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Feelings and emotions of mothers of preterm babies at a neonatal intensive care unit

Sentimentos e emoções de mães de prematuros de uma unidade de terapia intensiva neonatal

Sentimientos y emociones de madres de hijos prematuros de una unidad de cuidados intensivos neonatales

ABSTRACT

Purpose: To unveil the feelings and emotions of mothers of a premature child admitted to the Neonatal Intensive Care Unit to understand the meaning of this experience. **Method:** A qualitative study under Heidegger's phenomenological perspective. The study subjects were seven women who experienced being a mother of a child hospitalized in a Neonatal Intensive Care Unit. **Results:** Their speeches were analyzed through three analytical categories: dream of being a mother at risk and the feeling of frustration and guilt; ambivalent feelings in the postpartum period and the experience of suffering due to the fragile condition of the child; and the redefinition of the experience and the feeling of hope and faith. **Conclusion:** There was an affective ambivalence of mothers' feelings and emotions. The mothers' experiences were marked by the dream of being a mother at risk as well as the re-signification of this suffering built by expectations around recovery.

Descriptors: Mothers; Infant; Premature; Mother-Child Relations; Intensive Care Units; Nursing.

RESUMO

Objetivo: Desvelar os sentimentos e emoções das mães que se deparam com filho prematuro internado na Unidade de Terapia Intensiva Neonatal, para compreender o sentido dessa vivência. **Método:** Estudo qualitativo sob a perspectiva fenomenológica fundamentada em Heidegger. Os sujeitos do estudo foram sete mães que experenciaram o ser mãe de uma criança hospitalizada, em Unidade de Terapia Intensiva Neonatal. **Resultados**: Os discursos foram analisados, por meio de três categorias analíticas: sonho de ser mãe em risco e o sentimento de frustração e culpa, sentimentos ambivalentes no pós-parto e a vivência de sofrimento pela condição de fragilidade do filho e a ressignificação da experiência e o sentimento de esperança e fé. **Conclusão:** Houve ambivalência afetiva de sentimentos e emoções das mães. O vivido das mães foram marcados por experiências, cujo sentido se expressaram pelo sonho de ser mãe em risco até à ressignificação desse sofrimento construído pelas expectativas em torno da recuperação.

Descritores: Mães; Recém-Nascido Prematuro; Relações Mãe-Filho; Unidades de Terapia Intensiva; Enfermagem.

RESUMEN

Objetivo: Revelar los sentimientos y emociones de las madres que se enfrentan a un niño prematuro ingresado en la Unidad de Cuidados Intensivos Neonatales para comprender el significado de esta experiencia. **Método:** Estudio cualitativo bajo la perspectiva fenomenológica basado en Heidegger. Los sujetos del estudio fueron siete madres que vivieron la experiencia de ser madres de un niño hospitalizado en una Unidad de Cuidados Intensivos Neonatales. **Resultados:** Los discursos se analizaron a través de tres categorías analíticas: el sueño de ser madre en riesgo y el sentimiento de frustración y culpa, los sentimientos ambivalentes en el posparto y la vivencia del sufrimiento por la frágil condición del niño y la redefinición de la experiencia y el sentimiento de esperanza y fe. **Conclusión:** Hubo ambivalencia afectiva de los sentimientos y emociones de las madres. La vida de las madres estuvo marcada por experiencias cuyo significado fue expresado por el sueño de ser madre en riesgo hasta la resignificación de este sufrimiento construido por expectativas en torno a la recuperación.

Descriptores: Madres; Recien Nacido Prematuro; Relaciones Madre-Hijo; Unidades de Cuidados Intensivos; Enfermería.

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INTRODUCTION

The birth of premature newborn causes a series of concerns for the mother and family. There is an interruption in the expected pregnancy-puerperal course and changes in the processes of construction of motherhood, imposing anticipation in becoming a mother. The anticipation of birth and the sudden separation from the baby often cause stress for mothers. As a result of prematurity, there is deprivation of parental care and concern about the baby's survival and hospitalization. In this sense, there is a state of crisis for parents and family members and also for professionals who deal with this context[1].

Brazil is one of the countries with the highest rates of prematurity. Approximately 12% of births occur before 37 weeks of gestation. Prematurity and complications resulting from this phenomenon are revealed as serious public health problems. There are several maternal factors associated with this condition[2].

Prematurity is directly associated with the demand for hospitalization in Neonatal Intensive Care Units (NICU) resulting from the expected complications and health problems. The repercussions of this situation directly influence the interaction between parents and their babies, being a period of anguish. The procedures that babies are submitted hinder the parents to provide care[3].

There is a necessary leave to guarantee the baby's life. However, it disorganizes the interpersonal dynamics of the mother-infant binomial, which can compromise the construction of the bond. This context can generate ambivalent maternal feelings in the postpartum period[4].

The relationship established between the mother and the health team, specifically the nursing team that stays with the newborn all the time, influences the woman's experience with her baby, a fact that highlights the importance of reflecting on interpersonal relationships in a NICU. In the condition of accompanying the mother of the child, the woman is subjected to the hospital routine and away from her family and social life to prioritize care for the hospitalized child[5].

It is important to highlight that the multidisciplinary team that takes care of premature infants has an important role in the emotional support to be offered to parents. They contribute to making the environment welcoming, and they must offer support and provide the necessary information. Several care strategies have been used to help parents deal with their various feelings due to their child's prematurity conditions, such as facilitating their access to support networks and including them in the baby's care, providing consistent clinical information, encouraging skin-to-skin contact, and the participation in support groups[6].

Since pregnancy, there are expectations that parents build for the baby's birth. At first, we have an imaginary baby built at the expense of the image that the parents formulate in the baby, being conscious and realistic fantasies of the parents. This baby, little by little, is invested with desire. However, it will later be confronted with the baby of reality. With childbirth, what you have is the real baby that is different from the imagined and idealized baby that was fantasized about during pregnancy. In the case of premature infants, this real baby is different from the idealized one, it is in a situation of intense fragility. This reality ends up producing different feelings and emotions in the parents and, mainly, in the mothers of premature babies[7].

Feelings are stable affective states and configurations. Concerning emotions, they are more attenuated in their intensity and less reactive to transient stimuli. They are commonly associated with intellectual content, values, representations and, in general, do not imply somatic components. They are much more a mental than a somatic phenomenon. Emotions are acute, momentary affective reactions, triggered by significant stimuli. Thus, it is an intense affective state, of short duration, generally originating as the individual's reaction to certain internal or external excitations, conscious or unconscious. They may be accompanied by somatic reactions[8].

We believe that nurses need to understand the emotional reactions expressed through the feelings and emotions of mothers, as well as their repercussions so that it is possible to implement their care, based on this reality. From this perspective, this research was built to produce an understanding of the unique experiences of the mothers of premature children. Thus, this study aimed to unveil the feelings and emotions of mothers who face their premature child admitted to the NICU to understand the meaning of this experience.

METHODS

This is a qualitative and descriptive study based on theoretical, philosophical, and phenomenological methodological references. This reference seeks to know the essence of the phenomenon as it is presented. Etymologically, phenomenology is the science of phenomena. By seeking to make, appear and show, it allows capturing human experiences in their existential content. Through phenomenology and adopting Heidegger's hermeneutics, the phenomenon is shown in its language, so that the hidden meaning in its description is unveiled through understanding[9].

The study setting was the NICU of the University Hospital Clemente de Farias, of the State University of Montes Claros (Unimontes) in the city of Montes Claros-MG. The service has 20 beds (10 for intensive care and 10 for intermediate treatment).

To unveil the mothers' feelings and emotions and to understand the meaning of living with a premature child admitted to the NICU, we performed four steps. In the first stage, there was an approach to research participants in the NICU. There, they were invited and informed about the study and its objectives, as well as the guarantee of anonymity and confidentiality. After accepting to participate in the research, they signed the Informed Consent Term, complying with the ethical recommendations in research.

In the second stage, we applied a descriptive questionnaire to obtain the profile of the mothers in the study. Thus, we collected the following information: age of the mothers, average period of gestation, average number of children of mothers, origin, and marital status. In the third stage, the interviews were carried out, individually, in a reserved space within the NICU. This moment consisted of establishing a bond and dialogue, creating an adequate environment for the mothers to talk about the phenomenon, aiming to extract their understanding through the speech. Through phenomenology, it is possible to have access to reality based on what makes sense to the subject who lives the experience. The researcher questions the subject who is accessed by answering freely.

Then, we conducted open and semi-structured interviews, audio-recorded and guided by the following open question: "What feelings and emotions did you have when you learned that your child was a premature newborn who would have to stay in the NICU after childbirth?"

During the interviews, we carefully observed the mothers' non-verbal communication, body language, and gestures, or other manifestations that were recorded in a field diary.

The question was established and the mothers were able to freely express their experiences. The interviews were closed after their saturation. The sample was defined by theoretical saturation. Thus, once the lines began to suffer redundancy, not bringing new data to the object in question, the study sample was defined[10]. Subsequently, the speeches were transcribed in full.

Data collection was carried out in the third quarter of 2017. The study population consisted of seven mothers who had premature newborns hospitalized in the NICU during the period of data collection. The inclusion criteria were: being mothers of babies with a gestational age of fewer than 37 weeks and with a hospital stay of 48 hours or more, being over 18 years old. They were in clinical condition to answer the questions and accepted, freely and spontaneously, to participate in the research.

To achieve the research objectives, the phenomenological reference allowed an approximation to the essence of being a mother of a premature child admitted to the NICU, after birth. Thus, we could extract their feelings and emotions through the lived experience. In the fourth stage, the extracted speeches were read and reread, being identified in similar units and grouped were composed in three categories of analysis. The mothers were represented by the letter I (from interviewees) and the Arabic numerals determined a sequence code, assigned by the researchers, guaranteeing the anonymity of the women, assuring them of the secrecy of their identities.

The study was previously approved by the Research Ethics Committee of Soebras, under opinion nº 633.361 and CAAE 46644815.1.0000.5141.

RESULTS AND DISCUSSION

Seven mothers with a mean age of 29.1 years were interviewed. The average duration of pregnancy was 29 weeks. The average number of children of mothers was 1.85, and of these, 2 mothers live in a city other than the NICU city.

There was a predominance of postpartum women with marital status, married or in a stable relationship, as opposed to single women. In one of the interviewed mothers, prematurity recurred. Her first child was premature and she had a second pregnancy with premature twins that died.

We observed that with an average of 29 weeks of gestation, most newborns were in a situation of moderate prematurity (28 to 31 weeks). This finding is worrisome since the more pronounced the prematurity, the greater the risks to extrauterine life, due to the immaturity of the organs and the high risk of neonatal morbidity and mortality. Two mothers had babies with a gestational age of 27 weeks, that is, in a condition of extreme prematurity (less than 28 weeks). These numbers aggravate preterm births, as neonatal morbidity and mortality are mainly concentrated in extremely preterm infants[4-11].

After reading the speeches, they were grouped into common units and consisted of the construction of three analytical categories.

Dream of being a mother at risk and the feeling of frustration and guilt

O nascimento de um bebê idealizado pelos pais, durante a gravidez é um momento de realização. Há toda uma reestruturação familiar, uma renovação de sentimentos, renovação de vida expressa por meio da expectativa de ter o bebê. A gravidez, no entanto, pode trazer consigo sentimentos e emoções contraditórios, conforme o curso que se desenvolve. Nesse sentido, a sensação de alegria ou de preocupação pode existir. A notícia da prematuridade e sua ocorrência podem fazer emergir emoções e sentimentos diversos[12].

The birth of a baby idealized by the parents during pregnancy is a moment of fulfillment. There is a whole family restructuring, a renewal of feelings, a renewal of life expressed through the expectation of having the baby. Pregnancy, however, can bring with it contradictory feelings and emotions, depending on the course that develops. In this sense, the feeling of joy or worry can exist. The news of prematurity and its occurrence can bring out different emotions and feelings(12).

A facticidade se refere ao fato do ser humano estar no mundo à mercê dos contextos da vida cotidiana, mesmo não tendo participado dessas decisões. O mundo aqui é constituído pelos aspectos históricos, sociais e econômicos nos quais os sujeitos estão imersos, o que ultrapassa seu aspecto geográfico[9].

Facticity refers to the fact that human beings are in the world at the mercy of everyday life contexts, even though they did not participate in these decisions. The world here is constituted by the historical, social, and economic aspects in which the subjects are immersed, which goes beyond its geographical aspect(9).

Antes do nascimento do bebê, a informação sobre a antecipação do parto e prematuridade produziu nas mães a vivência de possibilidade do sonho de ser mãe estar em risco, o que resultou na sensação antecipada de fracasso:

Before the baby's birth, the information about the anticipation of childbirth and prematurity produced in the mothers the experience of the possibility of the dream of being a mother to be at risk, which resulted in the anticipated feeling of failure:

> "É uma sensação horrível, esse é o maior sonho de uma mulher, de ser mãe. Me sinto frustrada [...]" (E_1).

> "Fiquei um pouco desnorteada por ser meu primeiro filho, sabia que podia ser prematuro, que poderia correr risco. Não sei mais se serei mãe [...]" (E_3).

> "It's a horrible feeling, this is a woman's greatest dream, to be a mother. I feel frustrated [...]" (E1).

> "I was a little confused because I was my first child, I knew I could be premature, that I could be at risk. I no longer know if I'll be a mother [...]" (E3).

Ser mãe é uma experiência intensa. Na prematuridade, a expectativa e alegria para dar amor e carinho ao filho foi substituída pelo sentimento de frustração. Nesse sentido, conforme as falas revelam é evidente a experimentação de sensações horríveis e desagradáveis, assim como a impressão de estarem desnorteadas perante o inesperado dessa condição. As preocupações com a saúde e o futuro do bebê passam a coexistir fazendo as mulheres questionarem se o sonho de ser mãe é algo que está em risco naquele momento.

Being a mother is an intense experience. In prematurity, the expectation and joy to give love and affection to the child were replaced by a feeling of frustration. In this sense, as the speeches reveal, the experience of horrible and unpleasant sensations is evident, as well as the

impression of being bewildered by the unexpectedness of this condition. Concerns about the baby's health and future start to coexist, making women question whether the dream of being a mother is something that is at risk at that moment.

Essa interrupção inesperada sobre ser mãe, enquanto um processo de subjetivação,contraria a experiência antecipada de idealização nas trajetórias das mães que se viam capazes para o exercício da maternagem. Esse percalço no processo natural, somado à internação do filho e às particularidades do funcionamento hospitalar incide sobre as mães, produzindo a necessidade das mesmas reterritorializarem suas expectativas quanto ao ser mãe. Agora, sob condições inesperadas[13].

This unexpected interruption about being a mother, as a process of subjectivation, contradicts the anticipated experience of idealization in the trajectories of mothers who saw themselves capable of exercising mothering. This mishap in the natural process added to the hospitalization of the child and the particularities of hospital operation, affects the mothers, producing the need for them to reterritorialize their expectations about being a mother. Now, under unexpected conditions(13).

A hospitalização do filho recém-nascido, redimensiona os sonhos produzidos durante a gravidez. A frustração emerge como sentimento comum nas mães que agora procuram respostas para justificar essa situação. Comumente se sentem culpadas pela situação. O sentimento de culpa é comum em situações da vida que não se realizam do jeito imaginado pelo indivíduo. É uma frustração criada pelo confronto da realidade com o que imaginamos ser o correto. Sendo então um confronto das expectativas humanas com a realidade[13].

The hospitalization of the newborn child resizes the dreams produced during pregnancy. Frustration emerges as a common feeling in mothers who are now looking for answers to justify this situation. They commonly feel guilty about the situation. The feeling of guilt is common in life situations that do not take place in the way imagined by the individual. It is a frustration created by the confrontation of reality with what we imagine to be right. Therefore, it is a confrontation of human expectations with reality(13).

As falas, a seguir expressam as vicissitudes vivenciadas pelas mães ao se depararem com a experiência de ter um filho que não se encontra na situação desejada. Implicitamente verificou-se a presença do sentimento de culpa manifesto pelos gestos, falas das mães que expressam sua responsabilidade por estas condições:

The statements below express the vicissitudes experienced by mothers when faced with the experience of having a child who is not in the desired situation. Implicitly, there was the presence of the feeling of guilt manifested by the gestures, speeches by the mothers who express their responsibility for these conditions:

"Vejo ele só de longe, ele fica sem mamar. Não sei onde errei [...]" (E_2).

"Fico sem saber o que poder fazer. O que poderia ter feito pra não ter sido assim [...]" (E_3).

"Meu filho teve que ficar no oxigênio, teve rejeição ao leite [...]" (E_6).

"Nasceu com anemia, meu primeiro filho foi de 07 meses, o segundo de 06 meses era um casal de gêmeos [...]" (E_7).

"I only see him from afar, he doesn't breastfeed. I don't know where I went wrong [...]" (E2).

"I don't know what to do. What could I have done not to have been like that [...]" (E3).

"My son had to stay on oxygen, he had rejection of milk [...]" (E6).

"I was born with anemia, my first child was 07 months old, the second, 06 months old, was a couple of twins [...]" (E7).

Psiquicamente, a mãe tende a se culpar por qualquer intercorrência, doença e pela prematuridade de seus bebês. A culpa evoca um questionamento sobre os cuidados com a gestação, se fez adequadamente o pré-natal. Também costuma estar presente quando o bebê nasce com alguma anormalidade física. Há por trás do sentimento de culpa um medo intenso de perder o filho e a culpa seria a antecipação de um julgamento que poderia existir, posteriormente[14].

Psychically, the mother tends to blame herself for any complications, illnesses, and the prematurity of her babies. Guilt evokes a questioning about the care with the pregnancy if the prenatal care was properly done. It is also usually present when the baby is born with some physical abnormality. Behind the feeling of guilt, there is an intense fear of losing the child and the

guilt would be the anticipation of a judgment that could exist later(14).

O sentimento de culpa pode ser analisado como consequência e necessidade humana de buscar explicações racionais para a prematuridade dos filhos. Seja consciente ou inconscientemente, os pais se culpam por ter um filho prematuro[15].

The feeling of guilt can be analyzed as a consequence of and human need to seek rational explanations for the prematurity of children. Whether consciously or unconsciously, parents blame themselves for having a premature child(15).

Destaca-se que o sonho de ser mãe colocado em risco é capaz de produzir o sentimento de frustração e culpa como resultante do confronto entre realidade imaginada e desejada e as experiências reais vividas pelas mães. Considerando-se essa realidade frustrante, é preciso que o enfermeiro desenvolva um cuidado de enfermagem que seja capaz de acolher essa experiência. Esse acolhimento legitima a possibilidade de uma assistência que inclua em seus fazeres a dimensão psicossocial. Ao acolher as mães e suas experiências, o enfermeiro deve buscar um equilíbrio entre o que é vivido por elas e a realidade imposta aos seus sonhos com o filho[8].

It is noteworthy that the dream of being a mother placed at risk is capable of producing the feeling of frustration and guilt as a result of the confrontation between the imagined and desired reality and the real experiences lived by the mothers. Considering this frustrating reality, nurses must develop nursing care that can accommodate this experience. This embracement legitimizes the possibility of assistance that includes the psychosocial dimension in their actions. When welcoming mothers and their experiences, nurses must seek a balance between what they experience and the reality imposed on their dreams with the child(8).

Ambivalent feelings in the postpartum period and the experience of suffering due to the fragile condition of the child

The study showed that mothers experienced ambivalent feelings and emotions with the birth of premature children and their hospitalization in the NICU. Suffering is a result of experiencing the child's frail condition.

"It's a horrible feeling, it's a mixture of feelings and a lot of suffering [...]" (I4).

"We want him to be born and take him home, I was happy with the news that he survived, but he's been in the ICU for a long time and that makes me sad, anxious and with very bad self-esteem, with no desire for anything. I'm afraid he can't stand it [...]" (I7).

"It's difficult to control the emotion, while I'm happy for his life, I'm afraid of losing him [...]" (I5).

The joy for the child's life, in prematurity and consequent hospitalization, brought fear, apprehension, anguish, and anxiety. The feeling of loss, breaking the family bond, and sadness, added to low self-esteem, cause suffering to mothers.

If, inexorably, there is a feeling of joy for the child's life and birth, paradoxically the feelings and emotions that express impotence, sadness, anxiety, emptiness, fear, low self-esteem, feeling of loss of the child's fragility emerge[12,16- 17].

The mother, as part of the binomial established with her child, will find the experience of anxiety in the context of prematurity. In an ambivalent way, while she feels relieved about her health and about being discharged, she suffers from apprehension about the future of her child, who will remain hospitalized and at risk of death [18-19].

The particularities involving the work of the NICUs, the experience of invasive procedures, the complexity of the procedures end up producing feelings of fear, apprehension, and anxiety in mothers. The feelings of apprehension/emptiness and anxiety experienced by mothers of premature babies result from fear of losing their children. Hospitalization is a difficult situation in any clinical condition. Family members are invited to live in an environment with pain, death, and anguish[18].

The possibility of the baby living or not imposes intense suffering on the mother that can contribute to her emotional imbalance, which can be manifested through various symptoms, such as anxiety[13].

"I'm having an emptiness, for not having my son in my arms [...]" (I1).

"I'm afraid of losing, I'm anxious every day, I don't know what news I'll get, I don't sleep well, I'm afraid the phone will ring and I get bad news [...]" (I2).

"One day there is good news, the other day there is bad news, I don't know what to do [...]" (I3).

"The worst feeling is when I enter her room and see her crib empty [...]" (E4).

"I get distressed for every day that goes by without knowing what news I receive [...]" (I5).

The ICU environment is frightening, especially for those who are unaware of and unaccustomed to their routine[5].

"My son had to stay on oxygen, two months in the ICU. It was scary [...]"(I6).

Fear, expressed in the mothers' statements, is associated with the possibility of the child's non-survival. Anguish, largely expressed in the state of continuous anxiety, is very common and results from the experience of waiting for news that reveals the baby's clinical condition and evolution[20]. At this point, it is up to the team to clarify the family members so that this feeling and emotion can have some calming[13].

The moment of the mother's hospital discharge, without her child in her arms, is a moment of the strong breaking of the mother-child bond. This moment is experienced with great difficulty and suffering for mothers and their families. Mothers experience with this rupture the feeling of loss.

The feeling of loss can be unconsciously generated and means, to a lesser or greater degree, a risk of death[21]. This imminent loss plagues mothers who are discharged from the hospital without their children in their arms:

"It's as if I had ripped him from me, it's a feeling that can't be explained [...]" (I1).

"I'm afraid of losing [...] I'm afraid of losing my hospitalized child [...]" (I2).

"It seems like a loss, sadness, my arms felt empty because I already imagined having her constantly after I was discharged from the hospital [...]" (I4).

"It's difficult to control the emotion, I'm afraid of losing him [...]" (E5).

The feeling of losing the child was very common among mothers in the first days of their children's hospitalization in the NICU. It can be explained by the interruption of the dream of motherhood and of being with the idealized child. Another explanation would be the impossibility of performing her maternal role, due to the distances established with hospitalization[13].

Under ideal conditions, the mother can establish a symbiotic relationship with the baby, having a biological preparation to receive him and uniquely adapt to his needs. She can develop a state of primary maternal concern, which allows the baby conditions for his psychic development[3].

In an existing family, the expectation created with the arrival of a baby generates a feeling of joy in the development of the pregnancy. However, the mother, when returning home with empty arms, disorganizes, even for a while, the family bond. In addition to the feeling of loss, the mother experiences the suffering resulting from the break with the family bond[22].

The affective relationship, denied to the baby in the first days, if not months of his life, represses the family, and especially in the newborn, the immediate and relevant opportunity for affective contact.

The mother, as the parent of the family, has in her figure the image of a caregiver, both for the children and also for the husband. The child's hospitalization and change in the mother's routine end up providing a break in the family bond, not only for the newborn but also for the rest of the family:

"I thought I wasn't going to go back without my son, I only took my son once [...], I only see him from afar, he doesn't breastfeed [...]" (I2).

"A month ago, tomorrow, I never took him. I'm far from my husband [...]"(I3).

"The feeling is worse when I enter her room and see her crib empty [...]" (I4).

"Since the day I couldn't take my son, it's been a harrowing day [...]" (I5).

"I saw my son after eight days [...]" (I6).

"We want to be born and take it home, he spent a long time in the ICU, intubated on oxygen. I am far from the family. [...]" (I7).

The total distance from the family is expressed in the following statements:

"I live in Buritizeiro, I had a son in Pirapora and he sent my son here to undergo surgery [...], I stay in the support house because I live in another city, I have three children aged 10 years, 8 years and 4 years (mother cried) [...]" (I2).

"I'm from São Francisco and I stay at the support house [...] my husband and children miss me, but he had to stay to work [...]" (I6).

The mother's felt absence, both by the children and by the spouse, is a factor of suffering and emotional change in the entire family circle. In addition, for the family of a premature baby, it is very difficult not only to establish but also to maintain the bond with the child[23].

The loss in the establishment of bonds and attachment with the premature infant can harm

the baby's development, and generate disorders in the future relationship of the premature infant with his family[24].

The feeling of sadness was one of the two feelings shown by all the mothers interviewed:

"Because I deal every day with this sadness" (I1).

"Very bad, bad, really bad, shaken, sad [...]" (I2).

"It's been a month tomorrow (sadness), I come every day [...]" (I3).

"It's a mixture of feelings, it seems like a loss, sadness [...]" (I4).

"It's difficult to control the emotion (crying) [...]" (I5).

"I was very sad, we want him to be born and take it home [...]" (I7).

Sadness reiterates the result of a series of emotions and feelings experienced by the mother, such as the child's fragility, the suffering due to separation, the common clinical complications. Also, the situation to which they are exposed, being tiring experiences, produce suffering[24].

Sadness can also be related to feelings of distress, fear, guilt, insecurity, and powerlessness. The desire to be close to the child and the impossibility of this happening, in various contexts, also produces suffering[15].

Along with the experience of sadness, it is common for women to experience feelings of low self-esteem. The mother with her baby in her arms is the imaginary figure that every family hopes to see fulfilled when a woman goes into labor. In the impossibility of this act to materialize, at that moment, it produces in the woman the compromise of her self-esteem and suffering.

"Fico sem saber o que poder fazer [...]" (E_3).

"It's a horrible feeling, this is a woman's greatest dream, to be a mother. It's a lot of suffering [...]" (I1).

"I don't know what to do [...]" (I3).

"It's a horrible feeling, it's a mixture of feelings and a lot of suffering [...]" (I4).

"The uterus and the tubes had to be removed [...]" (I6).

There was a report of the need for psychological support given the emotional commitment manifested by one of the mothers:

"I was hospitalized, I had to go through a psychologist [...], I was unwell, psychologically shaken [...]" (I6).

From this perspective, nursing care in the NICU is essential to accommodate the suffering and repercussions of the feelings and emotions that afflict them. In the same direction, the creation of support strategies and referrals to professionals when necessary. [25]

We noticed that the nurse represents a figure of care that can contribute to the control of fear, anxieties, suffering, and difficulties experienced by mothers in the hospitalization of their children in a condition of vulnerability. Functions such as psychosocial support, comfort, embracement, and care given to mothers are necessary to alleviate their suffering. The proximity of nursing and its direct care are strategic conditions to ensure an adequate reception and development of an expanded clinic that considers the unique experiences of mothers, ensuring quality nursing care[25].

The redefinition of experience and the Feeling of Hope and Faith

Despite the feelings of fear, anguish, apprehension, sadness, and suffering that have been recurrent, in the mothers' experiences with prematurity and hospitalization in the NICU, the mothers revealed to seek in spirituality the primordial way to face and live better with the condition in their existence.

Hope for the child's recovery can be expressed through a belief in some religious figure. References to faith and religiosity are strategies and inventions constructed by mothers of premature babies to deal with suffering and the feeling of loss[15].

The feelings of hope and faith are explicit in the following statements:

"I saw my son after eight days, I felt bad, it was God, it was a miracle to see him improve [...]" (I6).

"But soon I will be with her, living a normal life. I believe in God and his healing power [...] "(I4).

Positive feelings usually arise after a certain period of hospitalization, according to the mothers' statements. Instead of suffering, over time, mothers begin to experience hope for their children's recovery.

The understanding of the NICU as a care space that aims to recover lives is necessary for the emergence of these feelings in mothers. The emergence of these positive feelings favors closer

bonds with the children and trust with service professionals[15].

In this sense, religiosity and the expression of faith have been highlighted as one of the most positive solutions found by them when confronted with situations that involve illnesses and situations of emotional suffering. Regardless of the religious belief, spirituality emerges as an important factor for reframing the suffering experiences of family members, especially mothers[23].

Religiosity and spirituality can represent a positive dimension for coping with suffering, producing relief and comfort for mothers. Thus, nurses must consider this influence as an element of their care and favor the possibility of creating coping strategies with relief production[23].

In the dimension of care, nursing is concerned with the holistic aspects that involve its performance. When caring for premature newborns, it is necessary to transcend the individual and welcome mothers or their family members. Subverting the concept of health that is no longer the absence of disease, it is possible to consider the person as a whole. From this perspective, in addition to welcoming mothers, we should consider their psychological, social, and spiritual aspects. Recognizing religiosity and spirituality as ways of appeasing human suffering, it is essential to consider this basic human need as a component of nursing care[13].

FINALS CONSIDERATIONS

With this study, we could unveil the feelings and emotions of mothers who came across their premature child hospitalized in the Neonatal Intensive Care Unit and understand the meaning of this experience.

The interruption of the imagined and idealized universe of mothers gives rise to an explosion of negative feelings and emotions. At first, mothers experience the sensation of having their dream of being a mother at risk fulfilled, justified by the risk of the baby's death. Added to this, the feeling of frustration and guilt arises as to the mother's attempt to find a justification for this reality.

The universe of hospitalization and all the changes produced by the child's hospitalization end up producing ambivalent feelings and emotions in the postpartum period and the experience of suffering due to the child's fragility. The negative feelings of anguish, sadness, fear, apprehension, anxiety, loss, breaking the family bond, and low self-esteem translate, at this moment, into the world of uncertainty and the powerless position assumed by mothers in the face of an uncertain future.

However, as the days went by, positive feelings emerged as a way of reframing this experience of suffering. Grounded in religiosity and spirituality, feelings of hope and faith demonstrate the possibility of emotional calming of negative experiences. At that moment, being a mother, negative feelings give way to expectations for the recovery of their children and the future.

Thus, in this study, there is an important reflection on the forms of care that nurses and health professionals should implement when approaching mothers of premature newborns admitted to the NICU. Mothers also need to be welcomed, listened to, and cared for to prevent their illness and encourage them to participate in the care of their children and also take care of themselves.

Thus, the importance of thinking about programs that can provide comprehensive care to mothers emerges. Studies are needed to analyze the support strategies implemented for mothers of newborns admitted to the NICU.

We expect that this study can contribute and produce reflections on nursing care, so that professionals develop expanded care, recognizing the expectations and needs of mothers of newborns admitted to the NICU. As a limitation of the study, we highlight that it does not exhaust the theme. Thus, there is a need to carry out further studies to deepen the theme to favor the discovery of strategies that help to improve nursing care.

REFERENCES

1 - Pinto MJC, Oliveira MS. Estresse e espiritualidade de mães de bebês prematuros. Rev Psicol Divers Saúde. 2019;8(3):317-32. DOI: 10.17267/2317-3394rpds.v8i3.2437

2 - Oliveira LL, Gonçalves AC, Costa JSD, Bonilha ALL. Maternal and neonatal factors related to prematurity. Rev Esc Enferm USP 2016;50(3):382-9. DOI: 10.1590/S0080-623420160000400002

3 - Baseggio DB, Dias MPS, Brusque SR, Donelli TMS, Mendes P. Vivências de mães e bebês

prematuros durante a internação neonatal. Temas Psicol. 2017;25(1):153-67. DOI: 10.9788/TP2017.1-10

4 - Luz LS, Minamisava R, Scochi CGS, Salge AKM, Ribeiro LM, Castral TC. Predictive factors of the interruption of exclusive breastfeeding in premature infants: A prospective cohort. Rev Bras Enferm. 2018;71(6):2876-82. DOI: 10.1590/0034-7167-2017-0762

5 - Joaquim RHVT, Wernet M, Leite MA, Fonseca MML, Mello FD. Interações entre mães e bebês prematuros: Enfoque nas necessidades essenciais. Cad Bras Ter Ocup. 2018;26(3): 580-9. DOI: 10.4322/2526-8910.ctoAO1051

6 - Correia LA, Rocha LLB, Dittz ES. Contribuições do grupo de terapia ocupacional no nível de ansiedade das mães com recém-nascidos prematuros internados nas unidades de terapia intensiva neonatal. Cad Bras Ter Ocup. 2019;27(3):574-83. DOI: 10.4322/2526-8910.ctoAO1694

7 - Carvalho LS, Pereira CMC. As reações psicológicas dos pais frente à hospitalização do bebê prematuro na UTI neonatal. Rev SBPH 2017 [citado em 10 out 2020]; 20(2):101-22. Disponível em: http://pepsic.bvsalud.org/pdf/rsbph/v20n2/v20n2a07.pdf

8 - Dalgalarrondo P. Psicopatologia e semiologia dos transtornos mentais. 3a ed. Porto Alegre: Artmed; 2019.

9 - Heidegger M. Ser e tempo. Parte I. 12a ed. São Paulo: Vozes; 2002.

10 - Minayo MCS. Amostragem e saturação em pesquisas qualitativa: Consenso e controvérsias. Revista Pesquisa Qualitativa 2017 [citado em 11 out 2020]; 5(7):1-12. Disponível em: https://edisciplinas.usp.br/pluginfile.php/4111455/mod_resource/content/1/Minayosaturacao.pdf

11 - Oliveira LL, Gonçalves AC, Costa JSD, Bonilha ALL. Fatores maternos e neonatais relacionados à prematuridade. Rev Esc Enferm USP 2016;50(3):382-9. DOI: 10.1590/S0080-623420160000400002

12 - Lelis BDB, Sousa MIM, Faleiros D, Wernet M, Velozo FBA, Moraes AL. Acolhimento materno no contexto da prematuridade. Rev Enferm UFPE 2018 [citado em 12 out 2020]; 12(6):1563-9. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/biblio-981977

13 - Lima LK, Kind L. Processos de subjetivação vivenciados por mães em uma unidade de neonatologia. Psicol Estud. 2014;19(4):575-85. DOI: 10.1590/1413-73722157901

14 - Veronez M, Borghesan NAB, Corrêa DAM, Higarashi IH. Vivência de mães de bebês prematuros do nascimento a alta: notas de diários de campo. Rev Gaúcha Enferm. 2017;38(2):609-11. DOI: 10.1590/1983-1447.2017.02.60911

15 - Frigo J, Zocche AAD, Palavro LG, Turatti AL, Neves TE, Schaefer MT. Percepção de pais de recém-nascidos prematuros em unidade de terapia intensiva neonatal. Rev Enferm UFSM 2015;5(1):58-68. DOI: 10.5902/2179769212900

16 - Silva RMM, Menezes CCS, Cardoso LL, França OFA. Vivências de famílias de neonatos prematuros hospitalizados em unidade de terapia intensiva neonatal: Revisão integrativa. Rev Enferm Cent-Oeste Min. 2016; 6(2):2258-70. DOI: 10.19175/recom.v6i2.940

17 - Lima VF, Mazza VA, Mór LM, Pinto MNGR. Vivência dos familiares de prematuros internados em unidade de terapia intensiva neonatal. Rev Min Enferm. 2017;21(1026):1-8. DOI: 10.5935/1415-2762.20170036

18 - Zani AV, Silva CA, Oliveira GS. Sentimentos dos pais frente ao nascimento do filho prematuro: Revisão integrativa da literatura. Varia Sci. 2015;1(1):50-9. DOI: 10.48075/vscs.v1i1.11909

19 - Nascimento AKS, Santos OMN, Souza NM. Experiência materna no cuidado com o filho prematuro. Rev Interd. 2016 [citado em 14 out 2020]; 9(3):84-95. Disponível em: https://dialnet.unirioja.es/servlet/articulo?codigo=6772007

20 - Melo RA, Araújo AKC, Bezerra CS, Santos NM, Marques WF, Fernandes ECV. Sentimentos de mães de recém-nascidos internados em uma unidade de terapia intensiva neonatal. Id on line Rev Mult Psic. 2016;10(32):89-179. DOI: 10.14295/idonline.v10i32.569

21 - Schaefer MP, Donelli TMS. Psicoterapia mãe-bebê: Uma intervenção no contexto da prematuridade. Contextos Clín. 2017;10(1):33-47. DOI: 10.4013/ctc.2017.101.03

22 - Kegler JJ, Neves TE, Silva MA, Jantsch BL, Bertoldo SC, Silva HJ. Estresse em pais de recém-nascidos em uma Unidade de Terapia Intensiva Neonatal. Esc Anna Nery 2019;23(1):1-6. DOI: 10.1590/2177-9465-ean-2018-0178

23 - Arruda CP, Gomes GC, Juliano LF, Nornberg KO, Oliveira SM, Nicoletti MC. Reações e sentimentos da família frente à internação do recém-nascido na unidade neonatal. Acervo Saúde 2019;11(15):1-9. DOI: 10.25248/reas.e1444.2019

24 - Pego CO, Barros MMA. Unidade de Terapia Intensiva Pediátrica: Expectativas e sentimentos dos pais da criança gravemente enferma. Rev Bras Ciênc Saúde 2017;21(1):11-20. DOI: 10.4034/RBCS.2017.21.01.02

25 - Palmarella Neto M, Silva VGSV, Dutra LP. Percepção de mães de recém-nascidos prematuros sobre o cuidado intensivo neonatal. Id on Line Rev Mult Psic. 2017;11(38):778-90. DOI: 10.14295/idonline.v11i38.928

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