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"You're the child I never wanted": an interpretative phenomenological analysis about the invisible struggle of families in crisis raising a child with persistent and severe regulatory problems

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Abstract

Background Infant regulatory problems (RP), such as sleeping disturbances, feeding difficulties and excessive crying, affect a significant number of families and can persist beyond typical developmental stages, leading to distress for both the child and parents. These challenges disrupt the co-regulatory bond between parent and infant, often resulting in mutual dysregulation, parental burnout, and strained family relationships. Sociocultural values in Western societies, combined with conflicting role expectations, can contribute to heightened parental stress. Despite growing recognition of infant mental health (IMH), families' lived experiences dealing with persistent and severe RP remain underexplored.

Methods This study addresses the existing gap by employing an Interpretative Phenomenological Approach (IPA), specifically the Multi Family Member Interview Analysis (MFMIA), to explore the nuanced and shared experiences of families in crisis. Interviews were conducted with six father–mother dyads who had received specialised tertiary IMH treatment due to persistent and severe RP in their child.

Results Analysis revealed four phenomenological themes. First, families experienced more than stress or fatigue; RP represented an existential rupture that dismantled the predictability of everyday life (*Disrupted lives*). Second, traditional gender roles shaped coping strategies: fathers often sought refuge in work while mothers remained confined to relentless caregiving, creating a painful asymmetry that intensified exhaustion (*A gendered struggle for balance*). Third, social isolation emerged through external minimisation and internal reluctance to show vulnerability, leaving families increasingly disconnected (*Alone on an island: trapped in a vicious cycle of isolation*). Finally, the crisis extended beyond its acute phase, with participants describing a prolonged period characterised by significant

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differences between families, where persistent vulnerability intertwined with varying degrees of resilience *(The past shapes the present)*.

Conclusions These results reveal a bidirectional dynamic, i.e., a spiralling mutual influence, operating between the infant and the parents, as well as within the co-parenting dyad. In this cycle, the challenges of raising a child with RP and the disruptions within the parent–child and parenting subsystems mutually reinforce each other, eroding identity, straining relationships, and fostering isolation. This study highlights the critical importance of societal recognition, accessible social support, and responsive government policies for families facing infant RP.

Keywords Infant regulatory problems, Parental lived experiences, Interpretative phenomenological approach, Multi-family member interview analysis, In depth-interviews

Background

An important aspect of a child's development involves acquiring the ability to regulate their internal state and behaviour [1]. Self-regulation in children develops through ongoing co-regulation processes with caregivers, wherein responsive and attuned interactions during infancy provide the foundation for later emotional, cognitive, and social aspects of mental health [2, 3]. However, these processes are not always smooth, and regulatory problems (RP) can occur [4]. Although the presentation of RP may vary with age and development [5], crying, sleeping, and feeding issues are the most common in infancy, affecting about 20% of children in their first year [6, 7]. Most early RP are self-limiting and resolve spontaneously as the child matures [8]. However, excessive crying beyond 3 months of age, and sleeping and feeding problems beyond 6 months of age are considered persistent and severe RP [6, 7]. A small subset (2–9%) of children exhibit more complex or persistent patterns, often involving multiple concurrent difficulties [7].

The literature predominantly highlights the impact of RP on the child, with persistent and severe RP linked to developmental and mental health issues throughout childhood and beyond [5, 6, 9, 10]. Infant RP also significantly affect parents [11]. In typical infant-caregiver relationships, a positive feedback loop gradually develops where the caregiver's soothing responses effectively calm the infant, thereby reinforcing the parent's sense of competence [3]. However, infants with RP may be in a physical state that makes them unresponsive to typical soothing strategies [12–14]. Highly stressed and exhausted parents may struggle to access their capacity for relationally grounded co-regulation, making it harder to manage their infant's dysregulation. This can lead to a cycle of mutual dysregulation between parent and infant, resulting in elevated stress levels for both [14]. Indeed, several studies revealed that infant RP are associated with parental distress, frustration, anxiety, and/or depression and difficulties in the parent–child relationship [11, 15–21]. For example, an integrative literature review [22] examining the effects of excessive infant crying on families identified several parental implications: feelings of desperation, disrupted daily life, isolation and loneliness, strained and damaged family relationships, physical and mental exhaustion, and a sense of parental failure. In severe cases, persistent excessive crying in infants has demonstrated to be a big risk factor for infant abuse and non-accidental trauma [23–26].

These parental experiences cannot be viewed in isolation but must be understood within the broader socio-cultural context in which they unfold. Parenting is deeply embedded in societal structures where exposure to stressors and the capacity to cope are shaped by social roles and available resources [27]. Contemporary parents often navigate the complex, non-linear reality of attempting to integrate active labour market participation with emotionally involved parenthood [28–31]. This balancing act creates a palpable tension between the realities of modern life and the sociocultural ideal of the 'good parent'. Drawing on foundational literature regarding 'intensive parenting' [32], this dominant trope dictates that parents should be unconditionally responsive and solely responsible for their child's well-being. In a sociocultural climate characterised by information overload and the pressure to perform 'perfect parenting', an inconsolable child is frequently internalised not just as a difficult developmental phase, but as a profound personal failure [33, 34]. Consequently, within the contemporary individualistic context of Western Europe, where nuclear family self-reliance is heavily idealised, these feelings of inadequacy frequently lead to isolation rather than help-seeking behaviour [35]. In Belgium, this is reflected in alarming rates of parental burnout (7–8%) [36], which can induce escape ideations and severe distress [36, 37].

Although research on infant mental health (IMH) and RP have recently gained significant recognition, the experience of families raising a child with RP is currently underexplored. Most qualitative studies focus specifically on the impact of infant crying on parental mental health while the impact of other RP, such as sleeping and feeding difficulties, has received less attention [38, 39]. Moreover, fathers are often underrepresented in research on this topic [40–44], and there is a notable lack of dyadic studies [40, 45], including both parents,

highlighting a significant gap in the literature. This study aims to address these gaps by exploring the everyday lived experiences of families in crisis raising a child with persistent and severe RP. Rather than solely capturing distress, this study seeks to explore how parents perceive and make sense of the impact of extreme caregiving demands on their daily lives, how this crisis shapes their parental identity, and how they navigate these challenges within their unique family and sociocultural contexts. To closely examine lived experiences from the participants' perspectives while acknowledging the interpretative role of the researcher, this study required a phenomenological approach. Consequently, Interpretative Phenomenological Analysis (IPA) [46] was adopted as the primary methodology. To extend this framework to the family unit, we utilised its family-focused variant, Multi Family Member Interview Analysis (MFMIA) [47]. By applying the MFMIA approach, individual interview data are synthesised into cohesive family-level interpretations, constructing a nuanced understanding of the family's shared lived experience beyond individual stress factors.

Methods

This study is part of the ongoing Co-PRIME (Co-regulation as the foundation of PReventive Infant MEntal health care) project [48]. The project brings together three Flemish (Dutch-speaking part of Belgium) universities, the University of East London, and various societal partners (e.g., non-governmental family and employers organisations, midwifery and paediatrics associations). This multidisciplinary project explores how co-regulation contributes to the development of self-regulation in infants, and how this process may play a role in preventing mental health difficulties in early childhood [49].

Participants

This study builds on our previous research [50], in which we interviewed 14 families who received specialised IMH treatment within tertiary child psychiatric care services in Flanders. The previous study aimed to identify missed opportunities in parents' clinical care trajectories. In the present study, we focus on a subsample of six families who had received specialised tertiary IMH treatment at "kleine k" (the Infant Unit of the University Psychiatric Centre in Leuven, Belgium) to explore the impact of persistent and severe infant RP on families in crisis. This clinic provides specialised third-line care for families where the severity and persistence of infant RP have resulted in families being considered in crisis. In this context, 'crisis' is defined through both a clinical and service-based lens: it refers to an acute period of severe parental distress and systemic dysfunction where primary and secondary care interventions have been exhausted or proven insufficient, necessitating urgent, multidisciplinary intervention to stabilise the parent-infant dyad.

In alignment with IPA's idiographic focus, which necessitates contextually-specified samples to do justice to the complexity of individual experience [46], this study employed a purposive selection of participants. To meet the study's objective, namely, to specifically capture the experiences of both mothers and fathers within the family context, the inclusion criteria for the current IPA study were as follows: (1) families in which both father and mother participated (2), families where the father and mother remained a couple at the time of the interview and (3) interviews that met IPA's criteria for richness and depth. Consequently, the remaining six families (comprising six mothers and six fathers) form the basis for this IPA study.

The participants in this study represent a relatively homogeneous sample, as all were Belgian, except for one parent with another nationality (specific nationality not mentioned for anonymity reasons). All were highly educated, living in the Flemish Region of Belgium, and aged between 31 and 44 years. Three parents were self-employed, while the remaining nine were employed in salaried positions. It is important to note that this sample is specifically representative of a Western European, highly educated, and middle- to upper-class demographic. This particular socio-economic positioning may influence the manifestation of family dynamics. Therefore, the ways in which stress, coping, identity and support are experienced or articulated in this study should be interpreted within the framework of this specific sociocultural group. Table 1 provides additional characteristics of the participating families, specifically their household composition. To ensure confidentiality, participants' names have been pseudonymised.

Data collection

Eight face-to-face in-depth- interviews were conducted by two female qualitative researchers and four interviews were conducted by the first author alone. Each family member was interviewed individually, enabling them to present their perspectives on the research topic without being influenced by the other parent [51, 52]. To prevent partners from discussing the interview content with each other, interviews were preferably conducted consecutively on the same day, where practically feasible for both parents. This approach was successfully applied in 4 out of the 6 families. The interviews were conducted between March 2024 and October 2024 and took place at a location of the participant's choice. Seven interviews took place online via Microsoft Teams, four interviews took place at the participants' homes and one interview took place at a research facility. The inclusion of remote interviews via Microsoft Teams was a deliberate,

Table 1 Families' characteristics

	Child's gender	Child's age at the time of the interview (in months)	Number of children in family
Family 1			
David	Male (Daan)	26	4
Dorien			
Family 2			
Mauro	Female (Mila)	31	2
Manon			
Family 3			
Joris	Female (Julia)	13	2
Jolien			
Family 4			
Arthur	Female (Amelie)	18	1
Anna			
Family 5			
Liam	Male (Leon)	20	1
Lena			
Family 6			
Floris	Female (Fleur)	59	2
Fien			

pragmatic, and ethically responsive choice. In qualitative research, particularly with participants experiencing heightened vulnerability or navigating a personal crisis, flexible interviewing formats enhance accessibility and significantly reduce participant burden. For parents managing the intense, 24/7 demands of an inconsolable infant, offering an online alternative provided essential practical relief. Furthermore, this adaptable approach successfully supported rich data generation; we observed that deeply emotional and detailed accounts were readily shared across both online and in-person settings. The interviews were conducted in Dutch and lasted between 80 min and 140 min (mean: 106 min). Each interview was audio-taped and transcribed verbatim in Dutch by the first author and additional nonverbal elements (e.g. 'crying') were incorporated. To illustrate the findings, verbatim quotations were purposefully selected based on their interpretative richness and evocative power, ensuring they vividly captured the essence of the emerging themes. Furthermore, care was taken to maintain an equitable distribution of quotes across the entire sample, thereby representing the diverse voices of all participating families and avoiding an over-reliance on any single participant's account. The quotes presented in this paper were translated into English. The quotes presented in this paper were translated into English.

To address the research question, "How do families in crisis experience the everyday challenges of raising a child with persistent and severe RP?", we developed a semi-structured interview guide through an iterative process (available as Supplementary File). The open-ended questions were informed by existing literature and the expertise of a multidisciplinary infant psychiatry team and aimed to elicit parents' in-depth perspectives on how their infant's RP affected various aspects of their personal, social, and family life. The interviews started with the broad open-ended question: "How is your child doing at the moment?"; more specific questions from the interview guide addressed parents' personal well-being (e.g., "Could you describe how this period affected your personal well-being?"), their couple relationship (e.g., "How did you as a couple endure this period?"), and their relationship with their infant (e.g., "To what extent was there an influence on your relationship with your infant?"). In light of the participants' responses, additional probes were employed to gather further information. Interviews were audio-recorded, and the interviewers took observational and reflexive notes during and immediately after the sessions to capture non-verbal communication and emotional shifts. After the interview was conducted, the parents were asked about their sociodemographic background (see Table 1) and their reflections on the interview.

Data analysis

Inspired by IPA [46] and Dyadic Interview Analysis [53], MFMIA [47] aims to understand broader family dynamics by obtaining and combining the perspectives of multiple family members, enabling a detailed and systematic examination of shared family experiences through its three-phase process. In the first phase, individual interviews were analysed separately in accordance with IPA principles, as outlined below. Reading through the transcript, descriptive (e.g., content-related), linguistic (e.g., language use) and conceptual (e.g., more abstract reflections about the data) notes were made in order to obtain familiarity with the case and enhance interpretation of the data [46]. For example, the use of particular metaphors (e.g. fighting for the child like "a tiger") and possible meanings of this metaphor were discussed in a linguistic note. Subsequently, line-by-line coding was conducted, followed by clustering the codes into higher-level (sub)themes, and composing a narrative summary for each interview. This procedure was systematically repeated for each participant. In the second phase, a within-family analysis was performed: themes relevant to each parental dyad were identified by integrating the themes from both parents' individual transcripts. In the third phase, parallel themes between parental dyads from different families were identified. To enhance the rigour of these interpretations, the analysis incorporated both researcher reflexivity and an independent audit. The first author (FH), a medical doctor and PhD researcher, conducted the primary analysis. While the first author's medical background supported a structured and systematic

engagement with the data, it also required ongoing reflexivity to avoid interpreting participants' accounts through a primarily clinical or diagnostic lens, and instead focus on their lived experiences and meanings. Moreover, her current position of being childless shaped the analytic process in multiple ways. While FH did not share these specific parental experiences, this positionality informed the interpretative process within the double hermeneutic. It encouraged a reflexive engagement with the data, whereby the researchers actively interpreted how parents made sense of their experiences, while critically reflecting on their own role in this meaning-making process. To support reflexive transparency and deepen interpretative engagement, FH maintained a continuous reflexive journal and engaged in ongoing dialogue with the multidisciplinary research team, whose expertise spans family psychology and sociology. These discussions contributed to the iterative development of the analysis by opening up alternative perspectives on the emerging themes. In addition, the second author (DS) drew upon her background as a clinical psychologist with expertise in systemic therapy to attend specifically to the interactional and systemic dynamics within the parents' accounts. This perspective enriched the analysis by bringing greater sensitivity to how infant RP reverberate throughout the family unit. This approach, known as researcher triangulation [54, 55], also involved assessing the extent to which the analysis was carried out systematically and transparently [55]. Finally, the co-authors were invited to critically evaluate the themes and subthemes constructed.

Microsoft Word and Microsoft Excel 365 were utilised to annotate transcripts and organise individual and couple themes, facilitating the data-analysis process. Themes across couples were compared and developed using paper strips, which helped in organizing and visualising the theme structure more effectively. The SRQR quality checklist was employed to ensure the quality of the qualitative research [56].

Ethics

This study was conducted according to the guidelines of the Declaration of Helsinki and was approved by the Ethics Committee for the Social Sciences and Humanities (registration number SHW_2023_307). Written and verbal informed consent was obtained from all participants prior to the interviews. Participants were informed about available support services in case emotional issues resurfaced during the interview, and received a €15 gift voucher as compensation [50]. Following the interview yet preceding the initiation of this analysis, parents were recontacted to provide an addendum to the consent form, specifically addressing potential recognition of their partners.

Results

The MFMIA resulted in four phenomenological themes: (1) Disrupted lives, (2) A gendered struggle for balance, (3) Alone on an island: trapped in a vicious cycle of isolation, and (4) The past shapes the present. Each theme is introduced by an opening paragraph providing further context, and the first theme is subdivided into five subthemes. An overview of the themes and subthemes, indicating which family contributed to each, is presented in Table 2.

Disrupted lives

The experiences described by these families extended beyond simple stress or fatigue, often manifesting as a disruption in the taken-for-granted predictability of everyday life. For many participants, this 'existential' impact was experienced specifically as a diminished sense of intuitive understanding of their infant's needs and a breakdown of their own sense of agency within daily routines. Confrontation with a baby with RP not only dismantled the sociocultural expectation of a joyful postpartum period but also deeply altered how everyday life was experienced. Crucially, this was not a uniform collapse; the intensity and nature of the disruption varied across accounts, manifesting in diverse ways as parents navigated their shifting daily realities.

The collapse of the envisioned future: between despair and fragile hope

The experience of RP compelled parents into a silent and complex grieving process, in which they continually sought points of stability while their vision of the future gradually deteriorated.

For the families involved, the confrontation with reality was not a single shock but the beginning of a prolonged grieving process. Rather than a definitive break, many parents described how their anticipated understandings of parenthood were gradually destabilised and reconfigured in diverse ways. This experience often entailed a disruption in their sense of time: not only was the present profoundly altered, but the expectation of a joyful future often collapsed entirely. The contrast between parents' lived realities and prevailing sociocultural norms, within the Belgian context strongly shaped by narratives of postnatal happiness (often encapsulated in expressions such as 'being on cloud nine') and by highly performative postpartum practices such as extensive maternity visits, baby gatherings, and the distribution of birth favours, contributed to feelings of being positioned outside what was considered normal. Practices commonly framed as celebratory, such as baby showers, were thus experienced by many as burdensome obligations, moments in which parents felt pressured to publicly conform to an ideal of happiness that starkly contradicted their own despair. Liam

Table 2 Theme structure and family contribution

		David & Dorien	Mauro & Manon	Joris & Jolien	Arthur & Anna	Liam & Lena	Floris & Fien
1. Disrupted lives							
	The collapse of the envisioned future: between despair and fragile hope	X		X	X	X	X
	The changing nature of care	X	X	X	X	X	X
	Existing without being	X	X	X	X	X	X
	Unmet needs for closeness	X	X	X	X	X	X
	The painful awareness of feeling and acting harshly		X	X		X	X
2. A gendered struggle for balance							
	Fathers: work as escape	X	X	X	X	X	X
	Mothers: home as a prison	X	X	X	X	X	X
	Relational asymmetry	X	X	X	X	X	X
3. Alone on an island: trapped in a vicious cycle of isolation							
	Island isolation	X	X	X	X	X	X
	Movements by providers	X	X		X		
	Recognition, representation, and institutional support	X	X	X	X	X	X
4. The past shapes the present		X	X	X	X	X	X

described how, despite the complete disarray, the family had tried to adapt to what was deemed appropriate.

> *"The baby parties were awful… Honestly, we just weren't in any state to host. It just wasn't doable. And yet, you go along with it, because, well, 'that's what you're supposed to do,' isn't it? And there you are, completely distressed, either he's downstairs crying in front of everyone, or you're upstairs alone with him…" (Liam; Liam & Lena).*

For Arthur and Anna, the confrontation with this 'ordinary happiness' was so painful that they removed all congratulatory cards; every symbol of joy confronted them with their own painful reality. In this vacuum of despair, hope became a necessary yet fragile anchor. To make the overwhelming reality bearable, some parents clung to imagined milestones. Anna quite literally used time as a survival tool, reducing her suffering to a cold countdown.

> *The feeds were terrible, it was like a war, every three hours all over again. But somewhere in my head I hoped that with Amelie it was just a bit worse than with the average baby. And that once we reached that three-month milestone, her bowels would be more mature. So for quite a long time I held on to that hope, telling myself, 'okay, we're just having a tough time here, only 137 feeds to go.' (…) And it became like someone in prison, marking off the days: 'yes, another feed done, one less to go.' And then we reached that milestone, and in my mind it became clear: this isn't going to get better." (Anna; Anna & Arthur)*

Although this hope served as a necessary anchor for getting through the days, it proved to be extremely fragile. When the long-awaited milestone brought no improvement, hope gave way to a profound realisation that the crisis was far from over.

The changing nature of care

The daily reality for these families was marked by a complex tension: parents described an exhausting 'awakening', an ongoing struggle to comprehend and navigate their child's distress, while constantly balancing their profound vulnerability with a search for agency. The very nature of care underwent a profound transformation, becoming more urgent in emotional tone, more physically demanding, increasingly fragmented in time, and marked by sustained pressure and constant vigilance.

All families described the immense challenges they faced daily in caring for their child. Even seemingly simple everyday tasks, such as changing or dressing the baby, demanded an almost superhuman effort. Daily life turned into a chaotic race and a constant struggle.

> *"We had to physically restrain him in order to put a nappy on. You simply couldn't get his pyjamas on. I*

ended up sending him to nursery in the clothes he'd slept in, because it was just impossible. That sheer practical impossibility of getting anything done, getting somewhere on time, getting food into him… it was a massive challenge. And of course, that's a huge burden. 'Everything was a battle,' my wife often says." (David; David & Dorien)

While some participants initially reached for extreme vocabulary to convey their exhaustion, using terms as 'surviving', 'fighting' and 'war', a closer analysis reveals this not as a form of combative resistance, but as an articulation of the sheer physical and emotional weight of caring for a highly dysregulated infant. Caregiving was no longer experienced as a reciprocal rhythm, but rather as an urgent, high-stakes exertion of energy to manage the child's unrest. Within this high-pressure environment, parents did not move from a lack of agency to a sudden mastery of the situation. Instead, they described the activation of what Anna termed an inner 'tiger'. Rather than reflecting a stable, calm parental love, this metaphor signifies a raw, instinctive mobilisation born out of necessity. It captures a state of hyper-arousal, an intense, consuming drive to sustain care that coexists directly alongside feelings of profound vulnerability and overwhelm.

"What are we going to do? Because doing nothing just isn't an option. This just isn't bearable… I've never felt anything like it in my life. And at the same time, I discovered this sort of 'tiger' in me. (…) Really fighting for that child, but at the same time feeling so powerless. Those are the two extremes. And the more powerless you feel, the harder you fight." (Anna; Arthur & Anna)

This heightened state of alert was sometimes grounded in an all-encompassing fear that obscured the usual space for nuance. For instance, an infant's refusal of food could be experienced as an immediate, critical threat.

"I was absolutely convinced, Amelie wasn't eating, and not eating meant dying. So that Thursday evening… I genuinely thought: we're going to have to plan a funeral, this isn't going to end well." (Anna; Arthur & Anna)

The immense pressure to ensure the child's physical well-being necessitated relentless, intense interventions. Yet, this urgent approach collided head-on with a paralyzing counter-fear: parents simultaneously worried that their forceful methods might compromise their child's psychological integrity. As a result, parents found themselves caught in an agonising ethical bind.

"We were scared. How do you get her to enjoy eating? We didn't want to force anything, we were terrified it might cause trauma later on. Anorexia, bulimia… We meant well, we really did, but maybe we were actually making it worse." (Arthur; Arthur & Anna)

This dilemma, caught between the perceived risk of physical harm if they did not intervene, and the risk of psychological harm if they did, illustrates that parents were not simply 'battling' their child. Instead, they were navigating a deeply complex landscape where the pressure of caregiving constantly compromised their sense of agency, leaving them with the painful feeling of falling short despite their relentless efforts.

Existing without being

For many of these families, the parental experience was characterised by a tension between conscious, relational engagement and a state of mere functional presence. In this reality, their sense of 'being', understood phenomenologically as their 'being-in-the-world' and how they meaningfully inhabited their family life and environment, was often overshadowed by enforced survival. Rather than reducing this simply to a loss of individual autonomy, which varies depending on specific family dynamics and sociocultural backgrounds, participants described a profound narrowing of their lifeworld.

The exhaustion described could not be reduced to mere fatigue; it involved a systematic erosion of physical and mental resilience. Manon captured the brutality of this experience poignantly when she stated that the sleep deprivation felt like torture: *"Yeah, the sleep deprivation… it's brutal. Honestly, it's the perfect torture method. I don't know how else to describe it." (Manon; Mauro & Manon).* This metaphor of 'torture' illustrated an altered capacity for managing their daily reality, as parents found themselves navigating a situation that consistently overwhelmed their usual coping mechanisms.

This altered capacity translated into an experience of intensified surveillance and embodied hypervigilance. The care crisis was not confined to moments of direct interaction with the child but extended far beyond them, eroding genuine moments of rest: *"What I really needed, concretely, was rest, but I just couldn't find it anywhere… whenever Lena rang me, I could hear Leon screaming through the phone. So even then, I couldn't relax… I could actually feel my body trembling…" (Liam; Liam & Lena).* Joris similarly described how even the physical absence of the child offered no reprieve: *"The only time we weren't stressed was when we were asleep. But even then… the slightest flicker on the baby monitor screen, and we'd both be instantly tense." (Joris; Joris & Jolien).* Body and mind remained permanently tethered to the crisis at home; the

much-needed space for rest was consumed by constant anticipatory anxiety.

When the physical tension became unbearable, parents often shifted into survival mode. To cope with the overwhelming reality, a necessary disconnection occurred. Parents described functioning on 'autopilot', with their consciousness narrowing to the bare essentials of caregiving. Mauro encapsulated this with the term 'zombie', signifying a state where deeper, active connection with the world was temporarily suspended: *"You're basically a zombie. You can't think straight. You're just in survival mode." (Mauro; Mauro & Manon).* Dorien described how the body continued to perform out of a compelling sense of duty, while the mind became exhausted: *"Honestly, all I did was feed him… and then he'd wake up screaming again. You just feel like: I don't have a choice. I can't count how many times I thought: I don't want to do this again tomorrow. I just can't." (Dorien; David & Dorien).* The emotional system became so overloaded that Joris perceived this as a process of affective blunting, where space for other emotions was shut down:

> *"Apart from those negative feelings of 'I don't want this', you don't really have any space left for other emotions. So you sort of shut yourself off and just try to ignore it. You end up kind of numb, because you're not really paying attention to it anymore. It's just the crying, nothing else." (Joris; Joris & Jolien)*

The profound consequences of this disconnection for the experience of time and one's own life narrative became evident in Floris's words: *"I barely remember any of it… because a few times over the past years I've had the feeling that I woke up and was suddenly three years older." (Floris; Floris & Fien).* This reflects a disorienting temporal rupture and memory fragmentation: time continued to move forward rapidly, but the mind's detachment prevented the formation of anchored, consciously lived moments.

The paradox of this survival mode was that it allowed parents to keep functioning while simultaneously alienating them from their active being-in-the-world. The realisation that they were merely 'acting' out of necessity rather than fully 'existing' sometimes broke through abruptly in small, absurd moments. For David, this was the awareness that he had run to the pharmacy in the rain wearing his slippers: *"That was the moment I realised: oh wait… I'm really not okay." (David; David & Dorien).* For Fien, the realisation came only in retrospect: *"Back then I thought I was being really resilient, but now I think: I wasn't resilient at all, I was just surviving, full stop."* (Fien; Floris & Fien).

Unmet needs for closeness

The impact of RP created a fault line that penetrated deeply into the most essential relationships within the family. This subtheme demonstrates how the fundamental human need for connection and reciprocity was profoundly disrupted. To understand this complex relational crisis, it is necessary to first explore the parent–infant processes, followed by the dyadic partner dynamics, and finally, how these two spheres continually interacted.

The ongoing crisis struck families at the very heart of their existence: their relationship with their child. One of the most painful experiences for parents was interpreting the child's crying as an active, personal rejection. Liam articulated the bitter reality of a love that seemed to remain unanswered: *"We felt like he never wanted cuddles, like he didn't need us, like he didn't even love us, really. And that's hard. That really hurts." (Liam; Liam & Lena).* This sense of rejection contributed to a profound crisis in parental identity, leaving parents feeling physically present but emotionally detached. The extreme exhaustion often forced parents into experiences where the secure parent–child relationship came under severe pressure. To endure the constant weight, a form of emotional depersonalisation occurred. As a highly effective, but painful, psychological defence mechanism, the child was sometimes reduced from a subject of love to an object of misery: *"I couldn't talk about my daughter anymore. Honestly, and it's awful to say, she just felt like an object. Something that cried constantly and completely drained you." (Joris; Joris & Jolien).* This objectification highlights the brutal reality of caregiving under extreme distress.

Furthermore, the boundary between parent and child could completely blur, exposing parents, mothers in particular, to a destructive internalisation of the child's suffering. The child's suffering could become deeply absorbed and felt as internal proof of personal failure. Anna's testimony illustrated how she perceived her child's pain as a direct consequence of her own choice for motherhood: *"That child didn't choose to be born, but I did. And then her life is just pain and fear. So I'm the one doing that to her. Yeah, the whole mental spiral… I felt guilty about it for a long time." (Anna; Arthur & Anna).* Lena shared this burden, but framed it from a place of deep compassion for the false start her child had to make: *"And beyond how awful it was for us, what really broke me was how terrible it was for him. That his life had to start like that, with so much sadness, pain, and struggle." (Lena, Liam & Lena).* In Manon's case, this sense of guilt turned into a devastating self-judgement; the normative pressure of 'good motherhood' weighed so heavily that she interpreted her inability to read her child's needs as emotional neglect: *"I actually mistreated Mila… I just couldn't see what she needed. (…) So we just kept doing*

what we'd always done. I call that emotional neglect." (Manon; Mauro & Manon).

In contrast, the paternal accounts appeared more frequently anchored in action-oriented scripts of 'doing' rather than the intensive 'being' demanded of mothers. This action-oriented focus functioned as a protective shield against the spiral of guilt. Because fathers often evaluated their moral standing as a parent based on their tangible effort and sincere intention, they were able to maintain a healthier distance from the outcome of the soothing attempts: *"Fien often felt guilty about it. But I'm like: sorry, I just can't feel guilty for not handling everything perfectly… At least I tried. I meant something to that child. I still do. So no, I can't feel guilty about that." (Floris; Floris & Fien).*

These intense parent-infant struggles inevitably reverberated through the dyadic partner relationship. Precisely where partners needed each other most, the space for mutual support was often severely diminished: *"You're both going through the exact same thing, and it's just as hard for each of you. So you end up not being able to properly support one another." (Lena; Liam & Lena).* In an attempt to regain a sense of control amidst the chaos, a dynamic of unequal 'expertise' sometimes emerged. For Jolien, this meant trusting her gut instinct over her partner's reasoning. Unintentionally, this marginalised the other parent:

> *"I really felt like I wanted to take the lead, I just had a better sense of things. That sounds awful, but I don't mean it like that. I just always felt like my gut instinct was more accurate than what he was saying. Like when she was crying, he'd say, 'I think she's got a fever,' and I'd think, 'No, she's just hungry." (Jolien; Joris & Jolien)*

Instead of forming a united front, the shared powerlessness often forced both partners into a defensive withdrawal, leading to a breakdown in communication and increased conflict.

> *"In the end, you both start feeling like you're on your own, because you shut each other out. You stop reaching out to one another. There's more conflict, because you're just not communicating anymore." (Mauro; Mauro & Manon).*

This partner tension was frequently exacerbated by the infant's behaviour, particularly when the child appeared to develop an exclusive preference for one parent. This dynamic fostered jealousy and functional disconnection rather than shared care. Fien felt sidelined as a mother and began to perceive her partner as a rival: *"The fact that Fleur was so focused on Floris really knocked my confidence. And it made me really angry with him too. I felt like he was taking my child away from me. But it wasn't really his fault, was it? Yeah… she was the one doing that." (Fien; Floris & Fien).* Simultaneously, this 'preferred parent' role was not a privilege but an oppressive burden, forcing partners to take over care out of necessity while witnessing their partner's despair: *"It was really frustrating for Manon, you know. Because when I wasn't home and she had to get Mila to sleep, she'd often end up crying along with her out of sheer desperation… (…) But it's a bit helpless, really, you don't know what you can do to fix it." (Mauro; Mauro & Manon).*

The parent-infant and interparental processes did not operate in isolation; they continuously fed into one another. The moral weight and internalised failure experienced in the parent-infant relationship drained the emotional resources needed to maintain the partner bond. Conversely, the interparental disconnection and defensive withdrawal left parents feeling isolated in their caregiving, intensifying the distress experienced with the infant. Despite this challenging interaction, a fundamental sense of connectedness persisted in the majority of families. The ability to articulate this shared vulnerability functioned as the ultimate buffer against a complete relational breakdown. Fien shared:

> *"There was never a moment where we thought, 'We're not doing this together anymore.' We kept going, even though we often disconnected from each other, and then found our way back again." (Fien; Floris & Fien)*

For couples who managed to keep the dialogue open amidst the moral and physical exhaustion, the crisis shifted from being solely a source of isolation to an experience that ultimately strengthened their relationship.

> *"We're really good at communicating, and that made a huge difference. We talked a lot, and thankfully we got through it together. It wasn't easy, but it actually made our relationship stronger." (Arthur; Arthur & Anna)*

The painful awareness of feeling and acting harshly

As a devastating outcome of this ongoing struggle for survival, parents described a painful disruption not only of their anticipated futures, but of how they ethically experienced themselves as caregivers in relation to their child. What began as a necessary protective mode gradually pushed them to the outer limits of their endurance, to a point where the instinct to survive came into tension with their core values of care and protection. Participants experienced this as a profound crisis of their perceived ethical boundaries: the ways in which they

were compelled to act no longer aligned with how they believed a caring parent ought to be present for a vulnerable child.

In this state of extreme exhaustion, actions were sometimes taken over by raw impulses. It was not mere impatience, but a symptom of a system that was 'spent'. Joris candidly admitted how this exhaustion led to impulses to handle or address the child roughly, despite the immediate sense of guilt that followed.

> *"It happens in the heat of the moment, you don't think. You're exhausted, just wanting sleep, and you say, 'You've eaten, just be quiet for a bit.' Out of frustration, you sometimes grab them a bit roughly, even though they don't deserve it. And afterwards you think, wow, I don't want to do that again, she's a baby, she can't even hold her head up. Yet there you are, talking to her like she should calm down like an adult. The next day you feel awful, and things usually go better because that guilt is so heavy. But then it creeps back in… We never did anything physical, but you get those impulses, like, 'Now you'll be quiet,' or you speak to them like a dog: 'WHAT IS IT?!' And of course, that doesn't help, you know it only makes things worse. But in that moment, stopping yourself feels almost impossible." (Joris; Joris & Jolien)*

For Joris, these moments marked a painful conflict regarding a direct violation of his deeply held values of protection and his relational positioning towards his vulnerable child. At the core of this incomprehension was the disillusioning realisation that, under the weight of the circumstances, they were capable of inflicting harm on the infant they so profoundly loved. Floris similarly described reaching a limit where his usual ethical judgment and emotional regulation crumbled under the weight of exhaustion. He reflected on how persistent frustration unleashed deeply rooted emotions that would normally have been tempered by his normative values of patience and care: "*When it's 3 a.m. and you've already been up for an hour and a half… you just lose it. I remember shouting twice: 'JUST SLEEP!' The frustration is just unbearable. And even while you're shouting, you're already thinking: 'How stupid can you be?'." (Floris; Floris & Fien).* Although Floris emphasised that he never crossed the boundary into physical violence, the realisation that he had lost control over his own reactions left a profound impression. It illustrated how the previously described 'zombie mode' not only brought numbness but also a temporary breakdown of the ethical filters and relational reciprocity that would normally guide caregiving behaviour.

For other parents, despair and the perceived harshness turned inward, becoming a destructive self-rejection. When they were no longer able to meet the child's fundamental needs, the parents began to see themselves as the problem. Manon described a moment of complete disarray in which she no longer recognised herself and had lost hope of finding a way out.

> *"When things were really at their worst, I remember running outside and shouting at Mauro… telling him I just couldn't do it anymore. That I didn't want to be here. Yeah… it's embarrassing to say now, but I was really… acting irrationally. I remember picking up leaves in the garden, crying my eyes out. I was completely… honestly, I looked like a psychiatric case. Let's just put it that way. I was doing things that weren't normal. And then I just said… 'You'd all be better off without me, I can't go on… I wish there was a suicide pill'." (Manon; Mauro & Manon)*

These words revealed that the crisis culminated in a devastating outcome: it was not merely an external battle against exhaustion, but a profound collapse of the parents' ethical self-conception, questioning their place within the family as a reliable source of safety and care. The extreme demands of caregiving ultimately led to a painful awareness of how far the conditions of survival had distanced them from the protective, nurturing stance they valued most.

A gendered struggle for balance

The struggle to balance the overwhelming demands of the infant with professional life seemed to be a highly gender-dependent process shaped by systemic conditions. Fathers often used work as a necessary 'escape route' from the overwhelming demands of care, while mothers felt trapped in an isolating 24/7 caregiving reality. This tension exposed a painful asymmetry in which one partner's self-preservation often directly contributed to the other's exhaustion.

Fathers: work as escape

Fathers experienced compelling systemic pressure to resume work immediately after the birth. The limited paternity leave in Belgium (20 days) functioned as a structural mandate that forced them back into the regular labour market, reinforcing the capitalist expectation that combining work and family life should proceed effortlessly.

> *"We've got this idea that you're supposed to be able to juggle everything. Everyone else seems to manage, so why wouldn't it work for us? You just think, after a while it'll get better." (Mauro; Mauro & Manon)*

Mauro's statement demonstrated how the prevailing illusion of feasibility kept him trapped in an exhausting work rhythm. For many fathers, fulfilling the structurally mandated role of the 'breadwinner' also functioned as a necessary mental and physical buffer against the crisis at home. Floris described this as living in separate worlds:

> *"It felt like I was living in two bubbles, two separate worlds. When I was in one, I couldn't think about the other, because it just completely absorbed me. For me personally, it was a clear switch between the two. And I just needed something else in my life besides what was going on at home." (Floris; Floris & Fien)*

This compartmentalisation enabled fathers to maintain dimensions of their individual selfhood and professional identity beyond the all-consuming reality of caregiving. Joris explicitly acknowledged that this separation was a privilege, allowing him to 'escape' the chaotic home situation: *"Jolien was in it 24/7, while I could go to work. I'll be honest: I dropped the older ones off and left. And I was glad I could just focus on my job without having to worry. On the one hand, I wanted to help at home, but on the other, I thought: let me work, at least then I'm off the hook. As a dad, maybe you escape more easily, simply because you can." (Joris; Joris & Jolien).* His honesty exposed the inner conflict between guilt over his absence and the immense relief provided by the structure of labour. Jolien perceived Joris's work as *"his 'alcohol', his 'drug' to survive" (Jolien; Joris & Jolien)*, revealing a painful paradox: by fulfilling his systemic role as a worker, Joris protected his own psychological selfhood and indirectly safeguarded family stability, yet simultaneously placed the burden of care on Jolien.

Conversely, David refused this compartmentalisation and attempted to maintain the highest standards in both his professional labour and his identity as an engaged father: *"I stop working at four, then I'm fully with the kids until they're asleep, and after that, I work through the night. Compromises? I didn't allow any for myself. That made it hard, because I didn't want to give in on anything. (…) I never thought I'd be vulnerable to that. I've always had loads of energy, always been optimistic, ready to take on any challenge." (David; David & Dorien).* David's rigid adherence to an unrealistic standard illustrated the destructive downside of trying to simultaneously satisfy the relentless demands of both labour and intensive parenting, leading to a neglect of his own physical limits.

Mothers: home as a prison

While fathers often used labour as a buffer, mothers struggled with an inevitable shrinking of their world, frequently finding themselves structurally relegated to the domestic sphere. For many mothers, such as Lena, staying at home in a 24/7 care reality was not a conscious choice but a systemic necessity that led to a complete merging of their personal identity with the mandated caregiving role.

> *"I wanted to work, I didn't want all that just to end up stuck at home. It's awful, because everyone around you is working, getting on with life, and you feel like your family's down in a hole. You're not at home for fun, and yeah… I still find that really tough." (Lena; Liam & Lena)*

For mothers who had temporarily interrupted their careers, this break represented more than a mere pause; they experienced a standstill in which their autonomy was reduced entirely to the caregiving role. The confrontation with their partners' uninterrupted professional progress exposed a painful asymmetry. This transformation was described by Anna as a rupture in her life trajectory and professional selfhood:

> *"I've always worked hard, it was my life. (…) His life just keeps moving forward, he looks ahead. I look back, wondering how to shift gears again. My body's been through it, I was pregnant, he wasn't. My life came to a halt. I hope I can pick it up again one day, but the impact's been huge." (Anna; Arthur & Anna)*

For Anna, the impact of this 'standstill' was a lasting sense of alienation, in which the path back to the labour market appeared not merely as a logistical challenge, but as a laborious reinvention of a lost identity. As Jolien wondered: *"When, and more importantly, how will I return to work?" (Jolien; Joris & Jolien).*

Relational asymmetry

The gendered divergence between the working father and the caregiving mother created significant relational friction. Although mothers appreciated their partners' professional efforts, their accounts revealed a deeper longing for shared care. Fien's experience exposed how the structurally supported paternal 'escape route' generated maternal exhaustion and resentment:

> *"He was working, and I was left to handle everything on my own. That stayed with me for a long time. It's exactly what society expects: the man works, and the woman's left to cope alone. (…) And now it feels like it's always the women who crash. I held that against him for a while. If he'd been home longer, I could've slept, we could've taken turns. Instead, I was responsible for everything, while I was completely exhausted." (Fien; Floris & Fien)*

This traditional tendency was only broken when structural interventions were actively resisted or altered. In one family, both parents remained at home together to care for their child, with Lena describing the end of Liam's paternity leave as a looming catastrophe:

> *"I still remember when Liam's paternity leave ended and he had to go back to work. Everything in me screamed: 'This isn't going to work, I can't do this on my own'. If I'd been alone with Leon crying like that, I would've sunk even deeper." (Lena; Liam & Lena)*

Recognising how the clash between care and labour conditions damaged both partners, several fathers advocated for more extensive structural support. Liam criticised the 20-day leave policy not just as insufficient, but as a systemic failure that forced parents into an untenable conflict between labour and care: *"They've increased paternity leave from 15 to 20 days, but it's still madness, even for women. At the nursery, you see tiny babies who just shouldn't be there yet. (…) I was on sick leave for a year, and that costs money too. So that leave should be much longer, even if you're not in crisis." (Liam; Liam & Lena).* His critique highlighted that extended leave is an essential structural measure to protect the family system from burnout and financial insecurity.

Alone on an island: trapped in a vicious cycle of isolation

The path towards social isolation for families emerged from external invalidation and internal struggle. From the outside, they experienced trivialisation and judgmental advice, while internally a battle raged between the painful confrontation with their situation and the high threshold required to show vulnerability to others. This dynamic caused families to become gradually entangled in a lonely reality, in which connection with their surroundings seemed increasingly out of reach.

Island isolation

The invalidation often began with the undermining impact of trivialisation. When others responded with remarks such as *"Well, babies cry!" (Joris)*, the exhausting nature of the situation was reduced to an everyday inconvenience. However, for families, this felt like a denial of their reality, suggesting their helplessness stemmed from a lack of personal resilience. This trivialisation was painfully reinforced when a child presented its best side to the outside world, creating a distorted image that unintentionally minimised the parents' lived reality:

> *"And then when we asked my parents to babysit, and it just happened to be a good night while she was with them, well, that doesn't really help to show what things are actually like." (Mauro; Mauro & Manon)*

Alongside this trivialisation, the social environment frequently reacted with solution-oriented advice. As Fien described, such suggestions were frequently experienced as a direct judgement:

> *"One of the biggest problems was that people around us just didn't understand at all. The only thing our families said was that we were doing it all wrong. 'You need to get her into a routine, then she'll sleep.' But that wasn't the case. (…) Everything we did was judged. Those comments, which I now know were complete nonsense, really got to me at the time and made me feel very insecure as a parent. (…) It caused way more stress than was necessary. If we'd had some recognition from the start, I don't think it would've been so bad." (Fien; Floris & Fien)*

Furthermore, parents frequently encountered a tendency from their environment to offer quick fixes. When others suggested the problem could be solved with a simple intervention, the profound complexity of the situation was disregarded. This dynamic forced families into a position where the societal ideal of early parenthood served as a painful mirror. The inability to align with the normative experiences of their social circle created a profound sense of alienation:

> *"I really felt like we were such an exception. No typical baby experience, no rosy glow. That whole idea of enjoying your baby, we just couldn't. (…) And no one in our circle had ever gone through anything like it. It was really tough, and it made us start avoiding things and shutting down a bit." (Jolien; Joris & Jolien)*

Through this constant confrontation with an unattainable societal ideal, parents were pushed into a defensive isolation. This withdrawal functioned as a form of self-protection against the pain of invalidation: *"After hearing all those comments over and over, I just didn't want to go out anymore, I couldn't bear it. And that actually makes things worse, because you end up isolating yourself even more." (Joris; Joris & Jolien).* Paradoxically, this isolation was also perpetuated by the parents themselves, driven by an internalised stigma and a desperate desire to maintain autonomy. As David shared:

> *"My parents didn't offer much help, but to be fair, it works both ways, we didn't really ask either. So it's hard to blame them; maybe they couldn't quite grasp how serious it was. (…) We both have this bad*

habit of not asking for help or accepting it when it's offered. (…) You end up trying to sort everything out on your own. I also have this urge to stay in control of everything." (David; David & Dorien)

Furthermore, Lena's testimony demonstrated a clear distinction in the type of assistance parents dared to request, revealing the shame surrounding the need for emotional rather than just practical support:

"Asking for help is just really hard, because you're putting yourself in a vulnerable position and admitting that things aren't going well. (…) Asking for practical help was easier (…) But saying, 'I need mental support because Leon cries too much', that was much harder. There was a bit of shame around that." (Lena; Liam & Lena)

Movements by providers

The sense of isolation that parents experienced within the personal network also extended to interactions with professional caregivers. The behaviours and movements of providers played a pivotal role in how parents interpreted their crisis. When professionals attempted to normalise the extreme crying or offered standard pedagogical advice, they inadvertently reinforced the parents' sense of failing to apply the 'right' techniques. As such, rather than alleviating distress, these movements toward normalization contributed to feelings of isolation by positioning the problem as resolvable.

Conversely, when professional caregivers explicitly acknowledged the limits of their own expertise, it produced a highly complex emotional response. David described a moment when the childcare professionals labelled the child as an unmanageable exception. This experience, where caregivers openly delineated what could and could not be held within standard care practices, was deeply confronting, yet simultaneously offered a radical, powerful form of recognition:

"They [= the childcare professionals] said, 'We can't manage him. You can leave him for an hour, but then you'll need to come and pick him up'. That was really confronting. In a way, it was a confirmation: this isn't an easy situation. But also, if that amazing nursery, with all their patience and staff, can't handle it… yeah, then you start worrying even more. They probably see a hundred kids a year, and we're the one exception they can't cope with." (David; David & Dorien)z

The providers' inability to cope confirmed that the family's suffering was not the result of personal, parental failure, but of an objectively untenable reality. This professional movement, admitting defeat, acted as a double-edged sword: it heightened anxiety about the child's future by underscoring how far the situation fell outside what systems of care were designed to contain, yet provided the profound recognition needed to counter the trivialisation they experienced elsewhere by reframing the situation as institutionally untenable rather than personally mismanaged.

Recognition, representation, and institutional support

Ultimately, escaping this island of isolation required more than fleeting social interactions; it demanded deep recognition, representation, and structural institutional support. For parents carrying this burden, particularly those with a limited network or a migration background, the profound dialogue needed to break through the barrier of misunderstanding rarely found space in everyday encounters. As Arthur observed: *"Not everyone gets it. (…) You really need to have a long conversation with someone to properly explain it, like this conversation with you now, that's not something I get very often." (Arthur; Arthur & Anna).* Structural assistance offered those who were open to it the opportunity to step out of survival mode. Unlike one-off help, which sometimes felt like a precarious favour, regular institutional support provided necessary predictability. Moreover, it functioned as an active representation of their struggle; it was an institutional validation of the untenability of their situation: *"If we'd had that kind of support on a regular basis, it would've taken a real load off us mentally." (David; David & Dorien).*

The most valuable support did not lie in offering pragmatic solutions to 'fix' the baby, but in the fundamental willingness to truly witness and acknowledge the gravity of the parents' reality.

"When Daan was five months old, we went away for five days with some friends. They really saw how hard it was, they're the only ones I feel truly understood it. They asked, 'Okay, what can we do to help?' (crying). And that's something I'll never forget." (Dorien; David & Dorien)

It was precisely this profound recognition that served as a necessary buffer, drawing parents out of their isolation and restoring their resilience. Genuine recognition provided peace for both body and mind. As Mauro summarised: *"It's nice to get a bit of a break, sure, but… yeah. You just don't get that recognition." (Mauro; Mauro & Manon).* Ultimately, it was this form of 'being seen' that made the experience of parenthood, despite the crushing reality, human again.

The past shapes the present

This final theme demonstrated that the crisis is not a closed chapter, but an ongoing, unresolved process that continued to resonate in the families' present lives.

Pushing beyond their usual limits left residual effects that manifested as a heightened, continuous state of alertness. For parents such as Joris, the fear of relapse remained latently present; a bad day for the child was not perceived as an isolated incident, but as a possible harbinger of an ongoing vulnerability.

> *"Whenever Julia has a tougher day now, we both immediately think: is it starting again? That feeling's still there, even a year later, like it could all tip over at any moment. It's buried deep down, like something you never want to think about again. But at the same time, it's right on the surface too, because the moment it happens, you're like: Jesus, that was absolutely awful, we never want to go through that again. (…) And when I hear other parents talk about it now, I sometimes get tears in my eyes, just because I know how truly horrible it was." (Joris; Joris & Jolien)*

This hypervigilance showed that both body and mind continued to carry the somatic imprint of that traumatic period: everyday stimuli, such as a baby's crying, acted as triggers that immediately brought parents back to their initial state of panic and helplessness. This resonance, however, extended beyond fear alone; parents described it fundamentally altered specific domains of the their lives, particularly their physical health, professional trajectories, and relational positioning. For parents like Anna and Liam, the traumatic period had led to an ongoing rupture. When they spoke of a loss of their 'former self,' they were not merely referring to a change in their social *identity*, such as their professional status or roles, but to a profound, unresolved shift in their *selfhood*: their embodied vitality, baseline emotional resilience, and continuous subjective experience of being in the world.

> *"I'm still feeling the effects of it now. I'll probably carry them with me for years. My health's not great. My professional career, well, how can I put it, it doesn't really exist anymore. My whole life's been turned upside down, and it's going to take time to find some kind of balance again." (Anna; Arthur & Anna)*
>
> *"I still feel it… because I was in such a dark place back then. I'm still recovering, I'm still not the person I used to be." (Liam; Liam & Lena)*

The trajectory of recovery was not a return to a static former state, but an ongoing, often difficult negotiation to find a new equilibrium in a lifeworld that had been irreversibly changed. This enduring impact also continuously shaped the families' outlook on the future, particularly their wish for another child. The naivety and optimism that had accompanied beginning parenthood had been permanently disrupted. Lena expressed a profound sense of unresolved injustice:

> *"I know it sounds awful, but it just feels so unfair that people who've had an easy first baby can go on to have a bigger family, and it's like that's been taken away from us. (…) And coming to terms with the fact that, because of what we've been through, we might never have two children… that really hurts. It's just so hard to be naïve and optimistic again, like we were the first time. We just can't anymore…" (Lena, Liam & Lena)*

Lena illustrated how the crisis had not only marked the past, but continued to deprive them of the carefree ability to contemplate expanding their family. A new pregnancy, as in Dorien's case, was therefore not experienced solely as a joyful event, but as an active, unresolved confrontation with past trauma and the fear of having to 'survive' once again.

> *"When I found out I was unexpectedly pregnant again, it suddenly brought on a really difficult period. It was like I could finally start processing everything, what actually happened, how did we even get through it? (crying) (…) I was also really scared it was going to be just as hard again. (…) For us, it was a real moment of, oh no, is everything about to start all over again? Another baby phase like that?" (Dorien, David & Dorien)*

Nevertheless, for some parents, the ongoing resonance of the crisis also involved a continuous process of meaning-making. Floris and Fien, for instance, described how they integrated these experiences into a heightened self-awareness and a more deliberate, critical positioning towards societal pressures and their parental roles.

> *"That wasn't an easy time. (…) But we were lucky enough to be able to learn from it, and that really changed the way I parent. I think I'm a completely different dad now than I would've been otherwise. I'm much more involved, and I have a lot more respect for my child's pace. I've come to realise just how much pressure comes from society, not just from schools, but also from parents, family, the whole environment. (…) I just see life differently now. And I really believe we need to invest in supporting young families." (Floris; Floris & Fien)*

This theme ultimately illustrated a broad spectrum of unresolved and ongoing processes: rather than culminating in a definitive closure or a simple emergence of 'resilience,' parents navigated a continuous interplay between enduring vulnerabilities and newly integrated perspectives on care and family life.

Discussion

A qualitative study was undertaken to gain a deeper understanding of the lived experiences of families in crisis while raising a child with persistent and severe RP. Individual interviews were conducted with six couples, with each partner interviewed separately, and the data were analysed using the MFMIA framework [47]. This interpretative approach seeks to illuminate experiences in their full complexity and meaning, with the aim of fostering recognition and understanding [46]. The primary objective of this study was to explore how parents perceive and make sense of the impact of extreme caregiving demands on their daily lives, how such a crisis shapes their parental identity, and how they navigate these challenges within their unique family and social contexts. In this discussion, we interpret these findings by situating these lived realities within the existing literature and aim to provide a deeper explanation for the varied parental responses identified.

From caring to surviving

The parental experience of raising an infant with RP can be interpreted as a profound phenomenological shift: a transition from the sociocultural expectation of reciprocal, nurturing parenthood to a state focused primarily on hyper-mobilised survival. This is not a simple process of fatigue, but a sudden rupture in the lifeworld that completely dismantles the predictability of daily family structures. The taken-for-granted nature of daily life disappears, giving way to a fragmented, high-pressure reality. Whereas care normally arises from emotional attunement between parent and child, persistent crisis compels the parent into a mode in which instinctive, urgent mobilisation predominates.

Central to this state is an altered temporality and texture of care. Parents described their experience not as a lack of agency, but as an exhausting, reactive awakening, the 'inner tiger', driven entirely by fear and the absolute necessity to manage the child's unrest. These experiences resonate with what Giallo et al. [57] conceptualise as a 'survival mode': a condition in which acute stress displaces reciprocal parental engagement. This survival mode surpasses the ordinary fatigue that is often central in the literature on early parenthood [58, 59]. Recent research by Patty et al. [60] employs survival mode as a core phase within the burnout process: it is a state in which parents, on the one hand, continue to fight to meet demands ('fighting'), while on the other hand emotionally detach in order to endure ('fleeing'). It marks a transition from normal parental stress to chronic mental exhaustion that undermines emotional involvement. This is clinically significant, given the documented impact of parental burnout on both parental well-being and child development [36].

This survival mode has a profound impact on how parents perceive time and reality. Parents described time as no longer unfolding as a coherent sequence of events, but instead as a repetitive succession of crisis moments. When the day revolves entirely around soothing the baby or using feeding as a source of comfort, life begins to lose its coherent narrative. This relentless cycle of tasks pulls parents out of the present moment and into a purely functional 'zombie mode,' where they operate rather than truly exist. This functional state operates as a form of self-protection: the emotional system is temporarily switched off to endure the extreme strain and exhausting circumstances. This survival mode embeds itself deeply in the body as a constant state of hypervigilance. Even when physically away from the child, the tension remains palpable, blurring the distinction between rest and struggle.

Within this survival mode, hope transformed from a passive feeling into an active, taxing practice. This aligns closely with the insights of medical anthropologist Cheryl Mattingly [61], who frames hope as a paradoxical and laborious exertion. To endure their overwhelming reality, parents continuously 'worked' at hoping, often using time as a survival tool and clinging to imagined milestones. While this structured, daily exertion was necessary, it was also paradoxically fragile. Because this hope was so intimately tied to their vulnerability, the failure of a milestone to bring improvement resulted in more than mere disappointment. Instead, for many, this fragile hope shattered, giving way to a profound realisation that the crisis was far from over.

In order to endure these relentless demands, parents at times described emotionally distancing themselves from the child, perceiving the infant less as a subject of love and more as an object of misery. This form of dehumanisation refers to the process by which an individual is seen or treated as lacking essential human qualities [62, 63].

The survival mode leaves deep somatic and psychological traces. In line with the review by Botha et al. [22], parents frequently struggle with embodied hypervigilance, negative emotions, and a disorienting temporal rupture that continues to affect daily functioning even when the child is absent.

Moral injury and the erosion of relational selfhood

This survival mode not only shapes daily actions but profoundly disrupts parents' ethical self-conception and

relational positioning. Rather than viewing this simply as a crisis of a broad "parental identity", our findings point to a deep fracturing of the moral and sociocultural scripts that govern modern parenting. Within the contemporary Western European context, early parenthood is heavily influenced by the ideology of 'intensive parenting'. This dominant ideology, particularly the 'good mother' trope, demands child-centred, expert-guided, emotionally absorbing, labour-intensive, and highly gendered care [32, 64, 65]. When parents encountered an infant unresponsive to typical soothing, it shattered their ability to cultivate what Thomas [66] describes as a 'positive imaginary', the culturally scripted, joyful narrative of what having a child should look like. Measured against the exacting standards of intensive parenting, the child's distress was frequently internalised as direct proof of personal and moral failure. This destructive internalisation, which was particularly evident among mothers, embeds a profound sense of guilt within the parent's relational selfhood [67]. It results in what Sutherland [68] describes as a spiral of guilt and shame, where the boundary between the child's distress and the mother's self-worth becomes entirely blurred. Conversely, facing this same fracturing of scripts, some fathers attempted to protect their sense of self by compartmentalising different life domains, with work sometimes functioning as a form of 'escape'.

Previous research by Barr et al. [25, 26] demonstrates that inconsolable crying can increase frustration to such an extent that it becomes a risk factor for child maltreatment, aligning with literature on parental burnout [69]. Our results complement this by emphasising the parent's inner ethical conflict: the painful awareness that extreme exhaustion pushes them toward harsh impulses fundamentally clashes with their core values of care and protection. This dynamic can be understood as a moral injury [70]; psychological harm occurring when an individual's behaviour conflicts with their deepest ethical convictions.

Parents often described that their relational selfhood and moral positioning did not simply return to their original state. For most families, a persistent sense of vulnerability remains an ongoing reality. Consequently, the narrative of 'recovery' for these families does not point to a completed positive transformation, nor does the data robustly support a neat trajectory of 'post-traumatic growth' [71]. Instead, the aftermath of the crisis is experienced as an ongoing, unresolved, and processual negotiation. While some parents do develop a more conscious sense of self and adopt a critical stance towards societal expectations, this meaning-making does not simply erase the past; rather, it is intricately woven together with their lived vulnerability. Ultimately, the data reveals a profound and hard-won resilience in these parents. Rather than a static, completed end-state, this resilience manifests as an ongoing, dynamic strength, a continuous, evolving interplay between navigating past vulnerabilities and forging a newly integrated, deeply empathetic outlook on family life.

Navigating relational and social contexts

The crisis of RP forces families to navigate an increasingly alienating social world, highlighting the severe clash between the raw reality of the home and the stifling normative expectations of society. In the specific Belgian and broader European context, this normative landscape is characterised by the cultural narrative of 'being on cloud nine', an expectation of seamless familial bliss, coupled with highly performative postpartum traditions and the structural demands of the dual-income/dual-care model [72].

Within this systemic framework, the struggle for balance is profoundly gendered. The limited paternity leave in Belgium functions as a structural mandate that forces fathers back into the labour market. Our findings show that fathers often used this structurally mandated 'breadwinner' role as a necessary mental buffer, utilising their spatial mobility to maintain dimensions of their professional selfhood beyond the caregiving crisis. In contrast, mothers frequently experienced an inevitable shrinking of their world, spatially and emotionally trapped in an isolating 24/7 care reality. In contemporary contexts, maternal competency is increasingly associated with a mother's mobility and her capacity to provide access to external opportunities for her child. In contemporary contexts, the ideal of the 'good mother' extends beyond the home; maternal competency is increasingly associated with being active in public spaces and providing the child with external, developmental experiences [65]. Consequently, being confined to the home with an inconsolable infant represents a painful disruption of this active, modern maternal ideology. This spatial and gendered divergence leads to profound relational asymmetry and parallel loneliness, a condition in which both partners simultaneously 'sink' and lose the capacity to support one another. Ideally, effective dyadic coping serves as a buffer against such stress. As Bodenmann [73] argues, it functions as a crucial protective factor by fostering mutual trust and reinforcing the belief that partners can rely on each other. Couples who are able to construe the distress associated with raising a child with RP as a shared challenge, rather than an individual burden, successfully activate this dynamic. However, when couples lose the capacity to 'hold each other's hand' and effectively cope together, they experience a fundamental disconnection. In these instances, the partner relationship ceases to be a protective buffer and instead becomes an additional source of conflict and isolation [74–76].

Furthermore, the path toward social isolation is deeply embedded in sociocultural logics. Rather than stemming from malice, trivialising remarks (e.g., "all babies cry") or simplistic, solution-oriented advice often reflect a broader sociocultural logic: society heavily relies on the normalisation of infant crying to manage collective anxieties surrounding early parenthood. This tendency to offer quick fixes is deeply embedded in a sociocultural paradigm that frames parenting as a manageable project, assuming that 'correct' techniques inevitably yield quiet babies. However, there is a profound disconnect between this societal logic and the parents' lived experience. Despite the lack of malicious intent, parents often perceive these quick fixes as intense criticism, aligning with Muller et al. [38] and Botha et al. [22] who describe how parents in these situations feel constantly judged. In individualistic societies that privatise care and place exclusive responsibility on parents [36], this creates a profound sense of alienation. Here, the interactions with both the social network and professional providers become crucial. As Neumann et al. [77] demonstrate, care provider behaviours actively and profoundly shape parents' identities as 'good parents' to their struggling child. When professionals or peers dismiss the distress as a lack of routine, they inadvertently reinforce the parents' internalised sense of moral failure. Ultimately, this dynamic pushes families into defensive isolation, a necessary retreat to protect themselves from the pain of continuous misunderstanding [78, 79].

Ultimately, our findings indicate that effectively supporting these families does not lie in offering pragmatic solutions to 'fix' the infant, but in providing radical, structural recognition. In accordance with the stress-buffering hypothesis [80], the value of support depends on its perceived quality [81]. Recognition, whether through validating interactions with care providers [77] or by social sharing of emotions [82], functions as an active validation of an objectively untenable reality. It transforms the experience of exhaustion from an individualised moral failure into a collectively acknowledged struggle, serving as the essential buffer [74, 75, 83] needed to draw parents out of their isolation and restore a sense of shared humanity.

Limitations, methodological reflections and future research

The current study is characterised by several limitations, some of them could be addressed in future research. Firstly, only families in which parents were willing to share their experiences and provide insights into that period of their lives were included. This criterion ensured that the interviews contained sufficiently rich data for IPA. However, there is a risk that parents who were not willing to participate might feel more distressed, and thus might provide different insights into how they cope as a family. Secondly, for conducting IPA, a relatively homogeneous sample is required [84]. Consequently, the study focused exclusively on mother-father families in which both parents were still in a relationship at the time of the interview. This selection likely reflects the coping strategies of relatively stable and well-functioning couples, potentially excluding families experiencing ongoing relational difficulties. Future research could explore the experiences of single-parent families, same-gender couples, and separated parents, as their coping strategies may differ from those described in this study. Nevertheless, the accounts of the couples included in our study are highly informative for gaining a deeper understanding of the complexities of raising a child with persistent and severe RP. Thirdly, our sample consisted of cohabiting, highly educated parents living in Belgium. However, it is plausible that the experiences of parents with different educational backgrounds or from other cultural and geographical contexts may differ. Fourthly, a methodological consideration of this study is its reliance on retrospective accounts. From an interpretative perspective, we acknowledge that this approach captures parents' current sense-making of past events, rather than the immediate, concurrent reality of the crisis. The temporal distance inevitably shapes how these narratives are constructed, as parents interpret their past distress through the lens of their present circumstances. While this means the 'raw' lived moment is inaccessible, this process of recall is a normative component of qualitative inquiry. Furthermore, consistent with observations in other empirical IPA studies [85], we found that this temporal distance afforded parents the necessary space to reflect deeply and reframe painful experiences, yielding rich insights that might not have surfaced during the crisis itself. Fifthly, it is important to note that these findings reflect the experiences of families whose infants experienced prolonged RP and who eventually accessed tertiary care. As such, they primarily illustrate the challenges faced in highly stressful home environments where timely and adequate support was lacking. Lastly, for future research, it would be relevant to explore how both the social network and professional caregivers perceive the situation of these families and what their perspectives are, given the significant influence of the family's social environment on how this period is experienced.

Implications for policy and practice

Several implications can be derived from our study results. Our findings demonstrate that the impact of severe RP in infants can extend across multiple domains, significantly affecting parental well-being, family dynamics, and social life. It is crucial to avoid the negative, self-reinforcing cycle in which these parents may become trapped. Navigating support systems and gaining societal

understanding presents significant challenges for families, particularly because the term 'regulatory problems' is not widely recognised by the general public [86]. Moreover, there remains a need for further education among healthcare providers. Early identification of families struggling to cope with an infant with RP, as well as timely assessment of risks related to potential abuse, is also of critical importance. Hence, recognising infant RP as a condition that affects both the child and the parents is an essential first step, and support should therefore be provided at both levels [11]. Empowering parents to develop their own coping strategies and to respond positively to their infant's behaviour appears to be a recommended approach. Additionally, promoting realistic expectations of parenthood may help reduce feelings of guilt and mitigate unrealistic parental expectations. Moreover, from a therapeutic perspective, it may be valuable to strengthen the process of effective dyadic coping by externalising the stressor, as proposed in narrative therapy [87]. By separating the stressor from one's sense of self, couples are enabled to confront the external stressor together. Such reframing can create space to identify triggers, deepen mutual understanding, and reshape the narrative of the stressor in ways that foster healthier patterns within the relationship. Furthermore, our findings underscore the importance of a responsive environment in which both informal networks and professional caregivers are attentive to the needs of families, acknowledge their experiences, and refrain from offering unsolicited or judgmental advice. Social support proves to be of exceptional importance in reducing the isolation often experienced by these families and in fostering a more supportive environment. Local initiatives have already been launched to implement this approach at the neighbourhood level, such as the 'Village Dates' project [88]. Public policy can also play a role by strengthening local support networks, reducing the stigma associated with seeking help, and fostering a sense of community around parents. Finally, the current leave policy in Belgium provides 20 days of paternity leave for fathers and co-parents, and either 12 weeks (for self-employed mothers) or 15 weeks (for employed mothers) of maternity leave. Beyond these entitlements, parents may also take parental leave; however, this leave is compensated only through a limited flat-rate allowance for employees and is entirely unavailable to self-employed individuals. Together, these arrangements often pressure parents to return to work prematurely. In contrast, Scandinavian countries actively support work-life balance by encouraging both parents to take parental leave with up to 80% income retention, which is an important distinction from the Belgian system [89]. Expanding birth and parental leave could be an effective first step toward a more equitable division of work and caregiving responsibilities between mothers and fathers [72]. We hope that this study contributes to a deeper understanding of the lived experiences of families in crisis raising a child with RP, and that it may help foster the development of supportive environments tailored to their specific needs. As the saying goes, "It takes a village to raise a child", but in the case of children with RP, one might argue: "It takes *a whole society* to raise a child with RP!".

Conclusions

This study explored the everyday lived experiences of families in crisis raising a child with persistent and severe RP, an experience that could not be understood merely in terms of stress or fatigue but rather as an existential rupture that disrupted everyday life. Parents entered a complex grieving process, marked by the loss of future perspectives, erosion of identity, and the manifestation of a mere functional presence instead of the expectation of engaged parenthood. The burden of care led to a crisis in fundamental relationships and moral self-image, as survival instincts gradually displaced care. Traditional gender roles intensified this pressure: fathers often sought refuge in work, while mothers remained confined to an isolating, continuous caregiving reality, exacerbating tensions between partners. Social isolation emerged through a combination of external minimisation and internal reluctance to display vulnerability, causing families to drift further from their social environment. Finally, the crisis did not mark a closed chapter; its enduring impact ranged from a persistent sense of vulnerability and loss to the gradual emergence of resilient wisdom. This study underscores the vital need for societal recognition, accessible social support systems, and responsive government policies to support families navigating infant RP.

Abbreviations

RP	Regulatory problems
IMH	Infant Mental Health
IPA	Interpretative Phenomenological Analysis
MFMIA	Multi Family Member Interview Analysis
Co-PRIME	Co-regulation as the foundation of PReventive Infant MEntal health care
kleine K	Infant Unit of the University Psychiatric Centre of Leuven

Supplementary Information

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Supplementary Material 1.

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Authors' contributions
FH conceptualised the study, with iterative feedback from SDB, GVH, EW and KP. FH developed the interview guide, with iterative feedback from SDB, GVH, EW, KP, MD and BRHVdB. BS and FH were involved in the recruitment of participants. FH and SDB conducted the interviews, eight interviews were conducted by SDB and FH together and four interviews were conducted by FH alone. FH transcribed and coded the data. The qualitative data analysis was conducted with iterative feedback from MH and SDB, and it underwent an external audit by DS. FH took the lead in writing the manuscript. Feedback was provided by DS, MH, SDB, GVH, EW, KP, MD, BRHVdB, BB and BS. FH prepared the tables. All authors read and approved the final manuscript.

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Data availability
The datasets used and/or analysed (e.g. coded transcripts) during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate
The study was conducted in accordance with the Declaration of Helsinki and was approved by the Ethics Committee of the University of Antwerp, Belgium (protocol code: SHW_2023_307). Participation was confidential, voluntary, and written informed consent was obtained from all participants involved in the study.

Consent for publication
Written and verbal informed consent was obtained from all participants prior to the interviews.

Competing interests
The authors declare no competing interests.

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