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The Role of Peer Support in the Development of Maternal Identity for "NICU Moms"

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Abstract

Objective—To examine first-time NICU mothers' perceptions of the initial effect and stress of their birth experiences and hospitalizations of their infants and what facilitated or hindered the development of their maternal roles within the context of the NICU.

Design—A qualitative descriptive design.

Setting—A 57 bed, tertiary NICU in Chicago.

Participants—Twenty-three mothers of very low birth weight (VLBW) infants hospitalized in the NICU.

Methods—Participants were a subset of a larger longitudinal mixed-method study of psychological distress in 69 mothers of VLBW infants. Mothers were interviewed using an adaptation of the Clinical Interview for Parents of High-Risk Infants (CLIP) approximately six weeks after the births of their infants. Data were analyzed using conventional content analysis.

Results—Mothers characterized the infants' births and hospitalizations as a time of overwhelming change culminating in a new perspective on life. Primary themes were *Loss, Stress*

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Callouts

1. Most mothers need to explore and express their feelings about the traumatic births and NICU experiences before creating supportive, interactive environments for their infants. (Line 31,32)
2. Mothers referred to themselves as "NICU moms" and said until they were fully responsible for their infants' care, they wouldn't feel like "real" mothers. (Line 290)
3. Sharing with the NICU-based breastfeeding peer counselors helped mothers feel less alone, provided therapeutic emotional support, normalized their situations, and enhanced their confidence as mothers. (Line 343)

and Anxiety; Adapting; Resilience; Peer Support; and *"I'm a NICU Mom."* Mothers rated peer support as the most facilitative and supportive aspect of developing the maternal role in the NICU.

Conclusion—Peer support and role modeling by NICU-based breastfeeding peer counselors helped the mothers throughout every stage of their infants' hospitalizations, from giving them hope, to helping them begin to develop maternal identity, to providing anticipatory guidance about taking their infants home. Talking points are provided for nurses who work in NICUs without dedicated peer support to help mothers establish a healthy mother-infant relationship.

Keywords

Maternal role attainment; neonatal intensive care unit; very low birth weight infants; peer support; breastfeeding peer counselors; CLIP; talking points

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The constructs of maternal role attainment include maternal identity, e.g., the incorporation of motherhood into a woman's concept of herself, and perceived and demonstrated confidence in being a mother (Mercer, 2004; Rubin, 1984). For the mother delivering a very low birth weight (VLBW; <1500 g) infant, these constructs are altered significantly and unexpectedly. These mothers face the loss of their dreams, or fantasized children, and mourn the loss of what they never had: the opportunity to carry a pregnancy to term and to parent and bond with a healthy newborn in the first few days after birth (Black, Holditch-Davis, & Miles, 2009). According to Mercer's Theory on Maternal Role Attainment/Becoming a Mother (Mercer, 2004), women experiencing full-term births may spend several weeks learning about and getting to know their newborns before they feel confident and competent in the maternal role. The mother of an infant hospitalized in the NICU has limited opportunities for caregiving and interacting with her infant and must share these responsibilities with the NICU staff. This reality delays attainment of the maternal role.

The distress that accompanies the birth and subsequent NICU hospitalization of a VLBW infant may also compromise or delay maternal role attainment and is associated with symptoms of depression, anxiety, and perinatal post-traumatic stress (Black et al., 2009; Emmanuel et al., 2011; Holditch-Davis & Miles, 2000). These psychological distress symptoms potentially affect maternal caretaking of vulnerable infants and may lead to negative infant outcomes, including long-term behavioral and emotional difficulties and cognitive delays (Aarnoudse-Moens, Weisglas-Kuperus, van Goudoever, & Oosterlaan, 2009; Bhutta, Cleves, Casey, Cradock, & Anand, 2002).

CALLOUT 1

Authors of several recent studies have focused on interventions such as skin-to-skin holding and infant caregiving to decrease maternal anxiety and depression and to facilitate maternal role attainment in this population (Holditch-Davis & Miles, 2000; Lupton & Fenwick, 2001; Reid, 2000; Shaw et al,. 2013; Shin & White-Traut, 2007). Findings from separate studies have suggested that engaging in therapeutic conversations about their births and NICU experiences improves psychological and behavioral functioning in mothers with psychological distress (Elmir, Schmied, Wilkes, & Jackson, 2010; Feeley, Zelkowitz, Westreich, & Dunkley, 2011; Fenwick, Barclay, & Schmied, 2001; Gamble, et al., 2005;

Kendall-Tackett, 2014). Furthermore, the evidence suggests that mothers must first cope with their own distress and sense of loss surrounding the births and NICU hospitalizations before they can begin to create supportive, responsive environment for their VLBW infants (Feeley et al., 2011; Thoyre, 2000).

In our recent multi-method, longitudinal study of maternal distress in 69 mothers of VLBW infants, mean scores on all three sub-scales of the Parental Stressor Scale - NICU (PSS-NICU; Infant Look & Behavior, Sights & Sounds of the NICU, Altered Maternal Role in the NICU) declined significantly over the course of the NICU hospitalization (Rossman, 2011). This decrease in scores suggested that the mothers developed effective coping mechanisms to manage the inherent stress, anxiety, and flux of emotions associated with having infants hospitalized in the NICU. While it is unlikely that the mother of a NICU infant will fully realize the goal of maternal role attainment while her infant is still hospitalized (Black et al., 2009; Mercer, 2004), these results do not provide an understanding of how mothers shifted from adapting and coping with the stress and adversities of the preterm births and NICU hospitalizations to becoming engaged with their infant as they became familiar with the maternal role. The purpose of this study was to examine first-time NICU mothers' perceptions of the initial effects and stress of their birth experiences and immediate hospitalizations of their infants, their development of coping skills, and their perceptions of what facilitated or hindered the development of their maternal roles within the context of the NICU.

Methods

The study reported here is part of a larger longitudinal mixed-method study of psychological distress in 69 mothers of VLBW infants. In the larger study we sought to determine the relationships among maternal psychological distress, NICU visitation patterns, provision of breast milk, mothering behaviors, and longer-term neurobehavioral and neurodevelopmental outcomes in VLBW infants. Maternal report of psychological distress and parenting data were obtained via questionnaire data at four time points: two during inpatient NICU hospitalization and two at infant outpatient follow-up appointments. We obtained other psychological, medical, developmental, and breast milk data through a pre-existing, National Institutes of Health (NIH) breast milk database and inpatient and outpatient medical chart review. Mothers were enrolled, and data were collected from August 2011 to July 2013. A subset of enrolled mothers who had not previously given birth to an infant hospitalized in a NICU completed qualitative interviews. This sampling strategy permitted the study of the maternal role development of first-time NICU mothers even if they had another baby, versus those who may have had another infant in the NICU.

Design—We employed in-depth qualitative descriptive interviews to explore mothers' NICU experiences as they developed their maternal identities. Drawing from the tenets of naturalistic inquiry, the goals of qualitative descriptive research are to provide a comprehensive summary of the basic nature of an experience in the everyday language of the participants and an accounting of that experience that most people observing the same experience would agree is accurate (Sandelowski, 2000; 2010). Mothers were informed about the study by a NICU-based nurse research specialist approximately 2–4 weeks after

their infants were born or transferred to the NICU and after the survival of the infants was deemed probable by the NICU medical team. The first author conducted interviews approximately six weeks after the birth of the infants (range 4–8 weeks). This time period was chosen for two reasons. Primarily, we wanted to give mothers time to develop relationships with their infants. However, in the larger study, mothers completed a series of instruments related to maternal distress at 3–4 weeks after their infants' births, and we wanted at least a one week span between the quantitative questionnaires and the qualitative interviews. All interviews were completed between November 2011 and August 2012.

We developed a semi-structured interview guide based on the Clinical Interview for Parents of High-Risk Infants (CLIP) (Meyer, Zeanah, Boukydis, & Lester, 1993) and a review of the literature on maternal role attainment. The CLIP is designed to assess parental concerns and adaptation to the NICU environment and begins with the telling of the birth story, the infant's NICU hospitalization, and the parents' reaction to these events. We adapted the interview guide for this study to focus specifically on the maternal experience and questions were added to understand mothers' perceptions of barriers and facilitators to developing the maternal role in the NICU. Interviews were digitally recorded and lasted approximately one hour. See Table 1 for examples of interview questions.

Sample and Setting—A 57-bed tertiary NICU in Chicago was the study setting. For the larger study (from which the sample for this study was drawn), we offered enrollment to all eligible mothers. Inclusion criteria were mother of a VLBW infant with gestational age ≤35 weeks and absence of severe congenital anomalies; negative maternal drug screen at birth; able to speak and read English; and maternal age > 18 years. Additional eligibility criteria for the 23 mothers completing the qualitative interview included not having given birth to a previous infant hospitalized in a NICU although mothers could have had previously a healthy term infant. We chose to include multiparas in this study because the experience of giving birth to a VLBW infant and having that infant subsequently hospitalized in the NICU for an extended period of time presents a different experience of developing the maternal role and becoming a mother to that infant than achieving maternal identity with a healthy full-term infant. The institutional review board (IRB) of Rush University Medical Center approved the study and we followed all procedures in accordance with the ethical standards of the IRB. We obtained written informed consent from all participants.

Analysis—We used conventional content analysis to analyze the qualitative data (Hsieh & Shannon, 2005). Each interview was transcribed verbatim and checked for accuracy. The first author initially coded all interviews. An inductive and data-driven approach which focused on the participants' stories was used to generate descriptive codes, which were then sorted into categories based on how they were related and linked. We interpreted the data set by performing within and across case analysis to compare perceptions and experiences and to capture commonalities and differences between primiparas and multiparas. The analysis was a recursive process, as categories and themes became more refined as interviews were analyzed, and the relevance of and connection between issues became clearer. The three authors refined the coding and analysis until consensus was reached about the optimal

themes and sub-themes. To enhance the rigor of the data, we maintained an audit trail documenting all methodological and analytic decisions.

Results

Twenty-three mothers of VLBW infants participated in this study. Participants were predominantly single (74%), minority [(Black (57%); Hispanic; 17%)], low-income (78%), and primiparous (78%). There were four sets of twins. Two infants died at birth and one infant died at three weeks of age, leaving one set of twins at the time of the maternal interview. The mothers of the infants who died at birth and the mother of the infant who died at three weeks of age were not approached for the interview until approximately 5–6 weeks after their infants' births to give them time to grieve and to determine the health status of the remaining twin. Each of the three mothers consented to be interviewed about her living twin, and interviews were conducted approximately eight weeks after birth. Characteristics of the mothers and their infants are summarized in Table 2.

Themes—Mothers characterized the infant's birth and hospitalization as a time of overwhelming change culminating in a new perspective on life. In the analysis, five themes were identified: *Loss, Stress and Anxiety; Adapting; Resilience; Peer Support*; and *"I'm a NICU Mom."* Throughout the interviews, the mothers referred to the newborn infants as *baby* rather than *infant*, so *baby* is used to report the study results.

Loss, Stress, and Anxiety: Every mother described her pregnancy and birth as different from what she had planned and that the changes were unexpected and unwanted, leaving her feeling overwhelmed and unprepared psychologically for childbirth and being a mother to a VLBW infant hospitalized in the NICU. Some mothers withdrew from initial contact with the babies as a protective coping mechanism and because they felt they could not retain the amount of information given to them about their babies.

Loss of the dream. The retelling of the pregnancy and birth stories was important for these mothers, as evidenced by the fact that these stories took one-third to one-half of each interview. With the exception of two participants who began their pregnancies as high-risk patients, the mothers did not anticipate having VLBW infants and were preparing for full-term births. They described their birthing plans in detail. Almost half of the participants (n=10) mourned the loss of experiencing the last trimester of pregnancy. When a friend told one mother how good she looked after giving birth, she replied: "I *want* to look like I had a baby. I miss the fact that I never got to have a full belly." Several mothers learned they were pregnant only a few weeks before they delivered their babies. One mother's pregnancy was confirmed at 19 weeks and she delivered her son at 26 weeks gestation. She said, "It's like I was never pregnant. I got cheated through the whole thing."

Is this how it's supposed to happen? Although a majority (n=15, 65%) of the women developed pregnancy complications requiring either antepartum hospitalization or bedrest at home, the preterm delivery was still unexpected to many and traumatic to all. A primipara who delivered at 25 weeks gestation related the following:

> They told me I could stay at 4 cm dilated for the next couple of months and even when I was 9 cm I thought they were going to say he's not ready to come out. I could stay 9 cm for the rest of the 3 months, right? I was just so naïve.

Once the birth was imminent, the mothers' stress related to the births was intensified by concern for the health of their babies. If the birth was precipitous, the mother may not have had a support person with her, which added to the sense of anxiety. However, every mother praised the obstetric staff for keeping them informed before and en route to the delivery room.

In the delivery room, however, the focus shifted to the baby and away from the mother, often leaving the mother feeling alone, helpless, and vulnerable. All mothers were awake during delivery, but only eight (35%) heard their babies cry at birth. Because they did not hear a cry at birth, the remaining mothers were not sure if their babies had been born alive but were unsure about what questions to ask. An 18 year old primipara who was alone at her cesarean and did not hear her son cry described the immediate post-birth scene:

> "It was so confusing. I knew they were working on him, but it seemed like he was in another room. I was waiting for some sign to tell me he's okay, but nothing. I really didn't understand what was happening. It was my first birth and it was like 'Is this how it's supposed to happen?' I didn't really know what to ask, to say or anything."

Even mothers who had support persons during birth described feeling as if they were in a "haze" or a "dream" and unable to comprehend or retain what was being said to them.

Stress and anxiety. The majority of mothers got their first looks at their babies via cell phone pictures. While the picture accurately depicted the baby, most photos were close-ups and did not show the surrounding environments. Thus, when the mother saw the picture, her baby filled the whole screen and didn't appear as small and fragile as when seen in person. A mother of a 2 pound 1 ounce infant said, "My husband took a couple of shots on his cell phone and she looks big. When I actually saw her it was jarring. When they were saying she was so tiny it didn't quite register."

Most mothers saw their babies in the NICU within hours after giving birth, although some were not able to see them until the next day due to maternal complications. Many mothers were overwhelmed at their first visits and could stay for only several minutes. One mother described panic when visiting her son for the first time:

> I just saw him and started to freak out and had to leave right away. He was so tiny and the beeping and all the wires stuck out to me like he was hooked up to everything and the IV and I just couldn't process everything at that moment.

Only two mothers had toured the NICU prenatally, so for the majority of the mothers it was "scary," "frightening," "intimidating," "overwhelming," and "sad." Most mothers talked about how "tiny" their babies were and how "fragile" their skin was. Mothers' characterizations of their babies' appearances ran the gamut from "a baby doll" and "beautiful" to "fake," "not like a real baby," "ugly," "like a monkey," and "I wanted it to be someone else's baby."

The anticipated first touch of their babies did not happen for the majority (78%) of the mothers until the second or third visit, and holding the babies was delayed even longer. Even when told by the nurse that they could touch their babies, only five (22%) of the mothers touched them on the first visit, and three of these were multiparas. All of the remaining mothers voiced that they were afraid of "hurting" or "breaking" their babies by touching them, even when the nurse demonstrated the proper technique.

Adapting—Despite the critical nature of their babies' health status, mothers discovered ways to become acquainted with, provide for, and become advocates for their babies. Although the women did not feel ready to assume these responsibilities, they recognized that their lives had changed and that they needed to adapt to their new circumstances. One way mothers achieved this was to integrate mothering behaviors into their visits to their babies.

Caregiving. Within several days of their babies' births and NICU admissions, most mothers were comfortable touching their babies and some mothers held their babies. Both of these events were considered important milestones for the mothers. Once a mother was comfortable touching her baby, she could begin caregiving activities such as changing diapers, taking temperatures, washing her baby's face, and administering colostrum oropharyngeally. A mother explained the importance of caregiving: "It makes me feel more like a mom. And the more I do, the better she gets to know who I am and then we bond better that way." For almost three-quarters (*n*=17, 74%) of the mothers, holding their babies was the epitome of motherhood and they characterized it as the most important and rewarding time they spent with their babies. Kangaroo or skin-to-skin holding was particularly powerful in facilitating the bonding process. "I fell in love doing the kangaroo care with her. It was so beautiful it took my breath away when I first did it."

Providing milk. All of the mothers in this study provided milk for their babies by using a breast pump. Six mothers had planned to feed their babies infant formula but changed their minds after speaking with a member of the NICU lactation team about the importance of their milk for their babies. Mothers knew that providing milk was the one thing that only they could do for their babies, and 70% of the mothers (*n*= 16) considered providing milk as the most important thing they could do while their babies were hospitalized in the NICU. Mothers equated providing milk with "giving life" to their babies and had faith and hope that their milk was what their babies needed "to grow and be big and strong."

Resilience—Mothers developed coping skills that enabled them to adapt to NICU stressors, redefine, and give new meaning to their lives. They demonstrated inner strength when they understood they could not change what had happened.

Acceptance. Mothers recognized that their lives had changed in a way they had not contemplated. A mother who delivered at 24 weeks of gestation explained coming to terms with the reality of her new life:

> I was completely unprepared for any of this. How do I handle not being able to do the things I thought that I would be doing for this child, do the things that I have been trying to prepare for mentally, and now I have to be faced with a completely different situation? I think you just have to take it and go with it.

Mothers began preparing themselves not for the lives they had fantasized when they were pregnant but for new lives that might include a child with some degree of disability: “I always thought I’d have a big healthy baby. Why wouldn’t I? Now I’m thinking because of his brain bleeds that I can deal with a mentally handicapped child if I have to.”

You pick yourself up for your baby. Most mothers felt the need to remain strong for their babies. Mothers felt that their babies could sense their moods and could tell if they were upset or lost hope after an unexpected crisis. One mother said, “Do not panic. Whatever you do, you have to stay in an optimistic mindset even if your baby is doing the worst…just stay encouraging for your baby because she can feel you, she can sense you.” Another mother agreed:

> I’m constantly rootin' for her and I really believe they can pick up your vibe. If you sad, they're gonna be like, uh (motioning blah). Sometimes I’ll sit there and I get teary-eyed, but then I pick myself back up because I need her to feel me. I need her to hear me. I need to kiss her. I need her to know that your mama is right here. We all just try to hold on for our babies.

These mothers demonstrated the epitome of resilience as they learned to live with what was beyond their control.

Coping. Mothers used various means to cope with their babies' NICU hospitalizations. All mothers agreed that the hospitalization was stressful and that it was anxiety provoking and frustrating to deal with the uncertainties and the lack of control inherent in the situation. Especially difficult and emotional was leaving the baby at the end of each day. The most commonly described coping mechanism used by all but one mother was to stay in the present moment: “You’ve got to take it one day at a time. Every day is something different. You just don’t know.” The next most commonly reported (*n*=15, 65%) coping mechanism was prayer. Religion and spirituality were very important for these mothers. Mothers looked to their faith to help them cope with the adversity of their babies’ illnesses: “I wasn’t praying a lot. I do consider myself religious and as soon as I started praying, everything just kind of fell into place. I was less stressed and just felt more at ease and at peace with myself.” Other coping mechanisms reported included stay positive (*n*=12, 52%); a willingness to believe that things happen for a reason (*n*=10, 43%); ask questions/stay informed (*n*=8, 35%); talk with someone you trust (*n*=5, 22%); and write in a journal (*n*=2, 9%).

CALLOUT 2

Peer Support

Peer support was ranked as the most important factor for development of the maternal role in the NICU for 74% of mothers (*n*=17). Specifically, mothers looked to the NICU-based breastfeeding peer counselors (BPCs) (NICU lactation care providers who were mothers of former VLBW infants cared for in the same NICU) and their peers (other NICU mothers) for this support. Mothers appreciated the lactation information, assistance, and support the BPCs gave them: “One of the most positive things here is having the BPCs actually care that I get milk.” However, the mothers also found comfort in “…interacting with someone who

has been through a similar situation as yours. It gives you some validation of your feelings being okay." Mothers welcomed the thoughtful care they received from the BPCs: "I'm here every day, but I have (a BPC) calling me at least once a week just to see how I'm doing. It's nice that they check in on you because it shows they care about more than just the pumping." Mothers often found it difficult to relate to family members and friends who didn't understand the stress they were going through, so the peer relationship was especially important:

> At home, nobody understands. They don't get why coming here is all I am doing, why it's so hard to be separated from your child and not be able to bring him home. Here it's less stressful. It makes me feel better. Getting to see that other people have been in the same situation has been positive. So instead of thinking, "Why me?" here you get to see it doesn't just affect only you.

Table 3 summarizes additional barriers and facilitators reported by the mothers.

"I'm a NICU Mom"

Mother-infant interactions. All of the mothers acknowledged maternal feelings towards their babies. Most mothers (*n*=17, 74%) perceived their babies as being able to recognize them and described the reciprocal interactions between mother and baby. A mother of a baby born at 25 weeks gestation responded definitively:

> I know she knows me. I come in here and she hears my voice, she'll either open her eyes or her sats (oxygen saturations) will go up. She knows the difference in my touch from the nurses. When I hold her she grabs my hand tight and holds my little finger.

Other mothers were unsure: "I think he knows me because he sleeps so peacefully on me, but then I put him back in the crib and he still sleeps peacefully. So I don't know."

Shared responsibilities. Eleven mothers (7 primiparas, 4 multiparas) responded positively to the question "Do you feel like a mother?" Twelve (11 primiparas, 1 multipara) characterized themselves as mothers only while they were in the NICU ("It's easy to be a mother while you're here") but did not feel like a mother when they left the NICU. These mothers felt they needed the social validation of others seeing them with their babies: "I go to the same coffee shop every day. They don't know me as a mom. I don't get to push a carriage or stuff like that." Most of these 12 mothers felt they needed 24 hour responsibility for the care of their babies before they would feel like mothers:

> When people ask me how it feels to be a mom it's like well, "I'm a NICU mom. It's not like being a real mother yet." My baby is being taken care of by other people and I have limited access to her depending on her schedule and her health. I have a special connection with this baby but until I am responsible for her fully, I don't think I will feel like a real mother yet.

From the NICU to "normal." When asked to fantasize about life with their babies at home and being full-time mothers, the most immediate response was similar to this mother's: "I'm never going to let him go!" The majority of mothers also perceived that having their babies

home with them would bring a sense of “normalcy” to their lives: “I can’t wait to be a family at home, to be with her all day and night and have that be normal rather than this (coming to the NICU).” Mothers discussed being excited about doing “normal” things with their babies such as “taking stroller walks in the park,” “seeing all of her ‘firsts’ like first time she rolls over, first steps, first word,” and “learning all of her little habits and idiosyncrasies.”

Discussion

In this study we described the process by which first-time NICU mothers coped with their distress and became actively engaged in their infants’ care as they developed their maternal roles within the context of the NICU. Mothers described their experiences of the births and NICU hospitalizations as traumatic and overwhelming leaving them feeling helpless, confused, and vulnerable. However, once the mothers accepted having infants in the NICU and redefined the reality of their new lives, they showed remarkable resilience as they began to focus on strategies (e.g., infant caregiving, kangaroo care, staying informed) that reduced their stress and anxiety over time and facilitated development of the maternal role.

A primary purpose of this study was to describe the maternal perspective of transitioning from feelings of distress to developing the maternal role in the NICU. We found that mothers were able to cope with and/or modify the effects of adverse life events, reduce the stress associated with the infants’ NICU hospitalizations, and accept that their lives had changed as they learned to care for their infants. Although previous authors reported similar maternal responses to preterm birth and the use of coping strategies during the NICU hospitalization (Baum, Weidberg, Osher, & Kohelet, 2012; Coppola & Cassibba, 2010; Hendricks-Munoz, 2012), a unique finding in this study was the resilience and strength of purpose that mothers reported. For these mothers, the critical factor in shifting from their own distress to creating an environment of meaningful and positive patterns of interaction with their infants was their need to "pick themselves up and be strong" for their fragile infants. The processes inherent in this transition were facilitated by the mothers’ day to day interactions with the BPCs.

To our knowledge, this is the first study to report a link between the decrease in NICU-associated stress and the mothers’ perceptions of the importance of the peer support they received from the BPCs and other NICU mothers. This support was especially important because mothers in this study reported that the traditional advice and shared experiences from friends or family did not meet their needs. Thus, the mothers turned to their peers in the NICU to help them cope with the stress of having NICU infants. The mothers in this study and in other studies conducted by this research team (Rossman et al., 2011; Rossman, Kratovil, Greene, Engstrom, & Meier, 2013) found it therapeutic to talk with the NICU-based BPCs who had firsthand knowledge of the difficulties of coping with the emotional stress of traumatic preterm births and the NICU hospitalizations of VLBW infants.

The relationship between the mother and the BPC began in the early post-birth period when the BPCs shared stories of their own births and having infants in the NICU, giving the mothers personal, undivided attention (Meier, Engstrom, & Rossman, 2013; Rossman et al., 2011). As former NICU mothers, the BPCs provided therapeutic emotional support in the

form of chatting, a type of everyday communication that minimizes the power differential between parent and health care provider and encourages the mutual, collaborative exchange of feelings, thoughts, and behaviors (Fenwick et al., 2001). These informal conversations provided mothers with opportunities to process and normalize their births and initial NICU experiences (Kendall-Tackett, 2014). Being able to “share with someone who actually dealt with it” was important for mothers because it helped them to feel less alone, alleviated some of their anxiety about having infants in the NICU, helped them develop their maternal identities, and enhanced their confidence as mothers (Rossman et al., 2011).

Whereas our study results highlight the specific role of BPCs in the reduction of maternal psychological distress in the NICU, other researchers have reported on the importance of peer support in general. For example, findings from studies on NICU design indicated that mothers prefer the open-bay design because of their ability to meet other NICU parents for peer support; the single room design contributed to feelings of isolation (Domanico, Davis, Coleman, & Davis, 2011; Pineda et al., 2012). Pineda et al. (2012) also found that mothers with infants in private rooms visited their infants more but reported more stress on the maternal role alteration subscale of the PSS:NICU than mothers in open-bay NICUs. Other researchers have investigated the value of mother-to-mother support for the prevention of NICU-specific parenting stress and anxiety in new NICU mothers and found that the shared experience helped to reduce feelings of isolation, provided validation of new mothers’ experiences, and normalized the situation (Preyde & Ardal, 2003).

More than half of the mothers in this study qualified their maternal identities as “NICU mom” versus a “real” mother who has 24-hour responsibility for her child. While not using the same "NICU mom" terminology, findings from previous studies on maternal identity in the NICU (Black et al., 2009; Heermann, Wilson, & Wilhelm, 2005; Lupton & Fenwick, 2001) are consistent with ours. Black and colleagues referred to this as a liminal quality, or being "neither here nor there," a finding typical only of first-time mothers, whereas we found that multiparas and primiparas described themselves as "NICU moms." The fact that mothers reported not being a "real mother yet" while simultaneously scoring the maternal role alteration subscale of the PSS:NICU to reflect less stress over the course of the NICU hospitalization suggests that the subscale may not capture this maternal perception.

Since this is the first study in which the impact of BPC support is rated as the single most important facilitator of maternal role development in the NICU, it is possible that through their interactions with the BPCs, these mothers gained insight into the attainment of their maternal identities and were able to perceive being a "NICU mom" as one step in the process of developing a maternal role while having an infant in the NICU. Another defining step in the process would occur at NICU discharge, and mothers reported that the BPCs’ stories of taking their own infants home comforted them and gave them hope that once their infants were home, their lives would settle into a new normal as a family.

Although this study was limited to a sample of English-speaking mothers from one NICU with dedicated peer support, the characteristics of the 23 mothers do not differ significantly from those of the 69 mothers in the larger study from which this subsample was drawn. The timing of the interviews may also limit the generalizability of results. There is no best time

to study maternal identity because it is constantly evolving, but these results are generalizable to the NICU period that coincides with approximately six weeks after birth.

CALLOUT 3

Implications for Practice

The findings from this study further illustrate the favorable effect of BPC practice in the NICU and extend the utility of this role to one that promotes maternal role attainment. We have previously published data that exemplify the unique bedside nurse-BPC team with respect to the provision of lactation support in the NICU (Meier et al., 2013). However, the findings from this study indicate that the BPC, defined as a parent of an infant cared for in the same NICU, serves a multitude of purposes. Nurses and nurse administrators are in the ideal position to advocate for this role and there are substantial data at this point to merit consideration of such a position.

Similarly, there are several ways in which neonatal nurses can help mothers without spending extra time but rather by targeting talking points (See Table 4) while providing direct care to infants. For example, the nurse can say to the mother, "Your delivery must have been such a surprise and shock for you" or "Tell me the first thing you want to do when you take your baby home." These invitations to chat as a therapeutic intervention are targeted toward addressing barriers to maternal role attainment as delineated in this study. They allow the mother to explore and express her feelings about the traumatic birth and NICU experience so that she can proceed to create a safe and interactive mothering environment for her infant.

NICU nurses can also facilitate more maternal caregiving to promote the maternal role. For example, a nurse could reassure the mother who was unsure if her baby knew her because he slept as peacefully during kangaroo care with her as in his crib by saying, "Babies experience the deepest sleep during skin-to-skin care and the fact that he's resting so comfortably afterwards is that you settled him so well." Through constructive feedback and observations by the nurse, such as "You do that so well" or "Look how your baby's breathing becomes more regular with skin-to-skin care," every caregiving activity and mother-infant interaction provides opportunities for mothers to learn the nuances of their infants' behavior and how to comfort and care for them. This increases their sense of accomplishment and personal responsibility for their infants (Mercer, 2006).

A supplement to chatting is the mother-helping-mother model of peer support groups (Meier et al., 2013; Preyde & Ardal, 2006). Peer sharing of positive and negative maternal experiences within the community of the NICU has been shown to strengthen social relationships and networks and provides the potential for personal therapeutic benefit (Preyde & Ardal, 2003; Rossman et al., 2011). A support group led by an advanced practice nurse would give mothers who experienced their births as distressing the opportunity to talk through and process their experiences with a facilitator and other mothers who have also experienced traumatic birth. The nurse could then supplement the mothers' birth stories with evidence-based information about subsequent pregnancies (Reedy, 2007; Wood & Quenby, 2010).

Finally, the majority of mothers in this study discussed the importance of spirituality in times of crisis and day-to-day coping and described the need to connect with their faith through prayer. As part of a holistic approach to care, nurses can honor mothers' bedside rituals of praying and can arrange for pastoral visits and/or counseling during the NICU stay (Allen & Marshall, 2010; Schenk & Kelley, 2010).

Conclusion

Mothers in this study demonstrated resilience and inner strength through an understanding of the need to cope with their initial distress, developing effective coping mechanisms, and then creating environments for their infants that were conducive to maternal-infant interaction. By integrating mothering behaviors into their lives, they reduced their stress and shifted their focus to developing a synergistic relationship with their infants. Peer support and role modeling by the BPCs helped the mothers throughout every stage of their infants' hospitalizations, from giving them hope, to helping them begin to develop maternal identity, to providing anticipatory guidance. Hope and anticipatory guidance by the BPCs were especially valuable to the mothers because they felt like part-time mothers (“I’m a NICU mom”) and awaited the day they could take their infants home. The experiences of these mothers reflect the importance of peer support in helping mothers cope with their infants' hospitalizations and in engaging mothers in coming to know and learning to care for their infants as part of the process of developing their maternal identities.

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Table 1

Sample Quest ions from Interview Guide

Topic	Question
Pregnancy	What were your plans for birth? (probes: holding baby right away, unmedicated, partner present)
Birth Experience	Tell me about your birth (Probes: How many weeks gestation, C/S or vaginal, did you hear your baby cry, what were your thoughts in the delivery room)
Relationship with Baby and feelings as a Parent	Describe the first time you saw your infant. (Probes: How did you react? What thoughts/ feelings were going through your head?)What is your baby like now? Do you feel like your baby knows you? How can you tell?
Reaction to NICU and Relationship to Staff	From your point of view, what are some of the positive and negative aspects of the NICU? What have your experiences with the staff been like?
Relationship with Family and Social Support	What has this experience been like for your partner? Who helps you in terms of encouragement, support and getting things done?
Providing Milk	Would you describe what providing milk means to you? (Probe: How important is it that you pump? How important is your milk for your baby?)
Discharge and Beyond	As you look ahead, what do you think about when you think about going home with your baby? What are your concerns?

Table 2

Characteristics of the Study Participants (n=23)

Characteristics	*n*	%	M	Range
Maternal Age, years			26	19–37
Infant Birthweight, grams[a]			854.6	600–1445
Gestational age at birth, week[a]			26.9	23–33
Infant age at interview, week			6	4–8
Race/Ethnicity				
Non-Hispanic Black	13	57		
Non-Hispanic White	6	26		
Hispanic	4	17		
Economic Status				
WIC Eligible	18	78		
Non-WIC Eligible	5	22		
Education				
High School or less	12	52		
Some College	6	26		
College Graduate	5	22		
Marital Status				
Married	6	26		
Not Married	17	74		
Gravida				
Primipara	18	78		
Multipara	5	22		
Type of Birth				
Vaginal	11	48		
Caesarean	12	52		
Maternal Complications				
Pre-eclampsia with MgSO4	7	30		
Preterm Labor with MgSO4	6	26		
Preterm Labor without MgSO4	4	17		
Placental Abruption	2	09		
Incompetent Cervix	3	13		
Premature Rupture of Membranes	2	09		
Infant Complications				
Sepsis (Confirmed and Presumed)	6	26.1		
Patent Ductus Arteriosus (PDA)	15	65.2		
Necrotizing Enterocolitis (NEC)	2	8.7		
Severely Abnormal Head Ultrasound	2	8.7		
Any Abnormal Head Ultrasound	10	43.5		

[a]Note. Infant birthweight and gestational age based on n=27.

Table 3

Facilitators and Barriers to Maternal Role Attainment in the NICU

Facilitators and Barriers	*n*	%
Facilitators		
Peer support (Breastfeeding peer counselors and other NICU mothers)	17	74
Leaving their baby in a safe place	15	65
Learning from the staff	7	30
Barriers	12	52
Leaving the baby to go home	12	52
Noise of the monitors	10	43
Uncertainty	6	26
Lack of privacy	5	22
Lack of control	4	17

Table 4

Talking Points for Neonatal Nurses for Selected Facilitators and Barriers

Category	Goal	Talking Point
Facilitators		
Peer Support	Helps the mother realize her experiences of a traumatic birth and her infant in the NICU are shared	Lots of mothers with babies in the NICU find that their own family members try to be supportive but they just don't understand.
	Helps the mother understand her reactions (e.g., anxiety, not wanting to leave the baby, not finding helpful support from family and friends) are normal	Oftentimes, talking with another parent can be helpful. Have you met any of the other parents? Let me introduce you to Ms. X. Her baby has been through many of the same things as your baby.
Learning from the staff	Reinforces maternal role which increases the mother's sense of accomplishment	Look at how much weight your baby has gained from your breast milk.
	Fosters mother's sense of responsibility for her infant's health	Look how your baby's heart rate stabilizes when you hold her in the position I showed you. She knows your touch and calms right down.
		Your baby tolerates the gavage feedings better when you hold him than he does for any of us. I'm going to watch your "technique" so I can make sure I do it as well.
Barriers		
Leaving the baby to go home	Provides the mother with an opening to talk about her reactions to going home and leaving her baby each day.	Most mothers say that the hardest part of the whole NICU experience is leaving the hospital after giving birth and leaving your baby behind. They say it gets harder and harder as they spend more time with their babies and the babies really come to know when they are with their mothers. Lots of time, even close friends and family members do not understand how difficult it is to leave your baby. But, your hormones are "wired" to not want to leave your baby just like any other mother--NICU or not.
Uncertainty	Provides the mother with an opportunity to talk about her reaction to her infant's health and its impact on her life Provides the mother with a safe space to discuss her fears, anxieties	A lot of mothers say that having a baby in the NICU is like being on a roller coaster. There are a lot of different ways that mothers cope with the emotional ups and downs of having a baby in the NICU.
	Helps the mother understand her feelings are normal	Some mothers have difficulty thinking about what it will be like when they take their babies home. Have you thought about what is the first thing you will do when you take your baby home?
Lack of Control	Acknowledges and validates the mother's feelings and helps her understand her experience is normal	Many mothers say it's hard not to be able to take care of their baby all the time and to have to leave him or her with the NICU
	Helps to acknowledge the role of the mother as the primary caregiver while mother and nurse work as partners in the baby's care	It's a normal feeling for every new mother to have when she leaves her baby in the care of others What makes you feel the most relaxed and comfortable with respect to your baby's care?