NEOS

Volume 12, Issue 2
Fall 2020

Parents, Infants, and COVID-19: A Critical Autoethnographic Commentary

Elisha Oliver (Oklahoma State University)
elisha.oliver@okstate.edu

Critical Autoethnography provides an anthropological space to think about personal COVID-19 experiences and how they inform broader explorations of the biopsychosocial politics of Maternal-Child Health. I use "biopsychosocial" as an umbrella term that encompasses the ways in which biological, psychological, and social processes of birth and birthing are governed by institutional policies and procedures. Birthing agency is impacted, regulated, and often compromised beyond the control of the parent(s).

In using critical autoethnography as a method, I privilege the combined narratives of a personal biological and fictive kin group. Aiming to contribute to anthropological research on the bidirectional relationships between mothers and children, specifically infants from birth to three-years-old, I use autoethnography to "connect" combined and composite family "experiences with those of the readers" (Miheretu and Henward 2020, 2). The auto-ethnographic exploration below reveals important questions about topics such as birthing agency, parent-child bonding, infant mental health, and negotiated and regulated alloparenting. This exploration ends by raising important questions about how anthropologists can address these challenges at this time.

Pregnancy and COVID-19

When my daughter entered her last trimester of pregnancy, our family breathed a sigh of relief. She was in the homestretch, and she and baby were progressing well. This would be a special pregnancy for our family. We would be welcoming a "*rainbow baby*." Despite the daily increase in COVID-19 cases in Dallas county, the hypothesis that children, especially infants were less likely to contract COVID-19 floated around the Labor and Delivery halls in the hospital like a child's freshly blown bubbles—light and delicate—often popping in the air before finding a resting place. This gave a family of scientists *hope.* "Stay at home, social distance, wear your mask, and wash your hands"—(S^2W^2)— became our equation for best health practices and reducing the risk of maternal and neonatal infection.

In early March my daughter exhibited flu-like symptoms. With each cough, self-reported body ache not associated with pregnancy, and each labored and congested breath our rock-solid hope began to crumble. She was tested for COVID-19, and her results were negative. My daughter was sent home and, with what remained of our hope, we unpacked our scientific training and began exploring and examining Maternal-Child Health COVID-19 literature. We wanted to be ready. We wanted to know what to expect in worst-case scenarios.

My daughter was told she would have to deliver alone to eliminate possible COVID-19 exposure risks. This was a source of distress to the family. Being categorized as a "high-risk

pregnancy," we were aware a caesarean section would be the method of delivery. My daughter lamented about the lack of agency in the birthing process.

The Arrival

Winston arrived early. He remained in the Neonatal Intensive Care Unit (NICU) for two weeks. Initially, his breathing was labored. His team of physicians began monitoring him for signs of COVID-19 and informed his parents they would be restricted from skin-to-skin contact. Winston's parents were deeply distressed at the thought of leaving their son in the hospital. They were concerned about the impact the interrupted bonding process would have on Winston.

Diagnosis and Disruptions

Mother and child were reunited and progressing well. At the two-month mark after Winston's birth, my daughter began displaying symptoms of COVID-19. She was retested and received a positive result. She was advised to quarantine at home and separate from her newborn. This would be another interruption in the bonding and attachment process. Her husband became the primary caregiver for a newborn and a toddler. Two months after my daughter's positive result, Winston developed a dry cough. He was tested for the virus and received a positive test result. At present, we don't know the lasting impacts of the virus-related parent-child bonding interruptions and disruptions.

The Call for Inquiry

These potential lasting impacts are sites where additional anthropological inquiry, specifically longitudinal research that explores the impact of COVID-19 on infant-child mental health is needed. Reflecting on this brief autoethnographic commentary, I pose two questions to those engaged in child and infant mental health research: In what ways can an (auto)ethnographic approach inform biological and psychological anthropology of children and youth research? In what ways can multiple anthropology sections collaborate to further COVID-19 and children and youth research?

References

Miheretu, Kara R. and Allison Henward. 2020. "I Am Roha's Emaye: A Critical Autoethnography of Mothering in Liminal Spaces." *Genealogy:* Reimagining 'Childhood, Motherhood, Family, and Community.' 4 (2): 1-11

Author contact: Elisha Oliver (Oklahoma State University)
elisha.oliver@okstate.edu

To cite this article: Oliver, E. 2020. Parents, Infants, and COVID-19: A Critical Autoethnographic Commentary. *NEOS* 12 (2).

To link to this article: http://acyig.americananthro.org/neos/volume-12-issue-2/parents-infants-and-covid-19-a-critical-autoethnographic-commentary/