

Introduction

ON LOVE ALONE

I met one of my interlocutors, Célia, and her new baby for a postpartum and life history interview at their apartment complex in East Haven, Connecticut, before COVID-19 restrictions precluded in-person interviews. As I entered the building, kicking freshly mown grass from my shoes, I noticed that the mailbox for her apartment was scribbled with different versions of her surname and her husband's. The uncommonness of multiple surnames in the United States often provokes confusion in bureaucratic settings like medical registration or mail delivery.

I tapped the apartment door, clutching a gift bag. Almost immediately, Marcelina, Célia's sister-in-law, opened the door and ushered me in, her face glistening with sweat and her hair swept into a ponytail. "Thank you, you are too kind," she said, setting the bag on the countertop and returning to the stove, where she was prepping two meals at once. "Célia will be out in a minute."

A little boy with short, dark hair sat on a potty chair in the living room watching Nick Jr. in Spanish. His shirt, printed with the characters of *Paw Patrol*, rode up to reveal a round belly curving over his squatting legs.

After a minute, Célia appeared, wearing red plaid flannel pajamas with

a thick elastic band across her belly. She smiled softly, her face heavy with fatigue. “How’s the baby?” she asked Marcelina.

“Sleeping,” Marcelina answered, adjusting saucepans on the stove. “He’ll probably want his milk soon.”

I peered into the bassinet to see a wrinkly face framed by downy black hair. The baby’s fists stretched toward his face as he wriggled in his white swaddle blanket.

I reached into the gift bag and handed out the diapers, fruit, and slippers I had brought. Célia thanked me and called to her older son, Alonso, offering him an apple. Alonso rushed over, pants at his ankles, as Marcelina hurried to yank them up over his bottom. He grabbed an apple and took a too-big bite, smiling at me.

Célia and I sat at the small round table in the kitchen and began to talk. She shared the story of her migration, her adjustment to the New Haven area, and her baby’s birth. Back in Ecuador, she had studied to be an accountant, earning a certification equivalent to that of a US certified public accountant. She took a job as a bookkeeper at a large company. Despite working over sixty hours a week, Célia could barely pay her mortgage and other household expenses. Then their first baby was born, and her husband lost his job.

“Our country only offers jobs to young people,” Célia told me. “They want you to be young, but also to have work experience. It’s very contradictory. At forty, you’re already old. . . . They’d prefer a twenty- or twenty-five-year-old. If you can find a job, the options are limited. You have to take jobs that demand a lot of time for little pay. It’s not worth the sacrifice of so many hours away from home, away from your son or your wife, when your salary barely covers your expenses. You cannot even look for a job, thinking, well, with two jobs, I could help my family, because the first job demands that you work all day, ten to twelve hours.”

“They want you to have a bachelor’s degree to wash dishes,” Marcelina added, rolling her eyes.

Célia continued, “You face a tough decision. You think, I’m going to be away from my country, my family, everything I know. Here, I am with them, but I can’t feed them. We cannot live on love alone.”

Célia was among the fortunate few I interviewed who was able to obtain a family tourist visa to join her husband, who had already migrated, in the United States. She came with Alonso, then eight months old.

“We told her to be careful,” Marcelina said. “In Ecuador at the time, children were being kidnapped. So, we said to her, ‘Don’t let your guard down. If you have to lose the suitcase, drop it, but don’t let go of the baby for any reason.’”

Abruptly, Gabriel, the newborn, let out a high-pitched yell. “It’s okay, *mi amor*, we’ll solve it together,” Marcelina crooned. She jiggled Gabriel in her arms and passed him to Célia, who snuggled him to her breast to nurse.

When Célia and Alonso arrived in the United States, Célia took a job cleaning houses while her husband worked in construction. “Here, the work is harder, but you get paid enough to get by,” Célia told me. “I got used to it. I like to work. I would finish at three or four in the afternoon and come home to serve my husband and my son soup for dinner, to prepare his lunch for the next day. In my country, I could never see my baby.”

Everything changed when the pandemic hit in March 2020. Célia stopped working to avoid exposure while pregnant and to take care of her son. Meanwhile, her husband was laid off for several weeks from his construction job. When he resumed work, the entire family feared he would bring the virus home. “At first, it was very drastic,” Marcelina said. “He would come home and undress at the door. Even the baby panicked, and if his father tried to hug him, he’d yell, ‘No!’”

“It was pretty traumatic,” Célia commented. Yet the family planned how to get through their difficulties. “I talked with my husband about how we could cut back our expenses and ease our stress,” Célia said. “When you have children, you have to be calm for them—not act tense or fight. This is how we *seguir adelante* [press onward].”

FROM INTERGENERATIONAL TRAUMA TO PRESSING ONWARD

Célia narrates the challenges of living amid state failure and her strategies to adapt and *seguir adelante*. Her story is both exceptional and ordinary: her experiences of undercompensated work and insecurity in Ecuador resonated throughout my interviews with other women, and yet her advantage in arriving in the United States on a tourist visa was a privilege few others shared.

Célia's story exemplifies many ways in which my research surprised me. I had planned to study intergenerational trauma, a phenomenon I had observed at the local free clinic among migrant mothers seeking support for depression, who worried that their traumatic histories were affecting their children. Célia did not report any of the experiences of migration-related trauma that my study attempted to assess. Her symptoms—which scored 5 out of a possible 80—did not meet the clinical criteria for post-traumatic stress disorder (PTSD), but rather reflected her precarity as an undocumented migrant woman from an unstable situation in her home country. Célia disclosed unwanted memories of stressful experiences, primarily recalling poverty and attendant violence in Ecuador. These memories often resurge as she watches Spanish news. Célia also reported hypervigilance and mistrust of others as a mother of two young children living unauthorized in an unfamiliar country.

Célia also narrated some powerful ways of adapting to her circumstances. When the family's income in Ecuador could no longer cover their expenses, Célia made the difficult decision to leave and resettle in New Haven. To make ends meet, Célia told me, she and Marcelina occasionally cooked and sold typical Ecuadorian dishes, including *humitas* (steamed corn cakes), for extra income. When the pandemic challenged their finances, she sought support from local diaper and food banks, including the migrant mutual aid organization Semilla Collective.

Célia's story relates both the personal impact of the pandemic—including her small son's fear of contracting the virus from her husband—and the economic fallout. Because of the pandemic, the women I interviewed juggled job loss, reduced pay, the illness and death of friends and family, remote schooling for their children, mask mandates, and the inability to access pandemic relief benefits like expanded unemployment benefits or economic stimulus checks.

METHODOLOGICAL APPROACH

This book relies on person-centered ethnography to capture the experiences of migrant mothers. Person-centered ethnography shows how individuals are situated in social, material, and symbolic contexts. In medical anthro-

pology, this methodology permits interrogation of the ways that historical, political, social, and cultural contexts constitute human behavior, psychology, and biology (Bernard and Gravlee 2014). Specifically, I conducted in-depth, semistructured interviews with sixty-five women between January 2019 and May 2021. These interviews covered the topics of sociodemographics, migration histories, experiences of social adversity and adaptation in the United States, health and reproductive histories, attitudes toward parenting and motherhood, and responses to the COVID-19 pandemic. I completed follow-up interviews with twelve women and life history interviews with three. Follow-up interviews with postpartum women addressed birth experiences, with particular attention to COVID-19 restrictions, parenthood, infant care, and social support. Life history interviews had an open-ended format and often included experiences of childhood, especially parent-child relationships, education, labor, social relationships and romantic partnership, migration experiences, and motherhood.

Because of the pandemic, I conducted most of my interviews (94 percent) over the phone. This necessity led me to revise my assumptions about going “into the field.” On the one hand, connections and audio quality sometimes fell short, and I could not offer the same affirmation and encouragement through nonverbal cues that I might have done in person. On the other hand, rather than meeting women in a sterile conference room at a prenatal clinic, I could talk to them at home, amid their busy lives. Often, one of my interlocutors would pause to handle a hot pan on the stove or to settle a screeching toddler. Once or twice I asked for patience so that I could nurse my own baby or run interference before he slathered a plate of rice and beans all over the wall. The flexibility of phone calls also allowed interviews to pause and resume, or to take place at atypical hours, in the early morning or the evening. Particularly long interviews sometimes spanned living rooms, cars, and socially distanced outdoor strolls as my interlocutors fit conversations with me around their commitments to family and personal well-being. Discussions about financial stress often led to late-night messages in which I helped women connect with food banks, nonprofit organizations, and mutual aid funds. In many ways, I feel I grew to know my interlocutors more deeply than I might have had I spoken with them only during their clinic visits. (For more details on methodology, please see the appendix.)

To foreground the narratives of my interlocutors, I have employed the techniques of oral history interviews and archival research to describe patterns of Latin American migration to New Haven and consequent shifts in social and political relations. I conducted oral history interviews with thirteen individuals, including journalists, politicians, activists, and community leaders with ties to the Latinx population of New Haven. I corroborated information from these oral histories through archival and demographic research. I also interviewed three key staff members at the prenatal clinic from which I recruited interlocutors, the Women's Center of Yale–New Haven Hospital.

Because I began this research with an interest in intergenerational trauma, backed by clinical experience, I carried out surveys of migration-related trauma and trauma symptoms, using the instrument proposed by Keller et al. (2017) and the PTSD Checklist for the DSM-5 (Weathers et al. 2013). I had also originally intended to collect epigenetic and neuroendocrine biomarkers, aiming to assess correlations between traumatic experience, subjective narratives, psychopathology, and biological variation. Limitations on in-person research precluded the collection of hair and saliva samples, so I relied on ethnographic interviews and surveys to evaluate these relationships. Ultimately I found that the rigid instruments I had chosen could not capture the imprints of traumatic experience the way ethnographic narrative could. Similarly, I completed the Edinburgh Postnatal Depression Scale with postpartum women, and I note the ways that a focus on biomedical symptoms neglects the interconnectedness of social experience and psychology.

THE ETHICS OF STUDYING INEQUITY

Shortly after arriving at Yale University as a medical student, I came to resent the physical and imagined boundaries my colleagues constructed to separate themselves from “the community.” Many of my peers, despite having lived in New Haven for years or even decades, could not name the city's neighborhoods and knew little about local politics or history. Before beginning my research, I became involved in activism for immigrant and worker rights and for racial justice, and I joined a faith network well beyond the Yale catchment. I soon came to share the distaste

my activist peers swallowed down every time they heard the carillon-neurs clang the bells from the top of Harkness Tower: that sense that Yale owned New Haven and considered its residents as invited guests, rather than the other way around. When I decided to break with disciplinary convention and carry out my fieldwork in my own city, I confronted the challenging dynamics of using my Yale title—and benefiting from university resources—while seeking to collaborate with my neighbors outside the university. I continued to straddle this divide throughout the research.

Prior to the pandemic, I used my position as a medical student (I was then an MD/PhD student in medical anthropology) to connect with clinics where pregnant women from Latin America—particularly undocumented women—often sought care. Based on its volume of patients and its provision of free prenatal care for eligible women through the Me and My Baby program, I decided to work primarily through the Women’s Center of Yale–New Haven Health. Collaborating with clinical site directors and providers, I identified potentially eligible patients and recruited women in waiting rooms or exam rooms prior to their appointments or immediately afterward. If the patient had a long-standing relationship with a clinician—for instance, if she had seen the same provider throughout her pregnancy—I asked the provider to present the study and introduce me in the last few minutes of the visit. If the patient was new to the practice, I often wore my anthropologist’s hat to ease anxiety, turn the attention to her social concerns and her experience of pregnancy, and to help her navigate the visit as she desired.

When pandemic restrictions limited face-to-face contact, I shifted my approach. I included flyers for my research study in the welcome packet for new patients. Providers notified patients that they might be contacted about the study and, unless women declined contact at that time, my research assistants or I would call to assess their interest and schedule a phone interview for those who wished to participate.

To protect confidentiality, I have used pseudonyms for all migrant mothers, their children, and clinic staff quoted here. In rare instances when I became concerned that a woman could be identified by elements of her story, I have adjusted details while preserving the main features of her narrative. Those interviewed for oral histories granted permission for me to use their real names.

Although anthropologists often offer small tokens of appreciation