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Health professionals mothers' perceptions about relationships in the neonatal unit

Percepções das mães que são profissionais de saúde sobre as relações na unidade neonatal

Percepciones de las madres profesionales de la salud sobre las relaciones en la unidad neonatal

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ABSTRACT

Objective: to discuss the perceptions of mothers who are health professionals about relationships in the neonatal unit. **Method:** a qualitative study, based on Symbolic Interactionism, with 11 mothers of preterm newborns who are health professionals. After approval by the Research Ethics Committee, data was collected from May yo October 2021, through individual interviews, and subjected to thematic content analysis. **Results:** despite the mothers being health professionals, relationships in the neonatal unit were difficult, painful, uncomfortable, and restrictive to the process of 'being and becoming a mother'. They revealed feelings of not belonging to care and of being away from their children. **Conclusion:** the relationships between mothers and health professionals working in the neonatal unit were marked by suffering, limitations, and discomfort, and were lacking in collaborative process, going against Family-Centered Care.

Descriptors: Critical Care; Health Personnel; Professional-Family Relations; Maternal Behavior; Intensive Care Units, Neonatal.

RESUMO

Objetivo: discutir as percepções das mães que são profissionais de saúde sobre as relações na unidade neonatal. **Método**: estudo qualitativo, apoiado no Interacionismo Simbólico, com 11 mães de recém-nascidos pré-termo que são profissionais da saúde. Após aprovação pelo Comitê de Ética em Pesquisa, os dados foram coletados de maio a outubro de 2021, por meio de entrevistas individuais, e submetidos à análise de conteúdo temática. **Resultados**: apesar de as mães serem profissionais da saúde, as relações na unidade neonatal foram difíceis, sofridas, desconfortantes e restritivas ao processo de 'ser e tornar-se mãe'. Estas desvelaram sentimentos de não pertencimento ao cuidado e de afastamento de suas crianças. **Conclusão**: as relações entre mães e profissionais da saúde atuantes na unidade neonatal estiveram marcadas por sofrimentos, limitações e desconfortos, sendo lacunares em processos colaborativos, na contramão do Cuidado Centrado na Família.

Descritores: Cuidados Críticos; Pessoal de Saúde; Relações Profissional-Família; Comportamento Materno; Unidades de Terapia Intensiva Neonatal.

RESUMEN

Objetivo: discutir las percepciones de las madres profesionales de salud sobre las relaciones en la unidad neonatal. **Método:** estudio cualitativo, basado en el Interaccionismo Simbólico, con 11 madres de recién nacidos prematuros que son profesionales de la salud. Previa aprobación del Comité de Ética en Investigación, se recolectaron los datos de mayo a octubre de 2021, mediante entrevistas individuales y los sometieron a análisis temático de contenido. **Resultados:** aunque las madres eran profesionales de salud, las relaciones en la unidad neonatal fueron difíciles, dolorosas, incómodas y restrictivas al proceso de 'ser y volverse madre'. Revelaron sentimientos de no pertenencia a los cuidados y de alejamiento de sus hijos. **Conclusión: l**as relaciones entre las madres y los profesionales sanitarios que trabajan en la unidad neonatal estaban marcadas por el sufrimiento, las limitaciones y la incomodidad, y carecían de procesos de colaboración, lo que iba en contra de la Atención Centrada en la Familia.

Descriptores: Cuidados Críticos; Personal de Salud; Relaciones Profesional-Familia; Conducta Materna; Unidades de Cuidado Intensivo Neonatal.

INTRODUCTION

Brazil is among the ten countries in the world with the highest rates of premature births, those that occur before 37 gestational weeks, with a prevalence of 11%, a stable trend[1]. Prematurity is among the conditions that result in hospitalizations in Neonatal Units (NUs).

In NUs, the relational processes among professionals, woman, and the baby's family have been described as insufficient[2] and potentially stressful [3], largely because particular needs are not taken into account[4,5] and there are restrictions on entry[2,6]. As a result of this context, the parents' relationship with the newborn (NB) is compromised, despite being essential for the latter[6], and for parental coping.

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In this scenario, collaborative care processes in NUs, that is, the effective incorporation of Family-Centered Care (FCC) are still lacking and requires progress[6-8]. Decision-making and the carrying out of procedures are still centered exclusively on professionals[8].

Given the above and under the assumption that the mother's status as a health professional can favor interactions in the NUs, the question was asked: "What are the perceptions that mothers who are health professionals have about relationships with health professionals in the NU?".

In this context, the aim of the study was to discuss the perceptions of mothers who are health professionals about relationships in the neonatal unit.

The theoretical framework adopted was Symbolic Interactionism (SI), given its emphasis on meanings, interactions, and social actions. The SI understands that human beings interpret facts and behave towards someone or something according to meanings and that these are the result of social and internalized interactional experiences[10].

METHOD

A descriptive, exploratory, qualitative study based on the *Consolidated Criteria for Reporting Qualitative Research* (COREQ)[9].

The inclusion criteria were: having given birth to a preterm newborn who had been hospitalized in the NU for more than five days; having been at home with this child for more than six months; and being a health professional. The exclusion criteria were: the woman had deafness or any other impairment in constructing comprehensible narratives.

The "*Snowball Sampling*" (*Snowball Sampling*) technique directed the location and invitation to the study, given its indication for a specific population and focus on a particular theme[11]. The first steps were taken with the Health and Family research group, with the capture of three potential participants, and all of them agreed to take part in the study. Each of them indicated a new potential participant and this trend was repeated. A total of 12 women were invited, one of whom did not accept, due to a lack of time to get involved in an interview. The participants who agreed were contacted by telephone/online when the research was explained to them. After consenting to participate, the interviews were scheduled.

Data collection took place through a single semi-structured interview, remotely, via Google Meet®, from May to October 2021, lasting an average of 55 minutes; conducted by the first two authors, both with previous experience in qualitative studies. Before presenting the trigger for the interview, some characterization data was obtained: age group, profession, place and unit of professional activity, number of children, gestational age at the birth of the premature child and length of stay in the NU.

The prompt: 'Tell me about your relationship with health professionals during your stay in the neonatal unit' was used to trigger the interviews, which were audio-recorded only, then transcribed and analyzed using thematic content analysis[12]. The supporting questions, presented in a linked way to what the participant had to say, were: 'How did you feel in the relationships with these professionals you mentioned?'; 'Did you feel involved in your child's care?'; and 'How did you characterize the sharing of information?'. Data collection ended when it was saturated, that is, the quality and depth of the data made it possible to understand the phenomenon being investigated[12].

The analytical process began with fluctuating readings of the transcripts to capture the content of the clipped study, followed by rereading and highlighting passages to establish categories. A process of deductive and inductive interpretation led to the analytical conclusion[13].

The research protocol was approved by the Research Ethics Committee, and a digital Free and Informed Consent Form (FICF) was signed and sent in the invitation to the study. The participants' identities were preserved and they were identified by the letter W, alluding to the word 'woman', followed by an Arabic number, translating their entry into the study.

RESULTS

The participants in this study were aged between 30 and 45, and just over half of them were primiparous. The NBs' gestational age at birth was between 28 and 35 weeks, while the average stay in the NU was 65 days. Three participants were mothers of twins and one was the mother of a child diagnosed with *Down*'s syndrome. In terms of professional training, four were nurses, two physiotherapists, one psychologist, one biomedical, one occupational therapist, one nursing technician, and one surgical instrument technician. Only two mothers worked in the same

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hospital where their child was admitted but in a different department. None of the participants were from the neonatal area.

The following thematic categories emerged from the analysis process: “Insertion in the NU: negatives of co-participation”; “Professional solicitude: transformation of women's place”; and “Health professional symbol: impacts on interactional processes”.

Insertion in the NU: negatives of co-participation

The initial times in the NU encompassed the woman's attempt to be a co-participant in the care of her child, but they encountered barriers in their relationships with the professionals in the unit, they felt uncomfortable and a sense of displacement.

They did not identify the availability of professionals for private interactions and characterized the information provided as minimal. They also pointed out that the relational openness was unfavorable to dialogue, including on issues relating to NBs and their therapy. They were also repeatedly told to stop being ‘health professionals’ and be ‘just’ mothers. This intensified their discomfort and distrust.

> *I just think it could be said in a more human, less technical way and without hiding things. Because I think that if you have a diagnostic hypothesis, you don't hide the diagnosis, I was in a position to understand. Then you realize that there's something going on and you become alert, attentive to everything with doubts about whether it's being done properly. (W3)*

> *I felt they wanted to be away from me. Distance like that, no conversations about (child's name). I wondered ‘is everything really all right?’ You're out of place, you can only look on. I kept quiet, swallowing my worries, because they'd say: ‘You're just a mother here, you're not a professional’. (W11)*

> *[...] I wanted to change the way things were, but I was a mother. It's hard to say goodbye professionally. In the beginning, you're in this struggle. The team recommends saying goodbye, but it doesn't fit. (W2)*

On discharge from the hospital, with the greater physical distance from their child and the need to adjust their dynamics to be in the NU, they expanded their internalized reflections about health professionals being the first to touch, hold, or care for their NB. Faced with this, they felt emotionally fragile, amplifying their suffering and worries, with a recurring recollection of being spectators.

> *When I was discharged it was horrible. Now I had to think about how I was going to be there, think about everything: how to get here, whether they would let me come when I could]...]. (W7)*

> *One thing that struck me was that I was helping out, but it was their child, they said: ‘He's my child here, the moment I hand him over to you, he'll be yours’. So I thought to myself: ‘he's mine, I made him, he came from me’, but they said it like that, I don't know if it was out of affection or to put a boundary between us. It stirred things up inside me. (W6)*

In this context, they pointed out how the restrictions on the presence of significant family members negatively marked the woman's experience and had repercussions in terms of loneliness.

> *I missed [...] having someone closer, for example, someone from my family: my mother or my sister. It was a very difficult time for me. But sometimes you want a mother's lap, a word from a sister [...]. So the closest thing to you there was by phone, they called, and I called. (W4)*

The insensitivity of professionals was highlighted.

> *They (the nursing staff) are so busy with technical procedures that sometimes they forget that we're there. [...] And I also felt that at that moment of the first contact, of the lap, there wasn't that thing, they didn't see that I was holding the child for the first time. It's also very mechanical, very practical. (W6)*

Faced with this scenario, in the direction of her collaborative incorporation, one woman tried to demonstrate that she had health knowledge, but she didn't succeed.

> *I tried to get permission, I tried to gently show them that I understood and could think with them. The answer was: ‘Here you have to be a mother, just a mother’. [...] I'd try to give them hints like ‘I can't wait to change the diaper’, but nothing, they just changed the subject. (W11)*

Professional solicitude: transforming the place of women

In general, they commented that their interactions with the professionals had been harsh, with ways of being imposed on them. They emphasized that it was up to them to submit and/or adjust to what was determined by the team, living with their sufferings alone, so that they could guarantee care for their child.

> *I felt like an intruder when it came to treatment and feeding times. As I had both, I would ask: ‘If I'm 5 minutes late, please don't put the milk in the tube’. Even if I arrived 10 minutes early and she was crying, the milk was*

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> *there. Then I'd arrive after 1.5 hours in traffic, and I couldn't breastfeed because she was fed. I didn't get the welcome I expected, I put myself in a position of: 'Let them do what they want to do because I want to take my daughter away'. (W5)*

For some women, over time, some health professionals proved to be more supportive, empathetic, and helpful. Their impression was that they were able to put themselves in her shoes and give her a new meaning as a mother. When this happened, they commented on a gradual transfer of 'ownership' and care of their child to her. This eased the relational discomfort and contributed to the process of becoming a mother. The nursing technicians stood out in this regard.

> *Being perceived as a mother by some (health professionals) gives us a light, and helps us to believe. It's hard to be expected to do this or that, it's as if you're nobody, a robot who has to take care of things, only to be corrected all the time. They always have something to say, to be different. It's horrible, but when a professional comes along who understands you, who stays with you, then the child seems to be yours and no longer theirs. (W8)*

> *Because they (nursing technicians) cried with me the day the baby died, just as they applauded with me the day (the child's name) was discharged. (W1)*

> *[...]They (the nursing staff) brought two mothers from there who had children with Down's syndrome to talk to me, and that was really nice, because later I did it with other mothers too. (W4)*

As health professionals, the women felt a great deal of distress and anxiety about the instability of their children's condition. They associated this with understanding the symbols emitted in the NU. On the other hand, they were delighted when the team integrated this element into their relationship with her.

> *I'd go into a little room to milk, and they already knew I was desperate and anxious, and then they'd come in and say: 'Isn't that (child's name)'s monitor'. Because I would stop and get out of the little room with my breasts out: 'guys, is it (child's name)?' Because his monitor was the one who whistled the most, and they were worried about me, they said: 'Don't worry, it's not (child's name), everything's fine'. (W10)*

> *Over time, they (the nursing staff) even let me check the vital signs, and they said 'You can check the pressure' [...]. I even gave the medication, it was there in the little drawer, and when it was the time, they just told me: 'You can give this medicine', I gave it, changed diapers, gave baths'. (W4)*

Health professional symbol: impacts on interactional processes

The health professional symbol, in the woman's perception, influenced the behavior of health professionals towards her, given the understanding it provoked:

(1) 'health professional has knowledge about prematurity and does not need clarification';

> *The downside (of being a health professional) is that they (professionals) think that because I'm a health professional I already knew a lot of things, but when you become a mother, you forget everything, it seems that my mind fled when I became a mother. (W9)*

(2) 'communication with health professionals should be refined in its language, with no need for explanations or details'; and,

> *With me, the conversation was all about technical terms, as if I knew them all. You know those things where it's implied that it's clear and sometimes it's not. They used more technical words, and diagnostic terms and didn't bother to validate if I knew, if I understood. But sometimes I needed the simple, popular term to understand. (W8)*

(3) 'health professionals evaluate the care provided by other health professionals critically'.

> *I felt the team was uncomfortable with me, it seemed as if they needed to convey that they were great, I had the feeling that they were thinking: 'This woman is looking at everything, evaluating us on everything'. And it wasn't like that. (W11)*

In this way, they conceived that the symbol 'health professional' acted negatively in the interaction with the NU professionals, so that the woman's 'being a health professional' and 'being a mother' became mentally intertwined, pondering developments and deliberating actions. In this scenario, the mother self-tended to withdraw, as the professional self said: 'Don't get into a conflict'.

> *Interventions were made that I didn't agree with, such as passing a tube. She swallowed, I don't know why they put her on a tube, so I questioned it. She spent four days with a nasogastric tube, receiving milk through the tube. This led to a child who was lazy when it came to breastfeeding, early weaning, and the introduction of a bottle. Everything I didn't agree with, I questioned, and the team said: 'It's necessary'. Nobody considered my opinion, so I started to shut up. (W5)*

Some of the participants also reported that the experience helped them to improve their professional self, especially in terms of empathy, with commitments to improve their care for families and mothers.

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You can't say that the situation doesn't affect you as a professional. It does, and you can't do the same. You remember everything and make an effort to give the family space, to feel what they need. You leave transformed as a professional. (W8)

I think it would be completely different from what it is, from seeing us as a threat, to seeing us as partners, seeing us as family. I think it's difficult for us to put ourselves in the other person's shoes, we try, but it's still not there, it's not something that hits [...]. So I think that all of this is also related to culture, to a person's ethical principles, people are different, I left there different. (W6)

DISCUSSION

The failure to recognize the woman as a person and her needs was evident, bringing emotional suffering, a sense of exclusion and that her child do not belong to her[2].

Women want to be co-participants in the care of their NB[14] and this study indicates that the symbol 'health professional' seemed to contribute to accentuating this exclusion. The professionals' behavior was one of space delimitation and incisive signals to be 'just mothers'. One wonders if 'just a mother' is understood to mean being submissive and following professional protocols and commands, without the right to an opinion or a voice, as studies have shown[2,8,14].

Thus, relationships with professionals in the early days of the NU led to marginalization and loneliness for the women, resulting in suffering. In addition, when they were discharged from the hospital, new suffering arose, stemming from the questioning, in their minds, of their place with their child.

In this aspect, the CFF (Brazilian Federal Pharmacy Council, *Conselho Federal de Farmácia*) is based on the professional-family partnership, on achieving fluid, honest relationships, oriented towards recognizing and valuing the other[15]. During the stay in the NU, the indications are that efforts should be made to involve parents and family members[15-17], recognizing their particular needs and empowering them to provide responsive, appropriate, and timely care in terms of encouragement and management of adverse situations[16]. A scoping review identified the following as nursing interventions for the development of the bond: promoting interaction with the child, with the presence and physical proximity of the parents, as well as including them in the care of the newborn, when interaction between the parents and the nursing team is fundamental[18]. However, the findings of this study did not show the widespread presence of these markers in relationships, revealing dishonesty and concealment of information, fundamental elements in communicating difficult news[19].

Furthermore, it was identified that the women were trying to 'silence' their self-professional, who was always there to interact internally or externally with the situation. And so, as they tried to silence their self-professional, they led themselves to silence in the name of non-conflict, which caused intense emotional suffering. This behavior was achieved through an interactional process with themselves and, in an intense symbolic interpretation of the experience, directing actions[10].

In this way, the denunciation of suffering as a result of professional behavior points to the need for changes in the interactions and ways in which mothers are inserted into the NUs. In addition, the act of withdrawing for fear of the quality of care that will be given to the child was linked to the symbol of 'being a professional' and kept the women's *self* in intense activity. Another effect of the same symbol is that it leads the professional to believe that the woman has knowledge and is evaluating him.

It is worth highlighting the recommendation of the NU's health professionals that the woman stop playing the role of 'health professional' and just be a 'mother', which is innocence because historicity is manifested in everyone's being and in the different social roles they occupy, derived from dynamic, complex and interrelated mental processes. In this scenario, the SI highlights the role of the active human being as a central idea, emphasizing that the individual interacts, thinks, defines, applies their past, and makes decisions in the present[10]. In this way, the symbol 'health professional' should prompt the professional to inquire about the particular needs related to the symbol, a behavior not revealed in the results of this study.

One of the driving forces behind CCF (Family Centered Care, *Cuidado Centrado na Família*) is the negotiation and clarification of the roles of professionals and the family14,20 [14,20], which was not evidenced in this study. The professional is responsible for a daily exercise involving questions such as: 'Who is this woman-mother?', 'Am I giving her space to reveal herself to me?', 'Am I creating a safe and trusting space for her to show herself?', 'What needs do they have?', and 'Am I talking to her so that we can collaboratively identify ways in which I can respond to what she needs?'.

Therefore, the nurse, being immersed in the care relationship, has the potential to induce broader perspectives, partnerships, and welcoming in the NUs[18,21] and thus contribute to the safety and experience of this woman and her family[4,22].

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Therefore, the results of this article add to the knowledge about the experience of mothers in NUs, focusing on interaction with NU professionals and the perspective of "when" mothers are health professionals, an innovative element. The relationships were insufficient in terms of communication, dialog, and inclusion of the mothers, and the symbol 'health professional' acted as an intervening factor in the interactions. In addition, the incipient relationships indicated that they went against the structural elements of the CCF, which have also been mentioned in other studies[20,21,23].

On the other hand, the experience had repercussions in terms of transformations in the professional self-confidence of the mothers, with intentions to behave in a solicitous, empathetic, and supportive manner towards those who demand their professional care.

Study limitations

It should be noted that the study's limitation was the number of participants, which restricted generalization, as opposed to the rigor and theoretical-methodological alignment and density of the interviews.

CONCLUSION

The data from the study broadened the understanding of the perceptions of female health professionals and mothers of preterm NBs about their relationships with health professionals in the NU. It revealed that these relationships are a central determinant of the experiences lived, with chances of promoting suffering. This was due to the lack of investment in collaborative processes, the lack of openness to dialog, and the denial of maternity and motherhood projects, causing loneliness and exclusion. The symbolism of the 'health professional' acted as an obstacle to interactions, contrary to the initial assumption.

Regarding the implications for practice, the findings have the potential to direct and qualify relationships between professionals and mothers in the NUs, as well as discussions that can be taken up in health training courses.

Finally, studies are suggested, from the point of view of NU professionals, on the determinants of relationships with mothers and/or family members of health professionals who are accompanying premature babies.

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Authors' contributions

Conceptualization, M.A.B. and A.S.C.V.; methodology, M.A.B. and A.S.C.V.; software, not applied; validação, M.A.B. and A.S.C.V.; formal analysis, M.A.B., A.S.C.V., I.C. and M.A.B.; investigation, M.A.B., A.S.C.V. and I.C.; resources, M.A.B.; data curation, M.A.B.; A.S.C.V. and IC..; manuscript writing, M.A.B., A.S.C.V., I.C. and M.W.; manuscript review and editing, M.A.B., A.S.C.V., M.W., A.I.B.O. and G.P.; visualization, M.A.B., A.S.C.B., I.C., M.W., A.I.B.O. and G.P.; supervision, M.A.B.; project administration, M.A.B.; financial aquisition, I.C. All authors have read and agreed to the published version of the manuscript.