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Role of a support network for refugee mothers

O papel da rede de apoio a mães refugiadas

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Abstract

Recent studies on the transition to motherhood suggest that a support network plays a central role in maternal experience and in the development of the mother-infant relationship. Being a woman without a partner, having economic difficulties, belonging to an ethnic minority or being a recent migrant are some of the conditions that overlap with the demands of maternity and create multiple vulnerabilities. This article analyzes the maternal experience of two recent refugee women in Brazil. The analysis is based on psychotherapeutic sessions at a Winnicottian transcultural clinic offered at a host institution for pregnant women and mothers. We describe how loneliness and helplessness challenge maternal skills, while resilience and adequate shelter facilitate the construction of a support network that favors good motherhood. In our view, the professional can help ensure that maternal practices are guided by the cultural reference of origin as the mother integrates into the culture of the host country.

Keywords: Mother child relations; Motherhood; Psychoanalysis; Shelter.

Resumo

Estudos recentes sobre a transição para a maternidade sugerem que a rede de apoio tem papel central na experiência materna e no desenvolvimento da relação mãe-bebê. Mulheres sem companheiro ou com dificuldades econômicas, bem como membros de minoria étnica ou recém-migrantes são algumas das condições que se sobrepõem às demandas da maternidade, criando um quadro de múltiplas vulnerabilidades. Este trabalho aborda a experiência materna de duas mulheres recentemente refugiadas no Brasil, a partir de sessões psicoterapêuticas na clínica winnicottiana transcultural oferecida em uma instituição de acolhimento a gestantes e mães. Observou-se que a solidão e o desamparo desafiam as competências maternas, enquanto a resiliência e o acolhimento adequado permitem a construção de uma rede de apoio que favorece a maternidade suficientemente boa. Nessa perspectiva, o profissional pode facilitar ou impedir que práticas maternas se orientem pelo referencial cultural de origem, enquanto a mãe se integra à cultura do país de acolhida.

Palavras-chave: Relação mãe-criança; Maternidade; Psicanálise; Abrigo.

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Contemporary studies that address the transformations that occur when a woman becomes a mother affirm that the social support received during the gestation period until after birth directly influences the maternal experience and the development of the child (Leite et al., 2014). Being able to rely on a support network favors the evolution of the pregnancy, reduces risks to and adverse effects on the health of the child and enables the mother to experience feelings and emotions that encourage the development of an affective bond with the baby. Gonçalves, Costa-Vargens, Progiante, and Spíndola (2010) also observed that pregnancy develops better when the woman receives support and attention that help the woman experience feelings of happiness that directly affect conception and a good acceptance of gestation and, consequently, her future relationship with the baby.

Studies that note the importance of the support network (Alves et al., 2007; Brunton, Wiggins, & Oakley, 2011; Leite et al., 2014; Nicolson & Fox, 2010) describe three types of support: family, social and technical. As in contemporary society the family nucleus has become increasingly smaller, the partner and the mother of the pregnant woman become the primary source of support of the woman during gestation and childbirth as well as postpartum, either by assisting in domestic tasks or caring for the baby.

Having a family support network enables women to express and regulate feelings that tend to accompany the transition to motherhood, such as sadness and insecurity, which can be significantly enhanced postpartum (Behringer, Reiner, & Spangler, 2011). Zanatta and Pereira (2015) argue that maternal irritability is typically addressed to the partner. In this way, the woman externalizes the difficulties experienced in the process of becoming a mother. In this regard, Wedel, Wall, and Maftum (2008) call attention to the transition in the marital relationship that enables the father to construct new forms of support for his partner. In contrast, the lack of support, particularly from the partner and the family, accentuates maternal feelings of insecurity and solitude (Rapoport & Piccinini, 2006).

The technical support network corresponds to social and medical support. Nicolson and Fox (2010) investigated three generations of women during the transition to motherhood and noted how the process of becoming a mother has been marked by medicalization and the overvaluation of technical know-how, which are widely viewed as the safest way to become a good mother. When the woman has social and medical support, the incidence of psychiatric comorbidity during the transition to motherhood is lower (Wu & Hung, 2015).

In addition to the family and technical network, it is necessary to consider the social support that the pregnant woman can obtain in maternity preparation groups or her social circle. Such groups, in which it is possible to exchanging experiences with other women, favor the mother-baby relationship (Cáceres-Manrique, Molina-Marín, & Ruiz-Rodríguez, 2014). In a literature review on the process of becoming a mother, Brunton et al. (2011) observed an increase in the search for social activities by women, such as classes and groups for pregnant women and new mothers. This interest can be explained by the reduced chance of interacting with new mothers and newborn babies caused by the constant reduction in the birth rate in contemporary times.

Family, technical or social support networks play a key role in providing relief for suffering and solving the problems that the new family faces throughout the transition to motherhood. Brunton et al. (2011) note that the woman recognizes the need to develop and maintain the strength of support networks with her partner, family, friends and the local community when she becomes a mother.

Emmanuel, Creedy, John, Gamble, and Brown (2008) argue that women with little social support have greater difficulty adapting to the new demands of motherhood. Among such women, those who are most vulnerable to transition problems are those who are without a partner, have a low income, belong to an ethnic minority or are recent migrants (Barclay & Kent, 1998).

If the described factors jeopardize the establishment of a healthy mother-infant relationship,

how would the transition to motherhood appear when all these conditions overlap? Pregnant women who are recent refugees find themselves in a condition in which multiple vulnerabilities are added to the experience of becoming a mother. This experience possesses a disruptive potential that compromises the mental health of the mother and her ability to provide adequate mothering (Winnicott, 1956/2000).

An individual who fears persecution in her/his country of origin because of race, religion, or nationality; belonging to a particular social group; or having a particular political opinion may seek refuge in another country in accordance with international conventions.

Although losses, disruptions and changes mark the migration of refugees, whether their effect is traumatic depends on aspects shared by all migrants, different migration modes and individual experiences (Moro, 2015). According to Ramos (2012), the impact of the migration experience is associated with what was left behind, the age of the migrant, the voluntary or involuntary nature of the change, the characteristics of the new culture, the connection established with the new place of residence, linguistic differences, receptivity of the native population and, finally, the resilience of the individual.

In the context of an academic study, we had an opportunity to work with expectant mothers and mothers. This experience challenged us to reflect on the support network required to meet the demands of a situation of radical suffering, such as that encountered by certain refugees. The new migratory movements of refugees that we witness today in Brazil require psychologists and other professionals to investigate the limits of a severe cross-cultural experience. This study aims to reflect on how a support network was constructed for two refugee women and how it affected the development of the mother-baby relationship.

Method

Adopting a qualitative research perspective, we prioritize the in-depth reporting of situational

experiences (Stake, 2011). The object of study is the mother's real life as understood from her conduct. Here, "conduct" is understood following Bleger (1963/1984) as any human physical, psychic and social behavioral manifestation and whose meaning can only be understood in relation to its dramatic context.

As Politzer (1928/1998) observed, the drama narrated by the individual who lived it is the way to access psychological fact – the lived experience –, as psychoanalysis proposed to investigate it. The patient's narrative, conceived as an interpretive construct that communicates the experience lived by the individual and the senses attributed to by him or her (Bruner, 2004), invites the Other to live an experience and constitutes an opportunity for new senses to be woven into new integrations (Benjamin, 1936/1992).

Granato, Tachibana, and Aiello-Vaisberg (2011) note that the psychoanalyst and the patient access experience as lived through the patient's narrative, which is an effective resource for the production of knowledge regarding affective and emotional experience. Supported by this premise and the heuristic potential of narration to produce meanings, we adopted a qualitative study of psychoanalytic inspiration to understand the transition to motherhood of women who faced the radical experience of becoming a mother while being a refugee. In this article, we focus on the role of the support network and its impact on the initial relationship that the refugee mother establishes with her baby.

The psychological treatment that led to this article lasted up to two years and two months with up to two sessions per week for one patient and one year and four months for another patient. The sessions were held in a municipal institution in *São Paulo* that is home for women in various situations of social risk during pregnancy and puerperium. The institution has formed a partnership with the ONG *Habitaré*, where one of the authors is a clinical psychologist and project coordinator. The clinical setting that guided the consultations was inspired by the Winnicott Therapeutic Consultations (Winnicott, 1984), the proposition of a Winnicottian

maternity clinic by Granato (2000, 2004) and the unique care that Oliveira (2008) offers through therapeutic consultations to women in situations of social vulnerability. Clinical maternity as viewed in this light invites us to look at motherhood as an emotionally impactful experience that evokes a field of primitive anxieties (Granato & Aiello-Vaisberg, 2009).

Winnicott (1984) avoids conceptualizing the Therapeutic Consultation as a new technique, preferring to regard it as a way of approaching the suffering of his patient. Winnicott compared this mode of care to an initial interview, when the psychotherapist still occupies the place of subjective object (Winnicott, 1975), which refers to the initial lack of differentiation between the self and the non-self. This type of object relationship enables the patient to create/find the care he or she requires as the therapist becomes available as an object of use.

The management of the therapeutic consultations aims at offering the patient the possibility to live a complete experience (Winnicott, 1941/2000) and to integrate feelings that are still dissociated. In the Winnicottian perspective, this goal is the main focus of the therapeutic work, which is made possible by a human encounter whose primary quality is support, or *holding*. Thus, the Winnicottian maternity clinic focuses on maternal suffering to support the woman's creative potential and enable her to find her own way of being a mother. This was the starting point of our clinical research with refugee mothers, whose narrative material provides the foundation for the reflections we will offer here on the refugee support network.

For this study, we take the cases of two refugee women. Both women signed the Free and Informed Consent Form, thus agreeing to participate in research approved by the Human Research Ethics Committee of *Pontifícia Universidade Católica de Campinas* (PUCC, Pontifical Catholic University of Campinas; Opinion nº 802.542). Throughout the

study, ethical professional care was offered based on the guidelines of the Code of Professional Ethics for psychologists.

All sessions were first recorded as transference narratives (Aiello-Vaisberg, Machado, Ayouch, Caron, & Beaune, 2009). These narratives consisted of differentiated reports that include impressions and feelings experienced by the research psychologist during the procedure and transference movements, thus resulting in an associative/interpretive report of the session. The transference narratives produced from each clinical session were psychoanalytically analyzed, preserving free-floating attention and the free association of ideas while aiming to describe a phenomenon whose interpretation enables its subjective and social meanings to emerge (Flick, 2014).

Finally, the analysis and discussion of the results was based on the articulation of the transference narratives with Winnicottian contributions and contemporary scientific production, resulting in psychoanalytic narratives (Ogden, 2005) for each of the clinical cases selected for this study. This type of narrative production synthesizes the clinical case report, its analysis and interpretation to communicate to the reader the extent and depth of the understanding reached.

However, because of the large amount of clinical material gathered in the form of transference narratives or psychoanalytic narratives, we present a brief clinical report of the selected cases in view of the objectives of this study and space limitations. Then, in the discussion of the clinical material, we emphasize the role of the support network in establishing the care that the two refugee mothers provided their newborns.

Clinical Case 1: Yia³

Yia is a Nigerian. When she started to be seen, she was 38 years old and in her fourth pregnancy. She came to Brazil alone after she and her husband determined to leave their country

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³ Patient names have been changed to prevent their identification.

because their children's school suffered an attack by the Boko Haram extremist group. She left her three children in the care of her sister-in-law and traveled with her husband to Trinidad and Tobago. The couple traveled on separate flights. On a stopover in Brazil, her documents and purse were stolen, and she remained at the airport for ten days, unaware of her husband's whereabouts. She was eight months pregnant, and because she contracted influenza, she was referred to the General Hospital of *Guarulhos* and later to the institution where she met and requested assistance from one of the authors of this article.

Psychological counseling began ten days after cesarean delivery of her fourth child. Her son suffered seizures and was hospitalized at ten days of life. He remained in the Intensive Care Unit for a month and a half. Yia was seen twice a week during her two-month stay at the institution. On her release, she was offered on-demand psychological care in the following two years at a private clinic, which she accepted, subsequently scheduling sessions once or twice a month. Yia was the first refugee patient received by the institution.

Regarding her baby's care, Yia had many postpartum difficulties when her son had to be admitted to the Intensive Care Unit, and she did not understand the medical procedures or the severity of her son's condition. The first sessions were organized to address these problems, and the medical team was staffed to assist in the communication of the patient with the clinical professionals. Yia remained attentive to the signs of her baby, identifying the changes she perceived in his vitality, such as an increase or decrease in his ability to nurse. However, she was upset by the fact that he was intubated.

Outside the Intensive Care Unit, Yia experienced discomfort regarding the differences between her handling of the baby and that of Brazilian women, referring specifically to her inability to hold the child with her hands. According to her culture of origin, she was used to wrapping the child with a piece of cloth and then tying the child on her back to keep her hands free to work. Her difficulty in holding the baby in her lap was such that she preferred

someone else to take him in his/her arms, as she did at several of our sessions.

Yia told us of her other three children, stating that she has always valued their independence, which is encouraged early in her native culture. Babies sit at four months, and by eight months, they do not require diapers. To achieve this independence, the mother slept with the baby naked under her body, and when she perceived manifestations of a physiological need, she patted the baby's buttocks and placed him/her on the potty so that he/she learned sphincter control.

Yia's need to instill independence also expressed her difficulty with focusing on her child's needs at this critical time in her life when she struggled to find a job and to settle legally in our country while making numerous attempts to reunite with the family members who remained in Africa and were in danger. Yia hoped the baby would develop as her other children had, which prevented her from recognizing the baby's capabilities and limitations as well as the impact of the events that accompanied her escape and search for refuge.

In addition, Yia felt discriminated against by the institution, which interpreted her autonomy as disrespect for institutional rules, and by the Brazilian mothers, who interpreted her care practices as mistreatment. As the first refugee to arrive at the institution, Yia found a strange, hostile environment that was unprepared to face the challenge of hosting refugee mothers and understanding the cultural differences as well as the demands and risks to which the exiled individual is exposed.

Clinical Case 2: Udo

Also Nigerian, Udo was 33 years old and fled Nigeria after her residence suffered an attack by the Boko Haram extremist group, when she witnessed her father's murder and lost her husband and first child. She remained hidden in the woods for several days until she was placed in a ship that was heading to Brazil. It was her first journey abroad. She did not know how long she was on board the ship or where she had entered our country.

She arrived at the institution in a state of shock and was therefore referred to psychological care. She was seen by one of us during the six months she stayed in the institution, with weekly sessions that began during gestation and continued in the postpartum period with the presence of the baby.

She was six months pregnant and fantasized about the death of her baby after not feeling it move inside her womb and because she had a previous abortion at the same gestational age. Soon, she could confirm that the baby was healthy by means of an ultrasound. Her son was born at term by vaginal delivery. Initially, she was afraid of childbirth, particularly because she did not know what to expect from our culture. However, because she was able to accompany the delivery of a colleague at the institution, she was reassured when she realized that giving birth in Brazil was not greatly different from what she had experienced at home.

She remained in the institution until her child was five months old, when she determined to leave and to find a job. She was seen weekly during the entire period of her stay in the institution. After her release, she was offered on-demand psychological care in private practice until her child was one year old. During this period, Udo requested a session every two months.

When Udo came to the institution, there were already approximately 15 refugee women of various (but primarily African) nationalities, which established a different tone of hospitality than that received by Yia. However, she also reported difficulties during the early care of her baby because, formerly, the women in her family used to gather around the young mother and remain in her home to care for the mother-baby duo in the first three months after birth. Remembering her caring for her baby in the homeland, she stated that her only concern was to breastfeed when someone brought her the child. Now, in Brazil, she felt the burden of bearing sole responsibility for her son.

Udo was calm and attentive to each gesture of her child. She drew our attention to the fact that he was a baby who cried little and called his mother to look at him through babbling or smiles. She

exhibited sensitivity toward these manifestations of her son. She and the child indulged in long periods of silent gazing during the sessions, experiencing the tranquility of the moment. She was concerned regarding protecting her son so that he would not even perceive the "scent" of the horrors that had occurred, and she intended to continue to protect him from all the evil in the world.

Udo's son was a firm, strong baby who was able to remain face down, could arch his trunk and had control of his head from the first month. The mother described the bath ritual, which included stretching and massage to enable the baby to sit up soon. She realized that the Brazilian women became frightened at such times. However, because she shared the dormitory with only women of her country, she did not feel inhibited and maintained the ritual.

When the baby was four months old, Udo began to teach him to sit alone, leaving him for a few minutes in this position without back support. She put such free moments to use, but when she noticed a different type of babbling by the child, she said that was enough for that day's practice and that she should proceed slowly so the child would not get hurt.

Every day the refugees at the institution gathered in the nursery to sing songs, to talk and, according to Udo, to laugh, which made them momentarily forget the pain of separation from their families.

Discussion

After childbirth, the need to care for the newborn produces in the woman transformations and rearrangements in different spheres of her life, whether personal, conjugal or social, to meet the new demands of motherhood. When the postpartum period is experienced in a recent-exile situation, as was the case with our participants, the transition to motherhood becomes even more complex, as Ramos (2012) notes, insofar as the loss of cultural ties coupled with the social demand to be a good mother in an unfamiliar culture are

additional emotional demands that can overwhelm the woman.

In the situation of migration, the cultural, family and protective environment of the place of origin collides with the anonymous, distant, technological and incomprehensible universe of the host culture, and the differences between these two universes are accentuated (Ramos, 2012). As an example of this cultural shock, we observed in early infant care that the difference between cultures already begins to appear in terms of understanding what the baby is and the care it requires (Devereux, 2004).

Gottlieb (2012) conceives the baby, the social expectations regarding its development, care practices, the baby's education, and the meaning the child has in its family as social constructs. Such constructs can collapse in the transcultural situation. Similarly, Rogoff (2005) understands human development as a cultural construct, emphasizing that different expectations regarding the maturational achievements of the child can be perceived in distinct cultural communities, whose diversity is not restricted to the differentiation between ethnicities or nationalities.

Throughout this research, we witnessed various conceptions of the baby that guided maternal practices. For example, while Brazilian women viewed the baby as a fragile being, Yia and Udo viewed their babies as powerful, which, in turn, determined the handling of the baby's body in a manner that encouraged autonomy, for example by stimulating the baby to develop muscle tone and body control.

To promote their independence, African infants are stimulated by stretching and massaging so that they can sit by four months of age without support (Gottlieb, 2012). We observed that such practices caused substantial discomfort to the Brazilian cohabitants of the institution and in the technical team. Our observations confirm Moro's (2010) views on the situation of vulnerability in which the baby-mother duo is placed in the cross-cultural situation, when two systems of cultural representation still require integration.

Although care practices are guided by each mother's culture of origin, Rogoff (2005) invites us to view human development by understanding the regularities that attribute meaning to variations and similarities among cultural practices. Rogoff argues that cultural patterns exist through which human relations are organized and that depend on social and institutional support in the development of social roles. We observed that the need for a support network was shared by foreign mothers and Brazilian mothers, which suggests that the task of caring for a baby exceeds individual possibilities and requires community support. However, because such support networks reflect the culture in which they appear, the refugee mothers felt doubly orphaned, unable to resort to their own culture practices without incurring the disapproval of the Brazilian women and unable to seek help from local networks with which they could not identify or understand.

Leite et al. (2014) note that the social support received after gestation has a direct impact on maternal experience and child development. In this regard, Emmanuel et al. (2008) affirm that social support is the factor that most influences the development of the maternal role during the transition to motherhood. For our part, we too emphasize the importance of a responsive support network, particularly in the refuge situation.

Udo did not have family support in the initial care of her baby. Thus, she perceived this period as exhausting and demanding because in her homeland, she had a family support network that took care of her and the baby during the first three months of the child's life. However, in Brazil, she could rely on a technical network and, as described by Behringer et al. (2011), receive support that enabled the expression and regulation of the intense feelings that accompany the postpartum period, which benefited the bond with the baby.

As Udo told us, the women in her family remained united in the postpartum period, taking care of everything so that the mother could rest and dedicate herself to breastfeeding. Udo's experience agrees with what Ramos (2012) stresses regarding pregnancy experienced abroad, which can involve

numerous ruptures, such as the loss of family, social and cultural support. Meeting with other refugee women in the institution made the absence of family support easier. When Udo was able to sing and forget, albeit temporarily, the pain of exile, she felt closer to her culture.

Adding to this list of multiple vulnerabilities, Ramos (2012) notes that the woman who gives birth abroad experiences the impossibility of receiving cultural acceptance for her maternal practices. Yia realized that she could not put her baby to sleep with her as she was accustomed to do and that the stretches and massages performed on the baby during its first months of life to stimulate autonomy were disapproved of by the culture of the host country. Her mothering method was put in check, and Yia felt the violence with which one culture can impose itself on another when it wants to dominate. We know that the Brazilian mothers also felt that their ideal of a good mother was being challenged, and before seeking to understand and including the foreigner, they felt more comfortable excluding and condemning her.

Because she was the first refugee patient in the institution, Yia did not have a support network of fellow Nigerians or other refugees, which inhibited her ability to care for her baby in the familiar way. Because Yia was embarrassed and afraid of being accused of mistreatment, she abandoned the practices characteristic of the maternal care practiced in her culture of origin. This forced renunciation of her own habits triggered the fantasy that her son would develop crooked legs because of a lack of body stimulation, which for Yia was already beginning to materialize.

As Ramos (2012) suggests, the clash between the culture of origin and the culture of the host country enhances their differences, not their similarities. Udo was surprised how Brazilian women looked after their children alone, without the help of family members, while Yia was surprised by the Brazilians' ability to hold the baby in their arms. These differences can generate a sense of inadequacy and insecurity regarding one's own maternal capacity, further compromising the well-being of the baby-mother duo.

The monitoring of the Udo and Yia cases has enabled us to note that the transition to motherhood in exile can be made easier by enabling the mother to encounter other foreign and refugee individuals who share a similar experience. Such encounters strengthen the network of support and help integrate the experience of exile in all its radicalism into the life trajectory of mother and child refugees. The offer of a technical support network capable of promoting cross-cultural care that favors cultural mixing, as Moro (2010, 2015) argues, is a healthy solution for the integration of the immigrant in the host country.

During the institutional reception of refugee mothers, we observed that in the name of a supposed cultural integration both Yia and Udo had to give up certain rituals of care in addition to the way of carrying the baby or the bath ritual. According to local Nigerian custom, babies should be circumcised ten days after birth. However, in Brazil, this procedure is only performed by the *Sistema Único de Saúde* (SUS, Unified Health System) on medical recommendation, which made the procedure unfeasible.

Negotiation is necessary when cultures are mixed, and this process is not always painless. Udo felt personally invaded when she was not allowed to register her son under his father's name because the father was not present. Unable to understand the Brazilian law, Udo awarded another meaning to this event, concluding that in Brazilian culture, the woman had so much power that she did not need to submit to a man's wishes and could name and care for her son herself. She found an argument that supported her view of Brazilian women's strength when she saw in the news that a woman could win the presidency of the country.

As shown by the cross-cultural clinic, it is through integrating the different aspects of each culture that one can achieve the cultural mixing proposed by Moro (2010) and mitigate the impact of the refuge experience. In this way, maternal cultural practices can be legitimized, and the woman can recover the feeling of belonging and the ability to be a good mother in her cultural perspective.

We observed that the social support network becomes the only support alternative for the refugee mother in the absence of her family and while the technical staff is still seeking a means to better accommodate migrants. This observation corroborates Brunton et al. (2011), who found that in the absence of her mother, the woman resorts to other women who are going through the same experience in search of advice.

When we adopt the transcultural perspective in welcoming refugees, we must be careful that the Western maternal ideal that women should care for their babies does not cause us to ignore other, equally legitimate models of child care constructed according to the principles and customs of another culture. Otherwise, we will be compromising the establishment of primary maternal preoccupation (Winnicott, 1956/2000), which is a necessary condition for adequate care.

Thus, we conclude that there is a need for a broad, inclusive support network for refugee mothers. Achieving this goal in a transcultural clinic is only possible through the clinical professional's "decentering" (Moro, 2015), which enables the therapist or caregiver to distance him- or herself from the cultural model (Rogoff, 2005) to provide care that respects and integrates cultural differences.

Final Considerations

The clinical experience briefly reported here enables us to state that the provision of a specialized support network is essential in the refugee situation to prevent the host culture from overlapping the culture of origin and to enable the woman to develop her own authentic style of mothering her baby (Granato & Aiello-Vaisberg, 2011). We emphasize that in the Winnicottian perspective to be authentic and creative does not mean to break with one's culture or submit to it but to create something personal from the connection that links us to our tradition.

The clinical framework conceived according to the Therapeutic Consultations (Winnicott,

1984) that was initially proposed for the care of refugee mothers was enriched with the ideas of Moro (2015) regarding the cultural mixing and the decentering of the clinical professional and in response to the specific and moving character of our patients' suffering.

The social and technical support networks proved to be fundamental in the refugee situation insofar as they replaced the family network that was geographically distant. We observed how the lack of support could interfere in the relationship of the mother with her baby. She begins to react to the intrusions of the host culture and occasionally refuses it, which makes it difficult to include her without compulsion, which results in a loss of spontaneity and meaning for the experience.

We hope that the limits of this research will not prevent us from drawing attention to the new migratory movements, triggered by the most varied forms of violence, and the demand for differentiated care that facilitates the experience of becoming a mother in conditions as adverse as those we witnessed. In this sense, the development of public policies that prepare the way for the reception of migrants and the expansion of services that require specialized professional training do not fail to include the necessary sensitivity and respect for otherness.

Contributors

All authors participated in all phases of the research article.

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