22] have shown in their recent contribution entitled

[21] Following different researchers (Hurbon, 1999; Vonarx, 2012), I use the word "Vodou" to avoid confusions and misconceptions associated with the word "Voodoo".

[22] For similar contributions on psychoanalysis in Latin America see Brotherton, (2016), Plotkin (2002, 2003), and Ruperthuz (2015).

“Psychoanalysis in the barrios”, far from the classic setting of the patient on the couch promoted by the media, psychoanalytic practice – as with other psychological approaches - is part of clinical-community interventions in some Latin American countries. Within this context, the initial questions that guided the design of the research project in 2016 and 2017 focused on the historical, social, economic, political and material aspects that shaped afflictions and, consequently, the increase in rates of mental disorders in health centres.

However, contributions from the social sciences, particularly from medical anthropology, allowed me to ask broader questions and to interrogate models and technologies in mental health and interculturality. Specifically, this approach led me to question the adoption and uses of models and technologies such as “interculturality”, “cultural/structural competency”, and “global mental health”, among others. Gradually, from the formulation of the research project to the first months of fieldwork, the perspective of health institutions and practitioners became more prominent. In other words, the focus ceased to be exclusively on the perspective of migrants. Thus, as I mentioned before, the emphasis on frictions, conflicts and challenges between institutions and social actors allowed for an exploration of the multiple perspectives, discourses and practices involved.

Aiming to track those interactions, this thesis is based on a multi-sited ethnography conducted over 14 months during 2017 and 2018 in a low-middle income borough in northern Santiago. I understand a multi-sited ethnography as an approach through which it is possible to study a social problem that cannot be accounted for solely in one place (Marcus, 1995). The essence of this type of approach is to follow people, connections, and relationships through space; thus, in methodological terms, this approach requires the ethnographer to move through spatially dispersed fields (Falzon, 2009).

The borough is a low-middle income area that borders commercial sectors of the city. It has a population of around 150,000 inhabitants. In economic terms, 10.7%

of the borough population live in a situation of poverty[23] and 26.9% reside in overcrowded housing conditions. With regard to healthcare, 81% of the borough's population is part of the public health system administrated by the National Health Fund (FONASA)[24]. In cultural terms, 3.2% of its population declare to be part of an ethnic group[25] while 68.9% declare to be Catholic and 13.2% Protestant. In security terms, it has higher rates of "crimes of public concern"[26] (5.9%) than the Metropolitan Region (3.1%) and the country (2.8%). A significant number of migrants have arrived in the borough from 2010 to 2015 largely because of the availability of low rental housing. In 2019, around 25,000 migrants were residing in the borough. According to the Municipal's internal documents, there are currently 10,000 patients from other countries enrolled at a primary healthcare level (CESFAMs). Most of them are from Peru, Colombia, Haiti and the Dominican Republic.

"Family Health Centres" (CESFAMs) adopt a Family and Community Approach. That means, primary healthcare is not conducted only within CESFAMs but also in several places within the borough, such as neighbours' councils ("juntas de vecinos"), sports clubs, and social organisations, among others. In these places, practitioners[27] carry out mainly preventative and promotional health interventions focused on the family unit. The borough also has two specialised mental health centres for severely affected patients. Besides this, although the borough has different social organisations and churches with programmes focused on psychosocial issues, currently there are around ten organisations that work with migrants.

From December 2016 to January 2017, I carried out a pilot study in the borough. I contacted and interviewed gatekeepers in NGOs and the Municipal Health

[23] A 9.2% of the population of the Metropolitan Region is living in poverty.

[24] Chile has a strong privatised health system. In the country, there are two types of health administration systems: a public system (FONASA) and a private system (ISAPRE). Around 78% of people are part of FONASA and 14% of ISAPRE. The rest of the people are part of the health system of an independent system belonging to the Armed and Security Forces. These systems were created during the civic-military dictatorship (1973-1989).

[25] Mainly, Mapuche people (3.1%).

[26] The index includes crimes such as homicides, rapes, injuries and crimes against property.

[27] In CESFAMs, health practitioners are mainly physicians, nurses, dentists, midwives, nutritionists, psychologists, social workers.

Department. I also carried out observation sessions in public spaces such as different squares, hairdressers, sports clubs and churches. After completing the research project and subsequently receiving the approval of the Ethics Committee of King's College London[28], as well as the authorisation of the Municipal Health Department, I conducted the first period of the ethnography from February to December 2018, and the second from August to October 2019.

I began observations at the CESFAM with the highest number of migrants registered in the borough. Promptly, following key actors, associations and relationships, I conducted observations in the Municipal Health Department, the North Metropolitan Health Service, in homes and the everyday living spaces of migrants, as well as in churches. Similarly, I carried out 45 semi-structured interviews with health practitioners, Dominican and Haitian migrants, and other key actors, including policymakers, priests/pastors, and healers. A female research assistant conducted some interviews with Haitian and Dominican women intending to improve contact and reduce gender bias. She is a clinical psychologist who specialises in gender and community issues. She also contributed to some preliminary analysis of the material. Although most of the interviews were conducted in Spanish, some interviews with Haitians were carried out in French and English. Besides this, I reviewed relevant historical documents and public policies on issues of interculturality and mental health.

Through an inductive analysis (Russell, 2011), I analysed the ethnographic material and the information provided by social actors and documents. Thus, I identified patterns, emphases, and processes in the material. Subsequently, I contrasted and analysed several hypotheses with different contributions of social sciences. During the second ethnography period, I contrasted preliminary analyses with some observations and also discussed them with some key actors such as health practitioners, Haitian experts in interculturality and health, and Chilean scholars.

[28] King's College London Ethics Ref: HR-17/18-5319.

Two critical social events marked the writing process of this thesis, confirming some of the preliminary analyses mentioned. Firstly, the beginning of the social outburst ("estallido social") in Chile in October 2019 coincided with the end of the second period of ethnography. The "estallido" was the reaction of several social movements and people who argued against neoliberal polices, struggling mainly for better health, education and pension systems. According to different international organisations (Amnesty International, 2019; UN, 2019), the violation of human rights marked this outburst, revealing the presence of some past dictatorship practices. Several protesters were injured and killed by the police and army. Secondly, the COVID-19 pandemic revealed the inefficacy of neoliberal policies for providing social support to the population. Although I do not integrate the effects of these events in this thesis, both events became crucial by confirming some analyses – for example, the role of neoliberal policies, the precarity of the health system, and the racial practices of healthcare centres (associated with the COVID-19 outbreak), among others.

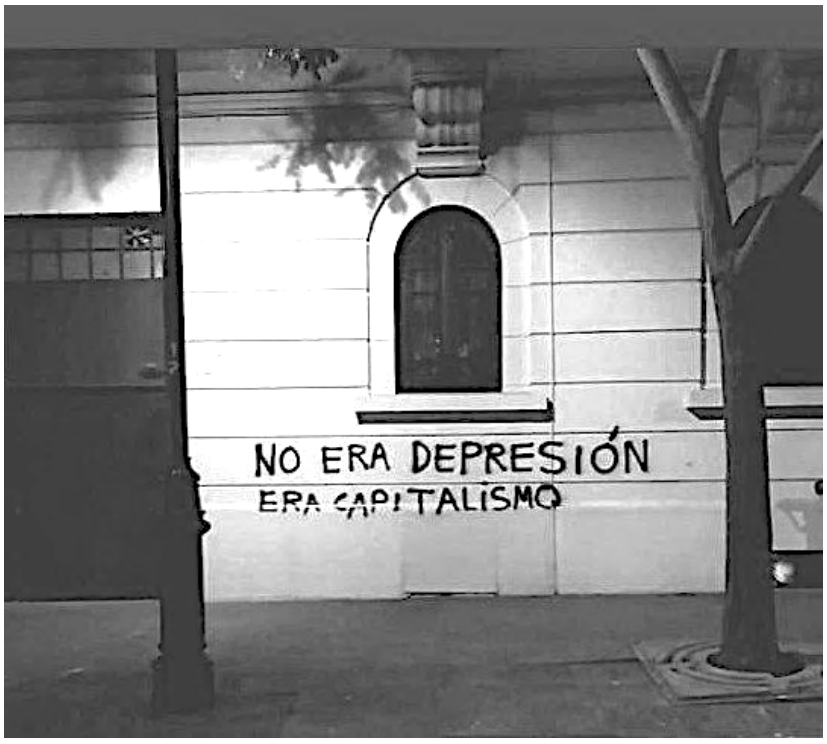

Figure nº1: Graffiti "It was not depression, it was capitalism". Graffiti written during the social outburst in October 2019 near the borough in Santiago.

Structure of the thesis

This thesis is divided into five chapters and a brief concluding chapter. Chapter I explore how historical, political, economic, sociocultural, and material aspects have shaped an intercultural health field (Fassin, 2000)[29] framed in what some researchers have called "neoliberal multiculturalism" in Chile. This form of multiculturalism is defined as a form of governance that prioritises the cultural recognition of ethnic/racial aspects of certain groups over the redistribution of resources and political power among different groups of the population (Hale, 2002, 2006; Horton, 2006; Postero, 2004, 2007; Laurie, Andolina and Radcliffe, 2003, Richards, 2016). I will pay special attention to how this emerging intercultural field interacts with mental health knowledge and practices in the borough's primary healthcare system.

This chapter sheds light on relevant contemporary decolonial debates in anthropology, global health and social medicine from a Latin American perspective (Briehl, 2003; Claros and Viaña, 2009; Gamlin, Gibbon, Sesia, et al., 2020; Santos, 2016). It focuses on the "refusal" of hegemonic knowledge and models, particularly, of the cultural competency model. By "refusal", I mean the generative action that can be part of the political/decolonial action of refusing, or at least limiting, specific structures and systems (McGranaham, 2016; Simpson, 2007). The potential of refusal lies on its capacity to create new and more equitable relationships between subjects (Benjamin, 2016). Thus, the ethnographic material questions how the adoption, resistance and refusal of the cultural competency model influences the ways through which health practitioners grasp and shape "the social" (Adams, Béhague, Caduff, et al., 2019; Yates-Doerr, 2020). In so doing it facilitates the interrogation of conceptual and empirical foundations of concepts such as "culture" and "structure", as well as

[29] By "intercultural health", I mean a field of diversity management that allows the legitimation of new practices and health agents (Fassin, 2000); however, this legitimation is not without unequal transaction between epistemologies through which dominant Eurocentric thought styles, such as biomedicine subordinate other forms of so-called "traditional" health knowledge and practices (Santos, 2016; Claros and Viaña, 2009).

ways of "knowing" certain health issues. In line with this, this chapter also sheds light on how intersectionality, as an "analytical sensitivity" tool, is conditioned by practitioners' previous socialisation of categories such as culture-ethnicity-race, class, gender, and others, as well as public healthcare systems' traditions, and historical and macrosocial processes in local contexts.

Chapter II explores how social, economic, political and material forces constrain[30] the body, subjectivity and sexuality of migrants, leading them to represent themselves as "immigrants". In this research, I do not merely conceive migrants as subjects who arrive intending to reside in a different country. On the contrary, following different studies that revitalise a transnational perspective (De Genova, 2009; Glick Schiller, Basch, Blanc-Szanton, 1992; Levitt, and Glick Schiller, 2004; Rodriguez and Schwenken, 2013; Sayad, 1999), I reconceive migrants as subjects whose experiences with processes of subject-making begin to take shape in the countries of origin. In other words, the process of becoming a migrant begins from the moment subjects imagine and evaluate the possibility of migrating. Following this, I will explore how these forces are impacting the Dominican community as well as how Dominicans are coping with the afflictions shaped by these forces. I will also draw attention to the emergence of epistemic differences between representations, knowledge and practices between health centres and the Dominican community as it relates to the way affliction is understood and experienced. In this way, I explore the emergence of differences in how Dominican communities represent their afflictions and how they develop coping strategies based on family and community for the afflictions' relief.

This chapter contributes to current debates on transnational migration studies (Arriagada and Moreno, 2012; Stefoni, 2011; 2014; Tijoux, 2016; Tijoux and Díaz, 2014; Stang and Stefoni, 2016), as well as race and racialisation theory in Latin America and in Chile mainly (Tijoux and Palominos, 2015; Viveros, 2009; Wade, 2010;

[30] I use this word following Norbert Elias' sociogenetic and psychogenetic contributions. See "The process of civilization. Sociogenetic and psychogenetic investigations" (Elias, 2000 [1939]).

2015; Wade, García Deister; Kent, et al. 2014). It illustrates how Dominican migrants usually find tools for managing malaise and suffering within their families and communities which leads them to partially refuse psychological and psychiatric support. This epistemic difference questions the impact of psy/neuro practices in afro-descendant migrant communities, particularly in the different subjectivation processes engaged in by children, young people and adults. Thus, this chapter falls in line with various studies that have stressed the significant role that families and communities play in the management of psychological malaise and suffering (Chase and Sapkota, 2017; Han, 2012; Kohrt, 2014), as well as the role of ethnopsychological aspects in seeking help (Kohrt and Harper, 2008).

Chapter III questions how health teams have adopted psy/neuro technologies (Rose, 1999; Rose and Abi-Rached, 2013) framed by the gradual implementation of mental health initiatives and the subsequent introduction of the global mental health (GMH) agenda in Chile (Araya, Alvarado, Minoletti, 2009). It interrogates how these technologies were impacting Haitian patients, as well as how Haitian patients were interacting with these technologies. Thus, it explores the relationships between science, religion (e.g. Vodou) and magic emerging in mental health interventions with the Haitian community at the CESFAM. Through the lens of mental health practitioners and Haitian patients, I focus on how practitioners translate migrants' afflictions into a biomedical and psy/neuro idiom. Besides, I centre on how dynamic and complex interactions and heterogenous subjectivation processes have emerged between healthcare centres and the Haitian community, highlighting the different systems of health knowledge and practices involved.

This chapter sheds light on current debates in GMH (Béhague and MacLeish, 2020; Lovell, Read, and Lang, 2019; White, Jain, Orr, et al. 2017) and medical anthropology (Duncan, 2015; Giordano, 2014; Jenkins, 2015; Ticktin, 2011) by highlighting how mental health practitioners translate Haitians' afflictions into a psy/neuro idiom within psychological consultations. It also emphasises how psy/neuro technologies tend to mask the relationships of neuro-knowledge with

Haitian cosmovision, as well as with other forms of knowledge such as Haitian-Creole medicine and Vodou (Auguste and Rasmussen, 2019; Damus and Vonarx, 2019; Pierre, Minn, Sterlin, et al., 2010; Vonarx, 2012; WHO, 2010). Besides, this chapter contributes to debates on the uses of race (Koenig, Lee and Richardson, 2008; Whitmarsh and Jones, 2010), emphasising how mental health practitioners tend to reduce mental afflictions to a genetic predisposition of the afro-descendant population.

Chapter IV focuses on the interactions between health institutions, psy/neuro knowledge and practices, and afro-descendant women registered in the Chile Crece Contigo (ChCC) programme, as well as how these interactions impact the everyday lives of women. This programme provides children with access to services and benefits, designed to meet their needs, from their gestation until they reach the age of nine. The premise of the programme is that childhood is a key phase for building the foundations of learning, language, physical health, mental health, and socio-emotional development (ChCC, 2015). Reproducing psy/neuro knowledge, ChCC's practitioners have tended to distinguish between women who were (not) "good mothers" and those who (do not) "promote attachment". From this, they placed different concerns on the table related to the paths that migrant children's development takes and the consequences and "risks" (Hacking, 1990; Rose, 2007) of the "lack of parenting skills" in adulthood. Moreover, these concerns also focused on what some practitioners occasionally called "potential social issues" such as "drug addictions" and "youth delinquency". Hence, ChCC's practitioners promoted representations of the "normal" and "abnormal" development, configuring moral ideals related to the future of children (Béhague and Lézé, 2015)

This chapter contributes to contemporary debates in anthropology and STS studies. Particularly, it shows how, in the context of the ChCC programme, the transmission of the attachment theory[31] as "authoritative knowledge" (Jordan, 1993

[31] See Bowlby and WHO, 1952 [1951].

[1978]) has delineated what some researchers have called the “neuroscience of poverty” (Farah, 2018; Farah, Noble, and Hurt 2006). In other words, the ChCC programme constructs the field through which it is possible to address the mutual relationships between socio-economic status and neuroplasticity. Specifically, the interventions of the programme focused on the epigenetic relationships between brain structure (e.g. neural activity, cortical volume, among other), brain functions (e.g. cognitive, emotional, among others) and environment (socioeconomic status, pollution, migration, stress, among others). Following Edwards and colleagues (2015), I highlight that promises of this kind of childhood policies are a “cruel optimism” that cloak social and gender inequalities, placing the responsibility of gestation and childrearing on mothers.

Chapter V analyses the mutual relationships between the Haitian community and evangelical churches in the borough, paying particular attention to church interests and religious experiences (Webb, 2017). I highlight what Didier Fassin (2009a) calls “moral economies”, which he defines as the production, transaction, and circulation of emotions, values, and norms in the evangelical churches. Through this concept, I distance myself from reducing the moral dimension to an understanding related to a particular set of categories, codes, and principles (“moral code”), or how the subjects assume these moral prescriptions (“moral behaviour”) (Das, 2012; Fassin, 2012; Lambek, 2010; Zigon, 2008). As some contributions in the field of anthropology of religion have shown (Asad, 1994; Mahmood, 2012), I approach the moral dimension from a Foucauldian perspective (1990 [1984]). Thus, I seek to revitalise practices that shape an “ethical subject” (Faubion, 2011; Fassin, 2012; Laidlaw, 2014). From this angle, I will focus on how a set of beliefs, practices, norms, and values shape Haitians’ religious experiences.

This chapter sheds light on current debates on the anthropology of migration and religion, as well as on psychological anthropology and GMH. It shows how, in the evangelical churches, migrants find relief for malaise and suffering associated with the migratory processes. The church has become an “ethnic church” (Ambrosini,

2008; Hirschman, 2004), in as much as it has established a specific identity and ethnic-national continuity with Haiti during the migration process. This chapter also illustrates how Haitians' religious experiences question Western conceptions of mind (Luhrmann, 2012, 2017a; 2017b; 2020a; 2020b) promoted by psy/neuro disciplines. Thus, the ethnographic material interrogates the scope of psy/neuro technologies while highlighting migrant and community potentialities.

Finally, in the conclusions section, I summarise the main research findings, highlighting the conceptual and clinical contributions of the thesis. Likewise, I raise some new questions for future studies in medical anthropology, global health and social medicine.

Chapter I:

Neoliberal multiculturalism, culture and intersectionality: The new intercultural field in the healthcare system in Chile.

In the lobby of the Family Healthcare Centre (CESFAM), health practitioners talked about a mental health and migration conference that was to be held at the psychiatric hospital. Yolanda, the Migrant Programme's coordinator, and Miriam, a social worker of the same programme, commented enthusiastically to some practitioners that Haitian experts would also participate in this event. For her, it was not only one of many initiatives that began to emerge in the borough and the northern healthcare network of Santiago around intercultural health matters, but also a chance to sensitise physicians and psychiatrists in what she called “social issues”. From her perspective, “biomedical area’s practitioners” in primary healthcare did not usually engage in actions promoted by the health plan that were related to “psychosocial” and “community” issues. Yolanda often said that some practitioners considered doctors to be “gods” (“dios-tores”) instead of “doctors” (“doctores”), light-heartedly revealing a certain form of stratification inside the health centre.

Yolanda, Miriam and I walked for about 30 minutes to the psychiatric hospital. The conference started at 11 am so we had to hurry because we had left the centre a little late. Additionally, while we were walking, Yolanda and Miriam sometimes met some of the centre's users who stopped to greet them, ask them questions, or tell them something related to their health or psychosocial condition. During the journey, Yolanda, who had worked since 2013 on migrant health issues in the borough, said that the conference was a “milestone” and an “opportunity” for intercultural work in the northern area. She stressed that intercultural health had gradually become a central issue due to the high number of Peruvian migrants who began arriving in the borough in the 1990s, as well as Dominican and Haitian migrants since 2000. They agreed that the arrival of migrants to the borough’s centres had brought with it a series of challenges for practitioners related to “language” and “cultural barriers”,

especially in mental health, and sexual and reproductive health[32]. Upon arriving at the hospital, we met a large group of people trying to enter the auditorium. For the most part, these were psychiatrists, psychologists and psychiatry students whose clean bright uniforms turned the auditorium into a sea of white. In total, there were around one hundred attendees.

The event gradually took on a ceremonial form and rhythm. The hospital director, who delivered the event's opening words, appreciated the experts' efforts to "show better how to intervene clinically in migrants' health" and "to show realities that were very different from that of Chileans' usual experience". Later, the event's coordinator invited the three experts to sit at a table placed on the stage. They were a Haitian physician, a Haitian psychologist, as well as a Chilean sociologist. The latter, who was the first to speak, focused her presentation on "racism" and the "different forms of racialisation" that operated in Chile with migrant communities, especially with afro-descendants. She emphasised that black communities were "subordinated in terms of class, race and gender".

The Haitian experts began their presentations after the Chilean sociologist's talk, generating more interest from the attendees. With the support of PowerPoint slides displaying information and photographs, the practitioners explained how mental health in Haiti is deeply related to Haitian-Creole medicine and religions, specifically Vodou. Particularly, they focused on how Vodou "plays a central role in the worldview" that shapes Haitian daily lives emphasising that "Vodou is not only a religion but also a health system"[33]. The experts explained how notions of personhood, causes, symptoms, experience, and classification of mental illness differed from Western psychiatry understandings. Somehow, the experts' talks seduced participants through the presentation of a black, unknown, exotic and

[32] I will describe and analyse in depth these health issues in the following chapters.
[33] I also address this in chapters nº3 and nº4.

attractive madness, which had to be controlled and managed through the acquisition of knowledge related to “Haitian culture” and “cultural competency”.

Some attendees seemed sceptical of the Haitian experts’ suggestions. For example, psychiatrists questioned the distinction between what experts called “normal trances” and “psychotic episodes” in the Haitian population. Although practitioners recognised that some “psychotic episodes in Haitians” went into remission without pharmacological treatments after three or four days, they pointed out that “doctors must carry out” treatments indicated in the protocols because they were in the public healthcare system. A psychiatrist at the event said: “I can't wait to see if the patient is having a trance or not. For me, if it is schizophrenia, I have to do what the clinical guidelines say. If I don't, the hospital’s director can sue me for neglecting my duty”. Quickly, another psychiatrist replied: “We can do what the protocol says, but we can do more harm to a migrant patient. And that could be considered a form of xenophobia or racism”. This kind of debate gradually revealed how practitioners occupied reflexive positions regarding the interactions between biomedicine and other forms of knowledge and practices related to mental afflictions.

The emergence of a new intercultural health field began to take shape in the borough from 2013. As Yolanda and Miriam discussed in several Migrant Programme meetings, their intention was to promote intercultural practices oriented to, in Yolanda’s words, the “encounter of different cultures from a rights perspective in health”. Through the progressive increase of training sessions on migration and intercultural health, health programme coordinators and practitioners began to place the “culture” category at the centre of their conceptions of migrant patients’ health issues. For this, experts promoted “a cultural approach” that would allow a better understanding of “meanings”, “representations” and “experiences” of migrants’ health/illness trajectories. Nevertheless, the introduction of multicultural approaches generated a series of tensions, conflicts and challenges with Chilean public healthcare traditions that have been based primarily on structural factors, such socioeconomic and gender inequalities.

In this chapter, I will explore how historical, political, economic, sociocultural, and material aspects have shaped an intercultural health field (Fassin, 2000)[34] framed in what some researchers have called "neoliberal multiculturalism" in Chile. This form of multiculturalism is defined as a form of governance that prioritises cultural recognition ethnic/racial aspects of certain groups over the redistribution of resources and political power among different groups of the population (Hale, 2002, 2006; Horton, 2006; Postero, 2004, 2007; Laurie, Andolina and Radcliffe, 2003, Richards, 2016). I will pay special attention to how this emerging intercultural field interacts with mental health knowledge and practices in the borough's primary healthcare system.

Mental health became relevant in this research for both empirical and conceptual reasons. On one hand, the Municipal Health Department and clinical teams have positioned mental health as one of the challenges due to, in Yolanda's words, "the increase in mental disorder rates in migrants in the borough". On the other, discussion among practitioners could be framed in broader conceptual debates on biomedicine and cultural approaches in health, as well as on global mental health (GMH) (Béhague and MacLeish, 2020; Lovell, Read, and Lang, 2019; White, Jain, Orr, et al., 2017). These debates have highlighted the tensions between cultural distinctions and universal commonalities (Estroff, 1985; Hinton and Good, 2009; Jenkins and Barret, 2004; Kleinman, 1991; Kleinman and Good, 1986)[35], as well as the inequalities in terms of access and treatment in which ethnic/racial aspects operate (Good, Willen, Hannah et al., 2003; Metzl, 2010). In this direction, the new migratory context of the borough revived these tensions within the healthcare centres.

[34] By "intercultural health", I mean a field of diversity management that allows the legitimation of new practices and health agents (Fassin, 2000); however, this legitimation is not without unequal transaction between epistemologies through which dominant Eurocentric thought styles, such as biomedicine subordinate other forms of so-called "traditional" health knowledge and practices (Santos, 2016; Claros and Viaña, 2009).

[35] See also Good (1993), Good and Hanna (2015), Luhrmann (2001), Mezzich, Kleinman, Fabrega, et al., (1996).

I will argue that although the policies of the Municipal Health Department have promoted a "cultural turn" to meet migrants' health needs, health practitioners have integrated this turn into a health approach in which the categories of class and gender play a key role. The introduction of multicultural knowledge, practices and values in the borough during the recent years shaped a new "field of meaning" (Lacan, 1966 [1953]), that is, a field where subjects are imbued with meaningful content around multicultural matters (Bhabha, 1998)[36]. However, the dynamic interactions of this cultural turn with other relevant categories such as class and gender have re-organised that field of meaning. The centrality of class and gender within practitioners' approaches is based on the reform movements of the mid-20th century, the implementation of a Model of Comprehensive Care in Family and Community Health, the strengthening of gender policies in public health, and the recent adoption of multicultural policies focused mainly on poverty ("class"), rather than on ethnic aspects. I will emphasise that such re-organisation has led practitioners to de-essentialise the culture category itself, as well as reshape intersectional understandings around migrant communities' health issues. By intersectional understandings, I mean the ability of practitioners to develop a specific analytical sensitivity that has allowed them, through the intersection between culture-ethnicity-race/class/gender (Collins, 2019; Crenshaw, 1989), "to think about the problem of inequality and difference and their relationship with power" (Cho, Crenshaw and McCall, 2013: 795).

This chapter will shed light on relevant contemporary decolonial debates in anthropology, global health and social medicine from a Latin American perspective (Briehl, 2003; Claros and Viaña, 2009; Gamlin, Gibbon, Sesia, et al., 2020; Santos, 2016). It will focus on the "refusal" of knowledge and models, particularly, of the

[36] The multicultural matter, following the Lacanian reading carried out by Homi Bhabha (1994), began to operate as a "floating signifier" within the borough. That means, a signifier that links and binds dispersed signifiers, shaping a specific field of meaning (Lacan, 1966 [1957]). From this, multicultural matters "become a floating signifier whose enigma lies less in itself than in the discursive uses of it" (Bhabha, 1998: 31).

cultural competency model. By "refusal", I mean the generative action that can be part of the political/decolonial action of refusing, or at least limiting, specific structures and systems (McGranaham, 2016; Simpson, 2007). The potential of refusal lies on its capacity to create new and more equitable relationships between subjects (Benjamin, 2016). Thus, my ethnographic material questions how the adoption, resistance and refusal of the cultural competency model influences the ways through which health practitioners grasp and shape "the social" (Adams, Béhague, Caduff, et al., 2019; Yates-Doerr, 2020). In so doing it facilitates the interrogation of conceptual and empirical foundations of concepts such as "culture" and "structure", as well as ways of "knowing" certain health issues. In line with this, this chapter also sheds light on how intersectionality, as an "analytical sensitivity" tool, is conditioned by practitioners' previous socialisation of categories such as culture-ethnicity-race, class, gender, and others, as well as public healthcare systems' traditions, and historical and macrosocial processes in local contexts.

The chapter is the result of multiple observations and interviews conducted in contexts, such as the CESFAM, specialised mental health centres and the borough Department of Health, as well as the Migrant Group ("Mesa Migrante")[37] of the Northern Metropolitan Health Service. I also carried out a series of interviews with policymakers, programme coordinators and practitioners at the CESFAM. In the same way, I collected some documents and artefacts related to the policies and actions implemented. From this, and to illustrate my arguments, I will focus on Migrant Programme activities in the borough and the CESFAM. Specifically, on the actions carried out by Yolanda and Miriam that shaped an intercultural health field in healthcare centres.

The chapter is divided into four sections. First, I will show how the implementation of intercultural health policies is recent in Chile. Framed in the mentioned "neoliberal multiculturalism", these policies operate primarily through the

[37] The "Mesa Migrante" was composed by health practitioners who worked on the Migrant Programme in different boroughs of north Santiago.

promotion of recognition and the non-discrimination of indigenous and migrant communities. Later, I will describe how an intercultural health field has taken shape in the borough during recent years. To explore this, I will examine the process by which local institutions and actors have promoted a series of initiatives around intercultural health that have led to the formulation of a central policy on migrant health. Within this context, I will describe how the first initiatives were aimed at improving the access of migrant communities to healthcare centres, as well as addressing racism in the CESFAM. Third, I will show how the Migrant Programme carried out a series of local initiatives aimed at improving intercultural encounters in clinical spaces. The introduction of multicultural knowledge, practices and values made the "culture" category central in understandings of migrant communities' health issues. Finally, I will describe how criticism of the cultural competency model, carried out by local actors, marked a turn in the Migrant Programme strategies, reconfiguring intersectional understandings in teams. I will highlight how this criticism is similar to the contemporary debate in the US regarding the cultural competency model and the structural competency model (Kirmayer, 2012a, 2012b; Metzl and Roberts, 2014; Metzl and Hansen, 2014, 2018; Metzl, Petty and Olowojoba, 2017).

Intercultural health in Chile: A recent history

Training sessions, such as the one held in the psychiatric hospital, became more frequent in the Northern boroughs of Santiago. Yolanda and Miriam considered these training actions as "local responses" or "local reactions" to the increase in the migratory flow in the borough[38]. By facing new meanings, representations and experiences of health/illness of afro-descendant migrants, health centres' coordinators and practitioners started to interrogate their knowledge and practices. Significantly, these questions circulated primarily around issues such as mental

[38] This increase even reached rates higher than countries belonging to the OECD characterised by receiving migratory flows (Thayer, 2019).

health, sexual and reproductive health, as well as motherhood in different communities. As I will show in depth in the next chapters, these issues became central challenges, not only for primary healthcare practitioners, but also for the entire system.

Yolanda and Miriam, who had experience working in other Latin American and European countries, frequently said that the country "was in diapers" ("estaba en pañales") on intercultural health issues. Using this metaphor, they compared the first actions in intercultural health that were taken with a baby, emphasising how most practitioners had no work experience in intercultural health. In part, this was because, compared to other areas of the country, the borough did not have a large number of people belonging to indigenous communities. More critically, Yolanda argued that, although the first actions in intercultural health started at the beginning of the 1990s with indigenous people, they had not had a significant impact on how practitioners understood intercultural problems. Yolanda said: "The Ministry of Health and the Indigenous Peoples' Programme have done some things (…) for example, the informational signs are in Mapudungun[39]. But if you ask most practitioners about the Mapuche worldview, they don't know anything about it. The intercultural issue has only been raised in practitioners' minds because now migrants have arrived in the borough".

The emergence of an intercultural health field is recent in Chile. This field has primarily been the fruit of a series of social and health policies carried out by the Chilean state and international organisations during the last three decades (Alarcón, Astudillo, Barrios et al., 2004; Alarcón, Vidal, Neira, 2003)[40]. However, despite the so-called "new migration" that began to arrive in Chile after the end of the civil-military dictatorship (1973-1989), these intercultural policies focused exclusively on indigenous communities through the implementation of different intercultural

[39] Mapuche language.

[40] However, some experts have highlighted specific initiatives in indigenous people health during the 1970s (Citarella, 2018).

programmes[41]. These policies have revealed the deployment of an intercultural model composed of three central aspects (Piñones Rivera, Mansilla Agüero, Arancibia Campos, 2017). Firstly, the model has sought "cultural pertinence"[42]. This concept refers to the adequacy of health actions for the specificity of both patients and their communities. Specifically, cultural pertinence has usually taken shape through training for practitioners on topics related to the patients' forms of life. Secondly, the model has highlighted "recognition"[43] as to how politics admits diversity. Lastly, it has

[41] For example, launched in 1992, the "Mapuche Programme" aimed at improving the quality of care for the indigenous population through practitioners' training and research development on the topic. It promoted "intercultural facilitators". However, they were mainly relegated to administrative and translation functions within the health centres (Trangolaf and Obando, 2006). Another example is the "Special Programme for Health and Indigenous Peoples" (PESPI) (2000), which was vital to the subsequent "Health and Indigenous Peoples Policy" of 2006. The programme aims were "to contribute to the reduction of inequality gaps, in the health situation of indigenous peoples, through the participatory construction of health plans that recognise cultural diversity, promote complementarity between medical systems and provide services of adequate health that respond to specific epidemiological needs, rights and profiles" (MINSAL, 2017a:11). Finally, the most important was the Origins Programme. The programme aimed at contributing to the development and improvement of the quality of life for the Mapuche, Aymara, and Atacameño people. The programme began its activities in 2003 with the formation of a Community Advisory Board ("Mesa Comunitaria"), which brought together different representatives of Atacameñas indigenous organisations and communities. This instance was the first to convene social actors and leaders interested in making the indigenous health system visible. The Origins Programme supported the carrying on of "ancestral and intercultural health meetings" where the so-called "demands for recognition of indigenous medicine" were systematised. The Origins Programme resumed its activities to support the "design of pilot experiences of intercultural health care and management in the first and second regions of Chile". This programme was partially funded through an $80 million loan from the Inter-American Development Bank. The primary executor during the first phase of Origins (2001-2005) was the MIDEPLAN (Ministry of Developing and Planning). From 2007, and at the beginning of the second phase, the programme was administratively incorporated into the National Corporation for Indigenous Development (CONADI), a public service created by the Indigenous Law 19.253 (1993).

[42] On cultural pertinence: "Interculturality in health entails the following elements: - comprehensiveness in the concept of health-disease. [...] - Holistic view. - The offer of regular, equitable and culturally relevant service. - Qualified health practitioners who are sensitive to the health needs of the population. The training systematically addresses local diversity and health issues. - Collaboration between official and indigenous medical systems" (MINSAL, 2013: 21).

[43] On recognition: "The State of Chile, following current legal norms and international treaties promulgated as the law of the Republic, is under the duty to respect, recognise and protect the indigenous peoples' health system. [...] Support processes aimed at the recognition, safeguarding, strengthening and complementarity of the cultural health systems of indigenous peoples" (MINSAL, 2013: 4).

pointed to "complementarity"[44], that is, the requirement to work collaboratively with indigenous healers.

However, these intercultural health policies have not paid enough attention to issues related to the power relationships involved (Piñones Rivera, Mansilla Agüero, Arancibia Campos, 2017; Boccara, 2007). Although aspects, such as cultural pertinence and recognition, are subject to a certain "voluntarism" of practitioners, complementarity reveals a structural aspect of intercultural health policies and strategies. That is, complementarity denies power asymmetry[45] (Boccara, 2007). By denying power asymmetry, the state would be unaware of its tendency to promote the biomedical approach, which takes shape through a bureaucratic governmental rationality focused on the health/illness/care process[46]. From this, Boccara (2007) describes the Chilean process through the concept of "ethnogovernmentality". By this, Boccara means a power relationship field that allows the management of Otherness in ethnic terms, promoting the decontextualisation of socio-cultural and historical aspects involved, as well as the depoliticisation of the indigenous subject. Within this framework, health policies and strategies would reinforce and reproduce ethnic/racial and class inequalities. As several researchers have revealed in Chile (Boccara, 2007; Boccara; Bolados, 2008; Piñones Rivera, Mansilla Agüero, Arancibia Campos, 2017), rather than a space of horizontality, intercultural health is a field of production and reproduction of relationships of power prone to the generation of subalternisation processes.

According to some scholars (Boccara, 2007; Boccara and Bolados, 2010; Bolados, 2008, Richards, 2016), intercultural policies in Chile have adopted the form

[44] On complementarity: "Inclusive, open health system that recognises, respects and applies health conceptions and practices of other cultures [...] - Collaboration between official and indigenous medical systems" (MINSAL, 2006: 21).

[45] According to the Ministry of Health (MINSAL) (2006: 21) "Interculturality will be understood as an interactive social process of recognition, respect, horizontality and collaboration between two or more cultures, in a given space. Interculturality then means the promotion of relationships of trust, mutual recognition, effective communication, cooperation and coexistence; and right to difference".

[46] A process with similar characteristics has been described by Eduardo Menéndez (2016) regarding the failure of intercultural health policies in various Latin American countries.

of the mentioned “neoliberal multiculturalism”. In the 1970s and 80s, Latin American countries committed to the recognition of indigenous rights, highlighting the diversity of ethnic components. However, after the end of the civil-military dictatorship in the 1990s, the Chilean multicultural approach situated indigenous people’s demands largely as a problem of poverty rather than one of ethnicity (Boccara, 2007; Boccara and Bolados, 2010; Richards, 2016). The policies addressed the health problems of the indigenous population from a perspective in which the category “class” prevailed over that of “culture/ethnicity”. Neoliberal multiculturalism pushed demands related to redistribution, territorial autonomy and self-management into the background (Richards, 2016). According to Bolados García (2012), as Chile was one of the first countries in the region to adopt neoliberalism, rather than a limited version of multiculturalism, the Chilean version of neoliberalism could be extended to other commonly ignored sociocultural fields. In fact, the author suggests naming this field of governance in Chile “multicultural neoliberalism”. Hence, neoliberal multiculturalism is a reduced version of multiculturalism, characterised by the promotion of rights and forms of cultural citizenship that, in turn, restricts and subordinates those rights that could be in conflict with economic and/or political interests (Hale, 2002).

Therefore, multicultural policies with indigenous populations in Chile seem to be closer to the forms that the debate has taken in the US rather than in Europe. In the US, multicultural policies have tended to promote mechanisms of “affirmative action” or “positive discrimination” leading to the “empowerment” of the ethnic/racial minorities (Giroux, 1994; McLaren, 1997). In Europe, on the other hand, multicultural policies do not seem to have followed the path of strengthening the identity aspects of the different groups, but rather have revealed the complexity of the new challenges that interaction between different groups has brought about (Verlot, 2001; Aguado Odina, 2003). Within this framework, multicultural policies in Europe do not focus so much on “identity” or “difference”, but rather on the “interaction” and the “hybrid” forms assumed by multicultural societies (Guilherme

and Dietz, 2015). As in the US, the multicultural policies promoted in post-dictatorial Chile have fostered difference and the empowerment of communities. Concepts such as "empowerment", "capacity building", "social capital" and "responsibility" of communities have become central to the neo-indigenous policies and strategies of present-day Chile (Boccara and Bolados, 2010; García Peter, 2016).

Recent intercultural health policies with the migrant population have generally followed the same direction as those with the indigenous people. Through its National Health Strategy 2010-2020[47], the Ministry of Health promoted the design and implementation of a "Migrant Health Policy". During Michelle Bachelet's presidential term (2014-2018), this policy fostered a participatory process that included different social actors and institutions. Likewise, as I will show in the following pages, the policy promoted the implementation of pilot programmes in primary care centres throughout Chile during 2015 and 2016. The experience accumulated in these pilots contributed to the Ministry of Health promulgating the "International Migrant Health Policy" in 2018. After the pilot's implementation, some boroughs across the country implemented the Migrant Programme[48].

[47] In 2008, a "Working Group on Immigrant and Refugee Health of the Ministry of Health" (SIR-MINSAL) (MINSAL, 2008) was created to technically advise the Ministry of Health decision on immigrants and refugees, including children. That same year the "Presidential Instruction on Migration Policy" was published to present to the public the different organs of the State related to immigration matters (Presidency of the Republic, 2008). This guideline sought to report on the various migration process dimensions, as well as on some government action axes on integration and non-discrimination. Based on these guidelines, the migrant population in Chile can: a) enrol in the health system, b) access medical controls, c) receive emergency care, d) access campaigns or preventive measures, e) receive medications and supplements, and f) be integrated into the "Plan Auge" in case of any illness included in the Explicit Health Guarantees (MINSAL, 2016)

[48] This occurred in 2017 just as Sebastián Piñera's right-wing government (2018-2022) reduced funds for this type of health initiatives. It should be noted that this second government of Sebastián Piñera did not sign the United Nations Migration Pact in 2018. This pact considers migration as a human right and establishes various guidelines to guarantee the fundamental rights of migrants, in particular, the rights to health, education and housing.

The "multicultural borough" and the first initiatives against racism

The municipality began incorporating some intercultural health local guidelines for work with indigenous[49] and migrant communities. In 2013, a politician belonging to a left-wing party took office after winning the municipal elections. Through what he called a "Citizen and Participatory Local Government Program", the new local administration left behind eight years of what it called "subsidiarity" practices ("prácticas asistencialistas") promoted by a conservative right-wing municipal government. From that moment, the new mayor's office defined the borough as a "multicultural borough". With this signifier, the mayor's office emphasised the need to promote local community participation policies that recognised both indigenous and migrant communities[50] of origin living in the borough. Particularly, these policies translated into strategic actions oriented to promote a rights' perspective and non-discrimination practices.

Particularly, the borough's Department of Health began to carry out a series of initiatives in migrant health, leading to the production and reproduction of multicultural knowledge, practices and values at the communal level. One of the first actions Yolanda carried out was the promotion of migrant communities' access to healthcare centres. According to the Health Department records, migrant communities, such as Dominicans and Haitians, had lower access levels to the borough's healthcare centres. Following this, Yolanda organised several meetings with health programmes coordinators and neighbours to coordinate the first actions.

[49] "Indigenous Peoples Programme" was inaugurated in March 2013. The programme aims are: "Promote the recognition and participation of indigenous peoples in the borough", "Encourage spaces for dialogue and intercultural dissemination", "Promote the participation and activities of organizations indigenous", and "Disseminate the public offer available to indigenous peoples". At first, the Programme called the so-called "Intercultural Table of Native Peoples" of the borough. In this line, an attempt was made to make ILO Convention 169 binding. One of the lines of work of the programme is the "Intercultural Health Line", from which the financing for the care of "machi" (traditional Mapuche healer), as well as dissemination activities are managed.

[50] In the middle of the 20th century, the borough received Palestinian, Chinese and South Korean communities, but these had never been integrated into intercultural policies.

However, Yolanda had to deal with several frictions and conflicts that began to emerge with practitioners and borough neighbours. In part, these points of disagreement occurred because the Health Department authorised that all migrants could only receive healthcare centres' attention by presenting their passport[51]. In an interview, Yolanda reported:

> When I got to work here there was no Migrant Programme (…) at that time, the main problem was how to deal with the arrival of the migrant population and how to guarantee healthcare centres access (…). We did surveys to migrants; we wanted to know the experience of people in healthcare centres (...). And we found much racism. Some practitioners said that migrants would collapse healthcare centres since human resources were lacking (...). Or, for example, in communities, racism from Chileans to migrants or even among migrant communities (...). At that time, we were very concerned about various social organisations. For example, neighbourhood units in which social leaders had a xenophobic attitude towards migrants. So, migrants could not participate in those spaces, and, as we carried out some educational interventions there, they did not receive information from the healthcare centres.

Although several studies have shown the reproduction of discrimination and racist dynamics by health practitioners against the migrant population in healthcare centres in Chile (Cabieses, Bernales and Mclntyre, 2017; Liberona, 2012; 2015a; Liberona and Mansilla, 2017), these dynamics did not seem to be explicit at the CESFAM. Indeed, Yolanda knew about these situations through the stories of migrants from different communities. She suggested that explicit racist dynamics commonly occurred in the "private" context of clinical care. In the same interview, Yolanda reported:

> When we started, we were very concerned about racism; how to improve the practitioners' care to patients. Some migrant patients also made some complaints against CESFAM due to practitioners' racist behaviours. So we carried out training sessions of users' care (...). For example, some doctors said that Haitians had rare or psychotics beliefs (…) Haitians patients have trances and some of them say that they see visions or speak with ancestors (...).

[51] This was an antecedent for what would later be known as Decree No. 67 at the national level. This Decree was published in March 2016. This establishes the circumstance and mechanism to accredit people without resources as a beneficiary of the National Health Fund (FONASA) public insurance, adding the circumstance of immigrants without resources, without documents or without residence permits, this protects the population in the most vulnerable situation, on the same condition as nationals.

> Midwives told Haitian women that they were bad mothers, doctors told migrants that they had to take a shower before coming to the office because they smelled bad (...) psychologists who said that Dominican migrants overreacted or dramatised their conflicts (...). Some practitioners said migrants that if they do not conform with Chilean norms, they had to leave the country.

In contrast, racist tendencies were evident but in a more covert way in the CESFAM's "public" spaces. In clinical meetings, at lunch times, and in self-care spaces, practitioners reproduced discourses that revealed discriminating attitudes based on national, racial, class and gender categories. Often this occurred through the telling of jokes that tended to mask more racist attitudes, but which allowed practitioners to "mediate"[52] (Pollock, 2012) their relationship with migrant-Otherness. In other words, and following Freud's contribution to this field in his paper "Jokes and their relation to the unconscious" (Freud, 1976 [1905]), as well as other psychoanalytically inspired works (Oring, 1984; Davis, 1995), jokes made representations circulate that helped practitioners soothe the angst associated with migrant-Otherness.

Jokes served to subtly demarcate a series of positions and power relations that regulated exchanges between practitioners and afro-descendant migrants[53]. Through jokes, practitioners reproduced a form of stratification that placed the afro-descendant migrant population in a subordinated position[54]. For the most part, these jokes were based on characteristics attributed to the blackness associated with disease, dirt, laziness, and sexual desire. In the previously mentioned "public" spaces of the centre, some practitioners commented to each other: "I do well with immigrants… as long as they don't bring HIV and tuberculosis (laughter)", "these

[52] In her book "Medicating Race. Heart disease and durable preoccupations with difference", Anne Pollock (2012) highlights how medicine is a field that "mediates" race. She argues: "Medical experts, disease categories, and pharmaceuticals all participate in medicating and mediating race" (Pollock, 2012: 3). Similarly, CESFAM's practitioners played a dual role as agents of racialisation and providers of care.

[53] Donna Goldstein (2003) described similar dynamics in her ethnography with women in impoverished sectors in Rio de Janeiro, Brazil.

[54] I will develop in depth this argument in the following chapter.

Haitians arrive in Chile and reproduce like rabbits (laughter)", "Some Haitians are slow, as slow-minded, slower than a bolero (laughter) ("más lento que un bolero")".

These jokes were linked to representations of nation and class that were rooted in the colonial and republican history of Chile. As in other Latin American countries, racial discourses in Chile are expressed through representations of the nation (Wade, 2010). Despite the fact that Latin American states have promoted multicultural policies with black and indigenous populations in the last thirty years, racial discourses are less prevailing than in countries such as the United States where standardised racial categories circulate in debates (Wade, García Deister; Kent, et al. 2014). Within this context and paraphrasing Peter Wade and colleagues (2014), in Latin America race expresses itself as an "absent presence". In other words, race is neglected and denied, but at the same time, it is present, for example through jokes, in the different domains of daily life where representations of the nation are at stake (Wade, García Deister; Kent, et al. 2014).

However, this absent presence of race is strongly ingrained, not only with representations of the nation, but also with representations of class in Chile. As I will show in the following chapters, this is due in part to what Lepe-Carrión (2017) has called "the racialisation of the lower classes" during the process of independence and the Chilean nation-state formation at the beginning of the 19th century. That is, the transformation of an ethnic indicator into a class differentiator, through which the mestizo population was subordinated to the ruling aristocracy. As such, whiteness was linked to social stratification: on one hand, the upper classes; working, European, white and civilised; while on the other, the base classes; lazy, South American, black/mestizo/indigenous, and barbarian. According to different researchers (Lepe-Carrión, 2017; Richards, 2016; Tijoux and Palominos, 2015), from the very beginning of the Chilean state-nation, policies, strategies and interventions have been deployed to subordinate indigenous and black people.

Yolanda also revealed during an interview that some Chilean people and migrant communities reproduced racist dynamics towards afro-descendant people in various borough's spaces. Beyond healthcare centres, discrimination and racism emerged in schools, neighbourhoods' units and Local Development Councils[55]. In these places, Yolanda highlighted how some "borough's neighbours" ("vecinos de la comuna") conceived of migration as a "threat" that could put at risk the population's health by transmitting diseases such as HIV and tuberculosis. Besides, she stressed that some people considered migrants as a "threat" due to the fact that they were in a position to dispute the benefits that the Chilean community received in healthcare centres. By doing this the "borough's neighbours" provided a plausible explanation[56] that allowed them to deny the health system's precariousness that Chileans had faced over the last four decades[57]. Yolanda also emphasised how migrant communities that have lived longer in the borough excluded afro-descendant migrants because they were not considered "neighbours". For example, she said: "there are Peruvians who have lived here for more than twenty years, and they say, 'we are neighbours, Haitians

[55] The Local Health Development Councils (CDL) are meeting places where health teams, users and community contribute to the improvement of the population's health and quality of life. This instance allows users to participate and comment on relevant issues both for the Health Service and the community. They are also called the Local Health Committee, the Advisory Council or the Users Council.

[56] This social mechanism could be understood from the concept of "scapegoat" (Appudarai, 2007; Girard, 1982). In the second chapter, I will analyse this in depth from the "internal enemy" strategy developed in countries such as the US, the UK, Brazil and Chile.

[57] The civic-military dictatorship (1973-1989) commanded by Augusto Pinochet was characterised by the strong repression exerted by the defence and state security organisations, the weakening of public social protection organizations, as well as the implementation of a neoliberal model inspired by the Chicago School (Paley, 2001; Taylor, 2006). In this framework, the State promoted the public health system's privatisation, creating a mixed system characterised by great disparities between public and private administration (Labra, 1995, 2000, 2002; Manuel, 2002; Molina Bustos, 2010), as well as by the segregation based on criteria such as risk or income (Vergara-Iturriaga and Martínez-Gutiérrez, 2006). Before the dictatorship, the National Health Service (SNS), founded in 1952, had a solidarity financing model whose funds came from the State, employers, and workers. However, in 1979, the State created the National Health Fund (FONASA), to provide health coverage both to indigent people and to workers and their children ("burdens"). FONASA is financed, to this day, through the payment of 7% of workers' wages, as well as resources collected through general taxes. However, the most significant reform carried out by the dictatorship was the establishment, in 1981, of the Social Security Institutions (ISAPRES). ISAPRES are private for-profit institutions that administer 7% of workers' contributions. These institutions offer various health coverage plans depending on the income and risk level of each person (e.g., pre-existence, age, sex). In this way, the privatization process of the health system during the dictatorship led to the system being financed mainly by employees.

constantly change their residence`. They do not say 'we are Chileans', but they behaved as Chileans and claim for their rights".

Within this context, Yolanda prepared informative materials to improve the healthcare access and address racist actions against migrant communities. Through these materials, the Health Department released information on the public health system's benefits and rights. According to her, communities' healthcare access was a key aspect in addressing the adverse effects of the migration process promptly and thus improve migrants' mental health indicators. Rather than follow a central mental health strategy, Yolanda based her initiative on her previous experience of working in other countries. She said: "I knew because I worked in other countries and I have been also a migrant that mental health is a key aspect if we want people to come to the CESFAM". To emphasise this, she added:

> Haitian women work at their home, and they have little contact with other people. They do not learn Spanish, and they relate to other people through their husbands. One of our goals was to have contact with them. It is not just healthcare access; it also led these women to an empowered position and better mental health.

Although there is little evidence on the migratory process' effects on migrants' mental health in Chile (Alvarado, 2008; Cabieses, Bernales and Mclntyre, 2017; Rojas et al., 2011; Yáñez and Cárdenas, 2010). Yolanda paid attention to these local studies to support her interventions. These studies indicate mainly that migrants find racist, administrative and language/cultural barriers in access to health services in Chile.

Figure nº2: Informative material for migrant communities created during the first phase.
"In the borough we shake hands with the migrant community. Multicultural borough"

Furthermore, Yolanda also implemented a training plan for CESFAM practitioners. Experts on migration issues from universities, international organisations (e.g. International Organisation for Migration) and different Non-Governmental Organisations (NGOs) (e.g. Jesuit Migrant Service) gave such training sessions to physicians, psychologists, social workers, nurses, midwives and nutritionists. They mainly taught the characteristics of migration in Chile, certain international regulations assigned by the country, as well as the migrants' rights.

Intercultural facilitators, cultural competency and uses of the "culture" category

The implementation of a Migrant Health Programme pilot, promoted by the Ministry of Health in 2015, strengthened Yolanda's first actions in the borough[58]. The

[58] The pilot was implemented in the borough during the period 2015-2017.

initiatives were framed in what began to be called the "Migrant Programme". According to their technical guidelines[59], the pilot was a set of actions that sought to reduce barriers to accessing health care for the migrant population. It carried out participatory diagnoses, regional discussion panels, "citizen dialogues"[60], and working days with health officials. In the context of an interview, a Ministry of Health's official involved in the pilot implementation said:

> The borough had already done many things for promoting access. However, the pilots tried to promote the first step in migrant health, and the first step is accessing. Many boroughs did not carry out actions yet (…). At that time, we did not talk much about intercultural matters, but about access. It is an emphasis matter. If you see the "Effective Coverage Model"[61], the intercultural matter is included in the level of "acceptability", but at that moment we were concerned about the level of "accessibility". The challenge now is to enter the "acceptability", but so to speak we were still in the SOME[62] or in the OIRS[63], but we have to enter the clinical space.

As the technical guidelines stipulated, after assuming the pilot's coordination in the borough, Yolanda carried out the strengthening of previous actions. With part of the funds provided by the Ministry of Health, she prepared better quality informative materials for both practitioners and communities.

[59] Ordinary N°1942 of 06/06/2015. Ministry of Health, 2015, Technical Orientations of Immigrant Health Pilot.

[60] These are instances that help to promote meeting and conversation spaces regarding public policies, with social and institutional actors.

[61] According to the Effective Coverage Model, access is the proportion of the population receiving effective care. It is effective when the service delivered is appreciated as satisfactory as it achieves a specific result. Access dimensions: Availability, Accessibility, Acceptability, Service contact and Effective coverage.

[62] The "SOME" is the CESFAM service desk where users request information and book attention hours.

[63] The Office of Information, Complaints and Suggestions (OIRS) is an establishment present in all government offices in Chile. The OIRS is responsible for channelling citizens' contact with public institutions.

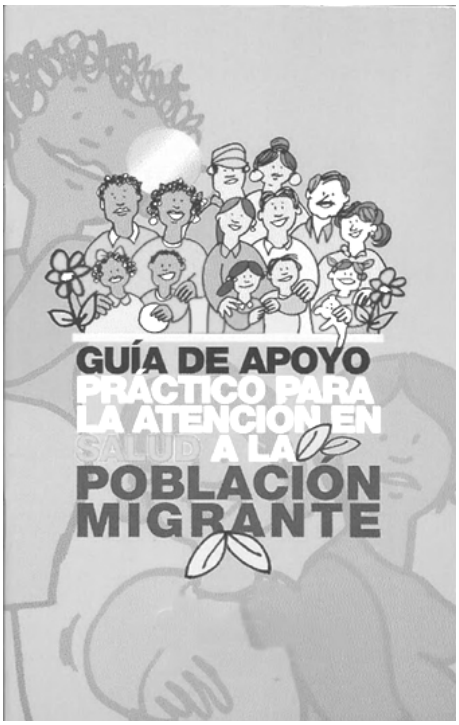

Figure nº3: Informative material created in the pilot phase
"Practical support guide for the migrant population care"

However, a large part of the pilot's funds provided by the Ministry of Health was allocated to the hiring of what Yolanda called "practitioners in the field". She hired Miriam, who began coordinating the programme at the CESFAM, as well as three Haitians who were hired as "intercultural facilitators". They joined the centres to help in what she called "intercultural encounters" and Spanish-Creole translation. "Practitioners in the field" played a central role in mediation between the CESFAM and migrant communities, especially those who did not have sufficient information on the functioning of the Chilean healthcare system. Yolanda pointed out hiring these practitioners allowed them to "improve communication" with communities and, along with this, the indicators of healthcare centre access.

Figure nº4: "Practitioners in the field" during a presentation with Haitian women.

Intercultural facilitators gradually began to gain notoriety at the CESFAM. Health practitioners started to understand symptoms and illnesses better from the facilitators' translations. However, in turn, they reported several problems. Practitioners said that facilitators did not arrive on time for clinical interventions, thus delaying clinical schedules. Additionally, they pointed out that the facilitators did not translate correctly, making some mistakes during interventions[64]. Some facilitators responded to these criticisms by arguing that, in Creole, there was no direct translation for certain technical words, so first, they had to translate from Spanish to French and then communicate the intervention to Haitian patients.

Nevertheless, Yolanda and Miriam had different opinions regarding practitioners' complaints. They argued that the low number of facilitators could not meet the growing demand of the Haitian population in the centres. In fact, facilitators

[64] Similar dynamics are described by Simeng Wang (2012) with Chinese population in Paris.

were often required by different practitioners at the same time during clinical hours, causing frictions between practitioners, facilitators and the Migrant Programme. Additionally, regarding the complaints that questioned the quality of the facilitators' work, Yolanda and Miriam tended to interpret them as a means through which practitioners could abdicate responsibility for interventions that had not been totally successful.

Although Yolanda and Miriam designed the intercultural facilitator position as an agent who could "mediate in intercultural encounters", several dynamics reduced the facilitators' work primarily to a translation role at the CESFAM. The multiple frictions between facilitators and practitioners, associated with the monotony of translation work, led the facilitators to express malaise and suffering regarding their working conditions. Yolanda pointed out:

> We were initially interested in facilitators doing more intercultural work. Something like they meet in the consultations. But the workload at the CESFAM, you know, the whole maelstrom, people running from one place to another, that burned them (...). For example, in the psychological consultations, between interventions and translation, the session lasted 15 minutes, and the psychologists had to continue with other patients, so there was no appropriate intercultural work. It was just translated (...). This not only happened here but also in other boroughs that hired facilitators (...) They experienced burn out as a result of the large amount of work they had and still have (...). Some no longer wanted to continue working, they said they suffered stress or that they were depressed by what some practitioners told them (…) A space had to be created in the northern area[65] so that they met at least once every two months and could talk about their practice, and the obstacles they face daily.

Despite the many challenges I have described, the work of the "practitioners in the field" did create conditions for some health teams to become more interested in intercultural issues. Teams tended to focus on culture, mental health and sexual and reproductive health. As I will examine in more depth in the following chapters, practitioners began to worry about their lack of knowledge of the impacts of migratory

[65] Yolanda was referring to a training and self-care space created by the Northern Metropolitan Service in 2018 for facilitators who worked in the northern area of Santiago. In its entirety, the Metropolitan Region is made up of six Health Services that administer the network of healthcare services.

processes on health and the ethnic aspects of migrant communities, as well as of the racialisation processes involved in health and illness trajectories. They were forced to reconceptualise issues such as diagnoses of the anxiety-depressive sphere, psychotic manifestations, as well as problems related to sexuality, sexually transmitted diseases, and maternity. With this in mind, Yolanda and Miriam began to prioritise what they called "cultural aspects in health". In an interview, Miriam noted:

> Teams began to wonder about things like why Dominicans or Haitians don't come to the psychologist when they have an appointment? For example, there were psychologists who said that psychology was not useful for Haitian cases that talked about witchcraft and curses, things like that (...) Or they also wondered why Haitian mothers are detached from their children and do not promote attachment? Things like that. (…) Then some practitioners began to ask and become interested in the he migrants' culture. They wanted to know more about people's way of being (...) so that meant that we had to focus on those issues in training.

Since 2017, the programme has carried out a series of training workshops to familiarise teams in what they called "migration as a social determinant of health"[66]. Within this framework, experts highlighted the institution and practitioners' need of adopting a "cultural competency model". The cultural competency model aims to create and improve the capacity of health practitioners and services to interact with patients' knowledge, values and practices (Kirmayer, 2012a; 2012b)[67]. The model foundations are that culture shapes the cause, course and outcome of illness, as well as forms of individual and family coping mechanisms, and recovery. Through this model, the intent was that health practitioners would acquire the skills needed to carry out appropriate and culturally significant interventions (Kirmayer and Swartz, 2014).

[66] The guiding principles of the municipal Health Plan were: Social determinants of health approach, the rights approach, mental health in all policies, and the model of comprehensive health care.

[67] In the US, cultural sensitivity became increasable institutionalised in the '90. In 2000, the Office of Minority Health released the CLAS standards, a list of 14 requirements and suggestions for "culturally and linguistically appropriate services" (Jenks, 2010: 207).

While multiple investigations both globally[68], as well as in Chile[69], have shown the relevance of adopting cultural competency in multicultural contexts, several studies have assumed a critical position regarding this model (Hunt, 2001; Jenks, 2010; Kleimann and Benson, 2006; Kumagai and Lypson, 2009; Tervalon and Murray-Garcia, 1998). These studies have shown that the cultural competency model tended to homogenise ethnic differences between migrant communities. Moreover, some authors have pointed out that there is little statistical evidence of the effectiveness of this model (Jenks, 2010). For its part, Comelles (2004) has argued that, while the cultural competency has questioned biomedicine by introducing "cultural" aspects in clinical interventions, at the same time, it has tended to reduce cultural differences to an ethnic taxonomy. He has also indicated that this approach does not question the health professional position as a subject within a specific "culture". That is, the "biomedical science culture" itself is not questioned. From this perspective, the migrant patient would be the only one who "would have a culture".

Cultural competency model criticisms are part of a broader critique of the culture category. This category, as an analytical concept, has begun to be questioned more frequently by both anthropologists, and health teams and institutions[70] (Good and Hanna, 2015; Smedley, Stith, and Nelson, 2002; Trouillot, 2003). It has allowed for understandings of how culture shapes health/illness representations, help-seeking behaviours, types of treatments, among others, as well as recognising the forms of discrimination and inequality re-produced in health. Nevertheless, its widespread use has alerted anthropologists to the category's low specificity and the risks of essentialisation of societies (Appudarai, 2007, Bhabha, 1994; Eagleton, 2000; Fassin,

[68] See Betancourt, Green, Carrillo, et al. (2016); Carpenter-Song, Schwallie, Longhofer, (2007); Cross, Bazron, Dennis, et al., (1989); Jeffreys, 2015; Mareno and Hart (2014); Osorio-Merchán and López (2008); Willen, Bullon, Good (2010).

[69] See Bernales, Cabieses, McIntyre, Chepo (2017); Cabieses, Bernales, McIntyre (2017); Jofré and Sepúlveda, (2017); Véliz-Rojas, Bianchetti-Saavedra, Silva-Fernández (2019).

[70] For example, see Office of the Surgeon General (US), Center for Mental Health Services (US), & National Institute of Mental Health (US). (2001). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Substance Abuse and Mental Health Services Administration (US).

2011a; Good et al., 2011; Kuper, 1999; Kirmayer, 2018; Rechtmann, 2011). Several studies have insisted that so-called "cultural communities", as in the case of migrant communities, are variable, situational, dynamic and inserted into power struggles and control over resources (Good and Hannah, 2015; Comelles, 2004). Thus, migrant communities tend to develop various processes of subjectivation and "hybrid" practices because they interact with numerous institutions and social actors (Bhabha, 1994)[71].

The "culture" circulation allows interrogating the specific uses of this category in the healthcare centre (Jenks, 2010). This question arises from, on one hand, the way in which practitioners began to use the category and, on the other, from the complex conceptual history of said category in health sciences and anthropology, as well as its close relationship with race (Boas, 1962, Hartigan, 2005; Jenks, 2010; Trouillot, 2003). While some authors have pointed out that the category creates a distance from biological and racial aspects (Armelagos and Van Gerven, 2003; Tapper, 1997), others have highlighted its potential to subordinate and exercise control over certain groups (Visweswaran, 1998) through the essentialisation and reification of social differences (Trouillot, 2003). In this wide range of uses, Dominguez (1992: 21) points out that it is necessary to ask "what is being accomplished socially, politically, discursively when the concept culture is invoked to describe, analyse, argue, justify, and theorise".

In clinical meetings, mainly, practitioners used the "culture" category to refer to various areas concerning the life of migrant communities. Through the "culture" signifier, they referred to a series of meanings associated with the habits, knowledge, practices, and values of migrant communities that, as a whole, had some kind of influence on their health and illness trajectories. The "culture" category provided mental health practitioners with a more comprehensive understanding of the psychic afflictions of migrant patients. For instance, in one of these clinical meetings, a

[71] From this framework, in the following chapters, I will show how afro-descendant migrants interacted with institutions and social actors within the borough, developing heterogeneous subjectivation processes and hybrid practices in which expert knowledge provided by psychiatry and neurology played a central role.

psychologist said: “if I had not attended the training I would not know that depression in Haiti tends to manifest with body aches, it is much more somatic than affective (…) and that in Haiti mental illnesses are very stigmatised, not like here”.

Intersectional understandings: The “culture” category in terms of class and gender

Through the training of cultural competency, practitioners adopted a position that recognised and granted some materiality to the so-called “cultural differences” between health teams and migrant communities. Practitioners seemed closer to the knowledge, practices and values associated with the migrant communities’ health/illness processes. Gradually, the “cultural competency” signifier began to circulate in the language of the teams. Even when I began this ethnography in February 2018, some practitioners were using it and revealed, to some extent, a feeling of pride when they were able to consider themselves “culturally competent”. Indeed, in some health teams, this knowledge operated as a differential that hierarchised them in acquiring cultural competency. For instance, in some conversations held in clinical meetings, they often shared information from a book that they had read, or a documentary they had watched regarding one of the countries from which the migrant communities had come. After this, they usually received the recognition of their colleagues.

Although the introduction of multicultural knowledge, practices and values through training sessions prioritised the category “culture” - materialising the “cultural turn” mentioned above - some practitioners tended to reduce health issues to a culturalist perspective. Moreover, some of them fell into what Didier Fassin (2001) has called “culturalism as ideology”, that is, the trend to conceptualise health/illness issues from a cultural explanation, neglecting other aspects (e.g. access, infrastructure, etc.). Within this context, the Programme sought to confront practitioners' reductive comments, such as: “Haitians and Dominicans tend to be more emotional people”, “Haitians have no parenting practices because they are distant”,

“Dominicans experience their emotions dramatically, as in a soap opera, it is their culture”, “Dominicans care a lot about their personal image, their beauty”, among others.

In order to address this, the Migrant Programme organised a series of training workshops at the CESFAM during 2018. In addition to extending the invitation to experts from universities and the Ministry of Health, the Programme convened Haitian experts to participate as speakers in these workshops. According to Yolanda, the Programme sought to address a “certain trend identified by the teams” related to the production and circulation of “racialised stereotypes” and “prejudices” based on supposed “cultural aspects” of the different migrant communities.

From the beginning, practitioners who attended these workshops positively valued the participation of Haitian experts because they endowed the analysis of various health issues with some complexity. Gradually, these workshops became a turning point in how practitioners understood “cultural differences”, as well as how they adopted the cultural competency approach. Leandre, a Haitian physician, invited to speak about Haitian-Creole medicine, said in his presentation: “People talk about Haitian culture as if Haitian culture was only one, whereas if I said that Chileans are culturally all the same, that would be absurd”. To illustrate this point, while he was training at the CESFAM, Leandre said:

> Haitian migrants who come to Chile belong to a low class or middle class. Many of them do not know what mental health is, and some of them do not even know what a psychologist is (...) But among them, some people do know because, for example, they are professionals. But it is very unlikely that they will come to the CESFAM to see the psychologist because mental illness is a much stigmatised issue in Haiti (...) But, for example, if you knew Haitian upper-class people, you would see that they do know much more about issues of mental health. Some of them have even been treated in the Dominican Republic, or even in France.

Experts distanced themselves from any culturalist reduction that tended towards the essentialisation of the Haitian community. In this context, Leandre

insisted that, for teams' work, it was "much more important to know how social classes or family structures in Haiti worked"[72]. Thus, Leandre's interventions, as well as those of other Haitian experts during the training sessions, seemed to boost the re-organisation of a field of meaning related to intersectional understandings of migrant health/illness trajectories. These resonated among practitioners because "class" and "gender" categories, as well as the interaction between them, were closer to the daily work of the health teams they had been developing in recent years. The knowledge transmitted by experts gradually began to have a significant impact on practitioners. Teams began to understand "culture", not as a static category, but as one that interacts dynamically and complexly with other categories such as "class" and "gender". From these workshops, both Yolanda and Miriam raised certain criticisms of the culturalist way in which, until then, they had conceptualised and adopted the cultural competency model.

The Migrant Programme distanced itself from culturalist approaches, seeking other approaches to the so-called "cultural aspects". Yolanda said that the programme sought for practitioners to acquire "a broader understanding of the cultural competency model". This change in the strategy not only sought to integrate the "culture" category into practitioners' understanding of health/illness processes, but also to place it on the same level as other categories such as "class" and "gender". This change was plausible since categories such as class and gender were familiar in the teams' daily work. In particular, the class category had a deep mark on the discourses, knowledge and health practices that circulated in the health system in Chile. This mark, which both health institutions and teams carried out when approaching health/illness processes, could be understood as the result of at least four possible aspects that can be traced back to the recent history of the country: the reform movements of the mid 20th century, the implementation of a Comprehensive Family and Community

[72] Although Haitian experts did not cite some of their theoretical references during training workshops, in some conversations that I had with them I realised that they highly influenced by the political thinking of Franz Fanon, as well as the anthropological contributions of Jean Price-Mars, and Nicolas Vonarx.

Healthcare Model, the strengthening of gender policies, and the recent adoption of multicultural policies in the country.

Between the 1950s and 1970s, the Chilean reform movements privileged class aspects in the social policies formulation over ethnic/racial aspects (Escobar, 2018; Richards, 2016). Inspired by Marxist principles, concepts such as "class", "structure" and "social stratification" became central to understandings of different social problems, whilst ethnic and racial aspects were neglected (Quijano, 1989). Unlike neighbouring countries, such as Peru and Bolivia, the Chilean reformist movements did not adopt the "mestizo nationalism" as a reference (Richards, 2016). That is, the series of discourses through which social movements - and some Latin American nation-states - have highlighted the constitution of a mestizo nation as a source of collective pride and resistance to neocolonial domination. On the contrary, Chilean reformist movements conceived multicultural issues mainly from a class perspective. For example, the indigenous subject was conceived of as a "poor subject" rather than as an "ethnic subject", thus serving to distance him/her from notions associated with miscegenation.

The progressive implementation of a Comprehensive Family and Community Health Care Model (MAIS)[73] in the primary healthcare network throughout the country since 2005 has also played a key role in shaping this structural health approach. The Chilean model was based on a curative model that was focused on the hospital as a central space for solving health problems. However, as a result of demographic and epidemiological changes, the state began to implement, within the framework of the

[73] The model is defined as: "A model of health teams' relationships with people, their families and the community of a territory, in which people are placed at the centre of the decision, they are recognised as members of a diverse and complex sociocultural system, where their members are active in the care of their health and the health system is organized according to the needs of the users, oriented to seek the best welfare state possible, through comprehensive, timely, high-quality and decisive health care, throughout the network of providers, which is also socially and culturally accepted by the population, since it considers people's preferences, social participation in all its work - including the intersector - and the existence of indigenous health systems. In this model, health is understood as a social good and the health network as the articulated action of the provider network, the organised community and intersectoral organisations" (MINSAL, 2012: 13).

Health Reform[74], a care model focused on primary care whose rationality emphasised the promotion, prevention and comprehensive and ambulatory resolution of most of the population's health problems (García-Huidobro, Barros, Quiroz, Barría, Soto and Vargas, 2018). This model has promoted a structural viewpoint of health, highlighting class and gender approaches, as well as relocating the focus not only on people but also on the multiple relationships that they establish within their families and communities.

The strengthening of gender policies through the promotion of health and social programs have prioritised gender in public institutions (ComunidadMujer, 2018; Franceschet; 2011; PNUD; 2019). Since Michelle Bachelet's government's first term in office (2006-2010), gender reforms have been implemented in areas such as work, education, health and civil rights, among others, in order to defend women's rights (Thomas, 2016). In 2015, for example, the Ministry of Health recognised gender as a social determinant of health[75]. Through this, the Chilean government brought into all health policies, programmes, and documents, a gender and human rights perspective in order to guarantee equality and equity between genders.

Finally, as I argued in the first section of this chapter, Chile has been characterised by the late adoption of multicultural policies, which has shaped the previously mentioned "neoliberal multiculturalism". After the end of the civic-military dictatorship (1973-1989), these policies have tended to prolong a conception of Otherness where the class difference has carried a more significant weight in explaining ethnic/racial differences (Richards, 2016). Within this context, the first social and health policies have had to conceptualise people, such as Mapuche, Aymara and Atacameño, as groups characterised by class, and particularly by the impacts of poverty (Boccara, 2004; 2007; Boccara and Bolados, 2010; Bolados, 2010; Bolados García, 2012).

[74] The new Health Authority Law ("Ley de Autoridad Sanitaria") and the Law on Explicit Health Guarantees ("Ley de Garantías Explícitas en Salud") (AUGE) came into force in 2005.
[75] Exempt Resolution Nº136 of March 30, 2015.

Overall, the search for a "broader understanding of the cultural competency model" carried out by the Migrant Programme is similar to the contemporary discussion in the US regarding the practitioners' training through cultural or structural competency models. The structural competency model promotes the reformulation of "cultural" aspects into "structural" aspects, highlighting how social, economic and political conditions produce inequalities in health (Hansen, Braslow, Rohrbaugh, 2018; Kirmayer, Kronick, Rousseau, 2018; Metzl and Hansen, 2014, 2018; Metzl, Petty, Olowojoba, 2017). From this perspective, practitioners must recognise how institutions, health and social policies, borough conditions, market forces, among others, shape symptoms and illness. Similarly, it encourages practitioners to take actions that reduce inequalities both in clinical spaces and outside of them (e.g. in boroughs)[76].

The development of the structural competency model has emerged from the training of health practitioners, mainly in the United States. While some studies have revealed how the "culture" category was considered limiting by US medical scholars when describing determinants of health (Hansen, Dugan, Becker et al., 2013), others have highlighted the frustrations derived from the adoption of cultural competency that, occasionally, are foreign or uncomfortable to them (Hannah and Carpenter-Song, 2013; Willen, Bullon and Good, 2010). Thus, the structural competency approach promotes training based on fundamental principles, such as understanding patients' experiences in the context of structural factors; addressing structural factors at an institutional level, for instance, by including other institutions such as schools, social

[76] In the structural competency approach, three levels of participation in the promotion can be distinguished: (1) recognise and understand the structural determinants of health and incorporate this knowledge in professional education, clinical practice and community intervention; (2) support coalitions and collective action that aim to change policies and practices; and (3) initiate, mobilise and organise actions to challenge social injustices. (Kirmayer, Kronick, Rousseau, 2018). The training of practitioners seeks five basic competency: (1) recognise the structures that shape clinical interactions; (2) develop an extraclinical structure language; (3) re-think "cultural" formulations in structural terms; (4) observe and imagine structural interventions; and (5) develop structural humility (Metzl and Hansen, 2014).

services, and the police; and community collaboration and connectivity, structural humility, and respect for times of social change (Hansen, Braslow, Rohrbaugh, 2018).

Although practitioners of the Migrant Programme did not name their critical approach as a "structural competency model", they reported that this approach would allow them to develop a "more complex intersectional understanding" for practitioners. The Migrant Programme suggested holding health and migration training sessions on a permanent basis in the following years. During some programme meetings, developed after these training sessions, Yolanda and Miriam asked themselves questions such as "how do we carry out better training for practitioners?" or "Is it necessary to continue talking about "culture" to refer to migrant communities?"

The questions posed during the Migrant Program meetings allowed broader conceptual and methodological issues, related to contemporary decolonial debates in anthropology, global health, and social medicine, to be addressed. Rather than carrying out an analysis of which training program is the most appropriate for practitioners ("cultural" or "structural" competency), this case interrogates how practitioners - and researchers – know and shape "the social". Particularly, from a decolonial critique (Mignolo and Escobar, 2010), I focus on how the adoption of categories, perspectives and models - in this case around the category "culture" - shapes a "way of knowing" "the social". My purpose is to distance myself from the use of categories, such as culture, race, class, gender, and others, as static or evident entities, and instead to understand them as mutable, synergistic and variable categories that operate in specific historical contexts (Adams, Béhague, Caduff, et al. 2019; Bowleg, 2012; Briehl, 2003; Yates-Doerr, 2020).

The emergence of the cultural competency model in the US was the result of various actions aimed at reducing health gaps for ethnic/racial minorities, primarily within the black population. In part, the advocacy of groups seeking greater social justice managed to position themselves in the debate on how race produced

inequalities in health[77]. However, this model has received a series of criticisms regarding the neglect of "structural" dimensions (for example, class, gender, sexual orientation, etc.) (Viruell-Fuentes, Miranda, Abdulrahim, 2012). Thus, in the US, the structural competency model is borne, to some extent, from criticism of the cultural competency model to account for "the social" and "cultural differences".

Nevertheless, this ethnography allows us to grasp what is currently called structural competency in the US, however, to some extent in Chile - and in other Latin American countries[78] - it is a way of approaching social issues that precedes the formulation of these models. The influence of reformist movements, public health models, gender policies, as well as policies focused on indigenous peoples in Chile account for a tradition that revitalises the so-called structural aspects of health. These aspects frame the way that practitioners are trained, as well as how they understand and produce "the social" and the Otherness.

The ethnography reveals that practitioners, rather than resist the introduction of knowledge and models around "culture", tend to "refuse" them (McGranaham, 2016; Simpson, 2007). The heuristic and empirical value of the concept "refusal" is that, instead of locating the problem in the polarity of domination/resistance, it highlights how professionals have carried out a generative action (McGranaham, 2016; Benjamin, 2016) that questions the introduction of knowledge and hegemonic models around "culture". Through this action, the culture category is integrated into representational frameworks through which practitioners grasp the social. However, they located it in a place of less descriptive/explanatory relevance compared to other categories such as "class" and "gender".

This generative action sheds some light on current intersectionality debates. As I defined earlier, intersectionality has been understood as that "analytical

[77] The centrality of the race category in the US can also be understood from some historical processes such as the fight for civil rights by the afro-descendant population in the 50-60s, the Black Lives Matter movement, among others.
[78] For example, see Ortega and Wenceslau (2019).

sensitivity" that allows us to think about social issues related to power and inequality in terms of culture-ethnicity-race/class/gender, as well as other categories (Collins, 2019; Crenshaw, 1989). However, categories that make up intersectionality tend to be conceptualised as mere demographic categories (Caldwell, Guthrie, Jackson, 2006), disengaged from their production in specific social and historical contexts (Viruell-Fuentes, Miranda, Abdulrahim, 2012). In other words, intersectionality tends to be conceived of as a tool in which each category carries the same "weight", an issue that would allow a "balanced" approach to "the social". Thus, as Bowleg (2012) suggests, the intersectional perspective has at least two relevant theoretical challenges: determining which intersectional categories should be included and also recognising that this perspective was not developed in order to predict either mental and behavioural processes or health. This ethnography in fact highlights a third challenge: to question how the categories are produced and how they are internalised by, in this case, health practitioners. Ethnographic material makes it possible to argue that intersectionality, as "analytical sensitivity", seems to be conditioned on the prior socialisation of professionals in each category involved, as well as the traditions of public health systems and historical and macro-social processes.

Therefore, as with various contributions in the field of social medicine (Adams, Béhague, Caduff, et al., 2019), Latin American critical epidemiology (Briehl, 2013), and critical medical anthropology (Gamlin, Gibbon, Sesia, et. al, 2020), the ethnographic material leads at least to question, from the so-called "Global South", how health agents – and researchers - capture and produce the social from the introduction of "cultural" or "structural" models, or others[79] - neglecting or excluding their own "ways of knowing" the health traditions of the local context (Davis and Todd 2017; Yusoff 2018). These contributions lead to a necessary reconceptualisation of not only models and knowledge, but also of Latin American researchers and health practitioners as colonised subjects (Sepúlveda Jara and Oyarce Pisani, 2020). Besides this, the Chilean case allows the interrogation of the foundations, as well as the forms, of the

[79] For example, "social determinants of health".

production of categories such as “culture” or “structure” (Claros and Viaña, 2009; Santos, 2016). Finally, by extension, this case allows to question how health institutions and practitioners conceive/shape the image of afro-descendant migrants as an identity politics group - are they closer to a (black)racial identity group, or to a hybrid or “mestizo” identity group (Anzaldúa 1999 [1987]; Bhabha, 1994)?

Chapter II:

Becoming a migrant: on racialisation and sexualisation practices and their psychosocial impacts

The Family Health Centre (CESFAM) practitioners looked more relaxed and cheerful on Friday afternoons. This was partly because the CESFAM's Director earmarked this time for, what was called, “self-care activities” that exempted the practitioners from clinical work. Often on Friday lunchtime, practitioners would go with their colleagues to eat at small restaurants located in the centre surroundings. Some of them said that Friday lunch was an opportunity to “change the environment” and “take the stress out of the week”. That Friday, the first of May, Viviana, the coordinating psychologist of the Mental Health Program, invited me to have lunch with her in what she called a “luxury clandestine restaurant” (“Un clandestino de lujo”).

While Viviana and I were waiting outside the CESFAM for some of her colleagues, a woman came to greet Viviana. Mercedes, a 45-year-old Dominican woman, was the mother of one of Viviana's patients. Mercedes told Viviana that Laura, her 15-year-old daughter, “was fine”, but that she had not attended her last session because she had confused the appointment with a football training session at her school. Viviana, who listened attentively with an open and welcoming body posture, told Mercedes “not to worry”, but stressed that she should request a new appointment as soon as possible. After thanking her, Mercedes entered the centre to request the appointment. In the meantime, Viviana and I began to walk towards “El clandestino” with another three of the CESFAM midwives.

The journey lasted no more than two minutes. “El clandestino” was an old adobe house that was in the middle of the street. The outside patio consisted of a small room made from a fabric shelter. Inside, the restaurant owner cooked lunch while no more than ten of the centre's health practitioners ate on two small tables sitting side by side. Other practitioners waited in a queue on the patio. Freshly laundered clothes hanging from washing lines obscured the sight of this queue. On

seeing us arrive, one of the practitioners happily told me “here you will eat the best food in the world, but it is a secret place. You cannot tell anyone. Here there are no tickets or anything. It's just for friends. This place has no alimentary security certification (laughter)”.

Viviana tended to have lunch with the midwifery team on Fridays. She preferred this option as it allowed her to “disconnect” from work and not have to talk about clinical cases or mental health problems for a moment. However, while we were finding a place to sit, Viviana was trying to describe the reasons why Mercedes and Laura attended the CESFAM. She was continuously interrupted by practitioners entering and exiting the hot space of “El clandestino”, as well as by the lively activity surrounding payments, and the distribution of plates, cutlery and glasses. The turmoil of the place seemed not to diminish the attention that practitioners paid to the different conversations that took place over the small tables. Indeed, Viviana lost neither the common thread of her own story nor that of many other simultaneous conversations.

Viviana described how Laura had started a “psychotherapeutic process”[80] at the CESFAM during the latter part of 2017 after having been referred by the school psychologist. The reason for the referral was Laura's manifestations of “anxiety”, “irritability”, and “aggressiveness”. According to Viviana, these “symptoms” had been the result “of dynamics of racism and bullying at school”, as well as of the recent “parents’ separation”. Laura was the victim of racist practices by some classmates, who classified her as “ugly black girl” or “dumb black girl”. Although Viviana argued that the symptoms had already declined, the next aim was to integrate Mercedes into a psychotherapeutic process. In particular, Viviana’s concerns focused on how “the mother-daughter relationship between Mercedes and Laura could affect Laura's development”. She said to her colleagues: “Laura’s mother has had financial

[80] Psychological consultations carried out by a psychologist at the CESFAM. In some cases, other practitioners, such as physicians and social workers, support this process.

difficulties, and problems with Laura's father after the separation (…). Also, her father is ill in the Dominican Republic (…) she transmits all those things to her daughter".

Although Viviana recognised these conflicts were a part of Mercedes' life, she also emphasised some frictions in her relationship with her daughter. She said: "Laura is growing up and her mother has not yet assumed it (...) her mother is afraid of everything, mainly men, and Laura's potential boyfriends ("pololos")". A few minutes later, she added, "she thinks that men here look down on black women and to some extent, it is true that they sexualise them". Two of the midwives with whom we had lunch agreed with Viviana. One of them, with a certain tone of resignation, told me: "It seems to be something very common among Dominican and Colombian mothers (…) to take care of their daughters as much as possible in order to keep them away from vices or men. They overprotect them and, in turn, their daughters see other Chilean girls with more freedom, and that becomes a problem".

While Viviana considered the potential conflicts between Mercedes and Laura to be significant, a certain degree of reflexivity around ethnic/racial themes, acquired partly in the training sessions, as I argued in the first chapter, allowed her to question how a set of social, economic, political and moral forces of Chilean society constrained afro-descendant migrants' lives. Viviana questioned, not only the subjective effects of racism in their daily lives, but also how this set of forces operated on the body, subjectivity and sexuality of the subjects, particularly of afro-descendant women. From an intersectional approach, Viviana questioned the forms that these forces assumed in the local context. She said: "I understand the mother's fear. Here in the borough, one sees that black is sometimes treated as an object (...). Being a black man is not the same as being a black woman. Here they are seen as women who come to have children or to prostitute themselves (…) for a mother it must be difficult". Her concern revolved around how racialisation and sexualisation practices constrained the afro-descendant population. That is, practices that produce and inscribe social markers or stigmas of a racial and sexual nature derived from the European colonial system and the shaping of Chilean national identities (Tijoux, 2016; Tijoux and

Palominos, 2015). These markers and stigmas delineate hierarchically ordered features that shape the social relations between "we" and "they" (Tijoux and Palominos, 2015). They also generate conditions for the emergence of different forms of intolerance, violence and exploitation (Balibar and Wallerstein, 1991; Fanon, 1961; Sayad, 1999; Viveros, 2009; Wade, 2010; 2015).

In this chapter, I explore how social, economic, political and material forces constrain[81] the body, subjectivity and sexuality of migrants, leading them to represent themselves as "immigrants". In this research, I do not merely conceive migrants as subjects who arrive intending to reside in a different country. On the contrary, following different studies that revitalise a transnational perspective (De Genova, 2009; Glick Schiller, Basch, Blanc-Szanton, 1992; Levitt, and Glick Schiller, 2004; Rodriguez and Schwenken, 2013; Sayad, 1999), I reconceive migrants as subjects whose experiences with processes of subject-making begin to take shape in the countries of origin. In other words, the process of becoming a migrant begins from the moment subjects imagine and evaluate the possibility of migrating. Following this, I will explore how these forces are impacting the Dominican community as well as how Dominicans are coping with the afflictions shaped by these forces. I will also draw attention to the emergence of epistemic differences between representations, knowledge and practice between health centres and the Dominican community as it relates to the way affliction is understood and experienced. In this way, I explore the emergence of differences in how Dominican communities represent their afflictions and how they develop coping strategies based on family and community for the afflictions' relief.

I will argue that the arrival of afro-descendant communities during the last two decades has re-configured a racial topology (Moffette and Walters, 2018; Collier, 2009; Lee, 1994) in which power relations have given way to racialisation and sexualisation practices on the bodies, subjectivities and sexuality of migrant

[81] I use this word following Norbert Elias' sociogenetic and psychogenetic contributions. See "The process of civilization. Sociogenetic and psychogenetic investigations" (Elias, 2000 [1939]).

communities. Within the context of the health and educational system, these practices have led to a wide spectrum of situations that range from violence and discrimination to the reproduction of racialised stereotypes. I will show that, although the reflexivity of health practitioners regarding contextual and ethnic/racial aspects[82] has allowed them to address the effects of racialised practices, they have in turn recognised that the scope of the interventions tended to be reduced to an individual clinical approach. However, such reflexivity allows them to assume an anti-racist position vis-à-vis other practitioners such as teachers and psychologists in schools. For their part, migrants usually find tools for managing malaise and suffering within their families and communities, which leads them to refuse partially psychological and psychiatric support. This epistemic difference questions the impact of psy/neuro practices in afro-descendant migrant communities, particularly in the different subjectivation processes engaged in by children, young people and adults.

This chapter contributes to current debates on transnational migration studies (Arriagada and Moreno, 2012; Stefoni, 2011; 2014; Tijoux, 2016; Tijoux and Díaz, 2014; Stang and Stefoni, 2016), as well as race and racialisation theory in Latin America and in Chile mainly (Tijoux and Palominos, 2015; Viveros, 2009; Wade, 2010; 2015; Wade, García Deister; Kent, et al. 2014). It illustrates how Dominican migrants usually find tools for managing malaise and suffering within their families and communities which leads them to partially refuse psychological and psychiatric support. This epistemic difference questions the impact of psy/neuro practices in afro-descendant migrant communities, particularly in the different subjectivation processes engaged in by children, young people and adults. Thus, this chapter falls in line with various studies that have stressed the significant role that families and communities play in the management of psychological malaise and suffering (Chase and Sapkota, 2017; Han, 2012; Kohrt, 2014), as well as the role of ethnopsychological aspects in seeking help (Kohrt and Harper, 2008).

[82] See chapter nº1.

In this chapter, I will focus on the life of Mercedes and her family to illustrate how racialisation and sexualisation processes operate in Chile and impact mental life. The chapter is the result of multiple observations conducted in contexts such as the CESFAM, and Mercedes' house, as well as spaces where she and her family spent free time, such as parks and hairdressing salons. Interviews were also carried out with family members and the CESFAM practitioners involved. As I mentioned in the introduction of this thesis, a female research assistant conducted part of the interviews with Mercedes and Laura, to try and reduce certain gender and generational biases, particularly with Laura. Similarly, the assistant contributed to the formulation of the first analyses.

The chapter is divided into four parts. In the first part, I will describe the migratory process of Mercedes and her family to Chile. Specifically, I will show the different forces that led Mercedes to conceive of Chile as a migratory destination. Following various investigations (Rodriguez and Schwenken, 2013; De Genova, 2009), I will call this landmark the process of “becoming a migrant at home”. From this, I will stress how Mercedes configured a representation of herself associated with being a “good worker” in the Chilean labour market. Likewise, I will show how, following the global trend of the feminisation of migration (Castles and Miller, 2004; Salazar and Choi, 2016), Mercedes shaped a global care chain (Arriagada and Moreno, 2012; Mills, 2017; Hochshild, 2003; Yeates, 2012) that allowed her to care for her children in the Dominican Republic. Later, I will show how a series of social, economic, political, and moral forces constrained the lives of Mercedes and Laura. I will call this the process of “becoming a migrant in the host country”. This process is characterised by discourses and practices that lead migrants to conceive of themselves as “immigrants”. In the specific case of Mercedes, this resulted in a self-representation of herself as a “second class person” in Chile.

Third, I will describe racialisation and sexualisation practices, as well as their psychosocial effects, particularly on Laura. Racist and bullying practices in the school led Laura to manifest symptoms of “anxiety”, “irritability” and “aggressiveness”. From

this, I will highlight how the passive attitude of education professionals towards racist and bullying practices in schools generated fertile conditions for the emergence of these types of psychosocial impacts. Finally, based on Laura's psychotherapeutic process at the CESFAM, I will show that, on one hand, the approach of mental health practitioners, and on the other, the experiences of Mercedes and Laura, reveal an epistemic difference in terms of discourses, knowledge and practices in mental health. This difference was not reduced to a lack of familiarity with psy/neuro technologies, but rather to the role of the family and community in managing malaise and suffering.

Becoming a migrant (woman) in the country of origin: On the feminisation of migration and global care chains

Mercedes arrived in Chile from the Dominican Republic in early 2010. In her home country, she had lived with her children Ramón (23) and Laura (15) in a house located on the outskirts of the capital Santo Domingo. She described her borough as a "quiet and safe place to live". At the time, Mercedes had a relationship with Laura's father. However, he lived with four children from a previous relationship. In Mercedes' words: "it was better to live like that because Ramón is my son from another relationship, so there were many of us in the same house. And that could cause problems. Even Laura's father already has grandchildren".

Economic uncertainty was the main factor that mobilised Mercedes to search for a new destination country. Although Mercedes worked in several trades, during her last years in the Dominican Republic, she had managed a small clothing business in a market near her borough. However, the economic instability caused by the subprime mortgage crisis[83] in 2007 and 2008 had badly impacted her business, leading her to close it due to bankruptcy. Faced with the impossibility of finding work to

[83] The global financial crisis was triggered by the bursting of a housing bubble in the US in October 2007.

support their children, Chile began to emerge as a destination that provided job opportunities. She said: “back in the Dominican Republic, people talked a long time ago that Chile had a lot of work, and that the country needed people to take care of people, to work cleaning a house or to run a business”.

Chile’s image as a country with economic stability[84], job opportunities, and security was largely disseminated in the Dominican Republic by those who participated in the United Nations Stabilisation Mission in Haiti (MINUSTAH). Through that mission, which operated from 2004 to 2017, Chilean troops from both the Chilean Army and the Police (“Carabineros” and “Policía de Investigaciones”) participated. The mission aimed at establishing a safe and stable environment that would promote the strengthening of institutions and the rule of law, as well as protect human rights (UN, 2019). For around 13 years, Chilean troops commonly spent their days off and holidays in the Dominican Republic. Mercedes said: “they were always resting there (…). They were the people who were helping in Haiti. They were good people, all very gentlemanly. They always talked about Chile being a safe country where there were job opportunities. People started talking about it in the Dominican Republic”.

The diffusion of Chile’s image as a country of opportunities was the first event that led Mercedes to start her process of becoming a migrant. She began, as Rodriguez and Schwenken (2013) point out, to “become a migrant at home”. According to various researchers (Rodriguez and Schwenken, 2013; De Genova, 2009), the process of becoming a migrant begins before arriving in the destination country[85].

[84] Several studies have reported the country's economic stability as one of the main factors of attraction for migration. See Kalawski and Serra (2016), Lube-Guizardi and Garcés (2013), Stefoni and Fernández (2012), Stefoni and Bonhomme (2014).

[85] Various “migratory studies” have attempted to answer why subjects migrate. While some studies have focused on microsocial aspects (e.g. motivations of individuals) (Lee, 1966; Todaro, 1969), others have instead focused on meso-social aspects (e.g. family groups) (Boyd, 1989; Massey, 1990; Stark and Bloom, 1985), as well as macro-social aspects (e.g. structural aspects) (Piore, 1979; Wallerstein, 1974). However, the perspective of “becoming a migrant at home” is consistent with what some authors have called the “transnational perspective” of migrations. Glick Schiller and colleagues (1992:1) have defined “transnationalism as the processes by which immigrants build social fields that link together their country of origin and their country of settlement. Immigrants who build such social fields are

Although various studies have found that bilateral and/or multilateral agendas generate the right conditions for the migration of the part of a particular country's population to another, these conditions also emerge from a wide range of social practices (Rodriguez and Schwenken, 2013)[86].

The process of becoming a migrant for Mercedes was the result of the unforeseen consequences of the presence of Chilean troops in the Dominican Republic as part of a humanitarian plan rather than a specific population mobility policy set up between Chile and the Dominican Republic. Mercedes began to adopt a certain subjective position from the time when she heard about the labour market in Chile. This position manifested in a representation of herself associated with being, in her words, "a good worker". She said, in a context marked by the lack of work in the Dominican Republic, that her "flexibility" would allow her to work anywhere in Chile. Mercedes said:

> I worked on many things in the Dominican Republic. I have always worked, why couldn't I do the same in Chile? That's what I thought at the time (...) I spoke once with the husband of a friend, he lived here and received me when I arrived. He said to me, 'what they want here is good workers`, and I am good for work ("buena para la pega") (laughing) (…). I explained that to my people; Laura was very young. And I came to Chile.

designated "transmigrants". Transmigrants develop and maintain multiple relations - familial, economic, social, organizational, religious, and political that span borders. Transmigrants take actions, make decisions, and feel concerns, and develop identities within social networks that connect them to two or more societies simultaneously".

[86] Regardless of whether mobility processes are the result of a specific policy or a set of random social practices, the documented effects seem to be similar in the trajectories of migrants. Specifically, as I will also show in this and the following chapters, researchers have recognised at least three effects. First, the formation of an image of the "good migrant" based on national and racialised stereotypes and bias (Rodriguez and Schwenken, 2013). Through a multidirectional and diffuse process, different institutions, actors, practices and values shape the process of the migrant subject-making. Second, the return to the country of origin of part of the earnings obtained in the host country (Delgado Wise, Márquez Covarrubias, Puentes, 2013). Finally, and in order to achieve the second effect, the creation of government techniques that allow the emergence of new subjective positions and emotional ties to the nation (e.g. "the compatriots who are missing" or "the responsible mothers who provide resources to their children") (Rodriguez and Schwenken, 2013).

However, ambivalent images of how she conceived the maternal role to be were superimposed onto the image of the "good worker". On one hand, she thought that she should travel to Chile to find a job and thus "give a better life" to her children. On the other hand, Mercedes evaluated this as a "type of abandonment", especially for Laura, being the youngest. She said: "Laura was seven years old, and I had to leave her alone, in a boarding school during the week, and on the weekends with my parents". Although Mercedes was confident that her parents would take care of Laura, the boarding school generated a certain distrust in her because her daughter was one of the youngest girls there. She said: "I was afraid that the older girls would bother her, or that some caregiver would not like her (...) but finally she was fine."

Like Mercedes, many migrant women around the world have embodied this conflict regarding the maternal role. This is due to what some authors have called "feminisation of migrations". That is, the increasing number of women who leave their countries in search of an improvement in the lives of their families and themselves (Acosta, 2014; Castles and Miller, 2004; Salazar and Choi, 2016). International migration has introduced fractures in traditional forms of care, as well as new temporal and spatial logics in relationships. These transformations have led to the emergence of "global care chains" (Millls, 2017). This concept describes a series of transnational or national relationships, mainly family relationships, based on care (Ehrenreich and Hochschild, 2003; Arriagada and Moreno, 2012). Commonly, in the host countries, women are replaced by migrant women in care work, while other women and/or institutions, in the country of origin, take care of the children or dependents of these migrant women (Yeates, 2012)[87].

[87] One of the main characteristics of these transnational care chains is the deep inequalities between their poles. On one hand, it is possible to identify a group, generally belonging to a country or region with greater economic development, with the ability to delegate attention to others. Conversely, a group that cares and, paradoxically, may suffer the loss of some of its care. In this sense, some women have found in domestic workplaces, a place where they can afford their lives and the lives of their families in the countries of origin. CASEN survey (MIDEPLAN, 2011) showed the Chilean women's participation in domestic service fell from 7.6% to 4.7% during the 1990s. Besides, from 2006 to 2011, immigrants working in the domestic sector have grown from 3.7% to 5.6%. Therefore, the "transfer" of care from sectors with greater power over others reveals a political dimension in these practices,

The feminisation of migrations has led to new family configurations in the last thirty years, shaping them into so-called "transnational families". In other words, households located in two or more nation-states (Salazar Parreñas, 2005). In Chile, some studies have focused on these new configurations mainly in the Peruvian community[88] (Cano and Soffia, 2009). These have highlighted how the increase of this population in domestic employment has generated an imbalance between care practices in the countries of origin and destiny. The data shows that children are usually separated from their parents for approximately five years (MIDEPLAN, 2006). At the time the family group splits, children are often cared for by other family members, such as grandmothers and aunts while waiting for their relatives to return[89].

Mercedes quickly found a job near to the borough. This allowed her to establish a home and to send money back to the Dominican Republic. She told me:

> I looked for a small room in a house. At the top of the second floor I had to sleep on the floor, on the lying floor, I had no bed, I had no sheets or anything. One lady gave me one blanket. Another gave me a second blanket. I put one on these blankets on the floor as a mattress. I spent a lot, a lot of sadness. I cried every night, before the first month, I already wanted to return to my country because I needed my family, Ramón and Laura". She added: "I started working in La Vega[90] where I washed dishes, and sometimes babysat. In La Vega, my hands swelled, my hands were injured. My fingers got a fever, and I kept fighting to have to pay the rent, and to send money to my family; my parents have always been sick.

The consolidation of Mercedes' image as someone who was a "good worker", as well as the distinction between "good" and "bad" migrants based on their economic contribution to the country, was not only configured from her achievements in her

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which reproduces differences at the social level by ranking women and families according to class, gender, race, among others.

[88] The Peruvian migrant community was the largest during the 1990s in Chile.

[89] According to the Jesuit Migrant Service published in 2010 (see Pavez, 2013), 66.6% of migrants have at least one child in their country of origin.

[90] A popular market situated in the north of Santiago. In its stores, sellers offer mainly fruits and vegetables coming from the central zone of Chile. Likewise, La Vega has small restaurants serving food from different Latin American countries.

integration process. In contrast, it was also the product of various social, economic, political and moral contingencies that took shape in the country during the years after her arrival. Specifically, during the first term of the Sebastián Piñera government (2010-2014), and the second term of Michelle Bachelet's government (2014-2018), a tense public debate began regarding the sustained increase in migratory flows towards the country[91], particularly from afro-descendant communities in Colombia, the Dominican Republic and Haiti. Right-wing political sectors blamed Michelle Bachelet for the lack of regulation on the migrant communities' arrivals. The former president Sebastián Piñera and some of his political allies classified Michelle Bachelet's administration as a "total disaster" or as having a "permissive" agenda (Radio Agricultura, 2018; La Tercera, 2018a; Publimetro, 2018). Furthermore, fake news circulated throughout the country indicating that the government's "permissive" policies were the product of a "secret agreement" between Michelle Bachelet and the United Nations for the withdrawal of troops from Haiti within the framework of MINUSTAH (Cooperativa, 2018). Some of this news suggested that such an "agreement" would allow Chilean troops to return to Chile or that government officials would receive money for each migrant.

Within this context, since his candidacy in 2017 and the beginning of his second-period administration, Sebastián Piñera's government (2018-2022) introduced various initiatives into the public debate on migration designed to what he called "tidy up the house" ("ordenar la casa")[92]. Through the promotion of this slogan, the government established a border policy that increased surveillance and punishment (e.g., consular visas, deportations, among others), and also set out to spread the notion of the "ideal" migrant. In other words, only migrants who "contributed" to the development of the country would be accepted. The border policy stated by Sebastián

[91] The migrant population in the country increased from 410,988 in 2014 to 1,119,267 people in 2017 (INE, 2019).

[92] Based on this slogan, as well as on the migration policies carried out since the 1990s, Luis Thayer (2019) distinguishes three stages in the recent history of migration policies: The "default policy" (1992-2002), the "state of mind" policy (2002-2017), and the "tidy up the house" policy (2018-present). See also Durán and Thayer (2017).

Piñera's government continued the strategies implemented by countries such as the United Kingdom (Brexit referendum), the US (Donald Trump's migration policy), and Brazil (Michel Temer and Jair Bolsonaro's migration policy), thus promoting an image of the "immigrant" as an internal enemy. That is, as a high number of migratory studies have revealed both internationally (Hansen, 2014; Orrenius and Zavodny, 2019; Provine, 2013) and in Chile (Stefoni, 2011; 2014; Tijoux, 2016; Tijoux and Díaz, 2014; Tijoux and Palominos, 2015; Stang and Stefoni, 2016), the process by which the fetishization of the migrant is promoted as a threat to the nation in order to mask internal contradictions.

The idea of the migrant as an internal enemy has adopted several forms in recent years. As reflected in the press, migrants were closely linked with the deterioration of services such as health and education (Cooperativa, 2018), the increase in crime and drug trafficking (La Tercera, 2016; 2017a; Duque, 2019), the appearance or increase of diseases such as leprosy, tuberculosis and HIV (La Tercera, 2017b; 2019), as well as the potential "change of [the Chilean] race" (CIPER, 2018). As a consequence, expressions of discrimination, xenophobia, and racism emerged in various spaces. In some cases, these expressions operated through opposition by the government and by the population to grant social rights to migrant communities, thus neglecting the minimum supports that guaranteed their quality of life and dignity. While, in others, they did so through violence and aggression against migrant communities (UDP, 2018).

The strengthening of migrant policies and the neoliberal market rationality converged to delineate an ideal image of the migrant in Chile[93]. In other words, economic racism served to differentiate between "qualified" and "unqualified" people for the country's productive system. The convergence between the border and

[93] The ways in which border policies and economic policies shape the migratory trajectories of subjects have been extensively analysed in different contexts (Brown, 2015; Calavita, 1996; Fassin, 2011b; Marshall, 1997; De Giorgi, 2010; Mezzadra and Nielson, 2013; Sassen, 1993, 1999, 2014; Walters, 2010), as well as in Chile (Aedo, 2017; Jensen, 2008; Liberona, 2015b; Quinteros, 2016; Stang and Stefoni, 2016; Stefoni, 2011).

economic policies can be understood, following Michel Foucault (2003 [1976], 2010 [1978]), as a biopolitical operation through which part of the migrant population must "die" with the aim of guaranteeing the lives of Chileans. More specifically, this operation revealed necropolitics (Mbembe, 2019), that is, the generation of conditions which guarantee the safety of a community through the "death" of members of another community. This operation took shape, in the words of Mercedes, by differentiating those migrants who, in her opinion, contributed (or did not) to the country in economic terms. She said: "I understand that people who come from other countries sometimes receive the hatred of Chileans. If they do not come with a clear idea of working, of setting up a business, or something, why are they coming? Many times, it is to do bad things. They should be deported out of the country".

The strengthening of migration policies led Mercedes to modify her original plans to reunite her family. The enactment of a consular visa for Dominicans in 2012 forced her to reassess her project[94]. After three years of working in various places, she saved money and travelled to the Dominican Republic. Together with Laura's father, they decided to get married so that he could apply for a consular visa at the Chilean Consulate in Santo Domingo. Mercedes said:

> I could bring my children without problems. But for Laura's father to come quickly, we had to get married (…). I wanted to get married, but at that moment, I was more concerned about Laura. Three years had passed, and my "morena" was growing away from her mother. And I'm not a bad mother! (laughs). She was in a boarding school all week and on weekends with my family or with her father (...) We got married, and I brought my children to Chile. And then he came when he had the visa, but he found another woman here in Chile and he left me.

[94] During the 2000s and 2010s, Chile registered a significant increase in the Dominican population. While they were 281 Dominicans in 2002 (INE, 2003), they were 17,959 in 2018 (INE, 2019). In 2016, the government estimated that around 50% of the Dominican population was in an irregular condition because they had entered the country as tourists, prior to the establishment of the consular visa in 2012.

As I will show in the next section, although this family reunification[95] marked the end of a cycle, the fact that the family, and particularly Mercedes and Laura, faced racialisation and sexualisation processes marked the beginning of another one.

Becoming a migrant in Chile: On racialisation and sexualisation practices

Mercedes's body was acquiring a particular centrality in her daily life in Chile. Mercedes was a plus-size mulatto woman who periodically brushed and changed her hair colour. She liked to use red and brown dyes, but she also did what she called "innovations" by dying her hair blonde or turquoise. Her long nails tended to follow the same colour trend. Until Mercedes arrived in Chile, she had never felt that these types of beauty practices made her subject to a sanctioning gaze. Mercedes said: "whether change the hair colour or straighten it, this was not an important issue in the Dominican Republic (…). There, it is something that every woman does (…). But here in Chile, it is different. People look at you. People chase after you like you're a weirdo. In the Dominican Republic, it is not a thing that matters like here".

Although Mercedes tended to normalise beauty practices in the Dominican Republic, these were strongly associated with complex and dynamic forms of social stratification not only in their country of origin but also in the Dominican diaspora (Lara, 2020). Particularly, the "brushing" ("alisado") of the "Dominican hair" ("pelo dominicano") occupies a central place within the beauty practices of Dominican women. Some researchers have classified brushing as a "whitening practice" (Collins, 2000; hooks, 1989; Omolade, 1983), as a "syncretic expression" (Amezquita, 2010; Candelario, 2007), or as a manifestation of "negrophobia" or "antihaitianism"[96] (Torres-Saillant, 2010). In Chile, based on an ethnography carried out in Dominican

[95] Migrant families have an average of 2.3 children in the country of origin, compared to 1.7 in Chile. It is also relevant to note that, only after 2004, the process of reunification of immigrant families began in Chile (MIDEPLAN, 2006).

[96] As different studies have shown (Howard, 2008; Rojas Pedemonte, Avode and Váquez, 2017; Tavernier, 2010), racist and xenophobic dynamics towards Haitians are widespread in the Dominican Republic.

beauty salons, Antonia Lara (2020) has suggested that “Dominican brushing” allows Dominican women to dispute the beauty (“el arreglo”) of women with Colombian, Haitian, Peruvian and Chilean women in national, racial and gender terms.

However, the centrality of Mercedes's body was not reduced to the social effects that her beauty practices had, but also involved a series of situations in which she lived the violent transgression of her personal boundaries. Situations of violence, humiliation and discrimination became increasingly present in Mercedes' life, affecting the way she inhabited public spaces. In an interview, she said: “Sometimes I would walk down the street, and people would yell at me things like 'go back to your country' (...). Or things in a sexual sense, men who told me ugly things like 'how much do you charge?', As if one were a woman of the street. That hurt me, and then I was afraid to walk down the street”.

Occasionally, these types of practices took on even more violent forms in private spaces. Particularly in workspaces, where there was an employer-employee power relationship. Although Mercedes emphasised that most of the Chilean people were “good people”, she pointed out that she was humiliated repeatedly. For example, Mercedes explained how she experienced the work of caring for an elderly Chilean woman:

> The lady had a good day, and then a bad day. I cooked with her and helped her because she liked to make her food. But when I ate in front of her, she said to me: 'Look at her as she eats, as a pig' (“chancho”), and she criticised me. I suffered a lot, every night I cried, cried, cried. Well, I said to my family, 'I want to go back, I'm going to the Dominican Republic, I'm going...', and my husband told me to hold on since I had taken that step.

Racialisation and sexualisation practices enabled Mercedes to realise, not only how forms of social stratification operated in Chile, but also how they promoted a subjective change through which Mercedes began to represent herself as an “immigrant”. These practices led Mercedes to represent herself, in her words, as a “second-class person”. In this representation, as I have previously shown, images such

as “an unwanted person”, the “sex worker”, and the “animal” converged. She said: “I know that I am not what people can say of myself, but when they treat you in a bad way, one can feel that one is not in the same position as other people here in Chile”.

Hence, a second landmark began to take shape: becoming a migrant in the host country. Through this second landmark, I highlight how subjects begin to represent themselves as “immigrants”, placing themselves in subordinate positions in the destination country. As different research has revealed in various contexts (Balibar and Wallerstein, 1991; Fassin, 2011a; Fassin and Rechtman, 2009; Sayad, 1999), migrants commonly receive violent, discriminatory, and stigmatising treatment as a result of their interaction with various constraint forces. Many of them are reduced to a place of supposed “dangerousness” and “threat”. In the Chilean case, various studies have shown how racialisation has turned the afro-descendant population into “visible subjects” due to their skin colour, bodies, and ways of inhabiting public spaces (Liberona, 2015a, 2015b; Tijoux, 2011, 2016; Tijoux and Palominos, 2015; Stefoni, 2011; Stefoni and Bonhomme, 2014). This visibility has taken shape in various areas. For example, in an interpersonal field, through racialisation practices and the reproduction of stereotypes and stigmas; in a security field, through the supposed insertion of criminal gangs and drug trafficking; and lastly, in the health field, through the supposed increase in the transmission of diseases such as leprosy, HIV, and tuberculosis, mainly. Specifically, in the afro-descendant women's case, practices of racialisation and sexualisation have reproduced representations that designate them to a place of “hypersexualisation” and “greater sexual desire” (Carrère and Carrère, 2015; INDH, 2017; Tijoux, 2014; 2016).

In order to understand the forms that racialisation and sexualisation practices take in the country, it is crucial to highlight some elements of colonial history and the formation of the Chilean nation-state. Although, in broad brush terms, slavery operated similarly in all Latin American colonies (Mignolo, 2005, Viveros, 2009, Wade, 2015), the relationship between the Chilean state and the afro-descendant population acquired some differential nuances in Chile (Cuseen, 2016). Specifically, unlike other

colonies, historical research suggests that there is no strong evidence to claim that Spanish settlers limited the social mobility of black slaves during the 17th century (e.g. paying for their freedom). On the contrary, there is evidence of a certain "appreciation" for black slaves by settlers (Cuseen, 2016; Grubessich, 1992)[97]. Indeed, the afro-descendant population reached some degree of integration[98] in the social stratification at the end of the colony. Their social rise can be understood through the fact that black slaves were not the only labour source. Spanish settlers also used indigenous people as workers[99], but continuous conflicts and wars with them made it harder for settlers to exploit this labour source. For example, settlers considered the Mapuche to be "not very docile"[100] people. Besides this, unlike other colonies, the number of afro-descendants was less than that of Spaniards and Creoles[101] in the Chilean colony (Cussen, 2016).

The conformation of the Chilean nation-state at the beginning of the 19th century promoted a liberal discourse based on a blood unit or, as I have highlighted in the first chapter, "mestizaje" (Wade, 2010; 2015). Given this, the idea of a "Chilean race" emerged as a mixture forged between Spaniards and the indigenous people (Larraín, 2001; Subercaseaux, 2007). The new national identity valued miscegenation and, at the same time, excluded the afro-descendant population from its national narrative, veiling racial differences - in an "absent presence", paraphrasing Wade and his colleagues (2014) - from social hierarchies. A clear example of this exclusion is that

[97] For the same reason, it seems to be no coincidence that the abolition of slavery occurred in 1823 in Chile, decades earlier than in other former Spanish colonies such as Peru (1854), Argentina (1853) and Colombia (1851).

[98] Indeed, as a result of their integration and the associated whitening process, the afro-descendant population began to decrease. According to the 1778-79 census, from Copiapó to Maule there were only 12% of "Mulatos", "Negros", or "Pardos" (Carmagnani and Klein, 1965).

[99] There was a form of clandestine slavery of the indigenous people under the euphemism of "criados" or "aucos".

[100] The Mapuche people were associated with the Arauco War. The Arauco War is the armed conflict that made it difficult for the Spanish colonists to continue advancing in the conquest of southern Chile.

[101] Although the afro-descendant population in Chile was less than that of other latitudes in Latin America, it reached 20-25% in the 16th century.

it was only in 2019 when the Chilean State granted legal recognition to the "Chilean afro-descendant tribal people"[102].

The Chilean nation-state formation at the beginning of the 19th century gave shape to what Balibar and Wallerstein (1991) have called "fictional ethnicity". That is, a fiction that has historical or institutional effects, and is capable of producing the naturalisation of belongingness. Fictional ethnicity, experienced by subjects as natural, has established a difference - as researchers in various contexts have highlighted (Balibar and Wallerstein, 1991; Wacquant, 2001) – between two positions: "we" (white of European origin) and "them" (black, Indian, barbarian)[103]. In line with this, although the processes of racialisation and sexualisation find their roots in the colonial history and formation of the Chilean nation-state, it is necessary to emphasise that such roots have not been static over time. On the contrary, the history of Chile shows a dynamic racial topology through which power relations have constantly shaped the interactions between actors and communities. In this sense, as I mentioned in the previous section, the diagram of power (Rose, O'Malley, and Valverde, 2006) of such a topology has recently placed the "black immigrant" in the position of the internal enemy. For example, according to the Annual Report of the National Institute of Human Rights (INDH, 2017), 44.5% of the Chilean population considers that crime has increased with the arrival of migrants[104], just as 68.2% agree in limiting access to the country's migrant population.

Racialisation and sexualisation practices and their psycho-social impacts

To fully understand the subjective change of Mercedes and her family, it is necessary to maintain distance from conceptions that reduce subjectivity to a psychological dimension. In other words, to highlight the impact of a set of constraints

[102] Law 21.151.
[103] According to a study by the National Institute of Human Rights (INDH, 2017), more than a third of the Chilean population considers themselves whiter than that of other Latin American countries.
[104] The same report indicates that 1% of migrants have been detained for committing crimes.

typical in Chilean society, one should not understand subjectivity as the inner life of the subjects. Far from a psychological approach, subjectivity should be understood as a complex and dynamic space through which we can examine a set of historical, social, economic, political and material forces (Biehl, Good and Kleinman, 2007; Blackman, et al., 2008). As I have shown, the impact of several of these forces led Mercedes to represent herself as a "second-class person". However, she managed to cope with this representation of herself through interaction with the image of a "good worker". Through this image, she represented her potential integration within the normative values of the Chilean society. Mercedes said: "one knows that they do not treat you the same, but in the end, the Chileans begin to realise that one does things well, that one works well. Not all Chileans are bad. Many of them are very good people, and they value me".

The racialisation processes not only constrained the life of Mercedes but also that of her daughter Laura. Furthermore, the emotional and behavioural effects seemed to be much greater on Laura. Upon arriving in Chile in 2013, Laura was ten-years-old. At that time, her mother enrolled her in a public school in the borough. Due to her age, she entered the fifth level of elementary education[105]. However, Laura twice failed this level. Mercedes said that it was difficult for Laura to pass the course since she did not fully understand the content and "the way of how Chileans speak". In this regard, she said: "Chileans speak very fast and have a lot of words that one does not understand". However, a central aspect during this period was the "bullying" that Laura suffered. Mercedes referred to this:

> The girl felt like she was disturbing the country. They said to her: "fuck you, Negra! ("Negra culiá") Go to your country!". People really like to say to one like that (...). They pushed her at school. They did what they call "bullying". The girl suffered and told me: "You brought me to this country so that they will look down on me! I want to go to my country; I don't want to be here. I used to tell her that she had to be here for me because I am her mother, and I needed her to be here (...). I told her not to listen to the children. But at school I had many conflicts, they called me because they [the schoolchildren] pushed her and she, as she is a strong "morena",

[105] In Chile, compulsory education is divided into three levels: pre-basic, basic and middle. Basic education, specifically, has eight levels.

> also did not let herself be pushed, from time to time; and I thought: “Oh Lord! What I am going to do?”

From Laura's viewpoint, she tended to adopt an ambivalent position towards instances of racism and bullying. Her position ranged from normalisation to the malaise associated with these events. On some occasions, she said: “They are things that happen, they are normal because people at school bully each other, I am used to it”. However, Laura, in an interview with Andrea, the research assistant, said: “bullying made me fight when I was bothered by my skin colour, and I did not like it (...). I never had problems there [Dominican Republic]”. As researchers at the national level have documented (Pavez, 2010; Suárez-Cabrera, 2015; Stefoni, Acosta, Gaymer, et al. 2008; Tijoux, 2013a; 2013b), migrant children become carriers of stereotypes, prejudices, and stigmas associated with their parents. They inherit the “immigrant status” of their ancestors. Thus, in children there converged a “self” shaped by images related to “threats” and “crime”, making them an identifiable social problem and, therefore, susceptible to intervention by the Chilean State.

Racialisation and sexualisation processes had important impacts on the relationship between Mercedes and Laura. These processes shaped a series of restrictions on body, subjectivity and the sexuality of both. Mercedes said: “I'm afraid for Laura that something will happen to her. Here many men do not look at women with good intentions. They see them as nothing. They are not attentive or romantic”. Mercedes expressed her concern about the potential dangers Laura faced in public spaces. She said: “She [Laura] is growing up, she is becoming a beautiful black woman (“una Negra bella”), so I ask her to come home from school. And if she wants to get together with a friend, get together here at home. I don't want her to get pregnant like other girls”.

Although Laura recognised, like Mercedes, that there were certain “dangers” in the public space, she contextualised the problem of racialisation and sexualisation practices differently. Laura more emphatically expressed the difference between the

Dominican Republic and Chile in terms of public security. Commonly, she said: “here you cannot do anything, at night you cannot go out. It is not like in the Dominican Republic where one could go out and everyone knows each other”. However, unlike her mother, sexualisation practices seemed to be part of the backdrop of her life. In an interview with Andrea, Laura said: “my mom exaggerates a little with that. She believes that all men here look at black woman with other intentions...like sexual intentions. She overprotects me. And I think that if she could, she would never let me have a boyfriend (laughter)”.

Laura was referred to the Mental Health Program at the CESFAM by the psychologist from her school. According to Viviana, the referral report revealed that she presented with manifestations of “anxiety”, “irritability” and “aggressiveness”. These manifestations affected her relationships with both her classmates and her teachers at school. The report detailed that these manifestations were due to “Problems related to the primary support group”, a category from the ICD-10 commonly used by psychologists in educational establishments and primary care centres in the borough. Specifically, the school psychologist described these as problems around the “parents' little concern for school issues”, as well as the recent “parents' separation”.

Viviana received Laura and Mercedes for a first interview at the CESFAM in September 2017. Laura was 14 years old at the time. Unlike the assessment carried out by the school psychologist, according to Viviana, in that first session, both Laura and Mercedes emphasised that the problems at school were the result of racist practices and bullying. Laura denounced the teachers by suggesting that, although the teachers were against this type of practice, she did not usually feel protected by them. In the same interview, Laura said:

> The psychologist saw that I pushed her, but she didn't say anything when they discriminated against me or said things to me because of my skin (...). She called me 'ugly Negra'. I think because she was jealous because a boy liked me, a blond boy. And she liked him (…). Once the teacher and the psychologist summoned us (...). The teacher told this girl that she was not a queen and that she could not treat

> people like that, but she started crying. She became the victim, and the victim was me.

Mercedes's perspective was similar to Laura's regarding the practices of school practitioners. Mercedes emphasised that school practitioners did not weigh the impact of this type of practice on Laura. She reported:

> The psychologist is haughty. She is not a warm person like Viviana. She doesn't listen to anyone, and she doesn't listen to what my girl is going through (…). She only sees the fact that Laura reacts, but those companions are the bad people (...). The psychologist calls me to go to school. I have gone, she tells me that I have to go to some talks when I went, the talks were cancelled. Then she called me again. I did not understand why I had to be there. I spoke to her and told her that I worked, that I couldn't always go to school. I attend parent meetings every month. But I can't always go.

Viviana affirmed that the reasons behind Laura's mental health issues were related to racist practices and bullying in the context of the school. By acknowledging these underlying causes, in turn, she was somewhat dissatisfied with the work that the psychologists were doing at the school. This disagreement was linked to a critical position that operated both on a technical and an ethical/moral level. On one hand, Viviana said that, as a result of a "bad diagnosis" by the school psychologist, cases like Laura's were referred to the centre. She referred: "the municipality also trains in schools on migration and racism (...), and we do it on mental health issues (...), so one does not understand how they fail to stop this type of behaviour of racism and bullying". However, on the other hand, Viviana argued that, associated with "misdiagnosis", there was a certain normalisation of racist practices and bullying in school contexts. She said: "even if practitioners are technically good (…) if practitioners do not interrogate these practices, they will not be able to see them". Through this, Viviana's critical position was not reduced to a matter of psychology in technical terms, but instead she adopted an anti-racist defence position.

Despite this, Viviana, like the school psychologist, also suggested that her parents' separation had impacted Laura. In Viviana's opinion, Laura associated her parents' union with a stage in her life that was marked by a feeling of "happiness" in the Dominican Republic. For this reason, her parents' separation impacted, in Viviana's words, Laura's "emotional stability". Regarding this situation, Mercedes, in the context of an interview, reported:

> The girl [Laura] started asking me what was wrong with her dad, why was he so strange. I was arguing with him. Why we argued and fought. The girl became aggressive also when seeing all those things. She saw her dad on Facebook with the other woman, sitting and him with his hands-on top. That caused her to have a rage inside her. The girl with me is not very talkative. She locked herself up and fell out with me. This was because her dad was still here, and I was allowing him to cheat on me the way he was. He would get ready in the morning, put on his clothes and arrive here in the evening. Sometimes he didn't come. The girl said: ´You are guilty because you accept it. The day I am a woman, I will not allow that'. All this made me suffer because I knew that the girl was right.

Viviana and Laura focused on issues such as violence at school and parents' separation during the six psychological consultations carried out between September 2017 and May 2018. In an interview conducted in June 2018, Viviana stated: "I would love to be able to work more with her, but we have many cases here at CESFAM (…). Sometimes I think that if we did more workshops in schools, something would change, but we don't have the time either". As I show in various chapters of this thesis, Viviana expressed her malaise at the reduced time she had to attend to each of the clinical cases. Despite the number of sessions, Viviana highlighted Laura as a "successful case" when considering other migrant children with various afflictions. She argued: "in schools, and here at the CESFAM, we see many affected migrant children (…). They adapt more quickly to the country, but they also suffer, they begin to see themselves as different, and they also miss their home countries and their families". Regarding Laura, she added:

> Laura has been fine, but, likely, she will soon have conflicts with her mother. She is growing up, and her mother is very conservative (…). She does not let her have a boyfriend ("pololo"), for example. I hope to work with her to show her that her

> daughter is growing (…). She will end up living as a Dominican at home and as a Chilean at school, and that cannot be.

The psychosocial and mental health aspects of migrant children and youths have tended to receive little attention from researchers in Chile (Abarca-Brown and Carreño Hernández, 2014). Most of the studies have focused mainly on the psychosocial impacts of racialisation practices (Cárdenas, Gómez, Méndez, et al., 2011; Hevia, 2009; Riedemann and Stefoni, 2015; Stang and Stefoni, 2015; Tijoux, 2013a, 2013b). For instance, according to Tijoux (2013a; 2016), Chilean teachers and students treat migrant students differently who, based on their characteristics, present certain similarities with indigenous traits. Besides, migrant families and children are often discriminated against because of their colour, branded as "Cholos"[106], "Indians" or "Blacks" (Tijoux, 2013b) which, in turn, affects their representation of themselves and the Chilean community. In parallel, UNICEF (2004) has affirmed that affected migrant children perceive their traits negatively and have an upbeat assessment of Chileans' bodily characteristics.

Tijoux (2013a, 2013b) states that, for instance, Peruvian children and young people are marked, not only for being migrants, but also by their social class. In schools, they are teased about their habits by other children, as well as by some teachers. They receive constant recriminations and corrections for their way of speaking, which teachers and students often conceived of as an indicator of intellectual deficiency. Similarly, Cárdenas and his colleagues (2011) have explored the prejudices of Chileans against Bolivian youths in different schools in Antofagasta (a city placed 1,400 km north of Santiago). They have shown a high level of discrimination and racism, as well as hostile and hateful reactions from Chileans. Likewise, Hevia (2009) has highlighted that both Chilean students and teachers tend to conceive of children belonging to the Peruvian community as "problematic" or "disruptive".

[106] Notion attributed to indigenous people in South America.

Children respond to discrimination practices by using a series of adaptation strategies in order to achieve a better degree of adjustment with Chilean society. For example, they tend to use the Peruvian accent only in the domestic context, distancing themselves from Chilean idioms when talking to their Peruvian family or colleagues (Tijoux, 2013a). Their families seek to transmit a certain capacity that allows them to discriminate between the normative elements that they can adopt from their Chilean peers and those that they want to keep as part of their traditions.

Some research on the mental health of migrant children and youths has focused on contexts other than schools. For instance, Pavez (2010, 2013) has revealed how overcrowded housing conditions in which many migrant families live lead children to suffer from the consequences of family conflicts caused by these confined spaces. This was associated with the potential violation of their privacy and dignity rights. Similarly, Pavez (2010) has also addressed the relationship that migrant families maintain with government institutions (services, government offices, etc.). She argues that institution officials usually do not know the rights of migrant children, particularly those related to non-discrimination.

Based on these studies, the spaces where it is possible to identify discrimination and the violation of rights more frequently are the school, the peer group, the borough, and the health centres. In these spaces, children become objects of physical and psychological abuse that, on one hand, disadvantage their integration into new communities and, on the other, affect their emotional stability, giving way to feelings of abandonment and anxiety (Stefoni et al., 2008). In part, this could explain why, from an epidemiological perspective, the prevalence of mental disorders in the adult and children-youth migrant population, conducted in the north of Santiago, has revealed that disorders in the child-youth population (second generation) is higher (29.3%) than in the adult population (17.8%) (Rojas, Fritsch, Castro, et al., 2011).

On the epistemic difference between representations, knowledge and practices in mental health

While Laura walked with Andrea towards the hairdresser to look for Mercedes, she commented that she liked to attend the "psychological sessions" at the CESFAM. Laura appreciated that this was a space where she could discuss her "problems" with someone "who was not part of the family". Unlike her mother, she seemed to speak more naturally about mental health problems and treatments. In part, this can be understood by her greater familiarity with discourses, knowledge, practices and agents in mental health. For example, Laura had daily contact with psychologists and also attended mental health prevention workshops conducted by the CESFAM practitioners at school. Also, several of her companions attended psychological therapy in one of the CESFAMs or other centres of greater specialisation in the borough.

On the way to meet her mother at the hairdressers, Laura told Andrea that racism and bullying issues occupied an important part of the psychological sessions at the CESFAM. She referred: "the psychologist Viviana knows many things. She gives me good advice (...). When I left the session, I felt that I am calmer, as well as lighter, like flying (laughs)". Laura recognised that Viviana had partially helped Laura to change her self-representation. Laura stated that: "Once Viviana told me that there are people who discriminate everywhere, but there are also good people… and she told me that she liked my skin colour. She said I had to love myself. That helped me".

When they arrived at the hairdressing salon, Mercedes was with two children of around four years old. On her days off or while she was in the process of changing jobs, Mercedes often used to take care of children. This activity allowed her to earn some additional money. Seeing them both arrive there, she exclaimed laughing "this is my therapy. To come to the hairdresser to talk for a while and do something to my hair or nails". After a few minutes, they started walking back home. On the way, Laura told Mercedes that she had been talking with Andrea about the positive effects of the

therapy at the CESFAM. After agreeing with Laura, Mercedes asked Andrea: “Do you know how long the therapies last? Because Laura has been going to the CESFAM since last year and she is already well”. Andrea told her that she did not know, and also informed her that she could go to the centre and ask Viviana directly. Mercedes pointed out: “Yes, about a month ago [Viviana] told me that she wanted to talk to me and said to Laura the same thing, I could not go because it is difficult for me to go before five in the afternoon, and she works until that hour”.

Figure nº5: The Mercedes house’s front door. The sign reads: “I babysit children” (“Se cuidan niños”) and Mercedes’ mobile number.

In their house, they met Ramón [Mercedes’ son]. Seeing them enter through the door that led to the central corridor that connected four other houses, Ramón was surprised at Andrea's presence. While he was cordial, he also maintained some distance. At moments, his comments revealed a certain distrust of Andrea's words.

When Laura started talking about the psychologist at her school, Ramón suddenly interrupted her and asked her in a certain aggressive tone: “Are you the CESFAM psychologist? Do you attend Laura?” Mercedes and Laura answered in unison that Andrea was not the psychologist. Faced with this misunderstanding, Ramón quickly replied:

> Ah! Okay, just look, with so much therapy they are going to drive Laura crazy (...). I don't know why here [in Chile] all teenagers go to the psychologist. Adolescents here drink, steal and some of them self-injure their skin (...). Have they no family? Are there no people who care about them? Laura here has a family that always protects her. A family with values. Laura is fine. She has no problems. She has no vices. She is a happy girl.

The tone of Ramón's words revealed malaise and conveyed a certain feeling of helplessness as he was not sure about the attention received by Laura at the CESFAM. His uncertainty was echoed by Mercedes, who shyly asked Andrea: “Laura is fine. But the psychologist wants to talk to me again. He told Laura that he wanted to talk to me for some sessions. Do you know about what?”

Mercedes and Ramón not only seemed barely familiar with the knowledge, practices and agents in mental health, but also revealed that they placed a significant emphasis on the role of the family and of community support in managing emotional and behavioural problems in the Dominican community. Aspects such as the objectives, goals and length of treatment seemed to be unknown to them. For them, the image of the psychologist appeared to be linked to madness and the psychological consultation a potential trigger of it; in contrast, the role of the family, community support, and the transmission of good values would protect Laura from “vices” such as alcohol, drugs, and emotional and behavioural problems.

Like Mercedes and Laura, much of the Dominican community seemed to have little familiarity with mental health discourses, knowledge, and practices. As it is possible to infer from various studies (Caplan, Little, Reyna, et al., 2016; Hernández, Gibbs, Gautreaux-Subervi, 2011; Luciano, Nadal, Brito et al. 2019) and international

organisations (OPS, 2019), mental health has not been a priority issue in the Dominican Republic. For example, there is limited funding for mental health services[107], an unreliable distribution of psychiatric medications, a low number of mental health practitioners[108], and stigmatising attitudes among health workers. Likewise, studies have pointed out that the Dominican community, both in their country (Luciano, Nadal, Brito, 2019) and in other destination countries, such as the United States (Caplan, 2016; Caplan and Cordero, 2015), tends to associate mental conditions with severe disorders such as schizophrenia and dementia, as well as cognitive difficulties. This association has led people to stop consulting specialised centres for fear of social stigma. Evolving out of this context, in 2019, the Dominican State put in place a mental health plan that promoted a "new paradigm in mental health", aimed at strengthening primary care with a preventive, community, and participatory approach (OPS, 2019). For its part, the centrality of family and community support in the managing of emotional and behavioural problems in the Dominican community has not been sufficiently researched. Indeed, mental health studies in the Dominican Republic have tended to focus on the shortage of mental health services and practitioners ("formal care"), over approaches that highlight so-called "informal care".

Although researchers have reproduced this trend in various contexts (Chase and Sapkota, 2017), some studies carried out in Caribbean countries such as Haiti (Coreil, 1983), as well as in other countries in the last decades (Chase and Sapkota, 2017; Janzen, 1978; Kleinman, 1978; Worsley, 1982) may shed some light on the Dominican case. These studies revitalise what Kleinman (1978, 1980) argued for in his tripartite popular-folk-professional model of health systems. Particularly, through the "popular sector", Kleinman highlighted the significant role that the individual, and the family and community environment all play in healthcare. Currently, various studies

[107] Less than 1% of the health budget.

[108] According to Alarcón (2003), the estimated number of mental health professionals in the Dominican Republic is 1.6 psychiatrists, 2.7 psychiatric nurses, 2.8 psychologists, and 1.9 social workers for every 100,000 inhabitants.

have stressed the significant role that is played by the family and community support in the management of psychological malaise and suffering (Chase and Sapkota, 2017; Han, 2012; Kohrt, 2014), as well as the role of ethnopsychological aspects in seeking help (Kohrt and Harper, 2008).

These antecedents point to the underlying conditions that began to shape the differences in representations, knowledge and practices around emotional and behavioural problems between Viviana and Mercedes' family nucleus. On one hand, as I mentioned earlier, Viviana planned to work on what she called the "generation gap" between Mercedes and Laura. Specifically, she had the intention of focusing the work on the "mother-daughter bond" since she considered it to be a potential "conflict space". Similarly, as other studies have shown (Béhague, 2016, 2017), Viviana, protected by expert knowledge provided mainly by psychology and neurology, circumscribed Laura within the margins of "adolescence" or, in her words, "a troublesome age". She conceived of Laura as a person in a crucial stage of development for adult life where sexuality was central. For Viviana, the restrictions imposed by Mercedes could potentially overshadow the development of Laura's potential. On the other hand, Mercedes and Ramón revealed particular forms of representing afflictions. In these forms, the manifestations of psychological malaise and suffering could be managed within the family space; a place where support, values and practices played a central role. Indeed, when Laura attended her eighth session with Viviana, Mercedes decided that Laura should no longer attend psychological consultations. Her argument was that: "the girl is fine; she no longer has problems at school, and I don't know why she should go if she is fine".

Viviana seemed to ignore the differences between her perspective and that of Laura's family regarding knowledge and practices of psychological well-being. Furthermore, Viviana seemed not to be aware that the way of representing problems and the forms of psychological help in Laura's family were not anchored in knowledge and practices provided by disciplines such as psychology, psychiatry and neurology. In other words, the disagreement between both forms of knowledge and practices

seemed not to be reduced to the lack of information from Laura's family regarding psychological practices, but rather to a way of understanding health and afflictions.

The epistemic difference between the health system in Chile and the Dominican community raises important questions regarding the potential modes of subjectivation of migrant communities, particularly of those who arrived in the country as children - as in Laura's case - and of the second migrant generations. For example, as I will show in the next chapter, how health institutions and psy/neuro technologies (Rose, 1989; 1996, 2007, 2013) begin to build afro-descendant migrants ("making up" people) (Hacking, 1985), and how a series of interactions and negotiations emerge between health institutions, psy/neuro technologies, religion, magic and migrant communities.

Chapter III:

Becoming a (neuro)migrant: Global mental health and Haitian community in Chile

María asked me to wait while, at her office door, she spoke to relatives of one of her patients about an urgent referral to a psychiatric hospital. She had worked as a psychologist at the Family Health Centre (CESFAM) for more than ten years and had developed her own unique management style: flexible scheduling and receiving patients without appointments due to what she considered to be "complex situations". María, as well as others psychologist of the team, usually dealt with this kind of situations once a week. They were commonly "clinical emergencies" related to the referral of severe patients from primary healthcare (CESFAM) to other specialised mental health centres such as the Community Mental Health Centre (COSAM) and the Psychiatric Hospital.

I was sitting in one of three chairs distributed in her office while she talked with her patient's parents. Unlike other spaces at the CESFAM, the room looked much smaller and more dated. Rather than looking like it was built for clinical work, this space was more of an add-on. Made of lightweight materials it appeared to be an extension to the main building. During the cold days of winter, the temperature here dropped sharply. In fact, María and her patients commonly wore jackets and scarves during their sessions. On her desk, an electric coffee maker was significant for its size and noise. The coffee maker's steam filtered through the small spaces between the walls and the ceiling. On the wall, there were three ornaments, all of them made of woollen fabrics. On the left, sunlight shone through a mandala of live calypso and fuchsia highlights. In the centre, a Mapuche loom of brown tones. On the right, there was a "dream catcher" from which long decorative extensions hung. While I studied these closely, María closed the door saying: "Do you want coffee for the cold?" I nodded and as I did, she rapidly launched into telling me about her day: "Today I met with a Haitian patient here that I attended a few months ago. A fascinating case".

While María drank her coffee and looked at the knitting and fabric she weaved during her free time, she described the two sessions with that particular Haitian patient. According to María, a physician at the Family Health Centre (CESFAM) referred the patient with a diagnosis of "psychotic disorder". The patient had told the physician she had consistently seen three men following, insulting and threatening her during the last week. María pointed out: "It was a vision that the patient had. She was aware that it was a vision and that the men did not exist at all (...) she said that her husband also saw these men". María recounted how difficult it was to thoroughly understand the experience of the patient. She emphasised that, as a result of language differences and the cultural facilitator's translation, her understanding became even more problematic. For María, the patient attributed her symptoms to a Haitian man who "had made a curse". The patient would have said "he cursed me with three dead people's spirits" ("me cargó tres muertos").

Attempting to use a psychological theoretical approach to understand patients' perspectives was troublesome for María. She argued "for me, that case was a psychotic episode, but it was also weird because she didn't seem so distressed or disorganised by the situation. She only seemed to be worried". At the same time, María also came to the conclusion that visual hallucinations were not common in patients without clinical records of schizophrenia or some types of epilepsy. At that moment, María made a clinical decision based not on expert knowledge provided by psychological, psychiatric and neurological disciplines[109], but rather on a vague understanding of magical-religious traditions that she attributed to "Santeria"[110]. María told me: "I don't know why I did it, but it was like an intuition. I didn't know if it would work. At that moment, I knew nothing about Haiti or Vodou[111] culture, but I told the patient to light a candle and told those men to follow the dead light as

[109] Hereinafter "psy/neuro" knowledge, following Nikolas Rose (1996, 2007)

[110] That is, a religion shaped by African Yoruba religion, popular Catholicism and 19th century French Kardecian spiritism (Brandon, 1997). This religion has spread throughout different Latin American and Caribbean countries where afro-descendant diaspora has arrived (Murphy, 1994).

[111] She was referring to the training workshop for health practitioners about migration and intercultural health. I developed in-depth this matter in the first chapter.

Santeria believers do". Her words and laughter suggested that she was juggling two opposing approaches. A scientific one that she was comfortable with and which in her perspective carried more authority, alongside a cultural one, imbued with magic, religion and spiritual connotations, that she was more uncomfortable. After that intervention, the patient's symptoms utterly subsided the following week. María pointed out: "don't ask me why, but the patient's visions were over".

The interplay between science, religion and magic began to occupy a central place at the CESFAM due to the arrival of Haitian migrants over the last five years. This convergence brought with it several tensions and conflicts around the different systems of knowledge and practices concerning mental afflictions. Moreover, these tensions and conflicts did not take place only at the CESFAM, but also emerged in the whole north healthcare network of Santiago. Specifically, similarly to the scene related by María, physicians, psychologists and social workers began to question the effectiveness of their practices. Mental health team meetings became a space where they started to challenge conventional diagnostic categories, as well as to reflect on the development of new interventions for what they called "the Haitian culture".

Within this context, I began questioning how health teams have adopted psy/neuro technologies[112] (Rose, 1999; Rose and Abi-Rached, 2013) framed by the gradual introduction of the global mental health (GMH) agenda (Araya, Alvarado, Minoletti, 2009), how these technologies were impacting Haitian patients, as well as how Haitian patients were interacting with these technologies. Thus, in this chapter, I will explore how the relationship between science, religion and magic took shape in mental health interventions with the Haitian population at the CESFAM. Through the lens of mental health practitioners and Haitian patients, I will focus on how interactions and subjectivation processes have emerged between healthcare centres

[112] By psy/neuro technologies, I refer mainly to the introduction of several evidence-based psychotherapies, psychopharmacology treatments and neuroimaging techniques in the public health system in Chile.

and the Haitian community, highlighting the different systems of health knowledge and practices involved.

I will argue that the implementation of psy/neuro technologies has led to subjectivation's heterogeneous processes in Haitian patients. Although a great number of Haitian patients refuse these technologies (McGranaham, 2016; Simpson, 2007), some subjectivation processes lead to question to what extent technologies are “making up” (Hacking, 1985) Haitian patients by shaping new representations of self, malaise, suffering and mental health anchored in a certain kind of brainhood (Ehrenberg, 2018; Dumit, 2000, 20004; Rose and Abi-Rached, 2007; Vidal and Ortega, 2017). I will also argue that although practitioners have shown reflexivity around ethnic and contextual aspects, they have tended to neglect ethnic and contextual aspects in their interventions, as well as to racialise the notion of “cultural difference” and abnormality/madness. By translating Haitian patients’ malaise and suffering into GMH references, practitioners reproduced, what I have called, a “cultural de-substantialisation” process. This means, the practice of extraction of “cultural aspects” in order to carry out a successful translational process according to a GMH framework.

This chapter sheds light on current debates in GMH (Béhague and MacLeish, 2020; Lovell, Read, and Lang, 2019; White, Jain, Orr, et al. 2017) and medical anthropology (Duncan, 2015; Giordano, 2014; Jenkins, 2015; Ticktin, 2011) by highlighting how mental health practitioners translate Haitians' afflictions into a psy/neuro idiom within psychological consultations. It also emphasises how psy/neuro technologies tend to mask the relationships of neuro-knowledge with Haitian cosmovision, as well as with other forms of knowledge such as Haitian-Creole medicine and Vodou (Auguste and Rasmussen, 2019; Damus and Vonarx, 2019; Pierre, Minn, Sterlin, et al., 2010; Vonarx, 2012; WHO, 2010). Besides, this chapter contributes to debates on the uses of race (Koenig, Lee and Richardson, 2008; Whitmarsh and Jones, 2010), highlighting how mental health practitioners tend to

reduce mental afflictions to a genetic predisposition of the afro-descendant population.

The chapter is based on multiple ethnographic observations conducted at the CESFAM over 14 months during 2018-2019. Here, I conducted observation sessions during initial individual psychological consultations, collective interview admissions, mental health liaison consultations, clinical meetings, as well as intersectoral meetings ("reuniones intersectoriales"). I also interviewed health practitioners who worked in the mental health programme, such as psychologists, social workers, and physicians, as well as psychiatrists who worked in specialised institutions of the north public health network (e.g. COSAM, Psychiatric Hospital). Besides this, I carried out some interviews with Haitian migrants and their family members.

This chapter is divided into five sections. First, I will show how the Chilean state has gradually introduced several mental health reforms informed by the GMH agenda. Although these reforms have driven a community approach, they have introduced policies, strategies, and technologies that have tended to individualise and depoliticise malaise and suffering, and to shape how people understand malaise, suffering and mental health. Then, I will describe how, through the adoption of the GMH agenda, expert knowledge has masked traditional magic-religious practices related to mental afflictions in Chile. Third, I will describe how the arrival of the Haitian population in Chile has led to the "return" of magical-religious aspects to the debate around mental health. As various studies have revealed (Auguste and Rasmussen, 2019; Pierre, Minn, Sterlin, et al., 2010), religions play a central role in Haitians' everyday lives, particularly Haitian Vodou. I will stress that Vodou is not only a religion anchored in a cosmovision but also a hybrid health system that interacts complexly with other religions, with Haitian-Creole medicine, as well as with biomedicine (Damus and Vonarx, 2019; Vonarx, 2012; WHO, 2010).

Fourth, I will show how, even though the culture category permeated discussions at the CESFAM, mental health practitioners tended to use it mainly in

racial terms. I will stress that, practitioners, based on the influence of genetics in psy/neuro disciplines, have carried out particular "race practices" (Whitmarsh and Jones, 2010; Koenig, Lee and Richardson, 2008). This has led them to associate the afro-descendant population with a genetic predisposition to certain mental disorders, particularly psychoses. Finally, I will show that, in a primary healthcare context marked by precarious conditions (e.g. high numbers of patients, reduced time for interventions, etc.), mental health practitioners tended to reproduce standardised individual interventions framed in a hegemonic mental health model, neglecting intercultural aspects in their clinical encounters, and providing neurobiological explanations of Haitians' afflictions. From this, I will stress how Haitians carried out heterogeneous subjectivation processes, highlighting three subjective destinies as a result of interactions between mental health technologies and Haitian patients: the internalisation of technologies in a context of specialised healthcare centres (e.g. the Psychiatric Hospital); the internalisation of technologies in a community interventions' context (e.g. school); and the refusal and resistance of technologies.

The global mental health (GMH) agenda in Chile

Since 2012, mental health practitioners have started to question and challenge their knowledge and practices by working with the Haitian community at the CESFAM. In clinical meetings, psychologists, social workers and physicians often discussed the different obstacles that they faced in their clinical encounters, such as the poor adherence of patients to treatments, the barriers caused by the language difference, as well as different symptomatic manifestations. However, they particularly stressed that the lack of familiarity with psy/neuro technologies as well as different idioms of distress (Nichter, 1981) were the greatest obstacles to working with Haitian patients. In other words, different references organised practitioners' and patients' discourses and practices around malaise, suffering and mental health. Psy/neuro disciplines seemed to occupy a hegemonic place, becoming a "regime of truth" (Foucault, 2003

[1976], 2010 [1978]) through which practitioners legitimised their knowledge and practices.

The conceptual and practical foundations of mental practitioners' hegemonic approaches found their roots in the gradual introduction in the country of what is currently known as a GMH agenda. Nevertheless, some local psychiatry and public health researchers have highlighted that even before the call to scale up mental health programmes in low/middle-income countries (Patel, Garrison, de Jesus, et al., 2008), the Chilean state initiated a "silent revolution" (Araya, Alvarado, Minoletti, 2009: 597). That is, the introduction of a set of policies, strategies, and technologies framed mainly in the Alma-Ata Declaration[113] (1978) and the Caracas Declaration[114] (1990), designed to improve mental health indicators in the country since the 1990[115]. Through the development of the "silent revolution" and the following adoption of the GMH agenda as an "imported magic" - paraphrasing Eden Medina and her colleagues (2014) - the state has promoted a mental health idiom based on psy/neuro technologies[116].

The Ministry of Health has implemented several mental health reforms to carry out the mentioned "revolution". These materialised in the formulation of three

[113]. The Alma-Ata Declaration was adopted at the International Conference in Primary Health Care, in Almay, Kazakhstan. It is a milestone in public health as it was the first declaration that underlined the relevance of primary healthcare. One of the excerpts is: "Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first elements of a continuing health care process (WHO, 1978).

[114] The Caracas Declaration was reached at the Regional Conference on the Restructuring of Psychiatric Care in Latin America, in Venezuela. The declaration claims that mental healthcare should focus on community treatment rather than psychiatric hospitals (PAHO/WHO, 1991).

[115] In a context marked by the end of the civil-military dictatorship (1973-1989), the adoption of a strong neoliberal model, as well as the development of an accelerated modernisation process, the Chilean State resumed an open dialogue with different international organisations and agencies (e.g. World Bank) oriented towards the "globalisation of healthcare" (Beneduce, 2019:712).

[116] In line with this, the first step was the creation of a Mental Health Unit within the Ministry of Health in 1990.

national plans. The first plan, launched in 1993, was called the "Plan for Mental Health and Psychiatry". The integration of a mental health perspective in all health programs and the development of mental health in primary healthcare centres became central for this plan. However, it was quickly replaced by the "Mental Health and Psychiatry Plan" of 2000. This second plan promoted community strategies[117] intended to achieve the social integration of patients[118]. The new plan also fostered the patients' deinstitutionalization and the diversification of mental health services, creating, for example, new devices such as "day hospitals", "work workshops" and "social clubs" (Monreal, 2007). Despite its community emphasis, some studies have shown that mental health professionals, especially psychologists, spend time making individual interventions rather than group or community activities oriented to health promotion and prevention (Scharager Goldenberg and Molina Aguayo, 2007). In addition, other studies have highlighted that this community emphasis has not considered the user organisations' perspectives properly (Cea Madrid, 2019), promoting an understanding of themselves as "outside" of the mental health system (Montenegro, 2018).

Several mental health initiatives took place during the implementation of this second plan. For example, in 2001, the Ministry of Health implemented the National Depression Treatment programme in primary healthcare. This programme was the first of its kind in a low-middle income country (Araya, Alvarado and Minoletti, 2009). In 2005, the Michelle Bachelet government, trying to reinforce the social protection system, launched the Explicit Health Guarantee (GES) law. This law guarantees access, opportunity, financial protection and quality of care for 80 health conditions (Calderón and Rojas, 2016). Among them, there are four mental health conditions: schizophrenia, depression, bipolar disorder, and substance addiction. Two years later,

[117] The plan defined six priority areas: 1) attention deficit hyperactivity disorder in children; 2) victims of domestic violence; 3) alcohol and drug abuse and dependence; 4) depression; 5) schizophrenia and 6) Alzheimer's disease and other dementias in older adults (Minoletti, Rojas, Horvitz-Lennon, 2012).
[118] This plan stipulated as central elements: a) Promote integration from promotion and prevention to healing and rehabilitation; b) Establishment of networks of territorial devices, added to an active role of user and family organizations and health teams and c) Stimulate the regulation of quality, financing and resources (Retamal, Markkula, Peña, 2016).

as I will analyse in depth in the next chapter, the government launched the "Chile Crece Contigo" (ChCC) programme, a national plan oriented to the biopsychosocial protection of maternal and child health. This kind of initiative has led to a gradual increase in the number of mental health practitioners, such as psychologists and social workers within the public health system, especially in primary healthcare centres (Calderón and Rojas, 2016).

However, despite several improvements in terms of access (e.g. GES) and availability of mental health practitioners in primary healthcare centres, some researchers have argued that mental health policies have promoted the medicalisation of malaise and suffering, individualising and depoliticising mental afflictions (CAC, 2013; Cea Madrid, 2018; Crespo Suárez and Machin Suárez, 2020; Aceituno, Miranda and Jiménez, 2012). Notably, some of them have highlighted the increase in the prescription of psychotropic drugs during the last three decades, leaving community interventions promoted by the Mental Health Plan as secondary. For instance, Jirón and colleagues (2008) have shown an increase of 470% in the consumption of antidepressants between 1992 and 2004. Similarly, other studies have pointed out that the use of benzodiazepines among primary healthcare centre patients reached 30-40%, being mainly older urban women (Galleguillos, Risco, Garay, et al. 2003; Olivera, 2009). Moreover, between 2011 and 2017, the Chilean state increased its spending on antipsychotics by 119.9%, as well as antidepressants by 162.5% (Cea Madrid, 2018).

Finally, in 2017[119], the Ministry of Health launched the "National Plan of Mental Health 2017-2025" (MINSAL, 2017), which places a strong focus on law and human rights, provision of services, intersectoral actions ("intersectorialidad"), and

[119] Before the launch of the third plan, the "National Health Strategy for the Compliance with the Health Objectives of the 2011-2020 Decade", contemplated a total of 50 objectives. Of these, four goals are focused on mental health: 1) decrease the prevalence of disability in people with mental illness; 2) reduce the consumption and risk associated with alcohol; 3) decrease the use of illicit drugs; and 4) decrease adolescent mortality associated with suicides (MINSAL, 2011). The strategy seeks to follow the example of countries such as England and Australia that have positioned mental health issues as a public policy priority (HM Government, Department of Health, 2011).

participation, among others[120]. The latter plan identifies the service gaps and the distortions observed concerning the community network model. An example of this is still the hegemonic presence of psychiatric hospitals, the persistence of institutionalised people, the coexistence of the insufficient inclusion of mental health in the family health model, and the inadequate intersectoral collaboration, among others. One of the biggest challenges of this plan is to achieve the enactment of a Mental Health Law.

The medicalisation of malaise and suffering has led the country to be part of what Béhague and MacLeish (2020) have called the "global psyche" - framed in the GMH. In other words, a society that finds in the psy/neuro evidence-based knowledge an idiom to express their afflictions. The medicalisation has tended to mask some crucial political, social, economic and material conditions related to mental afflictions, as well as has shaped the management of "biological citizens" in Chile (Cuthbertson, 2015). Among these conditions, researchers have highlighted the modernisation process, social and economic inequalities, reduction of the social protection system, crisis of social cohesion, and a lack of confidence in public institutions (Aceituno, Miranda and Jiménez, 2012; PNUD, 1998, Mayol, 2012). Thus, medicalisation processes have co-opted individual and collective forms of affliction making "mental disorders" central in the Chileans' everyday lives.

Nowadays, according to epidemiological studies, the country presents high prevalence rates of mental health disorders (Calderón and Rojas, 2016). Although the country has similar prevalence rates to other Latin American countries, it doubles the prevalence rates in dysthymia (8% v/s 3.5% in Latin America) and drug use (3.5% v/s 1.6% in Latin America) (Kohn, Levav, Caldas de Almeida, et al., 2005)[121]. Likewise, the

[120] This plan has a complementary document that guides the local management of mental health service networks (MINSAL, 2018b in Minoletti, Sepúlveda, Gómez, et al. 2018).

[121] In the same trend, the National Health Survey in 2010 indicated that the prevalence of depressive symptoms is 17.2% in the population over 15 years (MINSAL, 2010). Besides, 22.5% of children and young people aged 4-18 have some mental disorder (De la Barra, Vicente, Saldivia, et al., 2012). For example, the prevalence of attention deficit hyperactivity disorder (ADHD) is comparatively high in

country has experienced a 55% increase in suicide rates between 1995 and 2009, becoming the second country after South Korea within the OECD group (OECD, 2011; Silva, Vicente, Saldavia, et al., 2013). Consequently, the rapid increase of medical leaves due to psychiatric causes has become another critical indicator since 2008 (Miranda, Alvarado and Kaufman, 2012). Currently, mental disorders are the leading cause of medical leaves in Chile (22% of the total of medical leaves), displacing respiratory and musculoskeletal diseases to the background. The primary diagnosed mental disorders are depression (49%), anxiety disorders (24%) and stress (19%) (Superintendencia de Salud de Chile, 2016).

Neglecting "cultural" aspects of mental afflictions

The implementation of several mental health reforms during the last thirty years has shaped how people represent their malaise, suffering and mental health. Nowadays, Chilean society seems to be strongly influenced by psy/neuro knowledge and practices (Aceituno, Miranda and Jiménez, 2012; Han, 2012; Mayol, 2012). Although there is a lack of studies on this field in Chile, Clara Han's ethnography revealed the strong influence of psy/neuro technologies in Chileans' everyday lives (Han, 2012). In her study, Han (2012) explored the daily lives of those affected by economic inequalities and drug trafficking's social violence; all framed in the recent history of the country marked mainly by political violence and its consequences. Against this background, Han revealed how people meet several obstacles in accessing mental health services, occasionally practicing self-medication by psychotropic drugs that they access in local markets as a result.

Furthermore, the introduction of the GMH agenda has masked forms through which subjects tended to represent and treat their malaise and suffering in Chile. For example, in the late 1980s and early 1990s, there was a shortage of supply and

children aged 4 to 11 years in the general population (15.5% nationally and 5% globally) (Vicente, Saldivia, De la Barra, et al., 2012).

dissemination of instances of psychological assistance (Prado, Winkler, Casanueva, Cáceres, 1988); in this context, particularly in impoverished sectors, people tended to consider the experience of receiving psychological help as something "unknown" and "culturally distant" (Winkler, 1993). The image of the psychologist, disseminated mainly through the media, was that of a "doctor of the soul" and the consulting population tended not to distinguish their role from other health practitioners (Winkler, 1993). As various investigations pointed out at the time, there was a significant "sociocultural gap" between practitioners and patients (Winkler, 1993). The main issues reported by both patients and by "psychosocial practitioners" (e.g. psychologists and social workers) at that time were the "drug addiction", "alcoholism", "crime" and "emotional deprivation" (Winkler, Contreras, Aretio et al., 1996). For these issues, patients did not only seek solutions in biomedicine and psychiatry but also in magical-religious practices (Grebe and Segura, 1988; Prado, 1989; Winkler, 1999). That is, "aid practices that involve going to another person who acts as an intermediary before supernatural forces" (Winkler, 1999: 85). In this context, people carried out practices of popular Catholicism ("mandas" and "animitas"), divinatory practices ("ver las cartas", "leer las manos", "horóscopo"), practices of black magic ("trabajar a alguien", "tirar un mal", "mal de ojo") and, finally, practices of white magic ("de protección", "de ayuda") (Winkler, 1999).

Taking this as my point of departure, I am particularly interested in exploring the spread of the GMH agenda in Chile as "a diagnostically and metrics-driven psychiatric imperialism, reinforced by pharmaceutical markets" (Lovell, Read, and Lang, 2019: 519). However, rather than reproduce initial debates around global-local, universalistic-culturalist, emic-etic perspectives (Bemme and D'souza, 2014; Bemme and Kirmayer, 2020), I seek a more collaborative discussion around, as I will show in the next pages, the epistemic aspects that emerge in migrants' mental/illness trajectories. That is, the interactions between worldviews of mental health practitioners and afro-descendant migrants in Chile related to malaise, suffering and health. As it is well-known, different researchers have criticised the GMH agenda for

its tendency to globalise mental health diagnoses and interventions, prioritise psychiatric understandings of malaise and suffering, as well as neglect local knowledge (Ingleby, 2017; Fernando, 2011; Mills, 2014; Mills and Fernando, 2014; Summerfield, 2008). This neo-colonial tendency has situated psy/neuro knowledge and practices as hegemonic, damaging local ecologies of care and subordinating other forms of healing (Mills, 2014), especially, in the so-called "Global South".

As I will describe in the next section, the arrival of the Haitian population in Chile forced institutions, practitioners and researchers to interrogate hegemonic knowledge and practices in mental health. In other words, the Haitian migration led to the return of magical-religious aspects related to mental afflictions. Thus, practitioners have interrogated the GMH agenda through what Francisco Ortega and Leandro David Wenceslau (2018) have called the "silence of culture", or what Roberto Beneduce (2018) has named the "return of cultures"[122].

The "return" of the magical-religious realm and the cultural de-substantialisation process.

Mental health practitioners gradually found the growing emergence of what they catalogued as "magical" and "religious" aspects in their work with Haitian patients and families[123]. As I have shown, through the evidence of María's patient, curses, possessions, spirits, zombies, visions, and dreams, among others have occupied a central place in clinical consultations and meetings. Magic-religious contents seemed to encompass the whole of the Haitian patients' experiences. In other words, magic-religious aspects were present in health/illness trajectories, shaping causes, symptoms, representations and healing agents. However,

[122] Similarly, Ian Whitmarsh and Elizabeth Roberts (2016) have coordinated a special issue in Medical Anthropology arguing for a "nonsecular medical anthropology".

[123] As I evidenced in the first chapter, in practitioners' intersectional approach, the culture/ethnicity category seemed to prevail as a differential only when it came from Haitian patients. Usually, they tended to conceptualise other groups (e.g. indigenous people) via other categories such as class and gender.

practitioners emphasised that magic-religious aspects not only shaped the patients' experiences, but also their relatives' experiences. In fact, the husband of María's patient had the same vision as her. This "clinical phenomenon", as María called it, could not be explained within practitioners' psychopathological frameworks.

As with Maria's patient, several other clinical cases raised new questions and challenges as well. María and other practitioners usually described some of them as "emblematic" or "famous" cases. That is, cases that became popular among practitioners due to their clinical and therapeutic complexity. Among these Haitian cases, one of them was also known as an "extreme" case in the healthcare network due to the clinical and institutional aspects involved. In the context of an interview, María said:

> He was a patient who was catatonic on top of a big tree in his borough. He seemed a dead person. (…). People found him. They called the police and brought him to the hospital. The psychiatrist who treated gave him some antipsychotics and he got better. But one day, the psychiatrist allowed him to stay in the hospital garden, and the patient saw the trees and began to climb the tallest one. He climbed it in an inverted position, with the head down. Practitioners called to the cultural facilitator. He started talking to him in Creole. He said to him a couple of things and in a minute, he came down (...). After this, he was banned from going out to the garden, and they let the brother bring him figures and symbols that supposedly protected him from the spirit (...). The facilitator told me "He climbed the tree because a spirit was going to kill him. We need to do a ritual, get us a rooster and a healer, and then we send him to Haiti for the real ritual. Or the spirit will finally kill him". The psychiatrist who examined him said: "I pay to see this! I want to see this! Please tell me "yes", and I pay for everything! (…) Let's hire a healer ['macumbera`]". The facilitator told us: "no, you can't be in the rite, the spirit is mighty, he can possess you". He took it very seriously, and we were in a position between "what interesting!" and "I want to be in the ritual, I want to be part of this!". This case came to the hospital's authorities, but they said "no, that is not a biomedical practice (...) it is public money, and we can't do that. He was discharged from the hospital after four or five months. His brother then told me that the patient came back to Haiti because he needed his healer.

The socialisation of clinical cases considered "emblematic" introduced a series of questions and challenges for practitioners. These focused mainly on clinical aspects, such as the "cultural training" of clinical teams. In fact, as I suggested in the

first chapter, these kinds of “extreme cases” led the Health Department to promote training workshops on the so-called “cultural competency model”. Thus, these cases situated a crucial issue in a central place: the emergence of different explanatory models (Kleinman, Eisenberg and Good, 1978) and idioms of distress (Nichter, 1981).

Although practitioners referred in a dichotomic way to these explanatory models and idioms of distress, their everyday work with Haitians revealed a dynamic of complex interaction among different systems of knowledge and practices related to mental afflictions. I noticed a dichotomy between, on the one hand, mental health practitioners intervening based on psy/neuro technologies in their everyday work, reproducing Western conceptions of personhood, psyche, mental health/illness, among others. Whilst, on the other, Haitians provided a wide range of explanations for health and illness in which religion, especially Vodou, played a key role.

Several researchers have explored the relationship between Vodou and mental health since the second half of the 20th century (Auguste and Rasmussen, 2019; Pierre, Minn, Sterlin, et al., 2010; Vonarx, 2012). Before being declared an afro-American religion, Vodou was conceived as a set of superstitions classified as “scandalous” practices (Hurbon, 2001; Ramsey, 2011). However, from the ethnographic work of Jean Price-Mars in the 1920s, academia put aside the “evil” connotation of Vodou to position it as a centrepiece that reveals both the origin and the everyday life of the Haitian people (Byron, 2014; Price-Mars, 1990 [1928]). Moreover, during the 1960s, some researchers began to catalogue Vodou, not only as a religion, but also as a health system (Metraux, 1958; Vonarx, 2012). Vodou, from a cosmovision of reality, places the subject within a universe composed of ancestors, spirits, and the natural world (*“lwa”*) (Vonarx, 2012). Both the conceptions of “personhood”, “health”, and “disease”, as well as their classification, are composed by natural and supernatural categories (Coreil, 1983; Kiev, 1961). For instance, according to the World Health Organization (WHO, 2010), part of the Haitian population conceives the “personhood” from four dimensions: “body without life”

(*"Kò kadav"*)[124], "shadow" (*"Lonbraj"*), "big good angel", (*"Gwo bon-anj"*), and "soul/little good angel" (*"Nam/ti bon-anj"*). Thus, "health" is closely related to particular components: (a) non-human (plants, animals, earth, air, etc.), (b) human (nuclear and extended family, social networks and collectivities), and (c) spiritual (ancestors, gods, etc.). From Vodou, "disease" is conceived as a loss of harmony between components (a) belonging to the person, or (b) belonging to the person and some of the non-human, ancestral and/or spiritual aspects.

For its part, the Vodou classification of diseases differs from that based on an anthropocentric perspective. This includes diseases within: (a) domain of the visible or physical conditions (*"Maladi Bondyè"*), (b) domain of the invisible, secret or magical (*"Maladi fe-moun mal"* or *"maladi diab"*), and (c) invisible spiritual domain (*"Maladi Iwa"*). Commonly, diseases within the domain of the visible are treated by biomedicine or traditional healers (*"doktèfèy"*), while those belonging to the domain of the invisible and spiritual are treated by a magician of Vodou *("bòkò"*), a male healer *("oungan"*) or a female healer *("manbo"*) priestess (WHO, 2010; Vonarx, 2012). However, the social legitimation of these health agents may vary depending on the level of stigma that the community associates with Vodou and mental illness (Khoury, Kaiser, Keys, et al., 2012). Similarly, Haitians' trajectories of health/illness vary according to the extent of adherence of the patient to Vodou, as well as the ascription to another religion such as Catholicism or Protestantism (Vonarx, 2007; Desrosiers and Fleurose, 2002; WHO, 2010).

Haitians' explanatory models of mental afflictions can find their origin in personal, family, social and spiritual levels (Khoury, Kaiser, Keys, et al. 2012). Regarding the latter, the causes of the disease could respond, on a first dimension, to an imbalance with the spiritual world of the ancestors, while, on a second dimension, to spiritual possessions or curses received (Vonarx, 2012). Several investigations have

[124] In the original WHO research (WHO, 2010), the authors translate "Kò kadav" into English as "body". However, "Kò kadav" would refer to a "lifeless body", while "Kò ak vi" or "moun vivan" would account for a "living body" in medical terminology (Abarca-Brown, 2019).

stressed this from different psychotic and depressive conditions (Auguste and Rasmussen, 2019; WHO, 2010), as well as from disorders associated with the traumatic effects caused by violence in public spaces (Bolton, Surkan, Gray, et al., 2012) and the earthquake that affected the country in 2010 (Raviola, Severe, Therosme, et al., 2013; Cénat and Derivois, 2014). Similarly, some studies have focused on dissociative or "trance" phenomenon, while others on cultural-bound syndromes in Haiti, such as the "Sezisman" (Nicolas, DeSilva, Gray, et al. 2006), "Endispozisyon" (Phillipe and Romain, 1979) and "Pèdisyon" (Coreil, Barnes-Josiah and Augustin, et al. 1996).

Social sciences of health have provided a growing body of literature to address the emergence of multiple power relationships, tensions, conflicts as well as hybridisation processes between the expert psy/neuro knowledge and Haitians' explanatory models of mental afflictions (Khoury, Kaiser, Keys, et al., 2012; Vonarx, 2012; WHO/PAHO, 2010). Concepts such as "interculturality" (Bensa and Fassin, 2008; Fassin, 2009b), "intercultural health" (Campos Navarro 2016; Fernández Juárez 2004, 2006), "intermedicality" (Follér, 2004; Green, 1998), the "hegemonic model" and the "subordinate alternative model" (Menéndez, 1992; 2016) become crucial for this purpose.

However, in this chapter, I am interested in underscoring the epistemic differences, as well as how these differences shape the way in which practitioners represent and intervene in this new intercultural space. A series of concepts belonging to philosophy of science can shed new light on this epistemic difference. Despite concepts, such as "episteme" of Michel Foucault (1994[1966]), "paradigm" of Thomas Kuhn (1996[1962]), the research program of Imre Lakatos (1978), and the "style of reasoning" of Ian Hacking (1982), the concept of "thought style" of Ludwik Fleck (1979[1935]) seems to be the most relevant when analysing the epistemic difference between practitioners and patients. According to Fleck (1979[1935]), a "thought style" is "a definite constraint on thought, and even more; it is the entirety of intellectual preparedness or readiness for one special way of seeing and acting and

no other" (p.64). Thus, through this concept, it is possible to grasp how practitioners have adopted a particular epistemic angle based on biomedicine and a GMH agenda.

The "thought style" concept addresses frameworks governing practitioners' knowledge and practices in the context of public health in Chile. In this case, the relevance of Fleck's approach lies in what he calls "incommensurability", that is, the process by which training in a specific "thought style" tends to hide the ability to look at the same object from a different viewpoint (Fleck, 1934). Practitioners conceded to the idea of understanding the Haitian population's mental afflictions via psy/neuro knowledge and became less open to the integration[125] of aspects related to Haitian-Creole medicine and Vodou in their daily work. Although practitioners participated, as I showed in the first chapter, in intercultural training workshops, they tended to translate[126] patients' malaise and suffering into a psy/neuro idiom, neglecting or ignoring ethnic and contextual aspects as well as psychopathologising Haitians' lived experiences. By neglecting or ignoring these aspects, they could translate different manifestations into Western psychiatric categories. For instance, when describing a Haitian's experience (e.g. an ancestor's message or being under a curse), practitioners used technical words such as "psychotic episode", "catatonic", "hallucination", among others.

I call this process "cultural de-substantialisation", that means, the practice of extracting "cultural aspects" in order to carry out a successful translational process according to a specific hegemonic model. In this case, through the "cultural de-substantialisation", practitioners integrated Haitians' lived experiences into the GMH framework. Or, in other words, they translated Haitians experiences into a specific "thought style". By carrying out a "cultural de-substantialisation" process, mental

[125] Fadiman (1997) calls this a "collision of two cultures", that is, a cross-cultural misunderstanding.
[126] In her book "Migrant in Translation", Cristiana Giordano (2014) has highlighted a similar process of translation. She has shown how practices of translation make Nigerian migrant sex workers intelligible to the Italian state, reducing, to some extent, migrant difference and suffering to an expert language. However, based on Giordano's work, what I want to emphasise here is that, in the process of translation, mental health practitioners tended to neglect or ignore ethnic and contextual aspects to achieve the translational process.

health practitioners tended to decontextualise Haitians' experiences, which led them to psychopathologise their experience. Through this process, they reduced ethnic and contextual aspects related to causes, representations, manifestations, as well as forms of seeking help, to a psychosocial and mainly, as I will show in the next sections, neurobiological level[127].

In effect, practitioners usually evaluated the Haitians' experience as "extreme", shaping a "cultural difference" through which patients were situated in a place of "madness", "abnormality", "disruption", and "transgression". Although practitioners tended to leave aside ethnic and contextual aspects in their interventions, they paradoxically expressed, as I showed through the "emblematic case", a marked interest in knowing what they called "Vodou culture" or "Vodou healing's rituals". Moreover, intercultural training workshops carried out by the Health Department reinforced this curiosity. However, some practitioners seemed to follow a spectacularisation logic. That is, they shaped a specific Haitian-Otherness through its exoticisation.

The concept of "thought style" also provides an understanding of how expert and popular knowledge influence each other dynamically (Löwy, 1986; 2016). More than a dichotomised gap, I try to disclose how various thought styles determine practitioners' work. In other words, porosities and limits present among different epistemics. According to Fleck (1979[1935]), different "thought styles" can coexist in a specific domain, not only in different historical periods but also synchronously and within the same cultural universe. Thus, the "return" of magical-religious aspects mentioned above reveals not only the emergence of Haitian-Creole medicine and Vodou in the health system in Chile but also the multiplicity of knowledge and

[127] A very similar process has been described by Kidron and Kirmayer (2019) in their paper "Global Mental Health and Idioms of Distress: The Paradox of Culture-Sensitive Pathologization of Distress in Cambodia". The authors say: "While the notion of idioms of distress is intended to draw attention to everyday non-pathologizing forms of discourse, the creation of hybrid assessment and treatment constructs linking idioms to trauma-related pathology may obscure the pragmatic communicative functions of the idiom, making them subordinate to an existing model of psychiatric disorder and pathologizing everyday modes of coping" (p. 211).

practices of different Latin American traditions carried out by some mental health practitioners in their interventions. In other words, references to "Santeria", "Mapuche Medicine", or agents such as "traditional healer" or "macumbera" – as I evidenced in the introduction - appeared more and more frequently in clinical spaces. In those spaces, practitioners bordered the boundaries of psy/neuro technologies to interact with other forms of healing.

This suggests that psy/neuro technologies, Haitian-creole medicine and Vodou can be understood as "thought styles" that share a common intercultural space. Ludwick Fleck, as opposed to some later scholars in Science, Technology and Society (STS), argued against the notion of a difference between scientific and religious thought[128] (Gülker, 2019). Fleck was not arguing in favour of the idea that the two ways of thinking were the same, but instead noted that empirical aspects, not logical or theoretical, configure the difference between these ways of thinking. Fleck was arguing that magic, religion and science could all co-exist within a community and are not mutually exclusive as each is a social process. In the Haitian case, although the underlying reasons behind the central role of religion are multiple (Hurbon, 2001; Métraux, 1958), several studies reveal some material conditions that have allowed Vodou's legitimation as a health system. In fact, according to the Pan American Health Organization report published in 2003, Haiti's health system only had ten psychiatrists and nine psychiatric nurses. This provides evidence of both a shortage of resources and a difference between its biomedical practices and the predominant biomedical practices in other countries in the region. Some researchers have argued that such a scarcity of resources would be, precisely, one of the conditions that allowed Vodou to become a validated health system by the Haitian population (Wagenaar, Kohrt, Hagaman, et al. 2013; Vonarx, 2012).

[128] Fleck was contrary to the concept of "prelogical mentality" by Lévy-Bruhl (Fleck, 1935).

The practitioners' use of race: genetic predisposition and mental afflictions

Although the culture category has gradually gained a strong presence in debates since practitioners participated in training sessions[129], María and her colleagues tended to reduce Haitian patients' mental afflictions to a racial level[130]. The use of a culture category seemed framed within a racialised context that associated a "biological predisposition" with the presence of certain mental disorders in the afro-descendant population. The psy/neuro knowledge delineated the references for the manifestation of such association. For instance, in some clinical meeting discussions, some practitioners - especially psychiatrists[131] and psychologists - referred to various studies indicating that the "afro-descendant population" was "more likely" to suffer from mental disorders, particularly those disorders belonging to the "psychotic sphere". For example, during a Mental Health Liaison meeting, the psychiatrist said to María and other mental health practitioners:

> The migratory process generates a lot of stress for people, and that has many psychological consequences (…). The afro-descendant population tends to be more genetically susceptible to stress and many times, not knowing how to handle it (…). For example, in the Psychiatric [Hospital] being black and having psychosis are almost synonymous (...). More and more Haitians are arriving with

[129] As I showed in the first chapter, culture became a category that, with other more familiar categories such as "class" and "gender", began to occupy an important place in clinical approaches. During intercultural training workshops, Chilean and Haitian experts sought to familiarise CESFAM's practitioners with what they called "a socio-cultural approach to the Haitian culture". Through this, they aimed to create a distance from a biomedical and epidemiological reduction of health issues, introducing historical, political, social and ethnic aspects of Haiti. Sometimes, Haitian experts resorted to studies in medical anthropology conducted by Jean Price-Mars, Louis Mars, Paul Farmer, and Nicolas Vonarx. Moreover, experts tried to introduce practitioners to ethnic aspects of life in Haiti, trying to take distance from any cultural reduction.

[130] Similarly, as a study on cultural competency in the US health context revealed, Angela Jenks (2010) has highlighted that, although representations related to cultural differences overlap, not only with racial aspects, but also with ethnicity, nationality, language and religion, there has been a tendency to define cultural groups primarily in racial terms.

[131] Although psychiatrists did not work at primary healthcare centres, they had "Mental Health Liaison" (MHL) with mental health practitioners at the CESFAM. According to MINSAL (2015), MHL is "the joint and interactive activity between the specialty team in mental health and the general health team of Primary Health Care, with the purpose of enhancing the resolution capacity of the primary level, improve referral and counter referral of people served at both levels of care, guaranteeing the shared care and continuity of care of people with mental health problems or complex mental disorders". Sometimes, this plan led to the patient's referral to a more specialised centre (e.g. COSAM or Psychiatric Hospital).

> transient psychotic symptoms, which last very shortly, often three or four days and symptoms decrease (...). Many times, practitioners do not know whether to medicate them or not, but generally, they medicate because they follow the protocol (…). Also, nobody will run the risk of not doing it.

María and her colleagues usually associated a Haitian's supposed "genetic predisposition" with their tendency to suffer from mental disorders. According to many of them, stress provoked by the migration process and psychosocial vulnerability was the trigger for psychotic disorders. In part, the foundations of this "biosocial determinism" (Pitts-Taylor, 2019) were anchored in epigenetic theories of the pathogenesis of different mental disorders among most of the psychiatrists and some psychologists.

Moreover, there were mainly two reasons that reinforced the association between blackness and psychosis. As I describe in different chapters, one of the reasons for this was the Haitians' low levels of adherence to mental health treatments in primary healthcare centres. This can be explained somewhat by the hybrid health system in Haiti, the lack of familiarity of psy/neuro knowledge, and the stigma associated with mental afflictions (Vonarx, 2012; WHO/PAHO, 2010). Moreover, the increase in the number of Haitian patients admitted by "psychotic episodes" to the Emergency Service Department of the Psychiatric Hospital during the last five years played a crucial role in shaping this perception. Somehow, paraphrasing Jonathan Metzl's study (2009) in the US context, psychosis has gradually become a "black disease" in the context of CESFAM and the north healthcare network of Santiago.

There is a significant number of studies that have confirmed that the prevalence of mental health rates in the so-called ethnic/racial minorities are higher, especially in Afro-Caribbean groups (Chen, Harrison, Standen, 1991; Morgan, Charalambides, Hutchinson, et al. 2010). These studies have found that these groups have higher prevalence rates of chronic depressive disorders (Bailey, Mokonogho, Kumar, 2019), and mainly of psychotic disorders (Harrison, Owens, Holton, et al.,

1988; Kirkbride, Lunn, Morgan, et al. 2010; Fearon, Kirkbride, Morgan, et al. 2006)[132]. Although there is no clear evidence that explains the rate increase in these groups (Eack, Bahorik, Newhill, 2012), several studies have, however, proposed a range of explanations for understanding this increase. They primarily include genetic, neurodevelopmental and psychosocial hypotheses (Morgan, Charalambides, Hutchinson, et al., 2010).

Despite the significant anthropological criticism focused on race as a biological category, as well as its consequences related to discrimination and racism, common approaches do not focus on so-called "race practices" (Whitmarsh and Jones, 2010). That is, current uses of the race category and how knowledge about such uses can help understandings of the forms of relationship that are established with other social and political categories. Contributions such as "What's the use of race? Modern governance and the biology of difference" by Whitmarsh and Jones (2010) and "Revisiting race in a genomic age" by Koenig, Lee and Richardson (2008), raise questions about how the race category is currently used in different fields. Generally speaking, they argue that science, particularly genetics, has revitalised race as a social, legal and medical category. From this, it is possible to argue that, even though mental health practitioners have gained some intercultural reflexivity, practitioners' uses of race have reduced mental afflictions to a genetic predisposition in the afro-descendant population. The assumption was that the afro-descendant population had an underlying predisposition that could be awoken as a result of the presence of some environmental factors. However, there are no studies so far that confirm that the high prevalence rates of psychosis are a consequence of racial aspects (Morgan, Charalambides, Hutchinson, et al. 2010).

[132] It is also well known that many studies have associated migration with depression and psychosis. For example, see Bhugra, D. (2004), Davies, Thornicroft, Leese et al. (1996), Morgan, Charalambides, Hutchinson et al. (2010); Morgan, Knowles and Hutchinson, G. (2019), Okpaku, Adeponle, Kohn, R. (2018), Sharpley, Hutchinson, McKenzie et al., (2001), Schwartz and Blankenship (2014), Sugarman and Craufurd, (1994).

The idea of a "genetic predisposition" seemed to delimit a biopolitical field where practitioners oriented their interventions. Within this field, practitioners situated the afro-descendant population in, what several authors have referred to as, a place of "risk" (Hacking, 1990; Rose, 2007). In other terms, the set of ways of thinking and acting that involve calculations regarding probable futures made in the present, followed by interventions to control that possible future (Rose, 2007). In this case, a "genetic risk" led practitioners to delineate and individualise the afro-descendant population by carrying on a potential danger, namely: madness. Practitioners' practices aimed at patients being able to manage and control the stress associated with adverse environmental conditions caused by the migratory process, as well as by the psychosocial vulnerability in which some of them were situated. Through care technologies, such as psychotherapeutic and mainly pharmacological interventions, practitioners intervened in issues such as family separation, unemployment, and overcrowded homes, among others.

Mental health technologies and subjectivation: Becoming a (neuro)migrant

In a context characterised by a high number of daily patients (8-14 patients)[133], time reduced interventions (25-30 min), multiple daily incidentals, and the language difference within the Haitian community, mental health practitioners such as psychologists, physicians and social workers mainly tended to reproduce a standardised form of individual interventions that linked symptoms' causes to an emotional reaction, and then to neurobiological functioning. Commonly, they found that the causes were due to problems such as family separation, lack of work, or difficulties in housing due to overcrowding[134]. In order to deal with cases such as

[133] Although primary healthcare strategies fostered prevention and promotion actions, mental health practitioners have tended to perpetuate individual clinical interventions rather than the activities framed by the Family and Community Health Model (Scharager Goldenberg and Molina Aguayo, 2007).
[134] Occasionally, at this point, they referred to the so-called "Ulysses Syndrome", a diagnosis that many of them had learned during the training workshop. This diagnosis was created by the Spanish

these, practitioners made interventions such as: “As you were robbed twice in your home it is normal to be afraid, that makes your adrenaline go up and for you to be more paranoid”, or “being away from your family generates anxiety, and that makes your thoughts and brain not work very well, “ or “if you relax, you will sleep well, and your brain connections will work better”. Once these were translated by a facilitator, many patients agreed with their practitioner's assessment.

Nevertheless, cultural facilitators who participated in mental health consultations were aware of the gap between practitioners’ interventions and patients’ reception. In the context of an interview with a Haitian facilitator who worked with María and other practitioners in mental health consultations, he stated:

> I have worked at CESFAM from last year (…). Here the health system is different; people can come to CESFAM. I think many people from my country have heard about a psychologist or mental health for the first time here in Chile. What practitioners say sometimes is difficult to understand for patients (...). They say things about how the brain works or substances that cause emotions... neurotransmitters (...). It is very tiring for us because you want to help, but I do not know if what the psychologists or psychiatrists do here is useful for people of my country (...). Most of the patients just go to the first session and do not return (...). Or they take pills just for a while.

The different approaches by practitioners and Haitian patients towards the causes of illnesses and ways of healing became a central aspect of this cross-cultural misunderstanding. The growing concern about the emergence of these tensions and conflicts was not only reduced to CESFAM’s practitioners but also to the entire north healthcare network. In fact, a Psychiatric Hospital’s psychiatrist where CESFAM’s practitioners referred the most severe cases argued that barriers with Haitian patients are reducible not only to a technical issue but also an ethical one:

> Here, we have two treatments that require consent and require a lot of explanation to families, which are Clozapine and Electroconvulsive Therapy (ECT). Regarding both treatments, particularly in severe Haitian patients, it has been

psychiatrist Joseba Achotegui. This syndrome is characterised as a reactive stress disorder to migration extreme situations (Achotegui, 2009).

> tough to communicate this because they felt fear and because it is complicated to explain the need for treatment.

The facilitator and psychiatrist's descriptions focused on some central but, in turn, scarcely researched issues. Specifically, they revealed the brain function's centrality of the practitioners' approach. Besides this, they also showed the distant relationship between Haitian patients and their understandings of psy/neuro knowledge and practices.

It is well known that different studies have revealed how the modern project and the development of psy/neuro disciplines have placed the brain at the centre of the self (Castel, 2012; Ehrenberg, 2018; Dumit, 2000, 2004; Rose and Abi-Rached, 2013; Vidal and Ortega, 2017). Ideas, such as "we are our brains" (Vidal and Ortega, 2017) and mental disorders are "brain disorders" (Rose and Abi-Rached, 2013; Rose, 2018), have been widely spread in different spheres of social life, promoting specific forms of subjectivation. Although different studies have explored the impacts of these technologies on the subjective life (Kitanaka, 2020; Lock, 2013; Martin, 2009; Pickersgill and Van Keulen 2011; Raikhel, 2015), there is a scarcity of studies in Latin America exploring the impacts of these technologies on patients that, on one hand, are hardly familiar with these psy/neuro knowledge and practices and, on the other, have the foundations of their subjectivities fixed into a religious-health cosmovision.

With this in mind, following different studies (Béhague, Kanhonou, Filippi et al., 2008; Biehl and Locke, 2010; McGranaham, 2016; Simpson, 2007), I am interested in the impacts of mental health technologies on Haitian migrants' subjectivity, highlighting subjectivation processes and potentialities over issues related to biopower and governmentality only. In order to shed some light on these issues, in the following paragraphs, I will analyse three subjective destinies that occurred as a result of interactions between mental health technologies and Haitian patients: the internalisation of technologies in a context of specialised healthcare centres (e.g.

COSAM, Psychiatric Hospital); the internalisation of technologies in a community interventions' context (e.g. schools); and the refusal and resistance of technologies.

Mental health technologies have had a significant subjective impact on Haitian migrant patients with severe diagnostics and their families. CESFAM's practitioners referred patients diagnosed mainly with "psychotic episodes", "schizophrenia", and "bipolar disorder" to more specialised healthcare centres. In those centres, the multiplicity of pharmacological, psychotherapeutic and psychosocial interventions led some Haitians to internalise new forms of representation of themselves and their suffering that interacted with previous representations. For example, in the context of some interviews, a patient, after being admitted to the emergency services, said: "thoughts in my head were messy (...). I did not think well, but I started taking some drugs, and my mind, my brain began to calm down. The brain is not crazy anymore". In a similar way, another patient's brother pointed out: "Now he [the patient] is calmer. We miss our country and our life there. The doctor told us that this affected his brain (…). They said he had a psychotic episode and that he had to continue in treatment".

These subjectivation processes bring together at least two imbricated new questions. On one hand, they interrogate how health institutions and mental health care technologies are "making-up" (Hacking, 1985) Haitian patients in the context of public health in Chile. More specifically, how a label/diagnosis can create a reality that patients make their own by reproducing the affliction that practitioners must face in their daily work. Haitians' afflictions were translated into the references of psy/neuro knowledge, returning consistently to the causes and treatments. The cerebral function, as an explanation with material support, enables the emergence of an incipient "looping effect" (Hacking, 1999). By applying this concept, Hacking conceptualised the multiple interrelationships between categories and classified persons. Thus, through interaction with health institutions, Haitian patients were classified with psychiatric categories that situated them in a place of "madness" or as "potentially mad".

However, on the other hand, these subjectivation processes question to what extent Haitian patients' use of these new (neuro) idioms reveal the internalisation of a neuro narrative itself. Although the potential impacts of mental health technologies on Haitian patients could be understood through the "psychiatric subjectivity" concept (Behrouzan, 2016), this conceptual approach could overshadow relationships of neuro-knowledge with Haitian cosmovision, as well as with other forms of knowledge such as Haitian-Creole medicine and Vodou. Therefore, this raises new questions around how transformations on subjectivity and the lived experience of Haitians take place. As I will develop in depth in the final chapter, these questions become particularly relevant when considering Tanya Luhrmann's contributions around anthropological theory of mind.

For their part, mental health interventions in community settings (e.g. preventive workshops at schools, social organisations, etc.) carried out by CESFAM's practitioners revealed a dislocation of tensions and conflicts from a personal to an interpersonal level. Practitioners' interventions moved tensions and conflicts to an intergenerational dimension involving both children - first and second generation - and their parents. In schools, psychologists and social workers provided expert psy/neuro knowledge to Haitian children, as well as to children from other nationalities. From a perspective that revitalised expert knowledge and, above all, neurobiological functioning, practitioners covered topics such as "depression", "suicide", and "bullying". Thus, Haitian children learnt, reproduced and internalised new forms of representation of themselves and their suffering. However, these representations usually generated tensions and conflicts within families. Their parents tended to question or refuse mental health practices and practitioners. For example, according to María, after a school referred his son to the CESFAM, a Haitian father said: "I don't know why we have to come; I don't know what I have to say. We have to talk to someone we don't know about our son". However, María stated that his son seemed much more accepting of these mental healthcare technologies. He

referred: “I come to talk, they make me draw, the school psychologist told us that. This is to make one feel good (...) and to do better in school”[135].

Nevertheless, a greater number of Haitian patients refused and resisted the deployment of mental health technologies. As I mentioned previously, patients tended to abandon psychological and pharmacological treatments during the first weeks. As several studies focused on the Haitian population have revealed (Vonarx, 2012; WHO/PAHO, 2010), the family space is a socially legitimised place for managing malaise and suffering. Moreover, the family is relatively distant from social stigmatisation associated with mental disorders in Haiti. Besides, as I will show in the fifth chapter, a great section of the Haitian community tends to face their malaise and suffering in churches of both Catholic and Protestant denominations. Haitians perceived churches as spaces where they could find answers for their afflictions, as well as strengthen relationships with their family, community, and nation, shaping what have been called “ethnic churches” (Ambrosini, 2008; Hirschman, 2004). For instance, in the context of an interview, a Protestant patient treated for “depression” at CESFAM, said: “I do not need a psychologist, what I need is God (…) God is the one who orders my life and my family. It is because of his will that I am well”.

The implementation of mental healthcare technologies framed by the GMH agenda has led to subjectivation's heterogeneous effects in the Haitian community. To some extent, the GMH agenda's purposes have faced, somehow, a failure with Haitian patients in Chile. This case interrogates relationships between psy/neuro technologies, subjects and communities. For example, how do Haitian children/adolescents interact with psy/neuro knowledge and practices? What kind of interactions are going to emerge between Haitian parents and their children around these mental health technologies? How are mental health practitioners going to

[135] In the second chapter, through the presentation of a case, I analyse in depth the relationships between the health institution, expert knowledge and intergenerational conflicts.

address these issues? Or, more conceptually, how is the GMH agenda going to respond to these global/local challenges?

Chapter IV:

Becoming a (neuro)migrant: Motherhood, attachment and the government of the "future of Chile"

Every day
Everywhere
When you were killed in Africa
They said it was customary
When you were killed in America.
They said it was self-defence.
When you were killed in Chile
They said it is because I am a bad mother."

Jean Jacques Pierre
Extract from the poem "¿Por qué nadie es Joane Florvil?"
("Why is not anyone Joane Florvil?")

The practitioners of the "Chile Crece Contigo" (ChCC) programme have faced specific issues since afro-descendant communities started arriving at the Family Health Centre (CESFAM) in 2010. Since 2007, this programme[136] provides children with access to services and benefits designed to meet their needs, from their gestation until they reach the age of nine. The premise is that, during this period, children build the foundations of learning, language, physical health, mental health, and socio-emotional development (ChCC, 2015). The programme promotes a comprehensive childhood development founded on multiple evidence-based interventions provided

[136] The "Chile Crece Contigo" programme is one of the components of what some social scientists have called "the Bachelet generation in public policy" (Caro, 2009), a period characterised by the assurance of social rights through the promotion and strengthening of several social policies (Garretón, 2010). The ChCC's design began with a study on national and international experiences in early interventions with children in 2005. President Michelle Bachelet, in 2006, created the Presidential Advisory Council for Child Policy Reform composed by an interdisciplinary group of experts. The work of this Council had, as a result, published the document "El futuro de los niños es siempre hoy" ("The future of children is always today)". In this document, the Council emphasised the poverty in which a large number of children were living, as well as how these conditions affected them, persisting into adulthood. The programme implementation started in 159 boroughs in 2007 and continued in another 186 boroughs in 2008. In 2009, the programme was institutionalised through Law 20.379, within the Intersectoral Social Protection System (Caro, 2009; Torres, Lopez Boo, Parra, 2017). The programme is part of the Social Protection System, which aims to accompany, protect and support all children and their families integrally (ChCC, 2015). Within this framework, its purpose is to address the socioeconomic inequalities of the country, giving children more opportunities from their first years (ChCC, 2015).

mainly by neurosciences. It focuses mostly on the so-called "windows of opportunity" or sensitive periods of the infants, toddlers and children (ChCC, 2006; 2012; Torres, Lopez Boo and Parra, 2017).

In various clinical meetings held by the ChCC at the CESFAM, psychologists, social workers and midwives often talked about the "great difficulties" of working with afro-descendant women. They said that the relationships between these women and their children were different due to what they called "cultural aspects". In their words, migrant mothers "were distant and even more violent in the relationship with their children". Furthermore, they sometimes talked with shame about "irregularities" that had occurred in different healthcare network centres. Specifically, they identified how some practitioners re-produced some violent, discriminatory and racist dynamics. In one meeting, a bitterly disappointed social worker critically noted: "all of these have shown the dark side of our culture, you know... racism (…) some people here have made jokes that migrant women reproduce like rabbits to get the Chilean nationality (…) or [interventions] in the hospital[137] that might even be considered obstetric violence or ill-treatment"[138].

In this chapter, I focus on the interactions between health institutions, psy/neuro knowledge and practices as they are elucidated through the experiences of afro-descendant women who were registered in the ChCC programme, as well as how these interactions impact the everyday lives of these women. I base this chapter on a presentation of Lucy's life[139]. Lucy was a 30-year-old afro-descendant Dominican woman who arrived in Chile in 2015. Because she fell pregnant in Chile, health practitioners registered her in the ChCC programme. I focus on Lucy's life for two reasons. First, she clearly demonstrated complex interactions between afro-descendant migrant women and psy/neuro knowledge and practices in the context of

[137] She was referring to a public hospital placed in the north of Santiago.
[138] In 2017, some news had already revealed dynamics of violence against black pregnant women in hospitals. See El Mostrador (2017b).
[139] It should be noted that, to avoid gender bias and promote the production of heterogeneous information, a female research assistant conducted some of the interviews with women.

the ChCC programme. Second, when she became a mental health patient at the CESFAM, her experiences demonstrate the range of problems women often face during the gestation process.

Lucy's case is useful for understanding the sparsely explored domains of migration and motherhood. Although some studies have shed some light on the relationships between the migration process and motherhood (Alcalde, 2015; Andersson, 2004; Madianou, 2012)[140], it seems that little is known about the parental migrant women's acculturation process during pregnancy and early childrearing (De Souza, 2004; Fair, Raben, Watson, et al., 2020). In other words, researchers' interest seems focused on the mothering of older children, leaving in second place the subjective struggles that migrant women embody during pregnancy and the first years of mothering in host countries[141].

I will argue that, in the context of the ChCC programme, the attachment theory has gained authority by promoting a particular understanding of motherhood, child-mother bonding and child development framed in what some researchers have called as the "neuroscience of poverty" (Farah, 2018; Farah, Noble, and Hurt 2006). In other words, the ChCC programme constructs the field through which it is possible to address the mutual relationships between socio-economic status and neuroplasticity (Pitts-Taylor, 2019). Through the intersection of psychoanalysis and epigenetics, CESFAM's practitioners have situated attachment theory in a place of "authoritative knowledge" (Jordan, 1977, 1993(1978)), making a distinction amongst women who were (not) "good mothers" and who (do not) "promote attachment". Thus, they

[140] See also Milewski (2007, 2010), Mussimo, Grabielli, Paterno et al. (2012, 2015), Orozco Vargas (2018), Parrado (2011), Salazar Parreñas (2005), Urbańska (2016).

[141] In part, this paucity of interest in migrant women's subjectivity might be the result of a convergence of the invisibility of women in migratory studies before the mid-1970s (Kofman, 1999; Leckie, 1989), the construction of the migrant women's image as deficient, passive and without agency (Arisaka, 2000), and static and Eurocentric conceptions of motherhood (Dağdelen, 2018; Collins, 1998; De Souza, 2004).

associated afro-descendant women, especially Haitians, with a “lack of parenting skills”.

I will emphasise that ChCC’s practitioners placed different concerns on the table related to the paths that migrant children’s development takes and the consequences that ensue from this “lack of parenting skills” in adulthood. These concerns not only focused on cognitive, emotional and behavioural aspects of the children development but also on what some practitioners occasionally called “potential social issues” such as “drug addictions” and “youth delinquency”. ChCC’s practitioners promoted thus representations of the “normal” and “abnormal” development, configuring moral ideals related to the future of children (Béhague and Lézé, 2015). Hence, the programme has shaped an incipient and distinctive form of government on afro-descendant motherhood and child development during the last decade. This form of government delineated a particular diagram of power (Rose, O’Malley, and Valverde, 2006) that regulated the relationships between health practitioners, afro-descendant migrant women and their children. Specifically, this diagram differentiated between afro-descendant migrant women and other women based on the adoption of liberal values, specific childrearing practices, and a project of citizenship.

I will also argue that psy/neuro knowledge and practices play a crucial role in re-organising migrant women’s representations of childrearing and child development. I will stress that, although health practitioners have adopted some reflexivity around ethnic and contextual aspects of migrant communities, they tended to promote interventions marked by a certain form of brainhood (Ehrenberg, 2018; Dumit, 2000, 2004; Rose and Abi-Rached, 2013; Vidal and Ortega, 2017). In other words, these interventions shaped an understanding of childrearing and child development based on the central role of the brain. Thus, these interventions placed migrant women in a vexed position where different childrearing knowledges converged, fostering hybrid forms of childrearing.

This chapter will be divided into five sections. First, I will describe Lucy's migratory process, highlighting how social conditions, such as domestic violence, border restrictions, and poverty marked her trip to Chile. Then, I will show that, while the admission to the ChCC programme provided her with access to different health services, practitioners' interventions left her in a vexing and inhibitory position due to the imposition of liberal values. Thus, practitioners assessed this position as "laziness" or "passivity". Third, based on the concept of "authoritative knowledge" (Jordan, 1977, 1993(1978)), I will show how "attachment" became the ChCC's central concept, gaining authority to understand the mother's position and the child-mother bonding process.

Fourth, I will show how practitioners placed childrearing in a more complex dimension which can be developed and improved in the context of the ChCC programme. Through the transmission of expert knowledge, practitioners encouraged mothers to foster children's early stimulation in order to achieve positive effects on child development. However, this process tended to mask and devalue migrant women's knowledge and practices of childrearing. I will also highlight how the ChCC programme has placed childrearing responsibility within the family space particularly onto the mother. Thus, the ChCC programme puts women's bodies and subjectivities in a position where governmental strategies and techniques can appropriate them. Finally, I will describe how clinical discussions highlighted some concerns among practitioners related to children's disruptive behaviours. Within this context, I will show that ChCC programme frames afro-descendant migrant children as a potential risk. Moreover, practitioners' concerns are linked to a certain representation of the nation and specifically, the kind of Chilean citizen that afro-descendant children will become in the near future.

Violence and migration: Conditions for malaise and suffering

It was the first cold day of March in the fall of 2018 when I met Lucy. Daniela, the psychologist in charge of her case, told me that morning that she had to do a "rescue" because one of her "Chile Crece patients" had not attended their last session. According to the ChCC programme, women must attend a psychological consultation in case the midwife identifies risk factors during gestation, childbirth or the first months of childrearing. Shortly before arriving at Lucy's house, Daniela added that "many of the moms are alone or almost alone (…) their partners are not with them, or they have to work all day for a low salary". When Lucy opened the door, she reacted with surprise and joy when she saw Daniela. She was wearing a pink robe and, although her curly hair looked combed, she exclaimed, "oh! so sorry, my hair is very messy!"; while putting her hair in a bun. She invited us to sit in lacklustre velvet armchairs in the living room.

Lucy passed to the side of a white curtain that led to a bedroom to collect her daughter aged three months old. The girl was sleeping, but when Lucy picked her up, the baby woke immediately. Lucy said to her in a soft and warm voice "my beautiful little black girl". In the meantime, the baby was constantly looking for her breast: "She's a fat girl, a fat girl!", said Lucy laughing. It was in that living room, one of the main spaces of the house, where Lucy and I met several times during 2018 and 2019. During those meetings, she shared with me the recent events of her life related to how she experienced the migration process, as well as how she struggled to become a mother in Chile.

Lucy arrived in Chile in September 2015. Until then, she lived at her mother's house in a shantytown marked by drug trafficking and crime in Santo Domingo, the capital of the Dominican Republic. Lucy moved there with her two children - a 12-year-old boy and an 8-year-old girl after suffering domestic violence. During one of our talks, she pointed out, "I miss my country, but I could no longer live there (...) he [her former partner] hunted me down everywhere... he threatened me, he even hit

me once in the street". Lucy was one of thousands of women affected by domestic violence in the Dominican Republic. In fact, according to the last Demographic and Health Survey (ENDESA) conducted in 2013 (CESDEM, 2014), 26% of Dominican women aged 15-49 have suffered domestic violence. Moreover, in 2018, the Dominican Republic was one of five Latin American countries with the highest rates of femicide (1.9/100.000) (CEPAL-UN, 2018)[142].

Although Lucy denounced her former partner to the police, he transgressed the restraining orders dictated by the court. Because she was faced with constant and severe harassment and death threats, Lucy's mental health began to deteriorate badly. She was experiencing continuous anxiety, depressive moods and suicidal thoughts. Lucy's father convinced her to emigrate, arguing that it was necessary to leave the country at least for a while because her life was in danger. Besides this, according to Lucy, he said that nobody, neither him nor the police, could protect her. It was within this context that her father organised the trip to Chile. He considered the country a safe place for his daughter due to its location. According to Lucy her father had felt that this was somewhere that Lucy "could be safe and find a job quickly".

The so-called "hole" ("el hoyo") was the route that Lucy followed to arrive in Chile. This is the name that some Dominicans and other Latin American migrants give to the process of entering Chile clandestinely through unauthorised border crossings. After flying to Colombia and joining a bus tour that would take her to Peru, Lucy arrived in Chile crossing the desert with eight other migrant women. They were guided by two "coyotes"[143] during the night. She pointed out: "I could not enter Chile because of the visa issue. (…) My father made all the contacts for arriving in Chile illegally". Lucy was referring to the restrictions that the Chilean state established for the Dominican population in 2012. As I demonstrated in the second chapter, this

[142] The global female intimate partner/family-related homicide rate is 1.3 (nº women killed/100.000 inhabitants). By its part, Chile's rate is 0.6% (UNODC, 2019).
[143] Coyote refers to the person who practises the people smuggling across borders.

consular visa created a series of conditions for irregular transnational migration, leading some migrants to put their safety and health at risk on their journey to Chile (Rojas Pedemonte, Amode and Vásquez, 2017; Thayer, 2019).

When Lucy crossed the border, the “coyotes” left her in a small hotel in Arica – a city situated 2.079 km from Santiago - and told her how to obtain tickets for her trip. At that time, Lucy began her journey alone. When she arrived in Santiago, on the recommendation of one of the women with whom she crossed the desert, she went to the “Plaza de Armas”, where she expected to meet other Dominicans. On the contrary, none of that happened. Faced with the passing of time and the uncertainty that the situation generated, Lucy found herself crying in a seat in the square: “I thought in that minute that I had my children in the Dominican Republic, and here I had nothing... I talked with some Dominicans, but they did not help me, and I did not know where to start”.

In her first week in Chile, Lucy found a job in a nursing home. However, the owner of the home hired her “under the table” (“en negro”), arguing that she did not have her papers regularised by the Migration Department. Lucy received a salary of 250,000 pesos (around 360 US dollars). With no other job alternatives and the need to send money to the Dominican Republic, Lucy accepted it. She worked ten hours a day, six days a week. She also had to work a night shift every two weeks. Lucy pointed out “It was good, I spent 80,000 (around 100 US dollars) on one room, and this left me with 50,000 (around 63 US dollars). I sent the rest to my children in the Dominican Republic”. She alluded to the fact that her children would have money for basic expenses such as food and clothing.

In mid-2016, Lucy moved to a new house to a sector where the Dominican community predominated. She said this allowed her to feel “a little more at home”. A few months later, she met Raymundo, a Dominican man who became her partner. However, Lucy and Raymundo's work prevented them from spending much time together. Besides, some family problems forced Raymundo to travel for periods of

one or two months to the Dominican Republic. In June 2017, Lucy noticed that she was two months pregnant. She referred: “I took contraceptive pills, and I got pregnant, I was not looking to have a baby, but it was a blessing from God (…). The most painful thing was that he walked away, and he has not responded as a father”. Lucy went through her pregnancy with little company from Raymundo. Only occasionally did he visit or call her on the phone. When she was three months pregnant, Lucy attended the CESFAM for the first time. After the medical consultation, she was admitted to the ChCC programme. The programme's midwife informed her about preventive prenatal care, as well as the workshops before and after the delivery.

“Chile Crece Contigo” programme and the imposition of liberal values: Towards a vexing motherhood.

Lucy was five months pregnant when she received a devastating phone call from the Dominican Republic. It was a very close friend who wanted to alert Lucy to the living conditions of her son and daughter. Her friend said: “your mother has been spending the money betting with friends”. Until then, Lucy had sent money monthly for almost two years to her family. She added that this friend also told her that “[my] children sometimes did not even have enough to eat and that the neighbours often gave them a plate of food”. Lucy thought this situation had arisen because her mother lacked empathy for Lucy’s circumstances and did not value the great efforts that she had made in Chile.

As I demonstrated in the second chapter, the global care chains play a key role in the processes through which women migrate to different countries (Arriagada and Moreno, 2012; Hochshild, 2003; Mills, 2017; Salazar Parreñas, 2005, Yeates, 2012). To some extent, Lucy experienced this situation as a certain break of her family care chain. Anxiety and sadness as well as a deep sense that her efforts were not succeeding seized her conscience. She said: “nobody understands that here in Chile

nobody gives you a plate of food (...) here if you do not have a job, you die of hunger". It was this event that led a midwife from the ChCC program to refer Lucy for a psychological evaluation to monitor some possible psychosocial risks that could affect her pregnancy.

Lucy began attending psychological consultations in September 2017. Although she did not support this referral, Lucy accepted it because she understood that it was mandatory. She said me: "I went twice to a psychologist in the Dominican Republic when my former partner was hitting me, but she only listened to me, she did not tell me what to do with my life at that moment". Daniela started seeing Lucy every three or four weeks. Each consultation lasted 30 minutes. In this space, Lucy expressed her deep sorrow related to her children's situation in the Dominican Republic. In clinical meetings, Daniela and her team discussed how the therapeutic plan should "encourage Lucy to establish some limits in order to end the toxic aspects of her relationship with her mother", "foster a healthy relationship with her actual partner in Chile", as well as "promote a representation of herself as an independent woman who can plan a life with her child and, shortly, bring her two children to Chile".

Although practitioners' reflexivity around gender issues led them to adopt a critical position on some essentialist and normative aspects around power relationships that historically have oppressed women, they tended to leave afro-descendant migrant women in a vexing and inhibitory position through their interventions. These interventions demanded that Lucy adopt an active role in her life, leading her to challenge representations and values around family, mothering, and being part of a couple. Lucy seemed to receive these psychological interventions by adopting a position that practitioners evaluated as a lack of motivation for change. Consequently, ChCC's practitioners have reproduced and reinforced racialised stereotypes of afro-descendant women as "lazy" and "passive". For instance, the ChCC's social worker pointed out: "If Lucy continues to act like this, if she still has a depressed mood, it will be tough for her to bring her children to Chile".

While local studies have mainly focused afro-descendant migration and racialisation processes in Chile (Tijoux, 2016; Tijoux and Palominos, 2015), few studies have focused on health institutions and motherhood of afro-descendant women Chile (Abarca-Brown, 2018). However, some relevant contributions in the US can shed light on the approach to the health practitioners' attitude to afro-descendant women in Santiago[144]. The intellectual and political work of black feminists - such as Dorothy Roberts, bell hooks, Hortense Spillers, and Audre Lorde, among others – has shaped maternal theory as a distinct field of study (Nash, 2018). They have analysed how black motherhood has been considered as excess, pathological as well as marked by alleged heterosexual and gender disruptions that challenge the nuclear family and heterosexual state (Nash, 2018, 2019a, 2019b). The black feminist contributions have also examined how black mothers in the US have been subjected to state biopolitical surveillance, which operates under the pretext of marking black women's alterity or giving compassionate help, and, in turn, they have shown that black motherhood is cast as strong, creative, and spiritually rooted, highlighting how women resist and develop their potentialities in specific historical and social contexts (Nash, 2018)[145].

For instance, in her book "Killing the black body" (2017[1997]), Dorothy Roberts has carried out an extensive analysis of black women and motherhood in the US. She described how black women and mothers are represented as hyper fertile, lacking the capacity for self-control, and careless during the process of gestation and childrearing. These representations are the result of an ensemble of historical components rooted in slavery as well as both reproductive health and criminal

[144] Besides, there are similar studies with different ethnic/racial groups. See Bowler (1993a, 1993b), De Souza (2013), Bowes and Domokos (1998), Day (1992), Ladd-Taylor and Umansky (1998).

[145] Currently, from a black feminist approach, it is possible to identify at least four understandings about motherhood: as a subject position, as political location, as symbol and metaphor, and as embodied experience (Nash, 2018). See some titles such as Gumbs, AP; Martens, C.; Williams, M. (eds) (2016). Revolutionary Mothering: Love on the Front Lines. Oakland, CA: PM Press.; Nzinga-Johnson (eds) (2013). Laboring Positions: Black Women, Mothering and the Academy. Bradford, ON: Demeter Press.; Briggs, L. (2017). How All Politics Became Reproductive Politics: From Welfare Reform to Foreclosure to Trump. Oakland: University of California Press.; Oparah, J. and Bonaparte, A. (eds) (2016). Birthing Justice: Black Women, Pregnancy, and Childbirth. New York: Routledge (2016).

policies implemented from the 20th century. As Roberts has shown, these representations have also permeated academic works, leading some social researchers to reduce issues, such as poverty and segregation, to the responsibility of black women. Within this context, different actors have criticised welfare policies focused on black motherhood precisely for being considered "lazy" or "passive" (Bridges, 2011; Gordon, 1994; Roberts, 2003).

Despite the similarity in the analysis provided by black feminist scholars in the US, the racialised representations in healthcare centres did not reduce only mother-child bonding to afro-descendant mothers but also to the women's relationships with their families and partners. In clinical meetings, health practitioners were critical that families, and especially some women in the family sphere, such as aunts or grandmothers, "do not respect the limits of the mother-child space" or "overprotect mothers". They stressed that these kind of family practices and values perpetuate and reduce motherhood to the role of women, restricting their potentialities as women. Within this context, for practitioners, the Haitian case emerged as an "extreme case" among afro-descendant communities. In an interview, a midwife described how:

> In Haiti, women are mothers… it is like they cannot be women with their own desires, they cannot live their sexuality plenty (…). They usually do not use contraceptive methods, or they have to lie to their husbands if they use it (…). It is really complicated to promote reproductive and sexual health in this group.

The clinical setting became a space where different systems of values converged, triggering tensions and frictions between liberal and conservative values. Health practitioners' interventions promoted "women's liberation" - as some of them said - through which women could limit domestic labour and violence. In the same vein, although ChCC's practitioners did not usually mention the childrearing fathers' participation in their interventions, when they did so, they challenged women to "invite" or to "change the focus" of their partners.

ChCC's practitioners carried out interventions that tended to impose the adoption of values on women, thus following one of the programme's general principles related to the embracing of a gender perspective. Despite this, some migrant women, especially Haitians, seemed not to integrate these values into their everyday life. Haitian cultural facilitators who worked at the ChCC programme usually insisted to practitioners that women "did not respond" to their interventions. For instance, in a ChCC meeting, a cultural facilitator said to the practitioners: "if you said to a Haitian woman that she must find a job or must denounce her husband for domestic violence, it is hard for her to do that (...). In Haiti, women are at home, and the violence is normalised, nobody goes to denounce to the police". Moreover, as the cultural facilitator insinuated, these interventions appeared to go further than their representation frameworks. These interventions led some women to internalise feelings of disempowerment associated with potential changes in their everyday lives. In the same meeting, the cultural facilitator emphasised how "some women came here, and they felt that they could not fulfil the practitioner's tasks (...). They felt guilt or shame and then she did not come again here". Thus, the control of reproductive processes, the partners' participation in childrearing activities, and the addressing of domestic violence, among others, became significant challenges for health practitioners and afro-descendant migrant women.

The promotion of liberal values in the context of the ChCC programme can be understood as an obstacle for the development of a critical position in health care provision (Browne, 2001) as these values hide the effects of gender and race, as well as other dimensions that reproduce inequalities (Hyams, 2004). For example, De Souza (2013b) has highlighted how Plunket nurses in New Zealand who have promoted a feminist agenda have paradoxically disempowered migrant women. De Souza's findings reveal that nurses build three different constructions based on white norms and subject positions: Undisciplined children, considered to be the result of a lack of responsibility by the mother; the mother as irresponsible due to being passive and uninformed; and finally, the extended family as a barrier to the mother becoming

responsible. Nurses, for their part, promote disciplined children who are considered to be the result of a responsible mother operating without significant extended-family intrusions. Based on this study, De Souza points out that feminist critiques about motherhood should be reviewed by a critique of the implicit Western conception of motherhood to empower all women.

In the same way, Culley (2006) has stated that a liberal agenda in the nursing field could have at least two consequences: first, the neutralisation of an anti-racist agenda through the replacement of concepts such as "racism" for others as "culture", "diversity", and "ethnicity", among others, perpetuating colonial representations of Otherness. And second, the use of culturalist and "racialising" discourses that justify Eurocentric stereotypes in health care provision and contribute to the reproduction of health inequalities. As different researchers have shown, the arrival of migrant populations in a liberal and culturally "neutral" healthcare system (Puzan, 2003) represent a disruption for practitioners who commonly do not examine personal conceptions of motherhood (Grant and Luxford, 2009), privatising cultural needs (Davies and Papadopoulos, 2006) and providing a different quality of care during the pregnancy process (Malin and Gissler, 2009).

"Natural" attachment: On contested migrant motherhood

In addition to attending psychological consultations, Lucy continued participating in the ChCC workshops[146]. The next one was called "The attachment workshop" ("El taller de apego")[147]. This aimed to inform parents of six-month-old

[146] At the CESFAM, the ChCC programme implemented six workshops during gestation and seven during the first five years of the child.

[147] In the guideline, the concept of "apego" (attachment) is based on psychoanalytic contributions of John Bowlby and other researchers. See: "Cassidy, J., & Shaver, Ph.R. (Eds.) (2008). Handbook of attachment, Second Edition: Theory, Research, and clinical applications. New York: The Guilford Press"; "Lecannelier F., Hoffmann M., Ascanio L., Flores F, Pollack D. (2008). Programa de intervención para el fomento del apego en familias con hijos entre 1 y 4 años A-M-A-R. Centro de estudios evolutivos e intervención en el niño. Universidad del Desarrollo"; "Lecannelier, F. (2009). Apego e intersubjetividad. La influencia de los vínculos tempranos. LOM ediciones".

children of the positive effects of promoting attachment in the parent-child bonding. While Lucy and five other migrant women were taking care of their children, Jessica, the psychologist in charge of the workshop, commenced by saying: “this is one of the Chile Crece Contigo’s workshops, and today we are going to learn some important things about the children’s development and how we can be better moms (“mejores mamitas”) with our children”. She spoke for over a half an hour about children's mental development, specifically centering on how attachment plays a key role in cognitive, emotional and behavioural development, and “therefore in the type of person that your children will be in the future”. She added, “a person who can deal with their emotions, impulsivity and have healthy relationships (…) will prevent psychological problems such as depression, drug consumption and even social problems such as delinquency”. For their part, women listened carefully to her while trying to control the incessant physical movements of their children. Some mothers played with their babies using toys that they retrieved from their pushchairs to entertain them and keep them calm.

Jessica explained the “benefits of attachment” rather like a salesperson trying to describe the multiple qualities of a product or new technology. However, she emphasised that attachment is not something external to mothers but something “internal” or “natural”. She continued: “on the one hand, children are like little animals who are looking to be cared for by their mothers and, and on the other, ‘mamitas` naturally feel the need to take care of their animals, their cubs (´cachorros`) during the childrearing process”. Jessica stressed that “attachment” worked as a basis for early stimulation, suggesting that this leads to a “change in the brain structure and new neural connections”. Moreover, she elaborated on this by saying that this neurobiological process starts in the womb: “for instance, some scientific studies show that when a woman is pregnant and suffers stress, the level of cortisol goes up, affecting the fetus' neuronal development (...) that is the reason why it is important to be relaxed”. Jessica recommended women use toys and materials provided by the ChCC programme for the babies’ brain development. She finished by asking whether

any of the mothers had any questions. Only Lucy commented: “I had never heard something like this, neither with my first son nor with my second one in the Dominican Republic. I have taken care of my children as my mother did with me, as we take care of babies in the Dominican Republic (giggling)”. After the workshop, she told me:

> These things are interesting because one can learn (…) and that is the reason why here everything is more complicated, even to take care of a child (…). Here everything is like a professional thing (…). For example, when I arrived in Chile, I tried to get a job caring for children, but always people asked me ‘do you have any experience with children?` Why should I need experience in order to take care of a child? In the Dominican Republic every woman knows how to do it.

Figure Nº6: ChCC’s technical guidelines

Although the ChCC’s clinical team considered that Lucy should improve her “parenting skills”, they pointed out that a significant part of afro-descendant migrant women did not have these skills. There was a significant gap between women and practitioners around childrearing knowledge, practices and values. This gap led to the emergence of tensions and conflicts within the healthcare centre and clinical teams, as well as between practitioners and patients. In fact, during lunchtime after the

workshop, Jessica referred to the fact that afro-descendant women had "other childrearing practices". Accurately, she described that "they tend not to pay attention to their babies; they do not develop a close relationship with their babies". However, for Jessica, as well as for other practitioners, Haitian women caring represented an "extreme case" among afro-descendant women. She argued that:

> They definitely do not promote attachment with their babies (…). It is a kind of parental negligence that puts the children's health at risk. Sometimes they do not bathe their babies, nor do they breast-feed their babies because they consider that the milk is contaminated[148]. Do you remember the Joane Florvil[149] case? things like that, situations where professionals do not know what to do (…). I believe that this happens because, as we discussed with a doctor in a training session, the infant mortality rate is very high in Haiti[150]. So, mothers do not promote attachment until they feel sure that the baby is healthy.

[148] Although Jessica did not know the meaning of this practice, she was probably referring to "Bad blood". "Bad blood" is "somatically experienced and caused by emotional distress" (Farmer, 1988:62). This illness is lived – according to Haitians – as a disorder of the blood that is spread throughout the body, involving mostly head, eyes, skin, and other organs (Farmer, 1988). An important thing is that, although "bad blood" is considered pathological, it is a common reaction, especially among women who face a stressful situation (Vonarx, 2012). Moreover, pregnant women are the most vulnerable group to "bad blood", being affected mainly in the quality of their breastmilk (Farmer, 1988; Álvarez and Murray, 1981). In fact, Haitians, especially those who live in rural areas of the country, indicate that spoiled milk (in Creole "lèt gate") resulted from "bad blood" and is the main reason for early weaning, thus affecting children's health in the first year of development (Farmer, 1988).

[149] On August 30th 2017, Joane Florvil, a Haitian woman, went to the Municipality of Lo Prado, a borough placed in northwest Santiago, seeking help because her husband had been assaulted by robbers. Because she did not speak Spanish, Joane went out looking for a translator, leaving her 2-month-old daughter in the care of one of the Municipality's guards. Faced with her delay, Municipal officials decided to denounce to the police for what they considered to be child abandonment, and the girl was admitted to the National of Minors Service (SENAME in Spanish). By its part, Joane was arrested and charged with abandoning her daughter at the Office for the Protection of Rights (OPD in Spanish) in the Municipality of Lo Prado. The same night, she presented with health complications in the police station and was interned in a hospital where she died a month later. According to the Haitian physician who admitted her at the hospital, before entering a coma state Joane told him that police officers had struck her several times at the police station. Police officers disputed this stating that Joane had hit herself many times against walls, forcing officers to put a motorcycle helmet on her to protect her head. The case reached a broad audience through the media, impacting different social spheres. Particularly, non-governmental organisations (NGOs) dedicated to migratory issues, publicly condemned the actions undertaken by the different institutions and officials involved in the case (El Desconcierto, 2017; EMOL, 2017). Moreover, Lorena Fries, the Deputy Secretary-General of Human Rights, pointed out that the Chilean State had failed in its migratory approach, as well as the fact that the country could not be catalogued yet as an intercultural society (EMOL, 2017).

[150] Infant mortality rates of Haiti are considered one of the highest around the world. According to the United Nations (UN, 2015), in the period 2010-2015, in Chile, the number of infant deaths per 1,000 live births was 7.7, whereas in Haiti it was 46.96. For its part, in Colombia and the Dominican Republic, the rate was 17.95 and 25.09 per 1,000 live births, respectively.

The concept of "authoritative knowledge" (Jordan, 1993 [1978]) is central for understanding how expert knowledge – in this case, attachment theory – has gained authority, devaluing other forms of knowledge around motherhood at the CESFAM. By "authoritative knowledge" Jordan means the rules that "explain the state of the world better for the purposes at hand ("efficacy") or because they are associated with a stronger power base ("structural superiority"), and usually both" (Jordan, 1993 [1978]: 152). The concept has been widely used in cross-cultural childbirth research (Davis-Floyd and Sargent, 1997). In the context of this ethnography particularly, the concept becomes relevant as the attachment theory largely shapes practitioners' knowledge and practices, as well as women's representations on gestation and childrearing.

In ChCC's guidelines, attachment is defined as "a special type of affective bond, specific to a close person, which provides security and protection in times of stress and vulnerability", highlighting that "it is a biological need as important as eating or breathing" (Chile Crece Contigo, 2012: 38). Originally, the attachment theory was formulated by John Bowlby, a British psychoanalyst, and Mary Ainsworth, a US American psychologist, and emerged in the context of the end of World War Two (Bretherton, 1992)[151]. In particular, Bowlby's work became highly influential after the presentation of a WHO report entitled: "Maternal care and mental health: a report prepared on behalf of the World Health Organization as a contribution to the United Nations programme for the welfare of homeless children", in 1951. In the first chapter entitled "Some origins of mental ill-health", Bowlby argued:

> The infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother-substitute) in which both find satisfaction and enjoyment. Given this relationship, the emotions of anxiety and

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

> guilt, which in excess characterize mental ill-health, will develop in a moderate and organized way (Bowlby and WHO, 1952 [1951]: 11).

Although Bowlby's work gained influence in academic and health practitioners' spheres, attachment theory rapidly became controversial. Some psychoanalysts argued against the centrality of the maternal role, the child-mother bonding (Rutter, 1995), as well as the lack of relevance given to sexual aspects of psychoanalytic theory, particularly to sexual drive (Gullestad, 2001). Other scholars also criticised Bowlby's arguments for not being supported by enough clear evidence, leading to confusion around concepts such as privation, deprivation and other forms of under-stimulation (e.g. children in institutions) (Rutter, 1981). Besides, some feminist scholars have argued against the attachment theory claiming that it represents a conservative research programme, which could discourage women from leaving children in day-care homes (Duschinsky, Greco and Solomon, 2015; Rutter, 1981).

Moreover, this theoretical approach neglects different type of interactions between parents and children, as well as different conceptions of mind[152]. For example, US children pay attention to particular knowledge that adults indicate as important, which suggests that social invitation directs learning (Butler and Markman, 2012). Maya children instead participate as community members by learning through collaborative interaction (Rogoff, 2011). Likewise, Mapuche parents in Chile invite children to explore and reinforce their volition and autonomy (Murray, Bowen, Segura, et al., 2015).

In the last two decades, attachment theory has drawn the attention of disciplines such as anthropology, psychiatry, paediatrics, neurobiology, and molecular biology (Carter, Ahnert, Grossmann, et al., 2015; Keller and Bard, 2017, Otto and

[152] I will develop in depth in the final chapter, some recent anthropological contributions regarding to the theory of mind have shown how different societies have different forms of stimulation and, therefore, different local theories of mind (Luhrmann et al., 2011; 2020a; 2020b),

Keller, 2018). Several studies have argued in favour or against the different extents of the roles of biology, evolutionary underpinnings and cross-cultural variations of attachment (Carter, Ahnert, Grossmann, et al., 2015; Ladd-Taylor and Umansky, 1998; Faircloth, Hoffman, Layne, 2013; Keller and Bard, 2017; Otto and Keller, 2018; Quinn and Mageo, 2013; Roy, 2007; Schmidt, 2008). However, despite multiple approaches, mainstream attachment models have prevailed in the ChCC programme, neglecting those that integrate evolutionary and cross-cultural aspects (Ladd-Taylor and Umansky, 1998; Roy, 2007; Schmidt, 2008).

ChCC's practitioners tended to highlight children's needs and reduce attachment to the responsibility of mothers. In other words, they reduced their representations of afro-descendant women's motherhood to a deficit discourse. That is, a discourse that represents some people or groups in terms of deficiency, absence, lack or failure (Fogarty, Lovell, Langerberg, et al., 2018). Thus, practitioners divided women between those who are able to promote attachment (Chilean women) and those who are not able to (afro-descendant women). As different studies have shown (De Souza, 2004; Marshall, 1992), the deficit discourse around motherhood tends to individualise problems and neglect structural factors involved, thus reproducing social inequalities in health.

Although the ChCC's practitioners gained some reflexivity around ethnic and contextual aspects of mothering and attachment during intercultural training workshops[153], their interventions seemed to naturalise and individualise the

[153] As I argued in the first chapter, practitioners who participated in training sessions usually adopted a "culturalist approach" in their discussions. Similarly, a study carried out by Didier Fassin (2001) on sexual and reproductive health in Ecuador can shed some light on this discussion. The Ecuadorian Ministry of Health, concerned that it had one of the highest maternal mortality rates in Latin America during the second half of the 1980s, conducted a study to find out the reasons why indigenous women did not seek prenatal care. The results of the study were based on cultural factors related to "indigenous women's sense of modesty", which would have prevented them from attending health centres. Fassin, without ruling out the plausibility of the culturalist explanation proposed by this study, argued that falling into a "culturalism as ideology" trope would lead to a) the omission of any practical difficulty in accessing the health centre (e.g. accessibility to roads, public transport, among others); b) the omission of failures in the health system (e.g. fear founded on women due to the high number of caesarean sections); and, finally c) the conception of women as accountable for child health.

childrearing process. For instance, a Haitian expert who taught at some training workshops, based on Nancy Scheper-Hughes's study in Brazil[154], emphasised how the attitude of the mother to the new-born was due to the psychological consequences of high infant mortality rates in countries such as the Dominican Republic and Haiti. Following on from Scheper-Hughes' contributions, the expert argued that the attitudes of afro-descendant mothers to the new-born was a "mothers' protection form" through which women could manage the potential grief associated with the potentiality of their child's death. Thus, he argued the attitude of mothers could be the result of the prioritisation of "stronger babies" over "weaker babies" as a strategy of survival rather than an apparent maternal indifference to the death and suppression of grief. However, despite these reflections, practitioners tended to neglect these contextual aspects when they worked with women. They described attachment as a "natural" aspect of mother-child bonding and emphasised that mothers must promote it.

Governing mothering: The difference between care and rearing

From late 2018, Lucy started evaluating some strategies for taking care of her children in the Dominican Republic. She asked her father if he could take them into his home. Lucy also sent money to her father and best friend to pay for her children's expenses. Nevertheless, she began to perceive a certain distance growing on the part of her children, especially the youngest one. One time as we talked about her children at her home, she cried as she told me: "they asked me why I had another daughter. My first daughter complained to me that I was never going back to the Dominican Republic; that I had forgotten about them". The mental health team was concerned about Lucy's hopelessness and grief. On that basis, practitioners organised a

[154] The expert worked with CESFAM's practitioners in three training sessions during 2017 and four during 2018. Although he did not cite Nancy Scheper-Hughes' contributions explicitly during his sessions, in our conversations, he recognised the influence of her in the analysis of motherhood in the Dominican Republic and Haiti. See Nancy Scheper-Hughes (1984, 1985, 1993).

therapeutic plan characterised by a fortnightly frequency of psychological consultations and home visits.

Although the clinical team discussed Lucy's case during a clinical meeting, Daniela and a social worker argued in favour of what they called the "difference between 'care' and 'parenting'". Daniela stated:

> What happens in these cases is that women come with the fantasy that they live a life here and, in their countries, everyone stays the same (…). But the problem is that their children grow up and are raised by other women, so they expect [their children] to come here, and for those children to remain the same, but it turns out that they already made ties with those women (…). In Lucy's case, for example, she thinks her children will get used to it here, but really her mother has been the grandmother, so care ("cuidar") is not the same than rearing ("criar"). She hasn't really raised her children in the Dominican Republic.

The difference between "care" ("cuidar") and "rearing" ("criar") seemed to be a reasonable explanation for the rest of the clinical team. Specifically, this was not only separated conceptually as "care" and "rearing", but, in turn, placed the latter in a more complex dimension; a dimension that can be developed and improved. In fact, the social worker pointed out:

> Last Wednesday, I went to Lucy's home, and I saw her with other Dominican women and their babies in the central courtyard. They are her neighbours (…). And then I realised that these women take care of Lucy's baby some days when she is working (…). They are neighbours just for the past three or four months, and they already share this kind of task (…). The interesting thing is all children there were playing with toys from the ChCC programme (…). I said to Lucy, 'you are using the ChCC's toys' and she answered me laughing: ´I am teaching them about attachment and stimulation`. (…) I think that we should mainly focus on the relationship with her family and children in the Dominican Republic.

From this meeting, the clinical team's interventions decided to foster Lucy's parenting competencies both in terms of its scope and limits with her children in the Dominican Republic. According to practitioners, this would lead Lucy to establish healthy relationships with her children in the Dominican Republic and, consequently, with her new-born daughter in Chile. For its part, the emergence of parenting hybrid

forms seemed not only to be something new for the clinical team but something that generated in them some feeling of success. In other words, rather than a woman who individually raises her child, it was a group of women who collectively used the resources provided by the ChCC program. This feeling was associated, not only to the usefulness and legitimation of expert knowledge and practices, but also with the achievement of the programme's sanitary goals.

Practitioners assumed that the strengthening of attachment would lead mothers to take actions that promoted early stimulation in their children. Primarily, during the ChCC workshops, they used concrete comparisons and metaphors related to child development. These were associated with animal and vegetable realms. Cubs, butterflies, seeds, plants and flowers were some of the main characters of these comparisons and metaphors. Each of these characters experienced a critical moment in which, based on the stimulation provided by the environment, the animal or vegetable would be able to achieve specific goals with success. Thus, practitioners used these comparisons and metaphors as if each developmental milestone could be delimited to a natural - or biological - order, undifferentiating the influence of sociocultural and material aspects into development, as well as assuming a biological, essentialist and normative perspective of human development.

In the ChCC programme, developmental sciences and neurosciences supported the theoretical and technical foundations of early stimulation (ChCC, 2012, 2015). The programme fostered the "new Chile Crece Contigo's concept of stimulation". It defined this as:

> The whole actions aimed at fostering the child's gradual mastery of cognitive, motor, social-emotional and communicational skills, through strategies that allow the child to autonomously explore an enriched environment, where he or she finds appropriate stimuli to deploy and consolidate his or her capacities, according to his or her own developmental rhythm and individual characteristics[155].

[155] According to the guidelines (ChCC 2012, 2015), the definition of stimulation is extracted from "Thompson, P. (2006). Promoting early development. The Guilford Press".

The ChCC's Guidelines for the Local Team (2012), based on an epigenetic approach[156], stressed the key role that parents' stimulation plays in the development of different potentialities in the "windows of opportunity" or sensitive periods[157] during the first years of life.

The Chilean childhood policies have progressively integrated evidence provided by neurosciences over the last decades (Calquín, 2013; Calquín Donoso and Guerra Arrau, 2018; Rovira Rubio, Boero Chancy, and Calquín Donoso, 2017; Calquín Donoso, Guerra, Vasquez et al. 2019)[158]. This evidence highlights how the quality of childrearing is associated with functional and structural components of the brain (Edwards, Gilles and Horsley, 2015). The programme has delineated what some researchers have called as the "neuroscience of poverty" (Farah, 2018; Farah, Noble, and Hurt 2006). In other words, the ChCC programme constructs the field through which it is possible to address the mutual relationships between socio-economic status and neuroplasticity. Specifically, the interventions of the programme focused on the epigenetic relationships between brain structure (e.g. neural activity, cortical volume, among other), brain functions (e.g. cognitive, emotional, among others) and environment (socioeconomic status, pollution, migration, stress, among others) (Pitts-Taylor, 2019). Hence, the ChCC programme promoted a "biosocial determinism", that is, a type of determinism that "elevates biological explanations for social problems even while attributing biological conditions to social causes" (Pitts-

[156] The guidelines provide evidence on epigenetic from the following literature: "Kandel, E.R. (2000), Cellular mechanisms of learning and the biological bases if individuality. Principles of neural sciences. Mc-Graw Hill. New York"; "McCain M, Mustard F. & McCuaig K. (2011). Early years study 3. Toronto. McCain Family Fundation".

[157] The guidelines provide evidence on sensitive periods from the following literature: "Shore, R. (1996). Rethinking the brain: new insights into early development. F&W institute"; "Siegel, A., Hreday, N., Sapru, P. (2010). Essential neuroscience. Lippincott Williams & Wilkins"; "Lecannelier, F. (2009). Apego e intersubjetividad. La influencia de los vínculos tempranos. LOM ediciones"; "Eluvanthingal, T. J., Chugani, H. T., Behen, M. E., Juhász, C., Muzik, O., Magbool, M., et al. (2006). Abnormal brain connectivity in children after early severe socioemotional deprivation: A diffusion tensor imaging study. Pediatrics, 117, 2093–2100".

[158] In a recent study, Calquín Donoso et al. (2019) analysed the ChCC's policy documents, finding that policies constitute the brain as a grammatical subject that has different qualities, actions and valuations. Indeed, they argued that the brain is represented with a human face in some of the ChCC's materials.

Taylor, 2019: 672)[159]. Unlike biological determinism, biosocial determinism allows a mutual influence between experience and biology.

The circulation and legitimation of "neuro" and "psy" knowledge and practices in the Chilean social protection policies have placed responsibility within the space of the family, and particularly, on the mother's role (Calquín Donoso et al., 2019). Thus, women and children have become subjects of a biopolitical operation. The ChCC programme positions women's bodies and subjectivities in such a way that governmental strategies and techniques can appropriate them by both medicalising their bodies (e.g. control of reproductive processes from gestation) and by psychologising and psychopathologising subjective aspects (e.g. "lack of parental skills", "postpartum depression", etc.). This, in turn, delineates the woman-object of pedagogically-oriented interventions for the governmental purposes of maternal and child health policies. Therefore, according to Calquín and her colleagues (2019), the ChCC programme is a liberal social policy that takes a central element - the family sphere - from conservative States.

For migrants, particularly, the ChCC's programme has set out the references for a "parental acculturation". That is, the process through which parenting models of migrant parents are compared with parenting models transmitted by different socialisation institutions and agents of the host country, causing the emergence of different images of successful parenting and different strategies for childrearing (Bornstein and Bohr, 2011; Roer-Strier, 2001). In this framework, parents, and mothers in particular, have faced an "intensive parenting" ideology. In other words, the ensemble of institutions, knowledge, practices, values and actors that lead parents to put children's needs first and pay attention to child development experts (Hays, 1996). Thus, ChCC's practitioners have played an active role in transmitting both strategies for childrearing and an image of successful parenting. Nevertheless, through this process, they tended to ignore their Eurocentric representations of

[159] Michelle Pentecost has carried out a similar analysis on "The First Thousand Days" programme in South Africa. See Pentecost (2018), Pentecost and Ross (2019).

motherhood, as well as historical, class, race, and gender aspects that shape motherhood (Collins, 1998). Besides this, they did not seem to recognise the subjective struggles that migrant-women embodied during pregnancy and the first years of mothering in Chile[160].

Therefore, the ChCC programme established at least three promises for afro-descendant migrant women: the healthy future of their children, the personal recognition of maternal work based on the programme's criteria, and finally, the materialisation of their integration into the new country. However, following on from Edwards and colleagues (2015), promises of these kind of childhood policies are a "cruel optimism" that cloak social and gender inequalities, placing the responsibility of gestation and childrearing on mothers.

The management of risk and representation of the nation.

Lucy permanently sought to bring her children from the Dominican Republic to Chile, however, some ChCC's practitioners suggested that Lucy's children could present "problems of adaptation to the Chilean reality". In a clinical meeting, a physician said: "They were not raised with their mother, and if they are already presenting disruptive behaviours against their mother in the Dominican Republic,

[160] Tensions originated by the "intensive parenting" ideology have not only emerged in its mismatches with afro-descendant migrant women knowledge and practices but also with Mapuche people's childrearing traditions in Chile. Marjorie Murray's work on parenting practices have highlighted how the Mapuche people face an "intensive parenting" ideology in Chile (Murray, 2012, 2013; Murray, Bowen, Segura, et al., 2015). She has shown how, through the early socialisation process, the Mapuche people transmit a sense of volition proper of Mapuche notions of autonomous personhood. Thus, Mapuche's parenting practices promote children's initiative for exploring, learning, and socialising with others. In this context, according to Murray et al. (2015), one of the greatest fears of Mapuche mothers is that their children become a "mamón", a Chilean word for children who are too dependent and attached to their mothers. However, due to the introduction of new forms of parenting promoted by expert knowledge and public policies in Chile, Mapuche mothers sometimes must negotiate their parenting knowledge and practices, feeling pressured to incorporate some practices to become "good mothers" (Richards, 2004, 2007).

here in Chile this could be exacerbated in adolescence. So, maybe not now, but we have to think about this". While the ChCC programme focused on both Chilean and migrant patients, concerns related to the so-called "disruptive behaviours" seemed to emerge among professionals particularly when they discussed an afro-descendant migrant.

In response, a nurse compellingly argued for the need of more "cultural training modules" to avoid a situation in which "the ChCC became a disaster". She added:

> "Every day we see families, mainly migrant families, in which parents do not have parental skills, or they are working all day, or they live in overcrowded houses (…) children resent this…they are not being stimulated by their environments (…). The problem is not now; the problem will be in 15 or 20 years when they will have adjustment problems".

According to the nurse, the absence of early stimulation and the presence of some social conditions would lead to emergence of psychosocial problems related to mental health disorders and transgressions of the law in the following years. Besides, some practitioners linked these conditions to "habits" and "customs" of some afro-descendant migrant parents such as "the inclination for parties and drugs".

In the ChCC programme, children became a potential risk that must be managed from early childhood to prevent likely disruptive behaviours in the future through a "psychopolitics of otherness" (Fassin, 2011c). That is, a "technology that normalises through psychiatry and psychology those who are constructed and governed as radical others" (Fassin, 2011c:.225). Thus, in the ChCC programme, developmental sciences positioned some children in a place of "risk" (Béhague and Lézé, 2015), reducing them to both a kind of psychological and neurobiological susceptibility of risk (Rose, 2000, 2007). In other words, the reduction of migrant children to a somatic level, which it is possible to modify - or improve – through the control of the environment.

Moreover, practitioners' concerns seemed to go further, linking afro-descendant children to representations of the nation. The reproduction of racialisation processes tended to place children, depending on the risk management carried out by their families, within apparently antagonistic destinations. In other words, a biopolitical operation (Foucault, 2003 [1976]; Rabinow and Rose, 2006) that, on the one hand, co-opt children as subjects who will potentially embody a place of "abnormality" (e.g. in practitioners words, "mental disorders", "infractions of the law"), and on the other, subjects who can develop and optimise their capacities at higher levels within particular frameworks (e.g. in practitioners words, "black professional sportsmen").

In the context of the ChCC, both destinations are part of a broader issue on representations of the nation. Indeed, sociocultural representations of the nation are often associated with biological representations of the maternal role (De Souza, 2013). Yuval-Davis (1993) argues that mothers reproduce the nation biologically through the birth of a new-born, as well as socially by transmitting culture within domestic space. The representation of the nation as home thus delineates the borders through which the perceptions, attitudes, and stereotypes take form in the relationship to Otherness (Chantler, 2007). Based on this, it is possible to argue that, through the ChCC programme, health practitioners re-produce representations of the nation through migrant families, configuring the limits of what society will consider as Chilean citizens.

Chapter V:

Belongingness and mental health beyond healthcare centres: On the "good" Haitian and the evangelical church in Chile.

After leaving the monthly meeting of the Migrant Group of the North Metropolitan Health Service[161], Yolanda, the Migrant Programme's coordinator of the borough's Health Department, told me that the meeting left her with a "bitter feeling". In that space, practitioners from different boroughs belonging to the north of Santiago met to discuss the progress, issues and challenges they faced in their work with migrant communities. Yolanda's reaction was the result of a social worker's comment. He told a story about how a clinical team from his Family Health Centre (CESFAM) had carried out a health intervention ("operativo de salud") outside a Pentecostal church on Sunday. They made around 150 registrations to the CESFAM, as well as some Adult Preventive Medicine Exams (EMPA)[162]. He assessed this intervention as a "successful experience" due to the fact that practitioners were able to meet some of their "health goals"[163] ("metas sanitarias"). He said: "Haitians go to church, so we went there to find them (...) more than 300 Haitians go to that church every Sunday, and many of them are registered in the CESFAM".

While Yolanda valued the team's efforts, in turn, she questioned this type of interventions. In her opinion, if the Haitian community attended both Catholic and Evangelical churches, the contact with churches should not be reduced to a single intervention. Instead, it should be part of the permanent community and territorial

[161] The National Health Services System (SNSS) has 29 territorial Health Services that have responsibilities for health action on defined geographic territories, which may be regional or sub-regional in scope. These are state agencies, functionally decentralised, and endowed with legal personality and their assets, which are in charge of the articulation, management and development of the corresponding healthcare network, for the execution of integrated actions for the promotion, protection and recovery of health and rehabilitation of sick people.

[162] The EMPA seeks to identify high prevalence risk factors such as smoking, alcohol consumption, obesity, diabetes, among others, in order to reduce morbidity and mortality and aspects that threaten mental health in both patients and their family groups.

[163] Health goals are incentives for collective performance in primary health care. In particular, the professional referred to the enrolment of users in the Family Health Centre (CESFAM) and the conduct of some Preventive Medicine Exams for Adults (EMPA).

work of the network. However, collaboration between the municipality and churches in the borough had not historically been successful. Although there had been some initial conversations between the Health Department and some churches since 2013, approaches had not been successful. The most that had happened in these conversations was that both parties had only declared their intentions to start a collaboration. Nevertheless, these intentions never translated into specific actions. In part, Yolanda attributed this to what she called differences in "the moral agenda" ("agenda valórica") and she emphasised how moral differences were greater with evangelical churches. Yolanda said: "We have a mayor who is on the left, who is in favour of matters such as abortion and gay marriage (…). And in evangelical churches, pastors are not open-minded about these issues. They say they are pro-family, but the question is what kind of family?"

"Moral agenda" differences seemed to have much deeper historical, social, political, and moral roots. According to Yolanda, from the municipal government's viewpoint, the evangelical churches reproduced a conservative moral agenda strongly linked to right-wing political parties. As I will demonstrate in the following pages, these links found their roots in the civic-military dictatorship (1973-1989). Yolanda emphasised how, from the churches' perspective, there was no record of collaboration between these institutions and other social organisations. Both Catholic and Evangelical churches tended to develop some actions from their own organisations (e.g. pastoral, vicar, ministries, among others), regardless of the health network, as well as other types of organisations.

It was within this context that health practitioners adopted at least three discourses around churches, particularly evangelical ones. Some of them tended to devalue subtly religious spaces. They tended to draw representations of health institutions and work from categories such as "science" and "knowledge", while representations of religious institutions were drawn from a category of "uncivilization" ("retraso"). For their part, some practitioners recognised and appreciated that churches had become vital spaces for migrants in terms of "support",

"mental health" and "belongingness". Nevertheless, others considered evangelical churches "opportunists" since they welcomed the arrival of the migrant population due to the increase in the number of faithful subjects it created, despite the anti-migration policies of the right-wing parties. Thus, these practitioners argued that churches had become not only spaces of "belongingness" and "support" but also spaces of "political indoctrination".

Within this scenario, in the framework of my ethnographic work, questions began to emerge related to the historical, social, and political aspects that have strained the relationship between health and religious institutions in recent years. For example, what knowledges, practices, norms and values emerged in the evangelical churches with the arrival of the Haitian population? How are Haitians' religious experiences shaped in these churches? What role do the churches play in the management of migrants' malaise and suffering? And, finally, what value does the religious experience of migrants have for the evangelical church?

In this chapter, I will analyse the mutual relationships between the Haitian community and the evangelical churches in the borough, paying particular attention to church institutional interests and religious experiences. By religious experience, I understand the instance in which the subject attributes some extent of objective reality - individual, collective or a state of things – as well as some religious importance to the experience itself (Webb, 2017). Based on religious experiences, I will highlight what Didier Fassin (2009a) calls "moral economies", which he defines as the production, transaction, and circulation of emotions, values, and norms. Through this concept, I distance myself from reducing the moral dimension to an understanding related to a particular set of categories, codes, and principles ("moral code"), or related to how the subjects assume these moral prescriptions ("moral behaviour") (Das, 2012; Fassin, 2012; Lambek, 2010; Zigon, 2008). As some contributions in the field of anthropology of religion have shown (Asad, 1994; Mahmood, 2012), I approach the moral dimension from a Foucauldian perspective (1990 [1984]). Thus, I seek to revitalise practices that, framed within some moral references, shape an

"ethical subject" (Faubion, 2011; Fassin, 2012; Laidlaw, 2014). From this angle, I will focus on how certain beliefs, practices, norms, and values shape Haitians' religious experiences.

I will argue that, despite the closeness of evangelical churches with conservative and nationalist political and moral agendas, pastors have adopted a welcoming position to the arrival of migrant communities. This position has emerged particularly with Haitians due to their diverse religious experiences that are often characterised by, as some pastors said, a "greater connection with God". This "connection", in turn, has legitimised the evangelical churches' institutional mission in the eyes of pastors. Therefore, a set of beliefs, practices, norms and values have delineated the image of the "good Haitian" or "good-Christian". In order to illuminate these religious experiences, I will draw on the contributions of Tanya Luhrmann (2012, 2017a; 2017b; 2020a; 2020b), basing my arguments on her concept of "local theory of mind" or "infrastructure of mind", to question Cartesian conceptions that are ontologically anchored in the notion of experience and promoted by psy/neuro disciplines. Thus, the ethnographic material interrogates the scope of psy/neuro technologies, as well as highlights migrant and community potentialities. Besides this, I will also argue that, for Haitian migrants, these religious experiences allow for the relief of both malaise and suffering associated with uncertainties present in the migratory process. Thus, the evangelical church has become an "ethnic church" (Ambrosini, 2008; Hirschman, 2004), in as much as it has established a specific identity and ethnic-national continuity with Haiti.

This chapter is the result of multiple observations carried out in the services of an evangelical Methodist church in the borough. The church is part of an international assembly. Today, the assembly has a presence in different Latin American countries. Additionally, I conducted observations within the daily context of Haitian families, as well as interviews with migrants and their families, health practitioners, and evangelical pastors.

In order to develop my arguments, I will present the case of Pierre, a 32-year-old Haitian man who participated with his family in the previously mentioned Methodist church. Unlike other cases presented in the previous chapters, Pierre was registered with the CESFAM but had never used any provision of the health centre. I met Pierre and his son Renaud (5) at a "Community Fair"[164] carried out by the CESFAM together with other community organisations in a borough's square.

The chapter will be divided into five sections. First, I will describe the migration process of Pierre and his family to Chile and the role of religion in their daily lives. Following this, I will demonstrate the centrality of religion in Haiti, as well as the rise and strengthening of evangelical churches in recent decades in Chile. Third, I will describe the evangelical services, as well as the moral image formation of the "good Christian" or "good Haitian". Then, I will analyse how the multiplicity and complexity of Pierre's religious experiences, as well as those of other Haitians, allows us to question the Western theory of mind and to distance itself from any reading that tends to psychopathologise such experience. Finally, I will show how evangelical churches have become an ethnic-national space that allows for the development of individual and collective potentialities.

Follow God's will: Haitian migration, religion and daily life

Pierre arrived in Santiago in 2015 from "Cap Haitien", a small city[165] in northern Haiti. The country's political and economic instability were the main reasons that led Pierre and his wife, Rose (31), to migrate to Chile. In their home city, Pierre, Rose and Renaud had shared a room on the second floor of Pierre's parents' house. In addition to Pierre's parents, three of his brothers lived there too. He described life

[164] A community fair is a community-type intervention where the CESFAM and different social organizations provide information on services and benefits that the population can access in the borough.

[165] According to the Haitian Institute of Statistics and Informatics (IHSI), Cap Haitien (in Creole "Kap Ayisyen") had around 275,000 inhabitants in 2015.

in Haiti as “very familiar” and “attached to the church”. Weekly, the family attended a borough evangelical church. Pierre and some of his brothers participated in services two or three times a week, as well as in other activities that took place at the church such as Bible study groups.

Uncertainty regarding the country's political and economic future in Haiti led Pierre and Rose to search for alternatives to make a better future for themselves. Pierre, who worked as a teacher at an elementary school, and Rose, who had a small grocery business, saw little chance of improving their income and quality of life. The couple began planning their trip in mid-2015. Chile appeared to be an attractive and feasible destination primarily, as I have shown in previous chapters, for its economic stability and security[166]. The latter was also strongly associated with the image projected in Haiti by the United Nations Mission for Stabilisation in Haiti (MINUSTAH). However, Pierre, unlike other Haitians in Chile, was also critical of MINUSTAH, revealing a certain moral dimension linked to his Christian religious affiliation. He said: “The army helped us a lot. They were not only from Chile (...). But they were also badly spoken because crimes sometimes happened, people were killed in my country (...). I think soldiers were sometimes scared when there were protests, and they killed people, and nobody sanctioned them, but God will sanction, he always does”[167].

Initially, Pierre expected to travel with his family in October 2015. However, after travelling by bus to Santo Domingo (Dominican Republic) to take the plane to Chile, Pierre and Rose were forced to change their plans. The airline informed them

[166] As recent studies on the Haitian diaspora have revealed (Rojas Pedemonte, Amode and Vásquez, 2017; Nieto, 2014; Keys, Kaiser, Foster, et al. 2015; Vásquez, Busse and Izaguirre, 2014), the 2010 earthquake and the 2013 cholera outbreak in Haiti, the increase in border restrictions in both Europe and the United States, the economic stability of some South American countries, and the growth of anti-Haitian sentiment in the Dominican Republic converted countries like Chile and Brazil into attractive migration destinations.

[167] This view is likely to have changed based on new information that emerged in late 2019. An article published in The Conversation magazine by researchers Sabina Lee and Susan Bartles concluded that 265 cases of children born in Haiti were the result of sexual violence committed by military personnel belonging to the UN peacekeeping mission. The children born have been baptised in Haiti as “petit minustah”, “babies casques bleus”, or “children of peace”. The investigation revealed that 21 children were linked to the Chilean military. On January 7, 2020, the Chilean Chamber of Deputies approved the creation of an Investigative Commission of this situation.

that, according to Chilean regulations, they had to prove financial solvency. Specifically, airline staff asked them to provide evidence that they were in possession of $1,500 per person. For their part, they only had two thousand dollars. Pierre was unaware of this information because it was not actually an official regulation. As such, he tried to persuade the airline staff to let him and his family travel, but without success. Like many Haitian migrants, Pierre and his family faced an arbitrary decision made by one of a series of actors involved in migration trajectories to Chile.

The staff of the Chilean Migration Department began informally demanding that Haitian citizens should be in possession of an invitation letter and at least a thousand dollars in cash during 2012 (Rojas Pedemonte et al., 2017). Thayer (2019) has called this period of recent history in immigration policy as the stage of "mood politics" ("políticas del estado de ánimo")[168]. That is, actions that were subject to officials' arbitrary discretion. These actions, in combination with the language difference, generated a series of difficulties for Haitians who intended to arrive in the country. Indeed, the fluctuating trend in the rate of Haitians' deportations between 2012 and 2015 reveals, not only a stable pattern of the rejection of Haitians entering the country, but also the presence of inconsistent instructions from the migration authorities (Rojas Pedemonte, Amode and Vásquez, 2017).

The arbitrariness of these measures gave rise to conditions of illegality that led to the emergence of an informal market of migration where people and travel agencies gave money loans or charged US$250 for an invitation letter. This, in turn, created a particular set of circumstances that forced Haitian migrants into entering Chile through unauthorised routes, facing various types of risks that compromised their safety and health (Tapia and Liberona, 2018; Cabieses, 2019). Unlike a significant number of Haitians who have been victims of several situations of abuse, discrimination and racism by the agents involved during the migration process both

[168] Luis Thayer (2019) distinguishes three stages in the recent history of migration policies: The "default policy" (1992-2002), the "state of mind" policy (2002-2017), and the policy of "ordering the home "(2018-present). For Thayer, the second stage characterises by the significant increase in State actions, the discontinuity of these actions, and the low level of institutionalisation of these actions.

in Chile (Rojas Pedemonte, Amode and Vásquez, 2017) and in Latin America (Nieto, 2014; Vásquez, Busse and Izaguirre, 2014), Pierre and Rose only had to reorganise their trip. As I will show in this chapter, despite the setback at the airport, Pierre viewed his set of circumstances as a plan that had "followed the will of God".

As Pierre and his family checked out of the airport, Rose recalled a dream[169] she had had the week before. In that dream, Rose travelled with just Renaud to Chile. A voice, which she interpreted as the voice of God, had told her that she would travel without Pierre and that she should not feel any fear on her journey. After listening to Rose, Pierre began to feel deeply conflicted. According to him, on one hand, the dream revealed the will of God; while, on the other, acceptance of God's will meant exposing his family to possible difficulties and risks during the trip. In other words, the divine message challenged the foundations of his masculinity, particularly what he considered his protective and provider role, because it meant that his wife and son would have to travel alone[170]. Pierre, after thinking for about ten minutes, and without consulting his wife, made the decision: Rose and Renaud had to travel to Chile that same day. He said: "It was God who spoke through my wife, and we decided to follow the will of God. God puts challenges like this, like separating yourself from your family and not knowing how they are. God sometimes tests". Two months later Pierre managed to raise the $1,500 for him to travel and reunite with his family in Chile.

The Haitian community played a central role in the process of integration for Pierre and his family in Chilean society. Although they had severe difficulties in communicating in Spanish during the first months, community members helped them in different areas of daily life. After going through various sporadic jobs, Pierre began

[169] Within the Vodou worldview, dreams play a central role in Haitians' everyday life. For many Haitians, dreams are an instance for the encounter with ancestors and God. See Abarca-Brown (2020), Bourguignon (1954), and McGee (2012).

[170] From an anthropological viewpoint, the conflict experienced by Pierre revealed not only what various studies have highlighted regarding the patriarchal structure of Haitian society (Fouron and Glick Schiller, 2001; Padgett and Warnecke, 2011), but also the social and political place that both Pierre and Rose attributed to the dream. Several studies carried out in anthropology of dreams (Paul, 1989) have revealed that the dream life of some groups, rather than a residual space of psychic life, seems to be a legitimate space from which subjects make decisions regarding the future.

steady work at an industrial waste processing company in mid-2017. Meanwhile, a couple of months later, Rose got a work as a saleswoman at a grocery store. Pierre said: “A Haitian friend got us the jobs. The owner of my company hires more Haitians than Chileans. He [the owner] is an evangelical too and says he does it because we are good workers and because he wants to do something good with the migrants and with the people of the church”.

Unlike much of the Haitian community, Pierre was able to access well paid work due to his affiliation with a specific evangelical church. Although there are few investigations on the subject (Rojas Pedemonte, Amode and Vásquez, 2017), various studies have shown that the Haitian population has tended to integrate themselves into precarious and low-skilled jobs in Chile (Rojas Pedemonte and Bueno, 2014; Rojas Pedemonte, Amode and Vásquez, 2015; 2017; Solimano, Mellado, Araya, Lahoz and Ocón, 2012). Among them, employment in construction, agriculture, domestic services or informal trade stand out (Bravo, 2019). Likewise, the Haitian community has usually suffered the violation of their labour and health rights, even so far as being defrauded by their employers (Villanueva, 2014). On the contrary, Pierre was satisfied at work, he highlighted specifically the respect and appreciation of his colleagues. He said: “I know that this is not the case in all jobs. Some Chileans are not good people with Haitians. At my job, my boss does not let people mistreat us. Neither a colleague nor a client can treat us badly”. For its part, the salary allowed Pierre not only to support his family but also to send monthly remittances of around US$100 dollars to his family in Haiti.

Despite the support network that Pierre and Rose were building in Chile, they reported that they occasionally felt lonely and that they missed their family. Pierre and Rose seemed to miss everyday life with their families, particularly during leisure times. Pierre referred: “There we did things like going to the square, or the church together. Or we were at home, and we ate together. That is what I miss the most, the family”. Rather than reducing the feeling of loneliness to the presence or absence of social networks, this feeling can be understood from the centrality of the family in

Haiti. As various studies have revealed (Fouron and Glick Schiller, 2001; Padgett and Warnecke, 2011), Haitian society is organised around the extended family as an institution, marginalising other forms of networks (e.g. groups of friends). Addressing this crucial aspect of social life in Haiti, Rojas Pedemonte et al. (2017), from a transnational perspective, focused on the perceptions by family members still living in Haiti of those who had migrated and were now living in Chile. The interviewees perceived that their migrant relatives experienced a certain degree of loneliness as a result of few family interactions and the geographical distance from their family back at home.

Work stability allowed Pierre and his family to find a better place to live. During their first year in Chile, they resided in peripheral boroughs in the north of Santiago marked by poverty and low access to essential services. However, in late 2017, Pierre rented a room in a residential place in the borough. Pierre and his family were living in this room when we met at the community fair. It was a room of five meters by three meters approximately, located in a corridor-shaped tenement that had ten rooms. Because the room was at the end of the corridor and had only a small window, it tended to be quite dark and musty smelling. Indeed, during the winter, they had to use artificial light throughout the day. In the room, there was a double bed where Pierre, Rose and Renaud slept, and another single bed for Ruth (28), Rose's sister who arrived in Chile in early 2017. A curtain separated both beds. Besides this, there was a fridge and an antique wooden chest of drawers that Pierre had picked up from the street. The room did not have a toilet. They shared three toilets with another fifty inhabitants also living in the corridor.

Pierre and Rose looked satisfied with their home. They said that it reminded him of the room they had in Haiti. The limited space, as well as Ruth's presence, seemed not to bother them. On the contrary, Pierre conveyed a certain sense of pride in being able to host her in his home. He said, “God will know when she can have her own house, and perhaps a husband to take care of her”. The relationship that Pierre established with his sister-in-law revealed a gender relationship in which he, as the

man, positioned himself as a substitute for Ruth's father. In other words, he occupied a masculine place marked by a role of protection and provision not only with Rose and their son but also with Ruth. However, this position was not only related to the forms that shape gender distribution and the centrality of the extended family in Haiti (Fouron and Glick Schiller, 2001), but also to the way Haitian society tends to conceive migration more broadly.

Unlike other migrant communities, Haitian migration tends to be a family strategy rather than an individual strategy (Nieto, 2014). Based on this, the first members who migrate establish ties of solidarity and support with those who remain in Haiti in order to improve their living conditions or to allow them to emigrate to another country. This strategy is not just reduced simply to actions such as sending money remittances to their relatives in Haiti, but also extends to helping those who can project a better quality of life and develop their potential in other latitudes. Pierre said: “Ruth wants to study, and here she can have a better education than we had there in Haiti. And she may also have a better job”. The conception of migration as a family strategy can be understood as a notion based on historical, political, social, economic and moral conditions that have led part of the Haitian population to emigrate from the country (Nieto, 2014; Bernal, 2014). The interference of foreign countries, political and economic instability, natural disasters, and health crises, among others, have led to the fact that currently, around two million Haitians live outside of Haiti, which represents 20% of the population of the country (Audebert, 2012; Nieto, 2014)[171].

[171] In fact, scholars such as Saint-Hubert (2012) have argued that, since the mid-20th century, it is possible to identify at least four phases of Haitian migration to the United States.

The centrality of religion in Haiti and the strengthening of the evangelical church in Chile

Pierre's choice of that particular home was closely related to religious motives. In May 2018, during one of the last sunny days before the arrival of winter, we talked with Pierre in the corridor while Renaud played football with other Haitian, Dominican and Peruvian children. Suddenly, Pierre's face lit up as he remembered a question that he wanted to ask me but had forgotten: "Do you know why I chose this house?" Before I was able to give him an answer, he added: "because it is next to a church". He concluded: "When a Haitian arrives in a country, he looks for a home and then a church".

Religion plays a central role in the lives of the Haitian people (Hurbon, 2001; Métraux, 1958). According to the Pew Research Center (2020), in 2010, 86.9% of the population ascribed to Christianity. Within this group, 56.8% of Haitians declared themselves Catholic and 26.9% Protestant. Although the same research centre maintains that 2.2% of the population subscribes to folk religions, this data may be undervalued as a result of the stigmatisation and even criminalisation that Haitian Vodou suffered by state policies during the 19th century (Ramsey, 2011). Indeed, a small number of people declare themselves Voudouizan (Vodou practitioners), that is, people who permanently carry out acts of devotion to spirits and/or ancestors (Rey and Stepick, 2013).

As Woodson (1993) has described, beyond the religious affiliations, a "religious triangle of forces" shape Haitian society. Catholicism, Protestantism and Vodou predominate in the country, interacting at the level of their practices and symbols. Furthermore, some researchers have argued that such interaction generates feelings of unity, fulfilment and recognition in the Haitian community (Rey and Stepick, 2013). In this scenario, Vodou is not only a religion to which subjects may or may not ascribe but is part of the foundations of the worldview of Haitian society (Byron, 2014; Hurbon, 2001; Vonarx, 2012). Because Haitian Vodou is a religion that

combines West African traditions and Catholicism, the Haitian Catholic population tends to be more receptive to Vodou than the Protestant Haitian population (Hurbon, 2001). However, even among Protestant Haitians who demonise Vodou, there is no question that Vodou "is real" (Rey and Stepick, 2013).

Pierre particularly valued that church because of its similarity to the one he attended in Haiti. The proximity of their house to the church, the small space of the temple, the small number of people who attended, and the number of services that were held each week were some of the reasons that led Pierre and Rose to choose this particular church. Pierre said: "Most of the people who go are Haitians, but there are also people from other countries. But we are not many. The temple is small. There are no more than 50 people (...). Here in the borough, there are churches where there are 300 Haitians on a Sunday". The magnitude of these services led Pierre to think that the Chilean population mainly ascribed to the evangelical religion over the Catholic. He said: "There are many evangelical churches here, but very few Catholic churches (...) I go through the cathedral, and there is never a service, there is nobody".

Although in Chile there are no records of migrants' religious affiliations, an ethnography carried out by Aguirre (2017) has revealed that larger proportion of migrants are evangelicals. According to Aguirre, evangelical churches have achieved a higher adherence of the Haitian population due to greater flexibility in services. For instance, these churches have rapidly integrated Creole into their rites. It is within this context that Haitian migrants mainly go to evangelical Pentecostal, neo-Pentecostal, and Methodist churches (Aguirre, 2017).

The increased participation of migrant communities in evangelical services has strengthened the continued rise of evangelical churches in the country[172]. This rise began with the civic-military dictatorship led by Augusto Pinochet (1973-1989), at which time the evangelical churches achieved social and political recognition as a

[172] During the last decades, the evangelical population has increased: 1992 (12.4%), 2002 (15.14%), 2012 (16.6%); while the Catholic population has decreased: 1992 (76.7%), 2002 (69.9%), 2012 (67.3%).

result of a distancing between the government and a part of the Catholic Church aligned with the defence of human rights (Lagos, 2001). The support shown by the vast majority of evangelical churches[173], particularly Pentecostal, was reflected in a statement known as "The Evangelical Position" (Maldonado, 2012). In this declaration, the evangelical church valued the military irruption, contrary to Marxism, and established some guidelines for the following years. Among these guidelines were the authoritarianism of the institution and the absolute leadership of the pastor (Chacón, 2002). The links between the dictatorship and the evangelical world were due to various reasons. The Pentecostal church had historically been undervalued for its proximity to impoverished sectors. Likewise, Augusto Pinochet needed a religious reference that legitimised his dictatorship due to the distancing from the Catholic world (Lagos, 2001). Finally, the theology of the Pentecostal world conceived that there was a strict relationship between disobedience to political authority and contempt for God (Maldonado, 2012).

As in other countries such as the USA and Brazil[174], evangelical churches have acquired an increasing role in public life in recent years in Chile, significantly influencing the debate on the country's political and moral agendas (Martín, 2016; Parker, 2012). Specifically, the "evangelical world", as some media have called these churches, has begun to exert intense pressure on the debate around topics such as abortion, gay marriage, sex education in schools, "gender ideology", among others (Martin, 1991). This has led to various reactions from the political field. For example, Sebastián Piñera, in his first term as president (2010-2014), declared, in a document

[173] The vast majority of the members of the Pentecostal Evangelical Church expressed their support for the 1973 coup d'état. This support was reflected in a statement made in the Diego Portales building known as "El Portalazo" (December 13, 1974). The declaration, entitled "The Evangelical Position", said: "The pronouncement of the Armed Forces (...) was God's response to the prayer of all believers who see in Marxism the satanic force of darkness in its maximum expression". Reading the declaration was considered a requirement for Augusto Pinochet to attend the opening of the Evangelical Cathedral in 1974. During that same year, the first evangelical "Te Deum" was held in Chile. However, some evangelical dissidents currently maintain that this declaration is not legitimate and that it represented a collective reflection.

[174] In countries like the USA or Brazil, evangelical churches have played a crucial role in presidential elections that left Donald Trump and Jair Bolsonaro respectively the leaders.

entitled "Thirty commitments to the evangelical Christian world", evangelical churches "have to carry out still many actions"[175]. In the same way, evangelical political proto parties have emerged[176], as well as political representatives of the evangelical churches. In fact, in the 2016 municipal elections, one hundred evangelical candidates were presented, with 29 of them elected (Berdía-Pfeifer, 2018). For their part, at the parliamentary level, three deputies[177] and one senator[178] have formed the "evangelical group" ("bancada envangélica"), seeking to protect Christian values (Infogate, 2018).

Despite the historical, social and political ties that unite evangelical churches with right-wing parties promoting conservative, nationalistic and anti-migration agendas, churches have tended to adopt a welcoming position. In part, this can be understood by the fact that the mission of this type of organisation is part of a humanitarian strategy focused on social inequalities and psychosocial consequences (Fassin, 2011a), embodied, in this case, in the migrant population. In other words, a strategy aimed at relieving the unequal and moral valuation of life[179].

The contemporary debate on Modernity, religion and secularisation could shed some light on the rise of evangelical churches within the Chilean secular state. In the debate that brings together researchers belonging to the "paradigm of secularisation"[180] (Berger, 1969; Luckmann, 1973; Tschannen, 1991), and those

[175] In 2013, in a document entitled "Progress of the 30 commitments with the evangelical Christian world", published by the National Office of Religious Affairs (ONAR), various evangelical leaders recognised the progress made by the Sebastián Piñera administration.
[176] In 2018, there were four evangelical political proto-parties in Chile: Partido Cristiano Ciudadano (PACC), Unidos en la Fe (UNEFE), Nuevo Tiempo (NT), and Unidad Cristiana Nacional (UCN) (Berdía-Pfeifer, 2018).
[177] Belonging to the Renovación Nacional (RN) party.
[178] Belonging to the Unión Demócrata Independiente (UDI) party.
[179] This strategy aims to give the living a certain dignity through protective strategies that endow the migrant community with "bio-legitimacy" (Fassin, 2011a).
[180] The secularisation paradigm holds that, as societies modernise, religious institutions and practices decline, and religious expressions tend to be relegated to a private space. However, within this paradigm, there are several authors who have conceptualised secularisation as a multidimensional concept (Dobblelaere, 1981; Iannaccone, 1998). They try to distance themselves from mechanical and unilinear analyses of the secularisation process.

belonging to the "religious economies theory"[181] (Stark and Bainbridge, 1985), various researchers have distanced themselves from the Modernity-religion dichotomy to reveal how states manage religious differences within a certain normative field, as well as how religious communities carry out various practices that allow them to sustain their beliefs in the contemporary world (Asad, Brown, Butler, and Mahmood, 2009; Butler, Habermas, Taylor, and West, 2011; Mahmood, 2012, 2016; Zigon, 2014). This debate has made it possible to create distance from certain secularist currents tending to place Europe and Christianity as points of reference.

In Chile, specifically, some researchers have argued that secularisation is part of a Modernity process with particular characteristics (Chacón, 1992, 2002; Lagos, 2005; Fontaine Talavera and Beyer, 1991). This process is synthesised in the acceptance of the modernisation process, but not the Modernity that it brings with it. In other words, the process centres on elements such as urbanisation, industrialisation, and technological and scientific knowledge, but not due to religious indifference, such as the secularisation paradigm that has been described (Chacón, 1992; Talavera and Beyer, 1991). In this sense, these researchers have discarded the idea of a "linear evolution" in which a supposed "religious past" and a "secular" current in the country (Chacón, 1992) is highlighted.

Through this approach, researchers dedicated to the secularisation process in Chile have argued that the Modernity process does not seem to have marked a significant distance from religious elements. On the contrary, during the 20th century, a religious market was consolidated in which religious identifications have constantly fluctuated (Viera Miranda, 2016). Within this context, Protestant and Evangelical religions grew gradually during the 20th century, strengthening in the 1970s through their relationship with the civic-military dictatorship (Lagos, 2001). According to Fediakova and Parker (2009), due to their civic habits and increased educational and

[181] The paradigm of religious economies highlights the dynamic nature of religions and the religious market. This paradigm highlights that 1) people make rational decisions when choosing a religion, 2) there is no decline of religions in modern societies, 3) the increase in pluralism brings with it the increase in religious commitment.

socioeconomic levels, evangelical communities have gradually become a "cultural citizenship". That is, a recognised group that is part of a democratic and pluralistic society. However, according to these researchers, this group does not act from a national perspective, but acts to defend corporate interests that, in turn, decrease their level of insertion in democracy.

In the health field, specifically, although the State and the Protestant and Evangelical churches do not seem to have established permanent collaborative relationships, the churches have gradually gained spaces in the work of prevention and rehabilitation for alcohol and drug consumption. In the 1980s, the first "therapeutic communities"[182] began to emerge under the remit of churches. Through multiple therapeutic tools, these communities have promoted interventions marked by a moralising tone based on Christian values[183] (Muñoz, 1996). These communities have received public funds, particularly from the Ministry of the Interior and Public Security, for the implementation of their programs[184]. According to an Evaluation Report of the Programme of Prevention and Rehabilitation published by such a ministry in 2009, "the churches and creeds (…) are an important support and, in some cases, have become protagonists in the establishment of work (…) as they act as bridges, applicants for intervention, and generate and strengthen social control" (Ministerio del Interior y Seguridad Pública, 2009: 269).

Evangelical Service and Religious Practice: Outlining the "good Christian/Haitian".

In one of our conversations, Pierre asked me somewhat shyly if I would like to accompany him to a service the following Sunday. He encouraged me by saying that

[182] The first therapeutic communities were "Corporación Comunidad La Roca" (1982) linked to the Evangelical Baptist Church, and the "Centro de Rehabilitación para Alcohólicos y Drogadictos" (CREHAD) (1982) linked to the Assemblies of God Evangelical Church.

[183] On the relationships between government programs and churches in the field of health, I suggest reviewing the work of Cristiana Giordano (2016), "Secular Redemptions: Biopolitics by Example". In Medical Anthropology, 35: 3, 278-290.

[184]. For example, in 2008, the Ministry of the Interior and Public Security allocated approximately US$ 30,000 for these programs.

if I wanted to understand “what Haitians were like”, I had to go to church. After accepting his invitation, Pierre cheerfully told me: “The pastor will be happy”. We agreed to meet outside the temple on Sunday at 11:30 am, thirty minutes before the service began. Pierre intended to introduce me to the pastor and some of the worshippers who were part of the religious community before the service began.

Upon arriving at the site, I found a two-story building that was more akin to a small warehouse than other evangelical temples I had seen in the borough and the northern part of Santiago. The façade of the building measured around ten meters in width. To the left was a metal door that had a protective grille. There was also a metal gate that was open through which a band could be heard playing religious songs. Pierre was a few minutes late but arrived shortly after me together with Renaud and Ruth. Rose was unable to attend as her boss had asked her to work that day. Similarly to the other twenty or so churchgoers from Haiti, the Dominican Republic, and Bolivia, who were in the temple, both Pierre and Ruth were dressed elegantly. Pierre was wearing a black suit, white shirt, and blue tie. Ruth, meanwhile, wore a calypso dress. After we greeted each other, Pierre invited me to come to the temple.

Figure nº7: Front of the church building

After walking through an entrance hall, we entered a small room that measured approximately eight by nine meters. In the corner was a pulpit. To the left of the pulpit was a flagpole with a Chilean flag. This was the room where the service was to be held. A group of three musicians who played the guitar, drums, and a bongo drum were noticeable in the little room. For their part, people sang songs by following the lyrics on a screen located to the right of the pulpit. Seeing us, the pastor approached to greet us. His name was José, a short man in his 50s. Pierre, who had already spoken to me about the pastor a few days beforehand, introduced me saying: "He is the person who is doing the study on how we [Haitians] live in Chile".

Although the pastor was receptive and approachable at first, as the conversation flowed, his tone revealed a certain degree of surprise and suspicion about my presence in the temple. As Pierre jovially greeted other Haitians arriving at the scene, the pastor began asking me different questions regarding my motivation for being there. Initially, the questions were vague, but gradually they became more direct. Indeed, at one point he asked me directly, "Do you work for the government?" At my rebuttal, the pastor seemed relieved. He added in a rather persecutory tone: "They say that people from the government are coming to the temples to find out what we do (...). They want to know how our faith is so strong and how people reject such atrocities as abortion, marijuana, or gay marriage (…). All of this goes against the family". Although the tone and content of his words seemed abhorrent to me since they revealed a significant value gap between us, the fact that I did not work for the government and my neutral attitude towards his position seemed to be enough for the pastor to trust me. He agreed to let me participate in this service, and the other services that I attended during 2018 and 2019. He closed our conversation by saying: "the doors of the Lord's house are open to everyone".

However, the emergence of sensitive issues became a constant in meetings with the pastor for at least six months. While I apparently appeared to be a non-threatening person to him, he repeatedly resorted to discussing government policies during our conversations. At times, I felt he was trying to convince me that the more

liberal policies were “atrocities” and at other times I felt that he was trying to test my position regarding these policies. Usually, he targeted Michelle Bachelet, who had ruled the country for the second time during 2014-2018[185]. The pastor, in addition to focusing on issues such as bills aimed at the approval of abortion and gay marriage, seemed upset with an alleged audit that “the government of Mrs Bachelet” carried out on the resources of the churches. He said: “the people of the government are getting into money matters of the churches (...) and according to the Worship Law (“Ley de Culto”), they are independent institutions, and the churches do not have to pay taxes”. Although the pastor touched on the subject twice in our conversations, he seemed to be unaware of the scope of the alleged “audits”[186].

Before the service began, the pastor introduced me to pastor Choy and his partner - both of whom were from South Korea - as well as James, the “Haitian pastor”. The way he presented them to me revealed a hierarchical structure in which he occupied an intermediate rank. Pastor Choy, also known as the “Korean pastor” by the worshippers, was the representative of the assembly in Chile. He was in charge of the religious and administrative guidelines of the church. He had hired Pastors Juan and James. The latter played a central role in adapting the services to the Haitian community, as well as, as I will show in the following pages, in the construction of the moral image of the “good Christian” or “good Haitian” through subtle work that set out to monitor the behaviour of Haitians in their daily lives. Within the church, the other pastors valued Pastor James for “his knowledge of the Haitian faith”, as well as for the various innovations they had made in order to “bring Haitians closer to the church.” Among them were his translation work, the installation of screens so that Haitians could follow the songs in karaoke mode and the Bible study groups.

[185] His presidency ended in March 2018.

[186] It is possible that the pastor's perception was influenced by a series of events that occurred around the management of resources by the Evangelical Church. In September 2017, a newspaper launched an investigation by the National Prosecutor's Office for possible money laundering crimes and tax offences by Pastor Durán, who was the representative of the First Pentecostal Methodist Church (La Tercera, 2018b).

Similarly to the various services I attended during my ethnographic work, on that day the service rigorously followed a series of specific stages. During the first fifteen minutes, the band, led by Pastor Choy, played songs in Spanish that were broadcast in karaoke mode on the temple screens. The song structures were simple with repetitive choruses, making it easy for attendees to learn, remember and repeat them every Sunday. Although the content of these was jovial, the monotony of the rhythm generated a calming effect and slight lethargy amongst the congregation. Pierre, however, sang them with glee, opening his arms to heaven or bowing his head compliantly.

Later, Pastor José invited the children and adolescents to participate in the "Sunday School" on the second floor. The Korean pastor's wife guided this "School". She introduced children to the world of the gospel through dynamic activities. After the children left the service room, Pastor James read Psalm 143, which was entitled "I am a servant". Similarly, he read Matthew 5, verses 1-3. As Pastor James read the text, Pierre, as well as the worshippers, adopted a position of recollection. Lowering their heads at the same time allowed them to follow the readings on the little bibles in their hands.

At the end of each reading Pastor José walked up to the pulpit to preach to the congregation and in so doing marked the service with an air of solemnity. Although he was not a large man his confidence radiated over the pulpit and created the sense that he held a considerable degree of authority over the room. The congregation responded by settling into their chairs and listening attentively. On that particular day, Pastor José stressed that those who become a servant of God might "face all the difficulties that life presents".

Through small messages, gestures, exchanges, and acknowledgements at the time of the preaching, the pastor outlined the image of the "good Christian". His primary message to the congregation was riven with ideas about how to become a good servant. He told the assembled room that "a good servant is he who comes to

service when he is tired", "a good servant is one, when everything is wrong, when he thinks that God has abandoned him here in Chile, he continues to do good", or "a good servant is he who, when there is no work, when there is discrimination and racist people, continues to do good because God is with him". He also held some of the members of the congregation up as exemplars of a "good servant". For example, he used the instance of "Marta who, despite problems finding a job, still comes to service", or "Rosemarie who comes to be with God even though her son is sick in Haiti". He told the room that "Marta and Rosemarie are not like those people who come because they want something from the church, or because they want immediate help. They know that God has this in his plans for them". When he finished each of these messages, Pastor James translated them into Creole for the congregation followed by a firm "Amén" to end each one. The congregation repeated "Amén" each time displaying an evident degree of strength and joy in their voices.

Pastor José asked the worshippers to stand up to "sing to God" and came to those who wanted to "make a special request to God". The songs of the worshippers reminded me of ethnographies carried out in Pentecostal churches (Luhrmann, 2012), as well as in Haitian diaspora contexts (McAlister, 2002; Mooney; 2009; Rey and Stepick, 2013; Richman, 2005) in the USA. They sang loudly, raising their hands to the sky and babbling words that were incoherent. As they sang, they appeared to display expressions on their faces that suggested this had been a cathartic process for them, especially when they sang in Creole[187]. In the meantime, Pierre and some of the others approached the pastor with their heads bowed to represent respect and obedience. The pastor took one of their hands and held it up. Holding the microphone in his other hand he prayed to God that the request of this particular member of the congregation would be fulfilled. As he did this, the person in question would close his eyes and intensely babble words that were inaudible to the rest of us.

[187] Songs in Creole were rare in services because Pastor Choy preferred that attendees be able to learn Spanish during services.

Figure nº8: Service. Moment of “petition to God”.

The service ended with the worshippers singing and giving an “offering” to the church that consisted of donating money, which they left in a small box. The pastors watched those who approached and made a small bow of their heads to show validity for each donation. Most of the attendees gave money but usually only small amounts[188], however, these donations would have represented a significant sacrifice to them. At the end of the tithe delivery, Pastors José and James invited people to give each other a “blessing” greeting.

After the end of that first service, Pastors José and James told me that having arrived with Pierre was the “best way” for me to get into the church. Pastor James described him as a “good Haitian” because he carried out “the word of our Lord Jesus Christ everywhere” and he was a person “dedicated to his family and to doing good”. He added: “Pierre could dedicate himself to this, he could be a pastor. He studies the Bible and teaches others by example”. The pastors spoke of Pierre with a degree of

[188] Donations were generally around US$ 0.5.

admiration that, in turn, positioned him as an 'ideal' member of the church. Indeed, as I will detail in the following sections, a few months previously the pastors had invited Pierre to register as an "active member of the church" signing a document in the presence of all the worshippers.

For the attendees, the church was a place where they could find some relief for their afflictions. The religious experience the church offered seemed to alleviate various forms of malaise and suffering associated with uncertainties linked to the migratory process, as well as acting to comfort them individually and collectively. After the services ended, their interactions, body disposition, and affective expressions tended to change from those at the beginning of the service. Their body movements tended to be more extensive, and their gestures were more expressive. They tended to hug each other and laugh with one another. The vast majority of those in attendance stood in the temple hall, talking about family, work, the political situation in Haiti, and football, among other topics. Both generational and gender aspects usually differentiated the conversational groups. Although, at the beginning of the service they spoke in Spanish, Haitians tended to speak in Creole in this instance. Speaking in their language, they looked more relaxed and comfortable in their bodies. Similarly to every Sunday, this moment was interrupted by the pastors who invited everyone to have a drink on the second floor. There, the conversation continued, lasting for more than an hour.

The Religious experience of evangelical Haitians: Questioning the Western Theory of Mind.

After accompanying Pierre to the church for about two months, I became aware of the multiple ways that Pierre's religious experience unfolded. During some conversations we had after leaving the service, or when visiting him at home, he said: "I felt God", "today God was present", "I connected with God", or, more directly, "God spoke to me". Although these expressions could be understood in metaphorical

terms, Pierre described his experience with God as an unquestionable certainty. By asking him explicitly if God ever spoke to him, Pierre replied affirmatively. He reported that God usually talked to him in dreams or through the Bible. However, Pierre emphasised that once, after leaving a service in his home city in Haiti, God had spoken to him audibly. At that time, Pierre was experiencing some conflicts within his family, an issue that kept him away from the church. After attending the service, a voice, which he attributed to God, told him "do not lose faith".

Research on migration and religion can shed some light onto Pierre's religious experiences. Researchers have mainly produced two lines of thought since the second half of the 20th century (Cadge and Ecklund, 2007). Although these traditions have originated from studies carried out on migratory flows to the United States, their contributions provide us with the framework to outline and analyse some aspects of the issue in Chile. On one hand, there is a research tradition focused on social services belonging to the churches that provide psychosocial and/or legal support to the migrant population (Hirschman, 2004; Levitt, 2007; Juárez, 2012)[189]. However, for this ethnography, the second tradition becomes more relevant. Starting in the 1990s, several studies have focused on the subjective experience of migrants around religion (Maduro, 2009; Odgers, 2013; Youkhana, 2012). In particular, these have highlighted how migrants live and transform religion, as well as how religion allows them to maintain a double permanence - or "absence", paraphrasing Sayad (1999) - both in the country of origin and the country of destination. Based on this tradition, a transnational perspective in migratory studies becomes relevant. As I highlighted in the second chapter, this perspective allows us to trace non-linear continuities regarding the migratory process, allowing us to approach how knowledge, practices, and symbols cross borders.

[189] From this perspective, said services affected a source of social capital that would affect the acculturation processes of the migrant population. From this line, for example, emerges the model of the "three Rs" of Hirschman (2004), which highlights essential functions provided by the churches: refuge, resources and respect.

Various ethnographies carried out with Haitian communities both in Haiti and in other countries have revealed the heterogeneity, dynamism and complexity of the religious practices (Brown, 1991; Ramsey, 2011; McAlister, 2002; Mooney; 2009; Rey and Stepick, 2013; Richman, 2005; Vonarx, 2012). As I described earlier, the historical and social anchors of Vodou, as well as the interaction of Vodou with other religions, shape a different worldview from the predominant Cartesian vision regarding conceptions of "person", "body", "health/illness", and "death", among others.

Within this context, the relevance of the focus on the religious experience of Haitian migrants lies not only in the question of how migrants live and transform religion in Chile, but also concerns, in the words of Tanya Luhrmann (2011; 2012), the "local theory of mind" or "infrastructure of mind" at stake. In other words, ways of imagining the act of imagination, thinking, and feeling (Luhrmann, 2011). Through this concept, she tries to approach those that Sneath et al. (2009) called "technologies of the imagination". That is the representations that structure mental action. According to Luhrmann, these types of questions are recent and controversial in anthropology and psychology since what psychologists tend to call "theory of mind" (Weisman and Luhrmann, 2020; Wellman, Cross and Watson, 2001) is seen as a universal achievement of human development. However, from an anthropological theory of mind, it is possible to trace at least six "theories of mind". Thus, there is an important body of evidence that suggests that a specific theory of mind can shape a particular mental experience (Luhrmann, 2011). Luhrmann's contributions to a local theory of mind and its effects on the configuration of experience shed some light on the religious experiences of Pierre, as well as the other Haitian churchgoers. These contributions reveal how a local theory of mind configures, through the interaction between the Vodou worldview and evangelical Christianity, a particular form of living in the presence of God (Luhrmann, 2012, 2017a).

Therefore, the question that becomes relevant here is whether a specific "infrastructure of mind" led Pierre to listen to God and also, as I will show further, what place the church gives to these kinds of religious experiences. According to

Luhrmann (2017b), in societies that attribute greater social importance to mental experience, fewer subjects tend to suggest that God speaks to them audibly. However, in societies where there is greater continuity between mind and body, subjects tend to report that they hear God, not in their minds, but more through their ears. From this dynamic continuum, Luhrmann and colleagues (2011, 2017a, 2017b) have identified the following theories of mind: a) The Euro-American modern secular theory of mind; b) The Euro-American modern supernaturalist theory of mind; c) The opacity of mind theory; d) The transparency of language theory; e) The mind control theory, and f) Perspectivism. Based on Pierre's experience, it is possible to argue that the infrastructure of the mind that shapes his way of knowing and living in the world tends to be "The Euro-American modern supernaturalist theory of mind". According to Luhrmann (2011), this local theory can be found in charismatic Christianity, in contemporary forms of Chinese healing, as well as in some practices considered to be "new age". From this theory, people "conceive" the mind as if it fits the modern secular theory, but with a few exceptions. Hence, for these subjects, the mental world becomes permeable for God, a dead person, or specific energies.

This contribution is consistent with a significant number of studies in Haiti that have reported how alleged psychotic episodes are religious expressions (e.g. hearing God or an ancestor) associated with Vodou (Auguste and Rasmussen; Cavanna, Cavanna and Cavanna, 2010; Desrosiers and Fleurose, 2002; Kiev, 1961; Khoury, Kaiser, Keys, et al., 2002; Vonarx, 2012; WHO, 2010). Thus, based on the case of Pierre, as well as other members of the church, it is important to distance oneself from readings that tend to psychopathologise the religious experience and emphasise that this type of experience does not necessarily mean the presence of a psychotic episode. Indeed, unlike those who experience a psychotic episode, the voices of those who report hearing from God tend to be rare (people usually remember one or two examples), brief (four to six words), and surprising, but not distressing (Luhrmann, 2017b).

As I showed in previous chapters, unlike what happened at the CESFAM, the "return of the magical-religious realm" seemed not to generate significant issues within churches. Instead, as I will show in the next section, the multiplicity and complexity of Haitian religious experiences, particularly those linked to a greater "connection with God", tended to legitimise the mission of the church. Although the analysis of Pierre's case from Luhrmann's contributions allows for the questioning of Western conceptions of the theory of mind and the scope of psy/neuro technologies, this case also invites us to question broader issues in the context of the evangelical churches in Chile. Specifically, I am referring to questions regarding the identity, political, and institutional issues at stake in such churches. For example, I address questions such as: What forms do the religious experiences of Haitians take in collective terms? What roles do the various religious expressions of the Haitian community play for the evangelical churches in Chile?

"The church is a piece of Haiti in Chile": On an ethnic-national space

Despite its recent inauguration, the church has managed to form a religious community who regularly attend services. In general, attendance was around 30 or 40 churchgoers. The feeling of belonging to the church and the ties between the worshippers grew stronger over time. Like Pierre, several members gradually accepted being "active members" of the church. This process consisted of a rite where one of the members publicly agreed "to follow the mission of the Lord Jesus Christ" and "to participate actively in the church". To seal this pact, they signed a symbolic document that served as information to the pastors to support, before the international assembly, the number of worshippers of the new church in Chile.

The process of becoming an "active member" of the church was not only a matter of the expression of religious practices consistent with the Christian faith but also involved a certain form of purification of some of the worshippers who had some beliefs and practices associated with Vodou. Pastor James claimed that this "type of

belief" was common in Haiti and that the mission of the church was "to extirpate those types of diabolical practices".

As some historical and anthropological works on Haiti have highlighted (Hurbon, 2001; Ramsey, 2011), the conception of Vodou as a practice associated with "witchcraft" and the "devil" is somewhat widespread, particularly in the Haitian evangelical population. In an interview, Pastor James said:

> In Haiti, people sometimes thought that there was a dead person who came to visit him or that they had cursed him (…) We went to church and purified his house in the name of the Lord. We threw into the garbage images or animals that have been given to them to perform rites and protect themselves from the devil. Vodou is just the devil, nothing else (...). Here in Chile, we do not see that much, but when someone says something about witchcraft, black magic, etc., we tell them that here is God, and God is the light.

Through this purification process, the church outlined, not only the image of the "good Christian" or "good Haitian", but a specific range of religious experiences that conformed to what the church considered acceptable and ideal. Along these lines, on one hand, the experiences that revealed a particular connection with God through the Bible, the preaching, or a divine message, became a coherent experience that, at the same time, legitimised the mission of the church. Instead, experiences linked to Vodou beliefs and practices were on the side of what was forbidden and what should be transformed by the church. On the other hand, by positioning the image of the "good Christian" or the "good Haitian" as the ideal, the pastors symbolically aligned the "foreigner-Haitian" with a specific ideological representation of the Chilean nation. Thus, the evangelical Haitian became someone who was "responsible", and a "worker", "concerned about his family" and, above all, "a good Christian". Similarly, as I demonstrated in the second chapter, the image of the "good migrant" can be situated within the framework of neoliberal economic policies. For example, Pastor José said in an interview:

> It is true that many people from Latin America began to arrive in Chile from one moment to another. Perhaps it was because of the irresponsibility of the

> Bachelet's government. But they are already here, and we want good people for our country (…). Chile is a country that is doing well and requires people who are hard-working and attached to Christ's values.

The Haitian community's participation in the church gradually revealed a collective ethnic-national experience. In fact, during an interview, Pierre said: "The church is a piece of Haiti in Chile". For him, for instance, "singing to God", especially in Creole, not only allowed him to connect with God but also with his compatriots around an ideology of "the nation". Pierre added: "when we are all in the church it is as if we were back in Haiti for a moment (…) we Haitians are united people, happy people (…). That helps a lot when you are away from home, you feel good and with strength". The collective experience of Pierre, together with the other faithful subjects, supported what other studies have similarly found, namely: that religion reinforces a sense of belonging and the reaffirmation of ethnic and national aspects (Cadge and Ecklund, 2007; Portes and Rumbaut, 2010). Religion marks a continuity with the migrant's place of origin, but, at the same time, also provides the migrant with the means to adapt more successfully to their country of destination (Hirschman, 2004). In this way, religion generates the points of reference through which migrants can locate themselves in a new country, rearticulating their identity (Aguirre, 2017).

The church thus became an "ethnic church"[190] (Ambrosini, 2008; Hirschman, 2004). However, while this concept highlights how churches and religion constitute certain points of reference that allow the preservation and stability of identity practices, at the same time it also reveals how they contribute to transforming those practices and their identity. Thus, churches become spaces for a constant negotiation between knowledge, practices, values and symbols. The Haitian community appreciated that other initiatives such as some Haitian festivities were carried out in the temple space. In an interview, Pastor José said: "This is the house of the Lord, and

[190] Possibly, as a result of the church becoming an ethnic-national space within the borough, the church received several racist and xenophobic attacks. Some weekends, the pastors had found some graffiti on the front of the church with hate messages.

when they come to Chile, they come with their beliefs and customs (…). The doors of the Lord's house are open to those things too (…). It is a church that is fundamentally a place for the family to come together". For his part, Pierre said: "in the church, we can be together and show who we are; show our culture. It is a space that God gives us to be closer to Haiti".

In this ethnic-national space, values such as solidarity and respect allowed for the development of a feeling of belonging, as well as support for both individual and collective potentialities. Worshippers continually shared experiences about the difficulties of living in Chile, as well as living away from their families in Haiti. However, rather than becoming a space that was used solely for relief from afflictions, the group was transformed into space where members produced reciprocal ties through which they exchanged resources, information, and small goods. For instance, many of them frequently shared information regarding jobs or houses for rent. Also, they could exchange goods such as small pieces of furniture or mobile phones. These practices allowed them to generate a social fabric that functioned as a support network to help them face the difficulties of the migratory process. Furthermore, the Haitian community recognised capacities or practices that allowed them to face the integration process in the country. For instance, Pierre told me: "I, as a teacher, sometimes help Haitian children with school things (…). Other people organise events for those who are worried because someone is sick and needs something". Therefore, the church became a space that empowered the community, marking a continuity for them regarding the ways of life in Haiti.

As I mentioned at the beginning of this chapter, the limited collaboration between the municipality and churches led the health teams to ignore the meanings and potentialities of these spaces. For the health teams, the churches were fundamentally indoctrination spaces in which migrants occupied a passive position. On the contrary, the case of Pierre shows how migrants coped with their afflictions individually and collectively in the context of churches. These findings are not only relevant to discussions in the fields of moral anthropology and religion, but also shed

light on current public health problems in Chile. For example, how do health institutions, programs and practitioners understand the concept of community? What forms does interculturality take in community-health contexts? What is the role and relevance of religious communities in mental health interventions?

Conclusions

In this thesis, I have interrogated how new discourses related to migration, multiculturalism and mental health have taken shape in post-dictatorial Chile. Specifically, I have explored how the introduction of health reforms framed in the global mental health (GMH) agenda, biomedicine and psy/neuro technologies have impacted and shaped afro-descendant migrants' subjectivity and everyday life. To address these aims, the thesis was based on a multi-sited ethnography in a low-middle income borough situated in the north of Santiago. Following the health practitioners' work and Haitian and Dominican migrants' everyday lives, I explored frictions, conflicts, and challenges among organisations, knowledges, practices and values, highlighting epistemic differences. Thus, in each of the chapters, the thesis emphasised the perspective of specific social actors. While chapter one revitalised the health practitioners' perspective, chapters two and four focused on Dominican migration, and chapters three and five on Haitian migration.

Bringing together contributions from anthropology, sociology, science and technology studies, psychoanalysis and feminist theory, I have argued that there are multiple forms of becoming a (neuro)migrant in a post-dictatorship neoliberal Chile. Through the negotiation, assimilation, resistance, and refusal of biomedical and psychiatric interventions, afro-descendant migrants engage in heterogeneous subjectivation processes that both affirm and challenge normative values of integration into Chilean society. Thus, these subjectivation processes reveal that psy/neuro technologies challenge migrants' representations of themselves, their malaise and suffering, as well as their mental health. Besides, these processes also reveal how Haitians and Dominicans develop individual, family and community coping strategies to address their afflictions in spaces such as neighbourhoods and churches mainly.

Although local initiatives in multiculturalism have encouraged health practitioners to reconsider their practices and values reflexively, they have also tended to racialise both the notions of "cultural difference" (Fassin, 2009a; Jenks,

2010; Sargent and Larchanché, 2009) and abnormality/madness (Metzl, 2010). Notably, as some studies have shown in different contexts (Ehrenberg, 2018; Rose and Abi-Rached, 2013; Rose, 2018, Vidal and Ortega, 2017), mental health practitioners have usually reduced migrants' malaise and suffering to a neurobiological level, neglecting the ethnic and contextual aspects involved. Through this, they reproduce and reinforce a conception of afflictions based on a "biosocial determinism" (Pitts-Taylor, 2019) framed in what some researchers have called "neuroscience of poverty" (Farah, 2018; Farah, Noble, and Hurt, 2006). Thus, through the causal linking of neurological, cognitive, biographical, vulnerability and poverty aspects, mental health practitioners mask structural conditions associated with afflictions.

The arrival of Haitian and Dominican communities during the first part of the 2010 decade have been the product of, rather than bi or multi-lateral programs of human mobility, random political, social and economic forces. The effects of the 2007-08 subprime crisis, the 2010 Haiti earthquake and its political, economic and institutional effects, the political and economic stability of Chile in the 1990s and 2000s, as well as the influence of the Chilean Army within the framework of the United Nations humanitarian mission, were all factors of expulsion and attraction that shaped those migratory flows. From this, following a transnational perspective in migration studies (Glick Schiller, Basch, Blanc-Szanton, 1992; Levitt, and Glick Schiller, 2004), this thesis has shown how the "migrant" category, rather than accounting for the mere mobility of a subject or community, reveals complex and dynamic forms of subjectivation that concern, not only the country of destination, but also the country of origin. Inspired by other migration studies (De Genova, 2009; Rodriguez and Schwenken, 2013; Sayad, 1999), I have called this process "becoming a migrant at home".

A group of historical, social, economic, political, moral and material forces have constrained afro-descendant migrants in Chile. Through what I have called "becoming a migrant in the host country", this thesis has shown how migrants

embody these forces, thus revealing forms of integration into Chilean society framed in neoliberal logics. Migrants engage in processes of subjectivation around images such as those of the "good worker", through which they seem to confront, resist and refuse dynamics of discrimination, racism and xenophobia. Despite these forms of subjectivation, racialisation and sexualisation processes have situated their bodies in a "visible" place in the public space, impacting their subjectivity, sexuality and daily life. This thesis has emphasised how, through the (re)production of racialised stereotypes, some Chileans, as well as some migrant communities, tend to subordinate Haitians and Dominicans into a "second class-people" place or even linked to the wild or animal realm.

Furthermore, these forces have had several psychosocial impacts in the daily life of migrants. As some studies in Chile have revealed in recent years (Cárdenas, Gómez, Méndez, et al., 2011; Hevia, 2009; Riedemann and Stefoni, 2015; Stang and Stefoni, 2015; Tijoux, 2013a, 2013b), this ethnography has shown how expressions of malaise and suffering have taken shape at individual, family and collective levels. As a consequence, migrant adults have revealed, for example, expressions such as anxiety, depressed moods, uncertainty, a feeling of insecurity, among others. In addition to these expressions, migrant children and youths revealed image disorders and identity crises mainly marked by situations of racism, family breakdowns, language difficulties, intergenerational disagreements with their parents and caregivers.

In this thesis, I have shown that, rather than within healthcare centres, migrants find relief from their afflictions mainly in family and community spaces such as neighbourhoods and churches. Unlike studies that have tended to approach the relationship between communities and health institutions based on the degree of familiarity to biomedical and psychiatric discourses and practices, this ethnography has revitalised how communities manage their afflictions based on their own representations and practices. In other words, rather than conceiving the healthcare practices of Haitian and Dominican migrants by a lack of familiarity with psy/neuro

technologies, this study has highlighted explanatory models, resources, spaces, agents, and unique and collective potentialities of the Haitian and Dominican communities.

This ethnography has confirmed[191] that both the Haitian and Dominican communities conceive imbalances or transgressions among the subject and the family/society as causes of mental afflictions. Moral and normative conflicts related to the experience of living in a "more liberal country" led both communities to such imbalances or transgressions. Thus, afflictions arise as a result of the interaction of one of the members of the community with "the vices", "the bad habits", "the little respect for the family and the traditions" present in Chile. For example, some of them were "crime", "alcoholism and drug use", "the lack of family values", "the lack of attachment to the church", among others. However, in large parts of the Haitian community, these imbalances or transgressions were framed by complex interactions between the Vodou worldview and affiliation to religions such as Catholicism and Protestantism. Such imbalances and transgressions were not only reduced to the relationship of the subjects with their family/society, but also with the natural and supernatural world. Thus, the causes of afflictions could also be the result of a curse or some form of spirit possession.

Family, borough, and community spaces such as churches became spaces where Haitians and Dominicans manage malaise and suffering. In these spaces, especially the family one, afflictions were handled with reserve to avoid stigmatisation. Likewise, these spaces became instances where migrants established a certain ethnic-national continuity and feelings of belonging with the country of origin. In the case of the Haitian community, due to the central role of Haitian-Creole religion and medicine in daily life, the help-seeking behaviours and the health/illness trajectories could take multiple forms depending on the severity of the affliction, the degree of adherence to the Vodou worldview, religious affiliation, relationships with

[191] For example, see Caplan and Cordero (2015), Luciano, Nadal and Brito (2019), Vonarx (2012), WHO/PAHO (2010).

knowledge and practices of Haitian-Creole medicine, and/or the availability of Vodou healers in Chile.

Even though the Municipal Health Department has carried out multiple efforts to promote intercultural health practices and values, these efforts seemed not to narrow the so-called "cultural differences" between health practitioners and afro-descendant communities. Through various training sessions primarily, the mentioned "multicultural turn" has allowed practitioners to gain some reflexivity around ethnic and contextual aspects of afro-descendant migrant communities. Besides this, some of them have taken up anti-racist advocacy positions in their daily work. However, on occasions, some practitioners have tended to reproduce culturalist practices that naturalise and normalise the so-called "cultural differences" with migrant communities.

Nevertheless, the predominance of health approaches that prioritise categories such as "class" and "gender" in the health system in Chile has led practitioners to de-essentialise the category of "culture" itself, as well as to reorganise their intersectional approaches to migrant communities' health issues. Thus, more than a passive adoption of a "cultural competency" model, practitioners have questioned and complexed these approaches based on the culture category when it comes to knowing "the social". I have taken as a reference to the debate between cultural and structural competency models to carry out a decolonial critique on the ways of knowing "the social".

From this decolonial criticism, this case allows for the interrogation of how some approaches in social sciences reify "identity politics" (Brown, 1995; Butler, 1990; Hardier, 2018; Lilla, 2018; Massoumi, 2015). The ethnography has highlighted how, rather than an understanding that essentialises "identity politics", health institutions and programme practitioners conceive identities as "hybrid" and "mestizo" in which different social categories converge (Anzaldúa, 1999; Bhabha, 1994; Spivak, 1990; Young, 2000; Nelson, 2001). Thus, health practitioners shape the "migrant" image, or

the “afro-descendant migrant”, with different social categories, defined mainly by class, gender or nationality. As I demonstrated in the first chapter, the predominance of these categories over others such as “ethnicity” or “race” is mainly the result of the public health tradition in Chile. On the contrary, most afro-descendant migrants have not been engaged in social movements based on the advocacy of racial identities[192]. However, based on some recent events such as the social outburst in October 2019, as well as the COVID-19 pandemic, this thesis recognises that potential black people movements could arise in the near future in Chile, looking to achieve greater social justice.

Figure nº9: Banner written in the context of social outburst in October 2019: “To be woman, migrant and Haitian is a crime in Chile”.

In this research, I have highlighted how the proliferation of biomedical and psychiatric discourses and practices in mental health in the country have shaped an “idiom” through which it is possible to represent afflictions. The introduction several

[192] Although some political groups (“colectivos”) have raised around the murder of Joane Florvil since 2017 (see Chapter nº4), these groups have tended to adopt an advocacy position based on the “migrant” political category rather than “racial” one.

health reforms and a GMH agenda has operated, to use Eden Medina and colleagues' words (2014), as "imported magic", modifying the language through which people talk of their malaise and suffering. Taking a different approach, this thesis has underlined how a large part of afro-descendant migrants represent, experience and treat their afflictions within references that differ partially or totally from those proposed by the psy/neuro disciplines.

Health practitioners translated migrants' malaise and suffering into the "idiom" of biomedicine, psychiatry, and neurology. Through what I have called "cultural de-substantialisation," psychologists, physicians and psychiatrists mainly achieved such translations by extracting ethnic and contextual aspects during clinical encounters. Thus, they tended to de-contextualise thoughts, emotions and behaviours of Haitians and Dominicans, psychopathologising their experiences and classifying them as "extreme", "strange", "dramatic", and "psychotic", among others. This issue interrogates precisely the intercultural clinical models implemented so far by the Municipal Health Department of the borough. In this context, what Emily Yates-Doerr (2018) has recently called "translational competency" could shed some light on these clinical encounters. This approach "encourages engagement with the relational contexts out of which health problems develop and transform, taking culture to be a process of negotiation and adaptation" (Yates-Doerr, 2018:106). Based on this, mental health practitioners can adopt more flexible and dynamic skills, understanding the multiple understandings of health involved in clinical encounters with migrant patients.

Biomedical and psy/neuro knowledge have not only become an available language to represent afflictions in contemporary Chile, but also a way through which specific uses of race shape a biosocial determinism. Based on the evidence provided by psy/neuro disciplines, mental health practitioners tended to attribute to afro-descendant migrant patients a certain genetic predisposition to suffer mainly from psychotic disorders. The stress caused by the uncertainty, vulnerability, and violence associated with the migratory process acts as a trigger for that predisposition, which,

until then, had been inactive. As an explanatory model, this biosocial determinism thus configures a biopolitical field that delineates and identifies the afro-descendant population as carrying a genetic danger and, therefore, at risk of madness. This explanation led to the deployment of a series of pastoral, disciplinary and management practices of mental health for afro-descendant patients.

As I emphasised in the third chapter, the precariousness of the public health system favoured the translation of migrants' malaise and suffering within the language of biomedicine and the psy/neuro disciplines. In a context marked by high patient demand, the short period of clinical care, language differences, among others, mental health practitioners tended to reproduce standardised interventions that linked patients' emotional reactions with neurobiological functioning. In other words, although practitioners revealed a certain degree of reflexivity and intersectional sensitivity in their clinical practice, the precariousness of the context led them to reproduce similar interventions. Thus, notions such as "brain connections", "neurotransmitters", and "plasticity", among others, were part of the explanations that professionals gave to patients. Along these lines, rather than understanding the borough's health context as a backdrop where knowledge and practices are reproduced, this ethnography raised questions about how context influences and shapes such psy/neuro knowledge and practices.

In this thesis, I have highlighted several forms of "becoming a (neuro)migrant". afro-descendant migrants have engaged in heterogeneous processes of subjectivation due to the implementation of psy/neuro technologies. More than an approach focused solely on biopolitical and governmental aspects, this thesis has revitalised migrants' subjective effects and potentialities. Thus, although the process of "becoming a (neuro) migrant" shows the neurobiologisation of Haitians and Dominicans' malaise and suffering, at the same time it reveals processes of negotiation, assimilation, resistance and refusal of such technologies. As demonstrated in this ethnography, the various subjective destinies depend on the explanatory models of migrant patients, the degree of familiarity with psy/neuro

technologies, the age of the patients, the severity of their conditions, and the type of clinic intervention, among others.

Furthermore, the influence of psy/neuro knowledge and practices was not limited to "classic" mental health interventions (e.g. depression, psychosis, among others), but also extended to maternal and child health programs such as the Chile Crece Contigo (ChCC) program. This program promoted the "integral development" of children through a series of interventions in family, community, and health contexts. Starting from central concepts such as "early stimulation" and "promotion of attachment", practitioners revealed racialised concerns that link the future of migrant children with psychosocial problems such as "addictions" or "juvenile delinquency". Through evidence provided by neuroscience, the ChCC program shapes a biosocial field (Meloni, Cromby, Fitgeral, et al., 2018) that delineates a biopolitical field of intervention. Thus, this thesis questions not only ethical and political considerations regarding the so-called "cruel optimism" (Edward et al., 2015) through which social policies in neoliberal contexts tend to place responsibility of childcare on mothers, but also how scientific understandings of difference are shaped within the framework of the "neuroscience of poverty" (Pitts-Taylor, 2019).

This thesis poses a series of questions for further research concerning anthropology, global health and social medicine, especially in Latin American countries. How are researchers, health practitioners and social actors politically and ethically engaging with imported mental health models, as well as with religion and magic? How are they using racial/ethnic categories in contexts marked by miscegenation ("mestizaje") and the rise of identity politics and allied social movements? What are the political and ethical challenges of multi-sited ethnographies in health and transnational migration in Latin America? And finally, how and with what new potentialities are social researchers in health and migration getting involved in global discussions from the so-called "Global South"?

References

Abarca-Brown, Gabriel (2018). "¡Promueva el apego!": sobre la maternidad de mujeres haitianas como objeto de gobierno en Chile. Revista Bricolaje, nº3: 12-17.

Abarca-Brown, Gabriel (2019). Religión, vudú y salud mental: nuevos desafíos para los servicios de salud en Chile. Revista Chilena de Salud Pública, 23(1): 68-71.

Abarca-Brown, Gabriel (2020). Haitian migration and dreams in Chile: Questions for global mental health during the COVID-19 pandemic. Somatosphere. Retrieved from: http://somatosphere.net/2020/haitian-migration-dreams.html/

Abarca-Brown, Gabriel and Carreño Hernández, Mauricio (2014). Inmigración y salud mental infanto-juvenil: análisis de los artículos publicados en revistas nacionales de Psicología durante el periodo 2003-2013. Summa Psicológica UST, 11(2): 45-56.

Aceituno, Roberto; Miranda, Gonzalo; Jiménez, Álvaro (2012). Experiencias del desasosiego: salud mental y malestar en Chile. Anales de la Universidad de Chile. nº36: 87-102.

Achotegui, Joseba (2009). El Síndrome de Ulises. Síndrome del inmigrante con estrés crónico y múltiple. Barcelona: El mundo de la mente.

Acosta, Elaine (2014). Valorar los cuidados al estudiar las migraciones: La crisis del trabajo de cuidado y la feminización de la inmigración en Chile. In Stefoni, C. (Ed). Mujeres inmigrantes en Chile ¿Mano de obra o trabajadoras con derechos? (p.193-228). Santiago: Ediciones Alberto Hurtado.

Adams, Vincanne; Béhague, Dominique; Caduff, Carlo; Löwy, Ilana; Ortega, Francisco (2019) Re-imagining global health through social medicine. Global Public Health, 14:10: 1383-1400.

Aedo, Ángel (2017). Encarnando (in)seguridad. Orden policial y política de la presencia en la frontera norte de Chile. Antípoda: Revista de Antropología y Arqueología, nº29: 87-103.

Aguirre, Tatiana (2017). Migración y religión. La conformación de una comunidad haitiana católica en Santiago de Chile. In N. Rojas Pedemonte and J. Koechlin (Eds). Migración haitiana hacia el sur andino. (p. 187-209). Perú: Universidad Antonio Ruiz de Montoya, Centro de Ética y Reflexión Social Fernando Vives SJ, Servicio Jesuita a Migrantes de Chile, Observatorio Iberoamericano sobre Movilidad Humana, Migraciones y Desarrollo OBIMID.

Alarcón, Renato (2003). Mental health and mental health care in Latin America. World Psychiatry, 2(1): 54-56.

Alarcón, Ana María; Astudillo, Paula; Barrios, Sara; Rivas, Edith (2004). Política de salud intercultural: perspectivas de usuarios mapuches y equipos de salud en la IX región, Chile. Revista Médica de Chile, 132: 11109-1114.

Alarcón, Ana María; Vidal, Aldo; Neira, Jaime (2003). Salud Intercultural: Elementos para la construcción de sus bases conceptuales. Revista Médica de Chile; 131(9): 1061-5.

Alcalde, Cristina (2015). Transformative journeys: The impact of first-time motherhood on Mexican women's migration experiences in the US South. Chicana/Latina Studies, 14(2): 64-101.

Alvarado, Rubén. (2008). Salud mental en inmigrantes. Revista Chilena de Salud Pública. Vol. 12(1):37–41.

Álvarez, María and Murray, Gerard (1981). Socialization for scarcity: Child feeding and practices in a Haitian Village. USAID/Haiti, Port-au-Prince.

Ambrosini, Mauricio (2008). Participación religiosa e integración de los inmigrantes. Una reflexión entre América y Europa, entre historia y actualidad. Migraciones, nº23: 11-44.

Amezquita, Ginette (2010). Hair raising power: Dominican hair salon owners in New York City. New York, U.S: Fordham University.

Amnesty International (2019). Chile: Deliberate policy to injure protesters points to responsibility of those in command. Retrieved from: https://www.amnesty.org/en/latest/news/2019/11/chile-responsable-politica-deliberada-para-danar-manifestantes/

Andersson, Gunnar. (2004). Childbearing after migration: Fertility patterns of foreign-born women in Sweden. International Migration Review, 38 (2): 747–774.

Anzaldúa, Gloria (1999). Borderlands/La Frontera: The new mestiza. San Francisco: Aunt Lute.

Araya, Ricardo; Alvarado, Rubén and Minoletti, Alberto (2009). Chile: an ongoing mental health revolution. The Lancet, Vol. 347(9690): 597-598.

Armelagos, George and Van Gerven, Dennis (2003). A century of skeletal biology and paleopathology: Contrasts, contradictions, and conflicts. American Anthropologist, 105(1):53-64.

Arriagada, Caronlina; Cubides, José; and Bartolotto, Idenilso (2016). Chile, inmigración e interculturalidad (Capítulo 1) In Migración e Interculturalidad: Una oportunidad no una amenaza. José Berrios, J. and Idenilso Bartolotto (Coords.). INCAMI – Fund. Scalabrini. Editorial San Pablo, Santiago.

Arriagada, Irma and Moreno, Marcela (2012). La constitución de cadenas globales de cuidado y las condiciones laborales de las trabajadoras peruanas en Chile. In C. Stefoni (Ed.), Mujeres inmigrantes en Chile. ¿Mano de obra o trabajadoras con derechos? (p.151-191). Santiago: Ediciones Alberto Hurtado.

Audebert, Cédric (2012). La diaspora haïtienne. Territoires migratoires et réseaux transnationaux. Rennes: Presses Universitaires de Rennes.

Auguste, Evan and Rasmussen, Astrid (2019). Vodou's role in Haitian mental health. Global Mental Health, Vol. 6(e.25): 1-6.

Asad, Talal (1993) Genealogies of religion: Discipline and reasons of power in Christianity and Islam. Baltimore: Johns Hopkins University Press.

Asad, Talal; Brown, Wendy; Butler, Judith. Mahmood, Saba (2009). Is critique secular? Blasphemy, injury, and free speech. Berkeley, CA: University of California Press.

Bailey, Rahn; Mokonogho, Josephine; Kumar, Alok (2019). Racial and ethnic differences in depression: current perspectives. Neuropsychiat Dis Treat; 15: 603-609.

Balibar, Étienne and Wallerstein, Inmanuel (1991). Raza, nación y clase. Madrid: IEPALA.

Béhague, Dominique (2016) Psychiatry, bio-epistemes and the making of adolescence in southern Brazil. História, Ciências, Saúde – Manguinhos, Rio de Janeiro, Vol.23(1): 131-153.

Béhague, Dominique (2017). Psychiatry, sex and science: The making of "adolescent" motherhood in southern Brazil. Medical Anthropology. http://doi.org/10.1080/01459740.2017.1313252

Béhague, Dominique; Kanhonou, Lydie; Filippi, Véronique et al. (2008). Pierre Bourdieu and transformative agency: a study of how patients in Benin negotiate blame and accountability in the context of severe obstetric events. Sociology of Health & Illness. Vol.30(4): 489-510.

Béhague, Dominique and Lézé, Samuel (2015). Shaping the modern child: Genealogies and ethnographies of developmental science. Social Science & Medicine, 143: 249-254.

Béhague, Dominique; MacLeish, Kenneth (2020). The global psyche: Experiments in the ethics and politics of mental life. Medical Anthropology Quarterly. Vol.34(1):5-20.

Behrouzan, Orkideh. (2016). The Prozac diaries. Psychiatry and generational memory in Iran. Stanford, California: Stanford University Press.

Bemme, Doerte and D'souza, Nicole (2014). Global Mental Health and its discontents: An inquiry into the making of global and local scale. Transcultural Psychiatry. Vol.51(6): 850-874.

Bemme, Dörte and Kirmayer, Laurence (2020). Global Mental Health: Interdisciplinary challenges for a field in motion. Transcultural Psychiatry. Vol. 57(1):3-18.

Beneduce, Roberto (2018). Une nouvelle bataille de vérité. Discours sorcellaires, cicatrices corporelles et régimes de crédibilité dans le droit d'asile. Cahiers d'études africaines 231(232):763–792.

Beneduce, Roberto (2019). ''Madness and Despair are a Force'': Global Mental Health, and how people and cultures challenge the hegemony of Western psychiatry. Cult Med Psychiatry, 43:710–723.

Benjamin, Ruha (2016). Informed refusal: Toward a justice-based bioethics. Science, Technology & Human Values. Vol 41(6): 967-990.

Bensa, Alban and Fassin, Didier (2008). Les politiques de l'enquête. Paris: La Découverte.

Berdía-Pfeifer, Daniela (2018). Movilización política evangélica en Chile: Partidos politicos y candidaturas públicas. Políticas Públicas, 11(2): 58-72.

Berger, Peter (1969). El dosel sagrado. Buenos Aires: Amorrortu editores.

Bernales, Margarita; Cabieses, Báltica; McIntyre, Ana María; Chepo, Macarena (2017) Desafíos en la atención sanitaria de migrantes internacionales en Chile. Rev Peru Med Exp Salud Pública; 34(2):167-75.

Betancourt, Joseph; Green, Alexander; Carrillo J. Emilio; Ananeh-Firempong, Owusu (2016). Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep, 118(4):293-302.

Bhabha, Homi (1994). The location of culture. Oxon: Routledge.

Bhabha, Homi (1998). Culture's in between. In D. Bennett (ed). Multicultural states: Rethinking difference and identity, (pp.29–36). London: Routledge.

Bhugra, Dinesh (2004). Migration and mental health. Acta Psychiatr Scand, 109: 243-258.

Bhui, Kamaldeep (2002). London's ethnic minorities and the provision of mental health services. In K. Bhui (Ed.), Racism and mental health: Prejudice and suffering (pp. 139–187). London: Jessica Kingsley.

Biehl, Joao; Good, Byron; Kleinman, Arthur (2007). Introduction: Rethinking subjectivity. In: Biehl, Good and Kleinman (eds), Subjectivity (pp 1-24). London: University of California Press.

Biehl, Joao and Locke, Peter (2010). Deleuze and the anthropology of becoming. Current Anthropology, 51:317-51.

Blackman, Lisa; Cromby, John; Hook, Derek; Papadopoulos, Dimistris and Walkerdine, Valerie. (2008). Creating subjectivities. Subjectivity, 22:1-27.

Boas, Franz (1962). Anthropology and modern life. New York: Dover.

Boccara, Guillaume (2004). Del buen gobierno en territorio mapuche. Notas acerca de una experiencia en salud complementaria. Cuadernos de Antropología Social, nº 20:113-129.

Boccara, Guillaume (2007). Etnogubernamentalidad: la formación del campo de la salud intercultural en Chile. Chungara Revista de Antropología Chilena, 39(2):185-207.

Boccara, Guillaume and Bolados, Paola (2010). ¿Qué es el multiculturalismo? La nueva cuestión étnica en el Chile neoliberal. Revista de Indias, 70(250): 651-690.

Bolados, Paola (2010). Neoliberalismo multicultural en el Chile democrático: gubernamentalizando la salud atacameña a través de la participación y el etnodesarrollo. Tesis para optar el grado de doctora en antropología. Universidad Católica del Norte-Universidad de Tarapacá, San Pedro de Atacama.

Bolados García, Paola (2012). Neoliberalismo multicultural en el Chile postdictadura: La política indígena en salud y sus efectos en comunidades Mapuches y Atacameñas. Chungará, Revista de Antropología Chilena, 44(1): 135-144.

Bolton, Paul; Surkan, Pamela; Gray Amber, et al. (2012) The mental health and psychosocial effects of organized violence: A qualitative study in northern Haiti. Transcultural Psychiatry, 49(3-4): 590-612.

Bornstein, Marc and Bohr, Yvonne (2011). Immigration, acculturation and parenting. In Encyclopedia on early childhood development (pp. 1-8). Retrieved from http://www.child-encyclopedia.com/documents/Bornstein-BohrANGxp1.pdf

Bourguignon, Erika (1954). Dreams and dream interpretation in Haiti. American Anthropologist. 56: 262-268.

Bowes, Alison and Domokos, Teresa (1998). Health visitors work in a multi-ethnic society: A qualitative study of social exclusion. Journal of Social Policy, 27(4): 489–506.

Bowlby, John and World Health Organization. (1952). Maternal care and mental health: a report prepared on behalf of the World Health Organization as a contribution to the United Nations programme for the welfare of homeless children / John Bowlby, 2nd ed. World Health Organization. https://apps.who.int/iris/handle/10665/40724

Bowleg, Lisa (2012). The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. American journal of public health 102(7): 1267-1273.

Bowler, Isobel (1993a). “They're not the same as us”: Midwives' stereotypes of South Asian descent maternity patients. Sociology of Health & Illness, 15(2): 156-178.

Bowler, Isobel (1993b). Midwives attitudes to clients of South Asian descent. Nursing Times, 89: 58.

Boyd, Monica (1989). Family and personal network in international migration: Recent developments and new agendas. International Migration Review, 23(3), 638-670.

Brandon, George (1997). Santeria from Africa to the new world: The dead sell memories. Bloomington, IN: Indiana University Press.

Bravo, Juan (2019). Mitos y realidades sobre el empleo migrante en Chile. In N. Rojas Pedemonte y J.T. Vicuña (Eds.). Migración en Chile. Evidencia y mitos de una nueva realidad (pp. 49-72). Santiago: LOM Ediciones.

Bridges, Khiara (2011). Reproducing race. An ethnography of pregnancy as a site of racialization. USA: University of California Press.

Brotherton, Sean (2016). Psychoanalysis in Buenos Aires. In L. Manderson, E. Cartwright, and A. Hardon (Eds.), The Routledge Handbook of Medical Anthropology. (pp. 102-106). London: Routledge.

Brown, Karen (1991). Mama Lola. A Vodou Priestess in Brooklyn. USA: University of California Press.

Brown, Wendy. (1995). States of Injury: Power and Freedom in Late Modernity. Princeton: Princeton University Press.

Brown, Wendy. (2015). Estados amurallados, soberanías en declive. Barcelona: Hender.

Browne, Annette (2001). The influence of liberal political ideology on nursing science. Nursing Inquiry, 8: 118–29.

Bretherton, Inge (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. Developmental Psychology, Vol. 28(5): 759–775.

Briehl, Jorge. (2003). Epidemiologia critica: Ciencia emancipadora e interculturalidad. Lugar Editorial.

Butler, Judith. (1990). Gender trouble. London: Routledge.

Butler, Judith. (1997). The psychic life of power. Theories in subjection. Stanford, California: Stanford University Press.

Butler, Judith; Habermas, Jurgen; Taylor, Charles; West, Cornel (2011). The power of religion in the public sphere. New York: Columbia University Press.

Butler, Lucas and Markman, Ellen (2012). Finding the cause: Verbal framing helps children extract causal evidence embedded in a complex scene. Journal of Cognition and Development. Vol. 13(1): 38-66.

Byron, Jhon Picard. (2014) La pensée de Jean Price-Mars. Entre construction politique de la nation et affirmation de l'identité culturelle haïtienne. In: Byron JP, editor. Production du savoir et construction sociale. L'ethnologie en Haïti. (pp 47-80). Québec/Por-au-Prince: Les Presses de l'Université Laval & Les Éditions de l'Université d'État d'Haïti.

Cabieses, Báltica. (2019). Salud y migración: un proceso complejo y multidimensional. In N. Rojas Pedemonte y J.T. Vicuña (eds). Migración en Chile. Evidencia y mitos de una nueva realidad. Santiago: LOM Ediciones.

Cabieses, Báltica; Bernales, Margarita; McIntyre Ana María (2017). La migración internacional como determinante social de la salud en Chile: evidencia y propuestas para políticas públicas. Santiago: Universidad del Desarrollo.

Cabieses, Báltica; Tunstall, Helena; Pickett, Kate; Gideon, Jasmine (2013). Changing patterns of migration in Latin America: how can research develop intelligence for public health. Rev. Panam Salud Pública, 34(1): 68-74.

CAC (Centro de Acción Crítica en Salud Mental) (2013). De la enfermedad a la diferencia. Revista Chilena de Salud Pública. Vol.17(3): 213-217.

Cadge, Wendy and Ecklund, Elaine (2007). Inmigration and religion. Anual Review of Sociology, 33: 359-379.

Calavita, Kitty (1996). The new politics of immigration: "Balanced-budget conservatism" and the symbolism of Proposition 187. Social Problems, 43(3), 284-305.

Calderón, Jorge and Rojas, Graciela (2016). Integration of mental health into primary care: a Chilean perspective on a global challenge. BJPSYCH International, 13(1): 20-21.

Caldwell, Cleopatra; Guthrie, Barbara; Jackson, James (2006). Identity development, discrimination and psychological well-being among African American and Caribbean Black adolescents. In A. J. Schulz, and L. Mullings (Eds.), Gender, race, class, and health: Intersectional approaches (pp. 163-191). San Francisco, CA: Jossey-Bass.

Calquín, Claudia (2013). De madres y de expertos: la psicología de posguerra y el disciplinamiento de los cuidados maternos. Summa Psicológica UST. Vol.10 (1): 119-129.

Calquín Donoso, Claudia; Guerra Arrau, Rodrigo (2018). Gobernando la infancia pobre. Familiarización y neuropsicologización en el programa Chile Crece Contigo. In Javiera Arce (Ed.) El Estado y las mujeres. El complejo camino hacia una necesaria transformación de las instituciones. Santiago: RIL Editores.

Calquín Donoso, Claudia; Guerra, Rodrigo; Vásquez, Sebastián.; Yañez-Urbina, Cristopher (2019). Sujetos cerebrales: reportorios interpretativos de los usos de la neurociencia en las políticas públicas de infancia temprana en el Chile actual. Psicología, Conocimiento y Sociedad, Vol. 9(2): 25-46.

Campos Navarro, Roberto (ed). (2016). Antropología médica e interculturalidad. Mexico City: McGraw- Hill.

Candelario, Ginetta (2007). Making community and displaying identity at a Dominican beauty shop in New York City. In G. Candelario (Eds). Black behind the ears: Dominican

racial identity from museums to beauty shops (pp. 177-222). Durham, Estados Unidos: University Press.

Caplan, Susan; Cordero, Carolyn (2015). Development of a faith-based mental health literacy program to improve treatment engagement among Caribbean Latinos in the Northeastern United States of America. International Quarterly of Community Health Education. Vol. 35(3):199-214.

Caplan, Susan (2016). A pilot study of a novel method of measuring stigma about depression developed for latinos in the faith-based setting. Community Mental Health Journal. 52:701-709.

Caplan, Susan; Little, Tariana.; Reyna, Patricia. et al. (2016). Mental health services in the Dominican Republic from the perspective of health care providers. Global Public Health. Vol. 13(7): 874-898.

Carmagnani, Marcello; Klein, Herbert (1965). Demografía histórica: la población del obispado de Santiago (1777-1778). Boletín de la Academia Chilena de la Historia, 72: 57-74.

Cárdenas, Manuel; Gómez, Fabiola; Méndez, Leyla; Yáñez, Susan (2011). Reporte de los niveles de prejuicio sutil y manifiesto hacia los inmigrantes bolivianos y análisis de su relación con variables psicosociales. Psicoperspectivas. Vol. 10(1): 125-143.

Caro, Pamela (2009). Análisis del programa Chile Crece Contigo desde los ideales normativos y la noción de prueba. Revista Trabajo Social, nº 77: 25-37.

Carpenter-Song, Elizabeth; Schwallie, Megan; Longhofer, Jeffrey (2007). Cultural competence reexamined: critique and directions. Psychiatric Services, 58(10): 1362-65.

Carrère, Cristián and Carrère, Michelle (2015). Inmigración femenina en Chile y mercado de trabajos sexualizados. La articulación entre racismo y sexismo a partir de la interseccionalidad. Polis. Revista Latinoamericana. Vol. 14 (42): 33-52.

Carter, C. Sue.; Ahnert, Lieselotte; Grossmann, K.E.; et al. (2015). Attachment and Bonding. A new Synthesis. US: MIT Press.

Castles, Stephen and Miller, Mark (2004). La era de la migración. Movimientos internacionales de población en el mundo moderno. México: Universidad Autónoma de Zacatecas

Cavanna, Andrea; Cavanna, Stefano; Cavanna, Alberto (2010). Epileptic seizures and spirit possession in Haitian culture: report of four cases and review of the literature. Epilepsy Behav, 19(1):89–91. doi: 10.1016/j.yebeh.2010.07.002

Cea Madrid, Juan Carlos (2018). Estado neoliberal y gasto público en psicofármacos en el Chile contemporáneo. Psicología, Conocimiento y Sociedad, Vol. 8(2): 50-70.

Cea Madrid, Juan Carlos (2019). "Locos por nuestros derechos": Comunidad salud mental y ciudadanía en el Chile contemporáneo. Quaderns de Psicologia. Vol.21(2) https://doi.org/10.5565/rev/qpsicologia.1502

Cénat, Jude Mary and Derivois, Daniel (2014). Assessment of prevalence and determinants of posttraumatic stress disorder and depression symptoms in adult survivors of earthquake in Haiti after 30 months. J Affect Disord, 159:111–7.

CEPAL-UN (2018). Indicadores: Feminicidios. Observatorio de Igualdad de Género en América Latina y El Caribe. Retrieved from: https://oig.cepal.org/es/indicadores/feminicidio

CESDEM (Centro de Estudios Sociales y Demográficos) (2014). Encuesta demográfica y de salud República Dominicana 2013. Maryland, EEUU: ICF International.

Chacón, Arturo (1992) Pluralismo religioso y modernidad en la sociedad chilena. Revista de Sociología, nº 6-7: 21-26.

Chacón, Arturo (2002). Religión y modernidad. Protestantismo en Chile. Revista Ciencias Sociales, nº12: 67-76.

Chase, Liana and Sapkota, Ram (2017). "In our community, a friend is a psychologist": An ethnographic study of informal care in two Bhutanese refugee communities. Transcultural Psychiatry, Vol. 54(3): 400-422.

Chen, Eric; Harrison, Glynn.; Standen, Penny (1991). Management of first episode psychotic illness in Afro- Caribbean patients. British Journal of Psychiatry, 158(4): 517-522.

Chile Crece Contigo (ChCC) (2006). Sistematización Programa de Estimulación Temprana. Santiago: Gobierno de Chile

Chile Crece Contigo (ChCC) (2012). Orientaciones técnicas para las modalidades de apoyo al desarrollo infantil. Guía para los equipos locales. Santiago: Gobierno de Chile

Chile Crece Contigo (ChCC) (2015). ¿Qué es Chile Crece Contigo? Santiago: Gobierno de Chile

CIPER (2018, September 10th). La "post verdad" en redes sociales: ¿nos han hecho creer que los chilenos somos racistas? Retrieved from: https://ciperchile.cl/2018/07/10/la-post-verdad-en-redes-sociales-nos-han-hecho-creer-que-los-chilenos-somos-racistas/

Citarella, Luca (Ed.) (2018). Medicinas y culturas en la Araucanía. Santiago: Pehuén.

Clarín (2017, March 2nd). El "sueño chileno" que termina en un basural. Retrieved from: https://www.clarin.com/mundo/sueno-chileno-termina basural_0_BktWFhHqx.html

Claros, Luis and Viaña, Jorge (2009). La interculturalidad como lucha contrahegemónica: Fundamentos no relativistas para una crítica de la superculturalidad. In D. Mora (Dir.) Interculturalidad crítica y descolonización. Fundamentos para el debate. (pp. 81-126). La Paz: III-CAB.

Collier, Stephen (2009). Topologies of power. Foucault's analysis of political government beyond 'governmentality'. Theory, Culture & Society. Vol. 26(6): 78-108.

Collins, Patricia Hill (1998). Shifting the centre: Race, class and feminist theorising about motherhood. In L. J. Peach (Ed.), Women in culture: A women's studies anthology (pp. 231-244). Boston: Blackwell.

Collins, Patricia Hill (2000). Black feminist thought: Knowledge, consciousness, and the politics of empowerment. New York: Routledge.

Collins, Patricia Hill (2019). Intersectionality as critical social theory. USA: Duke University Press.

ComunidadMujer (2018). Informe GET 2018: Género, Educación y Trabajo. Avances, contrastes y retos de tres generaciones. Chile.

Cooperativa (2018, March 18th). Fake news: Desmintiendo la supuesta "inmigración descontrolada" de haitianos. Retrieved from: https://www.cooperativa.cl/noticias/pais/poblacion/inmigrantes/fake-news-desmintiendo-la-supuesta-inmigracion-descontrolada-de/2018-03-18/135335.html

Coreil, Jeannine (1983). Parallel structures in professional and folk health care: A model applied to rural Haiti. Culture, Medicine and Psychiatry, 7: 131-151.

Coreil, Jeannine; Barnes-Josiah, Debora; Augustin, Antoine; Cayemittes, M. (1996). Arrested pregnancy syndrome in Haiti: Findings from a National Survey. Medical Anthropology Quarterly, 10(3): 424-436.

Crenshaw, Kimberly (1989). Demarginalizing the intersection of race and sex: Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. University of Chicago Legal Forum (pp.139-168).

Crespo Suárez, Jorge; Machin Suárez, Raudelio (2020). Medicalisation in public primary mental health care services in Chile. Social Theory & Health. https://doi.org/10.1057/s41285-020-00130-4

Cross, Terry; Bazron, Barbara; Dennis, Karl; Issacs, Mareasa (1989). Towards a culturally competent system of Care: A monograph on effective services for minority children who are severely emotionally disturbed. National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, Washington, DC.

Centro de Derechos Humanos-Universidad de Chile (2016). Informe Temático 2016: Migración y derechos humanos en Chile. Edición Centro de Derechos Humanos Facultad de Derecho – Universidad de Chile.

Culley, Lorraine (2006). Transcending transculturalism? Race, ethnicity and healthcare. Nursing Inquiry, 13: 44–153.

Cussen, Celia (2016). Raza y calidad de vida en el reino de Chile. Antecedentes coloniales de la discriminación. In M.E. Tijoux (eds). Racismo en Chile. La piel como marca de la inmigración (pp. 21-33). Santiago: Editorial Universitaria.

Cuthbertson, Courtney (2015). Pharmaceutical technologies and the management of biological citizens in Chile. In S. Bell and A. Figert (Eds.). Reimagining (Bio)Medicalization, Pharmaceuticals and Genetics: Old Critiques and New Engagements (pp. 137-159). New York: Routledge.

Das, Veena. (2012). Ordinary ethics. In Didier Fassin (ed.), A companion to moral anthropology (pp. 133-149). Oxford: Wiley-Blackwell.

Dağdelen, Buse Özum. (2018). The challenge to the concept of transnational motherhood in migration studies from the radical feminist perspectives. Sosyal Siyaset Konferansları Dergisi, 74, 103–116.

Damus, Orillant and Vonarx, Nicolas (2019). Anthropologie de la médicine créole haïtiene. Louvain-La-Neuve: Academia-L'Harmattan.

Davies, Myfanwy and Papadopoulos, Irena (2006). Notions of motherhood and the maternity needs of Arab Muslim women. In I. Papadopoulos (ed) Transcultural health

and social care: The development of culturally competent practitioners (pp. 145–63). London: Elsevier.

Davies, Sara; Thornicroft, Graham; Leese, Morven; Higginbotham, Andrew and Phelan, Michael (1996). Ethnic differences in risks of compulsory psychiatric admission among representative cases of psychosis in London. British Medical Journal, 312: 533–537.

Davis, Heather and Todd, Zoe (2017). On the Importance of a date, or decolonizing the Anthropocene. ACME: An International Journal of Critical Geographies 16: 761–80.

Davis, Murray (1995). The sociology of humor: A stillborn field? Sociological Forum, 10(2): 327-339.

Davis-Floyd, Robbie and Sargent, Carolyn (1997) (Eds.). Childbirth and authoritative knowledge. Cross-Cultural perspectives. USA: University of California Press.

Day, Lesley (1992). Women and oppression: Race, class and gender. In M. Langan and L. Day (eds), Women, oppression, and social work: Issues in anti-discriminatory practice. (pp. 12–31). London: Routledge.

De Genova, Nicholas (2009). Conflicts of mobility, and the mobility of conflict: rightlessness, presence, subjectivity, freedom. Subjectivity, 29: 445–466.

De Giorgi, Alessandro (2010). Immigration control, post-Fordism, and less eligibility. Punishment & Society, 12(2), 147-167.

De la Barra, Flora.; Vicente, Benjamin; Saldivia, Sandra and Milpillán, Roberto (2012). Prevalencia de trastornos psiquiátricos en poblaciones infanto-juveniles en Chile: Estado actual. Revista Médica Clínica Las Condes, Vol.23, N°5:521-529.

Delgado Wise, Raúl; Márquez Covarrubias, Humberto; Puentes, Ruben (2013). Reframing the debate on migration, development and human rights. Population, Space and Place, 19(4): 430–442.

De Souza, Ruth (2004). Motherhood, migration and methodology: Giving voice to the "Other". The Qualitative Report, 9(3): 463-482.

De Souza, Ruth (2013a). Who is a ´good` mother? Moving beyond individual mothering to examine how mothers are produced historically and socially. Australian Journal of Child and Family Health Nursing, 10(2): 15-18.

De Souza, Ruth (2013b). Regulating migrant maternity: Nursing and midwifery's emancipatory aims and assimilatory practices. Nursing Inquiry. 20(4):293-304.

Desrosiers, Astrid and Fleurose, Sheila (2002). Treating Haitian patients: key cultural aspects. American Journal of Psychotherapy, 56(4), 508-521.

Dobblelaere, Karel (1981): Secularization: a multi-dimensional concept. Vol. 29, Núm.2, Universidad Iberoamericana, London. Trad. Eduardo Sota García, Secularización: un Concepto Multidimensional. 1ª Edición. Materiales de Cultura y religión, Madrid: Universidad Iberoamericana, 1994.

Dominguez, Virginia (1992). Invoking culture: The messy side of "cultural politics". South Atlantic Quarterly. 91:19-42.

Dumit, Joseph (2000). When explanations rest: 'Good-enough' brain science and the new sociomedical disorders. In M. Lock, A. Young, and A. Cambrosio (Eds.), Living and working in the new medical technologies (pp. 209–232). Cambridge, UK: Cambridge University Press.

Dumit, Joshep (2004). Picturing personhood: Brain scans and biomedical identity. Princeton: Princeton University Press.

Duncan, Whitney (2015). Transnational disorders: Returned migrants at Oaxaca's Psychiatric Hospital. Medical Anthropology Quarterly 29(1): 24-41.

Duque, Mauricio (2019, January 23th). Delincuencia y migración: mitos y realidades. El Mercurio. Retrieved from: https://www.elmercurio.com/Legal/Noticias/Analisis-Juridico/2019/01/23/Delincuencia-y-migracion-mitos-y-realidades.aspx

Durán, Carlos and Thayer, Luis Eduardo (2017). Los migrantes frente a la ley: continuidades y rupturas en la legislación migratoria del Estado chileno (1824-1975). Historia 396, 7(2): 429-461.

Duschinsky, Robbie; Greco, Monica; Solomon, Judith (2015). The politics of attachment: Lines of flight with Bowlby, Deleuze and Guattari. Theory, Culture & Society. 32 (7-8): 173-195.

Eack, Shaun; Bahorik, Amber; Newhill, Christina; Neighbors, Harold; Davis Larry (2012). Interviewer-perceived honesty as a mediator of racial disparities in the diagnosis of schizophrenia. Psychiatr Serv.; 63(9): 875–880.

Eagleton, Terry (2000). The Idea of culture. Oxford: Blackwell.

Edwards, Rosalind; Gillies, Val; Horsley, Nicola (2015). Brain science and early years policy: Hopeful ethos or "cruel optimism"? Critical Social Policy, 35(2), 167–187.

Ehrenberg, Alain (2018). La Mécanique des passions: Cerveau, comportement, société. Paris: Odile Jacob.

El Colombiano (2015, December 17th). El sueño chileno. Retrieved from: http://www.elcolombiano.com/colombianos-en-chile

El Desconcierto (2017, October 6th). El mes de injusticia que apagó la vida de la haitiana Joane Florvil en Chile. Retrieved from: https://www.eldesconcierto.cl/new/2017/10/06/el-mes-de-injusticia-que-apago-la-vida-de-la-haitiana-joane-florvil-en-chile/

El Desconcierto (2019, January 30th). Nenet no quiere abandonar a su hija: las complicaciones que viven las madres haitianas con hijos chilenos a raíz del Plan de Retorno. Retrieved from: https://www.eldesconcierto.cl/2019/01/30/nenet-no-quiere-abandonar-a-su-hija-las-complicaciones-que-viven-las-madres-haitianas-con-hijos-chilenos-a-raiz-del-plan-de-retorno/

Elias, Norbert (2000 [1939]). The process of civilization. Sociogenetic and psychogenetic investigations. Oxford: Blackwell Publishers Ltd.

El Mostrador (2017a, May 5th). Piñera anticipa veto migratorio: "Puedo decidir quién quiero que entre a mi país. No tengo por qué aceptar a cualquier persona". Retrieved from: http://www.elmostrador.cl/noticias/pais/2017/05/09/pinera-anticipa-veto-migratorio-puedo-decidir-quien-quiero-que-entre-a-mi-pais-no-tengo-por-que-aceptar-a-cualquier-persona-que-quiera-venir-a-chile/

El Mostrador (2017b, May 1st). Parir en negro, la realidad de las mujeres haitianas que son madres en Chile. Retrieved from: http://www.elmostrador.cl/braga/2017/05/14/parir-en-negro-la-realidad-de-las-haitianas-que-son-madres-en- chile/

El País (2017a, November 19th). Exclusivo: el 'sueño chileno' se aborda en la Terminal de Cali. Retrieved from: http://www.elpais.com.co/cali/exclusivo-el-sueno-chileno-se-aborda-en-la-terminal-de.html

El País (2017b, December 13th). Piñera y Guillier enfrentan su postura sobre inmigración en el último debate en Chile. Retrieved from: https://elpais.com/internacional/2017/12/12/actualidad/1513118579_978856.html

EMOL (2017, October 18th). Subsecretaria de DD.HH. y muerte de haitiana detenida: "Aún no terminamos de estar preparados para una interculturalidad". Retrieved from:

https://www.emol.com/noticias/Nacional/2017/10/18/879778/Subsecretaria-de-DDHH-y-muerte-de-haitiana-detenida-Aun-no-terminamos-de-estar-preparados-para-una-interculturalidad.html

Erickson, Paul and Murphy, Liam (2017). A history of anthropological theory. Canada: University of Toronto Press.

Estroff, Sue (1985). Making it crazy: An ethnography of psychiatric clients in an American community. Berkeley: University of California Press.

Fadiman, Anne (1997). The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures. New York: Noonday Press.

Faircloth, Charlotte; Hoffman, Diane; Layne, Linda (2013) (Eds.). Parenting in global perspective: Negotiating ideologies of kinship, self and politics. London: Routledge.

Falzon, Mark-Anthony (2009). Multi-Sited ethnography. Theory, praxis and locality in contemporary Research. London: Routledge.

Fanon, Franz (2001 [1961]). The wretched of the earth. England: Penguin Books.

Farah, Martha (2018). Socioeconomic status and the brain: Prospects for neuroscience-informed Policy. Nature Reviews Neuroscience. Vol. 19 (7): 430–38.

Farah, Martha; Noble, Kimberly; Hurt, Hallam (2006). Poverty, privilege, and brain development: Empirical findings and ethical implications. In J. Illes (eds.), Neuroethics: Defining the Issues in Theory, Practice and Policy, (pp. 277–89). UK: Oxford University Press.

Farmer, Paul (1988). Bad blood, spoiled milk: Bodily fluids as moral barometers in rural Haiti. American Ethnologist, Vol 15(1): 62-83.

Fassin, Didier (2000). Les enjeux politiques de la santé. Editions Khartala: Paris.

Fassin, Didier (2001). Culturalism as ideology. In Obermeyer, C. (ed.). Cultural Perspectives on Reproductive Health. London: Oxford University Press.

Fassin, Didier (2005). Compassion and repression: The moral economy of immigration policies in France. Cultural Anthropology, 20(3), 362-387.

Fassin, Didier (2009a). Les Économies Morales Revisitées. Annales. Histoire, Sciences Sociales. 64(6): 1237–1266.

Fassin, Didier (2009b). Nommer, interpréter. Le sens commun de la question raciale. In D. Fassin & E. Fassin (eds.). De la question sociale à la question raciale. Représenter la société française (pp. 27-44). Paris: Poche.

Fassin, Didier (2011a). Humanitarian Reason. A Moral History of the Present. USA: University of California Press.

Fassin, Didier (2011b). Policing borders, producing boundaries. The governmentality of immigration in dark times. Annual Review of Anthropology, 40: 213-226.

Fassin, Didier (2011c). Ethnopsychiatry and the postcolonial encounter. A French psychopolitics of Otherness. In W. Anderson, D. Jenson, and R. Keller (eds). Unconscious Dominions. Psychoanalysis, Colonial Trauma and Global Sovereignties (pp. 223-246). US: Duke University Press.

Fassin, Didier (2012). Toward a critical moral anthropology. In Didier Fassin (Ed.) A Companion to Moral Anthropology. (pp 1-18). Oxford: Wiley-Blackwell.

Fassin Didier and Memmi, Dominique (2004) Le gouvernement de la vie: Mode d'emploi. In D. Fassin y D. Memmi (Coords). Le Gouvernement des Corps (pp. 9-33). Editions de l'École des Hautes Études en Sciences Sociales: Paris.

Fassin, Didier and Rechtman, Richard (2009). The empire of trauma: An inquiry into the condition of victimhood. USA: Princeton University Press.

Faubion, James (2011). An anthropology of ethics. New York: Cambridge University Press.

Fearon, Paul; Kirkbride, James; Morgan, Craig; et al. R (2006). Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP study. Psychol Med 36 (11): 1541–1550.

Fediakova, Evguenia and Parker, Cristian (2009). Evangélicos en Chile democrático (1990-2008): Radiografía al centésimo aniversario. Revista Cultura y Religión. Vol 3(2):43-69.

Fernández Juárez, Gerardo (ed.) (2004). Salud e interculturalidad en América Latina: Perspectivas antropológicas. Quito: Ediciones Abya-Yala.

Fernández Juárez, Gerardo (ed.) (2006). Salud e interculturalidad en América Latina: Antropología de la salud y crítica intercultural. Quito: Ediciones Abya-Yala.

Fernando, Suman (2011). A 'global' mental health program or markets for Big Pharma? Open Mind, 475, 27–30.

Fleck, Ludwik (1979[1935]). Genesis and development of a scientific fact. USA: University of Chicago Press.

Fogarty, William; Lovell, Melissa; Langenberg, Jeleigh; Heron, Mary-Jane (2018). deficit discourse and strengths-based approaches: Changing the narrative of aboriginal and Torres Strait Islander health and wellbeing. Melbourne: The Lowitja Institute.

Follér, Maj-Lis. (2004), Intermedicalidade: a zona de contato criada por povos indígenas e profissionais de saúde. In Esther Jean Langdon y Luiza Garnelo (orgs.), Saúde dos povos indígenas: reflexões sobre antropologia participative, (pp. 103-116). Rio de Janeiro: Associação Brasileira de Antropologia/ContraCapa.

Fontaine Talavera, Arturo and Beyer, Harold (1991). Retrato del movimiento evangélico a la luz de las encuestas de opinión pública. Estudios Públicos, nº 44: 1-52.

Foucault, Michel (1990 [1984]). The use of pleasure. New York: Vintage Books.

Foucault, Michel (1994 [1966]). The order of things. New York: Vintage Books.

Foucault, Michel (2003 [1976]). Society must be defended. Lectures at the College De France, 1975-76. New York. Palgrave Macmillan.

Foucault, Michel (2010 [1978]). The birth of biopolitics. Lectures at the Collège de France, 1978-1979. New York: Palgrave Macmillan.

Fouron, George and Glick Schiller, Nina (2001). All in the family: Gender, transnational migration, and the Nation-State. Global Studies in Culture and Power. Vol.7(4): 539-582.

Franceschet, Susan (2011) Gendered Institutions and women's substantive representation: Female legislators in Argentina and Chile. In M.L. Krook and F. Mackay (eds). Gender, politics and institutions. Gender and Politics Series. (pp. 58-78). Palgrave Macmillan: London.

Freud, Sigmund (1976). Jokes and their relation to the unconscious. Harmondsworth: Penguin.

Galleguillos, Tamara; Risco, Luis; Garay, José Luis; González, Marco; Vogel, Melina (2003). Tendencia del uso de benzodiazepinas en una muestra de consultantes en atención primaria. Revista Médica de Chile, 131(5): 535-540.

Gamlin, Jennie; Gibbon, Sahra; Sesia, Paola; Berrio, Lina (eds.) (2020). Critical medical anthropology. Perspectives in and from Latin America. London: UCL Press.

Garretón, Manuel Antonio (2010). Neoliberalismo corregido y progresismo limitado. Los gobiernos de la Concertación en Chile, 1990-2010. Santiago: Lom Ediciones.

Gherovici, Patricia and Christian, Christopher. (2019). Psychoanalysis in the barrios: Race, class, and the unconscious. London: Routledge.

Giordano, Cristiana (2014). Migrants in translation. Caring and the logics of difference in contemporary Italy. USA: University of California Press.

Giordano, Cristiana (2016). Secular redemptions: Biopolitics by example. Medical Anthropology, 35(3): 278-290.

Glick Schiller, Nina; Basch Linda; Blanc-Szanton, Cristina (1992). Towards a transnational perspective on migration: Race, class, ethnicity, and nationalism reconsidered. New York: NY Acad. Sci.

Goldstein, Donna (2003). Laughter out of place. Race, class, violence and sexuality in a Rio shantytown. London: University of California Press.

Good, Byron. (1993). Culture, diagnosis, and comorbidity. Culture, Medicine and Psychiatry, Vol. 66: 427–446.

Good, Mary-Jo DelVecchio; James, Cara; Good, Byron; Becker, Anne (2003). The culture of medicine and racial, ethnic, and class disparities in healthcare. In B. D. Smedley, A. Y. Stith, and A. R. Nelson (Eds.) Unequal treatment: Confronting racial and ethnic disparities in health care with CD (pp. 594–625). Washington, DC: National Academy Press.

Good, Mary-Jo DelVecchio; Hanna, Seth (2015). "Shattering culture": perspectives on cultural competence and evidence-based practice in mental health services. Transcultural Psychiatry. Vol. 52(2).198-221.

Gordon, Linda (1994). Pitied but not entitled. Single mothers and the history of welfare 1890-1935. Cambridge, Massachussets: Harvard University Press.

Grant, Julian and Luxford, Yoni (2009). Video: A decolonising strategy for intercultural communication in child and family health within ethnographic research. International Journal of Multiple Research Approaches, 3: 218–32.

Grebe, María Ester and Segura, José (1985). Psiquiatría folklórica en Chile: Estudio antropológico de seis enfermedades vigentes. Revista Chilena de Psicología, 8: 37-49

Grubessich, Arturo (1992). Esclavitud en Chile durante el siglo XVIII: el matrimonio como forma de integración social. Revista de Historia, 2: 115-137.

Gülker, Silke (2019). From 'science and religion' to 'transcedence in science ', or: What we can learn from the (History of) Science and Technology Studies. In Jones, S. et al. (Eds.) Science, belief and society: International Perspective on Religion, Non- Religion and The Public Understanding of Science (pp. 103-126). UK: University of Bristol Press.

Gullestad, Siri Erika (2001). Attachment theory and psychoanalysis: Controversial issues. Scand. Psychoanal. Rev. Vol 24: 3-16.

Hacking, Ian (1982). Language, truth and reason. In M. Hollis & S. Lukes (Eds.), Rationality and relativism (pp. 48–66). Oxford: Blackwell.

Hacking, Ian (1985). Making up people. In Heller, T.; Sosna, M. and Wellbery, D. (eds). Reconstructing Individualism. Stanford, CA: Stanford University Press.

Hacking, Ian (1990). The taming of chance. Cambridge, UK: Cambridge University Press

Hacking, Ian (1998). Mad travelers: Reflections on the reality of transient mental illnesses. US: University of Virginia Press.

Hale, Charles (2002). Does multiculturalism menace? Governance, cultural rights, and the politics of identity in Guatemala. Journal of Latin American Studies, 34: 485-524.

Hale, Charles (2006). Más que un indio: Racial ambivalence and neoliberal multiculturalism in Guatemala. Santa Fe: School of American Research Press.

Han, Clara (2012). Life in debt: Times of care and violence in neoliberal Chile. Berkeley: University of California Press.

Hanna, Seth and Carpenter-Song, Elizabeth (2013). Patrolling your blind spots: introspection and public catharsis in a medical school faculty development course to reduce unconscious bias in medicine. Culture, Medicine and Psychiatry, 37(2): 314-339.

Hansen, Randall (2014). State controls: Borders, refugees, and citizenship. In E. Fiddian-Qasmiyeh et al. (eds). The Oxford Handbook of Refugee and Forced Migration Studies (pp. 253-264). UK: Oxford University Press.

Hansen, Helena; Braslow, Joel; Rohrbaugh, Robert (2018). From cultural to structural competency – Training psychiatry residents to act on social determinants of health and institutional racism. JAMA Psychiatry, Vol. 75(2): 117-118.

Hansen, Helena; Dugan, Terry; Becker, Anne; et al. (2013). Educating psychiatry residents about cultural aspects of care: A qualitative study of approaches used by U.S. expert faculty. Academic Psychiatry, 37(6): 412-416.

Hardier, Asad (2018). Mistaken identity. Race and class in the age of Trump. UK: Verso.

Harrison, Gillian; Owens, Dwight; Holton, A.F.; Neilson, David; Boot, Diderik (1988). A prospective study of severe mental disorder in Afro- Caribbean patients. Psychological Medicine, 18, 643–657.

Hartigan, John (2005). Culture against race: Reworking the basis for racial analysis. South Atlantic Quarterly, 104: 543-560.

Hays, Sharon (1996). The cultural contradictions of motherhood. New Haven, CT: Yale University Press.

Hernández, Miguel; Gibbs, Tresha Ann; Gautreaux-Subervi, Luisa (2011). Mental health in the Dominican Republic. International Psychiatry, Vol.8(1):12-14.

Hevia, María Pía (2009). Niños inmigrantes peruanos en la escuela chilena. (Memoria Antropología Social). Universidad de Chile, Santiago.

Hinton, Devon and Good, Byron (Eds.) (2009). Culture and panic disorder. Stanford, CA: Stanford University Press.

Hirschman, Charles (2004). The role of religion in the origins and adaptation of immigrant groups in the United States. International Migration Review, 38(3): 1206-1233.

HM Government, Department of Health (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages. London: HM Government.

Ehrenreich, Barbara and Hochschild, Arlie (eds) (2003). Global woman: Nannies, maids, and sex workers in the new economy. New York: Metropolitan Books.

hooks, bell (1989). Talking back: Thinking feminist, thinking black. New York, USA: South End Press.

Horton, Lynn (2006). Contesting state multiculturalisms: Indigenous land struggles in Eastern Panama. Journal of Latin American Studies, 38(4): 829-58.

Howard, David (2008). Development, racism, and discrimination in the Dominican Republic. Development in Practice. Vol. 17 (6): 725–738.

Hunt, Linda (2001). Beyond cultural competence: applying humility to clinical settings. Park Ridge Center Bulletin, 24: 3-4.

Hurbon, Laënnec (1999). Haitian Vodou, church and anthropology. Anthropological Journal on European Cultures. Vol. 8(2): 27:37.

Hurbon, Laënnec (2001). Pentecostalism and transnationalism in the Caribbean. In: A. Corten et al. (Eds.), Between Babel and Pentecost: Transnational Pentecostalism in Africa and Latin America (pp.124-41). London: Hust & Co.

Hyams, Melissa (2004). Hearing girls' silences: Thoughts on the politics and practices of a feminist method of group discussion. Gender, Place & Culture: A Journal of Feminist Geography, 11: 105–19.

Iannaccone, Laurence (1998). Introduction to the economics of religion. Journal of Economic Literature, 24, 1465–1496.

INE (2003). Censo 2002. Resultados. Chile: Instituto Nacional de Estadísticas (INE). Retrieved from: https://www.ine.cl/docs/default-source/censo-de-poblacion-y-vivienda/publicaciones-y-anuarios/2002/sintesiscensal-2002.pdf

INE/DEM (2019). Estimación de personas extranjeras residentes en Chile al 31 de diciembre 2018. Informe Metodológico. Chile: Instituto Nacional de Estadísticas (INE). Retrieved from: https://www.extranjeria.gob.cl/media/2019/07/Estimaci%C3%B3n-Poblaci%C3%B3n-Extranjera-en-Chile.pdf

INE/DEM (2020). Estimación de personas extranjeras residentes en Chile al 31 de diciembre de 2019. Informe Técnico. Chile: Instituto Nacional de Estadísticas (INE). Retrieved from: https://www.extranjeria.gob.cl/media/2020/03/Estimaci%C3%B3n-Poblaci%C3%B3n-Extranjera-en-Chile-al-31-Diciembre-2019.pdf

INDH (2017). Informe Anual. Situación de los Derechos Humanos en Chile. Chile: Instituto nacional de Derechos Humanos.

Infogate (2018, May 15th). Parlamentarios de Renovación Nacional lanzan la bancada pro valores cristianos. Retrieved from: https://www.infogate.cl/2018/05/15/parlamentarios-de-renovacion-nacional-lanzan-la-bancada-pro-valores-cristianos/

Ingleby, David (2017). How 'evidence-based' is the Movement for Global Mental Health? Disability and the Global South 2014 1(2):203–226.

Janzen, John (1978). The comparative study of medical systems as changing social systems. Social Science and Medicine, 12(2B): 121-130.

Jeffreys, Marianne (2015). Teaching cultural competence in nursing and health care: inquiry, action, and innovation. New York: Springer Publishing Company.

Jenkins, Janis (2015). Extraordinary conditions: Culture and experience in Mental Health. London: University of California Press.
Jenkins, Janis and Barrett, Robert (Eds.). (2004). Schizophrenia, culture, and subjectivity: The edge of experience. Cambridge, UK: Cambridge University Press.

Jenks, Angela (2010). What's the use of culture? Health disparities and the development of culturally competent health care. In I. Whitmarsh and D. Jones (eds). What's the use of race? Modern governance and the biology of difference (pp. 207-224) London: The MIT Press.

Jensen, María Florencia (2008). Inmigrantes en Chile: la exclusión vista desde la política migratoria chilena. In E. Bologna (Ed) Temáticas migratorias actuales en América Latina: remesas, políticas y emigración. (pp. 105-130). Rio de Janeiro: ALAP.

Jirón, Marcela; Machado, Márcio; and Ruiz, Inés (2008). Consumo de antidepresivos en Chile entre 1992 y 2004. Revista Médica de Chile, 136(9): 1147-1154.

Jofré, Soledad and Sepúlveda, Claudia (2017). Migración en Chile: nuevo desafío para la formación de competencias culturales en estudiantes de enfermería. Revista Electrónica Enfermería Actual en Costa Rica, Nº33.

Jordan, Brigitte (1993 [1978]). Birth in four cultures: A cross-cultural investigation of childbirth in Yucatan, Holland, Sweden and the United States. 4th Edition. The USA: Waveland Press.

Juárez, Elizabeth (2012). Ser migrante temporal, mexicano católico en Estados Unidos y Canadá. Cultura y Religión. Revista de Sociedades en Transición, 2(2): 4-21.

Kalawski, Andrés and Serra, Daniela. (2016) Las cosas que no pasan: relato de una transmigración. Journal of Iberian and Latin American Research, Vol. 22(2): 187-203.

Keller, Heidi and Bard, Kim (2017). (Eds.) The cultural nature of attachment. Contextualizing Relationships and Development. US: MIT Press.

Keys, Hunter; Kaiser, Bonnie; Foster, Jennifer; Burgos Minaya, Rosa; Kohrt, Brandon. (2015). Perceived discrimination, humilliation, and mental health: A mixed-methods study among Haitian migrants in the Dominican Republic. Ethnicity and Health. Vol, 20(3): 219-40.

Khoury, Nayla; Kaiser, Bonnie; Keys, Hunter; Brewster, Aimee-Rika.; Kohrt, Brandon (2012). Explanatory models and mental health treatment: Is Vodou an obstacle to psychiatric treatment in rural Haiti? Culture, Medicine and Psychiatry, 36: 514-534.

Kiev, Ari (1961) Folk psychiatry in Haiti. J of Nerv Ment Dis, 1322: 260–265.

Kidron, Carol and Kirmayer, Laurence (2019). Global Mental Health and idioms of distress: The paradox of culture-sensitive pathologization of distress in Cambodia. Culture, Medicine and Psychiatry. Vol. 43(2):211-235.

Kirmayer, Laurence (2012a). Cultural competence and evidence-based practice in mental health: Epistemic communities and the politics of pluralism. Social Science and Medicine, 75: 249-256.

Kirmayer, Laurence (2012b). Rethinking cultural competence. Transcultural Psychiatry, 49(2),
149–164.

Kirmayer, Laurence (2018). Cultural psychiatry in historical perspective. In D. Bhugra and K. Bhui (eds.). Textbook of Cultural Psychiatry (pp. 1-17), Cambridge, UK: Cambridge University Press.

Kirmayer, Laurence; Kronick, Rachel; Rousseau, Cécile (2018). Advocacy as key to structural competency in Psychiatry. JAMA Psychiatry, Vol 75(2): 119-120.

Kirmayer, Laurence and Swartz, Leslie. (2014). Culture and global mental health. In V. Patel, H. Minas, A. Cohen, & M. J. Prince (Eds.), Global mental health: Principles and practice (pp. 41–62). New York, NY: Oxford University Press.

Kirkbride, James; Lunn, David; Morgan, Craig; et al. (2010) Examining evidence for neighborhood variation in the duration of untreated psychosis. Health Place 16 (2): 219-225.

Kitanaka, Junko (2020). In the mind of dementia: Neurobiological empathy, incommensurability, and the Dementia Tojisha Movement in Japan. Medical Anthropology Quarterly, 34(1): 119-135.

Kleinman, Arthur (1978). Concepts and model for the comparison of medical systems as cultural systems. Social Science and Medicine, 12: 85-93.

Kleinman, Arthur (1980). Patients and healers in the context of culture. Berkeley: University of California Press.

Kleinman, Arthur (1991). Rethinking psychiatry. New York, NY: The Free Press.

Kleiman Arthur and Benson Peter (2006). Anthropology in the clinic. The problem of cultural competency and how to fix. PLoS Med; 3: e294.

Kleinman, Arthur; Eisenberg, Leon and Good, Byron (1978). Culture, Illness, and Care. Clinical Lessons from Anthropologic and Cross-Cultural Research. Annals of International Medicine, Vol. 88: 251-258.

Kleinman, Arthur and Good, Byron (Eds.). (1986). Culture and depression. Berkeley: University of California Press.

Koenig, Barbara; Lee, Sandra and Richardson, Sarah (2008). Revisiting race in a genomic age. Piscataway, Nj: Rutgers University Press.

Kofman, Eleonore (1999). Female 'birds of passage' a decade later: Gender and immigration in the European union. The International Migration Review, 33(2): 269-299

Kohn, Robert; Levav, Itzhak; Caldas de Almeida, José Miguel; et al. (2005). Los trastornos mentales en América Latina y el Caribe: Asunto prioritario para la salud pública. Revista Panamericana de Salud Pública, Vol.18:4/5: 229-240.

Kohrt, Brandon (2014). The role of traditional rituals for reintegration and psychosocial well- being of child soldiers in Nepal. In D. E. Hinton and A. L. Hinton (Eds.), Genocide and mass violence (pp. 369–387). New York, NY: Cambridge University Press.

Kohrt, Brandon and Harper, Ian (2008). Navigating diagnoses: Understanding mind–body relations, mental health, and stigma in Nepal. Culture, Medicine and Psychiatry, 32(4), 462–491.

Kuhn, Thomas (1996 [1962]). The structure of scientific revolutions. Chicago: University of Chicago Press.

Kumagai, Arno and Lypson, Monica (2009). Beyond cultural competence: critical consciousness, social justice, and multicultural education. Academic Medicine, 84(6): 782-787.

Kuper, Adam (1999). Culture: The anthropologists' account. Cambridge, MA: Harvard University Press.

Labra, María Eliana (1995). As políticas de saúde no Chile: Entre a razão e a força. In P. Buss and M.E. Labra (Eds), Sistemas de Saúde. Continuidades e Mudanças (pp. 103-152), Rio de Janeiro: Editora Fiocruz/São Paulo: Editora Hucitec.

Labra, María Eliana (2000). Padrões de formulação de políticas de saúde no Chile no século XX. Dados, 43: 153-182.

Labra, María Eliana (2002). La reinvención neoliberal de la inequidad en Chile. El caso de la salud. Cadernos de Saúde Pública. Vol. 18(4): 1041-1052.

Lacan, Jacques. (1966 [1953]). Fonction et champ de la parole et du langage en psychanalyse. In Écrits, 237-322. Paris: Éditions Seuil.

Lacan, Jacques. (1966 [1957]). L'instance de la lettre dans l'inconscient ou la raison depuis Freud. In Écrits, 493–528. Paris: Éditions du Seuil.

Ladd-Taylor, Molly and Umansky, Lauri (1998). "Bad" mothers: The politics of blame in twentieth-century America. New York: New York University Press.

Lagos, Humberto (2001). El general Pinochet y el mesianismo político. Santiago: LOM editores.

Lagos, Humberto (2005). Chile y el mito del Estado laico. Santiago: Icthus Editor.

Laidlaw, James (2014). The subject of virtue. An anthropology of ethics and freedom. New York: Cambridge University Press.

Lakatos, Imre (1978). The methodology of scientific research programmes. Cambridge: Cambridge University Press.

Lambek, Michael (2010) Toward an ethic of the act. In Michael Lambek (ed.), Ordinary ethics: Anthropology, language, and action (pp. 39–63). New York: Fordham University Press.

Lara, Antonia (2020). El alisado es lo más propio de la mujer dominicana: prácticas ritualizadas y miméticas del "brushing dominicano". Polis. Revista Latinoamericana. Nº55: 40-55.

Larraín, Jorge (2001). Identidad chilena. Santiago: LOM Ediciones.

La Tercera (2016, November 29th) Piñera: “Muchas de las bandas de delincuentes en Chile son de extranjeros”. Retrieved from: http://www.latercera.com/noticia/pinera-muchas-las-bandas-delincuentes-chile-extranjeros/

La Tercera (2017a, May 15th). Movimiento de Acción Migrante por dichos de Piñera: “Vincular migración con delincuencia es una mentira”. Retrieved from: http://www.latercera.com/noticia/movimiento-accion-migrante-dichos-pinera-vincular-migracion-delincuencia-una-mentira/

La Tercera (2017b, August 1st). Lepra en Chile: Salud confirma que casos no sólo corresponden a inmigrantes. Retrieved from: http://www.latercera.com/noticia/lepra-chile-salud-confirma-casos-no-solo-corresponden-inmigrantes/

La Tercera (2018a, March 21st). Tras críticas a gestión Bachelet, gobierno alista indicaciones a Ley de Migración. Retrieved from: https://www.latercera.com/nacional/noticia/tras-criticas-gestion-bachelet-gobierno-alista-indicaciones-ley-migracion/106925/

La Tercera (2018b, June 17th). Fiscalía investiga alto patrimonio de obispo evangélico Eduardo Durán. Retrieved from: https://www.latercera.com/nacional/noticia/fiscalia-investiga-alto-patrimonio-obispo-evangelico-eduardo-duran/209592/

La Tercera (2019, February 14th). “Han venido extranjeros con VIH y por ello se incrementó la cifra”: Ministro de Salud dice que aumento de casos se vincula con llegada de contagiados a Chile. Retrieved from: https://www.latercera.com/nacional/noticia/ministro-salud-dice-aumento-casos-vih-se-vincula-llegada-extranjeros-contagiados-chile/529219/

Laurie, Nina; Andolina, Robert; Radcliffe, Sarah (2003). Indigenous professionalization: Transnational social reproduction in the Andes. Antipode, 35(3): 463-91.

Lee, Everett (1966). A Theory of migration. Demography, 3(1), 47-57.

Lee, Jayne Chong-Soon (1994). Navigating the topology of race. Stanford Law Review, Vol.46(3): 747-780.

Leckie, Jacqueline (1989). From race aliens to an ethnic group-Indians in New Zealand. In M.C. Howard (Ed.), Ethnicity and nation building in the Pacific (pp. 169-198). Tokyo: The United Nations University.

Lepe-Carrión, Patricio (2017). El contrato colonial de Chile. Ciencia, racismo y nación. Quito-Ecuador: Ediciones Abya-Yala

Levitt, Peggy (2007). Rezar por encima de las fronteras: cómo los inmigrantes están cambiando el panorama religioso. Migración y desarrollo, (8): 66-88.

Levitt, Peggy and Glick Schiller, Nina (2004). Conceptualizing simultaneity: A transnational social field perspective on society. International Migration Review. Vol. 38(3): 1002-1039.

Ley nº 20.584 (2012). Regula los derechos que tienen las personas en relación con acciones vinculadas a su atención en salud. Diario Oficial de la República de Chile, Santiago, Chile, 24 de abril de 2012.

Liberona, Nanette (2012). De la alterisación a la discriminación en un sistema público de salud en crisis: conflictos interétnicos a propósito de la inmigración sudamericana en Chile. Revista Ciencias Sociales, 28/2º semestre.

Liberona, Nanette (2015a). Poder, contrapoder y relaciones de complicidad entre inmigrantes sudamericanos y funcionarios del sistema público de salud chileno. Revista de Estudios Fronterizos, Vol.15 (2): 15-40.

Liberona, Nanette (2015b). La frontera cedazo y el desierto como aliado. Prácticas institucionales racistas en el ingreso a Chile. Polis, 14(42), 143-165.

Liberona, Nanette and Mansilla, Miguel Ángel (2017). Pacientes ilegítimos: Acceso a la salud de los inmigrantes indocumentados en Chile. Salud Colectiva, 13(3): 507-520.

Lilla, Mark (2018). The once and future liberal. UK: C. Hurst & Co.

Locke, Margaret (2013). The Alzheimer conundrum: Entanglements of dementia and aging. Princeton, NJ: Princeton University Press.

Lovell, Anne; Read, Ursula; Lang, Claudia (2019). Genealogies and anthropologies of Global Mental Health. Culture, Medicine and Psychiatry. Vol.43(4):519-547.

Löwy, Ilana (1986). The epistemology of the science of an epistemologist of the sciences: Ludwik Fleck's professional outlook and Its relationship to his philosophical works. In Robert Cohen and Thomas Schnelle (eds). Cognition and fact: Materials on Ludwik Fleck (421-42). Dordrecht, the Netherlands: Reidel

Löwy, Ilana (2016). Fleck the public health expert: Medical facts, thought collectives, and the scientist's responsibility. Science, Technology, & Human Values, 2016, Vol. 41(3) 509-533.

Lube-Guizardi, Menara and Garcés, Alejandro (2013). Circuitos migrantes. Itinerarios y formación de redes migratorias entre Perú, Bolivia, Chile y Argentina en el norte grande chileno. Papeles de población. Vol. 19(78): 65-110.

Luciano, Dinys; Nadal, Edna; Brito, Sonia; Negrete, Martín; Contreras, Ivette (2019). Análisis de situación en salud mental y atención primaria en República Dominicana. Society for Family Health (SFH/PSI), Ministerio de Salud Pública y Servicio Nacional de Salud. Santo Domingo, República Dominicana.

Luckmann, Thomas (1970). The invisible religion: the problem of religion in modern society. New York: Macmillan.

Luhrmann, Tanya (2001). Of two minds: An anthropologist looks at American Psychiatry. New York: Vintage.

Luhrmann, Tanya (2012). When God talks back. New York: Knopf.

Luhrmann, Tanya (2017a). Knowing god. The Cambridge Journal of Anthropology. Vol. 25(2): 125-142. doi:10.3167/cja.2017.350210

Luhrmann, Tanya (2017b). Diversity within the psychotic continuum. Schizophrenia Bulletin 43(1): 27–31.

Luhrmann, Tanya (2020a). Mind and spirit: a comparative theory about representation of mind and the experience of spirit. Journal of the Royal Anthropological Institute: 1-19. DOI: https://doi.org/10.1111/1467-9655.13238

Luhrmann, Tanya (2020b). Thinking about thinking: the mind's porosity and the presence of the gods. Journal of the Royal Anthropological Institute: 1-15. DOI: https://doi.org/10.1111/1467-9655.13246

Luhrmann, Tanya et al. (2011). 'Towards an anthropological theory of mind. Position Papers from the Lemelson Conference. Journal of the Finnish Anthropological Association 36 (4): 5–69.

McGee, Adam (2012). Dreaming in Haitian Vodou: Vouchsafe, guide, and source of Liturgical Novelty. Dreaming. Advance online publication. DOI: 10.1037/a0026691

Madianou, Mirca (2012). Migration and the accentuated ambivalence of motherhood: the role of ICTs in Filipino transnational families. Global networks, 12(3): 277-295.

Maduro, Otto (2009). Religión y exclusión/marginación: Pentecostalismo globalizado entre hispanos en Newark, Nueva Jersey. Revista Cultura y Religión 3(1), 35-48.

Mahmood, Saba (2012). Politics of piety. The Islamic revival and the feminist subject. Princeton, NJ and Oxford: Princeton University Press.

Mahmood, Saba (2016). Religious difference in a secular age. A minority report. New Jersey: Princeton University Press.

Maldonado, Matías (2012). Evangélicos y política en Chile, 1974-1986. El Consejo de Pastores y la Confraternidad Cristiana de Iglesias. Informe final para optar al grado de Licenciado en Historia. Departamento de Ciencias Históricas, Facultad de Filosofía y Humanidades, Universidad de Chile.

Malin, Maili and Gissler, Mika (2009). Maternal care and birth outcomes among ethnic minority women in Finland. BMC Public Health, 9(84). https://doi:10.1186/1471-2458-9-84

Manuel, Annick (2002). The Chilean health system: 20 years of reforms. Salud Publica Mex 2002; 44:60-68.

Marcus, George (1995). Ethnography in/of the world system: The emergence of multi-sited ethnography. Annual Review of Anthropology 24, 95–117.

Mareno, Nicole and Hart, Patricia. (2014). Cultural competency among nurses with undergraduate and graduate degrees: implications for nursing education. Nurs Educ Perspect; 35:83-8.

Marshall, Harold (1992). Talking about good maternity care in a multi-cultural context. In P. Nicholson and J. Ussher (Eds.), The psychology of women's health and healthcare (pp. 200-224). Basingstoke, United Kingdom: Macmillan.

Marshall, Ineke Haen (1997). Minorities, migrants and crime. Diversity and similarity acroos Europe and the United States. London, UK: SAGE.

Martin, David (1991). Otro tipo de revolución cultural: El protestantismo en Latinoamérica. Revista de Estudios Públicos, 44: 39-62.

Martin, Emily (2009). Bipolar expeditions. Mania and depression in American culture. USA: Princeton University Press.

Martín, María (2016, April 19th). Deus derruba a presidenta do Brasil. El País. Retrieved from: http://www.cat.elpais.com/brasil/2016/04/18/politica/1460935957_433496.html?rel=epr

Martínez, Jorge (2003). Breve exámen de la inmigración en Chile según los datos generales del Censo de 2002. Documentos para Trabajo OIM, N° 3: 1-20.

Massey, Douglas (1990). Social structure, household strategies, and the cumulative causation of migration. Popul Index, 56(1): 3-26.

Massoumi, Narzanin (2015). Muslim women, social movements and the "War on Terror". UK: Palgrave Macmillan.

Mayol, Alberto (2012). El derrumbe del modelo. La crisis de la economía de mercado en el Chile contemporáneo. Santiago: LOM Ediciones.

Mbembe, Achille (2019). Necropolitics. Durham: Duke University Press.

McAlister, Elizabeth (2002). Rara! Vodou, power and performance in Haiti and its diaspora. Berkeley: University of California Press.

McGranaham, Carole (2016). Theorizing refusal: An introduction. Cultural Anthropology. Vol. 31(3): 319-325.

Medina, Eden; da Costa Marques, Ivan; Holmes, Cristina (2014) (Eds.). Beyond imported magic. Essay on Science, Technology and Society in Latin America. US: MIT Press.

Meloni; Maurizio; Cromby, John; Fitzgerald, Des; et al. (2018). Introducing the new biosocial landscape. In M. Meloni, J. Cromby, D. Fitgerald, S. Lloyd (eds). The Palgrave Handbook of Biology and Society. London: Palgrave Macmillan.

Menéndez, Eduardo (1992) Modelo hegemónico, modelo alternativo subordinado, modelo de autoatención. Caracteres estructurales", In Roberto Campos (comp.), La antropología médica en México. Universidad Autónoma Metropolitana, México, pp. 97-113.

Menéndez, Eduardo (2016). Salud intercultural: propuestas, acciones y fracasos. Ciênc. saúde coletiva. Vol.21(1): 109-118.

Métraux, Alfred (1958). Le Vaudou Haïtien. Paris: Gallimard.

Metzl, Jonathan (2009). The protest psychosis: How schizophrenia became a black disease. Boston: Beacon.

Metzl, Jonathan, Roberts, Dorothy (2014). Structural competency meets structural racism: Race, politics, and the structure of medical knowledge. Virtual Mentor 16 (9), 674.

Metzl, Jonathan; Hansen, Helena (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. Social Science and Medicine, 103: 126-133.

Metzl, Jonathan; Petty, JuLeigh; Olowojoba, Oluwatunmise (2017). Using a structural competency framework to teach structural racism in pre-health education. Social Science and Medicine, 199: 189-201.

Metzl, Jonathana and Hansen, Helena (2018). Structural competency and psychiatry. JAMA Psychiatry, Vol. 75(2): 115-116.

Mezzadra, Sandro and Neilson, Brett (2013). Border as method, or, the multiplication of labor. London: Duke University Press.

Mezzich, Juan: Kleinman, Arthur; Fabrega, Horacio; Parron, Delores (1996). Culture and psychiatric diagnosis: A DSM-IV perspective. Washington, DC: American Psychiatric Press.

Mignolo, Walter (2005). The idea of Latin America. Oxford: Blackwell.

Mignolo, W.; Escobar, A. (2010). Globalization and the decolonial option. USA: Routledge.

MIDEPLAN (2006). CASEN 2006: Resultados Nacionales. Ministerio de Planificación y Cooperación. Gobierno de Chile. Chile. Chile

MIDEPLAN (2011). CASEN 2011: Resultados Nacionales. Ministerio de Planificación y Cooperación. Gobierno de Chile. Chile.

Milewski, Nadja (2007). First child of immigrant workers and their descendants in West Germany: Interrelation of events, disruption, or adaptation? Demographic Research 17(29): 859−896.

Milewski, Nadja (2010). Fertility of immigrants: a two-generational approach in Germany. Demographic Research Monographs (6) XXI. https://doi:10.1007/978-3-642-03705-4

Mills, China (2014). Decolonizing Global Mental Health: The psychiatrization of the majority world. New York: Routledge.

Mills, China and Fernando, Suman (2014). Globalising Mental Health or pathologising the Global South? Mapping the ethics, theory and practice of Global Mental Health. Disability and the Global South, Vol. 1(2):188-202.

Mills, Mary Beth (2017) Gendered divisions of labour. In L. Disch and M. Hawkesworth (Eds), Oxford Handbook of Feminist Theory (pp. 283-303) UK: Oxford University Press.

Ministerio del Interior y Seguridad Pública (2009). Informe final de evaluación. Programas de Prevención del consumo de drogas. Programas de Tratamiento y Rehabilitación. Programa Previene (Municipios). Santiago: Gobierno de Chile. Retrieved from: https://www.dipres.gob.cl/597/articles-141124_informe_final.pdf

MINSAL (2003). Política de salud y pueblos indígenas. Documento del Gobierno de Chile. Ministerio de salud. División de Rectoría y Regulación Sanitaria.

MINSAL (2006). Resolución Exenta no 91, de 10 de febrero de 2006. Contribuye al mejoramento de la situación de salud de los pueblos originarios, a través del desarrollo progresivo de un modelo de salud con enfoque intercultural que involucre su activa participación en la construcción, ejecución, control y evaluación del proceso. Santiago: MInisterio de Salud.

MINSAL (2010). Encuesta Nacional de Salud 2009-2010. Chile: Ministerio de Salud.

MINSAL (2011). Estrategia Nacional de Salud para el Cumplimiento de los Objetivos Sanitarios de la Década 2011-2020. Santiago: Ministerio de Salud.

MINSAL (2013). Resolución Exenta no 20, de 17 de enero de 2013. Aprueba Programmea Especial de Salud y Pueblos Indígenas “PESPI”. Santiago: Ministerio de Salud.

MINSAL (2015). Orientaciones para la planificación y programación en red, año 2016. Chile: Ministerio de Salud,.

MINSAL (2017). Plan Nacional de Salud Mental 2017–2025. Santiago, Chile: Ministerio de Salud.

MINSAL (2017a). Plan para Pueblos Indígenas. Proyecto de Apoyo al Sector Salud. MINSAL – Banco Mundial.

MINSAL (2018a). Orientaciones Técnicas Pertinencia Cultural en los Sistemas de Información en Salud. Variable de Pertinencia a Pueblos Indígenas en los Registros y Formularios Estadísticos del Sector Salud. Santiago, Chile: Ministerio de Salud

MINSAL (2018b). Modelo de gestión: red temática de salud mental en la red general de salud. Santiago, Chile: Ministerio de Salud

Minoletti, Alberto; Alvarado, Ruben; Rayo, Ximena; Minoletti, Marissa (2014). Evaluación del sistema de salud mental en Chile. Informe sobre la base del Instrumento de evaluación del sistema de salud mental de OMS (OMS IESM / WHO AIMS).

Minoletti, Alberto; Rojas, Graciela; Horvitz-Lennon, Marcela (2012). Salud mental en atención primaria en Chile: aprendizajes para Latinoamérica. Cad Saúde Colet, 20(4): 440-7.

Minoletti, Alberto; Sepúlveda, Rafael; Gómez, Mauricio, et al. (2018). Análisis de la gobernanza en la implementación del modelo comunitario de salud mental en Chile. Rev Panam Salud Publica, 42:e131. https://doi.org/10.26633/RPSP.2018.131

Minoletti, Alberto; Sepúlveda, Rafael; Horvitz-Lennon, Marcela (2012). Twenty years of mental health policies in Chile: Lesson and challenges. International Journal of Mental Health. 41(1): 21-37.

Minoletti, Alberto and Zaccaria, Alessandra (2005). Plan Nacional de Salud Mental en Chile: 10 años de experiencia. Rev Panam Salud Publica/Pan Am J Public Health 18(4/5): 346-358.

Miranda, Gonzalo; Alvarado, Sergio; Kaufman, Jay (2012). Duración de las licencias médicas FONASA por trastornos mentales y del comportamiento. Revista Médica de Chile. Vol. 140(2): 2007-2013.

Moffette, David and Walters, William (2018). Flickering presence: Theorizing race and racism in the governmentality of borders and migration. Studies in social justice. Vol. 12(1):92-110.

Molina Bustos, Carlos (2010). Institucionalidad sanitaria chilena 1889-1989. Santiago: LOM Ediciones.

Monreal, Angélica (2007). Ministerio de salud chile. Plan nacional de salud mental y psiquiatría en chile. Reforma en la reforma. XXVI. Congreso de la Asociación Latinoamericana de Sociología. Asociación Latinoamericana de Sociología, Guadalajara.

Montenegro, Cristian (2018). Beyond Participation: Politics, incommesurability and the emergence of mental health service users' activism in Chile. Culture, Medicine and Psychiatry. Vol. 42(3): 605-626.

Mooney, Margarita (2009). Faith makes us live: Surviving and thriving in the Haitian diaspora. Berkeley: University of California Press.

Morgan, Craig; Charalambides, Monica; Hutchinson, Gerard; Murray, Robin (2010). Migration, ethnicity and psychosis: Toward a sociodevelopmental model. Schizophr Bull, 36 (4): 655-664.

Morgan, Craig; Knowles, Gemma; Hutchinson, Gerard. (2019). Migration, ethnicity and psychoses: evidence, models and future directions. World Psychiatry. Vol 18 (3): 247-258.

Muñoz, Remigio (1996). Comunidades terapéuticas (C.T.). Cuadernos Médico – Sociales. Tema Central Drogadicción. Vol. XXXVII, 3/96, pp. 24-36. Colegio Médico de Chile (A.G.) Departamento de Salud Pública. Santiago de Chile.

Murphy, Joseph. (1994) Working the spirit. Boston, MA: Beacon Press.

Murray, Marjorie (2012). Childbirth in Santiago de Chile: Stratification, intervention and child-centeredness. Medical Anthropology Quarterly, Vol. 26(3):319–337.

Murray, Marjorie (2013) "Staying with the baby": Intensive mothering and social mobility in Santiago de Chile. In Charlotte Faircloth, Diane Hoffman and Linda Layne, eds. Parenting in Global Perspective: Negotiating Ideologies of Kinship, Self and Politics. p. 256–284. London: Routledge.

Murray, Marjorie; Bowen, Sofia; Segura, Nicole; Verdugo, Marisol (2015). Apprehending volition in early socialization: Raising "little persons" among rural Mapuche families. ETHOS, Vol. 43(4): 376–401.

Nash, Jennifer (2018). The political life of black motherhood. Feminist Studies. Vol. 44(3): 699-712.

Nash, Jennifer (2019a). Birthing black mothers: Birth work and the making of black maternal political subjects. WSQ: Women's Studies Quarterly, Vol 47(3&4): 29-50.

Nash, Jennifer (2019b). Black maternal aesthetics. Theory & Event. Vol. 22(3): 551-575.

Nelson, Hilde (2001). Damaged identities, narrative repair. Ithaca, NY: Cornell University Press.

Nichter, Mark (1981). Idioms of distress: Alternatives in the expression of psychosocial distress: A case from South India. Culture, Medicine, and Psychiatry 5:379–408.

Nicolas, Guerda; DeSilva, Angela; Grey Kathleen, et al. (2006). Using a multicultural lens to understand illness among Haitians living in America. Professional Psychology: Research and Practice, 37(6), 702-707

Nieto, Carlos (2014). Migración haitiana a Brasil: Redes migratorias y espacio social transnacional. Buenos Aires: CLACSO.

Odgers, Olga (2013). Religión e integración: Creencias y prácticas de los inmigrantes. Migración y desarrollo, 12(21), 133-157.

Olivera, Mauricio (2009). Dependencia a benzodiazepinas en un centro de atención primaria de salud: Magnitud del problema y orientaciones para el manejo integral. Revista Chilena de Neuro-psiquiatría, Vol. 47(2): 132-137.

Okpaku, Samuel; Adeponle, Ademola; Kohn, Robert (2018). Migration and psychosis. In. D Moussaoui, D. Bhugra, A. Ventriglio, Mental health and illness in migration. Springer: Singapore. https://doi.org/10.1007/978-981-10-0750-7

Omolade, Barbara (1983). Hearts of darkness. In A. Snitow, C. Stansell and S. Thompson (eds). Powers of desire: The politics of sexuality. (pp. 350–67) New York: Monthly Review Press.

Organización Panamericana de la Salud [OPS] (2019). República Dominicana reafirma nuevo paradigma de salud mental. Retrieved from: https://www.paho.org/dor/index.php?option=com_content&view=article&id=2980:republica-dominicana-reafirma-nuevo-paradigma-de-salud-mental&Itemid=362

Organisation for Economic Co-operation and Development (OECD) (2011). Health at glance 2011: OECD indicators. Paris: OECD

Oring, Eliott (1984). The jokes of Sigmund Freud. Philadelphia: University of Pennsylvania Press.

Orozco Vargas, Arturo (2018). Aculturación, involucramiento parental y autoeficacia materna: Un estudio cualitativo con mujeres latinoamericanas en los Estados Unidos. Interdisciplinaria, 35(1): 87-104.

Orrenius, Pia and Zavodny, Madeline (2019). Do immigrants threaten US public safety? Journal on Migration and Human Security. Vol. 7(3): 52-61.

Ortega, Francisco and Wenceslau, Leandro David. (2019). Challenges for implementing a Global Mental Health agenda in Brazil: The “silencing” of culture. Transcultural Psychiatry. 57(1): 57-70.

Osorio-Merchán, May and López Alba (2008). Competencia cultural en salud: necesidad emergente en un mundo globalizado. Index Enferm; 17(4):266-70.

Otto, Hiltrud and Keller, Heidi (2018). Different faces of attachment: Cultural variation on a universal human need. UK: Cambridge University Press.

Padgett, Andrew and Warnecke, Tonia (2011). Diamonds in the rubble: The women of Haiti. Journal of Economic Issues. Vol. 45(3): 527-558.

PAHO/WHO (1991). Memorias de la Conferencia Regional para la Reestructuración de la Atención Psiquiátrica, Caracas, Venezuela, 11-14 de noviembre, 1990. PAHO/WHO-Mario Negri Institute: 79-90.

Paley, Julia (2001). Marketing democracy. Power and social movement in Post-dictatorship Chile. University of California Press, Berkeley, Los Angeles.

Parker, Cristian (Ed.) (2012). Religión, política y cultura en América Latina: Nuevas Miradas. Santiago: Instituto de Estudios Avanzados, Universidad de Santiago.

Parrado, Emilio (2011). How High is Hispanic/Mexican fertility in the United States? Immigration and Tempo Considerations. Demography 48(3): 1059−1080.

Patel, V; Garrison, P; de Jesus, MJ; et al. (2008). The Lancet's series on global mental health: 1 year on. Lancet, 372: 1354–57

Paul, Robert (1989). Psychoanalytic anthropology. Annual Review of Anthropology. Vol 18:177-202.

Pavez, Iskra (2010). Los derechos de las niñas y los niños peruanos en Chile. La infancia como un nuevo actor migratorio. Revista Enfoques Ciencia Política y Administración Pública, 8(12) 27-51.

Pavez, Iskra (2013). Los significados de "ser niña y niño migrante": conceptualizaciones desde la infancia peruana en Chile. Polis. Revista Latinoamericana, 35: 1-19.

Pentecost, Michelle (2018). The First Thousand Days: Epigenetics in the age of global health. In: M, Meloni, J. Cromby, D. Fitzgerald, S. Lloyd (eds) The Palgrave Handbook of Biology and Society. Palgrave Macmillan, London.

Pentecost, Michelle and Ross, Fiona (2019). The First Thousand Days: Motherhood, scientific knowledge, and local histories. Medical Anthropology. 38(8): 747-761.

Petryna, Adriana (2002). Life exposed: Biological citizens after Chernobyl. USA: Princeton University Press.

Pew Research Center (2020). The Future of World Religions: Population Growth Projections, 2010-2050. Retrieved from: http://www.globalreligiousfutures.org/countries/haiti#/?affiliations_religion_id=0&affiliations_year=2020&region_name=All%20Countries&restrictions_year=2016

Philippe, Jeanne and Romain, Jean Baptiste (1979). Indisposition in Haiti. Social Science and Medicine, 13B(2), 129-133.

Pierre, Andrena; Minn, Pierre; Sterlin, Carlo, et. al. (2010). Culture and mental health in Haiti: A literature review. Santé Mentale au Quebec, (35)1: 13-42.

Piñones Rivera, Carlos; Mansilla Agüero, Miguel; Arancibia Campos, Rodrigo (2017). El imaginario de la horizontalidad como instrumento de subordinación: la Política de Salud Pueblos indígenas en el multiculturalismo neoliberal chileno. Saúde Soc. São Paulo, v.26(3): 751-763.

Pickersgill, Martyn and Van Keulen, Ira (2011). Sociological reflections on the neurosciences. Bingley, UK: Emerald.

Piore, Michael (1979). Birds of passage. Migrant labor and industrial societies. Cambridge: Cambridge University Press.

Pitts-Taylor, Victoria (2019). Neurobiologically poor? Brain phenotypes, inequality, and biosocial determinism. Science, Technology & Human Values. Vol. 44(4): 660-685.

Plotkin, Mariano (2002). Freud in the Pampas: The emergence and development of a psychoanalytic culture in Argentina, 1910-1983. USA: Stanford University Press.

Plotkin, Mariano (2003) Argentina on the couch: Psychiatry, state and society, 1880 to the present. USA: University of New Mexico Press

PNUD (1998). Desarrollo humano en Chile. Las paradojas de la modernización. Santiago: PNUD.

PNUD (2019). Una década de cambios hacia la igualdad de género (2009-2018): avances y desafíos. Santiago de Chile: Programa de las Naciones Unidas para el Desarrollo.

Pollock, Anne (2012). Medicating race. Heart disease and durable preoccupations with difference. Durham and London: Duke University Press.

Portes, Alejandro and Rumbaut, Rubén (2010). Religión: La presencia duradera. In América inmigrante (pp. 239-272). España: Anthropos Editorial.

Postero, NG (2004). Articulations and fragmentations: Indigenous politics in Bolivia. In N. Grey Postero and L. Zamosc, The struggle for indigenous rights in Latin America (pp. 189-216). Sussex: Academic Press.

Postero, N. Grey (2007). Now we are citizens: Indigenous politics in postmulticultural Bolivia. Stanford: Standford University Press.

Prado, María Teresa (1989). Una primera exploración a la medicina tradicional y religión. Psicología y Ciencias Humanas. Universidad Central, Vol.2: 7-17.

Prado, María Teresa; Winkler, María Inés; Casanueva, Cecilia; Cáceres, Claudia. (1988). Actividad psicológica en sectores populares: resultados de un studio exploratorio. Revista Terapia Psicológica, nº10: 58-65.

Price-Mars, Jean (1990 [1928]). So spoke the uncle. Pueblo: Passeggiata Press.

Provine, Doris Marie (2013). Institucional racism in enforcing migration. Norteamérica. Vol. 8(Sup): 31-53.

Publimetro (2018, December 11th). Migración: la frontera que divide a los gobiernos de Bachelet con el de Piñera. Retrieved from: https://www.publimetro.cl/cl/noticias/2018/12/11/bachelet-versus-pinera-migracion.html

Puzan, Elayne (2003). The unbearable whiteness of being (in nursing). Nursing Inquiry, 10(3): 193–200.

Quijano, Anibal (1989) ¿Nuevos temas, nuevos contenidos? Las ciencias sociales de América Latina y el Caribe ante el nuevo siglo. Caracas: Nueva Sociedad - UNESCO.

Quinn, Naomi and Mageo, Jeannette (Eds) (2013). Attachment reconsidered. Cultural perspectives on a Western theory. US: Palgrave Macmillan.

Quinteros, Daniel (2016). ¿Nueva "crimigración" o la vieja economía política del castigo? Dos aproximaciones criminológicas para entender el control punitivo de la migración en Chile. Astrolabio, 17: 81-113.

Rabinow, Paul and Rose, Nikolas (2006). Biopower today. BioSocieties, 1: 195-217.

Radio Agricultura (2018, December 15th). Piñera culpa a Bachelet de situación migratoria en Chile: permitió un "desorden alarmante" Retrieved from: https://www.radioagricultura.cl/politica/2018/12/15/pinera-culpa-a-bachelet-de-situacion-migratoria-en-chile-permitio-un-desorden-alarmante.html

Raikhel, Eugene (2015). From the brain disease model to ecologies of addiction. In L. Kirmayer, R. Lemelson, and C. Cummings (eds), Revisioning Psychiatry: Cultural Phenomenology, Critical Neuroscience, and Global Mental Health (pp.375–99). Cambridge: Cambridge University Press.

Ramsey, Kare (2011). The spirits and the law. Vodou and power in Haiti. USA: The University of Chicago Press.

Raviola, Giuseppe; Severe, Jennifer; Therosme, Tatiana, et al. (2013) The 2010 Haitiearthquake response. Psychiatr Clin North Am, 36(3):431–50.

Retamal, Pedro; Markkula, Niina; Peña, Sebastián (2016). Salud mental en Chile y en Finlandia: desafíos y lecciones. Revista médica de Chile, 44(7): 930-5.

Rey, Terry and Stepick, Alex (2013). Crossing the water and keeping the faith: haitian religión in Miami. New York: New York Univerty Press.

Richards, Patricia (2004). Pobladoras, indígenas, and the State: Conflict over women's right in Chile. New Brunswick: Rutgers University Press.

Richards, Patricia (2007). Bravas, permitidas, obsoletas Mapuche Women in the Chilean Print Media. Gender and Society, Vol. 21(4):553– 578.

Richards, Patricia (2016). Racismo. El modelo chileno y el multiculturalismo neoliberal bajo la Concertación 1990-2010. Santiago: Pehuén.

Richman, Karen (2005). Migration and Vodou. Gainesville: University Press of Florida.

Riedemann, Andrea and Stefoni, Carolina (2015). Sobre el racismo, su negación, y las consecuencias para una educación anti-racista en la enseñanza secundaria chilena. Polis. Revista Latinoamericana. Vol. 14(42): 191-216.

Roberts, Dorothy (2003). Punishing drug addicts who have babies. Women of color, equality, and the right of privacy. In Adrien Katherine Wing (Ed). Critical Race Feminism. New York: New York University Press.

Roberts, Dorothy (2017[1997]). Killing the black body. US: Vintage Books.

Rodriguez, Robyn and Schwenken, Helen (2013). Becoming a migrant at home: Subjectivation processes in migrant-sending countries prior to departure. Population, Space and Place, 19: 375-388.

Roer-Strier, Dorit (2001). Reducing risk for children in changing cultural contexts: recommendations for intervention and training. Child Abuse and Neglect. 125(2): 231-248.

Rogoff, Barbara (2011). Developing destinies: A Mayan midwife and Town. Oxford: Oxford University Press.

Rojas, Graciela; Fritsch, Rosemarie; Castro, Ariel (2011). Trastornos mentales comunes y uso de servicios de salud en población inmigrante. Revista Médica de Chile, 139(10): 1298-1304.

Rojas Pedemonte, Nicolas and Bueno, Sebastián (2014). Redes de inclusión: estudio estadístico de las condiciones sociolaborales de migrantes en Arica. In N. Rojas Pedemonte and J.T. Vicuña Undurraga. Migración y Trabajo. Estudios y propuestas para la inclusión sociolaboral de migrantes en Arica (pp. 56-100). Santiago de Chile: OIM, SJM.

Rojas Pedemonte, Nicolas; Amode, Nassila; Vásquez, Jorge (2015). Racismo y matrices de "inclusión" de la migración haitiana en Chile: elementos conceptuales y contextuales para la discusión. Polis, Revista Latinoamericana, 14(42): 231-259.

Rojas Pedemonte, Nicolas; Amode, Nassila; Vásquez, Jorge (2017). Migración haitiana hacia Chile: origen y aterrizaje de nuevos proyectos migratorios. In N. Rojas Pedemonte and J. Koechlin (Eds). Migración haitiana hacia el sur andino (pp.65-172). Peru: Universidad Antonio Ruiz de Montoya, Centro de Ética y Reflexión Social Fernando Vives SJ, Servicio Jesuita a Migrantes de Chile, Observatorio Iberoamericano sobre Movilidad Humana, Migraciones y Desarrollo OBIMID.

Rose, Nikolas (1989). Governing the soul: the shaping of the private self. London: Routledge.

Rose, Nikolas (1996). Inventing ourselves. Psychology, power and personhood. London: Cambridge University Press.

Rose, Nikolas (1999). Powers of Freedom: reframing political thought. Cambridge: Cambridge University Press.

Rose, Nikolas (2000). Government and control. British Journal of Criminology, vol. 40(2): 321-339.

Rose, Nikolas (2007). The politics of life itself. Biomedicine, power, and subjectivity in the twenty-first century. UK: Princeton University Press.

Rose, Nikolas (2018). Our psychiatric future. UK: Polity Press.

Rose, Nikolas; Abi-Rached, Joelle (2013). Neuro. The new brain sciences and the management of the mind. US: Princeton University Press.

Rose, Nikolas; O'Malley, Pat; Valverde, Mariana (2006). Governmentality. Annual Review of Law and Social Science, Vol. 2: 83-104.

Rovira Rubio, Rayén; Boero Chancy, V.; Calquín Donoso, Claudia (2017). Biopolítica del cuidado en contextos neoliberales. Reflexiones sobre el programa Chile Crece Contigo. In J. Patiño López (Ed). Cuidados y políticas públicas en América Latina. Asuntos del VI Seminario Internacional de la Familia (pp.111-136) Buenos Aires: CLACSO

Roy, Stephanie (2007). "Taking charge of your health": discourses of responsibility in English-Canadian women's magazines. Sociology of Health & Illness, 30(3): 463–477.

Ruperthuz, Mariano (2015). Freud y los chilenos. Santiago: Pólvora Editorial.

Russell, Bernard (2011). Research methods in anthropology: Qualitative and quantitative approaches. USA: Altamira Press.

Rutter, Michael (1995). Clinical implications of attachment concept: Retrospect and prospect. Journal of Child Psychology and Psychiatry. 36 (4): 549–571.

Saint-Hubert, Francis (2012). La Migration Haïtienne, un défi à relever. Migration Policy Practice, Vol. 2(2):14-15.

Salazar, Rachel and Choi, Carolyn (2016). Migration. In L. Disch and M. Hawkesworth (Eds), Oxford Handbook of Feminist Theory (pp. 490-507). UK: Oxford University Press.

Salazar Parreñas, Rachel (2005). Children of global migration: Transnational families and gendered Woes. Stanford: Stanford University Press.

Santos, Boaventura de (2016). Epistemologies of the South. Justice against epistemicide. USA: Routledge.

Sargent, Carolyn and Larchanché, Stéphanie (2009). The construction of "cultural difference" and its therapeutic significance in immigrant mental health services in France. Culture Medicine Psychiatry. Vol. 33(1): 2-20.

Sassen, Saskia (1993). The global city. Princeton: Princeton University Press.

Sassen, Saskia (1999). Guest and aliens. New York: New York Press.

Sassen, Saskia (2014). Expulsion: Brutality and complexity in the global economy. The Belknap Press of Havard University Press. London, England.

Sayad, Abdelmalek (1999). La double absence. Des illusions de l'émigré aux souffrances de l'immigré. Paris: Seuil.

Scharager Goldenberg, Judith; Molina Aguayo, María Loreto (2007). El trabajo de los psicólogos en los centros de atención primaria del sistema público de salud en Chile. Rev Panam Salud Publica. Vol. 22(3):149–59.

Scheper-Hughes, Nancy (1984). Infant mortality and infant care: Cultural and economic constraints on nurturing in northeast Brazil. Social Science and Medicine, 19(5): 535-546.

Scheper-Hughes, Nancy (1985). Culture, scarcity, and maternal thinking: Maternal detachment and infant survival in a Brazilian shantytown. Ethos 13(4): 291-317.

Scheper-Hughes, Nancy (1993). Death without weeping. The violence of everyday life in Brazil. London: University of California Press.

Schild, Verónica (2000). Neo-liberalism´s new gendered market citizens: the "civilizing" dimension of social programmes in Chile. Citizenship Studies 4:275-305.

Schmidt, Johanna (2008). Gendering in infant feeding discourses: the good mother and the absent father. New Zealand Sociology, vol. 23, no. 2, pp. 61–74.

Schwartz, Robert and Blankenship, David (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. World J Psychiatry, 22, 4 (4): 133-140.

Sepúlveda Jara, Rafael and Oyarce Pisani, Ana María (2020). New and old knowledge aimed at decolonising mental health: reflections and proposal from Chile. International Review of Psychiatry. Vol. 32(4): 334-339.

Sharpley, Mandy; Hutchinson Gerard; McKenzie, Kwame; Murray, Robin (2001) Understanding the excess of psychosis among the African-Caribbean population in England. Br J Psychiatry; 178 (suppl 40): s60-s68.

Silva, Daniel; Vicente, Benjamin; Saldivia, Sandra; Kohn, Robert (2013) Conducta suicida y trastornos psiquiátricos en Chile, un estudio poblacional. Rev Med Chile, 141(10): 1275-82.

Simpson, Audre (2007). Ethnographic Refusal: Indigeneity, 'Voice' and Colonial Citizenship. Junctures: The Journal for Thematic Dialogue, no. 9: 67–80.

Smedley, Brian; Stith, Adrienne; and Nelson, Alan (2002). Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: National Academies Press.

Sneath, David; Holbraad, Martin; Pedersen, Morten (2009). Technologies of the Imagination: An Introduction. Ethnos 74 (1): 5–30.

Solimano, Andrés; Mellado, Viviana; Araya, Claudia; Lahoz, Sonia; Ocón, Yelca (2012). Incorporación laboral de los migrantes en la Región Metropolitana de Chile. Santiago de Chile: OIM.

Spivak, Gayatri (1990). The post-colonial critic: Interviews, strategies, dialogues. Sara Harasym (ed.), New York: Routledge.

Stang, María Fernanda (2016). De la doctrina de seguridad nacional a la gobernabilidad migratoria: la idea de seguridad normativa migratoria chilena, 1975-2014. Polis. Revista Latinoamericana. Vol. 44: 1-22.

Stang, María Fernanda and Stefoni, Carolina (2016). La microfísica de las fronteras. Criminalización, racialización y expulsividad de los migrantes colombianos en Antofagasta, Chile, Astrolabio, nº17: 42-80

Stark, Oded and Bloom, David (1985). The new economics of labor migration. The American Economic Review, 75(2): 173-178.

Stark, Rodney and Bainbridge, William (1985). The future of religion. California: University of California Press.

Stefoni, Carolina; Acosta, Elaine; Gaymer, Marcia; Casas-Cordero, Francisca (2008). Niños y niñas inmigrantes en Santiago de Chile. Entre la integración y la exclusión. Santiago: OIM-Universidad Alberto Hurtado.

Stefoni, Carolina (2011). Ley y política migratoria en Chile. La ambivalencia en la comprensión del migrante. In Feldman-Bianco y otros (Comp.). La construcción social del sujeto migrante en América Latina. Prácticas, representaciones y categorías. Quito: FLACSO-CLACSO-UAH. Pág: 79-109.

Stefoni, Carolina and Bonhomme, Macarena (2014). Una vida en Chile y seguir siendo extranjeros. Si Somos Americanos: Revista de Estudios Transfronterizos. Vol. 14(2): 81-101.

Stefoni, Carolina and Fernández, Rosario (2012). Mujeres inmigrantes en el trabajo doméstico: Entre el servilismo y los derechos. In C. Stefoni (ed.), Mujeres Inmigrantes en Chile. ¿Mano de obra o trabajadoras con derechos? (pp. 43-72) Santiago: Ediciones Alberto Hurtado.

Suárez-Cabrera, Dery Lorena (2015). Nuevos migrantes, viejos racismos: Los mapas parlantes y la niñez migrante en Chile. Revista Latinoamericana de Ciencias Sociales, Niñez y Juventud, Vol. 13(2): 627-643.

Subercaseaux, Bernardo (2007). Historia de las ideas y de la cultura en Chile. Tomo IV: Nacionalismo y cultura. Santiago: Editorial Universitaria.

Sugarman, Philip and Craufurd, David (1994). Schizophrenia in the Afro-Caribbean community. Br J Psychiatry, 164: 474-480.

Summerfield, Derek (2008). How scientifically valid is the knowledge base of global mental health? British Medical Journal, 336(7651):992-994.

Superintendencia de Salud de Chile (2016). Análisis de Licencias Médicas y Gasto en Subsidios por Incapacidad Laboral en el Sistema Isapres Año 2015. Retrieved from: www.supersalud.gob.cl/documentacion/666/articles-14336_recurso_1.pdf

Tapia, Marcela and Liberona, Nanette (2018). El afán de cruzar las fronteras. Enfoques transdisciplinarios sobre migraciones y movilidad en Sudamérica y Chile. Santiago: RIL Editores

Tapper, Melbourne (1997). An “anthropathology” of the “American Negro”: Anthropology, genetics, and the new racial science, 1940-1952. Social History of Medicine, 10: 263-289.

Tavernier, LaToya (2010). The stigma of blackness: Anti-Haitianism in the Dominican Republic. Socialism and Democracy, 22(3): 96-104.

Taylor, Marcus (2006). From Pinochet to the “third way”: Neoliberalism and social transformation in Chile. Pluto Press, London.

Tervalon, Melanie and Murray-Garcia, Jann (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved, 9(2): 117-125.

Thayer, Luis Eduardo (2019). Causas y consecuencias de la irregularidad migratoria. In N. Pedemonte Rojas and JT Vicuña (eds). Migración en Chile. Evidencia y mitos de una nueva realidad (pp. 297-334). Santiago: LOM Ediciones.

Thomas, Gwynn (2016) Promoting gender equality: Michelle Bachelet and formal and informal institutional change within the Chilean presidency. In G. Waylen (ed.) Gender, Institutions, and Change in Bachelet's Chile. Studies of the Americas (pp. 95-120). New York: Palgrave Macmillan.

Ticktin, Miriam (2011). Casualties of care. Immigration and the politics of humanitarism in France. London: University of California Press.

Tijoux, María Emilia (2011). Negando al «otro»: el constante sufrimiento de los inmigrantes peruanos en Chile. In Carolina Stefoni (ed.), Mujeres inmigrantes en Chile: ¿mano de obra o trabajadoras con derechos? (pp. 17-42). Santiago: Universidad Alberto Hurtado.

Tijoux, María Emilia (2013a). Niños(as) marcados por la inmigración peruana: estigma, sufrimientos, resistencias. Convergencia. Revista de Ciencias Sociales, 20(61): 83-104.

Tijoux, María Emilia (2013b). Las escuelas de la inmigración en la ciudad de Santiago. Elementos para una educación contra el racismo. Polis. Revista Latinoamericana, 12(35): 287-307.

Tijoux, María Emilia (2014). El Otro inmigrante "negro" y el Nosotros chileno. Un lazo cotidiano pleno de significaciones. Boletin Onteaiken. Nº17: 1-15.

Tijoux, María Emilia (2016) (Eds.). Racismo en Chile. La piel como marca de la inmigración. Santiago: Editorial Universitaria.

Tijoux, María Emilia and Díaz, Gonzalo (2014). Inmigrantes. Los "nuevos bárbaros" en la gramática biopolítica de los estados contemporáneos. Quadranti Rivista Internazionale di Filosofia Contemporanea, 2(1): 283-309.

Tijoux, María Emilia and Palominos, Simón (2015). Aproximaciones teóricas para el estudio de procesos de racialización y sexualización en los fenómenos migratorios de Chile. Polis, Vol. 14(42): 247-275.

Todaro, Michael (1969). A model of labor migration and urban unemployment in less developed countries. The American Economic Review, 59(1): 138-148.

Torres, A.; Lopez Boo, Florencia; Parra, V.; et al. (2017). Chile Crece Contigo: Implementation, results, and scaling-up lessons. Child: Care, Health and Development, 44(1): 4-11.

Torres-Saillant, Silvio (2010). Introduction to Dominican blackness. New York: CUNY Dominican Studies Institute.

Trouillot, Michel-Rolph (2003). Global transformations. Anthropology and the Modern world. New York: Palgrave Macmillan.

Tschannen, Olivier (1991). The secularization paradigm: A systematization. Journal for the Scientific Study of Religion, 30(4): 395-415.

UDP (2018). Informe anual sobre Derechos Humanos en Chile. Santiago: Universidad Diego Portales.

UN (2015). World population prospect. Vol II: Demographic profiles (2015 revision). New York: United Nations.

UN (2019). MINUSTAH fact sheet. United Nations stabilization mission in Haiti. Online: https://peacekeeping.un.org/en/mission/minustah

UN (2019). Violence can 'never be the answer': UN rights experts condemn excessive force during Chile protests. Retrieved from: https://news.un.org/en/story/2019/11/1051011

UNICEF (2004). Informe anual de actividades 2004. Santiago: UNICEF

UNODC (2019). Global study on homicide 2019. Vienna: United Nations.

Urbańska, Sylwia (2016). Transnational motherhood and forced migration. Causes and consequences of the migration of polish working-class women 1989-2010. Central and Eastern European Migration Review, 5(1): 109-128.

Van der Horst, Frank; van der Veer, René; van Ijzendoorn, Marinus (2007). John Bowlby and ethology: An annotated interview with Robert Hinde. Attachment & Human Development, 9:4, 321-335.

Vásquez, T., Busse, E., and Izaguirre, L. (2014). La migración haitiana en Perú y su tránsito hacia Brasil. En La migración haitiana hacia Brasil: características, oportunidades y desafíos (Cuadernos migratorios n°6). OIM.

Véliz-Rojas, Lizet; Bianchetti-Saavedra, Andrés; Silva-Fernández, Marta (2019). Competencias interculturales en la atención primaria de salud: un desafío para la educación superior frente a contextos de diversidad cultural. Cadernos de Saúde Pública, Vol. 35(1): e00120819.

Vergara-Iturriaga, Marcos and Martínez-Gutiérrez, María Soledad (2006). Financiamiento del sistema de salud chileno. Salud Pública Mex, 48(6): 512-521.

Vicente, Benjamín; Saldavia; Sandra; de la Barra, Flora; et al. (2012). Prevalence of child and adolescent mental disorders in Chile: a community epidemiological study. Journal of child psychology and psychiatry, 53 (10): 1026-35.

Vidal, Fernando and Ortega, Francisco (2017). Being brains. Making the cerebral subject. USA: Fordham University Press.

Viera Miranda, David (2016). ¿Secularización en Chile? Análisis crítico de la evolución de católicos y evangélicos entre 1895 y 2012. Explorando el potencial teórico y metodológico del "paradigma de las economías religiosas". Thesis. Santiago: University of Chile.

Villanueva, Alejandra (2014). Construcción del relato biográfico y proyecciones de vida. Versiones de la migración haitiana en Santiago de Chile. Santiago: CLACSO.

Visweswaran, Kamala (1998). Race and culture of anthropology. American Anthropologist, 100:70-83.

Viveros, Mara (2009). La sexualización de la raza y la racialización de la sexualidad en el contexto latinoamericano actual. Revista Latinoamericana de Estudios de Familia. Vol. 1: 63-81.

Vonarx, Nicolas (2012). Le Vodou haïtien. Entre medicine, magie et religion. PUR: Rennes.

Wacquant, Loïc (2001). Parias urbanos. Marginalidad en la ciudad a comienzos del milenio. Buenos Aires: Manantial.

Wade, Peter (2010). Race and ethnicity in Latin America. (2nd Edition). UK: Pluto Press.

Wade, Peter (2015). Race. An introduction. UK: Cambridge University Press.

Wade, Peter; García Deister, Vivette; Kent, Michael; Olarte Sierra, María Fernanda; Díaz del Castillo Herández, Adriana (2014). Nation and the absent presence of race in Latin American Genomics. Current Anthropology. Vol. 55(5): 497-522.

Wagenaar, Bradley; Kohrt, Brandon; Hagaman, Ashley, et al. (2013). Determinants of care seeking for mental health problems in rural Haiti: Culture, cost, or competency. Psychiatric Services, 64(4): 366-372.

Wallerstein, Immanuel (1974). The modern world-system. New York: Academic Press, pp. 347- 57.

Walters, William (2010). Migration and security. In: J.P. Burguess (ed.), The Routledge handbook of new security studies. (pp. 217-228). London, UK: Routledge.

Wang, Simeng (2012). Analyses sociologiques des practiques de l'interprétariat-médiation en pédopsychiatrie: l'exemple des familles d'origine Chinoise à Paris. Enfances & Psy, nº56: 136-145.

Webb, Mark (2017) Religious experience. The Stanford Encyclopedia of Philosophy, Edward N. Zalta (ed.), Retrieved from: https://plato.stanford.edu/archives/win2017/entries/religious-experience/.

Weisman, Kara and Luhrmann, Tanya. (2020). What anthropologists can learn from psychologist, and the other way around. Journal of the Royal Anthropological Institute: 1-17. https://doi.org/10.1111/1467-9655.13245

Wellman, Henry; Cross, David; Watson, Julanne (2001). A meta-analysis of theory of mind development: The Truth About False Belief. Child Development 72 (3): 655–684.

White, Ross; Jain, Sumeet; Orr, David; Read, Ursula (2017). The Palgrave Handbook of Sociocultural Perspective on Global Mental Health. London: Palgrave Macmillan.

Whitmarsh, Ian and Jones, David (2010) (Eds.). What's the use of race? Modern Governance and the biology of difference. USA: MIT Press.

Whitmarsh, Ian and Roberts, Elizabeth (2016). Nonsecular Medical Anthropology. Medical Anthropology. Vol. 35(3):203-208.

WHO (1978). Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

WHO/PAHO (2010). Culture and mental health in Haiti: A Literature review. Geneva.

Willen, Sarah; Bullon, Antonio; Good, Mary-Jo DelVecchio (2010). Opening up a huge can of worms: Reflections on a "cultural sensitive" course for psychiatry residents. Harvard Review of Psychiatry, Vol 18(4): 247-253.

Winkler, María Inés (1993). Trabajo psicológico en sectores populares. PSYKHE, Vol.2 (1): 59-67

Winkler, María Inés (1999). Representaciones sociales de prácticas mágico-religiosas en una comuna urbana. PSYKHE, Vol.8 (1):83-91.

Winkler, María Inés; Contreras, Hernán; Aretio, Cecilia; Martínez, Irma (1996). Necesidades de asistencia psicosocial en sectores populares según pobladores y agentes de salud psicosocial. PSYKHE, Vol.5 (2): 95-107.

Woodson, Drexel (1993). Review of Bellegarde-Smith, Haiti: The Breached Citadel. New West Indian Guide, 67, ½: 156-159.

Worsley, Peter (1982). Non-Western medical systems. Annual Review of Anthropology, 11: 315-348.

Yáñez, Susan and Cárdenas, Manuel (2010). Salud mental y bienestar psicológico en un grupo de inmigrantes sudamericanos en Chile. Rev Salud Soc, 1(1):51–70.

Yates-Doerr, Emily (2018). Translational competency. On the role of culture in obesity interventions. Medicine Anthropology Theory. Vol. 5(4): 106-117.

Yates-Doerr, Emily (2020). Reworking the social determinants of health: Responding to material-semiotic indeterminacy in public health interventions. Medical Anthropology Quarterly. https://doi.org/10.1111/maq.12586

Yeates, Nicola (2012). Global care chains: A state-of-the-art review and future directions in care transnationalization research. Global Networks 12(2): 135–154.

Youkhana, Eva (2012). Formas de pertenencia religiosa y procesos de construcción del espacio en la migración latinoamericana: entre vínculos colonizados y redenciones creativas. Procesos: Revista Ecuatoriana de Historia, (36): 111-142.

Young, Iris Marion. (2000). Inclusion and democracy. Oxford: Oxford University Press

Yusoff, Kathryn (2018). A billion black Anthropocenes or none. Minneapolis: University of Minnesota Press.

Zigon, Jarrett (2008) Morality: An anthropological perspective. Oxford: Berg.

Zigon, Jarrett (2014). Multiple moralities and religions in Post-Soviet Russia. New York: Berghahn Books

Appendix

I. Information sheet

INFORMATIVO PARA PARTICIPANTES

REC Número de Referencia: HR-17/18-5319

UNA COPIA DE ESTE INFORMATIVO LE SERÁ ENTREGADA

Título de la Investigación

Discursos y prácticas en salud mental y migración: Una aproximación etnográfica a la subjetividad de jóvenes afro-caribeños en Chile.

Invitación

Me gustaría invitarlo/a a participar en una investigación que forma parte de mis estudios doctorales en King's College London (KCL). Usted debe participar sólo si lo desea. Si decide no participar esto no lo perjudicará de ninguna manera. Antes de decidir es importante que comprenda por qué estoy realizando esta investigación y qué implicará específicamente su participación. Por favor, tómese el tiempo que estime conveniente para leer cuidadosamente este informativo y discutirlo con otras personas si lo considera necesario. Pregúnteme si hay algo que no está claro o si desea mayor información.

¿Cuál es el propósito de la investigación?

La investigación tiene por objetivo explorar y analizar las mutuas relaciones que establecen entre sí los jóvenes afro-caribeños/as y las diversas instituciones de cuidado en Chile (servicios de salud, organizaciones sociales e instituciones religiosas), centrándose específicamente en aspectos relativos a la salud mental.

¿Por qué he sido invitado/a a formar parte de esta investigación?

Estoy invitando a jóvenes entre 14 y 25 años provenientes de Haití, Colombia y República Dominicana a participar en esta investigación. Asimismo, invito a otras personas relevantes en sus vidas cotidianas tales como miembros de la familia, amigos, profesionales de la salud, sacerdotes/pastores, entre otros.

¿Tengo que participar en esta investigación?

La participación es voluntaria. Usted debe leer este informativo y, si tiene alguna pregunta, me puede consultar directamente.

¿Qué implica participar en esta investigación?

Si lo desea, usted puede participar en una sesión de observación y/o en una entrevista. En el caso de la primera, estaré observando dentro de "salas de espera", "salas de reuniones", "intervenciones individuales y grupales", y "reuniones clínicas". Los objetivos de la investigación no son evaluar el desempeño del personal o el comportamiento de los pacientes. Una persona clave de la institución le informará cuándo se realizará la observación y le preguntará por su consentimiento antes de que comience a observar. Me sentaré en un lugar apartado para no interferir en su rutina. Durante esta instancia, observaré y probablemente tomaré algunas notas. Si tiene alguna pregunta o inquietud antes o durante el período de observación puede preguntarle a la persona clave y/o directamente a mí. Ambos estaremos encantados de responder cualquier pregunta. Si desea que deje de observar o que me traslade a otro lugar, puede solicitármelo en cualquier momento. Si no desea participar en esta parte del estudio, puede informarme antes o durante la observación y usted no será incluido/a. Toda la información será confidencial y las notas se guardarán en un lugar seguro. Si considero que usted puede contribuir con más información para este estudio, lo invitaré a participar en una entrevista.

Si decide participar le entregaré este informativo y le solicitaré que firme un formulario de consentimiento. Luego discutiré el procedimiento con usted y coordinaré una entrevista en un lugar que garantice la privacidad (por razones de confidencialidad). La entrevista durará aproximadamente entre 60 y 90 minutos, y se basará en una guía temática, la cual está diseñada para ser flexible a fin de satisfacer sus requerimientos (por ej. disponibilidad de tiempo). En algunos casos, si es necesario profundizar en algunos temas, es posible que le solicite hacer más de una entrevista. La entrevista se grabará en formato audio sólo si usted está de acuerdo. Cabe señalar, que todas las grabaciones se eliminarán después de la transcripción. Incluso, si ya ha decidido participar, puede suspender su participación en cualquier momento de la entrevista. Asimismo, puede tomar la decisión de retirar la información proporcionada por usted hasta el 31 de marzo de 2019, sin la necesidad de dar ninguna explicación.

¿Cuáles son los posibles beneficios y riesgos de participar en esta investigación?

La información recogida en esta investigación ayudará a comprender los diferentes aspectos de la vida cotidiana y la salud mental de los jóvenes afro-caribeños, así como también el cómo diversas instituciones de cuidado están prestando servicios de salud y cuidado en Chile a esta población. A partir de esta investigación, será posible reconocer diferentes problemáticas con el objetivo de formular estrategias sociales y de salud mental para la población inmigrante. Asimismo, al finalizar la investigación, le haré entrega de una versión resumida del reporte final del estudio con los principales hallazgos.

La principal desventaja de participar es que usted donará alrededor de una hora de su tiempo. No hay riesgos previsibles al participar en el estudio. Sin embargo, en caso de que las preguntas relacionadas con temas delicados

que le hayan producido estrés psicológico y/o ansiedad, yo me ocuparé de ello. Si necesita apoyo adicional, le consultaré si alguien de confianza le puede ayudar en ese momento (por ej. un miembro de la familia, un amigo, etc.) y/o le recordaré que puede acercarse a su centro de salud.

¿Mi participación será confidencial?

La información proporcionada por usted en la entrevista se considera estrictamente confidencial y se mantendrá guardada de forma segura hasta que la investigación haya finalizado. La información será anonimizada para su posterior análisis. En los resultados, no revelaré los nombres de ningún participante. En todo momento, no habrá posibilidad de que los participantes sean vinculados con los datos.

Tanto la Ley de Protección de Datos del Reino Unido de 1998 como la Ley de Protección de la Vida Privada de Chile (Ley n°19.628) se aplicarán a toda la información reunida. La información se guardará en archivos digitales bloqueados con contraseña y en gabinetes cerrados dentro del King's College Londres. Los archivos y transcripciones de datos anonimizados se conservarán indefinidamente y permanecerán protegidos con contraseña. Las grabaciones de audio anonimizadas serán destruidas después de que la entrevista haya sido transcrita (hasta 1 año). Solo yo y mi supervisora, la Dr. Dominique Béhague, tendremos acceso a los datos.

Es importante señalar que, en algunos casos, se requerirá romper con la confidencialidad. Por ejemplo, frente a un peligro inminente y grave para el o la participante u otra persona, y/o en casos de abuso infantil. De ser así, me pondré en contacto con un centro de atención médica y/o una persona a cargo (por ej. padres o cuidadores). Esto no aplica en caso de algún tipo de actividad delictiva (presentes o pasados). En resumen, solo podré romper con la confidencialidad de la información en las siguientes situaciones: (i) información que sugiere que la vida de la persona puede estar en peligro actual; (ii) Información que sugiere que la vida de otra persona puede estar en peligro actual; (iii) Información sobre abuso infantil anterior o continuo; (iv) Información sobre las intenciones de causarle a alguien un daño grave de manera que su vida pueda estar en peligro.

Si poseo una razón genuina para creer que existe tal peligro, le explicaré mi preocupación y que, posiblemente, deba entregar esta información a alguien que pueda ayudarlo/a. Si es posible, le preguntaré si alguien ya tiene conocimiento de esto, y averiguaré quién (por ejemplo, servicios sociales, la policía, profesional de la salud mental). Finalmente, terminaré la entrevista.

¿Cómo se financia esta investigación?

El proyecto es financiado por una beca de investigación llamada BecasChile (Comisión Nacional de Investigación Científica Tecnológica CONICYT-Chile).

¿Qué pasará con los resultados de esta investigación?

Escribiré un informe final que resumirá los principales hallazgos. Este informe le será enviado. También proyecto diseminar los resultados de la investigación a través de publicaciones tales como informes internos (tesis), artículos, libros así como también conferencias.

Todos los documentos se guardarán en un archivador cerrado y seguro, y todas las carpetas se etiquetarán con precisión dentro de la oficina en la cual trabajo en KCL durante 7 años.

Podré usar la información proporcionada para estudios futuros. En ese caso, la confidencialidad y el anonimato también se mantendrán y no será posible identificarlo/a a usted en ninguna publicación.

¿A quién debería contactar para mayor información?

Si tiene alguna pregunta o necesita más información sobre este estudio, contácteme usando los siguientes datos de contacto:

Gabriel Abarca Brown
Department of Global Health and Social Medicine
King's College London
Strand Campus
London
SE 1 2AB
gabriel.abarca_brown@kcl.ac.uk
Tel: +56 9 3337 1837

¿Qué sucede si tengo más preguntas o si algo sale mal?

Si este estudio le ha perjudicado de alguna manera o si desea presentar una queja sobre su realización, usted puede ponerse en contacto con King's College London utilizando los contactos que se presentan a continuación:

Dr Dominique Béhague
Department of Global Health and Social Medicine
King's College London
Strand Campus
London
SE 1 2AB
dominique.béhague@kcl.ac.uk
Tel: +44 (0)207 848 7061

Gracias por leer este informativo y por considerar participar en esta investigación.

II. Informed consent for participants between 14 and 17 years of age.

CONSENTIMIENTO PARA PARTICIPANTES (14-17 AÑOS)

Por favor, complete este formulario después de haber leído la hoja de información y/o haber escuchado una explicación de la investigación.

Título de la investigación: "Discursos y prácticas en salud mental y migración: Una aproximación etnográfica a la subjetividad de jóvenes afro-caribeños en Chile"

N° de Ref. Comité de Ética de King's College London: HR-17/18-5319

Gracias por considerar ser parte de esta investigación. El investigador debe explicarle la investigación antes de que usted acepte participar. Si usted tiene alguna pregunta relacionada con la hoja de información o con la explicación que le fue dada, por favor pregunte al investigador antes de decidir si desea participar. Se le entregará una copia de este consentimiento para que quede en su poder y para que pueda contactar al investigador en cualquier momento.

	Por favor, marcar
Confirmo que comprendo que al marcar cada una de las casillas estoy aceptando participar en este estudio. Comprendo que será asumido que el no marcar una casilla significa que NO ENTREGO mi consentimiento para participar en este estudio. Comprendo que al no marcar ninguna casilla se le considerará como no participante de este estudio.	☐

	Por favor, marcar
1. Confirmo que he leído y he entendido la hoja de información (fechada el 15 de enero de 2018, versión n°2) para este estudio. He tenido la oportunidad de considerar esta información y plantear preguntas que han sido contestadas satisfactoriamente.	☐
2. Estoy de acuerdo en participar voluntariamente de este estudio.	☐
3. Comprendo que puedo retirarme del estudio en cualquier momento sin dar ninguna razón, y que ni seré sancionado ni que se me preguntará por qué me he retirado.	☐
4. Comprendo que puedo retirar la información proporcionada hasta el 31 de marzo de 2019.	☐

5. Los procedimientos relacionados a la confidencialidad me han sido claramente explicados (por ej. uso de nombres, seudónimos, anonimato, etc).La información se manejará de acuerdo con los términos de la Ley de Prot.ección de Datos del Reino Unido de 1998, y la Ley de Protección de la Vida Privada de Chile 19.628. ☐

6. Comprendo que el investigador puede romper la confidencialidad en una situación relacionada con un peligro inminente y grave para mí y/o para otra persona. ☐

7. Comprendo que mi información puede estar sujeta a revisión por parte de personas responsables de King's College London con fines de supervisión y auditoría. ☐

8. Doy mi consentimiento para que mi entrevista sea grabada en audio ☐

9. Estoy de acuerdo en que el investigador puede usar la información proporcionada para estudios futuros y comprendo que en ese caso también se mantendrá la confidencialidad y el anonimato. ☐

10. Comprendo que la información que he entregado se publicará como un informe y deseo recibir una copia. ☐

11. El uso de la información proporcionada, las publicaciones, la difusión y los procesos de archivo me han sido explicados. ☐

_____	_____	_____
Nombre del/a Participante	**Fecha**	**Firma**
_____	_____	_____
Nombre del Investigador	**Fecha**	**Firma**

III. Informed consent for participants over 18 year of age.

CONSENTIMIENTO PARA PARTICIPANTES

Por favor, complete este formulario después de haber leído la hoja de información y/o haber escuchado una explicación de la investigación.

Título de la investigación: "Discursos y prácticas en salud mental y migración: Una aproximación etnográfica a la subjetividad de jóvenes afro-caribeños en Chile"

N° de Ref. Comité de Ética de King's College London: HR-17/18-5319

Gracias por considerar ser parte de esta investigación. El investigador debe explicarle la investigación antes de que usted acepte participar. Si usted tiene alguna pregunta relacionada con la hoja de información o con la explicación que le fue dada, por favor pregunte al investigador antes de decidir si desea participar. Se le entregará una copia de este consentimiento para que quede en su poder y para que pueda contactar al investigador en cualquier momento.

Por favor, marcar

Confirmo que comprendo que al marcar cada una de las casillas estoy aceptando participar en este estudio. Comprendo que será asumido que el no marcar una casilla significa que no entrego mi consentimiento para participar en este estudio. Comprendo que al no marcar ninguna casilla se le considerará como no participante de este estudio. ☐

Por favor, marcar

1. Confirmo que he leído y he entendido la hoja de información (fechada el 15 de enero de 2018, versión n°2) para este estudio. He tenido la oportunidad de considerar esta información y plantear preguntas que han sido contestadas satisfactoriamente. ☐
2. Estoy de acuerdo en participar voluntariamente de este estudio. ☐
3. Comprendo que puedo retirar la información proporcionada hasta el 31 de marzo de 2019. ☐
4. Doy mi consentimiento para el procesamiento de mi información personal para los fines que se me explicaron. Entiendo que dicha información se manejará de acuerdo con los términos de la Ley de Protección de Datos

del Reino Unido de 1998, y la Ley de Protección de la Vida Privada de Chile 19.628 ☐

5. Comprendo que el investigador puede romper la confidencialidad en una situación relacionada con un peligro inminente y grave para mí y/o para otra persona. ☐

6. Comprendo que mi información puede estar sujeta a revisión por parte de personas responsables de King's College London con fines de supervisión y auditoría. ☐

7. Comprendo que se mantendrá la confidencialidad y el anonimato, y que no será posible identificarme en ninguna publicación. ☐

8. Doy mi consentimiento para que la entrevista sea grabada en audio ☐

9. Acepto que el investigador puede usar mis datos para estudios futuros y comprendo que en ese caso también se mantendrá la confidencialidad y el anonimato. ☐

10. Comprendo que la información que he entregado se publicará como un informe y deseo recibir una copia. ☐

_____	_____	_____
Nombre del/a Participante	**Fecha**	**Firma**

_____	_____	_____
Nombre del Investigador	**Fecha**	**Firma**