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**Short Communication**

# Holding on through crisis: mothers' experiences in the neonatal intensive care unit

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## ABSTRACT

Motherhood is often seen as a transformative and fulfilling journey; however, this experience is profoundly disrupted when infants are admitted to a neonatal intensive care unit (NICU), leading to fear, uncertainty, and emotional distress. The sudden physical separation, exposure to complex medical care, and disruption of expected caregiving roles challenge mothers' emotional well-being, coping mechanisms, and developing maternal identity. This study explored the lived experiences of mothers with infants in the NICU, focusing on the meanings they attach to these experiences. Eight mothers with infants admitted to a government hospital's NICU in Southwestern Mindanao shared their experiences. Findings revealed four interconnected themes. First, mothers experienced embodied struggle and transformative resilience, marked by physical exhaustion and emotional strain while gradually developing coping strategies. Second, they navigated issues of safety, control, and emotional security within the NICU environment. Third, supportive relationships and guidance from healthcare providers and family members emerged as essential in helping mothers understand and manage their situation. Finally, relational support served as a lifeline that sustained mothers throughout the hospitalization period. The study concludes that although NICU experiences are highly challenging, they also foster resilience, self-growth, and adaptive coping among mothers. A structured and supportive environment, along with strong relational connections, plays a crucial role in promoting maternal well-being and caregiving capacity. These findings highlight the importance of family-centered care, consistent emotional support, and responsive communication in improving maternal experiences during neonatal hospitalization.

**Keywords:** Family-centered care, Maternal coping, Motherhood, NICU, Resilience

## INTRODUCTION

Motherhood is often celebrated as a transformative journey marked by joy, bonding, and the natural rhythm of caring for a newborn. Yet, for mothers whose infants require admission to a NICU, this anticipated experience is abruptly disrupted by fear, uncertainty, and emotional upheaval. The expected routines of holding, feeding, and nurturing are replaced by medical interventions, physical separation, and a sense of helplessness, fundamentally altering the maternal experience. Qualitative research has highlighted how mothers in the NICU often experience ambivalence about their maternal identity, perceive their role as unreal, and endure profound distress regarding their infants' fragility and risk.[1] These experiences underscore the emotional and relational complexities that characterize early motherhood within the NICU context.

Extant literature consistently identifies the emotional impact of NICU hospitalization on mothers. Mothers frequently report overwhelming feelings of anxiety, fear, guilt, and helplessness, which are intensified by the uncertainty surrounding their child's survival and limited control over caregiving.[2-4] Hospitalization often disrupts maternal identity and bonding, as strict medical protocols,

incubators, and visitation restrictions interfere with direct caregiving and physical closeness.[2,3] Coping strategies, including reliance on spirituality, family support, or professional guidance, play a critical role in maternal adaptation.[5,6] Additionally, studies emphasize that clear, compassionate communication from healthcare professionals significantly alleviates stress and fosters trust, highlighting the importance of integrated emotional, relational, and psychosocial support systems in promoting maternal resilience during NICU hospitalization.[3,6]

Despite substantial contributions, gaps remain in understanding the nuanced lived experiences of NICU mothers. Much of the existing research emphasizes emotional distress, disruptions in maternal roles, or the efficacy of support interventions.[2,3,5] However, limited attention has been given to how mothers personally interpret and assign meaning to their interactions with medical staff, equipment, and the NICU environment, which shape day-to-day experiences and maternal identity.[7,8] Moreover, contextual factors such as cultural beliefs, logistical constraints, and pandemic-related visitation restrictions remain underexplored, indicating a need for studies that examine both emotional and relational dimensions of NICU experiences in diverse settings.[6,9]

Given these gaps, this study sought to explore the lived experiences of mothers with infants admitted to the NICU, focusing on emotional, psychological, and relational dimensions of care. Anchored in Swanson's Theory of Caring[10], Meleis's Transitions Theory, Peplau's Interpersonal Relations Theory[12], and Travelbee's Human-to-Human Relationship Theory, the study aimed to illuminate how mothers navigated the challenges of NICU hospitalization, adapted their maternal roles, and constructed meaning through interactions with healthcare professionals.[11,13] Findings are expected to provide insights for NICU nurses, administrators and policymakers to design interventions that support maternal well-being, foster family-centered care, and enhance the overall quality of neonatal healthcare delivery.

## METHODS

### *Research design*

This study employed a qualitative interpretive phenomenological design guided by van Manen's framework, which seeks to explore the essence and meaning of lived experiences through reflective interpretation of participants' narratives.[14] Phenomenology is particularly suited for examining complex, emotionally charged phenomena, allowing in-depth exploration of participants' perceptions, feelings, and interpretations rather than relying on numerical measurement.[15] This design was appropriate for exploring how mothers navigate the emotionally intense, uncertain, and often overwhelming journey of having an infant admitted to a NICU, highlighting the embodied, temporal, spatial, and relational dimensions of their maternal experience.

### *Setting and participants*

The study was conducted in a government hospital in the southwestern part of Mindanao, a provincial referral center with a NICU staffed by multidisciplinary professionals providing advanced neonatal care. This setting offered a rich context for examining the emotional, relational, and caregiving challenges mothers face, as well as their interactions with healthcare providers.

Eight mothers whose infants had been admitted to the NICU participated, selected through purposive sampling to ensure rich, relevant experiences. Inclusion criteria were: mothers aged ≥18 years, primary caregivers of a single infant admitted to the NICU within the past two weeks, emotionally ready to participate, and fluent in English, Cebuano, or Filipino. Mothers were excluded if experiencing acute psychological distress, involved in multiple NICU admissions, or not primary caregivers. Data saturation determined the final sample size.

Participants ranged in age from 23 to 39 years old and included both first-time mothers and multiparous women. The infants comprised both preterm and term newborns delivered through various modes, including normal spontaneous vaginal delivery and cesarean section, some of which were emergency procedures due to complications such as fetal distress and pre-eclampsia with severe features. Several participants had complex reproductive histories marked by previous pregnancy losses or repeated high-risk pregnancies. The duration of NICU admission varied from one to twelve days, reflecting differing levels of neonatal acuity.

### *Instrument and data collection*

The study was conducted from July to December 2025. Data were collected using a semi-structured interview guide developed from a literature review and aligned with van Manen's phenomenological method. Expert consultation ensured clarity, sensitivity and relevance. The guide elicited rich narratives regarding emotional responses, maternal identity, perceptions of care and meaning-making.

In-depth, face-to-face interviews were conducted in participants' preferred language, English or Cebuano, in private settings at home or outside the hospital. Each session lasted approximately 30 minutes, was audio-recorded with consent, and supplemented with field notes capturing non-verbal cues and environmental context. Participants were assured of confidentiality, voluntary participation, and the right to withdraw at any time. Data were anonymized, securely stored, and retained for six months before secure destruction.

### Ethical considerations

Ethical approval was obtained from the Misamis University Research Ethics Committee. The researcher maintained a clear distinction from clinical roles to ensure objectivity. Participants were fully informed about study objectives, procedures, potential emotional risks and voluntary participation. Privacy, confidentiality and autonomy were prioritized, with no recruitment occurring in the hospital to avoid coercion. Pseudonyms were assigned, and digital data were encrypted and password-protected. No incentives were provided, ensuring unbiased, authentic responses.

### Data analysis

Data were analyzed following van Manen's phenomenological approach, emphasizing reflective engagement with participants' narratives to uncover the essence of their lived experiences.[14] The researcher immersed in transcripts and recordings, taking reflective notes to capture initial impressions and emerging insights.

Significant statements were clustered into thematic categories, synthesizing physical, emotional, relational, and temporal dimensions of the NICU maternal experience. Emerging themes included embodied struggle and resilience, negotiation of safety and control, temporal disorientation, relational support and evolving maternal identity. Findings were validated through member checking, ensuring credibility, confirmability and fidelity to participants' experiences.

## RESULTS

Four interrelated themes emerged from the mothers' narratives: (1) embodied struggle and transformative resilience, (2) negotiating safety, control, and emotional security in the NICU environment, (3) supportive relationships and guidance as anchors for coping, and (4) relational support as a lifeline in the NICU journey. Together, these themes illuminate how NICU motherhood is lived through the body, shaped by space, structured by time and sustained through relationships.

### Theme 1: Embodied struggle and transformative resilience

Motherhood in the NICU was lived through a body that was simultaneously wounded and determined. Mothers described intense physical pain from surgical wounds, fatigue, sleep deprivation, and repeated physical exertion like walking back and forth to the NICU, breastfeeding despite exhaustion and recovering while emotionally strained.

Their bodies carried not only postpartum vulnerability but also the weight of fear, guilt, and helplessness as they witnessed their infants attached to machines and undergoing invasive procedures.

Mothers vividly described the physical toll of childbirth compounded by the emotional weight of having a hospitalized newborn. One mother shared: *"Lisod kaayo akong kahimtang ato. Sakit pa gyud akong tahi, unya sige kog lakaw padulong sa NICU. Murag dili pa ready akong lawas, pero kinahanglan ko mobarog para sa akong anak."* ("It was very difficult for me. My stitches were still painful, and I kept walking to the NICU. My body didn't feel ready, but I had to stand up for my baby.")

Her words reveal the tension between bodily limitation and maternal obligation. The body, still healing and fragile, was pushed beyond comfort by love and responsibility. Physical pain did not suspend motherhood; instead, it intensified the urgency to act. The lived body became a site where suffering and devotion coexisted-where recovery was secondary to maternal presence.

Another participant described exhaustion intertwined with emotional distress: *"Wala koy tarong tulog. Maghuna-huna ko pirmi kung okay ra ba siya didto. Maski kapoy na kaayo, dili gyud ko ka-relax."* ("I didn't have proper sleep. I kept thinking if my baby was okay there. Even when I was very tired, I couldn't relax.")

Here, fatigue was not only physiological but existential. Time at night was filled with intrusive thoughts and anxious anticipation. Even when the body demanded rest, the mind remained alert, anchored in concern for the infant's survival. Sleep deprivation thus became an embodied expression of attachment, a manifestation of maternal vigilance that refused detachment.

Witnessing their infants connected to medical equipment deepened this embodied vulnerability. The NICU environment intensified awareness of fragility, compressing fear into physical sensations such as tightness in the chest, heaviness in the body, trembling hands. Postpartum recovery was therefore experienced not in quiet rest, but within emotional turbulence.

Yet within this embodied suffering, resilience gradually emerged. Prayer, worship, intentional rest, proper nutrition, and the creation of daily routines became grounding practices. These were not passive adjustments but deliberate acts of self-stabilization. Mothers began to care for their own bodies so they could continue caring for their infants. In doing so, they reclaimed a sense of agency over bodies that initially felt depleted and powerless.

Moments of physical closeness with their infants were especially transformative. One mother expressed: *"Kung makagunit ko niya bisan kadiyot lang, mawala akong kakapoy. Murag ma-recharge ko."* ("When I get to hold my baby, even just for a moment, my tiredness disappears. It's like I get recharged.")

Holding her infant transformed fatigue into vitality. Physical contact restored meaning and reaffirmed

maternal identity. The same body that felt weak regained strength through touch. Fatigue did not vanish biologically, but it was reinterpreted emotionally-overpowered by love and connection. In these moments, resilience was not abstract; it was felt, embodied, and renewed through contact.

Spiritual grounding also emerged as embodied resilience. One mother stated: *"Mag-ampo gyud ko pirmi. Mao ra gyud nay makapakalma sa akong dughan."* ("I constantly pray. That's the only thing that calms my chest.")

Prayer was described in bodily terms such as calming the chest, easing breath, settling the heart. Faith functioned as physiological regulation amid anxiety. Through prayer, mothers surrendered fears they could not control, reframing uncertainty as something entrusted to a higher power. Spirituality thus became intertwined with corporeal endurance.

Phenomenologically, the lived body became both a site of suffering and a vessel of transformation. Through endurance, mothers reconstructed their maternal identity-not as passive observers of medical care, but as strong, spiritually anchored caregivers who persisted despite exhaustion. Their narratives reveal that resilience was not the absence of weakness; rather, it was strength forged within vulnerability. Physical pain, emotional strain, and spiritual surrender converged to shape a deeper, more resolute experience of motherhood.

Across accounts, embodied struggle did not culminate in defeat. Instead, suffering became the pathway through which maternal strength was clarified and affirmed. The NICU journey reshaped their understanding of themselves, not merely as recovering patients, but as mothers whose love compelled the body to rise, endure and transform.

***Theme 2: Negotiating safety, control, and emotional security in the NICU environment***

The NICU initially appeared overwhelming, filled with alarms, unfamiliar equipment and clinical routines. For many mothers, entering the unit for the first time was an emotionally destabilizing experience. The environment felt cold, mechanical, and foreign, intensifying their sense of displacement as new mothers. One mother recalled: *"Hadlok kaayo ko pag una nako sulod. Daghan kaayo og machine, unya daghan kaayo og tunog. Murag dili nako lugar."* ("I was very scared the first time I entered. There were so many machines and sounds. It didn't feel like my place.")

Her words convey spatial alienation. The NICU was not immediately experienced as a place of maternal belonging but as a technological domain dominated by medical apparatus and unfamiliar routines. The constant beeping of monitors and the visual complexity of machines amplified anxiety, reinforcing the fragility of her infant and her own perceived inadequacy within that space.

Another participant shared: *"Pagkakita nako sa akong baby nga naay tubo ug wire, murag nabug-atan akong dughan."* ("When I saw my baby with tubes and wires, my chest felt heavy.")

The sight of tubes and wires attached to her newborn generated a visceral response, "a heavy chest", an embodied expression of fear and sorrow. The medical equipment, while life-sustaining, symbolized vulnerability. The NICU thus became a space where technology and maternal instinct collided, producing emotional tension.

However, as mothers spent more time in the unit, their perception of the environment gradually shifted. What once evoked fear began to signify protection. This transformation occurred largely through their observation of healthcare professionals' competence and consistency.

One mother explained: *"Makita man nako nga bantayan gyud nila akong baby. Kada lihok nila, klaro nga kabalo sila unsay buhaton."* ("I could see that they really monitored my baby. In every move they made, it was clear they knew what they were doing.")

Visible expertise fostered trust. The nurses' attentiveness, careful monitoring, and confident procedures reassured mothers that their infants were in capable hands. Safety was not inherent in the machines themselves but emerged relationally through professional presence. The technological environment began to feel less threatening and more protective as mothers recognized the skill behind each action.

Clear explanations further strengthened emotional security. When procedures and treatment plans were communicated openly, uncertainty diminished. The NICU was no longer an incomprehensible medical world but a structured environment where mothers could understand and anticipate what was happening.

At the same time, mothers actively sought to regain a sense of control. Participation became a crucial pathway to emotional stability. One participant shared: *"Mangutana gyud ko pirmi. Gusto ko makasabot unsay nahitabo. Para dili ko maghuna-huna og lain."* ("I always ask questions. I want to understand what's happening so I won't imagine other things.")

Asking questions functioned as a coping strategy against catastrophic thinking. Information reduced imagined fears and replaced them with concrete understanding. Through inquiry, mothers reclaimed psychological agency within a highly regulated clinical setting.

Regular visitation, breastfeeding, observing care, and establishing small routines also contributed to restoring

maternal involvement. These actions allowed mothers to move from passive spectators to active participants in their infants' recovery. Even within institutional boundaries, they found ways to assert presence and responsibility.

Over time, the NICU was no longer experienced solely as a technological space but as a lived world in which mothers invested emotionally. Interpreted through lived space, the NICU became a relational environment where trust, knowledge, and participation co-constructed safety. Safety and control were not fixed conditions; they were negotiated experiences shaped by interaction and observation.

Thus, the NICU gradually transformed, from an alien, intimidating environment into a structured and meaningful space where endurance and hope became possible. Through trust in healthcare professionals and deliberate engagement in their infants' care, mothers reconstructed emotional security within a world initially defined by fear.

***Theme 3: Supportive relationships and guidance as anchors for coping***

Mothers' coping was deeply relational. Emotional stability was sustained not in isolation, but through supportive encounters with nurses, physicians, partners, and family members. Within the unfamiliar and highly medicalized NICU environment, relationships became grounding forces that stabilized fear and uncertainty.

Relational encounters with healthcare providers were central to coping. One participant expressed: *"Ang mga nurse, buotan kaayo. Ila ko gi-encourage ug gi-tudloan unsaon paghawid sa akong baby."* ("The nurses were very kind. They encouraged me and taught me how to hold my baby.")

Guidance from nurses restored maternal confidence. Teaching was not merely technical instruction about positioning or feeding; it was an affirmation of her maternal role. In being taught, she was also being trusted. Through encouragement and demonstration, mothers began to see themselves not as outsiders in a clinical domain, but as capable caregivers. Relational affirmation replaced self-doubt with competence.

Another mother emphasized the importance of explanation: *"Kung mag-explain sila, mahupay gyud ko. Dili ko mahadlok kaayo kung kabalo ko unsay plano."* ("When they explain things, I feel relieved. I'm less afraid when I know the plan.")

Clear communication functioned as emotional regulation. Explanation bridged the gap between medical complexity and maternal understanding. Fear often thrives in uncertainty; when healthcare providers outlined plans and procedures, anxiety softened. Relief emerged not only from the content of information, but from the relational act of being included and respected.

Family presence further anchored resilience. One participant stated: *"Akong bana pirmi naa sa akong kilid. Siya'y mag-atiman nako kung kapoy na ko."* ("My husband was always by my side. He took care of me when I was tired.")

In this account, care flowed toward the mother as well. While she remained focused on her infant, her husband ensured she rested, ate, and regained strength. This reciprocity of care reduced isolation. Shared responsibility transformed the NICU journey from an individual burden into a collective endeavor. Emotional reassurance and practical support-pushing wheelchairs, preparing food, accompanying visits-symbolized partnership in adversity.

Relationally, guidance functioned as more than instruction-it became emotional shelter. Being listened to, reassured, and supported allowed mothers to reinterpret uncertainty as manageable rather than overwhelming. Their resilience was co-constructed within networks of care. Supportive relationships acted as emotional scaffolding, holding mothers steady when fear threatened to destabilize them.

***Theme 4: Relational support as a lifeline in the NICU journey***

Beyond individual supportive encounters, mothers described relational support as a lifeline that sustained them throughout the NICU experience. Professional care, family presence, and spiritual faith formed an interconnected web that upheld their emotional well-being.

One mother reflected: *"Dili gyud ko makaya kung ako lang isa. Salamat sa mga nurse ug sa akong pamilya."* ("I couldn't have handled it alone. I'm thankful for the nurses and my family.")

Her statement underscores interdependence. Strength was not solitary; it was relationally sustained. The NICU experience was endured through collective presence-through nurses who monitored vigilantly, physicians who explained carefully, and family members who accompanied faithfully.

Compassionate nursing care fostered trust; clear communication reduced fear; and family encouragement strengthened resolve. Yet beyond human relationships, spiritual reliance deepened this network of support. One participant shared: *"Gisalig na lang nako tanan sa Ginoo. Siya ra gyud akong kusog."* ("I entrusted everything to God. He is my only strength.")

Faith provided transcendence beyond medical uncertainty. In moments when outcomes could not be

guaranteed, surrendering to God offered emotional release. Spiritual trust complemented medical trust. Where healthcare professionals offered skill and vigilance, faith offered hope and meaning. Together, these dimensions created emotional security.

Many mothers described how their faith intensified during the NICU period. Prayer reframed uncertainty—not as abandonment, but as something held within divine care. This spiritual anchoring did not replace reliance on medical professionals; rather, it expanded the relational field within which mothers coped.

From a phenomenological perspective, lived relation was foundational to endurance. Mothers did not persevere solely through internal strength, but through being-with others-healthcare providers who reassured them, partners who physically and emotionally supported them, and a faith that transcended the clinical setting. Within this relational world, maternal identity was preserved, hope was sustained, and suffering became bearable.

Relational support thus functioned not simply as assistance, but as a lifeline. It transformed isolation into companionship, fear into shared vigilance, and uncertainty into collective hope. In the web of human and spiritual connections, mothers found the strength to continue showing up, day after day, for their infants.

## DISCUSSION

The findings of this study provide a rich and nuanced interpretation of mothers' lived experiences as they navigated the emotional, physical, and relational challenges of having an infant in the NICU. These experiences align with recent empirical evidence and can be meaningfully understood through established nursing and transition theories.

Mothers described profound emotional distress, from fear and uncertainty regarding infant fragility to physical exhaustion and intrusive worry. Contemporary evidence confirms that NICU mothers experience psychological stressors that extend beyond typical postpartum adjustment.[16] Research further demonstrates that NICU-related stress is significantly associated with later maternal depressive symptoms and altered parenting interactions.[17] These findings reinforce that maternal distress in the NICU is not transient but may have enduring relational implications.

The mothers' narratives of enduring fatigue while sustaining hope reflect resilience grounded in meaning-making. This dynamic resonates with Kristen Swanson's Theory of Caring (1991).[10] Swanson's five caring processes, knowing, being with, doing for, enabling and maintaining belief, were reflected in mothers' accounts of nurse interactions that affirmed their value and restored confidence. Contemporary theoretical critique affirms the continued applicability of Swanson's framework in high-acuity settings.[18] In this study, when nurses explained procedures, demonstrated presence, and invited mothers into caregiving routines, anxiety decreased and maternal identity strengthened. Caring thus functioned not merely as task completion but as relational restoration.

Mothers initially perceived the NICU as intimidating and foreign, yet gradually described it as structured and protective. Transition-focused research characterizes the NICU experience as a situational and developmental transition requiring role redefinition.[19] Meta-syntheses of NICU-to-home transitions similarly report that parents must adapt to fluctuating emotional states, evolving competencies, and informational uncertainties.[20,21]

Meleis's Transitions Theory offers a framework for interpreting these shifts.[11] Meleis conceptualizes transition as a multidimensional process marked by vulnerability and identity reconstruction, wherein supportive conditions facilitate healthy adaptation. In this study, initial fear and unfamiliarity acted as inhibitors; consistent communication and structured caregiving opportunities became facilitators. Mothers' progression from passive observers to active caregivers exemplifies adaptive transition patterns described in the theory.

Supportive relationships emerged as central to coping and sustaining hope. A recent Italian qualitative study underscored the importance of compassionate communication and parental inclusion in fostering trust within the NICU environment.[22] Integrative reviews likewise identify social support and spiritual resources as protective factors for parental well-being.[21]

From a theoretical perspective, Hildegard Peplau's Interpersonal Relations Theory explains how therapeutic nurse–mother relationships evolve through orientation, working and resolution phases.[12] Mothers' accounts reflected this progression: initial anxiety (orientation), collaborative engagement and teaching (working), and emerging confidence (resolution). Contemporary scholarship confirms the enduring relevance of Peplau's framework in modern nursing practice.[23]

Similarly, Joyce Travelbee's Human-to-Human Relationship Theory emphasizes empathetic presence as central to meaning-making during suffering. Mothers' experiences of nurses who reassured, listened and validated their fears illustrate how authentic relational engagement transforms isolation into shared humanity.[13]

NICU motherhood represents a transformative experience affecting identity, emotional regulation, and maternal–infant bonding. Evidence supports family-integrated care models as mechanisms to improve parental confidence and neonatal outcomes.[24] Encouraging structured maternal participation, including kangaroo mother care and collaborative caregiving, may reduce anxiety and strengthen attachment.

For nurses, findings emphasize primacy of relational and therapeutic care. Nursing education should reinforce caring processes consistent with Swanson and Peplau, emphasizing presence, validation and maternal inclusion. Institutional policies should create structural support for meaningful nurse-mother engagement beyond technical tasks.

### *Limitations*

This study has several limitations that should be considered in interpreting the findings. The small number of participants (n=8) drawn from a single government hospital in Southwestern Mindanao limits the transferability of the results to other settings and populations. Data were based on self-reported narratives, which may be influenced by recall bias and social desirability, particularly given the sensitive nature of NICU experiences. Language translation from Cebuano to English may have affected subtle meanings despite efforts to preserve participants' intent. Finally, the interpretive nature of phenomenological analysis may introduce researcher subjectivity, although measures such as reflective journaling and member checking were employed to enhance credibility.

## CONCLUSION

Mothers' experiences in NICU, encompassing intense physical and emotional challenges, foster resilience, personal growth and adaptive coping strategies, while their efforts to ensure safety and emotional security for their infants underscore critical role of structured, supportive and reassuring NICU environments. Guidance and encouragement received from healthcare providers, coupled with emotional and practical support of family members, serve as essential resources that help mothers manage stress, maintain emotional well-being and navigate complexities of neonatal care. Collectively, these relational, spatial and intrapersonal factors function as vital lifeline, sustaining mothers through demanding and transformative experience of NICU motherhood.

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