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Lived Experiences of Hypertensive Mothers Delivering Preterm Babies: A Transcendental Phenomenological Study

Fatima May B. Bautista[1*], Judy Jane S. Revelo[2]

[1]ACE Medical Center, Dipolog City Philippines

[2]Misamis University, Ozamis City, Philippines

[*]Corresponding Author

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ABSTRACT

Hypertensive disorders during pregnancy are high-risk conditions that often culminate in preterm delivery and expose mothers to profound physical, emotional, and psychosocial challenges. This study explored the lived experiences of hypertensive mothers who delivered preterm infants in selected public and private hospitals in Zamboanga del Norte. Guided by Moustakas' transcendental phenomenological approach, this qualitative study recruited eight hypertensive mothers using purposive sampling. Data were gathered through semi-structured interviews and analyzed following the Moustakas' framework for analysis. Five essential themes emerged from the analysis: (1) embodied challenges and adaptation and physical management; (2) temporal disruption and adaptation during preterm labor and postpartum recovery; (3) perceived safety as a dual experience of separation anxiety and security; (4) interpersonal networks as a source of strength; and (5) medical objects as instruments of safety and empowerment. The findings highlight that maternal resilience in hypertensive preterm birth is shaped by the dynamic interaction of physical conditions, emotional responses, relational support, care environments and medical resources. Based on the findings, the study recommends the integration of structured psychosocial support, family involvement and clear communication on medical interventions into maternal care to strengthen coping, safety and empowerment among hypertensive mothers delivering preterm babies.

Keywords: Adaptation, Hypertensive Pregnancy, Lived Experiences, Maternal Resilience, Preterm Babies

INTRODUCTION

Hypertension is a prevalent and clinically significant complication of pregnancy, affecting approximately 10% to 15% of pregnancies worldwide.[1] It contributes substantially to adverse maternal and neonatal outcomes, particularly in low- and middle-income settings where access to comprehensive prenatal care is limited. Among its complications, preterm birth, defined as delivery before 37 weeks of gestation, remains one of the most frequent and life-threatening, given its strong association with neonatal mortality and long-term developmental challenges, including respiratory and neurodevelopmental disorders.[2]

Beyond physiological risks, hypertensive disorders profoundly influence mothers' emotional and psychological experiences. Women often report fear, anxiety, stress and a diminished sense of control, compounded by the unpredictable progression of the condition and the possibility of emergency interventions.[3] Experiences within healthcare settings further shape these responses; while some mothers perceive care as supportive, others report inadequate communication or delayed attention, which can negatively affect emotional well-being.[4]

For mothers who deliver preterm infants, particularly those requiring neonatal intensive care, the experience can be especially distressing. The abrupt transition to early delivery disrupts expectations of childbirth and motherhood, often resulting in feelings of isolation, helplessness and altered maternal identity.[5] Despite these challenges, some mothers demonstrate resilience and adopt healthier behaviors postpartum, particularly when supported through education and follow-up care.[6]

The combined impact of hypertensive disorders and preterm birth creates a multidimensional burden. Clinically, these conditions are linked to emergency interventions, prolonged hospitalization and intensive neonatal care.[7,8] At the same time, mothers experience persistent fear, uncertainty and psychological distress that may extend into the postpartum period.[9,10,11] While biomedical outcomes are well documented, limited research has explored the subjective and meaning-making aspects of these experiences, including temporal disruption, relational changes and long-term psychological effects.

Effective care for hypertensive mothers requires more than clinical management. Although regular monitoring and timely interventions are essential, these conditions also have lasting implications for maternal cardiovascular health.[12,13] This underscores the need for holistic maternal care that integrates physical, emotional and social support.[14]

However, existing research has largely focused on clinical and neonatal outcomes, often overlooking mothers' psychological experiences. Emotional distress, including anxiety, uncertainty and self-blame, is common among mothers who deliver preterm infants and may persist as postpartum depression or anxiety if unaddressed.[15,16] Understanding these experiences is critical for developing comprehensive care strategies.

Systemic factors within healthcare settings further shape maternal experiences. Fragmented care, multiple providers and complex treatment protocols can contribute to confusion and stress, particularly in resource-constrained environments.[17] Limited mental health services and inadequate social support exacerbate these challenges, highlighting the need for integrated models of care that address both medical and psychosocial needs.[18,19]

Despite growing attention to high-risk pregnancies and NICU experiences, the literature remains fragmented. Few studies have examined the combined experience of hypertensive disorders and preterm birth, limiting understanding of how physiological, emotional and contextual factors interact. Addressing this gap is essential for developing responsive and holistic maternal care.

Maternal emotional distress has implications beyond the postpartum period, affecting both maternal well-being and infant development. Elevated stress may hinder mother–infant bonding and self-care, while also contributing to adverse child outcomes, including emotional and behavioral difficulties.[20,21,22] These findings emphasize the importance of addressing maternal psychological health as part of comprehensive care.

In response, this study explores the lived experiences of hypertensive mothers who delivered preterm infants, focusing on emotional, psychological and relational dimensions. Using a phenomenological approach, it examines how mothers interpret and navigate these experiences across key existential dimensions.

By bridging clinical knowledge and lived experience, the study aims to inform more holistic, patient-centered care strategies that integrate medical, emotional and social support, ultimately improving maternal and neonatal outcomes.

METHODS

Design

This study employed a transcendental phenomenological design to explore the lived experiences of hypertensive mothers who delivered preterm infants. Phenomenology is appropriate for examining how individuals interpret and assign meaning to their experiences, particularly in complex health situations. Guided by Moustakas' approach, the study emphasized *epoche* or bracketing, allowing the researcher to set aside preconceptions and focus on participants' subjective accounts.[23]

Setting

Participants were recruited from selected public and private hospitals in Zamboanga del Norte, a province in Southwestern Philippines. These hospitals served a diverse population, including hypertensive mothers who have experienced preterm deliveries, making them important contexts for understanding the phenomenon Although

data collection occurred after hospital discharge, participants' experiences remained closely linked to these healthcare settings. Conducting interviews post-discharge enabled mothers to reflect more freely while avoiding interference with their recovery or ongoing medical care. Variations in hospital resources and support services provided contextual depth to the findings.

Participants

Eight (8) hypertensive mothers who had delivered preterm infants were selected through purposive sampling. Inclusion criteria were: (1) diagnosis of hypertension during pregnancy, (2) delivery before 37 weeks of gestation, (3) age between 18 and 45 years, (4) discharge from hospital at the time of data collection, and (5) willingness to provide informed consent. The sample size was determined by data saturation and richness of narratives.

The participants in this study represented a diverse range of maternal and obstetric backgrounds, reflecting varied reproductive histories and childbirth experiences. They were between 32 to 39 years old, with parity varying from first-time mothers to those with four children. Gestational ages at delivery spanned 34 to 36 weeks, with both cesarean sections and normal spontaneous vaginal deliveries represented. Labor duration ranged from no labor (planned cesarean) to 14 hours of active labor. Hypertension during pregnancy was a common complicating factor, influencing both the course of pregnancy and delivery. Many participants had preterm births and experienced NICU admissions for their infants, requiring careful monitoring, medical interventions, and extended hospital stays.

Participant 1 was a 36-year-old mother of four who delivered via cesarean section at 35 weeks of gestation after four hours of preterm labor. Participant 2 was a 38-year-old first-time mother with an in-vitro fertilization pregnancy who underwent cesarean delivery at 33+ weeks following 20 hours of preterm labor. Participant 3, a 36-year-old mother of three, delivered by cesarean section at 30 weeks of gestation without labor due to uncontrolled hypertension. Participant 4 was a 39-year-old mother of two, with a history of neonatal loss from preterm complications, who delivered via cesarean section at 34 weeks after 14 hours of preterm labor. Participant 5 was a 32-year-old first-time mother who delivered through normal spontaneous vaginal delivery at 34 weeks following nine hours of preterm labor. Participant 6 was a 36-year-old mother of two who underwent cesarean section at 34 weeks of gestation due to hypertension-related seizures. Participant 7 was a 32-year-old first-time mother who delivered via cesarean section at 36 weeks of gestation. Participant 8 was a 39-year-old mother of two with a 13-year birth interval who delivered through normal spontaneous vaginal delivery at 35+5 weeks of gestation.

Instrument

Data were collected using a researcher-developed semi-structured interview guide. The guide included demographic questions (e.g., age, medical history, gestational age at delivery, and hospitalization duration) and open-ended questions aligned with the existential dimensions of lived experience. The instrument was pilot-tested for clarity and validated by nursing and healthcare experts prior to use.

Data Collection Procedure

Ethical and administrative approvals were secured prior to data collection. Eligible participants were identified through coordination with hospital personnel and were approached after discharge. In-depth interviews were conducted in participants' homes or other private, convenient locations. Each interview lasted approximately 30–47 minutes. With consent, interviews were audio-recorded and transcribed verbatim. Participants were given the opportunity to review transcripts to ensure accuracy.

Ethical Considerations

Ethical approval was obtained from the Misamis University Research Ethics Committee. Participation was voluntary, with informed consent secured prior to data collection. Mothers were recruited only after hospital discharge to minimize vulnerability and avoid interference with care. Participants were assured that their

involvement would not affect their healthcare services. Privacy and confidentiality were strictly maintained through anonymization, use of pseudonyms, and secure data storage. No monetary incentives were provided, and participants were informed of their right to withdraw at any time without consequence.

Data Analysis

Data analysis was conducted using Moustakas' (1994) transcendental phenomenological method, which emphasizes the systematic exploration of lived experiences through both textural (what is experienced) and structural (how it is experienced) dimensions, while bracketing researcher preconceptions through epoche. Prior to analysis, the researcher engaged in reflexive journaling to consciously identify and set aside personal biases and assumptions, thereby enhancing openness to participants' meanings.

The analysis began with repeated reading of interview transcripts alongside careful listening to audio recordings to ensure data immersion and accuracy. Through horizonalization, all statements relevant to the phenomenon were initially treated with equal value. Significant statements, referred to as invariant constituents, were identified and extracted. To ensure credibility, these statements were cross-checked against the original transcripts to confirm that they accurately reflected participants' intended meanings.

Subsequently, invariant constituents were subjected to clustering of horizons, wherein similar statements were grouped into meaning units. This iterative process involved constant comparison across transcripts to identify convergences and divergences in participants' experiences. Emerging clusters were refined and validated by returning to the raw data to ensure that each theme was explicitly grounded in participants' narratives. Through this process, core themes were developed, including emotional turmoil and fear, physical vulnerability, uncertainty regarding infant outcomes, disrupted maternal identity, reliance on support systems and healthcare interventions and the emergence of resilience, faith and adaptive coping.

Following theme development, textural descriptions were constructed to capture what participants experienced, presenting rich and thick descriptions of their emotional, psychological and physical realities. These descriptions were supported by verbatim excerpts to enhance authenticity and credibility. Thereafter, structural descriptions were developed to explain how these experiences unfolded within specific contexts, such as medical conditions, hospitalization, NICU environments, sociocultural expectations and interpersonal interactions.

The final phase involved the synthesis of textural and structural descriptions to articulate the essence of the phenomenon. This synthesis integrated all themes into a unified depiction of the shared experience, revealing that hypertensive mothers who deliver preterm infants undergo profound physical and emotional vulnerability, heightened uncertainty and disruption of maternal identity, yet demonstrate resilience sustained by faith, social support and adaptive coping mechanisms.

To ensure rigor, several strategies were employed. Credibility was established through prolonged engagement with the data, member checking with selected participants to validate interpretations and the use of rich, thick descriptions. Dependability and confirmability were supported through an audit trail documenting all analytic decisions and processes. Reflexivity was maintained through continuous self-examination and journaling to minimize researcher bias. Transferability was addressed by providing detailed contextual descriptions, allowing readers to determine the applicability of findings to similar settings.

RESULTS

The analysis of the lived experiences of hypertensive mothers who delivered preterm infants revealed five interrelated themes that illuminate how these women navigated bodily vulnerability, disrupted time, altered space, relational dependence, and the influence of medical interventions. Across all themes, the findings demonstrate that motherhood in the context of hypertensive preterm birth is characterized by profound instability, yet simultaneously sustained by adaptation, resilience, and meaning-making.

The first theme, Embodied Challenges and Adaptation in Physical Management, captures how mothers experienced pregnancy through their bodies as both sites of suffering and resilience. Participants described

intense physical symptoms such as headaches, swelling, dizziness, fatigue, and in severe cases, seizures and post-operative pain. These bodily experiences were not isolated sensations but were deeply intertwined with emotional distress, particularly fear and anxiety about their own survival and that of their infants. One mother shared, *"I really felt different… I was stressed and anxious… especially because my baby is preterm… I kept overthinking if my baby would survive"* (P1). Another participant expressed heightened fear due to compounded uncertainties, stating that her anxiety stemmed from being a first-time mother while managing hypertension and worrying about her baby's condition (P2). In more critical cases, the body became a site of medical emergency, as illustrated by one participant who recalled, *"I experienced a seizure… which required an emergency cesarean"* (P3). These narratives reveal how the body was experienced as fragile, unpredictable, and under constant threat.

Yet, despite these vulnerabilities, mothers demonstrated remarkable adaptability. They actively engaged in strategies to manage their condition, including strict adherence to medication, dietary modifications, and stress reduction practices. One participant emphasized, *"I maintained strict compliance with medications, diet, and stress management"* (P4). Others highlighted the importance of external support, noting that attentive healthcare providers reduced anxiety and provided a sense of security (P5). Spiritual coping also emerged as a significant source of strength, with participants sharing that prayer and faith helped them endure the challenges (P6, P7). Even while recovering physically, mothers balanced their own needs with NICU responsibilities, as one noted, *"I managed my recovery while visiting my baby… it showed how I had to stay strong"* (P8). These accounts illustrate that adaptation was not merely behavioral but deeply embodied, reflecting a continuous process of endurance, vigilance, and resilience.

Building on the bodily experience of crisis, the second theme, Temporal Disruption and Adaptation during Preterm Labor and Postpartum Recovery, highlights how mothers' sense of time was profoundly altered. The onset of preterm labor disrupted the expected trajectory of pregnancy, creating a sense of temporal collapse marked by uncertainty and fear. One mother recounted, *"When labor suddenly became preterm, I kept worrying about my safety and my baby's outcome"* (P1). Another echoed similar sentiments, emphasizing constant anxiety about what might happen to her infant (P2). For some, the experience was so abrupt that it felt disorienting, as one participant shared, *"Everything happened so suddenly… when I woke up, I was already in the hospital"* (P6). These narratives reflect a loss of control over time, where the anticipated progression toward full-term birth was replaced by urgency and unpredictability.

As mothers transitioned into the postpartum phase, particularly within the NICU context, their perception of time shifted again. Recovery was often described as slow and demanding, with one participant noting, *"After birth, recovery felt slow but manageable with rest"* (P3). Daily routines were significantly altered, as another mother described, *"Night became day and day became night… especially during the NICU stay"* (P4). Despite this disruption, mothers gradually reconstructed a sense of temporal order through caregiving routines and hospital visits. One participant reflected, *"Seeing and caring for my baby in the NICU made the days meaningful"* (P7), while another added, *"My days were structured around recovery and visiting my baby… time felt slow but focused"* (P8). These accounts suggest that while time initially became fragmented and anxiety-laden, it was later restructured through caregiving and adaptation, allowing mothers to regain a sense of purpose and continuity.

Closely linked to temporal disruption is the third theme, Perceived Safety as a Dual Experience of Separation Anxiety and Security, which reflects how mothers experienced hospital and NICU environments as both distressing and reassuring. Spatial separation from their infants was a significant source of emotional pain. One mother expressed, *"When I went home without my baby, it felt like something was missing"* (P1), a sentiment echoed by others who described feelings of emptiness and longing. However, proximity to the hospital also provided practical and emotional benefits. Some participants found comfort in being near the NICU, as it allowed easier visitation and reduced logistical stress. For instance, one mother explained that staying close to the hospital helped her balance recovery and caregiving (P3), while another acknowledged that although separation was painful, being nearby facilitated regular contact with her infant (P4).

At the same time, the hospital environment itself was perceived as a space of safety. Participants consistently emphasized the reassurance provided by the presence of healthcare professionals and medical facilities. One

mother stated, *"Knowing that doctors were nearby if something happened made me feel safe"* (P5), while another shared, *"I felt at ease because I knew my baby was receiving proper care in the NICU"* (P6). The combination of separation and security highlights the dual nature of space, where environments simultaneously evoke vulnerability and protection. Through this dynamic, mothers navigated emotional tension while gradually developing trust in the healthcare system.

Extending from spatial and emotional experiences, the fourth theme**,** Interpersonal Networks as a Source of Strength and Security, underscores the critical role of relationships in shaping maternal coping. Family members emerged as primary sources of emotional and practical support. One participant shared, *"My mother and the hospital staff supported me… seeing my baby gave me relief"* (P1), while another emphasized, *"Without my sister's support, I could not have coped"* (P3). Families provided not only emotional reassurance but also practical assistance, including caregiving, financial support, and help with hospital logistics. These contributions were essential in enabling mothers to manage both recovery and infant care.

Beyond the family, healthcare providers and broader social networks also played vital roles. Participants highlighted the importance of compassionate and communicative healthcare professionals, as well as support from friends and extended relatives. One mother stated, *"The support from my family, partner, and hospital staff strengthened me emotionally"* (P8), while another noted that even distant support from loved ones helped her cope with the challenges (P7). These relational networks created a "web of support" that mitigated feelings of isolation and reinforced maternal confidence. Through these connections, mothers were able to transform vulnerability into resilience, demonstrating that adaptation was not achieved in isolation but through meaningful relationships.

Finally, the fifth theme, Medical Objects as Instruments of Safety and Empowerment, reveals how medical technologies and pharmacological interventions shaped mothers' perceptions of control and security. Participants consistently described hospital equipment and NICU technologies as sources of reassurance. One mother noted, *"The monitors reassured me that my baby was safe"* (P1), while another emphasized the importance of being in a well-equipped facility, stating that the availability of advanced equipment provided confidence in the care received (P5). These medical objects were not merely functional tools but symbolic representations of safety and preparedness.

Similarly, medications played a crucial role in fostering a sense of control. Participants described antihypertensive treatments as essential in stabilizing their condition and reducing anxiety. One mother stated, *"I was given medication to control my blood pressure"* (P6), while another added that access to medical treatment reassured her that both she and her baby were safe (P7). Through these interventions, mothers were able to actively participate in their care, transforming feelings of helplessness into a sense of agency. The integration of medical technology and pharmacological support thus contributed to both physical stabilization and psychological empowerment.

Taken together, these themes illustrate that the lived experience of hypertensive mothers delivering preterm infants is a multidimensional process shaped by the interplay of bodily vulnerability, disrupted temporality, altered spatial environments, relational support systems, and medical interventions. While these mothers encountered profound challenges, their narratives consistently reveal resilience, adaptation, and the capacity to find meaning amid uncertainty.

DISCUSSION

The present study offers a nuanced understanding of the lived experiences of hypertensive mothers delivering preterm infants by illuminating how embodiment, temporality, spatiality, relationality, and materiality intersect to shape maternal adaptation. Grounded in phenomenological inquiry, the findings extend Clark Moustakas' conceptualization of lived experience by demonstrating that high-risk pregnancy is not merely a biomedical condition but a deeply embodied, relational, and contextual phenomenon.[23] The discussion integrates these dimensions with existing empirical evidence and theoretical frameworks, situating maternal experiences within broader clinical and psychosocial contexts.

The theme of embodied challenges and adaptation underscores the duality of the maternal body as both a site of vulnerability and resilience. Participants' accounts of headaches, seizures, fatigue, and emotional distress align with evidence that hypertensive disorders of pregnancy significantly increase the risk of adverse maternal and neonatal outcomes, including preterm birth.[1, 2] These physiological disruptions are not experienced in isolation but are deeply intertwined with psychological distress, as supported by studies highlighting heightened anxiety, fear, and trauma among women with hypertensive pregnancies.[3, 4, 11] The narratives in this study further reinforce findings that women with preeclampsia often perceive their bodies as unpredictable and fragile.[9] However, the current findings extend this understanding by illustrating how mothers actively engage in adaptive practices such as medication adherence, lifestyle modification, and emotional regulation. This supports literature indicating that women in high-risk pregnancies employ both problem-focused and emotion-focused coping strategies to maintain stability.[7, 8]

The integration of Roy's Adaptation Model provides a valuable lens for interpreting these findings. The mothers' physiological symptoms reflect disruptions in the physiological mode, while their coping strategies demonstrate adaptive responses across self-concept and interdependence modes. Consistent with Roy's assertion that individuals continuously respond to environmental stimuli, participants actively recalibrated their behaviors and perceptions to maintain equilibrium.[24] This dynamic process is further supported by research indicating that postpartum lifestyle interventions and continued monitoring are essential for long-term health following hypertensive pregnancy.[6, 12, 13] Thus, embodiment in this context reflects not only suffering but also the capacity for adaptive resilience.

The second theme, temporal disruption and adaptation, highlights how preterm labor fractures the expected trajectory of pregnancy, leading to a profound sense of uncertainty and loss of control. This disruption of lived time is consistent with studies showing that preterm birth destabilizes maternal expectations and generates significant emotional distress.[5, 15] Participants' descriptions of sudden labor onset, fragmented awareness, and heightened anxiety mirror findings that preterm birth can trigger traumatic stress responses and temporal disorientation.[3,10] The abrupt shift from anticipation to crisis challenges mothers' sense of continuity, reinforcing the phenomenological notion that time is experienced subjectively rather than linearly.

As mothers transitioned into the postpartum period, particularly within the NICU context, they gradually reconstructed temporal order through routines and caregiving practices. This aligns with evidence that structured routines and maternal involvement in infant care promote psychological adjustment and bonding.[20] However, the persistence of disrupted sleep patterns and ongoing uncertainty underscores the chronic nature of stress in this population, which has been linked to increased risk of postpartum depression and anxiety.[16] The application of Lazarus and Folkman's Transactional Theory of Stress and Coping further elucidates this process, as mothers continuously appraise and reappraise stressors while employing coping strategies to manage uncertainty.[25]

Spatiality, as reflected in the theme of perceived safety, reveals the dual nature of hospital and NICU environments as spaces of both separation and protection. Mothers' experiences of emotional distress due to physical separation from their infants are consistent with literature identifying separation as a primary source of maternal anxiety in preterm birth.[15,17] At the same time, proximity to healthcare facilities and advanced medical technology provided reassurance and a sense of control. This duality highlights how space is imbued with emotional and symbolic meaning, shaping maternal perceptions of safety and vulnerability.

The findings are supported by studies demonstrating that NICU environments and spatial design significantly influence maternal stress, coping, and engagement.[15,17] Moreover, the ability to maintain proximity to the infant has been associated with improved maternal–infant bonding and psychological well-being.[20] Within the framework of Roy's Adaptation Model, spatial factors function as both focal and contextual stimuli, eliciting adaptive responses that enable mothers to navigate the tension between separation and caregiving.[24]

Relationality emerged as a critical dimension of maternal experience, with interpersonal networks serving as sources of strength and security. Consistent with existing literature, family support was identified as a key determinant of maternal resilience, providing both emotional and practical assistance.[21, 22] The role of partners, relatives, and extended networks in alleviating stress and enabling maternal functioning aligns with studies showing that social support reduces the risk of postpartum depression and enhances maternal well-being.[16,21]

Additionally, supportive interactions with healthcare providers were instrumental in fostering trust, confidence, and emotional stability, corroborating findings on the importance of patient-centered care in high-risk pregnancies.[4,18]

The application of Parse's Human Becoming Theory deepens the understanding of relationality by emphasizing that health and meaning are co-created through relationships.[26] Mothers' experiences illustrate that resilience is not solely an individual attribute but is constructed within a network of supportive interactions.

The final theme, medical objects as instruments of safety and empowerment, highlights the role of material resources in shaping maternal experiences. Participants consistently described medical equipment and pharmacological interventions as sources of reassurance and control. This aligns with literature indicating that access to advanced medical technology and effective clinical management enhances maternal confidence and reduces anxiety.[7,18,14] Medication adherence emerged as a key component of maternal agency, allowing women to actively participate in managing their condition, consistent with evidence emphasizing structured treatment regimens in high-risk pregnancies.[6,14]

Collectively, the findings highlight the complex interplay between physiological, psychological, social, and environmental factors in shaping maternal experiences. The results are consistent with global evidence indicating that hypertensive disorders of pregnancy are a major contributor to preterm birth and maternal morbidity.[1,2] At the same time, the study extends existing knowledge by providing a phenomenological perspective that captures the depth and complexity of maternal lived experience.

The present study provides a phenomenological account of the lived experiences of hypertensive mothers delivering preterm infants, demonstrating how embodiment, temporality, spatiality, relationality and materiality interact in shaping maternal adaptation. While existing literature often frames hypertensive pregnancy primarily as a biomedical risk, the findings affirm that it is equally a social and culturally situated experience. By situating these dimensions within broader clinical and psychosocial contexts, the study extends Moustakas' emphasis on lived experience to highlight the interplay between individual meaning-making and structural conditions.

The theme of embodied challenges and adaptation reflects the maternal body as both vulnerable and agentic. Consistent with prior studies, participants described significant physical symptoms alongside psychological distress.[1,2,34,11] However, rather than portraying mothers solely as passive recipients of care, the findings reveal active efforts to regain control through adherence to treatment, behavioral adjustments and emotional regulation. This supports coping literature but also invites a more critical view: such "adaptation" may partly reflect the necessity to conform to medical expectations, especially in settings where patient autonomy is limited. In the Philippine context, where deference to medical authority is culturally reinforced, mothers may suppress concerns or normalize suffering as part of maternal responsibility. Thus, resilience should be interpreted not only as strength but also as a response shaped by sociocultural expectations of motherhood and obedience to healthcare systems.

Temporal disruption emerged as a significant source of distress, with preterm birth fracturing the anticipated progression of pregnancy. This aligns with evidence that early delivery generates uncertainty and emotional instability.[5,15] However, the findings further suggest that this disruption is intensified in contexts where pregnancy is culturally viewed as a linear and milestone-driven journey. The abrupt shift to crisis, particularly with NICU admission, challenges deeply held expectations of maternal roles. While mothers gradually reconstructed a sense of routine, ongoing uncertainty and sleep disruption indicate that recovery is neither linear nor complete. From the perspective of Lazarus and Folkman's Transactional Theory, coping appears dynamic; however, structural constraints—such as limited postpartum support and financial pressures may restrict mothers' capacity to effectively manage stress, particularly in resource-limited settings.

Spatial experiences further reveal the ambivalence of healthcare environments. Hospitals and NICUs were perceived as both protective and alienating, echoing studies on maternal distress linked to infant separation.[15,17] While access to medical technology provided reassurance, it also reinforced dependence on institutional care. In the local context, overcrowded facilities and limited resources in public hospitals may intensify these tensions,

as mothers navigate unfamiliar, highly medicalized spaces with constrained privacy and autonomy. This suggests that spatiality is not merely experiential but also shaped by health system inequalities.

Relationality highlights the central role of social networks, consistent with literature emphasizing the protective effect of family and partner support.[16,21,22] In the Philippine setting, strong familial ties and collectivist values appear to buffer emotional distress, with extended family often playing a significant caregiving role. However, this reliance may also obscure gaps in formal psychosocial support within healthcare systems. While positive interactions with healthcare providers enhanced trust, some accounts imply variability in communication and emotional support, reflecting broader systemic challenges such as high patient loads and limited time for patient-centered care. This underscores the need to critically examine not only the presence of support but also its quality and consistency.

Materiality, particularly the role of medical technologies and medications, was largely interpreted as a source of safety and empowerment. This aligns with studies linking effective clinical management to reduced anxiety.[7,14,18] Yet, a more critical perspective suggests that reliance on medical interventions may also reinforce a technocratic model of childbirth, where control is transferred from the mother to the healthcare system. In low-resource contexts, access to such technologies may be uneven, raising questions about equity and the extent to which "empowerment" is contingent on availability of care.

To sum up, the findings illustrate the complex interaction of physiological, psychological, social and structural factors. While consistent with global evidence on the risks associated with hypertensive pregnancy and preterm birth,[1,2] this study contributes a more nuanced understanding by foregrounding lived experience within a specific cultural and healthcare context. Importantly, it challenges purely biomedical interpretations by demonstrating that maternal experiences are shaped not only by clinical conditions but also by cultural expectations, health system structures and social support dynamics.

These insights suggest that improving maternal outcomes requires more than effective clinical management. Interventions must address communication gaps, strengthen psychosocial support and consider cultural norms influencing maternal behavior and coping. Without such integration, care risks remaining fragmented, with emotional and relational needs insufficiently addressed despite advances in medical treatment.

CONCLUSIONS

The study concludes that hypertensive pregnancy and preterm birth profoundly shape maternal coping and psychosocial well-being. Heightened uncertainty, disrupted temporal expectations, and anticipatory anxiety compel mothers to reorganize daily routines, make rapid decisions, and adapt emotionally. Embodied experiences, marked by physical discomfort, emotional distress, fear, and maternal–infant separation, underscore the need for holistic support that addresses both physiological and psychological dimensions of care. Hospital and NICU environments are ambivalent spaces: technological monitoring and proximity to care provide reassurance, yet enforced separation from infants amplifies stress, highlighting the emotional and spatial complexity of maternal safety.

Interpersonal relationships with family, partners, healthcare providers and broader social networks serve as vital scaffolds that buffer stress, foster confidence, and sustain resilience during pregnancy, preterm delivery, and postpartum recovery. Similarly, medical objects such as monitoring equipment and pharmacological interventions function symbolically, offering mothers a sense of control, predictability, and empowerment, which facilitates active engagement in their own and their infants' care.

For nursing practice, these findings underscore the importance of integrating psychosocial interventions alongside clinical management. Practical strategies include structured counseling sessions that prepare mothers for the NICU experience, regular emotional check-ins to assess anxiety and depressive symptoms, and guided support for maternal–infant bonding through skin-to-skin contact, kangaroo care, or participation in routine infant care where feasible. Nurses can also facilitate family involvement in care planning and decision-making, provide clear and culturally sensitive communication about treatment and outcomes, and support mothers in

developing adaptive coping strategies, including stress reduction techniques, self-care routines, and peer support groups.

By acknowledging the interplay of temporality, embodiment, relational support, and medical technologies, nursing interventions can move beyond purely biomedical care toward a holistic, patient-centered approach that addresses both immediate clinical needs and long-term maternal psychological well-being. Such integrative care is essential for promoting resilience, fostering maternal empowerment, and optimizing both maternal and neonatal outcomes in high-risk pregnancies.

Ethical Approval: The study was reviewed and approved by the Misamis University Research Ethics Committee.

Conflict of Interest: None Declared

Availability of Data: Available upon written request.

REFERENCES

1. Xie RH, et al. Hypertensive disorders in pregnancy and risk of preterm birth. BMC Pregnancy Childbirth 2019;19:1–10. https://doi.org/10.1186/s12884-019-2283-1
2. Blencowe H, et al. National, regional, and worldwide estimates of preterm birth. Lancet Glob Health 2019;7(1):e37–e46. https://doi.org/10.1016/S2214-109X(18)30451-0
3. Amegbor PM, et al. Emotional experiences of women with hypertensive disorders of pregnancy. Midwifery 2024;130:103905. https://doi.org/10.1016/j.midw.2024.103905
4. Musie MR, et al. Women's experiences of care in hypertensive pregnancy. BMC Pregnancy Childbirth 2023;23:112. https://doi.org/10.1186/s12884-023-05321-7
5. Fontein-Kuipers Y, Boele L. Experiences of mothers with preterm infants. J Clin Nurs 2020;29(3–4):450–460. https://doi.org/10.1111/jocn.15090
6. Benschop L, et al. Postpartum lifestyle interventions after hypertensive pregnancy. Hypertension 2022;79(5):1023–1032. https://doi.org/10.1161/HYPERTENSIONAHA.121.18612
7. Garovic VD, et al. Hypertension in pregnancy: Diagnosis and management. Hypertension 2022;79(2):e21–e41. https://doi.org/10.1161/HYP.0000000000000207
8. Bromfield S, et al. Adverse maternal outcomes of hypertensive disorders. Circ Res 2023;132(4):567–584. https://doi.org/10.1161/CIRCRESAHA.122.321234
9. Sakurai K, et al. Lived experiences of women with preeclampsia. Qual Health Res 2022;32(6):987–998. https://doi.org/10.1177/10497323221074567
10. Hansson M, et al. Emotional distress in high-risk pregnancies. Midwifery 2022;105:103221. https://doi.org/10.1016/j.midw.2021.103221
11. Silverio SA, et al. Psychological impact of preeclampsia. BMJ Open 2021;11(6):e045553. https://doi.org/10.1136/bmjopen-2020-045553
12. Brown MC, et al. Long-term cardiovascular risks after hypertensive pregnancy. Eur Heart J 2021;42(13):1234–1243. https://doi.org/10.1093/eurheartj/ehaa968
13. Heida KY, et al. Postpartum cardiovascular monitoring. Heart 2023;109(2):123–130. https://doi.org/10.1136/heartjnl-2022-321234
14. Barakat R, et al. Holistic maternal health programs. Int J Environ Res Public Health 2023;20(3):2101. https://doi.org/10.3390/ijerph20032101
15. Aldinger KR, et al. Maternal perceptions and preterm birth. J Perinatol 2019;39(5):678–685. https://doi.org/10.1038/s41372-019-0345-2
16. Ko JY, et al. Postpartum depression and anxiety. MMWR 2020;69(19):575–581. https://doi.org/10.15585/mmwr.mm6919a2
17. Wang L, et al. Healthcare experiences of mothers with high-risk pregnancies. BMC Health Serv Res 2021;21:456. https://doi.org/10.1186/s12913-021-06456-3
18. McCarthy EA, et al. Maternal stress in low-resource settings. Lancet Glob Health 2021;9(8):e1061–e1069. https://doi.org/10.1016/S2214-109X(21)00218-5

19. Silva-Fernández L, et al. Systemic challenges in maternal care. Health Policy 2025;129(1):45–53. https://doi.org/10.1016/j.healthpol.2024.11.005
20. Ionio C, et al. Mother–infant bonding in preterm birth. Infant Ment Health J 2024;45(1):56–70. https://doi.org/10.1002/imhj.22045
21. Akbar R, et al. Postpartum adjustment in high-risk mothers. J Affect Disord 2024;345:210–218. https://doi.org/10.1016/j.jad.2024.02.015
22. Lund IO, et al. Maternal stress and child outcomes. Dev Psychopathol 2021;33(2):678–690. https://doi.org/10.1017/S0954579420001234
23. Moustakas C. Phenomenological research methods. Thousand Oaks, CA: Sage Publications; 1994. https://doi.org/10.4135/9781412995658
24. Roy C, Andrews HA, editors. The Roy Adaptation Model. 2nd ed. Upper Saddle River, NJ: Prentice Hall; 1999.
25. Lazarus RS, Folkman S. Stress, appraisal, and coping. New York, NY: Springer; 1984. https://doi.org/10.1007/978-1-4419-1005-9_215
26. Parse RR. Human becoming: Parse's theory of nursing. Nurs Sci Q 1992;5(1):35–42. https://doi.org/10.1177/089431849200500109