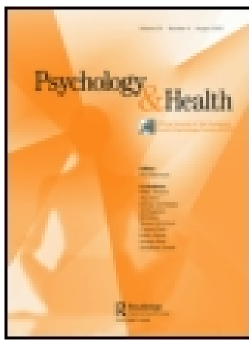

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"I Still Have Difficulties Feeling like a Mother": the Transition to Motherhood of Preterm Infants Mothers

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Abstract

Objective. The premature birth of their infant can constitute a sudden interruption of the transition to motherhood that requires a reorganisation of the process. The present study aimed to analyse the experience of the transition to motherhood of preterm infants' mothers, framing it within Stern's transition to motherhood theory (Stern, 1995).

Method. A semi-structured interview was administered to 30 mothers during the recovery of the infant in the Neonatal Intensive Care Unit. The interview explored the experience of mothers related to pregnancy, the infant's birth and recovery.

Results. Thematic Analyses evidenced four interrelated themes: disconnection from the child, perception of maternal inadequacy, loss of parental role and temporal suspension. The themes showed that the mothers' experience of preterm birth not only concerns the traumatic delivery, but is also embedded in the entire process of becoming a mother within an institutional context.

Conclusions. Results were connected to Stern's theory. Findings revealed difficulties for preterm mothers that could affect the development of the maternal constellation and thus their transition to motherhood. These difficulties may influence the construction of maternal identity, mother's representation of their child and the bond with their child.

Keywords: preterm birth, transition to motherhood, motherhood constellation, Thematic Analyses

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"I Still Have Difficulties Feeling Like a Mother": the Transition to Motherhood of Preterm Infants Mothers

It is well recognised that the pregnancy experience and the birth of a baby is a great turning point in the lives of parents, during which they are faced with a number of adaptive and transformative tasks (Stern & Bruschweiler-Stern, 1998). Women, in particular, are required to transform their identity, integrating new functions, related to the ability to care for, protect, empathise with and adequately respond to the new-born (Slade, Cohen, Sadler, & Miller, 2009). The premature birth of a baby is a sudden interruption in this process of building representations of the child and of oneself as a parent. Prematurity thus also becomes a characteristic of the developmental process of becoming parents. The present study aims to analyse the transition to motherhood for mothers of preterm infants in depth and to frame preterm mothers' experiences within Stern's (1995) theory of the transition to motherhood.

According to the World Health Organization (2012), an infant is preterm when she/he is born before completing the 37th week of gestation. Thanks to advancements in medical knowledge and modern technology available in Neonatal Intensive Care Units (NICU) (Alexander & Slay, 2002), the majority of preterm babies now survive. Consequently, over the past several decades preterm delivery has become an increasingly common occurrence (around 10% in western countries; Boldrini, Di Cesare, & Tamburini, 2009; WHO, 2012). However, a number of studies have identified prematurity as a risk factor, affecting the baby's development, the mothers' well-being, and the early mother-infant relationship (Aarnoudse-Moens, Weisglas-Kuperus, van Goudoever, & Oosterlaan, 2009; Korja, Latva, & Lehtonen, 2012; Spinelli, Poehlmann, & Bolt, 2013).

Prematurity as a Risk Factor: Impact on Mothers' Well-Being and the Mother-Infant Relationship

Many studies explored the impact of prematurity on infant development, but only a few qualitative studies focused on the effects of this experience on maternal well-being. Understanding

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this complex parental experience to a greater degree is important not only to meet the parents' needs and concerns and enhance their well-being, but also to promote the mother-infant relationship.

When a baby is born preterm, the end of the pregnancy is usually sudden and unexpected, thus catching the women off guard (Black, Holditch-Davis, & Miles, 2009; Suttora, Spinelli, & Monzani, 2014; Whittingham, Boyd, Sanders, & Colditz, 2014). In this sense, as suggested by Tracey (2000), mothers are 'hurled' into motherhood. Lupton and Fenwick (2001) and Baum, Weidberg, Osher and Kohelet (2012) reported that mothers describe preterm delivery as producing a sense of failure and inadequacy because they were unable to sustain their pregnancy to term and to protect the baby from harm, pain and discomfort. Furthermore, once mothers have the opportunity to see their infant, many experience their infant's physical appearance and behaviour as stressful. There is a great discrepancy between the mother's imagination and fantasies of her child and the preterm infant, who is perceived as fragile (Holditch-Davis & Shandor Miles, 2000). Meijssen et al. (2011) reported that 50% of preterm infant mothers described negative emotions about the first time they saw their baby, such as fear about how small the infant was, of his/her medical condition and feelings of alienation. Among these mothers, 31% felt that the baby was not theirs.

At the time of birth, the infant's central nervous system is not fully organised to sustain itself in the extra-uterine environment. The infant's risk for survival and serious on-going medical and physical complications may require hospitalisation in the NICU for several days or, sometimes, months (Talmi & Harmon, 2003). Thus, preterm babies are quickly separated from their parents, and mothers must leave the hospital without their infants, which is not what they had envisioned during their pregnancy (Hall, Kronborg, Aagaard, & Brinchmann, 2012). Consequently, very early interactions between mothers and their preterm infants occur in an atypical environment such as the NICU. As highlighted by Black et al. (2009), mothers, experience emotional exhaustion and helplessness because they face the possibility of the infant's morbidity and mortality. Moreover,

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mothers feel detached and uninvolved in the infants' care, due to the limited opportunity to stay with their baby.

Furthermore, the children's medical conditions and the highly technological NICU environment require expert knowledge, maternal participation and care thus tend to be in the background. The combination of the physical setting and the staff's intense involvement with the infant, coupled with limited opportunities for caregiving, may contribute to a sense that the staff has usurped the parental role, constituting a major stressor for mothers of preterm infants (Meyer, Zeanah, Zachariah Boukydis, & Lester, 1993) and a traumatic experience that determines loss of control as parents (Whittingham et al., 2014). Callery (2002) reported that mothers required permission to feel free to touch and care for the baby, and Watson (2010) highlighted that for some mothers, it is as if their baby belonged to someone else. Mothers perceive themselves as inadequate caregivers because they are unable to provide even the most basic needs for their sick infant (Padovani, Linhares, Pinto, Duarte, & Martinez, 2008).

Regardless of the reason for the early birth or hospital stay, this disruption of the typical relationship between mothers and their new-born during the infant's hospitalisation, with the absence of the opportunity to interact with and freely touch and cuddle their infants, may adversely affect the emerging mother-child relationship, maternal attachment behaviours and the representations of the baby (Feldman, Weller, Leckman, Kuint, & Eidelman, 1999; Muller-Nix et al., 2004). As described by Black et al. (2009), for some mothers, the bond of love that began in pregnancy and that they expected to deepen with birth is suspended until the baby's survival becomes more likely.

Theoretical Framework

Our theoretical framework refers to Daniel Stern's conceptualization of the psychological transformation of women in preparing to become a mother (Stern, 1995). Stern explained that the 'psychological birth of a mother takes longer and has many more phases than just labour and delivery' (Stern & Bruschweiler-Stern, 1998, p. 46). It is a process that starts from the beginning of

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pregnancy and continues through delivery and the first years of infant life. During this period, the new mother experiences a unique stage of life with a new set of tendencies, sensibilities, fantasies and wishes. Stern called this new organisation of mental life 'the motherhood constellation' (Stern, 1995). He defined it as a stable, basic mental organisation that emerges in most mothers and remains active from months to years. It can be reactivated during a life time when the child needs his/her mother's attention.

The motherhood constellation, developing during pregnancy, concerns three discourses and four themes that are crucial for the development of a relationship with the child. The first two themes regard a mother's protection of the baby. The first is about the physical care and the primary concern to keep the baby alive, while the second theme concerns the emotional care and protection of the baby, including providing sufficient love and attachment. Thus, mothers have different specific fears relative to their infant's survival and the quality of their mothering skills. The third theme is centred on the network the mother needs in order to fulfil the maternal role. Stern called this network the maternal matrix. Observing other successful mothers -the first being the mother's own mother- aids in developing an understanding of the meaning of motherhood, mother-child interactions and contributes to the validation of the new maternal identity. The fourth theme involves the transformation and reorganisation of the mother's new self-identity as a mother. All these themes are articulated through three symbolic and real discourses, between the mother and her own mother, her baby and herself concerning self-reflections on her behaviour, experiences and her role as a mother. The relationship that develops between the mother and infant is therefore the complex result of interactions between the intrapsychic mental representations of the mothers and their interpersonal dyadic exchanges (Bruschweiler-Stern, 2004).

The understanding of this particular mental organisation of mothers is essential in order to empathise with mothers, with their needs and to understand their experience.

In Stern's view, the last months of pregnancy and the first months of the infant's life are crucial in the development of the motherhood constellation. Consequently, within this theoretical

framework, we may hypothesise that the difficulties faced by mothers of preterm infants at delivery and during the recovery in the NICU, may seriously distort the motherhood constellation. As a consequence, the process of building a maternal identity and the relationship with the infant may become even more challenging (Stern & Bruschweiler-Stern, 1998). Even if Stern and Bruschweiler-Stern (1998) and Bruschweiler-Stern (2004) hypothesised this effect in their work, to date, the topic has not been explored within a structured qualitative study. The main aim of the present study is to fill this gap, by exploring the effects of preterm delivery and infant hospitalization on the development of the motherhood constellation.

Qualitative methods are widely used in health psychology to understand both the subjective experiences of participants and how they perceive their social worlds. Qualitative interviews may provide mothers with an opportunity to spontaneously express their emotions, anxieties and difficulties, related to the premature birth and the subsequent hospitalization of the infant. Understanding this complex experience from the mothers' point of view is important to meet mothers' needs and concerns, enhance their well-being and promote the mother-infant relationship (Herd, Whittingham, Sanders, Colditz, & Boyd, 2014). Moreover, a qualitative approach is particularly useful when topics are both contextually -related to the environmental conditions- and subjective -concerning the identity and the self- as in the case of preterm delivery in the hospital institution.

Method

Participants

The participants were 30 mothers of preterm babies born between 24 and 36 weeks of gestation with a mean gestational age at birth of 29 weeks. The characteristics of the participants, recruited in an NICU at a hospital in Northern Italy, are described in Table 1 [Insert Table 1 near here].

All mothers except one had a caesarean delivery. Twelve of them had experienced previous abortions, and ten of the pregnancies were a result of an assisted reproduction procedure. Twenty-four participants were first-time mothers, and six of them had twins. Prenatal characteristics of the

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sample are in line with the typical population of preterm mothers (Goldenberg, Culhane, Iams, & Romero, 2008).

The mean age of the mothers was 34 years (*range*: 23 - 41). Only one mother was not in a stable relationship and lived alone. One mother had a primary school certificate, 15 had a secondary school certificate, 13 had a university degree, and one had a post-graduate degree. Four mothers were housewives, and all the others were employed and on maternity leave at the time of the interview.

Procedure

Data were collected in the context of an agreement between the University and a hospital located in Northern Italy.

The mothers were approached when the infant's medical condition stabilised and they were transferred from the intensive therapy unit to the NICU (*M* = 34 days after infant birth, *SD* = 24). Nurses invited the families to participate in the study. We attempted to motivate the families to collaborate with us in 'a study of how families deal with prematurity so that we can find out how to improve our public health services'. The mothers were provided with written and verbal information regarding the project and were asked whether they would participate. Only mothers fitting the inclusion criteria were contacted: both parents consented to being involved; the infant was born between 24 and 36 weeks of gestation; the infant had no known congenital problems or significant neurological findings during the NICU stay; mothers were at least 18 years of age; and mothers could speak and understand fluent Italian.

After the mothers indicated their willing to participate, the researcher met the mothers in an appropriate room inside the hospital. The consent form was read in its entirety, and parent anonymity and confidentiality issues were discussed. Mothers were informed about how their experiences would be recorded and the strategies of managing the data, including storage and securing anonymity. Furthermore, the mothers understood that participation was voluntary and that

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they could withdraw participation in the study at any time without any repercussions. All the necessary information was given to mothers.

Information about the family was collected before starting the interview. Information about the infant's medical condition and his/her history of hospitalisation was collected in the review of medical records.

The interview was a semi-structured interview developed ad hoc for this research in alignment with the aims of the study and research questions. The literature review, particularly the study of Padovani et al. (2008) and the CLIP interview developed by Meyer et al. (1993), greatly assisted in specifying the range of useful questions to better understand maternal experience. The interview was intended to review the mother's lived experience of pregnancy, delivery, and the current situation of the infant's recovery. The mothers were asked to narrate the primary positive and negative aspects related to these key moments of the transition to motherhood. The questions and probes are reported in Table 2 [Insert Table 2 near here].

The interview was administered in an open way with a non-interventionist style in an empathic and understanding climate. The interviewers attended to the mothers' emotional reactions and made them feel comfortable and accepted.

The interviews lasted an average of 1 hour and were audio recorded and subsequently transcribed word by word.

Data analysis

A qualitative analysis of the interview transcripts was performed using inductive thematic analysis, in which dominant themes were identified through a careful examination of the data (Braun & Clarke, 2006; Flick, 2009).

The interviews were verbally transcribed taking annotations about any other useful information as well as the emotional tone of the mother. The transcribed data were then read and read again several times and notes and ideas were generated through transcription and data immersion. We identified codes and repeated patterns within the data that we considered pertinent to the

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understanding of maternal experience. The next stage involved searching for themes; different codes that may have been very similar or may have been considered focused on the same aspect within the data were combined. All initial codes relevant to the research question were incorporated into a theme. Further coding also took place at this stage to ensure no codes had been missed in the earlier stages. Once a clear idea on the various themes and how they fitted together emerged, the themes were defined and named. Then, the results of coding were discussed within the entire research group. Considerations were made not only around the story told within individual themes, but also around how these related to the overall story evident within the data. A further re-reading of all interviews permitted us to verify whether the identified themes were clearly recognisable in the transcripts and to ensure that all salient themes had been identified.

The final stage, the report production, involved choosing examples of transcripts that were selected based on their representativeness and relevance to the themes.

All data were analysed in their original language to preserve the participants' original meanings, although thematic headings were formulated in English only. The quotations were first translated from Italian to English by the primary investigator and then reviewed by a bilingual interpreter to ensure equivalence of meaning. Participant anonymity was protected by not using real initials.

Results

From the analyses of mothers' narratives four interrelated themes emerged. The themes characterise the experience of preterm mothers in relation to the transition to motherhood that they experience within the hospital institution of the NICU; thus, the themes can be thought of as dimensions around which the experience of becoming mother in an institution may be articulated. The first theme, the disconnection from the child, describes the feelings of dispossession experienced by mothers. These feelings are primarily linked to a bodily dimension characterised by lack of emotional and physical contact and lead to difficulties for mothers in recognising the baby as their own. The second theme, the perception of maternal inadequacy, relates to the mothers' feelings of being unable to protect and take care of the baby; it shows the contraposition between

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the dangerous character that mothers attribute to themselves and the safe character they attribute to the hospital staff. The third theme, the loss of the parental role, concerns the constant presence of nurses and physicians, who, according to the experience of mothers, are in charge of taking care of the baby; the institution's staff takes on the maternal role, which leads mothers to experience feelings of powerlessness and delegitimation. The fourth theme, the temporal suspension, relates to the discontinuity that characterises the mothers' experience of time; this disconnection between past, present and future makes them feel as if their transition to motherhood was suspended in a limbo. Overall, the NICU environment and policies -with its timetable and limited access hours, the medical technologies that surround the infants and the fundamental role of nurses and physicians- constitute an institutional Other that is seen by some mothers as both lifesaving and invasive and thus provokes feelings of ambivalence. These results show that the mothers' experience of preterm birth not only concerns the traumatic delivery but is embedded in the entire process of becoming a mother within an institutional context, which may influence the construction of the maternal identity, the mother's representation of the child and, therefore, the bond between mother and child.

Theme 1: The disconnection from the child

Mothers emphasised the immediate disconnection they experienced from their infants in relation to both the delivery and the infants' hospital recovery.

Regarding the delivery, some participants claimed that they felt as if they were deprived of the child and the natural experience of birth because of the artificial nature of the delivery. Indeed, all mothers but one underwent a caesarean birth, which is experienced as a surgical intervention, followed directly by the transfer of the child to the intensive care; this did not help the mothers experience the birth as a normal childbirth:

They took my little child away from me, and until I saw her the next day, I did not digest the birth. It was a weird situation in a sense. Yes, a delivery, but an artificial one. (ID. 5)

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The preterm deliveries in this sample were unexpected. Many of the mothers claimed that they did not have the time to construct an image of the baby; thus, they encountered their real baby without the support of an imaginary representation:

I hadn't imagined him yet because everything happened so quickly. (ID. 29)

The conditions of the delivery also prevented mothers from having an opportunity to see their baby directly after delivery, given that, due to difficult medical conditions, they were placed in the intensive therapy unit or in the NICU. Thus, the mothers could see the babies only when their own physical conditions allowed them to go to the NICU, and the initial interaction between the mothers and their infants occurred under the supervision of the medical staff: It was a third person, the physician, who showed the mother who her baby was.

It really influences the formation of the bond with the child; that is, you see her the next day, and they have to tell you that is your daughter… it is a bit tough… and even after that, the bond I imagined it would have been at the beginning did not develop. (ID. 2)

The first encounter with their infants is characterized by the sensation of being deprived of the child and the presence of a professional mediator. This led difficulties for the participants in recognising their baby as the same one who was in the belly and that they imagined and fantasised about during pregnancy:

After all, there is always this issue of being able to recreate this relationship. I have to understand that he's the one who was previously in the belly and now is out… (ID. 3)

Mothers developed an ambivalent attitude towards the context in which the first interactions between themselves and their children took place. On the one hand, the hospital environment is lifesaving and necessary for the baby; on the other hand, it is constraining and violent:

You know he cannot get out of there. I know that this is the best thing for him, that it is saving his life…however, it is really a violence…the noises, the needles and all the other things; they do that to every baby… you know they are helping them, but even so... (ID. 16)

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During the recovery, the medical equipment that surrounds the baby (e.g., the incubator, tubes, and masks) is viewed as a physical barrier that prevents the connection between the mother and the infant, as the first of the following quotes highlights, and makes mothers feel insecure in their approach to the baby, as shown in the second extract:

Between you and your child, there is this wall because it is really a wall! It's as if they took him away from me. (ID. 28)

I was not familiar with him. With a child so small… with the fact that he always had the mask and tubes, picking him up was really challenging. (ID. 1)

The presence of a physical barrier implied for all the mothers the necessity to rely on the hospital staff to interact with their baby, which introduced in the intimate space of the mother-infant relationship an unfamiliar power dimension related to issues of permission and authorisation:

You see your child in a little box. I call the incubator that. He is in there, and to pick him, up you must ask because he is attached to the tubes. (ID. 10)

Overall, mothers' feeling of being deprived of their child and the lack of non-mediated interactions may result in a reduced emotional and psychological connection with the infant and, consequently, in difficulties in the elaboration of an image of themselves as mothers, which in turn may negatively influence the construction of their bond with the baby.

Theme 2: The perception of maternal inadequacy

Mothers reported a feeling of inadequacy because they were not able to protect the baby throughout the duration of the pregnancy by carrying the baby to term.

Mothers of preemies generally blame themselves a bit…'Maybe I did something, maybe I could, maybe…' I do this even more because although I'm physically healthy, unfortunately, I could not, as a woman, take the pregnancy to the end. (ID. 24)

In this regard, the mother's body is not seen as a place that is able to generate and protect the baby. Instead, the mother's body may end up being experienced as an unsafe, risky and dangerous place for the infant. In the following quote, the mother expresses a feeling of detachment from her

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own body, whereby she speaks about her belly as if it was not hers. The belly is named "bastard" as if it was a separated entity. The attribution of negative features only to a specific part of the body may be interpreted as a way for the mother to manage her sense of guilty:

To take him out of my belly, they had to hurry to get him out of this bastard of a belly. Unfortunately, my belly was not generous to my son…. (ID. 27)

The sense of not having been able to protect the baby until the end of pregnancy translated into the fear of potentially harming the child during the infant's recovery that make them feel as potentially damaging:

I'm a little tense when I take her up because everything is new, but what's more important... I fear hurting her when I touch her. (ID. 17)

This mothers' representation of themselves as potentially damaging is simultaneously balanced and contrasted by their attributing the characteristics of competence to the hospital staff:

The nurses are very skilled, and I could see that they took care of the child, all children. (ID. 1)

Mothers see themselves as 'mothers in training' who have to learn how to manage their babies. This self-positioning is in a mutual and dialectic relationship with the positioning of the staff members; in teaching mothers how to behave, nurses simultaneously offer them important help and keep them in a childlike position:

The nurse who tells you how to touch him, I was never able to touch him because I was scared of hurting him, so you find these people […] who tell you what to do. (ID. 7)

They taught me a lot; the nurses that I found here taught me a lot. (ID. 2)

Thus, the transition to motherhood for these women is characterised by a dichotomy that juxtaposes safety and competence on the institutional side and inadequacy and harmfulness on the mothers' side. In this sense, the possibility of being a 'normal mom' passes through the legitimation of acting as a mother, which has to be facilitated by the hospital staff:

When they gave me her to hold for the first time, I did not expect it. I thought she was too small. So, for three seconds [crying], you feel almost like a normal mom! (ID. 12)

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These feelings of inability may affect women's construction of their maternal identity, which might be marked by mothers' self-perception as insufficient and inadequate, a perception that was also projected in the future after infant hospital discharge.

When he gets out of there, I really do not know. There is the fear that he will not feel well, the fear of not noticing that something is wrong, not immediately understanding his language. (ID. 5)

My fear is not being able to do things, but I'll do my best. (ID. 28)

Thus, mothers' lack of self-efficacy and confidence resulting from the premature delivery doesn't seem to be addressed by the mothers and the institution in a way that may empower the mothers, on the contrary it is solved through a double positioning that keeps mothers feeling unable and incapable.

Theme 3: The loss of parental role

The sense of inadequacy interplayed with another dimension that characterised the mothers' experience: the loss of the parental role that mothers had during their pregnancy and expected to have after delivery. Mothers not only perceived themselves as having been and still being incapable of protecting their baby; they also felt they were unable to take care of him/her because the hospital context in which they experienced motherhood was alongside the institutional Other, personified by the medical staff, who assumed the maternal role and the functions and tasks associated with it:

I cannot cuddle him at home. This is it. It is the situation itself that does not allow you to be the mother already (...) no, I already feel like a mom, but I cannot take care of my own child. (ID. 24)

The impossibility of bringing their child home represents to them the impossibility of building an intimate and familiar space for themselves and their babies and leads to a fragmentation in the experience that is difficult to assimilate: The baby is here but is not here.

Yes, I definitely have been thrown in another… dimension… because I now assert, 'he's here', although I haven't got him here at home; he is in the hospital. (ID. 27)

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It's not like giving birth and bringing home a baby and having the problems that a new-born baby can give you. It's something different. You come home, and the child is not there; it is here but in the hospital. (ID. 14)

For some mothers, a potential effect of this umpteenth element of disruption is that the baby sometimes is thought of as existing and sometimes is not:

While I'm here, I only think of her, and all the other thoughts are blocked…but especially at the beginning, every time I had to leave the hospital, it was almost as if she did not actually exist. (ID. 13)

In this sense, the discontinuity of the mothers' experience in terms of contacts and concrete interactions with their babies, who were present in their lives at intervals, produced an intermittence in the way mothers thought of the real existence of the baby, an existence that may be marked by an element of partiality, non-continuousness and non-entireness.

The loss of the maternal role is shown in the mothers' perception of not having the right or the opportunity to make choices or to do anything concrete for the baby. In particular, mothers express their discomfort in having to share their parental role with the institution's caregivers. This situation, in which they have to rely on decisions made by others who are positioned as more competent caregivers, seems to be characterised by a state of dependence on the medical and nursing staff:

And you had to rely; you had to rely because you know that you cannot do anything. It is not you who can decide. Then, I entrust them with the hope that they know what they are doing! (ID. 7)

The fact that decisions and actions are all on the side of the hospital staff not only reduces the proactive attitude of mothers but also introduces a power dimension that takes the shape of constant supervision, control, and the need for permission and instructions. Mothers felt they were always under the supervision of the staff because they needed permission to touch, handle or take care of their infant. In this sense, participants depended on the staff's judgment; they could behave as

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mothers only when they were allowed to. This dynamic increased their feelings of dispossession and loss, as is shown in the following extract:

It is very difficult because you say, 'May I hold him today?' And no, they say, 'not today' [she cries]. *It is as if he is no longer mine, and I have to accept it*. (ID. 10)

A major problematic aspect for mothers was what they experienced as the arbitrary character of the staff's decisions and instructions. When no explanation was provided and mothers had difficulties in understanding the reasons behind such decisions, they felt confused and perceived instructions as both a limitation of the maternal involvement in the infants' care and a delegitimation of their caregiving abilities, which led to feelings of powerlessness:

Moreover, every day, I find a different nurse, and everyone has his personal theory. One says you can hold him before meals, another says you can hold him after meals…now he's asleep; I'm not going to give him to you. Now he's asleep; I'll give him to you because he is quiet…. I said, damn you! You decide, but if you say I can hold him and you say this is right, that's okay, that's it! (ID. 6)

Powerlessness and disorientation, pervasive elements of the mothers' experience, were also caused by the fact that despite the permanent presence of the institutional Other, which established the rules to be followed, mothers lacked a reference point, that is, one or more figures on whom to rely for information and explanations about the evolution of the infant's situation, the procedures and the organisation of the institution. In this regard, the Other, incarnated by the institution, is always present but is also unstable, changeable, and impenetrable and therefore difficult to understand:

You are left on your own. I am still struggling in this sense. So far, I do not understand who's following Jack; I don't understand what kind of ideas they have, what is the procedure… I do not understand who drives the decisions. (ID. 29)

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I feel it lacks…someone who tells you how the situation evolves. You're a bit disoriented. It is true that the doctor comes by every day, but they don't really explain that much. You are always a bit afraid with your thoughts and concerns. (ID. 13)

Therefore, mothers were in an ambivalent relationship with the medical and nursing staff of the hospital institution. On the one hand, they recognised the competence of the professionals and the fundamental role they had for the baby and themselves; in this sense, the hospital was positioned as a 'putative mother' that should take care of both babies and mothers. On the other hand, this role differentiation, which was also a power differentiation, contributed to their feelings of inadequacy, loss of control and delegitimation.

Theme 4: The temporal suspension

Mothers associate their experience of preterm delivery with a suspension in time that is linked to a number of dimensions. First, the delivery represented for the participants a discontinuity between past and present. Indeed, many mothers reported that it was almost impossible for them to process what was happening at the moment of childbirth. For the mothers, it was like observing a situation into which they were thrown without having time to focus and understand:

A sudden thing changes your life in a few seconds. You cannot focus on it. You must run after it and that's it. (ID. 22)

There was absolutely no, no problem. This thing was just like a sudden 'cold shower'. Something I never thought about in my life. I was thrown into the baby's birth. (ID. 25)

The experience of time disruption is also tied to the fact that during infant hospitalisation the timetable is defined by the institution. Thus, the temporality of the relationship between mothers and babies is organised by an Other that establishes the rules and, in so doing, determines the separation from and reunion with, the infant. In the mothers' words, this dimension led them to experience continuous forced separations from the infant during his/her hospitalisation:

In my opinion, the main difficulty for the mother is when she has to go away. She is here for half an hour or for an hour. She does the kangaroo therapy and then she has to go… (ID. 5)

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The disruption concerning the past in relation to an unexpected present and the external definition of the temporality of contacts and interactions between mothers and babies affect both the way participants live their present and their ability to think about the future. Indeed, mothers tend to position themselves as powerless subjects who just have to wait and cannot be of any help to the child. The mothers' self-perception of impotence makes them live suspended in a sort of limbo:

Well, certainly seeing her there is not easy (she cries). Seeing her there like that… and I cannot do anything. I feel powerless. I can only wait. (ID. 25)

It's difficult because I still have difficulties in imagining myself as and feeling like a mother. I don't know why, whether it's normal or not. It happened 10 days ago but I felt (…) I'm still struggling with it. (ID. 19)

The disconnection from, and the overwhelming character of, the present situation makes it difficult for mothers to think about the future, as many participants reported. Most of the mothers, indeed, expressed fear and concerns when answering the question 'How do you imagine the infant in the future?' They felt it was impossible to even imagine a future for themselves and their baby:

I do not know… if I think of the future I say, maybe I'll have another setback, and this future will not come…for that reason, sometimes I think about it, it is impossible not to think about it, but I do not want to think too much of it because… I do have fear. (ID. 12)

Discussion

The aim of the present study was to explore how Stern's theory of transition to motherhood is detailed with respect to the experience of mothers of preterm infants during the hospital recovery of the baby. The analysis of 30 semi-structured interviews with mothers led to the identification of four themes that characterise the experience of mothers of preterm infants shortly after childbirth and during the baby's recovery in the NICU. The four themes are strictly interrelated and can be interpreted in terms of the transition to motherhood. Across these themes emerges the fundamental role of the medical staff and the hospital environment, which together represent an institutional Other that shapes and deeply influences the maternal experience. Within this complex situation, the

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development of the motherhood constellation as identified by Stern (1995) can become seriously distorted.

The first theme, the disconnection from the infant, describes the sense of dispossession and distance from the infant that the mothers experienced starting from the delivery and throughout the recovery of the baby. Stern (1995) wrote that, becoming a mother entails transforming and reorganising one's self-identity within the new constellation of motherhood. In essence, the new mother must shift her centre of identity from daughter to mother, from wife to parent, from one generation to the subsequent one. As the author highlighted, this process starts during pregnancy, a special period in which the mother fantasises about herself as a mother, about the child and about their relationship. Our results suggest that premature birth interrupts this process, thus interfering with the normally expected transition to parenthood. In line with the literature, the unexpected birth of the baby and separation from him/her occur before the mothers are psychologically and physically prepared (Lupton & Fenwick, 2001; Padovani et al., 2008). As indicated by our results, mothers not only felt deprived of the last months of pregnancy, but also had to reorganise their representations and adapt their fantasies about the ideal and imagined infant in favour of the real new-born. In line with previous studies (Meijssen et al., 2011), our results also suggest that the physical appearance of the infant and the supportive technologies that surround the baby are experienced as physical barriers, representing a significant source of worries for mothers and make them feel disconnected from their baby. Stern assumed that opportunities to interact freely with the infant and to develop intuitive, sensitive, caring and protective reactions towards the baby are essential for the development of the first two themes of the motherhood constellation. Our results evidenced that preterm mothers lack these experiences, suggesting that this distortion of the motherhood constellation may obstruct the mothers' ability to build a bond with their infant (Stern, 1995). Other authors reported this feeling of distance (Lupton & Fenwick, 2001) and revealed that this missed intimacy could lead to mothers having feelings of powerless and loneliness (Hall et al., 2012). Our findings extend the current literature, suggesting that the entire context of the hospital

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institution, with its mediating role between mothers and their babies, impact on the possibility to develop a physical and emotional contact with their infant, the first two fundamental themes of the motherhood constellation, resulting in an overall experience of disconnection.

This sense of disconnection from the infant and the consequent lack of interaction with him/her are connected to a sense of maternal inadequacy. This second theme relates to the mothers' feelings of being potentially damaging to, and unable to protect the baby during pregnancy, at delivery and throughout the infant's hospitalisation. As highlighted by Lupton & Fenwick (2001), mothers of preterm babies reported feelings of failure and guilt for the preterm birth, because they felt responsible for having given birth to a high-risk infant. As our results show, this is connected to feelings of inadequacy and fears of harming the baby. While fears regarding the baby's safety are typical of the motherhood constellation in general, stimulating mothers' protection of their child, our results show that preterm mothers perceived themselves as potentially dangerous for the baby. This aspect of the mothers' lived experience contrasts with the safety mothers attribute to the hospital staff and environment, which are perceived, respectively, as more competent and as necessary for the child's protection. As reported in the literature (Flacking, Ewald, & Starrin, 2007; Lupton & Fenwick, 2001), mothers 'learn' caretaking and routines from the medical staff. Furthermore, nurses' behaviours and comments strongly affect mothers' representations of parental efficacy (Aagaard & Hall, 2008). In this respect, our results add to the current literature by suggesting that mothers' may experience their position to be child-like. This in turn may interfere with the transition from a daughter-like identity to that of a parent, an important aspect in the development of the motherhood constellation. Stern's third theme is represented by the maternal matrix, that is, the new mothers' active search for a network of other mothers (Stern & Bruschweiler-Stern, 1998). Preterm mothers do not have this experience during the first weeks or months of their infant's life, since their maternal experience is confined to the hospital environment. Moreover, our findings show that, in the case of preterm mothers, the maternal matrix is represented by the institutional Other. As emerged in our third theme -the loss of the parental role- the constant

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presence of medical staff has a potential negative effect on mothers. On the one hand, mothers relied on the staff's competence; on the other hand, the caretaking role of the institution contributed to the mothers' perception that the medical staff had taken over the maternal role. For example, the fact that the main decisions about the infant were made by the medical staff, led mothers to feel like helpless observers of the caring and medical procedures applied to their babies, as already stated by Alderson, Hawthorne, and Killen (2006). Moreover, when mothers had the opportunity to participate in the care of their infant, they felt constantly supervised by the medical staff. Thus, the maternal matrix is perceived by preterm mothers as a figure that supervises and controls their behaviours, more than as a supportive context which provides suggestions and examples to imitate. Our findings particularly underlined how this inability to perform a normal parenting role leads mothers to have feelings of powerlessness and delegitimation and to be in a state of dependence on the institutional Other, which may seriously affect their ability to recognise themselves as mothers.

The disconnection from the infant, the maternal inadequacy and the loss of parental role result in a sense of temporal suspension, the fourth theme emerged, because of the discontinuity that characterises mothers' experience of time. The literature has already analysed aspects of the maternal experience related to time. In particular, the discontinuity starts from the preterm delivery itself that occurred earlier than expected and thus represented for mothers an abrupt interruption of their representational process of becoming mothers, an out-of sequence event that they did not have time to prevent or process (Black et al., 2009). During infant hospital stay, due to the impossibility to stay with the infant, mothers have also to cope with the difficulties related to the continuous separation. As Flacking et al. (2007) underlined, these separations resulted in feelings of being unimportant to the infant. Finally, the mothers' perception of being in need of the medical staff with the difficulties in establishing interactions with the infant led them to feel as they are in a sort of limbo between 'being a mother' and 'feeling as a mother' (Watson, 2010). Our findings give a more complete view of the phenomenon, showing that, in general, the timing experience of mothers is once again ruled by the institution, which decides not only how but also when the mother can feel

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and act as a mother. Results suggest that mothers need to be allowed to develop a maternal identity, in contrast with the process that characterises at-term mothers.

Overall, the four themes showed how the mothers' experience of prematurity is embedded in an entire transitional process to motherhood that takes place within an institutional context.

Our findings show how the hospital context plays a crucial role because mothers must cope with their limited parental role and with the rules of the institution. The hospital setting is often perceived, on one side, as a positive holding environment and, on the other side, as a great and expert 'mother' that rules maternal behaviours. In the light of Stern's theory of the transition to motherhood (Stern, 1995; Stern & Bruschweiler-Stern, 1998), the issues highlighted in this work may affect the construction of the maternal identity, the mothers' representation of the infant and, therefore, the bond between mothers and babies. Indeed, concerning the fourth theme – the identity reorganization- Stern assumed that if a mother is incapable of this reorienting process, her ability to execute other component themes is compromised (Stern, 1995). Our findings show that prematurity seriously affects preterm mothers' reorganisation of their representations of motherhood. The institutional Other plays a fundamental role in this process. Indeed the state of dependency on the institutional Other might risk to bring mothers back to a childlike status according to which they feel they need to have permission by the institution to play a role in their baby's life. This condition of dependence may prevent a transition towards the parental dimension and, therefore, threaten the mothers' reorganization of their identity.

Relevance to health psychology

As Stern firstly suggested, the understanding of the motherhood constellation is essential to help and work with mothers. In the particular case of prematurity, we believe that the understanding of how the motherhood constellation and its development could be distorted, as highlighted by the findings of the present work, should be taken into account in structuring preventive programs both for clinical practice and psychological intervention.

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Previous studies have underlined the importance of medical support for preterm parents (Pinelli, 2000). The perception of support from nursing staff results in a decrease of depressive symptoms (Davis, Edwards, Mohay, & Wollin, 2003) and better psychological functioning in preterm mothers (Feldman Reichman, Miller, Gordon, & Hendricks-Munoz, 2000). The present study extends the current findings in the literature, showing how the medical staff is seen as both lifesaving and constraining. Indeed the institutional Other plays a role in limiting mothers' participation and involvement with the child and in legitimating or illegitimating them to behave and consequently to feel like mothers of their preterm infants.

As Stern firmly stated, mothers do not need only advice, they need a positive psychological holding condition that lets them feel free to explore and try their natural maternal behaviour (Stern, 1995). In line with this, trainings for NICU professionals should be more focalized on appreciating and supporting the emerging relationship between preterm infants and their parents and encouraging parental involvement in the infant's care (Holditch-Davis & Shandor Miles, 2000; Rowe & Jones, 2008; Talmi & Harmon, 2003). At the same time, direct physical contact between mothers and infants should be promoted. This would help mothers become familiar with the proper, intuitive way to interact with their infant and would help them develop a personal way to protect the child and establish a bond with him/her (Stern, 1995). As highlighted by Fleury, Parpinelli and Makuch (2014), the possibility to exercise a maternal role within the hospital environment supports the natural processes of the mother-child relationship.

In conclusion, as a result of these findings, hospital practises focused on the mother-infant relationship and not only on infants' medical conditions should be improved (Obeidat, Bond, & Callister, 2009). This would help mothers in the transition to motherhood to develop a coherent motherhood constellation and consequently prevent difficulties in the development of a relationship with the infant. The medical staff should be aware of their important role in shaping the maternal experience. Beyond caring for the infant, they are indirectly caring for the mothers. They are in the powerful position of legitimating mothers to develop and act on their motherhood identity.

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Limits of the Present Study

Some limitations of this study should be noted. First, among the mothers interviewed, there was variability in the number of weeks they spent in the NICU before the interview. However, the identified themes were transversal between the mothers, indicating that their perception of the experience was similar and that their experience was not connected to the time they had spent in the context. Similarly, a wide percentage of mothers reported prenatal risk factors, like previous abortions and assisted reproductive procedure, but these backgrounds do not seem to affect their experience. Nonetheless, a specific analysis on how these prenatal factors could affect the development of the maternal constellation should be a focus of future work.

Another limitation of the present study is that we focused on the maternal experience, omitting fathers' point of view. We deliberately focused on mothers with the aim of exploring the development of the motherhood constellation of preterm mothers, but further studies should explore the complex process of being a parent of a preterm and hospitalised infant from fathers' perspectives.

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Table 1

Demographic characteristics of the participants

Mothers								Infants			
ID	Age	Employ	Education	Nationality	Status	First Mother	Hospitalization Before Delivery[a]	Age At Interview[a]	Gestational Age At Birth[b]	Multiples	Weight At Birth[c]
1	32	Housewife	High School	Italian	Cohabiting	Yes	3	85	31.00	No	1.280
2	23	Housewife	High School	Albanian	Married	Yes	0	46	30.00	No	1.580
3	33	Architect	University	Italian	Cohabiting	Yes	0	25	29.71	No	1.320
4	41	Office worker	University	Italian	Married	No	0	35	27.57	Yes	.955; .980
5	39	Freelancer	University	Italian	Married	Yes	23	69	27.28	No	.819
6	38	Nurse	University	Italian	Married	Yes	40	23	30.14	No	.710
7	39	Teacher	University	Italian	Cohabiting	Yes	0	21	30.00	No	.730
8	33	Clerk	High School	Italian	Married	Yes	44	79	27.28	No	.470
9	33	Teacher	High School	Italian	Married	Yes	0	31	30.00	No	1.095
10	41	Office worker	University	Italian	Married	No	35	48	29.42	No	1.570
11	40	Tour Manager	University	Italian	Married	Yes	1	23	36.00	No	2.000
12	40	Office worker	High School	Italian	Married	Yes	0	13	34.00	No	2.660
13	36	Office worker	University	Italian	Married	Yes	7	17	29.57	No	1.375
14	34	Office worker	University	Italian	Married	Yes	60	27	28.00	Yes	.981; .940
15	34	Teacher	Doctorate	Italian	Single	Yes	7	10	31.71	No	1.750
16	34	Housewife	Middle School	Italian	Married	No	4	36	29.85	No	.913
17	34	Qualified worker	High School	Ecuadorian	Married	Yes	20	9	32.00	No	2.080
18	35	Medical assistant	High School	Italian	Married	Yes	2	25	30.00	Yes	1.450; 1.450
19	36	Office worker	High School	Italian	Cohabiting	Yes	0	10	33.00	Yes	2.200; 1.600
20	41	Educator	High School	Italian	Cohabiting	No	1	60	24.57	No	.840
21	28	Carer	High School	Romanian	Cohabiting	Yes	4	10	30.00	No	.999
22	38	Housewife	University	Italian	Married	No	4	69	25.71	Yes	.605
23	35	Teacher	University	Italian	Cohabiting	Yes	21	65	32.28	No	1.560
24	27	Office worker	High School	Italian	Married	Yes	17	7	28.71	No	1.340
25	33	Office worker	High School	Italian	Married	Yes	4	5	32.71	No	1.750
26	29	Teacher	University	Italian	Married	Yes	30	12	30.57	No	1.263

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27	38	Barmaid	High School	Italian	Cohabiting	Yes	2	30	27.00	No	.580
28	34	Office worker	High School	Italian	Married	Yes	0	8	30.57	No	1.480; 1.370
29	36	Housewife	High School	Italian	Cohabiting	No	15	8	29.71	No	.770
30	31	Office Worker	University	Italian	Married	Yes	0	8	31.14	Yes	1.700; 1.650

Note. [a] = in days, [b] = in weeks, [c] = in kilos.

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Table 2

Interview's questions and probes.

- Would you like to talk about your own pregnancy experience? How did you experience it and how did you feel? Could you figure out some satisfaction aspects about the experience of pregnancy? And lack of satisfaction?
- Which is your opinion about the reasons for the preterm delivery? You have been given a medical explanation, does this latter match with your own opinion about the reasons why you had a preterm delivery?
- Would you like to talk about your own delivery experience? How did you experience it and how did you feel? Could you figure out some satisfaction aspects about the experience of delivery? And lack of satisfaction?
- Would you like to talk about the experience of child hospitalization? How are you experiencing it and how do you feel? Could you figure out some satisfaction aspects about the experience of infant hospitalization? And lack of satisfaction?
- How did you imagine your child should have been? What aspects of satisfaction do you have about your own child? And lack of satisfaction?
- If you think about the future growth of your child, how do you imagine him/her? How would you like the child to be and not want to be? What are you worrying about?

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