



GESTATIONAL RISKS AND PREMATURE BIRTH: COPING FOR MOTHERHOOD
RISCOS GESTACIONAIS E O NASCIMENTO PREMATURO: ENFRENTAMENTO PARA A
MATERNAGEM
RIESGOS GESTACIONALES Y EL NACIMIENTO PREMATURO: ENFRENTAMIENTO PARA LA
MATERNIDAD

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ABSTRACT

Objective: to understand the experience of motherhood after preterm delivery. **Method:** this is a qualitative, descriptive study with 12 participants, out in a university hospital through Madeleine Leininger's sociocultural questionnaire, the life narrative technique and the instrument to obtain information from the interviewed women's records and their newborns. The analysis was based on the Ethnographic survey. The results were also presented in figure form. **Results:** two analytical categories emerged: Gestational risks and premature birth and The confrontation of maternal premature infant. All women experienced confrontations for motherhood from the gestational period related to preterm birth to the time of hospital discharge. **Conclusion:** the experience of mothering of mothers with preterm infants became a confrontation from the moment of early delivery, which occurred related to biological gestational risks and also associated with individual characteristics and unfavorable sociodemographic conditions. The aim of this research is to contribute to the fact that the period of adaptation, both of the mother who becomes the primary caregiver and of the newborn, who belongs to a family environment, is articulated from the period of hospitalization. **Descriptors:** Maternal and Child Nursing; Neonatal Nursing; Mother-Child Relationships; Premature Newborn; Transcultural Nursing; Nursing Research.

RESUMO

Objetivo: compreender a vivência para a maternagem após o parto prematuro. **Método:** trata-se de estudo qualitativo, descritivo, com 12 participantes, em hospital universitário por meio do questionário sociocultural de Madeleine Leininger, da técnica da narrativa de vida e instrumento para obter informações dos prontuários das entrevistadas e de seus recém-nascidos. Baseou-se a análise na Etnoenfermagem. Apresentaram-se os resultados também em forma de figura. **Resultados:** informa-se que emergiram duas categorias analíticas: Os riscos gestacionais e o nascimento prematuro e O enfrentamento de maternar filho prematuro. Vivenciaram-se, por todas as mulheres, enfrentamentos para a maternagem desde o período gestacional relacionado ao parto prematuro, até o momento da alta hospitalar. **Conclusão:** tornou-se a vivência da maternagem de mães com filhos prematuros um enfrentamento desde o momento do parto antecipado, que ocorreu relacionado aos riscos gestacionais biológicos e também associado às características individuais e condições sociodemográficas desfavoráveis. Intui-se, com esta pesquisa, contribuir para que o período de adaptação, tanto da mãe que se torna cuidadora primária, quanto do recém-nascido, que passa a pertencer a um ambiente familiar, seja articulado desde o período de internação. **Descritores:** Enfermagem Materno-Infantil; Enfermagem Neonatal; Relações Mãe-Filho; Recém-Nascido Prematuro; Enfermagem Transcultural; Pesquisa em Enfermagem.

RESUMEN

Objetivo: comprender la vivencia para la maternidad después del parto prematuro. **Método:** se trata de un estudio cualitativo, descriptivo, con 12 participantes, en un hospital universitario a través del cuestionario sociocultural de Madeleine Leininger, de la técnica de la narrativa de vida e instrumento para obtener informaciones de los prontuarios de las entrevistadas y de sus recién nacidos. Se basó el análisis en la Etnoenfermería. Se presentaron los resultados también en forma de figura. **Resultados:** se informa que emergieron dos categorías analíticas: Los riesgos gestacionales y el nacimiento prematuro y el enfrentamiento de los cuidados maternos al hijo prematuro. Se han vivido, por todas las mujeres, enfrentamientos para la maternidad desde el período gestacional relacionado al parto prematuro, hasta el momento del alta hospitalaria. **Conclusión:** se hizo la vivencia de la maternidad de madres con hijos prematuros un enfrentamiento desde el momento del parto anticipado, que ocurrió relacionado a los riesgos gestacionales biológicos y también asociado a las características individuales y condiciones sociodemográficas desfavorables. En el caso de la madre que se vuelve cuidadora primaria, el recién nacido, que pasa a pertenecer a un ambiente familiar, se articula desde el período de internación. **Descriptor:** Enfermería Materno-infantil; Enfermería Neonatal; Relaciones Madre-Hijo; Recien Nacido Prematuro; Enfermería Transcultural; Investigación en Enfermería.

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INTRODUCTION

This article, by theme, confronts mothering after preterm birth because of gestational risks. Maternity is defined as the set of care provided to the newborn, having positive effects throughout the life, affirming that it has been interest of national and international researches, mainly to understand the importance of the approximation between mother and son and, in especially those who had their first days or months of life hospitalized in the Neonatal Intensive Care Unit.¹⁻²

It is demonstrated by the scientific literature that in the risk pregnancy and in the remoteness of the newborn that goes to the Neonatal Intensive Care Unit, the bond between mother and child may be compromised, making support necessary so that fear and the uncertainties decrease. It collaborates, therefore, by the adequate reception, for the mother to overcome the crisis and to strengthen the desire to take care of the newborn, to breastfeed, to take in the lap, to transmit affection and comfort and to assume the maternity.¹⁻³

This study is relevant for the reflection that mothers of preterm infants constitute a cultural group that must be valued for having particular experiences that give meaning to human expressions, interpretations and social interactions. In this sense, the dynamics of the context of motherhood are inseparable from aspects of behavior (maternal practices) and their representations (cultural and social dimensions).

It is a question of the research, considering that the context of the environment, ways of life and values exert influence on the outcome of the gestation of the women who had their children prematurely and in the maternity³⁻⁴: "In what way is the maternity experience given after the preterm birth?".

In order to answer the questioning, the following objective was constructed: to understand the experience of the mothering of mothers with preterm children.

METHOD

This is a qualitative, descriptive study, based on Etnoenfermagem, which had as its location the follow-up clinic of a university hospital in Rio de Janeiro. Data was collected from January to October 2016 with 12 women. Mothers of infants up to 24 months of age, of both sexes, born premature and who were

hospitalized for a period equal to or greater than seven days in the Neonatal Intensive Care Unit were included. Children living in shelters whose care was dispensed by others were excluded.

For data collection, three instruments were used: the first level of the Sunrise Model applied through the questionnaire on the dimensions of cultural and social structures; the Health Care Life Narrative technique⁴ with a single guiding question: "Tell me about your life and what it relates to the birth and care of your premature child." An instrument was also constructed to obtain information from the records of the interviewees and their newborns.

Ethical criteria were respected, following all the recommendations of Resolution 466/2012 of the National Health Council. The research was submitted to the Research Ethics Committee of the Federal University of the State of Rio de Janeiro with approval under opinion number 109.934 and CAEE 07717612.7.0000.5285. The Free and Informed Consent Form was signed by all participants. Speeches were identified to ensure anonymity, with the letter "P" followed by a numbering, according to the sequence of the interview, for example: P1.

Data was analyzed in the light of the Theory of Diversity and Universality of Cultural Care, Madeleine Leininger.⁴

RESULTS

Table 1 presents the factors related to the economic and educational lifestyles, showing the number of residents living in the same household as the respondent and the child, the number of rooms, the family income, the source of income family, schooling and the reasons that prevented them from continuing their studies.

Table 1. Factors of life, economic and educational. Rio de Janeiro (RJ), Brazil, 2016.

Ident	N of inhabitants	N of rooms	Family Income(R\$)	Source of income	Schooling	Motive of Pause
P1	10	5	1.100	Couple, sister	CHS	Pregnancy
P2	4	3	370	Own	CES	Pregnancy
P3	2	1	470	Own	CES	Work
P4	9	6	1.000	Parents, brother	IHS	Pregnancy
P5	3	3	450	Companion	IES	Option
P6	8	4	880	Mother	IES	Option
P7	5	4	880	Companion	IHS	Pregnancy
P8	8	3	880	Companion	IHS	Pregnancy
P9	6	4	950	Couple	IES	Work
P10	7	4	800	Companion	IHS	Pregnancy
P11	5	6	470	Companion	CHS	Pregnancy
P12	2	3	880	Companion	IHE	Pregnancy

Ident: Identification / Resident's number: Resident's number / Motivation pause: Study pause reason / CHS: Completed High School / CES: Complete Elementary School / IHS: Incomplete High School / IES: Incomplete Elementary School / IHE: Incomplete Higher Education

It is revealed, in relation to economic conditions, that seven of the 12 interviewees depended on the income of other people in the family, be they companions, father, mother or brother; of these, five women refer to raising their children with monthly income below a minimum wage, considering that the minimum wage, at the time of the interview, was R\$ 880.00.

It is described, as regards the living conditions, that women live in houses with one to six rooms, dividing the space with up to ten people, which may favor a daily life marked by conflicts and embarrassing circumstances. It is also worth noting that families are exposed to unhealthy conditions, since eight mothers reported living in poor communities where the houses are joined to

each other, which prevents adequate ventilation and penetration of sunlight, risk factors for diseases respiratory problems in their children.

It is reported that three participants did not complete Elementary School; two mothers have complete Elementary Education; four have incomplete high school; two finished high school and one mother started Higher Education and did not finish. The pregnancy was cited as the main obstacle to the non-continuity of the studies.

Table 2 shows the results of the survey in the charts of the newborns, which obtained data related to maternal obstetric history.

Table 2. Characterization of obstetric data. Rio de Janeiro (RJ), Brazil, 2016.

Identification	Age	OP	Gestational Intercurrence	Childbirth	PN
P1	32	G2P2A0	Premature Amniorrexix	Vag	4
P2	30	G4P3A1	Cytomegalovirus	Vag	1
P3	36	G4P3A1	Eclampsia /Death	Sur	1
P4	18	G2P2A0	ITU	Sur	1
P5	18	G2P2A0	Pre eclampsia / ITU	Sur	1
P6	25	G3P3A0	ITU	Sur	0
P7	32	G2P2A0	Premature Amniorrexix	Vag	1
P8	31	G3P3A0	Digestive bleeding	Sur	3
P9	36	G2P2A0	Gestational AH	Sur	2
P10	27	G2P2A0	Gestational AH	Sur	2
P11	21	G2P2A0	Gestational AH	Sur	0
P12	25	G2P2A0	Premature Amniorrexix	Sur	2

OP /Obstetric priors G: Pregnancy / P: Parity / A: Abortion / Childbirth: Type of birth / Vag: Vaginal / Sur: Surgical / PN: Number of prenatal consultations / ITU: Urinary tract infection / AH: Arterial Hypertension.

It was identified, with these data, that the average age of the women was 27.5 years and that, among them, five had arterial hypertension; four were diagnosed with infection, three of them had urinary tract infection and one with the cytomegalovirus virus; P8 presented hemorrhagic disease; P7 manifested premature amniorrhexis and P12 underwent gastric surgery.

It should be noted that all women had experiences with previous gestation and delivery, but in the current pregnancy, two women had no prenatal visits and 66% had a cesarean delivery.

From the results, two analytical categories were codified: 1) Gestational risks and premature birth; and 2) Cohabitation of maternal premature infant.

◆ Gestational Risks and Premature Birth

This category is justified because of the biological risks, accumulated to the risks related to unfavorable sociodemographic conditions, influence in the premature birth and, consequently, in the maternity, because, besides the premature separation of the mother and the baby, the circumstances of life make the woman insecure to care for a child who was born at a different time. It is therefore fundamental to discuss gestational risks and premature birth to understand the bonding-related mothering and the care of the mother towards the baby.

All women presented a biological or social gestational risk, whether they were related to obstetric disease in the current pregnancy or related to the clinical interurrences, or related to the individual characteristics and unfavorable sociodemographic conditions.

It was reported that, among the two mothers who did not have a prenatal visit, the first one was to discover the pregnancy after being shot and, because of the circumstances of hospitalizations with recurrent surgical procedures, did not perform prenatal care, giving birth to 29 weeks and two days. It was justified, for P11, the non-accompaniment in the prenatal due to the lack of family support during the pregnancy.

I did not know I was pregnant, I took a shot, I was hospitalized and I was pregnant with him, I had surgery, I went through the X-ray room, all the things I could not have done. (P6)

Waiting to be taken care of? My mother said, "It's ... I've had you and I did not even need to consult." I realize it's because she did not want to accompany me. I did not want to stand there waiting alone. (P11)

The deficiency of amparo during pregnancy, sometimes caused by the family

support network, reveals aspects that directly influence the stimulation of the pregnant woman to continue the prenatal follow-up, as described in the following section.

My aunt, when I was pregnant with him, turned to me and said: I'll take you to the clinic to get it and pay. " I was six months pregnant. (P5)

It is added that due to the risks of biological characteristics, P2 prematurely gave birth at 29 weeks and two days; however, unfavorable sociodemographic conditions, characterized by domestic violence and depressive symptoms during pregnancy, linked to pregnancy rejection, may have contributed to the early birth component.

Because I arrived at the hospital, I remember until today when I entered, I came attacked. There was a time when I got angry at being pregnant with him, I said, "I do not want to be pregnant with the son of this guy who wants to kill me. This son wants to take me to the cemetery with him". (P2)

It was also demonstrated by other mothers (P5 and P11), a depressive state during pregnancy. It is noteworthy that these feelings were involved in an unfavorable context linked to the use of licit drugs such as alcohol.

I smoked, I really did, did you? I think I even had her drunk. (P5)

I wanted to kill myself, after pregnancy, I only thought about dying! At the time of delivery? I was calling to die! It was a Sunday, I was drinking, my pressure was already high, I had eclampsia. (P11)

◆ The confrontation of having premature child

Although each preterm birth had different narratives, there were singularities between them, especially when the mothers considered the situation difficult, unknown and distressing, being a delicate moment for the whole family. The uncertainty in the transition from the role of becoming a mother that, instead of a healthy and full-term child, occurs with premature infants and their physiological fragilities.

How could I care? I did not know if I could raise such a fragile child. (P1)

It was a big blow for me, I was very afraid. (P3)

Through the particular experience of prematurity, another sense is expressed in the expression of becoming a mother, as happened with P12. The delivery was marked by procedures to support the life of the newborn, considered by her as frightening, instead of

listening to the cry and having it on her lap, as in full-term birth.

They inhaled in front of me. It was scary! I wanted to take it and I could not give a fondness. (P12)

Anxiety about postpartum separation was also reported for P9, who was able to see the child in the Neonatal Intensive Care Unit after three days. It is reported that for P5, who was in a depressive state, seeing and being close to the child was even more important, because only after this contact was able to develop a mechanism capable of fighting against the will to die.

He was born, they went down with him, later, I did not see him anymore, they would not let me down. I only saw it three days later. (P9)

So, before I saw him, I just wanted to die. That was the bad, I wanted to get, see, feel! (P5)

It was frustrating to enter the technological environment of the Neonatal Intensive Care Unit and the encounter with the son different from the idealized one for the two mothers (P9 and P2), because they were anxious about the son's health, worried about the formation of all organs and were often discredited in relation to the survival of the newborn.

Seeing your baby over there, is he going to get better? Will he be going home soon? So skinny, eh? (P9)

When I came and saw, I almost fainted on top of the incubator because it was all intubated. (P2)

They were hampered by the feeling of not belonging to the specialized environment of the Neonatal Intensive Care Unit and by the insecurity and fear of disrupting the specialized service, the opportunities for care and approximation of P4 and P2 with their children.

The doctor was going to let me stay here longer, and I asked him to leave because I could not cope with that anxiety and he was disturbing the nurses (P4).

And there in the hospital they told me he liked to shower. He knew more about the voices of people who were in the ICU because I did not stay with him inside the ICU. (P2)

It is emphasized that she was offered orientation to the kangaroo position at P11, but despite this she recounts that she did not feel safe to put her child on her lap.

I felt bad to hold on, but they wanted to force me. But I think they thought I was [...] you know? Thank you to stay with S. all day on your lap. (P11)

On the other hand, it was reported by P8 that although she could not accompany her

child fully, she felt that her presence at the Neonatal Intensive Care Unit would be important for its recovery, and she described that she was talking and timidly touching her hands.

I would come and put my hand in his little hand and I would say "Mom is here". For me, love was fundamental. (P8)

She was told by one mother (P9) about breastfeeding, because although she did not have the experience of breastfeeding her first child due to a breast reduction surgery, it was not easy to accept that she could not offer her milk either the premature child; In addition, memories regarding the encouragement of breastfeeding were felt by this mother as an obligation.

Because the nurses force you to have milk! You have to have milk anyway! They said, "Go and try!" (P9)

It is possible to intervene, through the environment experienced by the puerpera, especially if she is in the Joint Accommodation, where the breastfeeding practice and the bond of the mother with the newborn are encouraged, in the maternal feelings and to encourage them in a negative way, like wanting to get away. It was made, for the long period of stay in inhospitable environment, by the absence of comfort and with a mass routine, with which P10, even feeling guilty, asked to leave the hospital.

How I blamed myself for not being able to stand it any longer. I asked him to release me. It was a very bad feeling that I was going and leaving her. (P10)

However, at the moment of the hospital discharge of the newborn, there was a mixture of feelings, such as joy and fear, in the narrative of P12. It is believed that this was the challenging moment for this mother, because it represented the opportunity for personal growth and maturity, imagining the chance to recognize herself as a fundamental part of the child's life, that is, the moment to develop the motherhood.

It was joy and fear on high. When she had a fever, because they gave the phone and said that any emergency could call, and sometimes I called here to ask. It helped me a lot the explanations of them and now I can take care of. (P12)

DISCUSSION

However, it is essential to be aware of the limitations of the qualitative interpretation based on Ethno-nursing, which is closer to a logic of uncertainties and probabilities than to true conclusions and deductive. One has as illusory the ambition to arrive at scientific generalizations that allow to describe

completely the cultural phenomenon related to the mothering of the premature born.

In a study carried out in hospitals in Rio de Janeiro, the fragility of prenatal care is evidenced, showing that only one fifth of the women have care compatible with the minimum procedures recommended by the Ministry of Health, reflecting the increase in the ratio of maternal morbidity and mortality from preventable causes in Brazil.⁵⁻⁶

In a study that evaluated prenatal follow-up, 69% were adequate in relation to the early start of health care in the gestational period; however, there were low proportions (60%) in relation to tetanus immunization, systematization of the procedures and examinations and with respect to educational activities, showing that even the lowest income women and those living in the rural area received the worst care during prenatal care.⁶

It should be noted that, although the interviewees did not complete the number of prenatal consultations stipulated by the Ministry of Health, as shown in table 1, the tendency to identify an association, often non-existent, between higher percentages of assistance inadequacy prenatal and prematurity. It is therefore necessary to correct for gestation duration any measures of adequacy of prenatal care in order to correctly evaluate the parameters of adherence to this care.⁶⁻⁷

It should be emphasized that there are risk factors for simple recognition during prenatal care, such as arterial hypertension, urinary tract infection and social risks, which may alert the health team to greater vigilance regarding eventual complicating factor. Preventive interventions are avoided through early intervention, with the ability to prevent severe morbidity and maternal death.⁶⁻⁸

It is understood from the narratives, the duplicity of risks to which the women were exposed, being, first, the biological risks, accumulated to the risks related to unfavorable sociodemographic conditions, including situations of stress due to the lack of family support and episodes of physical violence by the partner.

The results of this study also coincide with other studies on violence against women associated with unmarried women of reproductive age, with low schooling, low economic status and unfavorable social conditions, such as financial dependence.⁹⁻¹¹

Feelings of guilt and fear for the victims themselves, who are humiliated, shamed and dishonored in the context of society, are

displaced by violence against women. The types of violence against women are listed, ranging from physical and psychological violence, to moral, property and sexual violence; however, women who are raped during pregnancy are at increased risk for unsafe abortions. Violence is a risk to women's lives, as well as the possibility of harming their mental health.¹⁰⁻¹

Women who are raped during pregnancy can become depressive, which contributes to components of negative life events in the pregnancy-puerperal cycle, with low adherence to prenatal care, including malnutrition, irregular sleep habits and drug use, alcohol and tobacco.¹⁰⁻² It is important to note that in the two women diagnosed with a depressive state, the peak of feelings of the disease, such as deep sadness and the will to die, occurred moments before the birth.

In a study carried out in two Brazilian states, 24.4% of the pregnant women who used alcohol and drugs had a high level of stress and 40.8% had severe depressive symptoms,¹³ data supports this study. It is relevant to highlight that women diagnosed with depression at the time of delivery reported smoking and alcoholism, in addition to low adherence to prenatal care, increasing gestational risks for both the woman and the fetus.

It has been shown that in cigarette use, the effects of carbon monoxide and nicotine absorbed by the maternal organism are passed on to the fetus and have, as a consequence, spontaneous abortions, premature births and complications with the placenta. It generates, due to the use of alcohol during pregnancy, a serious disorder of disorders related to Fetal Alcohol Syndrome, with risks of congenital alterations in the central nervous system. The incidence of this syndrome increased nationally from 34 to 58 cases per thousand hospital births.¹³

It is believed that the health unit teams have not yet been able to identify the women who most need care and guidance during the gestational period, to offer individualized care, with a careful identification of the risks that have, as one of the consequences, premature birth. It is known that prematurity, in turn, is becoming a public health problem nowadays, with a higher probability of occurring among women who had low prenatal adherence and have unfavorable individual socioeconomic characteristics, such as low income and schooling.¹⁴⁻⁶

It is culturally related to the human expression of anticipated birth at birth "missing something", and this relationship is

still stronger when, through the cultural context of other mothers, the possibility of the disease or the premature birth is discovered, this because the desired cultural patterns of health, which are part of women's environmental context, can interrelate with the environmental context of those who are close, causing even more anxiety.

It is pointed out, in addition to the particular situation of preterm birth having had an impact, increasing the level of maternal stress, that the greatest wear happened at the time of the physical and emotional separation of the newborn when he was referred to the intensive care. This distress led to maternal anguish, due to the inability, often, to care for the child, to relate to him or to develop the motherhood.

It is understood that it might be necessary for the nurse of the Neonatal Intensive Care Unit, as one of the professionals who receive the newborn in the unit, to communicate to the mother that her child was already expected and that the hospital has a team of professionals who will take care of it, because this would be the opportunity for Nursing to perform one of the most relevant care: the reception of this mother, this because Nursing care should be more than doing or performing tasks of physical action, it has cultural and symbolic meanings, such as protection, respect and presence.¹⁵⁻⁷

It is also a question of the capacity for solidarity, since this type of involvement can mean the possibility of reducing emotional distress, especially of mothers who have their children hospitalized. It is added that another way of reducing anxiety and doubt is to place them at the center of care, involving them in the routines of the newborn's activities, thus enabling the motherhood in the Neonatal Intensive Care Unit.^{14,17}

However, caution should be taken to ensure that there is no imposition, and that the refusal should not be considered abnormal, but rather predictable because the link is vulnerable for both parties: on the one hand, a woman who has become a mother and needs emotional support because of the complex circumstances of her life; in contrast, there is a fragile newborn who, in addition to demanding professional and technological care, also requires the participation of the mother so that they can provide an emotional balance through motherhood.

It is related to the desire to distance itself also from the regulations instituted by the hospital routine. It is argued that daily praxis collaborates, in most cases, so that the

professional care associated with the rules established in the Neonatal Intensive Care Unit will overlap with maternal care in hospital institutions. It becomes clear that the importance of technical care can not be ruled out, but some mothers feel unnecessary in that setting, and so they eventually move away from it and, most of the time, only hear about the experiences of the professional staff with their children.¹⁸

It is suggested, however, that it is in the attempt to approach with the mothers that the Nursing team must assume two positions: that of health worker and educator.^{4,17} It is detailed that, although some mothers interviewed already have other positions children, the nurse, through the holistic approach, must be able to identify the vulnerabilities of the woman, regardless of how many children she has had or cared for. Quality care for the mother and newborn should include the reorganization of care to take advantage of the short periods in which she is present at the Neonatal Intensive Care Unit to involve her in the care.

It was verified, analyzing the other life narratives, that no mother explained that she cared for her children in the Neonatal Intensive Care Unit, and this happened, possibly, because she did not think it important to report her care to her children during hospitalization or for having been a mere spectator of the process. It is noticed that some mothers delegated total responsibility to the team considering that the only professional care is responsible and able to keep the child healthy.

However, the mother who has the possibility of touching her premature infant in the Neonatal Intensive Care Unit is valued, because it is the moment when she discovers her uniqueness before the community and where there is an opportunity to express the newborn's improvement or evaluate whether they are being cared for, well treated and even looking better.¹⁷

Further research is supported by the talk and touch between mother and newborn, which are the most prevalent contacts in the Neonatal Intensive Care Unit, and this attenuates the sense of mother-child separation, for although the newborn does not being able to understand the meaning of what is being expressed, it recognizes the melody and the feelings that are being exposed by the voice, which promotes the improvement of physiological parameters.¹⁸⁻⁹

One has the maternal contact with the child's skin, in the same way, as important so that he can feel that there is affectionate

touch and no pain. This contact refers to the movement of approach, constitutive of the dynamics of being, since, in most cases, the newborns are touched by the team of professionals for the administration of medicines, blood collections, among other procedures painful and impersonal.^{17,19}

Regardless of the opportunities for touching, skin-to-skin contact and melody making, the feeling of maturity becomes fragile when the mother realizes that she will not be able to breastfeed her child, especially when she is in an environment where other mothers breastfeed. professional team does not develop individualized care.²⁰

It is argued that when the woman realizes that she will not be able to breastfeed and her support for the difficulty is lacking, it is as if her maternal role was less important than that of other breastfeeding mothers, since, culturally, the act of breastfeeding determines the full involvement of the mother-child bond.²⁰

It is verified, due to the difficulties in the period of hospitalization, that some mothers narrated the desire to leave the hospital, revealing the uniqueness of the female human being, despite the feeling of guilt. Guilt occurs because the dynamics of the cultural dimension of the woman who was pregnant does not allow her to leave the maternity ward without her child on her lap. It is inferred that perhaps remaining beyond their physical and psychological limits is what mothers wish, since the construction of cultural values around women imposes the obligation to be a mother first of all, before her tiredness, before her stress and before her life.

It can be seen that, through the narratives about the discharge of the newborn, the arrival at the home with the child represents a break with the everyday world in the Neonatal Intensive Care Unit and generates situations that are specific to the family and home cultural context. It is known that it is the moment awaited by the mothers and relatives, however, it requires adaptation, because at this stage, mother and son seem to be one, despite the feeling of fear of being alone with the child, away from technology and professionals of the Neonatal Intensive Care Unit.^{17,20}

In view of the results analyzed and discussed, the limitation of the study was due to the interviews being collected in the hospital environment where, although the meeting was in a private place and with the guarantee of anonymity, the participants feared embarrassment when narrating

criticisms about the care of health professionals during the hospitalization of the child in the Neonatal Intensive Care Unit.

CONCLUSION

It has become the experience of mothering of mothers with preterm children a confrontation from the moment of early delivery, which occurred related to biological gestational risks and also associated with individual characteristics and unfavorable sociodemographic conditions.

The presence of concerns and doubts regarding the state of health and development of the newborn from the period of hospitalization up to the moment of discharge is shown by the findings discussed, which also lead to confrontations for motherhood.

The aim of this research is to contribute to the fact that the period of adaptation, both of the mother who becomes the primary caregiver and of the newborn, who belongs to a family environment, is articulated from the period of hospitalization. It is recommended, therefore, joint planning with the mothers and the accomplishment of home visits, by the health team of the Family Health Strategy, which has the responsibility of promoting individualized and integral attention, increasing the capacity of family adaptation, reducing the risks and the episodes of readmissions, constituting a source of support for the development of maternity at home. For this purpose, it is suggested that mothers be able to express their feelings and tell their experiences, resignificando the initial commotion associated with the birth and hospitalization of the child and helping in the maternity after discharge.

REFERENCES

1. Abendroth AK, Huffman ML, Treas J. The parity penalty in life course perspective motherhood and occupational status in 13 European countries. *Am sociol rev.* 2014 Aug; 79(5):993-1014. Doi: <https://doi.org/10.1177/0003122414545986>
2. Reis AT, Santos RS. Mothering the surgical newborn: foundations for nursing care. *Rev Bras Enferm.* 2013 Jan/Feb;66(1):110-5. Doi: <http://dx.doi.org/10.1590/S0034-7167201300010001>
3. Nazareth IV, Santos IMM. Sociocultural dimension of parents of premature infants discharged from a neonatal intensive care unit. *Rev RENE.* 2014 July/Aug;15(4):621-30. Doi: [10.15253/2175-6783.2014000400009](https://doi.org/10.15253/2175-6783.2014000400009)
4. Leininger MM, Mcfarland MR. Culture care diversity and universality : a worldwide

nursing theory. New York: Jones and Bartlett Publishers Inc.; 2015.

5. Gesteira ECR, Braga PP, Gomes IF, Oliveira JA, Lopes MR, Galdino MFG. Family living in child care with complications of prematurity. *Ciênc Cuid Saúde*. 2016 Oct/Dec;15(4):630-8. Doi:

<http://dx.doi.org/10.4025/ciencucuidsaude.v15i4.29959>

6. Domingues RMSM, Viellas EF, Dias MAB, Torres JA, Theme MM, Gama, SGN, et al. Adequacy of prenatal care according to maternal characteristics in Brazil. *Rev panam salud pública* [Internet]. 2015 [cited 2018 Feb 03];37(3):141-7. Available from:

<https://www.scielosp.org/article/rpsp/2015.v37n3/140-147>

7. Polgliane RBS, Leal MC, Amorim MHC, Zandonade E, Santos Neto ET. Adaptation of the process of prenatal care in accordance with criteria established by the Humanization of Prenatal and Birth Program and the World Health Organization. *Ciênc saúde coletiva*. 2014 July;19(7):1995-9 Doi:

<http://dx.doi.org/10.1590/1413-81232014197.08622013>

8. Fonseca SC, Monteiro DSA, Pereira CMSC, Scoralick ACD, Jorge MG, Rozario S. Inequalities in prenatal care in a southeastern city in Brazil. *Ciênc saúde coletiva*. 2014 July;19(7):1991-8. Doi:

<http://dx.doi.org/10.1590/1413-81232014197.04212013>

9. Beattie J, Hall H, Biro MA, East C, Lau R. Effects of mindfulness on maternal stress, depressive symptoms and awareness of present moment experience: A pilot randomised trial. *Midwifery*. 2017 July; 50(3):174-83. Doi:

<https://doi.org/10.1016/j.midw.2017.04.006>

10. Teixeira SVB, Moura MAV, Silva LR, Queiroz ABA, Souza KV, Albuquerque Netto L. Intimate partner violence against pregnant women: the environment according to Levine's nursing theory. *Rev esc enferm USP*. 2015 Dec;49(6):882-9. Doi:

<http://dx.doi.org/10.1590/S0080-623420150000600002>

11. Gomes ICR, Rodrigues VP, Nery IG, Vilela ABA, Freitas J, Diniz NMF. Coping of women in domestic violence situation after aggression. *Rev baiana enferm*. 2014 May/Aug; 28(2):134-44. Doi:

<http://dx.doi.org/10.18471/rbe.v28i2.8969>

12. Patrick SW, Davis MM, Lehman CU, Cooper WO. Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2013. *J Perinatol*. 2015

Aug; 35(8):650-5. Doi:

<http://dx.doi.org/10.1038/jp.2015.36>

13. Rocha PC, Alves MTSSB, Chagas DC, Silva AAM, Batista RFL, Silva RA. Prevalence of illicit drug use and associated factors during pregnancy in the BRISA cohort. *Cad Saúde Pública*. 2016 Feb;32(1):1-13. Doi:

<http://dx.doi.org/10.1590/0102-311X00192714>

14. Martinelli KG, Santos Neto ET, Gama SGN, Oliveira AE. Adequacy process of prenatal care according to the criteria of Humanizing of Prenatal Care and Childbirth Program and Stork Network. *Rev Bras Ginecol Obstet*. 2014 Feb; 36(2):56-64. Doi:

<http://dx.doi.org/10.1590/S0100-72032014000200003>

15. Melo EC, Oliveira RR, Mathias TAF. Factors associated with the quality of prenatal care: an approach to premature birth. *Rev esc enferm USP*. 2015 July/Aug; 49(4):540-9. Doi

<http://dx.doi.org/10.1590/S0080-623420150000400002>

16. Mendes CQS, Cacella BCA, Mandetta MA, Balieiro MMFG. Low birth weight in a municipality in the southeast region of Brazil. *Rev Bras Enferm*. 2015 Nov/Dec;68(6):857-63. Doi:

<http://dx.doi.org/10.1590/0034-7167.2015680624i>

17. Melo RCJ, Souza IEO, Paula CC. Neonatal nursing: the meaning of existential caring in intensive care unit. *Rev Bras Enferm*. 2013 Sept/Oct; 66(5):656-62. Doi:

<http://dx.doi.org/10.1590/S0034-71672013000500003>

18. Araújo BBM, Rodrigues BMRD, Pacheco STA. Promoting mothers' care for premature neonates: the perspective of problem-based education in health. *Rev Enferm UERJ*. 2015 Jan/Feb;23(1):128-31. Doi:

<https://doi.org/10.12957/reuerj.2015.14779>

19. Santos LM, Morais RA, Miranda JOF, Santana RCB, Oliveira VM, Nery FS. Maternal perception of the skin to skin contact with premature infants through the kangaroo position. *J res fundam care*. 2013 Jan/Mar; 5(1):3504-14. Doi:

[10.9789/2175-5361.2013v5n1p3504](http://dx.doi.org/10.9789/2175-5361.2013v5n1p3504)

20. Marques GCM, Pinho LMO, Rodrigues LSA, Martins CA, Matão MEL. Breastfeeding: mothers experiences who had hospitalized babies in neonatal intensive care unit. *J Nurs UFPE on line*. 2016 Feb;10(2):495-9. Doi:

[10.5205/reuol.8557-74661-1-SM1002201615](https://doi.org/10.5205/reuol.8557-74661-1-SM1002201615)

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