



# Experiences of hospitalization among pregnant and postpartum women with diabetes mellitus and hypertension: a phenomenological understanding

*Vivências da hospitalização de gestantes e puérperas com diabetes mellitus e hipertensão: uma compreensão fenomenológica*

*Vivencias de la hospitalización de gestantes y puérperas con diabetes mellitus e hipertensión: una comprensión fenomenológica*

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## ABSTRACT

**Objective:** to understand the implications of hospitalization for pregnant and postpartum women with diabetes mellitus and/or hypertensive syndromes from their perspective. **Method:** a descriptive qualitative study was conducted, based on the principles of Merleau-Ponty. Data collection took place in a public maternity hospital in Fortaleza, Ceará, Brazil, between August and September 2024, involving 11 pregnant women and 12 postpartum women. Data were obtained through interviews with questions about their experiences during hospitalization. Data organization followed the thematic modality, and the analysis was based on the conceptual frameworks of phenomenology. **Results:** the experiences reported by pregnant women included feelings of discouragement, anguish, and fear regarding their health condition and the possible repercussions for their baby. However, hospitalization was also perceived as a safe haven. Postpartum women reported that the period was marked by fear, anguish, and guilt due to complications that required specialized care. **Final considerations and implications for practice:** hospitalization, although necessary for the recovery of the woman and/or the child, resulted in physical and emotional strain. Feelings of fear, stress, and uncertainty intensified existing psychological distress. The findings highlight the importance of practices that address emotional and subjective dimensions through active listening and empathetic communication.

**Keywords:** Diabetes, Gestational; Pregnant People; Hospitalization; Postpartum Period; Pre-Eclampsia.

## RESUMO

**Objetivo:** compreender as implicações da hospitalização de gestantes e puérperas com diabetes *mellitus* e/ou síndromes hipertensivas, sob sua perspectiva. **Método:** pesquisa com abordagem qualitativa fundamentada nos preceitos de Merleau-Ponty. A coleta foi realizada em uma maternidade pública de Fortaleza, Ceará, Brasil, entre agosto e setembro de 2024, com 11 gestantes e 12 puérperas. Os dados foram obtidos por meio de entrevistas, com questões sobre as vivências da hospitalização. A organização seguiu a modalidade temática e a análise foi fundamentada nos marcos conceituais da fenomenologia. **Resultados:** os processos vivenciados pelas gestantes incluíram sentimentos de desalento, angústia e temor diante do estado de saúde e das possíveis repercussões para o bebê. No entanto, a hospitalização também foi vista como um porto seguro. As puérperas relataram que o período vivido foi marcado por medo, angústia e culpa, diante das complicações que exigiram cuidados especializados. **Considerações finais e implicações para a prática:** a hospitalização, mesmo necessária à recuperação da mulher e/ou do filho, resultou em desgaste físico e emocional. Sentimentos de medo, estresse e incerteza agravaram o sofrimento psicológico já existente. Os achados evidenciaram a importância de práticas que acolham dimensões emocionais e subjetivas, com escuta ativa e comunicação empática.

**Palavras-chave:** Diabetes Gestacional; Gestantes; Internação Hospitalar; Puérperas; Pré-Eclâmpsia.

## RESUMEN

**Objetivo:** comprender las implicaciones de la hospitalización para mujeres embarazadas y puérperas con diabetes mellitus y/o síndromes hipertensivos desde su perspectiva. **Método:** estudio descriptivo con enfoque cualitativo, basado en los principios de Merleau-Ponty. La recolección de datos se realizó en una maternidad pública de Fortaleza, Ceará, Brasil, entre agosto y septiembre de 2024, con 11 gestantes y 12 puérperas. Los datos se obtuvieron mediante entrevistas sobre sus vivencias durante la hospitalización. El análisis siguió un enfoque temático, guiado por los marcos conceptuales de la fenomenología. **Resultados:** las gestantes expresaron sentimientos de desánimo, angustia y miedo ante su estado de salud y las posibles consecuencias para el bebé. A pesar de ello, algunas consideraron el hospital un lugar de seguridad. Las puérperas relataron un período marcado por miedo, angustia y culpa debido a complicaciones que exigieron cuidados especializados. **Consideraciones finales e implicaciones para la práctica:** aunque necesaria para preservar la salud maternoinfantil, la hospitalización generó desgaste físico y emocional. Los sentimientos de miedo, estrés e incertidumbre intensificaron el sufrimiento psíquico ya existente. Los resultados destacan la necesidad de prácticas que consideren las dimensiones emocionales y subjetivas del cuidado, mediante escucha activa y comunicación empática.

**Palabras clave:** Diabetes Gestacional; Personas Embarazadas; Hospitalización; Periodo Posparto; Preeclampsia.

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## INTRODUCTION

The pregnancy-puerperal cycle involves intense physical, emotional, and social changes, requiring women to adapt to motherhood and physiological recovery during and after pregnancy. These transformations can accentuate biopsychosocial vulnerabilities and generate conflicts between expectations and the reality experienced with the arrival of the newborn.<sup>1-3</sup>

In high-risk pregnant and postpartum women, these changes may be accompanied by clinical or obstetric complications that negatively affect maternal and child health, posing a significant challenge to public health. This context reinforces the need for specialized care to protect the well-being of women, fetuses, and newborns.<sup>4,5</sup>

Among the various situations that lead to the classification of a high-risk pregnancy, gestational hypertensive syndromes (GHS) and gestational diabetes mellitus (GDM) stand out. About 10% of pregnancies worldwide develop GHS, which includes preeclampsia, eclampsia, chronic hypertension, chronic hypertension with superimposed preeclampsia, and gestational hypertension. Gestational hypertensive syndromes account for approximately 14% of maternal deaths globally and 22% in Latin America, making them the second leading cause of maternal mortality.<sup>3,6</sup>

In this context, the Sustainable Development Goals (SDGs) emerge as global guidelines aimed at reducing maternal and neonatal mortality, promoting the well-being of women and children, and strengthening sustainable development. According to the Pan American Health Organization (PAHO) and the World Health Organization (WHO), these goals express the international commitment to maternal, child, and reproductive health, seeking to address social inequalities and ensure quality care. Among the central objectives is the reduction of preventable deaths by 2030 through integrated actions across various sectors.<sup>7,8</sup>

The emotional implications of pregnancy and the postpartum period are complex and often marked by ambivalent feelings, in which positive experiences, such as joy and expectations of well-being for the child and personal fulfillment, coexist with negative emotions, such as fear and insecurity. In the case of pregnant women with gestational hypertensive syndromes or gestational diabetes mellitus, these emotions can be aggravated by their health condition, generating concern about possible complications for the mother and fetus. These women face sudden changes in their routine, such as dietary adjustments and constant monitoring of physiological and pathological factors, which make the experience even more stressful and challenging.<sup>9,10</sup>

In the context of postpartum associated with neonatal complications, the experiences of postpartum women go beyond the birth process, encompassing concerns related to their child's suffering, fear of possible complications, and uncertainties about the future. Thus, postpartum women may experience heightened vulnerability, marked by issues related to biopsychosocial aspects and the possibility of death for themselves and their children, which reinforces the need for continuous professional care and monitoring during this phase.<sup>5,11,12</sup>

In these circumstances, hospitalization may be recommended in order to ensure adequate control of these conditions and prevent complications for the mother and/or fetus. Constant monitoring of blood glucose and blood pressure changes, as well as the administration of medication, may be essential to maintain the clinical stability of pregnant and postpartum women, preventing conditions that put maternal and neonatal health at risk.<sup>2,13</sup>

The hospitalization scenario can be challenging because it takes women away from their homes and families, placing them in a hospital environment that is often perceived as impersonal and unfamiliar. This experience tends to intensify feelings of anxiety, helplessness, insecurity, and fear. It is a stressful event that places pregnant and postpartum women in a situation of unpredictability, which can affect the functioning of the family system and require a reorganization of roles and responsibilities among its members and within themselves.<sup>9,12</sup>

In this context, there is an urgent need to ensure comprehensive and humanized care that considers the biopsychosocial aspects involved and minimizes the adverse effects of hospitalization on maternal and neonatal well-being. Humanized care, in its comprehensiveness, can prevent unnecessary interventions, promote the establishment of relationships based on ethical principles, and facilitate better coping with the phenomenon experienced.<sup>14-16</sup>

Given the various nuances inherent to pregnancy and the postpartum period, and the adversities that may arise during these risky phases, especially in the context of hospitalization, questions were raised about the process experienced during the hospitalization of pregnant and postpartum women with diabetes mellitus and/or high blood pressure, as well as the challenges faced from the perspective of these women during their hospitalization.

Based on this approach, Merleau-Ponty's phenomenology, adopted in this study, underpins an understanding of hospitalization as a subjective and contextualized experience in which the body and the world intertwine in the construction of meanings. Thus, the purpose is not only to report the objective facts, but to understand how these women perceive and attribute meaning to the hospitalization process, considering its physical, emotional, and social dimensions.<sup>17</sup>

Given the above, it is believed that pregnant and postpartum women hospitalized with gestational diabetes mellitus and/or gestational hypertensive syndromes experience, in body and mind, a process of illness that goes beyond the biological aspect. Hospitalization becomes a space for unique experiences, marked by existential challenges, psychological suffering, uncertainties, and fears that affect their way of being and existing in the world. These experiences require care that recognizes the uniqueness of the lived body and the complexity of existence in this context.

The relevance of this study lies in the need to provide opportunities for pregnant and postpartum women experiencing clinical risk conditions to be heard and express themselves. Using a phenomenological approach, we seek to understand the meanings attributed to hospitalization, highlighting the

biopsychosocial impact of gestational diabetes mellitus and hypertensive syndromes, with relevant implications for public health. Despite advances in the analysis of clinical outcomes, there is a scarcity of qualitative studies that explore the subjective experiences of these women during prolonged hospitalizations.

That said, the study aimed to understand the implications of hospitalization for pregnant and postpartum women with diabetes mellitus and/or hypertensive syndromes from their perspective.

## METHOD

This is a qualitative research study based on Merleau-Ponty's theoretical assumptions. In addition, the study complies with the principles established by the Consolidated Criteria for Reporting Qualitative Research (COREQ).<sup>18</sup>

The adoption of a qualitative approach is justified in order to gain an in-depth understanding of the unique and subjective nature of the participants' experiences. The aim is to interpret the meanings attributed by the women to their experiences, considering the specificity of their sociocultural contexts, as proposed by Minayo,<sup>19</sup> in line with the phenomenological perspective adopted.

According to Merleau-Ponty,<sup>17</sup> the body is the subject that is immersed in the world, because it is through the body that perception and sensory experience occur. In his theory, the body is no longer seen as a consciousness separate from experience, but as a living and perceptive element, intertwined with and affected by its being-in-the-world. This perception awakens consciousness in the face of an experiential situation, which is the basis of knowledge. Thus, the body becomes the foundation for constructing meaning, representing the meanings that arise from the constant and dynamic interaction between the subject and the world around them. This understanding guides the analysis of participants' narratives, valuing the sensitive, situated dimension of lived experience. In the analytical context of this study, this conception guided the researchers' understanding of the "lived body" during hospitalization, valuing expressions, gestures, and discourses as existential manifestations.

Within the scope of this study, the concepts of lived body (*corps propre*), perception, and intentionality were used as interpretive axes in the analysis of the participants' discourses, guiding the understanding of the phenomenon as an expression of being-in-the-world. The discourses were understood not as simple objective descriptions, but as revelations of lived experience, in which body, time, and space are intertwined in the production of meaning. In light of Merleau-Ponty's phenomenology,<sup>17</sup> this approach allowed us to capture the meanings underlying the hospital experience, revealing how these women perceive and experience the process of illness.

Data collection took place at a public maternity hospital located in Fortaleza, Ceará, Brazil, between August and September 2024. The number of participants was defined by convenience, including 11 pregnant women and 12 postpartum women admitted to the maternity hospital, totaling 23 participants in the final sample. Of the 11 pregnant women, five were admitted for complications of GDM, three for GHS, and three were diagnosed

with both conditions. Among the postpartum women, four were hospitalized for conditions related to GDM, five for GHS, and three for both comorbidities.

The study included pregnant and postpartum women at risk, aged 18 years or older, hospitalized for GDM and/or GSH, as well as those with clinical conditions associated with these diseases. Inclusion criteria did not consider the number of children, socioeconomic status, marital status, ethnicity, or religious orientation. The exclusion criteria were defined as those who felt uncomfortable or embarrassed to continue with the interviews, as well as those who were in a condition that required rest due to physician advice. Thirteen participants were excluded and did not make up the final sample.

Data collection was performed using a semi-structured interview with sociodemographic questions and details about the challenges faced by pregnant and postpartum women with hypertension and/or diabetes during their hospital stay. The interviews were conducted by three researchers with prior training in qualitative methodologies and experience in maternal and child care contexts. To ensure the accuracy and reliability of the responses, the interviews were audio-recorded and transcribed, respecting all aspects of the discourse in its entirety. Subsequently, they were presented to all study participants again for validation.

Data analysis was conducted using Minayo's thematic method,<sup>19</sup> following the stages of pre-analysis, exploration of the material, and treatment of the results, with the aim of identifying similarities and differences in the participants' narratives. In the pre-analysis phase, a preliminary reading of the testimonials was conducted, and the corpus was constituted, enabling an initial approach to the content. Next, the material was explored, in which the units of meaning emerging from the statements were coded, enabling the organization of the meanings expressed.<sup>19</sup> Subsequently, the thematic categories were processed and interpreted, and linked to Merleau-Ponty's phenomenological framework<sup>17</sup> and to the available literature on the subject, which facilitated a broader understanding of the phenomenon studied.

The themes were constructed inductively, based on recurring meanings present in the discourses, and validated by consensus among the researchers, ensuring the reliability and consistency of the findings. Theoretical coherence and interpretive validity were strengthened through successive readings, reflective discussions, and triangulation among the researchers, which contributed to the robustness and rigor of the analysis.

The analysis resulted in the following themes: "Repercussions of the challenges experienced by diabetic and/or hypertensive pregnant women who are hospitalized" and "Adversities faced by postpartum women with hypertension and/or diabetes during hospitalization".

To maintain the anonymity of the participants, we chose to identify them using the abbreviations "GD" for pregnant women with diabetes, "GH" for pregnant women with hypertension, "GDH" for pregnant women with both diabetes and hypertension, "PD" for postpartum women with diabetes, "PH" for postpartum women with hypertension, and "PDH" for postpartum women with both

diabetes and hypertension. The interviews were numbered from 1 to 11 for pregnant women and from 1 to 12 for postpartum women.

The study received opinion number 6,844,667 from the Research Ethics Committee of the center participating in the research. Compliance with ethical recommendations regarding research involving human subjects was ensured, as provided for in Resolutions No. 466/12 and 510/16 of the National Health Council.<sup>20,21</sup>

## **RESULTS**

### **Characterization of study participants**

The 11 pregnant women were aged between 18 and 36 years, with a predominance of 30 to 35 years. Regarding diagnosis, five had GDM, three had GHS, and three had both GDM and GHS. The 12 postpartum women were aged between 18 and 36 years. In terms of diagnosis, four had GDM, five had GHS, and three had both GDM and GHS.

### **Repercussions of the challenges experienced by diabetic and/or hypertensive pregnant women who are hospitalized**

This theme addressed the implications of the challenges faced by pregnant women diagnosed with GDM and/or GHS in the context of hospitalization. In view of this, feelings of discouragement, distress, and fear emerged in relation to their health status, which could cause problems for the baby. However, hospitalization was also considered a source of security.

The statements revealed that hospitalization is permeated by intense fears. The fear of the baby's death, of one's own death, and of the worsening of one's health emerges as a feeling that permeates the experience, triggering anguish and uncertainty. This subjective reality makes the moment lived full of challenges, as can be seen in the following perceptions:

*It was distressing. The physicians said it was dangerous and that there was a risk of something happening to us, so I was a bit upset, which only got worse because we were in this hospital for so long. (GD 2)*

*I was hospitalized, I cried a lot, I've already had losses and I couldn't bear to lose another baby, and I take care of this problem, but I live with this uncertainty in life, we are constantly struggling. (GDH 3)*

*Our situation was very delicate, the baby's growth, my blood pressure, the hospitalization, it was causing us a lot of suffering, you know? And fear that worse things would happen. (GD 10)*

The statements of some pregnant women revealed that coping with the diagnosis and living with imminent risks aroused fears related to death and uncertainty about the continuity of life. However, the experience of hospitalization was also referred to as a space capable of offering security, comfort, and stability amid existential fragility. The experience of hospitalization proved to be a moment of suffering and support, in which the lived body became a space for expressing existence.

*I just thought we were going to die, that I wouldn't be able to cope, that maybe she would be born prematurely. I feel desperate because I'm hospitalized. On the other hand, I feel peaceful knowing that we are safe here. (GH 1)*

*The diagnosis made me think only of death, that it wouldn't work out, but when we got here, I felt that we would have a chance to live, even with so many risks. (GD 9)*

Furthermore, the pregnant women's statements revealed feelings such as anguish and suffering due to the distance from their daily lives. Separation from their family environment and support network brings sadness, pain, and fear, intensified by uncertainty about the outcome of the pregnancy. These experiences are expressed in the following statements:

*I feel pain and sadness because of the distance, because we need to be cared for. I am afraid that she will be born with problems or that we will die in childbirth. It is a whirlwind inside me. (GH 4)*

*The hospitalization process was difficult, sad, and somewhat unexpected. I never imagined being away from home, but because of the disease, for safety reasons, I am here. If I could, I would do things differently. I admit I did not take how dangerous it was seriously. (GD 5)*

*I was admitted to the hospital with bleeding. It was very painful, I believe for the baby too. We are far from home, from our children, fearing the loss of our daughter, thinking about what might happen, whether we will live or die during childbirth. (GD 7)*

The pregnant women in the study also expressed feelings of guilt when reflecting on the fact that they had not taken proper care of themselves after their diagnosis. The discouragement and insecurity generated by the disease were intensified by the realization of their carelessness, which culminated in hospitalization and risks that threatened the health of the baby.

*When I found out, it was a mixture of feelings, fear, and the urge to cry. At first, I did everything right, but then I*

*ended up being reckless, and today we are here in the hospital, taking risks because the pressure couldn't be controlled. (GH8)*

*I went through some very serious problems of sadness after I discovered all these illnesses. I didn't take care of myself, and now we're hospitalized. The bill has arrived, and today I feel guilty in case I lose my son. (GDH11)*

Emotional distress and feelings of loneliness were strongly present in the pregnant women's discourses, aggravated by the fear of being alone and ambiguities regarding the baby's health and childbirth. Insecurity and complications increased the already existing feeling of vulnerability, making hospitalization an even more distressing experience. These experiences were expressed in the following statements:

*The illness becomes more difficult with this fear of being alone and that he will be without me. Childbirth and pregnancy are uncertain, and it became more complicated to stay here in the hospital. (GDH 6)*

*I am shaken by the changes in pregnancy, trying to control myself so that we can be well. But things started to get worse, and we had to face hospitalization. (GD 9)*

The emotional experiences of pregnant women at risk revealed ambiguity in the face of diagnosis and hospitalization, affecting the lived body and reframing ways of feeling and existing. Being-in-the-world expresses the unity between body and existence, for it is through the body that the subject experiences and attributes meaning to life. Thus, more than frustration, these are different ways of expressing existence in the face of adversity. Emotions emerge as manifestations of the maternal-fetal risk condition, reflecting the intertwining of the desire to preserve life and the anguish in the face of the uncertainties and limitations imposed by hospitalization.

### **Adversities faced by postpartum women with hypertension and/or diabetes during hospitalization**

This theme addressed the implications of hospitalization of the newborn and/or postpartum woman after delivery, resulting from complications that required hospital care and treatment. The expectations of postpartum women regarding their desire for hospital discharge and their child's recovery were also addressed.

In the statements of the postpartum women, it was evident that the desire to return home is overshadowed by the eagerness for their child to complete treatment and recover, even if this wait is a difficult and painful process to experience.

*I will endure this difficult hospitalization, even though I want to leave. For a child, we endure. (PGH12)*

*It is difficult not to have family nearby, but I will endure the treatment. I ended up joking that this disease would not affect us, but we are suffering the consequences. (PD4)*

The treatment was experienced as a journey marked by anxieties and concerns. Upon awakening to the realization that both would need to be accompanied during hospitalization and that the treatment was something serious to be faced, the postpartum women were overcome by fears and anxieties, revealing the ambiguity and emotional intensity that permeated this experience. This ambiguity reveals the existence of phenomenology, in which human beings are simultaneously body and consciousness, reason and emotion intertwined. The postpartum women experienced this intertwining between the desire for recovery and the fear of the unknown, between confidence and uncertainty in the face of illness and hospitalization.

*I ended up bringing up concerns about the treatment. It's difficult; he'll have to be monitored, which isn't easy. I thought it was nonsense, but it's not. We only believe it when it happens. (PD 1)*

*My anguish is the uncertainty of the cure and the length of hospitalization. I wanted to go back, do everything differently, go to prenatal appointments without fail, and respect the care I was advised to take. (PH 11)*

*I worry because high blood pressure has caused so many problems since pregnancy. I look at him and wonder, 'will he have any sequelae?'. That's why I'm going to endure this hospitalization even though it's difficult, but for a child we endure everything. (PH 6)*

The postpartum women experienced multiple concerns beyond caring for their children, as they had to cope with the pain of leaving them in the maternity ward without their presence. In addition, they felt exhausted and desperate in the face of the situation they were experiencing and expressed their anxieties:

*I am afraid for my son's health and treatment. I had moments of despair because I had to leave him there in the maternity ward. I suffered a lot because of that. (PH 2)*

*I am treating my high blood pressure and diabetes, and they are under control. My concern about the baby and him staying in the hospital is wearing me down, even with the care he is receiving. (PDH 8)*

It was evident in the statements of the postpartum women that their children's health status is blamed for their actions, due to not having given real value to the diagnosis during pregnancy, which aggravated the situations in the postpartum phase.

*The postpartum period is difficult because of his health. I feel guilty; I didn't want my son to suffer because of me. I didn't take care of myself when I was pregnant, even though I knew I had high blood pressure. (PH 9)*

*Being away from my son, seeing him go through so many injections, made the postpartum period so difficult. I also had to be hospitalized, but nothing compares to the pain of seeing him suffer. (PDH 12)*

*And all of this was because of me. I didn't take care of myself when I was advised to. Now here we are, far from each other and sick. It breaks my heart. (PDH 10)*

In addition, the statements of the postpartum women showed that hospitalization generated frustrations in the face of the rupture of expectations deeply embedded in the lived body and symbolic perceptions of pregnancy. While pregnant, these women planned the delivery, organized their lives according to the expected date of birth, and imagined themselves, in their intentionality of being, leaving the maternity ward with their children. However, illness and hospitalization frustrated their hopes and their way of being in the world, revealing how the pregnant body is the place where meanings, affections, and expectations about motherhood are inserted.

*I hadn't planned on a premature birth, but this illness brought everything forward and I wasn't prepared to have a premature baby. This caused me suffering, I hadn't planned for it, I stayed away from him. (PD 3)*

*A lot of things upset us, because we want to have the baby in our arms, and when he is taken to another room, far away from us, our hearts are sad. (PD 4)*

In the following statements, hospitalization is revealed as an obscure and destabilizing process, marked by physical and emotional exhaustion, which permeates the lives of postpartum women. Even in a context of regrets and uncertainties, the participants reported that the care they received opened up new meanings and ways to cope with the moment they were experiencing:

*The changes we faced were not easy because of the illness and hospitalization. But we were well cared for*

*at the hospital, which helped us weather this storm with the baby. (PD 6)*

*I was already very shaken, I was afraid when I was pregnant, and this intensified during the postpartum period because we had to be hospitalized, but the treatment is necessary, and for that I endure it. (PH 5)*

The postpartum period, as experienced by the participants in this study, was marked by significant changes that emerged from the postpartum women in their experiences of discouragement and despair, often related to the physiological aspects inherent to this period. In addition, emotional factors and health conditions also impacted the mother-baby dyad, adding complexity to the postpartum experience and revealing multiple dimensions of vulnerability in this context of risk.

## DISCUSSION

The hospitalization of pregnant and postpartum women represents a significant challenge for women and their families, as it disrupts their domestic routine and requires them to adapt to an institutional environment marked by rules and procedures that differ from those at home. This scenario generates feelings of fear, uncertainty, and helplessness, impacting the subjective experience of care.<sup>22-24</sup>

The findings of this study, in line with those of Medeiros<sup>25</sup> and Alzahrani,<sup>26</sup> reveal hospitalization as an experience of suffering, marked by distress, loneliness, and longing. Unfamiliarity with the hospital environment causes emotional and structural changes that intensify discomfort.

Based on Merleau-Ponty's theory of perception and interpretation of the unconscious,<sup>17</sup> anguish is understood as an opening to existence, situated between the present and the future. For the author,<sup>27</sup> perception involves cultural and social elements and contradictions of the lived world, with anguish being a break with everyday life that calls for accountability for choices and the search for meaning even in pain.

This pain is accentuated by uncertainty about health, disruption of routine, and separation from support networks, as reported by the participants. Such feelings, often present even when there is only a suspicion of risk to the newborn, tend to intensify with hospitalization.<sup>4,5,15</sup>

In this sense, Merleau-Ponty<sup>28</sup> emphasizes that all human experiences are ambiguous, which also applies to existence. Health and illness are categories that represent the body's flow in search of adaptation to survive in the world. Thus, health and illness are existential peculiarities that manifest themselves phenomenally, as demonstrated in the experiences of pregnant and postpartum women facing illness and hospitalization, with ambiguous feelings between fear for their health condition and confidence in the treatment and care provided by the multidisciplinary team.

In addition, the reasons that led to hospitalization, often linked to unexpected health complications, aggravate the situation, causing distress, frustration, and concern, as demonstrated in the statements of pregnant and postpartum women. In this context, it is common for mothers to experience increased stress, especially when they feel somehow responsible for their baby's problem, which can compromise their emotional well-being and their ability to cope with the situation calmly.<sup>16,23</sup>

The fear of losing the baby is a constant concern for pregnant women at risk, especially during prolonged hospitalizations. Although the hospital environment is distressing, it offers a sense of security through continuous monitoring. The participants' statements reveal the conflict between despair and relief: staying in the hospital intensifies fear, but the care received brings calm in the face of the risk of complications. The constant fear that something will go wrong is partially mitigated by confidence in the treatment, although the fear of losing the baby persists.<sup>15,22</sup>

For pregnant and postpartum women with children at risk, hospitalization represents a prolonged wait for discharge and a loss of autonomy in the hospital setting, marked by an existential perception of time in which the past and future intertwine in the present, generating a discontinuity in self-perception and influencing emotional experience.<sup>17,26,29</sup>

In addition to the wait, the uncertainty and instability of information about the baby make the experience stressful, which can trigger symptoms of depression, anxiety, and stress, and affect the maternal-neonatal bond.<sup>4,24,29</sup>

Fear, anxiety, frustration, dread, and suffering in the face of hospital procedures, guilt, and the search for explanations for hospitalization are recurring feelings among mothers, intensifying their perception of responsibility for the situation they are experiencing,<sup>6,12,26</sup> as evidenced in the statements of GH4, GH8, GDH11, PH9, and PDH10.

Despite the challenges, the quality of care received plays a central role in the hospitalization experience. Care that addresses physical and emotional dimensions offers greater comfort and security.<sup>29,30</sup> In this sense, the embrace provided by the healthcare team facilitates adaptation to the hospital environment and helps mothers face adversity with greater peace of mind, even in the face of uncertainty.<sup>26,31,32</sup>

According to Merleau-Ponty,<sup>28</sup> care permeates bodies, integrating instinct and reason in a dynamic system that alternates between attention and neglect, profoundly impacting lived experience. From this perspective, care goes beyond the technical dimension; the body, as the subject of perception and a way of being in the world, becomes the space in which care manifests itself as openness to others and an expression of empathy.

According to Paiva,<sup>33</sup> the need for treatment and the desire for the baby's well-being are sources of strength to face this challenging period. Despite the desire to return home and the emotional difficulty in the hospital, love for her child motivates the woman to endure the suffering. This maternal bond strengthens her resilience, allowing her to go through hospitalization for the sake of her baby's health.

International research converges with the findings of this study, showing that hospitalization of pregnant and postpartum women at risk is a threshold experience, situated between a sense of protection and the suffering experienced. Research conducted in Canada reveals that the perception of vulnerability is heightened by emotional, social, and environmental factors, requiring care practices that value the centrality of women and their families in the care process.<sup>34</sup>

Similarly, studies conducted in Iran and China point to the presence of feelings of guilt, fear, and ambivalence in the face of pregnancy risk, which reinforces the universal nature of these existential repercussions.<sup>35,36</sup> Together, this evidence reiterates the need for a humanized and interdisciplinary approach that goes beyond the limits of the biomedical model, recognizing the subjective and relational dimensions that permeate hospitalization.

## FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

This research, based on Merleau-Ponty's phenomenology, revealed the complex and intense experiences of pregnant and postpartum women hospitalized for gestational diabetes and/or hypertensive syndromes. Hospitalization goes beyond the clinical aspect, affecting these women emotionally, socially, and existentially, as they experience fear, anguish, guilt, and isolation, along with hope for positive outcomes.

Emotionally, psychological suffering predominates; socially, the loss of support networks intensifies isolation; and existentially, the loss of autonomy leads to a discontinuity in self-perception. Understanding these experiences highlights the importance of humanized obstetric care that values listening, embracement, and emotional support.

The present study points to the urgency of policies and practices that respect the dignity of these women in risky contexts. Restricted access to the target population is recognized as a limitation, which may have influenced the diversity of experiences learned and restricted the scope of theoretical saturation. The qualitative approach, combined with the hospital context in which the research was conducted, although favoring interpretative depth, may not fully reflect other regional or institutional realities. It is therefore recommended that new studies be conducted in different care settings and with more heterogeneous samples in order to broaden the transferability and scope of the results.

This research offers important contributions to the phenomenological understanding of maternal experiences in situations of risk, proposing reflections that support the training of professionals who are more sensitive to the existential dimension of care. Based on corporeality and the perception of lived experience, it highlights the possibility of reframing obstetric practices based on the principles of comprehensiveness and humanization, which are essential pillars for strengthening the maternal and child care network.

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## DATA AVAILABILITY RESEARCH

The contents underlying the research text are included in the article.

## CONFLICT OF INTEREST

None.

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