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Becoming a mother of a premature baby in the context of the pandemic: a place of dual helplessness

Tornar-se mãe de um bebê prematuro no contexto da pandemia: um lugar de duplo desamparo

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Abstract

Objective
The study aimed to investigate women's maternal experience in response to the premature birth of their babies during the pandemic.

Method
A multiple case study design was used, with the participation of six women residing in different cities in Brazil. An inductive thematic analysis of the interviews was adopted.

Results
Factors related to the pandemic, such as social isolation, vaccination, fake news, and the risk of preterm birth, accentuated women's feelings of loneliness. Work overload was identified as a stress factor among the participants that may have contributed to premature birth. The intermittent threat of virus contamination triggered signal anxiety, resulting in a dual sense of helplessness for these women. The relationship with the care network was ambiguous and deficient; however, when effective, it was experienced as emotional support and significantly reduced the feeling of helplessness.

Conclusion
The results provide insights for the development of clinical approaches by revealing that women were exposed to illness-inducing factors that intensified their psychological strain due to confinement and prematurity.

Keywords: Experience; Maternity; Premature birth; Pandemic.

Resumo

Objetivo
O estudo buscou investigar a experiência materna diante do nascimento prematuro do seu bebê durante a pandemia.

Método
Foi utilizado um delineamento de estudos de caso múltiplos, com a participação de seis mulheres, residentes em diferentes cidades do Brasil. Uma análise temática indutiva das entrevistas foi adotada.

Resultados
Fatores que envolveram a pandemia, como o isolamento social, a vacinação, as fakes news e o risco de parto prematuro acentuaram o sentimento de solidão das mulheres. O excesso de trabalho laboral foi apontado como um fator de estresse que pode ter contribuído para o nascimento prematuro. A ameaça intermitente de contaminação pelo vírus acabou desencadeando uma angústia sinal, resultando em um duplo desamparo dessas mulheres. A relação com a rede de cuidado foi ambígua e deficitária, porém, quando efetiva, foi vivenciada como um suporte emocional e diminuiu significativamente o sentimento de desamparo.

Conclusão
Os resultados oferecem insights para elaboração de abordagens clínicas ao revelarem que as mulheres foram expostas a fatores adoecedores que intensificaram seu desgaste psicológico por conta do confinamento e da prematuridade.

Palavras-chave: *Experiência; Maternidade; Nascimento prematuro; Pandemia.*

Prematurity is defined by the World Health Organization (World Health Organization [WHO], 2023) as birth before 37 completed weeks of gestation and is associated with high infant mortality and morbidity. Preterm birth is classified based on three subcategories (WHO, 2023): extremely preterm (less than 28 weeks of gestation), very preterm (28 to less than 32 weeks of gestation), and moderate to late preterm (32-37 weeks of gestation). Recent data reveal that more than 14.8 million babies are born annually worldwide before completing 32 weeks of gestation (WHO, 2020). Globally, Brazil ranks tenth among countries with the highest number of preterm births (Ministério da Saúde, 2020).

The complexity surrounding childbirth was particularly impacted due to the rapid spread of the Coronavirus Disease 2019 (COVID-19), leading the WHO to declare a global public health emergency (WHO, 2020). The novel coronavirus Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2,) emerged in December 2019 in the city of Wuhan, China, and the significant increase in infections worldwide led COVID-19 to be characterized as a pandemic (WHO, 2020). To contain the virus spread, in the absence of medication and vaccines, the WHO (2020) recommended that countries adopt stringent sanitary measures such as city lockdowns, quarantine, isolation, and social distancing, aiming to reduce virus transmission and/or to prevent the disease from emerging in new locations (WHO, 2020).

This had a particular impact on pregnant and postpartum women, as the threat of COVID-19 infection was linked to a higher chance of health complications, including preterm birth (Centers for Disease Control and Prevention, 2020). Facing potential risks, official institutions such as the Royal College of Midwives (2021) issued manuals with guidelines recommending that pregnant women be considered a risk group and a priority for vaccination. In Brazil, the Ministério da Saúde (2020) advised that pregnant women and those up to the 14th day postpartum should be considered a high-risk group and recommended that women postpone planned pregnancies. During the pandemic, women whose babies were born prematurely faced various challenges during pregnancy and during their baby's hospitalization in the Neonatal Intensive Care Unit (NICU) (Reichert et al., 2021; Veenendaal et al., 2021). For instance, the pandemic had a negative impact on the mental health of 71% of pregnant women, who reported anxiety, stress, and helplessness. These feelings were associated with undergoing prenatal exams without their partners, giving birth alone, and having minimal contact with their baby and medical staff during childbirth (Chatwin et al., 2021; Green et al., 2021; WHO, 2020). These women expressed more concern about infecting their

babies and greater feelings of helplessness during hospitalization, compared to women with full-term babies (Bin-Nun et al., 2021). In addition to feelings of helplessness as a consequence of the pandemic, negative impacts on family relationships, anxiety about family health, and diminished marital support were also reported by women after the discharge of premature babies (Bin-Nun et al., 2021; McKay et al., 2021). In this process of becoming a mother of a preterm baby during a pandemic, the sense of helplessness experienced by these women was evident. Among the authors that have worked with the concept of helplessness, the contributions of Freud and predecessors stood out, which will be presented below.

The concept of helplessness (*Hilflosigkeit*) in psychoanalytic theory accompanies the individual throughout their life, from birth to adulthood, and corresponds to the subject's need for the Other to protect and shelter them (Freud, 1936/2006). The feeling of helplessness, therefore, appears in the earliest experiences of life, as a result of the incompleteness of the organism, its need for exchanges with the world, and the extreme dependence on others' help (Freud, 1930/2006). In helplessness, the subject will try to connect with an object in an attempt to alleviate their suffering (Freud, 1936/2006). Thus, immediately after birth, the baby will need the external help of an adult to perform this task in their place (Pereira, 2008).

In this sense, for the baby, the condition of helplessness involves their dependence on others to satisfy primal needs. However, for the adult, this condition is characterized as the prototype of the traumatic situation that generates anxiety (Laplanche & Pontalis, 1991).

According to Freud (1926[1925]/2014), the psychic apparatus seeks to defend itself against events by transforming that which is invisible into something visible, while also attempting to articulate what is unspeakable. When such an experience is registered in the realm of perception, the individual has the possibility to protect themselves from threat through the use of defensive mechanisms (Freud, 1926[1925]/2014). In this ongoing dynamic, the psychic apparatus would continually seek to anticipate the worst in order to activate its defenses. This functioning has been termed as signal anxiety (Freud, 1926[1925]/2014). It is with the emergence of the primary caregiver, aiming to alleviate the state of urgency in which the helpless baby finds itself, that caregiving and the presence of another become part of the constitutive process of subjectivity (Dauer & Martins, 2015).

However, when the baby/subject does not receive such care or cannot engage in such preparation for anticipation of threat in adult life, the traumatic experience may occur inevitably (Freud, 1926[1925]/2014). It is in this situation that the ego signals anxiety, announcing its expectation of a situation of helplessness (Freud, 1936/2006; Menezes, 2012). This event will result in an experience of tension accumulation, which the ego cannot cope with (Freud, 1936/2006; Menezes, 2012).

From a psychological standpoint, the COVID-19 pandemic may have had a traumatic impact on the individual, as the virus in question presented itself invisibly and thus could not be announced through language (Birman, 2022). Thus, helplessness can be considered a structural form of subjectivation and has influenced part of the symptomatic productions (Birman, 2022). As discussed earlier, the metapsychological notion of helplessness corresponds to the subject's need for the Other to protect and shelter them.

Based on these Freudian considerations on traumatic experience and helplessness, authors have understood the NICU as a place of helplessness (Krodi, 2008). In this environment, everyone faces a lack of guarantees and answers and the certainty of their own finitude (Krodi, 2008). The author emphasized that families with children hospitalized in a NICU are constantly confronted

with instability, unpredictability, and the fear of their baby's impending death. The notion of danger is linked to not knowing, to the threat of the establishment of a traumatic situation, a situation that threatens to emerge, in which the ego may not have the structure to assimilate the situation at hand, such is the real anxiety associated with this event (Krodi, 2008). In this context, helplessness is experienced as a human condition and as a traumatic experience (Krodi, 2008; Mathelin, 1999).

These issues can be particularly extended to the situation of prematurity in the context of COVID-19. The virus emerged as the nameless threat that hovered over everyone, maintaining an atmosphere of fear, anxiety, and eternal preparation for the danger of contamination and death. The initial hypothesis of the study was that mothers of premature babies experienced a dual helplessness, traversed by all the discontinuities and intrusions that normally affect mothers of babies born before their time, compounded by the imminent danger of virus contamination. Furthermore, all isolation measures ended up leaving them even more separated from their children after birth and more isolated from important care networks, which may have further accentuated the experienced helplessness. Corroborating this perspective, the experience of isolation from their own families, for preventing transmission of COVID-19, awakened feelings of helplessness and loneliness in pregnant women (Freitas-Jesus et al., 2022), especially those facing a high-risk pregnancy. However, according to these authors, despite the sense of being close to death, knowing that they were generating a baby brought strength for women to deal with the difficulties and intense suffering, even to those who gave birth to babies born prematurely due to COVID-19 infection (Freitas-Jesus et al., 2022). The evidence presented above indicated the complexity of premature birth in the context of the pandemic, as well as the implications of the dual helplessness to which women were subjected. In this sense, the aim of the present study was to investigate maternal experience regarding the premature birth of their baby during the COVID-19 pandemic.

Method

Participants

Six women participated in this study, whose babies were born prematurely during the COVID-19 pandemic, between 2020-2021. The women were aged between 27 and 32 years (x = 29.6 years), had an upper-middle socioeconomic status, and all had completed higher education. At the time of data collection, four women were on maternity leave, and two were working in person. They all lived with their partners in various cities in Brazil (South, Southeast, and Midwest), and their participation was via the internet, considering the pandemic's sanitary restrictions.

The babies were born between 27 and 35 weeks and, at birth, weighed between 1095 g and 1675 g. The causes of the newborns' prematurity were: preeclampsia, gestational diabetes, generalized infection, and unspecified infection. All participants were part of the study "*Parenting and coparenting in families of premature infants*: *subjective and behavioral aspects from three to 12 months of the child's life*" (Esteves & Piccinini, 2021b). The inclusion criteria were families in which the woman and the father cohabitated and were over 18 years old. Families in which babies had any type of congenital malformation, significant sensory impairments, meningitis, and Human Immunodeficiency Virus (HIV) were excluded. Table 1 presents the women's sociodemographic data and the babies' clinical data.

Table 1
Sociodemographic data of the women and clinical data of the babies

Case	Age	Occupation	Baby's age at interview	Gestational age (weeks)	Birth weight weight	Cause birth
M1	32	Lawyer	4	36	1705	Gestational diabetes
M2	30	Journalist	3	29	1580	Infection
M3	32	Psychologist	5	31	1675	Infection
M4	28	Entrepreneur	4	33	1405	Urinary tract infection/ generalized infection
M5	29	Pedagogue	5	29	1305	Pre-eclampsia/ Infection
M6	27	Entrepreneur	5	27	1207	Infection/ Bleeding

Research Design

A longitudinal, multiple case study design (Stake, 2006) was employed to investigate maternal experience regarding the premature birth of their babies during the COVID-19 pandemic.

Procedures

The study was disseminated through social media and among the researcher's personal contacts. The researcher, the first author of this article, responded to inquiries from individuals interested in participating in the research and explained the study's objectives and procedures. The study includes the first six families who contacted and consented to participate. After the initial contact, a date and time were scheduled for data collection. The number of cases aligns with Stake's (2006) recommendation of including four to ten cases to ensure the benefits of a multiple case study and an in-depth investigation, characteristic of qualitative research. The interviews were conducted in the 3rd month after the babies were discharged.

Instruments

During the first interview, the participants signed the Informed Consent Form (ICF), and they were asked to complete the *Family Demographic Data Sheet* (Núcleo de Infância e Família-NUDIF, 2015). This data sheet gathers sociodemographic information from each participant, including details such as age, occupation, education, socioeconomic status. Additionally, participants responded to the Interview about *Parenting Experience in the Context of Prematurity at Three Months of the Baby* (Esteves & Piccinini, 2021a), which investigated various aspects of parenthood, particularly the subjective aspects of motherhood in various family contexts. The interview consisted of eight blocks of questions and covered aspects such as (1) the experience of pregnancy during the pandemic; (2) daily life with the child; (3) first moments with the child after birth; (4) child development; (5) relationship with the child; (6) parental experience; (7) perceptions of the spouse as a mother/father; and (8) relationship with the family of origin. The interviews were structured and conducted in a semi-directed manner. They were conducted by the first author of this article, recorded via Google Meet, and subsequently transcribed.

Ethical Considerations

The research project received approval from the Ethics Committee of the Universidade Federal do Rio Grande do Sul (Opinion No. 4,576,010).

Results

Thematic inductive analysis (Braun et al., 2019) was used to analyze the participants' accounts of the maternal experience regarding the premature birth of their baby during the COVID-19 pandemic. The analysis procedure followed the steps proposed by Braun et al. (2019), aimed at gaining an in-depth comprehension of the phenomena emerging from the participants' accounts. Initially, to familiarize themselves with the participants' accounts, all interviews were read by the first three authors of the article. After immersing themselves in the dataset, in line with the research objectives, a pattern of shared meaning among the three authors was sought. The entire data coding process was discussed until the authors reached a consensus regarding the six identified themes: (a) The experience of being pregnant during the COVID-19 pandemic: encompassed the participants' accounts related to the maternal experience of pregnancy during the pandemic; (b) The early rupture of gestation: included verbalizations about the moments preceding premature delivery and the moment of childbirth itself; (c) Distancing, estrangement, and recognition: referred to the initial impressions associated with the puerperium; (d) The threat of prematurity and COVID-19: comprised participants' accounts of potentially traumatic experiences related to the lack of guarantees and encounters with their own finitude that prematurity and the pandemic provided; (e) Lack of psychological support: the dual helplessness: this theme highlighted the ambivalent feelings of the women related to the need for environmental care to be able to exercise their motherhood, while also suffering from intense feelings related to the risk of contracting the virus; (f) Puerperium confinement in prematurity: women's perception of the challenges of daily life with their prematurely born children at home during the pandemic.

Each of the themes is presented below, using the women's accounts to illustrate the maternal experience regarding the premature birth of their baby during the COVID-19 pandemic. Finally, an attempt is made to articulate the main findings by discussing them in the light of the literature.

The Experience of Being Pregnant during the COVID-19 Pandemic

The women reported the complexity of the gestational process and the inherent feelings related to this moment: "Pregnancy was something I was afraid of, getting pregnant, and it was super easy. My biggest fear was getting pregnant because I thought it would be horrible" (W4). Feelings of surprise at the moment of discovery were also highlighted: "It was a shock" (W5); compounded with the distancing from the idealized notion of being healthy during this period, moving to a period of risk and concern: "I usually say that my pregnancy was completely healthy until it wasn't anymore" (W2).

Some of the women in the study were particularly impacted while discovering they were pregnant during a pandemic: "*It was in the middle of the pandemic, it was a shock. I wasn't accepting it well, it took me by complete surprise, it wasn't supposed to happen*" [emphasis added] (W3). The plan to postpone pregnancy in the year that the pandemic started was also highlighted: "*Common [Experience], perhaps not normal, but common in pregnancy, we got pregnant last year, when the prospect was that this year things would improve in regard to the pandemic*" [emphasis added] (W2). The same woman also pointed out that she was persuaded not to get pregnant during the pandemic:

> I mentioned it to the doctor, about my desire [to get pregnant] and what would be a reasonable period to do it after the surgery and she said [...] Actually, she sent me a text saying that I shouldn't

> get pregnant, that it was something completely [...] As if it were unethical to get pregnant during the pandemic. (W2)

Conversely, another account stated the opposite: "We talked to the doctor, she said there wouldn't be any problem at all, that I should just keep taking care of mysel" (W1).

The vaccine and all the complexity surrounding this process were also verbalized by the pregnant women:

> *I have a cousin who took the vaccine and a week later lost the baby, but at the same time, I was afraid not to take it. There's a lot of uncertainties. Fifteen days after I took the second dose, my blood pressure started to rise. So, I don't know if there was any connection or if it was just due to the end of the pregnancy, given that the end of pregnancy is complicated* [emphasis added]. (W5)

Despite diverse opinions, one pregnant woman sought to reflect on the vaccine: "*And so, it's not the COVID vaccine's fault* [for deaths], *a lot of people said: 'Oh, if I were you, I wouldn't take the second dose*' "[emphasis added] (W4). Even with intense ambivalence among the women, the relief of protection was highlighted by some: "*Just the first dose itself, which I already know passes a lot of antibodies to her (the baby), I was already super happy*" [emphasis added] (W1); and support was sought from trusted doctors to decide whether to take the vaccine or not: "*And then he [obstetrician] said: 'You can get vaccinated against COVID, with Pfizer*'" [emphasis added]. (W4)

The participants' attitudes related to prevention and isolation recommendations varied according to their lifestyle and work context:

> *Throughout the whole pregnancy, we were locked up at home. No visitors, every now and then we went out, we had to buy her layette. I bought her entire layette at once because I thought: "We don't know how this pandemic is going to be like*" [emphasis added]. (W1)

However, the loneliness of isolation was also verbalized: "*My pregnancy was very peaceful, but at the same time very lonely, because I was already working from home prior to the pandemic*" [emphasis added] (W2). Some women reported changes in their work modality, which led them and their partners to adopt remote work and allowed them to spend more time together, as well as better protect themselves from the possibility of contamination: "*I am, and so is he, he's been doing home office since the start of the pandemic*" [emphasis added]. (W2)

On the other hand, two pregnant women had to expose themselves to the virus due to work, which caused much fear and anxiety:

> *The pandemic situation made things worse because my husband works with events, so he was without work. And I had to stop my course and started providing my services in peoples' homes, and with that, I worked 15 hours a day. I couldn't stop because my husband was not working, we didn't have a plan B" (W5); and "No, I haven't gotten it yet, thank God. I was very afraid because I used to work at the store, and every day, even while pregnant, I would come in to work*" [emphasis added]. (W6)

Excessive work was pointed out by one participant as a possible factor that influenced premature delivery:

> *All that physical effort, of being pregnant and having to deliver, having to be productive. I even sort of attribute this premature delivery to a work situation* [...] *I went into labor on Wednesday, it was* even a *holiday, and I was there having to be productive like crazy to deliver materials that went far beyond than what I should have* [emphasis added]. (W2)

One pregnant woman brought an account of close people who were infected and died: "*We met a lot of people; we lost many loved ones. My uncle who lives with my grandmother lost his brother* [...] *everyone knows someone who lost their life to COVID*" [emphasis added] (W5). In this sense, the threat of contracting the virus during pregnancy seems to have added anxiety and fear to the experience of the women in the study:

> *And so, we doubled the precautions we had regarding COVID because, as you known, it is a risk factor [during pregnancy]*" (W2); and "*They [cousins] were infected, they infected my grandmother and my aunt, infected everyone, and I had been at my grandmother's. So like, I had contact with everyone who was infected, and I got really desperate, but I had already taken both doses* [emphasis added]. (W5)

One participant's partner worked on the front line in a hospital, and she expressed all the rigor that the couple adopted in their daily routine to protect her and the baby: "*The care we took was doubled, he only spoke to me, touched me, or we got close, while talking, when he had already taken a good shower with everything, everything that was possible*" [emphasis added] (W2).

The Early Rupture of Gestation

Regarding the moment when the pregnancy was interrupted, one woman's account highlighted the emotional impact that this event had caused, as well as demonstrating the fantasy of an environment, inside of her, that could be hostile to her daughter: "*Wow, I can't get air to [daughter's name], she's going to die inside me, and besides, she's not ready, she was supposed to be born at the end of August, it was the end of June*" [emphasis added] (W3). Fear of being infected with COVID-19 was also present at this time:

> *Thank God I moved [to another hospital], because in the ICU there are ten beds, two of which were not COVID-related, which was me and a guy, the rest were all COVID, it was full with COVID, if I had caught it I possibly wouldn't have survived because I was very debilitated* [emphasis added]. (W4)

Paradoxically, premature delivery was announced by the medical team to save the woman's life, as both were at risk of death:

> *Before I entered the ICU, he [doctor] told them [partner and M4's father]: "Listen, just pray, there's nothing else that can be done, and if someone is to be saved, it's the woman, it's hospital orders". [Partner's name] kept voicing: "Guys, if we lose [daughter's name], I won't have the courage to live anymore, how am I going to tell that to [partner's name]?" because she was very desired, her arrival was eagerly awaited, then [partner's name] said: "No, you're going to get both of them out of there", then the doctor said: "Then pray, pray a lot"* [emphasis added]. (W4)

Another participant described a feeling of despair when she realized what was happening:

> *The cervix holding the pregnancy was already dropping. And I let out the most desperate scream to [partner's name], for him to come to the bathroom and get me, already crying, already very shaken, heart pounding,* [...] *I was desperate* [emphasis added]. (W2)

The process of premature delivery was filled with concerns, and idealizations of this moment were shattered, as feelings of fear and anxiety seem to have reverberated at this time:

> *Well, I wasn't doing well, as it was considered almost extreme prematurity, my delivery was not in those humanized rooms. My delivery was in the operating room. And it was wild, because I didn't have that golden hour [...] I barely saw him [son]* [emphasis added]. (W2)

Concerns about the baby's life were highlighted: "*I said 'what do you mean? Being born already?' then he [doctor] said, 'If she's alive, she'll be born, so she can survive*' " [emphasis added] (W6). Accounts of the traumatic experience of not being cared for in the hospital were noted:

> *So, I was very traumatized, in relation to the hospital and the fact that she [daughter] was born with two cord loops, and the ultrasounds I did there that week, no one visualized anything. If I hadn't gone into labor, [daughter's name] would have died suffocated* [emphasis added]. (W5)

Distancing, Estrangement, and Recognition

The first impressions after childbirth were of estrangement, as observed by one woman:

> *But the next day there was a void because I thought 'my God, they're not in my belly, they're not in my arms, they're over there in the incubator. It's a very strange feeling because it feels as if that child in the incubator didn't come out of you* [emphasis added]. (W3)

The importance of the medical staff bringing a photograph of the daughter was also emphasized:

> *The worst part was the ICU and not seeing her [my daughter], I didn't know how she was, then the neonatal staff took a photo of her in his [partner's] arms and brought it for me to see, then I knew my daughter was alive, I didn't even see her face in the photo, I saw [partner's name], I said, "He wouldn't be holding a baby for no reason, that's my daughter, it must be" (W4). The difficulty of connecting with one's feelings at the time of childbirth was also verbalized: "They showed me [son's name]. And I was so stunned, and [partner's name] was crying, and I couldn't cry, you know, I looked at him and I could just think to myself 'my God, he's beautiful'"* [emphasis added]. (W2)

The negative impacts of policies restricting family access to the NICU during the pandemic were also described:

> *At first, we only had 2 hours with her, from four to six in the morning because of COVID. Then, after she started breastfeeding, I had to be there from 9 a.m. to 6 p.m. because you would go in at 9 a.m., breastfed from nine to ten, then you had to leave, come back at noon, breastfed from noon to 1 p.m., then leave again* [emphasis added]. (W4)

Such measures made it even more challenging for the baby to become integrated into the family's mental imagery, as no one besides the woman could come into contact with the baby:

> *So the 21 [days] she spent there, it's almost as if she didn't exist because no one had seen her yet, so everything was more distant, very cold, so I think for the father [...] If I already found it strange, distant, you can only imagine what it's like for him* [...] [emphasis added]. (W4)

The first longer physical contact with the babies also happened a long time after birth:

> *Only 10 minutes a day. It was either the father or the mother who went to visit that day. They didn't even allow both to go together. I went to pick her up and I think it must've been thirty-something days that she was there in the hospital* [emphasis added]. (W6)

One woman brought up her feelings of emotional distance from the babies, especially regarding the dynamics of the NICU and the restrictions caused by the pandemic:

> *Yes, at the hospital, the NICU's dynamics were changed quite a bit. Visits were very restricted. So, I could only see the babies during the daily medical briefing, once a day, and only he (woman's partner) and I were allowed in. I couldn't even breastfeed, only for an hour each day, so this bond was quite [...] and this part was really difficult* [emphasis added]. (W3)

The precautions taken by the staff to prevent babies from getting infected ended up increasing feelings of fear and accentuating the separation of the women from their babies:

> *Yeah, so we don't form a bond in the hospital, everyone telling you what you have to do, you become... you even hesitate to touch the baby. She didn't have easy access, so they inserted the access into her jugular. And then, every day I arrived, I hadn't even held her yet, and they would say 'you can hold her if you want, but if the access comes out of the jugular, so and so will happen. "I would get terrified, I said 'no, just leave her there, I won't hold her"* [emphasis added]. (W5)

The women's accounts highlighted that the moments of separation were experienced with difficulty:

> *And because of the pandemic, we always had to wear masks. And the nights were terrifying, because at night I would leave, I would stay until around ten, eleven at night, then I had to get some rest. And then I would get there already crying, I would get in the car and start crying* [emphasis added]. (W1)

The incubator and the moment of discharge from the hospital were recalled with emotion:

> *She was there in the incubator, this connection that we gradually had, it was quite [...] I felt bad on the day [of her discharge], I cried a lot. When I would go back home it was always difficult from seeing the baby in the ICU* [...] [emphasis added]. (W3)

However, there were moments when new possibilities seemed to emerge to contemplate the human side of the women's encounter with their baby:

> *I had this idea that babies in the ICU had to remain inside and all, and that we could even hold them, but not at first. And then, when I put him on my breast and he stayed there and made that little sound [...] it was, my God, it was like, many hours delayed from when I expected to have my baby in my arms, but it was incredible. And there was also a nurse [...] He was saturating eighty-nine/eighty-eight, which is very close to the limit down there, and when he got to my breast, he went to a hundred* [emphasis added]. (W2)

The Threat of Prematurity and COVID-19

One point that stood out in the reports of one of the women was the extent to which prematurity can impact the experience of motherhood:

> *I joke when people ask me why it seems as though I still haven't had time to assimilate. Because it was, you know, when you're like this, you're in a state where things have to be done, where things have to happen, and you haven't even realized it, like, "my God, my daughters went to the ICU"* [emphasis added]. (W3)

This experience was described as traumatic: "*About ten days before I left the ICU, I would ask people not to even talk near me because I was suffering from trauma, I understood it was a trauma that I wasn't being able to deal with*" [emphasis added] (W3). The psychic process of beginning to comprehend what had happened was highlighted: "*And I think that's what happened, I started to process everything afterwards, and sometimes I think that maybe even today, for me, I know that everything we went through is still in the trauma*" [emphasis added] (W2). This woman also noted the importance of the team's support so that she could understand and give meaning to what was happening: "*And she said that sometimes these experiences, somewhat traumatic or very intense, physically or psychologically, sometimes the brain softens the blow, so you don't feel it all at once*" [emphasis added] (W2). The same woman described a moment when she seemed to understand the context she was experiencing: "*My God! It was when I asked them to take a picture, it was when I*

started to cry a little because I have this, this difficulty. Everything for me was still like 'this is a dream'" [emphasis added] (W2).

The premature birth of the baby seems to have represented an abrupt anticipation in the experience of being a mother:

> *Oh, no, I couldn't imagine it, I had never even heard of these things, of prematurity. In my mind, I was going to schedule the cesarean section, give birth, and leave. Spend about 3 days there and come back, but, wow, I was very traumatized, even now I'm a little [...]* [emphasis added]. (W6)

Direct contact with the risk of one's own death was also mentioned: "*Because I was practically in a coma for 3 days, I was intubated* [...] *I had her on Sunday and I was intubated on Wednesday, myself, yeah [...] I had to be resuscitated*" [emphasis added] (W4). The child's risk of death was also mentioned, with emphasis on how the news was given: "*Wow, it was, at first it was very difficult, I never thought I would spend 60 days in the hospital. It really shook me, that when we got there, they said 'look, there's a 30% chance of survival'*" [emphasis added] (W6). Several women recalled the impact of seeing their daughters with a respirator for the first time: "*They were on a respirator for a day and a half, then they breathed normally, but seeing that scene for me was very shocking*" [emphasis added] (W3). However, over time, the situation was reframed by this woman:

> *Afterwards [...] humans are impressive. We adapt, so it was a month of suffering in the ICU, then for me it was already normal to see them there, I started to understand how all the devices worked, that they were only there to gain weight* [emphasis added]. (W3)

However, other women seem not to have been able to reframe this experience of premature birth during a pandemic, a process that is impactful, ambivalent, and difficult to reframe:

> *I think I have, I'm having, I have many mixed feelings about it. I'm still going through that mourning, of what we didn't experience, it hit me really hard this week because as I said, it reached the date that we imagined would likely be the birth date. So, it has been very difficult, a real emotional roller coaster for me, for him [the son], for his father, but it's like that, there are these mixed feelings, and, at the same time, I have a lot of gratitude* [emphasis added]. (W2).

Lack of Psychological Support: The Dual Helplessness

The lack of environmental support for the women's suffering during their children's hospitalization further intensified their sense of helplessness. The context seems to have triggered a feeling of helplessness in the face of a fragile baby who needed to be in the incubator, exacerbating feelings of guilt and concern for the risk of death combined with the lack of support from the environment, noticeable factors that recurrently appeared:

> *And I couldn't cry, couldn't, you know, feel bad, because someone would come out of nowhere to say: 'look, you, you have to be okay because otherwise your baby will feel it. "And I was like, 'well, but then I'm screwed because I can't get rid of this feeling"* [emphasis added]. (W2)

Having a space where women could talk about their pain was highlighted by this same woman as something fundamental:

> *This was actually a very difficult thing in the hospital because despite the service being humanized and having this space, not everyone thinks to [...] Have this sensitivity, you know, to approach you and say: "listen, your pain is valid"* [emphasis added]. (W2)

Perceptions of how the presence of partners in obstetric ultrasounds was affected by the pandemic were highlighted: "*But at the doctor's appointment, he [partner] couldn't enter the office because of COVID, only the pregnant woman, so I would tell him 'there's no point in you going, you're just going to wait outside?', so I would go alone*" [emphasis added]. It was also recalled how excluding partners from prenatal exams was difficult for them:

> *Because of the pandemic, he couldn't attend any ultrasound appointments, so it was really tough for him, especially after we found out about her little problem, because he could never even go in, so he would just wait at the clinic's door for me to come out and give him news* [emphasis added]. (W1)

However, exceptions also occurred: "*He [the partner] could accompany [as he worked there] me, because in the other clinics we went to I had to go in alone for everything, so it was a bad thing for me*" [emphasis added] (M2). The NICU families were also remembered as a network of care and support: "*The parents' group, we find strength in each other, become friends, so something that was supposed to be heavy, dense, ended up becoming light. Thinking about the idea of an ICU was more painful than actually living it*" [emphasis added] (W3).

Some reports described a feeling that seemed not to be legitimized and welcomed by the external environment:

> *It's this clash of perceptions, while simultaneously another thought comes: 'oh, but you're in a position that many couples would like to be in, your child is premature, but doing well'. I don't know, what if he had died, what if he had a serious sequela, what if he had an intellectual disability, imagine all that we would go through, but* [...] *I don't know, maybe trying to feel better by saying: 'oh, but your baby is fine. Oh, but so-and-so is worse'. Like, should that make me feel better? It was something that hurt me a lot when people told me what it was that I was feeling, the baby was feeling, you know?* [emphasis added]. (W2)

This woman saw no point in comparing her pain with other women in the NICU so that her feelings could be acknowledged: "*And comparing yourself to others who might be in a 'worse' situation, but everyone knows their own pain, there's not really a way to measure what one feels, what the other feels*" [emphasis added] (W2).

Puerperium Confinement in Prematurity

Due to the pandemic, women's isolation from the external environment began at the hospital: "*Because I couldn't see [partner's name]. Then, when we would go to the room for Kangaroo care, we couldn't have contact with anyone else anymore*" [emphasis added] (W2). Immediately after discharge from the hospital, intense anxiety and difficulty sleeping appeared:

> *I couldn't sleep, I would sleep for half an hour, and it wasn't because I was on my phone, I was in the room, lights off, alone, quiet, I would [...] I would think about a lot of nonsense, a lot of things. My body felt like it was rotten, with a lot of pain, I couldn't bend down to get water!* [emphasis added]. (W4)

The first moments after discharge from the hospital were filled with ambivalent feelings such as happiness with the long-awaited departure from the hospital, but also apprehension related to caring for the baby at home: "*So that's when we effectively learned, about care too. What I wanted most in the world, which was to go home with my child, at the same time is that which I feared the most*" [emphasis added] (W2). Reports also illustrated that the psychological impact of caring for the baby at home can persist for months after hospital discharge: "*Between the first and second month, I had about three panic attacks, the kind where you cry, with him [partner] having to pick her up and move away from me, because I needed to scream*" [emphasis added] (W1).

The arrival of the baby at home was filled with intense care due to prematurity and fear of the virus:

> *We didn't have visitors for thirty days, so the family couldn't understand. Now I get visitors, but it's like, I'll be in the house, they have to take off their shoes, wash their hands. I don't care, I'm not going to let my daughter [...] COVID is out there, a lot of people think it's over, right? [emphasis added] (W4); And then, when she came home, we wouldn't let [...] We let our mothers come see her [...] but like, with masks and far away, without touching or anything* [emphasis added]. (W1)

However, another woman observed that some exposure was necessary: "*My uncles and the closest people, I also have no problem letting them hold [daughter's name] [...] Man, if we're going to live in a bubble, it's complicated*" [emphasis added]. (W5)

Nevertheless, this woman did not fail to demand certain precautions: "*Oh, use the cloth, put on some alcohol, wash your hands, put on a mask, okay*" [emphasis added] (W5). Not all women were able to remain isolated because they needed to go back to work and, therefore, followed various sanitary measures to protect themselves:

> *It's transparent [the mask], and so to teach literacy, where they [students] need to see the enunciation of the letter. That way, I can also see if they are articulating the letter correctly, and then it becomes easier and everyone wears a mask, everyone is happy and ready* [emphasis added]. (W5)

The first moments outside the home environment also required precaution and were stressful: "*And very paranoid, going out for the first time on the street, I didn't enjoy the walk at all. The first times, then later we loosened up a bit*" [emphasis added] (W1).

The absolute dependence and degree of devotion that babies require during puerperium were remembered by all the women in the study: "*I think that, in a way, her dependence on me does me a lot of good, while at the same time it's super tiring*" [emphasis added] (W1). There were also reports from women about their ability to keep the baby alive and promote their growth and development. There were even reports indicating a state of alertness, as if something bad could happen:

> *This routine was very tense, very tiring, even exhausting because, besides not sleeping at night, it was tension, it was 24-hour tension, will something happen? Even today I have to check if they are breathing* [emphasis added]. (W3); "*Only in the first month we were afraid to sleep, that something would happen, we stayed vigilant, checking constantly*" [emphasis added]. (W6)

There was also concern about the time they could dedicate to the child:

> *So this exterogestation of his will last for five months, which is exactly the full period of my leave, so I'm really worried about how the next few months will be with this issue. I'm even getting [...] emotional here, with this dependence he has, I didn't want to subject him to that. Now, it's very tiring, very* [emphasis added]. (W2)

Discussion

Despite the experience of prematurity in a pandemic being full of particularities when compared to a term pregnancy in a non-pandemic context, some similarities can also be found in the processes of each of the six cases that make up this study. Furthermore, it can be understood that the experience of becoming mothers was always influenced by the pandemic bias, even if it was not directly mentioned in the reports. Based on the evidence gathered in the cases, it was noticed that the process of becoming a mother occurred with a high level of stress and feelings of helplessness, as indicated in recent studies on this topic (Bin-Nun et al., 2021; Freitas-Jesus et al.,

2020; Preis et al., 2021). Beyond the prematurity situation, several studies conducted during the pandemic placed helplessness as a central issue, even in non-pregnant/puerperal women (Birman, 2022; Johnson et al., 2023; Rosen et al., 2020). In this sense, it is worth highlighting the aspect of "dual helplessness" in this context of prematurity crossed by the pandemic.

For example, from the reports present in the theme "*the experience of being pregnant during the COVID-19 pandemic*", it was possible to verify the profound impact of the pandemic context on the experience of being pregnant. Four participants reported feelings of loneliness and intense concern about their health. The reports brought to light the fears, fantasies, and loneliness of the participants, exacerbated by the pandemic. Vaccination was a theme that was continually addressed, sometimes ambivalently, as was social isolation. Despite all the difficulties, widespread fake news, and absence of governmental public policies focused on vaccination, four participants were vaccinated during pregnancy with at least one dose. Regarding social isolation, at least three women (M1, M2, and M3) managed to work from home and protect themselves. However, the excess of work affected all the women in the study, which was highlighted in their statements as extremely stressful.

The evidence brought by the studied cases allows us to think that the experience of pregnancy for these women was perceived as a threat because they were considered a risk group living in a pandemic. It is important to highlight that, during the period of pregnancy and childbirth, it is inherent for the mother to feel as helpless as the baby (Krodi, 2008; Winnicott, 1987/2002). By having a sufficiently good care base, stemming from environmental support, the mother will be able to devote herself to her child and live through helplessness more smoothly (Campana et al., 2019; Dauer & Martins, 2015). However, this was not the case for the study participants, who were isolated, frightened, and unsure whom to rely on for protection. Thus, they felt at the mercy of chance and the indeterminate nature of human existence, feeling that the worst could happen to them and their babies, affecting different registers of reality and psyche (Birman, 2022).

The theme the *early rupture of gestation* brought up feelings related to early and potentially traumatic rupture in the continuity of pregnancy and the fear of contracting COVID-19. Feelings of despair and fear of one's own death and the death of the baby were highlighted by all women, in addition to the rupture in the idealizations built during pregnancy about the moment of childbirth. With the early interruption of pregnancy, Druon (2011) suggested the occurrence of trauma, a "psychic volcanic explosion" (Druon, 2011, p. 42), in which women need a minimum of supporting elements. Given the characteristics of premature birth, authors have highlighted that it resembles a psychological trauma in the woman's psychic structure (Agman et al., 2011; Canin & Bain, 2023; Druon, 2011; Krodi, 2008). In this sense, just as the prematurely born baby is not yet ready for life, the woman is also not mentally and emotionally prepared to care for this baby. However, it is important to note that not all mothers will experience the rupture of pregnancy in the same way. The personality structure and characteristics of the woman's internal world play an important role in her subjective experience. Trauma can activate fault lines that are already present in personality (Canin & Bain, 2023).

Based on the reports, it is possible to presume that at least two mothers (M1 and M2) evoked unresolved traumas and losses from their childhood and adult lives that were awakened by premature birth (Canin & Bain, 2023). Those whose needs for love and security were not met, as well as those who have a particular type of history with their own mothers (Vanier, 2015), may have the greatest difficulty in recovering from premature birth.

Based on the reports of the theme *distancing, estrangement, and recognition*, and of reports from the other themes, it can be considered that after the initial impact of premature birth, some women in the study (M1, M2, and M4) may have sought to avoid traumatic memories associated with birth and presented symptoms of hypervigilance. In this sense, unexpected and premature births can accentuate the risk of traumatic experience and helplessness, adding to the hostile reality of living in a pandemic, this threat may have been further accentuated, as the cases in this study seem to indicate. Such results are expected since premature birth is marked by a severe alteration, which can open up an unrepresentable abyss, a loss of illusion, without time and without words (Battikha, 2008).

Regarding social distancing, the statements from all women show a significant reduction in the time allowed to spend with their babies in the NICU, as well as the impossibility for other family members to access this environment. Thus, the ritual of celebrating birth, which aims to welcome the new family and community member, is severely impaired, if not extinguished (Cunha, 2004). This suggests the idea of a baby coming into the world in the shadows, reinforcing premature birth as inadequate, that is, something that should not have happened.

The lack of news about what was happening, as well as the impossibility of finding a place to accommodate their feelings after childbirth, was also verbalized by them, which made them fall into an even deeper void. In this way, the unsaid prevents the individual from being able, through imagination and anticipation, to protect themselves from the worst, so that this anticipatory imagination is a symbolic psychic agency (Freud, 1926[1925]/2014). When the subject cannot anticipate such preparation for the worst, the traumatic experience can inevitably occur.

Accounts from the six women pointed to a non-recognition of their children and an impression of being disconnected from the moment. The literature has highlighted difficulties in women with prematurely born babies in establishing initial closeness since prematurity ends up generating an affective shock, experienced in a painful and traumatic manner (Arnold et al., 2013; Druon, 2011; Mathelin, 1999). Restrictions imposed by the pandemic added even more suffering to these women, who seemed unsure how to approach their babies. Still, it is important to highlight how socially pacifying it is to believe that all women will always have a sufficiently good maternal gaze on their babies (Iaconelli, 2021). Thus, regarding the "maternal function", it is necessary to understand that this gaze may falter, whether the baby is premature or not, and that this relationship is a contingent construction, without guarantees, which may or may not be linked to the organic event of pregnancy and childbirth (Iaconelli, 2021).

At least two types of recognitions are necessary in the baby's early approaches: a first moment, in which someone (external environment) recognizes it as a baby; a second moment, in which someone recognizes a baby as their own baby, as they attribute this belonging to them, a fact associated with the woman's narcissistic investment and which does not dispense with the first recognition (Iaconelli, 2021). In this sense, the baby is only constituted in the presence of "another" who, in the presence of the woman, repositions her narcissistically (Battikha, 2008). In the context of women with prematurely born babies, it is necessary to sustain the woman's gaze, in terms of presence and libidinal investment (Laznik, 1999). In this study, the reports from the six women pointed to a lack of psychic and physical support, which ultimately prevented the opening of a space to talk about their experience and reframe their own history. Such environmental care is fundamental to balancing the discontinuity caused by the mismatch between the phantasmatic baby, the baby of parental narcissism, and the baby who is there, pointing to something beyond what can be seen (Zornig, 2001). The external environment, represented by the NICU, can establish, strengthen, or

even modify the parental perspective, through the gaze that the team itself has on the baby and the woman. The team allows itself to be surprised by the "little king" that exists in the baby, and from there, encourages women and parents to identify with this "gaze" (Laznik, 1999). In conclusion, it is not enough to save babies physically, it is necessary to save the bond between them and their mothers (Mathelin, 1999).

In the face of the women's verbalizations on the theme "*the unnamed threat: prematurity and COVID-19*", the potentially traumatic experience of prematurity was once again highlighted. Direct contact with the dual possibility of death further accentuated the participants' suffering. In line with the participants' reports, a study by Reichert et al. (2021) pointed out that maternal understanding of COVID-19 and social isolation may have also affected the experience of motherhood and the care of prematurely born babies. Based on the reports, it can also be emphasized that such an experience may have been difficult to reframe and strongly ambivalent for the women in the present study, since all of them were alive and with their babies. However, something in this experience had not yet found room for naming (labeling the experience) and psychic elaboration.

It is worth noting that the encounter with the vulnerable baby, whose life was maintained by wires and probes, produced in women anxieties that are difficult to represent. The encounter with that which cannot be named places the woman before an abyss of signifiers (Mohallem, 2005). Such is her disorientation that her experience is permeated by temporal dissonance: she has just given birth, but still feels that she has not "made it happen" (Mohallem, 2005).

Thus, the theme *lack of psychological support*: *the dual helplessness*, is illustrated by reports of lack of support both during pregnancy and childbirth. The exclusion of their partners from obstetric ultrasounds due to pandemic-related restrictions was recalled by several women (M1, M2, M3, and M5) as something impactful in the experience. One woman (M2) sought external resources to change this situation, advocating for the partner's presence and care during ultrasounds.

In several reports (M1, M2, M3, and M4), it was possible to observe that this experience of not feeling cared for by the partner during neonatal hospitalization, due to the impossibility of paternal presence in the hospital, globally impacted these women's experience of motherhood with their babies. One woman (M2) highlighted that she felt that her feelings were not validated and recognized by the medical team. In support of this result, the literature points out that there is a trauma that needs words to be enunciated; the signified word rearticulates, sliding from the traumatic to the unrepresentable (Battikha, 2008). In this sense, assisting parents to talk about "this birth, that is different from the others, is based on the idea that that which is unsaid favors the formation of a cyst that then distills, day after day, the poison that poisons the child's relationship with the parents" (Druon, 2011, p. 41). From the subjective repositioning of the parents and the positioning of the professionals involved in their care while in the NICU, the history of these children, which is in the process of being constituted, may have different developments (Battikha, 2008).

It is worth noting that faced with the lack of guarantees of life and death, it will be difficult for parents to name the discomfort they feel (Battikha, 2008). Thus, the reports of the women in this study corroborate with the theory in the sense that the anxiety experienced by them was temporarily linked to signifiers such as the sensation of not being well attended to, of not being considered responsible and participating in decisions about the treatment of their child, and not feeling respected in their condition as mothers (Battikha, 2008). Anxiety may appear precisely in the connection with technical knowledge: parents incorporate medical jargon into their discourse

and may experience a state of *primary medical concern* (Agman et al., 2011; Battikha, 2008), with the intention of getting closer to their children. Often, it is the difficulty of looking at a baby who differs profoundly from their ideal and responding affectively to their child, which sets the psyche and its defenses in motion (Battikha, 2008).

The parents of these babies are faced with helplessness as a human condition, but they are also faced with the helplessness experienced by their children (Krodi, 2008). Such helplessness was also verbalized by women in empirical research investigating the context of the pandemic and premature birth (Bin-Nun et al., 2021; McKay et al., 2021). Such a state could resurface a dual helplessness and the women's own experience as helpless babies (Krodi, 2008). Regarding the theme *puerperium confinement in prematurity*, the six women reported a feeling of physical and psychological confinement. Some of the psychological symptoms reported by the women in the study corroborate with the findings of the literature that link social isolation to increased vigilance in the face of social threats, social withdrawal, difficulties sleeping, daytime fatigue, as well as depression and anxiety, which were prominently highlighted by the participants (Lima, 2021). Estrela et al. (2020) also emphasized anxiety and depression as sickening factors that intensified psychological distress due to confinement during the pandemic.

Before concluding, it is important to note that the present study has some limitations, one of which is being a study of few cases, although adequate when seeking to deepen each lived experience (Stake, 2006). It is also worth remembering that all participants were white mothers, with a high level of education, and were from nuclear families of middle or upper-middle class originating from various cities in the country. It would be important to have more representative cases of Brazilian women who can report on their experiences of parenthood. Furthermore, the investigated phenomenon is exacerbated by various risk factors for the development of parental helplessness. Longitudinal studies would greatly contribute to evaluating the long-term effects of prematurity and the pandemic on the family. However, despite these potential limitations, the study brought important contributions about parenthood in the context of prematurity and the pandemic.

Final Considerations

The present study aimed to investigate maternal experience regarding the premature birth of their baby during the COVID-19 pandemic. From the thematic analysis of the participants' accounts, it was possible to perceive the need to expand our knowledge about the psychological well-being of pregnant women who had preterm babies during the pandemic. The dual context investigated by the study, prematurity and the pandemic, may have exacerbated the traumatic experiences linked to prematurely interrupted pregnancies and the permanent threat of virus contamination. Such a hostile and unsupportive environment for women may have contributed to a state of dual helplessness, accentuating anxieties and dread in the face of what cannot be named and reframed.

In this context, it is important for healthcare professionals and family members to acknowledge maternal anxiety because, as observed in the present study, mothers often perceive this support as a valuable opportunity to better learn about their prematurely born child. The gesture represented by sensitive listening and professional support directed towards mothers could have provided an opportunity for their voices to gain prominence and, from there, to reinterpret the difficult experiences of this context.

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