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An Examination of the Impact of Psychosocial Factors on Mother-to-Child Trauma Transmission in Post-Migration Contexts Using Interpretative Phenomenological Analysis

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ABSTRACT


Objectives: The impact of psychosocial factors and social support in the transmission of trauma related to migration and the mother-child dyad has not yet been amply explored. This article examines this impact and the role that psychosocial factors may have in the transmission of the traumatic experiences of migrant mothers to their children. **Patients and method:** This study was conducted in France and focused on 14 mother-child dyads in which mothers were exposed to potentially traumatic events in the absence of the child, before or after birth. To analyse the corpus of information collected, the team used a qualitative method based on Interpretative Phenomenological Analysis (IPA) guidelines. **Results:** The study's findings show that a lack of support from the family and lack of support from the host country are two of the major psychosocial factors involved in the exacerbation of maternal challenges. This negative impact on the maternal function leads to mirror reactions between the mother and child marked by the transmission of depressed moods and instinctive behavioural disorders, such as insomnia. Among other findings, factors are identified that help protect mother-child interactions, including religion and faith in God. **Conclusion:** These findings provide a foundation for further studies into the transmission of trauma from mother to child among migrant women and will help direct further clinical insight into the role of psychosocial factors in traumatic experiences and their transmission.

KEYWORDS

Migration; trauma; mother-child; transmission; interpretative phenomenological analysis; risk and protective factors

Introduction

In the past two decades, the number of refugees, asylum seekers and irregular migrants around the world, and particularly in Europe, has steadily increased. For instance, between 2013 and 2019, 123,900 asylum seekers arrived in France (UNHCR, 2019).

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The causes leading to this rise in migration vary. Wiese (2010) mentions that migrant families of different origins and cultures are forced to migrate to escape life-threatening civil wars, inter-community strife and/or political conflicts as well as natural disasters, among other causes. Research has shown that migrant women, in particular mothers of young children, may be at high risk of post-traumatic stress disorder (PTSD). Pregnancy and the postnatal period are times when women are increasingly vulnerable to trauma exposure and the development of PTSD, or the re-emergence or exacerbation of PTSD symptoms (Anderson et al., 2017).

Many studies have focused on the trauma that migration can involve. In a French sociological study, Nathan (1986) uses the concept of “migratory trauma” to refer to the psychological and identity-related distress associated with migration. The migratory journey constitutes a traumatic experience borne of various geographical, temporal, cultural and relational ruptures (Nathan, 1986). These ruptures make migration itself a particular trauma, where the *self* is upset and affected by instability (Baubet & Moro, 2000). Many other factors make migratory experiences potentially traumatic. There are pre-migration traumas, including the circumstances leading to a forced departure, the travel conditions surrounding the migration, and the guilt experienced by migrants about leaving family behind (Li, 2016). Then, there is the trauma related to the difficulties and precarious conditions encountered in post-migration resettlement environments, including financial instability, isolation, inadequate social support and anxiety about the future (Li, 2016; Nickerson et al., 2011; Steel et al., 2006, 2009).

Intergenerational transmission of trauma is defined as the traumatic impact suffered by one family member on another member of a younger generation, regardless of whether the younger family member was directly exposed to the trauma (Williams et al., 2020). Beyond pre-, peri- and post-migration traumatic encounters, the transmission of trauma-related distress experienced by migrants to their offspring is a subject of critical importance. However, this issue has received little attention in current literature (Dozio et al., 2016; Rezzoug et al., 2008). Nevertheless, several studies have been conducted on the possibility of traumatic transmission from a mother to a child that did not directly experience the traumatic events (Flanagan et al., 2020; Schore, 2001, 2002; Stern, 1985; Yehuda & Lehrner, 2018). A study by Feldman et al. (2019) using Gampel’s concept of radioactivity (Gampel, 2003), proposes that mothers who have experienced traumatic events can become emitters of “radioactive residue” to their children. Stern (1985) also proposes a transmission route based on the sharing of emotional states between the mother and the child through intermodal exchanges using the concept of “affective tuning.” According to this theory, a traumatised mother may transmit her emotional state through her gestures that are then internalised by the child. In the same vein, Schore (2002) suggests that traumatised mothers are unable to regulate stimulus and response to their infants’ needs, leading to hyperstimulation or the opposite, neglect of the child. The work of Ciccone (1999) is more directed towards an unconscious mode of transmission. The psychic development of a child is made up of the parents’ expectations of the child in his/her infancy, including the parents’ fantasies and ambitions, which are then transmitted to the child. Findings from a study by Flanagan et al. (2020) suggest that parental exposure to trauma and the sequelae of trauma affect the well-being of the child through potential insecure attachment mechanisms, accumulation of family stressors and the severity of parental

symptomatology. With the recent emergence of the epigenetic paradigm, more studies are considering the intergenerational transmission of trauma-related distress through other mechanisms. Two recent reviews of such epigenetic studies have shown that the effects of a parental trauma can persist into the next generation through epigenetic markers encoded in DNA that pass through the germ line and extracellular vesicles (Scorza et al., 2020; Yehuda & Lehrner, 2018).

These studies help explain different mechanisms for the transmission of trauma. However, factors related to the transmission processes or the transmission of the content of a mother's trauma and its impact on the child have been less explored. To this end, a study by Dozio et al. (2019) provides preliminary findings covering the humanitarian context among survivors of war that aim to understand the processes of direct transmission of trauma and its impact on mother–child interactions. These findings provide information that confirm mother–child interactions are highly impacted by the level of exposure of the mother to trauma. This study further identified “poor” mother–child interactions such as poor verbal, visual and bodily exchanges. These “poor” exchanges become even more striking during moments of a mother's recollection of traumatic events and in which mother and child interactions differ in quantity and quality.

This team's study builds on the work by Dozio et al. (2019, 2020) and focuses particularly on migrant mothers. Although the Dozio et al. study provides some insight into the impact of maternal trauma on mother–child interaction, it does not address the impact of psychosocial factors on the transmission of trauma from mother to child. Indeed, the role of psychosocial factors, such as the impact of social support on the well-being of mother–child dyads, has become the subject of considerable attention. The emerging literature on the link between social support and PTSD show that inadequate social support is a powerful predictor of the development and persistence of PTSD symptoms (Fredette et al., 2016, 2020; Guay et al., 2011; Ozer et al., 2003). This finding is consistent with conclusions in other studies that have found associations between social support and the behaviour of parents facing adversity (Ajduković et al., 2018; Sim et al., 2019; Tracy et al., 2018). For example, a cross-sectional study by Sim et al. (2019) on Syrian mothers in Lebanon reveals the positive impact that social support provides for parental resilience in a refugee context.

The aim of this study is to explore psychosocial factors involved in the transmission of traumatic experiences of migrant mothers to their children in a post-migration context in France. Furthermore, using the interpretive phenomenological analysis (IPA) approach that demands an in-depth interview methodology (Smith et al., 2009), this study seeks to understand the role that the availability of social support has in mitigating or exacerbating the transmission of traumatic experiences from migrant mothers to their children.

Methodology

Approach and participant selection

This study was conducted in the city of Le Havre in the Normandy region of France. Interviews took place from May 2019 to July 2020 and covered a period of 15 months. Participants were recruited from a list of migrant women accessing mental health services

provided by the Department of Pedopsychiatry at the Hospital Group of Le Havre. The research protocol was validated by the Research Laboratory Ethics Committee (n° 12-065) and accepted by the Hospital Group of Le Havre.

The selection criteria for participants included:

- Migrant mothers from mother–child dyads, who:
 - Experienced traumatic events in the absence of their children, before or after birth;
 - Scored above the clinical threshold (≥ 33) on the Revised Impact of Event Scale (IES-R; Creamer et al., 2003); and
 - Speak French or English.
- Children of migrant mothers included in this study had to be between the ages of 0 and 3 years at the time of the interviews.

Exclusion criteria included:

- Non-migrant mothers;
- Migrant mothers who cannot speak French or English;
- Children over the age of 3 years; and
- Children present at the time of their mothers' exposure to traumatic events.

Eligible migrant mothers were informed about the purpose and methodology of the research. Two to three weeks before interviews commenced, the research protocol and consent forms were shared in-person with the participants. At that time, eligible mothers were informed that their children could be present during their interviews.

Interview methodology

Mothers participating in the study were provided with in-person briefings about the interviews, modalities and context of the research. Each mother was provided with a written, informed consent form that included consent for the use of data recorded during interviews. Mothers also were informed that they could ask to stop an interview at any time.

Interviews were designed to be semi-structured and addressed several aspects of the mother–child relationship and the mother's traumatic experience. On average, each interview lasted between 60 and 90 minutes and was conducted in three parts. The first part covered a mother's perception of her child and of her relationship with her child. In the second part, the mother was invited to talk about her traumatic experience, including whether there was more than one traumatic event or repetition of traumatic events, the nature of the event/s, the time the event/s occurred, the migration process, the impact of changes in environments and of breached family ties, and grief and grieving processes. The final part included questions to the mother about other extenuating factors including the presence of the child's father or other conditions that she felt offered protection for her and her child. During this last stage of the interview, the mother was invited to talk about her experience with the child's father.

Protective conditions and circumstances were explained to the participants as any factor that the mother feels enabled her and her child/children to survive or mitigated

the extent of traumatic transmission from her to her child. Such protective factors could be internal, or linked to representations of oneself and others, as well as external, including the intervention of other individuals or entities that offered support and resolutions to certain challenges and crises. Other protective factors, which could be perceived as playing a role in mitigating an original traumatic experience and/or the transmission of trauma from mother to child, include religion or faith in God.

The analytical approach

To analyse the corpus of information collected, the team employed a qualitative method based on Interpretative Phenomenological Analysis guidelines (IPA; Smith et al., 2009). IPA is a phenomenological psychology approach and methodology that is particularly focused on the subjective experience of individuals. This methodology is considered a suitable approach to reconstructing an individual's personal experience or what Eatough and Smith (2006) have called "the world of the individual's life."

Following IPA guidelines, each interview was individually conducted, transcribed, analysed and coded. Codes were then grouped through a deductive analysis into categories (themes) designed to consolidate the dispersion and heterogeneity of the information collected. Refining the interpretation of the coded data led to the development of a table divided into meta-themes and sub-themes. Subsequently, three authors conducted independent analyses of the collated data which then underwent an in-depth evaluation and discussion to agree on emerging themes, and to justify prejudices and preconceptions. As the IPA method indicates, recruitment of participants and interviewing was concluded at the point of data saturation. Finally, the data was processed using NVIVO 10 for Windows (QSR, 2019), and to ensure anonymity, all characteristics that could reveal the identity of the dyads were concealed without altering the facts.

Results

Characteristics of the sample

Twenty mother–infant dyads ($n = 20$) were invited to participate in the study. Five of the dyads refused to participate because of language barriers. One dyad did not specify the reason for her refusal to participate. Thus, in total, the study is based on the analysis of data collected from interviews with 14 dyads.

Table 1 presents the general and shared characteristics identifying the 14 dyads as migrant women from Africa and Albania who have resided in France for at least one year. One dyad is identified as having refugee status, one has resident status, while the rest are pending administrative processing of their status (four dyads have pending status under OFPRA¹; four have pending status under appeal at CNDA²; and four have pending status at the prefecture level). The average age of the participants in this study is 29.9 years, with the youngest participant being 19 and the eldest being 42 years of age. Seven of the participants are married and live with their spouses. The remaining seven are identified as single parents.

All 14 participants have experienced various levels of potentially traumatic events including female genital mutilation, rape, forced marriage, domestic violence, armed

Table 1. Socio-demographic profile of the dyads.

DYAD	Origin	Mother's age	Date of entry in France	Age of the baby (by month)	The Sex of the baby	Primitive Mother	Number of children	Status in France	Infant born after the event	Pregnant mother during the event	The presence of the father	Reason for the absence of the father
Dyad 1 (Mme K et Bb M)	Senegal	26	2016	13	M	No	1	Resident	Yes	Yes	No	Divorced
Dyad 2 (Mme M et Bb S)	Algeria	42	2017	21	F	No	5	Waiting for the préfecture	Yes	Yes	No	Separated
Dyad 3 (Mme P et Bb K)	Albania	28	2016	30	M	No	2	Waiting for CNDA	Yes	Yes	Yes	
Dyad 4 (Mme K et Bb J)	DRC ^a	31	2018	15	F	Yes	1	Waiting for CNDA	Yes	No	No	Rape/Single
Dyad 5 (Mme M et Bb A)	Mali-Senegal	31	2018	7	F	No	2	Waiting for CNDA	Yes	No	Yes	
Dyad 6 (Mme T et Bb G)	Ivory Cost	33	2016	30	M	No	4	Waiting for the prefecture	Yes	No	No	Separated
Dyad 7 (Mme T et Bb A)	Mali	29	2019	15 jours	F	No	2	Waiting OFPRA	Yes	Yes	No	Separated
Dyad 8 (Mme D et Bb I)	Guinea Conakry	23	2017	8	M	No	2	Waiting OFPRA	Yes	No	Yes	
Dyad 9 (Mme B et Bb R)	Ivory Cost	19	2018	13	F	Yes	1	Refugee	Yes	No	Yes	

Dyad 10 (Mme F et Bb C)	Ivory Cost	29	2018	12	M	Yes	1	Waiting for CNDA	Yes	Yes	No	Separated
Dyad 11 (Mme K et Bb F)	Guinea Conakry	26	2017	12	F	No	2	Waiting for the prefecture	Yes	No	Yes	
Dyad 12 (Mme B et Bb M)	Ivory Cost	34	2016	11	M	No	3	Waiting OFPPRA	Yes	No	Yes	
Dyad 13 (Mme G et Bb M)	DRC	35	2017	29	M	No	5	Waiting for the prefecture	Yes	No	Yes	
Dyad 14 (Mme K et Bb A)	DRC	33	2018	20	F	No	4	Waiting OFPPRA	Yes	No	No	Rape/Single

^aDRC means Democratic Republic of Congo.

conflict, the loss of a child, the loss of a spouse, and/or rejection by their families and/or in-laws. Five participants were pregnant when they experienced their traumatic event, and their children were born after the traumatic event. At the time the interviews took place, the children born to the participants were either the last child among a group of siblings or the only child born to their mothers. All the children in the participating dyads were between 15 days and 30 months old at the time the interviews took place. They include seven boys and seven girls.

Presentation of IPA data

The analysis of the data through the IPA allowed the team to identify three meta-themes: psychosocial factors exacerbating maternal challenges; mirror reactions between mother and child; and protective psychosocial factors for maternal function. Each meta-theme is then grouped into sub-themes that are discussed further in each section.

Meta-theme: psychosocial factors exacerbating maternal challenges

Within this first meta-theme, the team identify two sub-themes that related to the major psychosocial factors that exacerbate maternal challenges. The first sub-theme addresses the reactivation of past traumatic experiences and conflicts during the pre-natal and post-natal period. The second sub-theme shows the inadequacy of social support from the host country relative to the expectations and needs of these migrant women.

Sub-theme one: past traumatic experiences and conflicts

The interviews conducted with the participants in this study expose the suffering and trauma these women experienced in their countries of origin. Of these traumas are conflicts with their families regarding forced marriage, with some participants having been married off by their fathers without their consent. Other participants reveal extensive suffering and abuse at the hands of their in-laws, or excision³ or rejection because of an inter-ethnic marriage. Finally, domestic violence compounded all these women's other sources of suffering.

My husband and his father didn't like me because I'm Senegalese. I'm also not excised; and for their family, excision is a must. You can't marry a woman who hasn't been excised. (Dyad 5)

Faced with such suffering, domestic violence and abuse, all the participants considered divorce. However, none could get family approval to divorce because their families believed mothers should withstand any marriage and remain in their households however these marriages or households may be. Thus, our participants experienced a lack of family support that triggered a decision to migrate, despite the difficulties that migration may pose.

I left Algeria because of my family. They didn't want me to divorce. So, I decided to leave. When I spoke with my family, I told them that my husband destroys the house, he hits me, and he hasn't found work. My family said you must endure. (Dyad 2)

Sub-theme two: lack of support from the host country

The analysis of the participants' interviews also reveals issues regarding their expectations of support from their host country, which several participants articulate. These problems made their pregnancy experience stressful and challenged their maternal functions. Participants recall being anxious about losing their child before giving birth or being anxious that their child that would suffer serious impairments or defects at birth.

When I was pregnant, I was only eating once a day. I thought that this was going to harm my baby. Frankly, it was difficult. All I worried about was my child. I worried about losing it before it was born or that, once it was born, it would have health problems and things like that. I felt so much pain and discomfort. I was admitted to the hospital for ten days because I felt so unwell. (Dyad 1)

In addition to the difficulties of adapting to an environment (e.g. social, cultural), without reference points, there was also the precariousness of their socio-economic living conditions. Some of the participants we interviewed faced homeless, serious food insecurity or difficulties accessing health care. Moreover, all these mothers experienced social isolation and feelings of separation from their families.

I have no livelihood. I have no official documents. I don't have anything. It hurts so much. When it becomes too difficult to bear, I call 115.⁴ Today, we sleep here, tomorrow, there. It's very difficult for my children. (Dyad 13)

It is very hard. I feel isolated. I don't have anyone here. I'm alone. (Dyad 1)

Meta-theme: mirror reactions between mother and child

The data collated under this meta-theme shows that the child becomes a symptomatic sounding board for his/her mother's trauma. Indeed, the participants see evidence of their trauma's transmission to their children. They notice the transmission of their sadness resonating in their children. They recognise that when they are sad, their children become silent, cry or are unable to laugh. The anguish suffered by the mothers are seen as exacerbating their children's agitation or stuttering.

When I have problems, I always cry. When I have problems, I cry, and he cries too. He cries. (Silence). (Dyad 3)

I've noticed that when I'm anxious my daughter stutters more. She stays in a corner all the time. You can sense in her that she's not well. And the little one becomes more agitated. I have no doubt that when I don't feel well, they feel it too. (Dyad 6)

The dyads also see their sleep disorders reflected in their children. The children share their mothers' insomnia.

When I think like this, I don't sleep at night, and Baby C and his sister don't sleep either. (Dyad 10)

Meta-theme: protective psychosocial factors for maternal function

This meta-theme examines the protective factors that support maternal function. These forms of protection include support provided by the family, spouse, and/or host country, in addition to other forms of psychosocial reinforcement, such as religion or faith in God.

Sub-theme one: family and/or spousal support

An analysis of the discussion with the mothers reveals that support received from family members, friends and/or the presence of a spouse are all considered protective factors for the migrant mothers and their maternal functions.

I made some girl friends here, and they were the ones who got me through all this. (Dyad 10)

What protected me on the road was my husband and my God. It was my husband who was working hard in Libya so we could get the money to pay for our journey. (Dyad 8)

Sub-theme two: support from the host country

Interviews with the participants further reveal the importance of the support provided by the host country and the social net it provides. The mothers speak of the freedom they feel in France and how this freedom allows them the space “to breath.”

I found many organizations in Paris that really helped me. (Dyad 2)

Here I can breathe a little. I can go out. Back home, I had to ask everyone’s permission to do anything—every member of my husband’s family. Was I just a slave? (Dyad 3)

Despite the difficulties the dyads have encountered in France, access to healthcare, enrolling their children in schools and women’s support groups in the facilities where the dyads reside are all considered sources of protection. Support groups are deemed particularly important to the dyads, as the mothers feel supported and heard by women from many different backgrounds but with shared challenges.

In France, if you are sick, you can go to a hospital. If your child is sick, you can take him to a hospital. A child can go to school. (Dyad 6)

I have met many people here who are in the same circumstances as me. We see each other. We often sit down together to talk. We encourage each other. (Dyad 13)

There’s the women’s workshop, where we meet. Guest speakers come to talk to us, and we all make presentations about our countries. Sometimes a gardening workshop is offered as well. Once, during the summer, they took us to the beach and even to a park. (Dyad 8)

Sub-theme three: support from religion and faith in God

For some of the dyads, religion and faith in God are seen as providing protection and support for them and their children. According to these dyads, their religion and faith are means of resistance and hope.

Since I am a believer, I tell myself that it is God who protects us. Otherwise, it gets complicated. Because we’ve been through very difficult times. We slept in very difficult spaces. I was pregnant with the little one. His sister and I were forced to live outside on some days. I tell myself this is by the grace of God. So, I think it is God who protects us. Otherwise, with the children, it hasn’t been easy. (Dyad 6)

Discussion

The main purpose of this article is to document the experience of traumatised migrant mothers through in-depth, semi-structured interviews using a qualitative and analytical

approach to assess the function of the migratory environment and its role in the transmission of trauma from mother to child. From the analysis of the interviews with these 14 dyads, the lack of support from family and from the host country emerges as the most influential psychosocial factors exacerbating the challenges to these mothers' maternal functions. The difficulties and traumas that these migrant mothers experience then lead to mirror reactions between them and their children who internalise the transmission of their mothers' depressed moods and other instinctual behavioural disorders, such as insomnia.

The interviews also show that our participants have experienced repeated and prolonged potentially traumatic situations or what is described by Josse (2019) (see also Herman, 1992) as "complex trauma." Most of these women are victims of traumatic events such as genital mutilation, rape, forced marriage, domestic violence, the loss of a child or spouse and/or rejection by their families and/or in-laws. Compounded by the lack of support from family, these traumatic experiences cause these women to consider migrating. The decision to migrate is seen by these women as an alternate means for escaping the burden of their traumas, and for fundamentally changing their living conditions and environment.

For our participants, the lack of family support is a form of "negative social support" as described by Guay et al. (2011) that amplifies the painful re-experience of trauma. This conclusion corroborates a study by Fredette et al. (2020) that examines the impact of support and marital interactions on the symptomatology of PTSD.

Among our participants, ruptures with their family result in mothers fending for themselves and feeling alone in the dyadic relationship. Children receive care only from their mother, whereas in these women's cultures of origin, the care of a child after birth is not provided by the mother alone, but by women from the extended family (grandmother, aunt, cousins, etc.). In their countries of origin, family support creates a "cultural cradle" (Moro, 1998) that allows mother to go through the postpartum period with some semblance of serenity.

As some responses by our participants indicate, the absence of family means that mothers often are overwhelmed by painful emotions reactivated by reliving past trauma. In a dyadic relationship without a filter, the child then risks becoming saturated with the overflow of the mother's negative emotions and anxious and depressive affects (Rezzoug et al., 2008). Making the same point, Stern (1985) proposes that this unfiltered transmission of emotional states from mother to child occurs through inter-nodal exchanges through "affective tuning."

Additionally, in situations where the mothers have suffered sexual violence and are abandoned by their families, the child unconsciously becomes a defence strategy—or a kind of shield—that helps the mother avoid facing her traumatic past. It can then be concluded that the failure of families to provide support to mother and child is a factor that exacerbates the maternal challenges experienced by the dyads, which results in the unfiltered, unconscious transmission of negative affects to children linked to pre- and post-migration traumas.

The results of this study also show that the precarious conditions these migrant mothers experience in their host country—remaining undocumented, unemployed, insalubrity conditions in temporary housing facilities, homelessness, etc.—are key factors in the severity of the difficulties they encounter, particularly during their

pregnancies (Gosselin et al., 2016). Indeed, all the mothers in our study express having experienced depressive episodes during their post-migration pregnancies. Isolation from family and sources of support in the host country is then compounded by the loss of reference points and language barriers. These migrant mothers have no pre-existing social network of family or friends in the host country. Moreover, in their countries of origin, their relationships with their own families or in-laws are viewed as having been at best, difficult and at worst, abusive. These conclusions are consistent with the literature on motherhood in migratory contexts and confirms that when motherhood, precarious living conditions, and lack of support intersect, the psychological fragility of these women becomes a major issue for the health and future of the mother–child relationship (Panaccione & Moro, 2014). In short, the quality of the life of migrant mothers in host countries is exceedingly challenged by multiple, concomitant negative factors and events, leading to great difficulties suffered during pre- and post-natal periods, including a deep sense of loneliness and insecurity.

This study's results provide further evidence and a new perspective on the link between the impact of protective psychosocial factors on maternal function and the transmission of trauma from the mother to child. The study also reveals that, despite the negative psychosocial factors that have exacerbated their maternal difficulties, these migrant mothers feel supported by various organisations, women's support groups and new friends in the host country. These networks of support offer spaces for empathy, for the women to be heard, and for finding relief from negative emotions. In these spaces, the mothers feel they can openly emote and express their sadness—all so that they can better interact with their children.

Support provided by the migrant mother's partner/spouse is also considered essential among certain dyads. Our data echoes a study by Fredette et al. (2016) that shows that an intimate partner generally is considered the most important source of support for people with PTSD. However, for our participants, spousal support is not considered as important as the support they wish they had from their own families, particularly from their own mothers who were absent during their pre- and post-partum periods. In fact, several of the migrant mothers express that the absence of their mothers led to deep feelings of emptiness in their postpartum periods. Nevertheless, the presence of the child's father does provide a protective physical presence and contributes to more functional mother and child interactions and exchanges of emotions.

Finally, the other psychosocial factor considered as protective for some of the migrant mothers is their religion and faith in God. In line with the integrative paradigm of the psychology of religion and spirituality, some experts acknowledge that religion and spirituality function as a complex and multifaceted way to better cope with life's stressors (Gall & Guirguis-Younger, 2013). In our study, seeking solace in religion and in God are seen as factors that support the resilience of the migrant mothers in facing their psychological suffering and thus, contribute to more balanced and functional mother–child interaction.

Conclusion

The findings of this qualitative study on migrant mothers in France paves the way for more clinical reflection on the psychosocial factors involved in the transmission of

trauma-related distress from mother to child in post-migration context. Indeed, our study confirms that the environment plays a regulatory role for mother–child interactions in the process of transmission of psychological trauma (Dozio et al., 2019). Admittedly, the transferability of this study’s data and findings must consider the characteristics of our sample. In this study, the participants were recruited from a list of patients under the out-patient care of a psychiatry department. Hence, our findings are specific to migrant women who can access psychiatric services and support. It also should be noted that the host country in this context is France. Therefore, caution is required in transposing these results to other host countries, particularly non-Western countries where mental healthcare and other health services may not be readily available or accessible. However, and in line with the principles of the IPA, these findings provide an in-depth understanding of our participants’ perceptions of their lived experiences. These findings allow us to reflect on steps that can be implemented in host countries to support migrant mothers, and to help them better integrate and protect themselves and their children. The results also make it possible to recommend a psycho-affective therapeutic setting for persons in the mothers’ immediate environment.

Finally, our study recommends certain preventative measures that can be implemented that may minimise the transmission of trauma from the mother to the child in migration contexts. These measures include providing proactive community networks, which offer support and support groups in maternity wards and temporary resettlement and housing facilities for migrant women, and other forms of follow-up support for migrant mothers after they give birth so that they may functionally interact with and try to rebuild a “cultural cradle” for their children (Moro, 2010).

Notes

1. OFPRA is the French Office for the Protection of Refugees and Stateless Persons.
2. National Court for Asylum Rights.
3. Excision is genital mutilation practiced by some traditional communities on adolescent girls and young women. It consists of a ritual ablation of the clitoris and sometimes of the labia minora.
4. This is a call centre in France that people or families facing difficulties can reach out to regarding issues such as lack of housing or domestic violence. Social workers at this call centre listen, evaluate the situation and propose possible solutions.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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