

Retrieving the offspring and caring for it during the first night at home

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Abstract

Objective. To describe experiences of mothers caring for their preterm offspring on the first day after being discharged from the hospital. **Methodology.** This was an interpretative phenomenological study with 10 mothers. **Results.** Release of the infant from the hospital was interpreted by the mothers as an event that permits them to retrieve the offspring that did not belong to them but to the hospital personnel. The experience of caring for the child during the first night at home was undertaken with uneasiness, angst, and total dedication. **Conclusion.** After the child's hospitalization, the mothers doubt their own capacity to care for it. It is necessary to implement strategies that permit mothers to know their offspring and participate in the care during the hospitalization to build trust in their capacity to care for the child at home.

Key words: mother-child relations; infant, premature; caregivers.

Recuperando al hijo y cuidándolo en casa la primera noche

Resumen

Objetivo. Describir las vivencias de las madres con respecto al cuidado de su hijo prematuro el primer día después del alta. **Metodología.** Estudio fenomenológico interpretativo con 10 madres. **Resultados.** El alta del bebé fue interpretada por las madres como un evento que les permite recuperar al hijo, quien no era suyo sino del personal del hospital. La experiencia de cuidarlo la primera noche en casa fue vivida con zozobra, angustia y total dedicación. **Conclusión.** Después de la hospitalización del hijo, las madres dudan de su capacidad para cuidarlo. Por lo tanto, es necesario implementar estrategias que les permitan conocer a sus hijos y participar en el cuidado durante la hospitalización con el fin de desarrollar confianza en su capacidad para el cuidado en el hogar.

Palabras clave: relaciones madre-hijo; prematuro; cuidadores.

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Recuperando ao filho e cuidando-lhe a primeira noite em casa

■ Resumo ■

Objetivo. Descrever as vivências das mães com o cuidado de seu filho prematuro o primeiro dia depois da alta. **Metodologia.** Estudo fenomenológico interpretativo com 10 mães. **Resultados.** O alta do bebê foi interpretada pelas mães como um evento que lhes permite recuperar ao filho que não era seu senão do pessoal do hospital. A experiência de cuidar-lhe a primeira noite em casa foi vivida com soçobra, angústia e total dedicação. **Conclusão.** Depois da hospitalização do filho, as mães duvidam de sua capacidade de cuidá-lo. É necessário implementar estratégias que permitam às mães conhecer a seus filhos e participar no cuidado durante a hospitalização com o fim de desenvolver confiança em sua capacidade para cuidar-lhe no lar.

Palavras chave: relações mãe-filho; prematuro; cuidadores

Introduction

Women in general, during the gestation process do not consider the possibility of having a disease or complications that can cause anticipated birth of their offspring. Hence, preterm delivery comes as a surprise to most of them and becomes the start of unimagined experiences when entering the world of a Neonatal Intensive Care Unit (NICU) and going from being a pregnant woman to visiting her hospitalized preterm offspring. In the NICU, the mothers must respect limited visiting hours and norms that can sometimes be difficult to understand and accept and which definitely do not facilitate their continuous and intimate contact with their offspring, from which emerge processes of attachment and appropriation of the caring mother role.

Mothers face various crisis, given that the surprise of the preterm birth, the hospitalization, and the ups and downs of the child's clinical situation overwhelm them emotionally, spiritually, socially, and economically; in addition, the separation from the offspring during hospitalization breaks with the dynamics of parent care and has consequences in all the members of the family group.¹⁻³ Report of the child's release from the hospital leads to the emergence in the parents of real and imagined fears, feelings, and expectations such as insecurity and lack of trust in their

possibilities of successfully caring for the infant.⁴⁻⁶ Studies conducted in recent years have permitted recognizing part of what occurs within families whose newborn child requires hospitalization in the NICU, how they experience the hospitalization process, what happens with their roles, what are their doubts, fears, strengths, expectations, biggest hopes and joys.^{4,7}

Nevertheless, little is known about how families face the care of their infants at home.^{5-9,10} Some of the questions to be answered are: What is the real meaning of bringing the child home and caring for it after others have done it for weeks? How is home care begun by the parents? To help in the search for some of the responses to these questions, an interpretative phenomenological study was carried out, whose results on the experiences of the mothers upon the child's release from NICU and during the first night at home caring for their offspring are presented in this publication.

If each member in the healthcare team working in NICU recognizes and understands the complexity of the experience faced by the parents of hospitalized children when these are released from NICU, they can have a dimension of their needs since the hospitalization period and offer them over that time care actions that permits their

more effectively confronting caring for the infant at home.

Methodology

The study used interpretative phenomenology based on the philosophy by Martin Heidegger. Interpretative phenomenology as a research method seeks to “understand the abilities, practices, and daily experiences and articulate similarities and differences in meanings, commitments, practices, abilities, and experiences of human beings”.¹¹ The world for Heidegger is not unique or universal, on the contrary, it is different for each human being according to his/her culture, time and historical period, and the family in which we are born and raised. The way of “behaving” and “being” in the world is guided by the meaning each individual attributes to things and situations in their own and particular world.

These meanings are constructed by each person from their own culture and are supported on all the forms of expression available. Through phenomenological studies, we can approach the essence of a human phenomenon, to know and understand phenomena as they appear on the conscience of individuals. The sample was made up of 10 who were between 18 and 37 years of age at the moment of conducting the interviews. With relation to the educational level of the individuals participating, one of the mothers was illiterate, six had some degree of secondary education, two had technical level, and one had professional level education. Four of the women lived in common-law with the father of their offspring, one was separated, two were single and lived with family members, two were married and lived with their spouses, and one was a widow. Seven of the 10 women participants were working when they discovered their pregnancy; however, by the time of the interviews only one was working. The nine remaining were dedicated full time to caring for their offspring and did not know when they would return to labor activities.

For six of the women, it was their first pregnancy, three had had two pregnancies, and one of them had been pregnant three times; two women had antecedents of premature offspring. None of the 10 women planned or sought the pregnancy; eight attended to more than four prenatal controls, one only attended one, and another never attended because she did not know she was pregnant. The births of the children occurred through C-section in six of the cases and the rest through vaginal delivery.

The gestational age was calculated according to the Ballard scale during the newborn's first 48 hours of life in the NICU, fluctuating between 28 and 34 weeks, for an average of 30.3 weeks. The weight of the children at birth fluctuated between 670 and 1495 grams, with an average of 1182 grams. Hospitalization of the infants was on average of 34.2 days (maximum 75 and minimum 16). All the children received complementary oxygen, five received it at 100% and the other five had maximum fraction of inspired oxygen at 40%; only two of them required assisted ventilation, the eight remaining needed micro-chamber; four were administered exogenous surfactant, one needed surgical closure of the patent ductus arteriosus, six were polytransfused, and the 10 received phototherapy and total parental nutrition. The children were hospitalized in a tier III NICU, in a city in Colombia's south west, with installed capacity for 46 children, 12 of them critically ill. The inclusion criteria involved being 18 years of age or more, being the mother of a child born preterm and hospitalized in the NICU for at least during two weeks, without congenital malformations, stomas, or oxygen dependence requiring special care.

Prior to collecting the information, one of the researchers established contact with the mothers to verify the inclusion criteria, explain the characteristics of the study, and invite them to participate. All the mothers contacted accepted to participate, signed the informed consent, and received a copy of the consent. The information collected by the researcher who contacted the mothers and had two in-depth interviews with

each of them; each interview lasted between 45 and 90 minutes. A digital recorder was used in all the interviews. Until the interviews with the fifth participant, the researcher textually transcribed the interviews, and then this work was carried out by two digitizers known for their ethical qualities. The researcher revised their transcriptions to corroborate their exact correspondence with the recording.

To protect the identity of the participants, fictional names were used. Each interview was oriented with a thematic guide, but the women were permitted to speak freely and spontaneously. At the beginning of the second interview, the researcher described to the mother a summary of the understanding of the information obtained during the first interview, so she could confirm the interpretations of the researchers, clear them, expand on them, or correct them according to the need. Saturation of information was reached with 10 participants, given that the interviews no longer revealed new or different information; the homogeneity found at that point permitted identifying the themes in rich detail.

Information analysis was performed at two levels and moments: 1) During data collection, after verifying the literal transcription of each interview, the interviewing researcher analyzed its text to start understanding the story of each participant and to identify aspects that needed completion, more in-depth detail, or confirmation during the second interview. The other researcher revised the interview texts to help the interviewing researcher identify voids in information or aspects that should be delved into during the following interview. 2) Upon finishing the information collection, we proceeded to profound analysis of the interviews. For this, one of the researchers read and re-read their text and wrote the story of each participating woman, which was revised with the other researcher. Once all the stories were written, the researchers sought similarities, differences, and patterns in the mothers' stories to identify the themes and sub-themes that permitted describing the mother's experiences.

To ensure the methodological rigor during the study, the researchers considered the credibility

or internal validity criteria and audit ability or confirm ability by Guba and Lincoln.¹² The study was approved by the Human Ethics Institutional Review Committee of the Faculty of Health at Universidad del Valle, according to Proceeding #013-09.

Results

The narrations made by the mothers participating in the study on how they experienced the infant's release from NICU permitted understanding the meaning of said discharge for the mothers. They felt they retrieved their offspring, whom they had perceived as someone else's throughout the hospitalization. They did everything necessary to go home with their offspring as soon as possible and show it to their family and friends. The first night at home caring for the offspring was full of fears, insecurity, and uncertainty; the following describe in detail these two themes that comprise the experiences of the participating mothers.

Retrieving the offspring

Retrieving their offspring, that is, having the child with them and caring for it all the time, was an illusion the mothers had while the infant was hospitalized; sometimes this seemed to them remote and distant over time, some mothers even doubted that the moment of taking the child home would become a reality. This doubt was more frequent at the beginning of the child's hospitalization and during the days in which some clinical complication arose. Upon overcoming those critical moments and from the comments from the NICU personnel, the mothers regained the hope that the day would come in which they could have the child at home.

The nursing personnel taught the mothers how to perform some procedures on the infant, but the mothers doubted if they would know everything necessary. All the mothers, without exception, were willing to make their best effort; to dedicate the time and will required learning whatever was necessary to provide good care to the infant. They

consciously or unconsciously made the decision to work hard to gather the requirements to retrieve their offspring; they concentrated their efforts to learn everything needed and waited the time necessary for the child to also be in conditions to be returned to its family: *that is like a process... you are doing things to win a prize, to win the best, the best prize, so what am I doing to win that prize? I come to visit every day, never failing, taking care of her milk, being there for bath time and to learn how to care for her...*

In none of the cases was the infant's release announced for a precise day. That day, the mothers arrived for the visit as usual, that is alone, without extra money, without the child's social security documents, without clothing or an extra blanket for the infant. When they were told their offspring was being discharged, they only thought that the long-awaited moment had arrived and immediately got moving and within a few hours secured the resources necessary for the infant, they did the discharge paperwork and left with their offspring to where they felt it was completely their child. This place was not initially at home for five of the 10 mothers who did not live in Cali, given that after the child's release they frequently had to take the children to the hospital to control their health status and confirm their wellbeing. These mothers had to stay temporarily with family members or friends or in shelters.

The child's release from NICU meant to the mothers that they had gained the necessary merits to have their offspring with them and that they could care for and raise their children. During the hospitalization, they yearned the moment of the child's discharge from NICU; they had a list of pending things they wanted to do. Which is why upon the idea of retrieving the infant and having it under their care and responsibility, the mothers experienced diverse feelings. Initially, they felt great joy by having the child 24 hours a day – every day, without schedule restrictions and contact in the intimate, warm and private space at home, where they could feel, see, touch their children, as well as embrace and feed them, that is, do everything they and their offspring needed

and wanted. Another feeling was the fear of being alone as responsible for the child and the lack of confidence in their capacities to become the mother the child needed: *... how shall I say it, something that feels good in the heart that comes from within and at last I am going to have the child and I'll be able to do things that I wish to do, at least to cuddle with the child whenever I want to, and give it kisses – at least on the cheeks, tell her things that at least here I said them, but for limited time... while having the baby there I said everything every so often, she would be sleeping and I'd say: wow! How beautiful, I could express all my feelings all the time... and I did not have to ask for permission... it was like feeling that I could do whatever I wanted whenever I wanted, and show my love... as I wanted.*

Upon arriving to where they would be with the child, the mothers felt happy and proud of being able to introduce their offspring to the family members and friends. The mothers felt that having left the hospital with their offspring was a test they had overcome, that they had defeated death, that the worst part of the experience lived with their premature offspring had passed. The family members had varied expressions to welcome the child home. For the mothers living in Cali, the joy was completely shared with the extended family and all were able to meet the child and express their good wishes and affection.

The mothers had received instructions at the hospital on some norms that had to be followed at home to protect the child from infections. However, when getting home they realized that strictly adhering to them meant continuing to limit the number of people who could come in contact with the child; hence, some mothers decided that this rule was not to be strictly complied with. Thereby, they allowed their offspring to be seen by all the family members; nevertheless, none of the mothers invited as many people as they would have wished and all made sure the people coming close to the child were not sick and washed their hands if they were going to touch the infant.

After the welcome given to the child and staying only in the company of those living in the house,

the mothers organized the place where the child would sleep for the first time with them, away from the hospital environment and with only them responsible for the child's welfare. The mothers knew that the following morning they had to bring the child to the hospital for control in which the results of their actions during that first night would be seen, especially the body weight increase. When organizing the place where the child would sleep, they used what they had learnt at the hospital, this was how two women organized the basinet with the *nest* used in the hospital as a crib to hold the children in the incubators; nobody had told them to use it at home, but they saw that in the NICU all the children had it and seemed comfortable in it, thus, they decided to make one so their offspring would not miss the way they were accustomed to sleeping; besides, they covered the basinet with thermal blankets and placed it close to the bed where they would be sleeping. The other eight mothers organized a space on the bed where they slept, given that for them it was very important for the child to receive their body heat and companionship. When going to bed, most of these mothers lay on one side of the bed and placed the infant by their side; only one mother convinced her partner to place the child in between them: *...yes, I did not leave her in the basinet, she spent so much time sleeping in that incubator alone... no I did not leave her in the basinet, I put her to bed with me, and the father and I slept there, everyday it was the same, they said it was bad that our energy was too strong for infants, that I don't know what but we did not care and placed her there.*

First night at home

At the end of that first day at home, the mothers were very tired because they had gone from one place to another in and out of the hospital doing the paperwork for the child's discharge and the receiving the family members who came to meet the child. The first night at home was described by the mothers as *the hardest they had experienced*; they could not rest because every two or three hours they had to feed, watch, and change the baby's diaper. The mothers had a lot of information

and were absolutely willing to continue with the process of becoming real mothers for their offspring in spite of the physical exhaustion. However, uncertainty and angst prevailed given the novelty of the situation and the fact of not fully knowing their offspring because the maximum time they had spent with the children was a couple of hours when breastfeeding or when learning how to bathe or dress them: *And... I don't know, I already fed her, you start and it is the first time the baby is with you... they give him to you.. you can take him home but you know nothing... they have given him many things... but it must also be that you have so much information and you want to do things so well that in the end you get stressed, but a moment comes in which...*

For all the mothers, feeding the child was the most stressful aspect during the first days at home but particularly during the first night. Upon discharge, on average, the children were 35 weeks old (corrected age), which is why they had been prescribed feeding every 3 h, but the mothers decided to feed them every two or three hours. The mothers felt overwhelmed by the task of feeding the infant when realizing that it was impossible to do it every 2 h because one cycle was over it was time to start another, given that the children took too long to complete the amount prescribed; they sucked weakly, slowly and made long pauses during which they fell asleep; when they finally finished the dosage, they had to take out the gases, a process that also took time and against which there were doubts such as: how long could the child be held with the head upright, how to know if all the gases were out. When they considered that the child had completely eliminated all the gases, they laid the baby down avoiding sudden jerky movements that could cause the child to vomit. These situations made feeding the child initially a tiresome task and upon which the mothers had questions and difficult situations to solve: *One of the things I saw was that I insisted all the time, but she was sleeping, she drinks it in one hour and 30 minutes and feeding is every two hours; in other words, she finished eating and 30 minutes later it was already two hours and you had to start again...*

so as a mother you do not rest and you are awake all the time because you have to be on top of everything. The other thing is that before feeding him you have to change the diaper because if you do it afterwards... he will vomit and you will have wasted what you have done... actually, you end up feeding the child all the time.

Besides the insufficient time to comply with the Schedule to feed the infant, several mothers had to face difficulties when breastfeeding, like not knowing what to do when the child was not able to hold the nipple because it was too big and the baby could not hold it and suck on it, or because the nipple was too short (flat) and the was also not able to adequately suck. These mothers, after trying to breastfeed the child on several occasions, opted to offer baby formula from a bottle. Other mothers had to face the baby's rejection of the bottle pacifier; after spending some time trying to have the child feed from the bottle as he/she did in the hospital and not understanding what was the problem, these mothers suspected that it could be the size or the texture of the pacifier because it was new; it felt harder than the ones in the NICU and, furthermore, it had a different shape because the ones there had a flat border at the tip and were not cylindrical like the ones they were using. The mothers did not notice these details on the pacifier before buying it so when they were in the drug store or the supermarket they simply *purchased a baby bottle*, then sterilized it and used it.

One mother experienced the child's rejection of lactic formula; during hospitalization, this mother extracted her own milk and fed it to the child from a bottle, when necessary to complete the amount prescribed she was provided a liquid formula that is not for sale to the public in our environment. Consequently, when at home she offered the child the formula she had purchased in the supermarket, she noted that the child frowned and pushed the pacifier and the milk from its mouth, leading her to conclude that the infant found strange the flavor of the milk and did not accept it.

The mothers looked for ways to solve these difficulties; some more successfully and less angst

than others who had to watch their offspring cry for prolonged periods of time. For example, one mother who produced large amounts of milk that the infant had difficulty swallowing, opted to open the child's mouth with her hand and direct a stream of milk from her breast into the child's mouth and wait for the child to swallow to repeat the process until the infant fell asleep, which she interpreted as the child being satisfied. This mother was staying at a shelter and shared the room with several people; thereby, to avoid troubling them by turning on the lights, she laid the child on the bed and leaned over him to breastfeed and covered her back with the blanket and provided light with her cell phone.

The circumstances experienced by some mothers during the first night when feeding the infant left them with many questions to ask the following morning in the hospital, this was how they asked for the pacifiers used in the NICU and bottles with the formula the child was familiar with. They also wanted to know how to make the children drink the whole bottle more quickly, how to wake them up when they fell asleep with the bottle in their mouths, how to know if all the gases had been expelled, where to buy the same pacifiers used in the hospital.

Another aspect that concerned all the mothers during the first night with the child was the fear the child would die because it *stopped breathing and choked*. Said concern led them to use small sources of light to frequently observe the child without waking the other people sleeping in the same room. With light from a flashlight or from a cell phone they frequently checked on the child's respiratory rhythm; one of the mothers upon noticing that her offspring showed shallow breathing placed her hand on the child's chest to confirm if it moved with the breathing, waking him up several times. In summary, the first night transpired between feeding the infant, keeping it from vomiting, making sure the child was breathing, and keeping him/her with a clean and dry diaper: *One of the things I saw was that I insisted all the time, but... he is sleeping, he drinks it in more than one hour and then take*

the gases out, and 30 minutes later you have to start again... the other thing is that because they are always sleeping, you are always checking to make sure they are breathing; turn him over because the ears still don't have cartilage and you see that they fold and hurt him badly"

The following morning, inevitably the mothers woke up very tired, but knew they had to go to the hospital for the child's first medical control; therefore, they changed the child's clothes, prepared the diaper bag with everything necessary and left to find public transportation that took them to the hospital; only three mothers were accompanied. The mothers knew they had to show that they could care for their offspring; nevertheless, they acknowledged that caring for the child was a more demanding and exigent process than they had imagined and that they still needed to know their offspring better and have more clarity on what they had to do to act with security and confidence.

Discussion

The study revealed that the mothers interpreted the infant's discharge as the event that let them retrieve the offspring they perceived as someone else's during hospitalization. Likewise, it showed that the first night at home caring for the offspring was experienced by the mothers with uncertainty and angst and total dedication due to lack of knowledge they had of their offspring and how demanding it was to care for them. These findings coincide with that reported by several authors who point to the mothers not being able to appropriately establish a bond with their hospitalized child,^{1,2,4,7,9,10,13} the feeling of helplessness to care for the offspring at home after the hospital discharge,^{3,5,6,8,13} the doubts and questions about how to carry out some actions of caring for the infant.^{3,5,6,13} The findings of the study evidence the importance of the continuity of interaction between the mother-offspring dyad during hospitalization of the premature child, mainly for the mother to progress in the process of becoming a mother.

According to Mercer,¹⁴ the process of becoming a mother implies, besides the physical birth of the offspring, the "psychological birth" of the woman to the identity of being a mother, with the constant and positive interaction between both being the fundamental aspect to develop a strong maternal identity. This author recognizes four stages in the process of becoming a mother: the initial stage of "commitment, attachment, and preparation" experienced during gestation when the woman undergoes psychological adjustments and prepares to experience the expectations of her new role. The second stage is "knowledge, learning, and physical recovery" that starts with the infant's birth, a moment in which the woman assumes and begins to learn the mother role within her social context. In the third place is the stage of "advancing toward a new normality", which takes place along the first months of the child's life, when the mother makes the necessary adjustments for her new role to fit her own particular life style, which implies modifying her motivations, values, and routines. Finally, there is the stage of "accomplishment of the maternal identity" during which the woman internalizes her role and experiences it with skill, harmony, joy, and confidence. This is accomplished, according to Mercer, around four months after birth.¹⁵

Mercer¹⁶ holds that the mother's interaction with her offspring is what generates the capacity, confidence, and joy of the woman in her maternal role. Women who have a hospitalized premature offspring experience additional stress factors in the process of becoming mothers due to having a child with higher probability of dying, who requires painful processes, from whom she is separated, and whose future seems more uncertain. Additionally, these situations bear great impact on the mother-offspring interaction, which affects the woman's progress in the process of becoming a mother.^{16,17} In Colombia, it is necessary to broaden scientific knowledge on the mother-offspring interaction when the preterm infant is hospitalized, given that their separation is almost total because of the norms and practices existing in most of the NICUs. In addition, a diversity of demographic, social, and cultural characteristics

of the women, of the clinical characteristics of the infants and of the social support at family and community levels justify inquiring on the process of becoming mothers from Colombian women enduring this situation.

Mercer¹⁶ also considers that nurses can play a key role by promoting empowerment of women during the process of acquiring their maternal role because it has been demonstrated that mothers value and accept the actions of the nursing personnel aimed at strengthening the mother-offspring interaction and the mother's knowledge on caring for the child. To make sure nurses include in their daily work support to women during the process of being mothers, which requires providing the theoretical basis suggested by Mercer and other authors like Barnard¹⁴ and Bowlby¹⁸ among others, with respect to how the interaction of the mother-offspring dyad is modulated by diverse personal factors and the environment. Hence, in our country, it is pertinent to investigate the results of the work by nurses in NICUs on the mother-offspring interaction and, thereby, on the process experienced by women to become mothers when having their child hospitalized.

The results of the study also justify the implementation of strategies that, during the infant's hospitalization, promote mother-child contact and permit mothers to feel that their offspring belong to them, that they learn to interpret the child's behaviors and experience day-to-day care of the infant. Strategies like body-to-body contact or kangaroo mother care offer the ideal conditions for the children to get stronger and the mothers to participate and be empowered in caring for their offspring, contributing to the healing and growth process of both and appropriation of the maternal role.¹⁹⁻²¹ Another measure that should be implemented to maintain mother-child contact is that of opening the NICU doors to the mothers without limitations in schedules. Besides, these measures are fundamental to accomplish the human care proposed by Jean Watson.²² Several pediatric societies in Europe and Latin America have begun this path with the care of preterm children.²³⁻²⁵ The initiative by the Hospital *Amigo*

del Niño,²⁵ brought about since the 1980s by the World Health Organization and the United Nations Children's Education Fund (UNICEF) has caused a highly positive impact on the mother-offspring dyads attended in the puerperium and pediatric services in terms of breastfeeding, attachment, lower abandonment and child abuse; but this initiative has yet to become extensive to most NICUs, where what usually occurs is the abrupt mother-child separation and the subsequent limitation in processes of attachment and development of the maternal role²⁴. Permitting the presence and participation of the family in caring for the preterm child hospitalized in the NICU is nothing more than recognition and respect for the rights²⁵ of hospitalized children and recognition of their parents who should not be passive spectators, but active participants in caring for their offspring. In the 1991 Colombian Political Constitution in title I, article 44, the State was also in favor of the rights of Colombian children and recognized among them that of *having a family and not being separated from it*.

Additionally, and to facilitate the transition of the mother to care for her offspring at home and minimize the mothers' uncertainty when facing the care of the child during the first night at home, it is ideal to establish for the mother and offspring to remain together the night before the child's discharge from NICU. Thus, the mother will have the opportunity to provide care for the child with the possibility of receiving support from the nursing personnel, if required, and will be better prepared to assume her responsibility at home. Also, telephone communication can be implemented between the family and the nursing personnel as a support and accompaniment strategy for the mothers during the start of home care. It is essential to investigate the effects these support strategies can have on caring in the infant's home and on the women's process to become the mothers of their premature offspring.

This study concludes that lack of contact and interaction of the mother with her offspring during the infant's hospitalization in NICU affection appropriation and the exercise of the maternal

role during the infant's stay in the hospital and, consequently, makes caring for the infant at home more difficult for the mother, at least during the first night at home. Nurses can play a key role for the women to successfully enjoy the process of becoming mothers of children hospitalized in the NICU by implementing strategies that maintain the mother-child contact and interaction.

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