Igiene e Sanità Pubblica 2025; 98 (5)

Maternity and Critical Care: A Qualitative Survey of the Experience of Nurse Mothers

Anna Arnone[1], Francesco Riccardo[2], Giovanni Gioiello[3], Alessandro Marino[4], Zeppetella Luisa[5]

Affiliation

[1]Nurse, A.O.U. Federico II, Naples (Italy)

[2]Nurse, ASL Na 2, Naples (Italy)

[3]Researcher, University of Enna "Kore", Enna (Italy)

[4]Nurse, AORN Cardarelli, Naples (Italy)

[5]Nurse, AORN Cardarelli, Naples (Italy)

Keywords*: motherhood, nurses, critical care, work–family balance, phenomenology*

Abstract

Background: Returning to work after maternity leave is a critical transition for nurses, especially in critical care units, where intense workloads and clinical responsibilities may conflict with family needs.

Aim: To explore and understand the meaning of the lived experiences of nurse mothers returning to critical care work in the Italian context.

Methods: Qualitative study using an interpretative phenomenological approach. Snowball sampling; 12 nurse mothers with at least one year of post-partum work were interviewed through semi-structured interviews (45–60 minutes). Data were manually analyzed using thematic analysis (Braun & Clarke, 2006), with researcher triangulation and member checking. Informed consent was obtained.

Results: Four main themes emerged: work–family conflict; informal vs. organizational support; redefinition of professional identity; coping strategies. Nurses reported emotional strain, lack of institutional support, and reliance on personal coping mechanisms.

Conclusions: Nurse mothers in critical care face both vulnerability and resilience. Inclusive organizational policies and structured return-to-work programs are urgently needed.

Introduction

The return to work after maternity leave represents a delicate and complex phase for health professionals. For nurses employed in critical care areas, this transition is accompanied by intense work rhythms, high clinical responsibilities and significant emotional loads. International literature highlights how difficulties in reconciling work and family life can generate stress, guilt, burnout and even abandonment of the profession (Allen et al., 2013; Maslach & Leiter, 2016, Aiken et al., 2002). However, motherhood can also enrich professional identity, promoting greater empathy and relational sensitivity (Gatti & Chiorri, 2020).

Many nurses report difficulties in finding a sustainable balance between caring for patients and caring for their children, especially on night shifts or in high-intensity wards.

The lack of spaces for listening or re-elaborating these experiences can result in a progressive detachment from the profession or in symptoms of work-related stress (Fiorilli et al., 2017; WHO, 2016).

On the other hand, motherhood can also enrich nursing identity, strengthening empathy capacity and the relational dimension of care (Gatti & Chiorri, 2020). It is therefore essential to promote an organizational culture that recognizes and values the experience of motherhood as a resource for nursing practice.

In the context of critical care nursing, critical care requires presence, flexibility, decision-making responsibility, and emotional endurance. However, when these characteristics intersect with the experience of motherhood, professionals are faced with identity and organizational conflicts. In a health system still centered on productivist models and not very sensitive to the needs of reconciliation, the return to postpartum work becomes a critical step, often underestimated (Allen et al., 2020).

The literature highlights how work overload, the absence of organizational support and the rigidity of hospital facilities are risk factors for stress, burnout and abandonment of the profession (Dall'Ora et al., 2022). In this context, motherhood is not only a personal event, but also a professional dimension that needs to be understood and integrated into organizational policies.

In Italy, few studies have explored in depth the experiences of nurse mothers in critical care contexts, making it necessary to carry out an investigation that gives voice to this experience and provides useful elements to guide inclusive organizational policies. The present study therefore intends to fill this gap, adopting an interpretative phenomenological approach to understand the meaning of lived experiences.

Objective

To explore and understand the meaning of the experiences lived by nurse mothers upon returning to the critical area, with particular reference to the Italian health context.

Materials and methods

A qualitative methodology with an interpretative phenomenological approach has been adopted (Smith et al., 2009). The sample was selected by snowball sampling. 12 nurse mothers with at least one year of postpartum work and experience in critical care were recruited. The median age was 32.75 years. The main socio-demographic data are shown in Table 1.

Semi-structured interviews, lasting an average of 45-60 minutes, recorded and transcribed in full, were conducted by videoconference between May and July 2023 by two experienced researchers. The data were analysed by thematic coding, with triangulation between researchers to ensure internal validity.

The semi-structured interviews were conducted in a confidential setting, via videoconference, to ensure comfort and privacy. A grid of open-ended questions was used focused on: experience of returning to work, perception of organizational support, adaptation strategies, impact on career. Informed consent was obtained from all participants. All conversations were recorded, transcribed in full and anonymized.

Data analysis was conducted with a thematic coding method (Braun & Clarke, 2006),

Igiene e Sanità Pubblica 2025; 98 (5)

developing a first theme map independently by two researchers, followed by comparison sessions to ensure triangulation and reduction of interpretive bias. The process followed the classic phases: initial familiarization with the transcriptions, systematic coding, construction and revision of the themes, up to their final definition. To ensure the quality and reliability of the analysis, the researchers worked in triangulation, periodically comparing their interpretations; In addition, an audit trail was maintained that transparently documented the analytical path. The preliminary results were shared with the participants (member checking), so as to ensure consistency and fidelity with respect to their experiences.

To ensure the credibility and transferability of the results, member checking (returning preliminary results to participants for confirmation) and audit trail (documentation of the analytical process) strategies were adopted according to COREQ guidelines (Tong et al., 2007).

CODE	AGE	REGION OF ORIGIN	FREQUENCY REGION OF ORIGIN	YEARS OF WORK EXPERIENCE	POSTPARTUM YEAR OF EMPLOYMENT
01	29	CAMPANIA	0,2	6	1
02	27	LATIUM	0,2	3	1
03	31	LOMBARDY	0,2	9	1
04	37	LATIUM	0,2	8	2
05	29	TUSCANY	0,1	5	1
06	38	MOLISE	0,1	12	3
07	34	EMILIA-ROMAGNA	0,1	10	2
08	35	LOMBARDY	0,2	11	2
09	33	CAMPANIA	0,2	6	1
10	31	LIGURIA	0,1	8	1
11	36	ABRUZZO	0,1	13	2
12	33	APULIA	0,1	9	1

Table 1. – Socio-demographic characteristics of the participants.

THEMES	SUBTHEMES
At. Work-family conflict	· Psycho-physical exhaustion
B. Informal support vs. organizational support	
C. Redefinition of professional identity	· The organization · Expertise
D. Adaptation strategies	· Psychological support

Table 2. – Themes and sub-themes.

Igiene e Sanità Pubblica 2025; 98 (5)

Results

Four main themes emerged from the qualitative analysis:

1. Work-family conflict

The participants described a constant sense of guilt related to the difficulty of being "sufficiently present" both as mothers and as nurses. The return to work is experienced as an ambivalent moment, between a sense of duty and personal renunciation.

All participants reported experiencing a constant tension between the demands of work in the critical area and those of the family. The recurring perception is of a double insufficiency:

> *"When I'm on the ward, I think I should be at home with my son; When I'm at home, I think about what's happening to my patients." (P3)*

Guilt was associated with close shifts and inability to plan time with children. Some have used the expression "frenetic pace" to describe this period.

2. Informal support vs. organizational support

While the support of colleagues was perceived as empathetic, healthcare facilities appeared rigid and unwilling to personalize shifts or listen to family needs.

The interviewees indicated as the main source of support their direct colleagues, described as a "lifesaver network" in the most complex moments:

> *"My colleagues covered my shifts when I had problems with kindergarten; without them I wouldn't have made it." (P7)*

On the contrary, organizational policies have been perceived as rigid and insensitive:

> *"For the company, motherhood is an obstacle, not a natural phase of life. They make you feel like a burden." (P11)*

3. Redefining professional identity

Some interviewees report a renewed sensitivity in taking care of patients, especially pediatric or frail patients. However, others report a sense of alienation, of emotional detachment as a form of self-defense.

Many mothers described a positive change in the perception of their role after motherhood, with a more empathetic and person-centered approach:

> *"Becoming a mother taught me to see patients as someone's children and this changed the way I car." (P5)*

However, this new awareness has collided with the feeling of being less considered professionally:

> *"After returning they removed me from the most complex cases, as if I was no longer capable." (P2)*

4. Adaptation strategies

Strategies that emerged include family self-organization, giving up career opportunities, entrusting grandparents, and enduring high levels of emotional stress. None of the participants received a structured reintegration program.

To cope with the difficulties, the participants implemented several strategies: request for more predictable shifts, temporary reduction of hours, entrustment to family support networks or psychological support:

> *"I asked to concentrate the shifts in a few days, so at least I have more continuous time with my son." (P8)*
> *"I started a path with a psychologist because I could no longer separate the emotions of work from those of home." (P1)*

Discussion

The results confirm the absence of a systemic vision in the management of maternity in critical areas. Nurse care, a key element of fundamental care, has no place in current organizational policies. Motherhood continues to be experienced as an anomaly, a "management problem", rather than a natural condition worthy of protection (Allen et al., 2020; Dall'Ora et al., 2022). This perpetuates the gender gap, limiting equal access to careers and fueling burnout.

The results that emerged from this survey confirm that maternity in nursing, especially in critical care wards, is located in an area of tension between personal identity and professional identity. Participants reported experiences of work-family conflict that are not limited to the practical management of shifts or emergencies, but extend to the emotional sphere, influencing their perception of themselves as a professional and as a mother.

These data are consistent with what was reported by Allen et al. (2013), according to which work-to-family conflict can generate a vicious circle of stress and guilt, with negative repercussions on both mental health and job satisfaction. The literature highlights how, in health professions, the pressure from long shifts, high workloads, and clinical responsibilities can amplify the risk of burnout (Maslach & Leiter, 2016; WHO, 2016).

A recurring element in the testimonies was the perception of poor organizational flexibility: if emotional and practical support came mainly from colleagues and family networks, institutional measures were perceived as insufficient or inadequate. This reflects a systemic gap already highlighted in international studies (McLellan & Weitzman, 2022), which show that many healthcare organizations do not integrate parenting as a structural variable into personnel planning. Also interesting is the redefinition of the professional identity reported by some participants: motherhood, while introducing complexity in the management of work, has contributed to enriching relational, empathic and clinical prioritization skills. This transformation, if recognized and valued by the organization, could represent a competitive advantage for the quality of care (Gatti & Chiorri, 2020). From the point of view of adaptation strategies, the participants identified personal solutions such as temporary ward changes, request for modulated shifts or psychological support. However, in the absence of structured organizational welfare, these initiatives remain fragmented and dependent on the goodwill of individual managers or colleagues (Luyben et al., 2017).

The overall picture therefore highlights the need to move from a reactive approach - in which maternity-related issues are addressed only on request or in crisis situations - to a proactive model, which includes systemic measures of reconciliation, mentorship and enhancement of parenthood. Such an approach would not only reduce turnover and absenteeism (Hayes et al., 2012), but would improve organizational well-being and the quality of care provided.

Maternity should not be considered a disturbing variable in the work context of the critical area, but rather a human and professional resource to be integrated into the strategic planning of health resources. The results highlight an important critical issue in the management of maternity in the health professions, especially in highly complex contexts. The lack of institutional support reinforces the perception that motherhood is an "organizational problem" rather than a natural stage of working life (McLellan & Weitzman, 2022). The gender gap remains both in terms of invisible burdens and in the possibilities of post-maternity professional growth. However, the experience of motherhood can be an asset to the profession, if properly supported and valued (Luyben et al., 2017).

The results show how maternity in critical care is characterized by a constant tension between experiences of vulnerability and resilience. The absence of adequate organizational support tends to amplify work-family conflict (Allen et al., 2013), while informal networks of colleagues and family members often represent the only real barrier to daily difficulties. A specificity that has emerged in the Italian context is precisely the lack of structured reintegration programs, which accentuates the sense of loneliness of professionals upon return.

On a theoretical level, these experiences can be interpreted in the light of the work-family conflict model and the theory of resource conservation (Hobfoll, 1989): when personal resources are continuously consumed without adequate replenishment by the organization, stress increases and it becomes difficult to maintain a balance between the different roles. However, if supported and recognized, motherhood can transform from a risk factor into a resource, enriching nursing practice with new empathic and relational skills.

The study has some limitations, related to the small sample size, snowball sampling, manual analysis of the data and the non-in-depth reflexivity of the researchers. At the same time, it is a strong point to give voice to a phenomenon that is still little investigated in the Italian context, offering concrete ideas for the practice of care and for the development of more inclusive organizational policies.

Conclusions

To promote a fair and sustainable health system, it is urgent to rethink organizational policies in an inclusive way. Recommended actions include: development of individualized plans for post-maternity return; mentoring among peers and listening groups; flexibility in shifts and recognition of parenting as an added value.

The results of the study show how motherhood, experienced in the professional context of the critical area, represents both an opportunity for personal growth and a moment of professional vulnerability.

The nurses interviewed highlighted a strong need for organizational recognition, which is not limited to formal measures (leave, leave) but includes proactive parenting support policies, such as: gradual return plans, the possibility of modulated shifts, mentoring programs to balance career and family life, dedicated psychological support.

The international literature confirms that the reconciliation of maternity and nursing has direct repercussions on well-being, retention and quality of care (Shields & Wilkins, 2009; Luyben et al., 2017). The absence of adequate strategies can lead to burnout (Maslach & Leiter, 2016), abandonment of the workplace (Hayes et al., 2012) and reduced motivation.

In light of this, health organizations should overcome a reactive approach and develop systemic organizational welfare policies, capable of transforming motherhood from a perceived obstacle to a resource for the growth of the care culture.

Motherhood is not a limit, but an experience that can enrich nursing practice, if properly valued. To build an inclusive and sustainable work environment for nurse mothers, organizational policies need to be rethought. It is suggested to introduce greater time flexibility, facilitate reintegration and mentoring paths upon return, and recognize parenthood as an integrated dimension of professional identity. Only a systemic approach, oriented towards well-being and the enhancement of human capital, will be able to counteract phenomena of burnout, abandonment and inequality.

Future studies should deepen the topic with quantitative, longitudinal and comparative approaches, recognizing the role of motherhood as a resource capable of enriching nursing practice.

Bibliography

Aiken LH, Clarke SP, Sloane DM. (2002). Hospital staffing, organization, and quality of care: Cross-national findings. International Journal for Quality in Health Care, 14(1), 5–14.

Alhani, F. & Mahmoodi-Shan, G. (2018). Work-family conflict as a stressor in the lifestyle of nurses: a content analysis. Journal of Nursing and Midwifery Sciences, 5(3), 79–88.

Allen TD, Herst DE, Bruck CS, Sutton M. (2013). Consequences associated with work-to-family conflict: A review and agenda for future research. Journal of Occupational Health Psychology, 8(2), 115–135.

Braun V, Clarke V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

Cohen MZ, Kahn D, Steeves R., Hermeneutic phenomenological research: A practical guide for nurse researchers. Thousand Oaks, California: Sage, 2002.

Fiorilli C, Albanese O, Gabola P, Pepe A. (2017). Teachers' emotional competence and social support: Assessing the mediating role of burnout. Scandinavian Journal of Educational Research, 61(2), 127–138.

Gatti E, Chiorri C. (2020). Maternity, work-family balance and wellbeing in nursing: A qualitative approach. Journal of Advanced Nursing, 76(5), 1254–1264.

Graneheim U.H., Lundman B. (2004) Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse education today, 24(2), 105-112.

Havaei, F., Tang, X., Smith, P., Boamah, S. A. & Frankfurter, C. (2022). The association between mental health symptoms and quality and safety of patient care before and during COVID-19 among Canadian nurses. Healthcare (Basel), 10(2).

Hayes LJ, O'Brien-Pallas L, Duffield C, Shamian J, Buchan J, Hughes F, et al. (2012). Nurse turnover: A literature review. International Journal of Nursing Studies, 49(7), 887–905.

Luyben AG, Fleming V, Vermeulen J, Dahlen HG, et al. (2017). Midwifery education in Europe: Outcomes and challenges. Midwifery, 48, 1–8.

McLellan S, Weitzman B. (2022). Gender, caregiving, and workplace policy: Implications for health care professionals. Health Services Research, 57(1), 25–34.

Polit DF, Beck CT, Essentials of nursing research. 8th ed. Philadelphia: Lippincott Williams & Wilkins, 2014.

Proter E, Cohen MZ, Phenomenology In: Trainor A., Graue E., eds. Reviewing Qualitative Research in the Social Sciences. New York: Routledge, 2013.

Shields M, Wilkins K. (2009). Factors related to on-the-job abuse of nurses by patients. Health Reports, 20(2), 7–19.

Smith JA, Flowers P, Larkin M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. Sage.

Tong A, Sainsbury P, Craig J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. International Journal for Quality in Health Care, 19(6), 349–357.

Yang, M-L. & Tsai, L-J. (2020). Work–family conflict and job performance in nurses: the moderating effects of social support. Journal of Nursing Research, 22, 200–207.

Weiss R.S. (1994), Learning from strangers: the art and method of qualitative interview studies. New York: The Free Press.

World Health Organization. (2016). Working conditions of health workers and impact on the health workforce and health systems. WHO.

Corresponding Author

Anna Arnone

E-mail: anna.arnone93@live.it