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Parenting Behaviors of Mothers with Hospitalized Children under Two Years of Age

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PARENTING ACTIVITIES OF MOTHERS WITH CHILDREN IN THE HOSPITAL

ABSTRACT

Diana Dawson

Parents, most often mothers, have been rooming-in with their children for more than a decade, yet their actual caretaking role in the hospital remains largely undefined. An exploratory descriptive research study using Johnson's Behavioral System Model for nursing was designed to examine the parenting behaviors of mothers with hospitalized children under two years of age. The purpose of this study was to identify and describe the actual and desired maternal parenting behaviors used by mothers in the hospital and factors that mothers perceived as influencing these behaviors. A convenience sample of six mothers whose children required hospitalization for a common pediatric illness was evaluated. Data were gathered through the use of a semi-structured interview guide and a behavioral observation checklist. Each observed behavior was scored as one point. Four serial observations were performed over a 36-48 hour period. Each observation lasted a total of 30 minutes and provided 15 minutes of recorded observations. An interview took place with each mother following the final observation. The average interrater reliability for the behavioral checklist was found to be 88.7 percent. Five categories were used to group the behaviors: nurturing, non-nurturing, protective, stimulating, and non-stimulating. The most frequently observed behaviors were protective and non-stimulating, with mean scores of 14.18 and 13.50, respectively.

The least frequently used behaviors were non-nurturing, with an average score of .21. These findings were validated by interview data. Analysis of interview data also suggested that although mothers enacted most of the behaviors they wished to do, they experienced discomfort with their role in the hospital. Possible sources of discomfort stemmed from the inability "to do" entirely for the child, ambivalence toward nurses, uncertainty interpreting the child's behavioral cues, their patient advocacy role, unfamiliar hospital routines, and disruption of family routines. Mothers reported a strong desire to parent their children and generally assumed their parenting roles with little hesitation. However, at the same time, mothers reported receiving inconsistent support and guidance from nurses for their parenting role. The findings of this study suggest the need for nurses to provide more consistent support and guidance to mothers, be more available and actively involved in the care of the mother and child, and facilitate the mother's contact with the well siblings at home. In addition, nurses need to familiarize mothers to the hospital setting and routines and provide updated information concerning their children's care so that mothers can achieve a level of comfort that enables them to parent their children to the best of their ability.

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CHAPTER I

INTRODUCTION

Hospitalization of a child for any reason can be a frightening and overwhelming experience for both parent and child. The strange hospital environment with its unfamiliar procedures and routines are major sources of stress and anxiety for both parent and child (Freiberg, 1972; Issner, 1972; Prugh, 1972). The event of hospitalization with its threatening environment disrupts the parent and child's usual living patterns and increases the child's need for support by the parent. Due to the infant's and young child's limited cognitive and emotional capabilities, the parent plays a significant role in helping her/him deal effectively with stresses inherent in the hospital setting (Erickson, 1965). However, hospitalization is an anxiety-producing and stressful experience for the parents as well and may hinder their ability to provide this support (Skipper, Leonard, & Rhymes, 1968).

Previous research indicates that parents, especially mothers as primary caretakers of children, experience tremendous stress and anxiety related to the following: lack of information about diagnosis and procedures, fears about procedures and treatment (Freiberg, 1972), appearance of their child (Lewandowski, 1980), competency of the physical care the child will receive (Smitherman, 1979), strange and new hospital environment, uncertain outcome of the child's illness, and

change in their parenting role (Miles, 1979). Feelings of guilt, inadequacy and helplessness related to the young child's illness, and need for hospitalization are frequently experienced by mothers (Hardgrove & Dawson, 1972). Parents' abilities to participate actively in their child's care alleviates some anxieties and diminishes the negative feelings they are experiencing (Fillmore, 1956; Jackson, Bradham, & Burwell, 1978; Miles, 1979).

Numerous studies have recognized the mother's need to maintain a role in caring for her child (Baty & Tisza, 1956-1957; Fillmore, 1956; Jay, 1977; Miles, 1979). Few studies have examined the activities and behaviors that mothers actually want to utilize in caring for their hospitalized child during the hospital stay (Hill, 1978; Jackson et al., 1978; Merrow & Johnson, 1968). If this knowledge were available to nurses, then they would be better able to facilitate the process by which mothers continue the parenting role in the hospital.

Most literature focuses on the disruption of parenting routines during hospitalization for specific populations, such as chronic illness, pediatric intensive care units, and operative procedures. However, the parenting patterns of mothers whose children must be admitted to a hospital for an acute illness has not been studied. Therefore, this study will focus on mothers of children admitted to the hospital for gastroenteritis and respiratory illnesses.

Problem Statement

A certain amount of stress and anxiety is experienced by parents when their child's condition necessitates hospitalization. Surrendering care of the child to the medical and nursing staff results in varying

degrees of parental role disruption and uncertainty during the hospitalization period. It is assumed that parents, especially mothers as primary caretakers, will utilize certain maternal parenting behaviors in the hospital and may be encouraged or inhibited by environmental factors from assuming other behaviors.

This study proposes to identify and explore the parenting behaviors actually utilized by mothers during hospitalization of their child, the extent to which these behaviors reflect behaviors mothers desire to utilize, and mothers' perceptions of factors that influence the selection of their behaviors.

Objectives of the Study

The objectives of this study are to:

1. Identify the behaviors mothers utilize while caring for their children in the hospital.

2. Establish whether mothers' actual behaviors reflect the behaviors mothers would like to use in their children's care.

3. Identify the process by which the mothers decide which behaviors they will utilize in caring for their children.

4. Identify the extent to which nurses influence the actual behaviors utilized by mothers.

Significance

When a child's condition necessitates hospitalization, mothers experience a great deal of stress and anxiety. Although they may initially experience a sense of relief at surrendering the responsibility of caring for the ill child to the more highly skilled

nurses, this initial reaction is quickly followed by vague feelings of guilt, helplessness from her inability to continue to protect her child, and inadequacy in her caretaking skills (Baty & Tisza, 1956-1957; Hardgrove & Dawson, 1972). These maternal needs are superimposed onto the highly stressful and anxiety-producing event of hospitalization. Studies indicate that if the needs of mothers are not met, they may be unable to support their child adequately. It is suggested that parental anxieties may be transferred to the child, increasing the child's anxieties and possibly delaying the recovery process (Roskies, Bedard, Gauvreau-Guilbault, & Lafortune, 1975; Visintainer & Wolfer, 1975).

Providing opportunities for a mother to participate actively in her child's care lessens her anxieties and increases her confidence as primary caretaker. Active participation allows her to provide the comfort needed by the child to deal more effectively with illness and the hospitalization experience (Baty & Tisza, 1956-1957; Bright, 1965; Fillmore, 1956; Jackson et al., 1978; Mahaffy, 1964). Nurses are in a position to promote and encourage mothers to be involved in their children's daily care as much as possible. For nurses to be knowledgeable and support mothers in their parenting role, however, information concerning the caring activities mothers actually perform and those activities they would be willing to perform needs to be available to nurses.

The transitional period during which mothers are learning and assuming their new role of parenting the ill child in the hospital can be a time of confusion and frustration for both mothers and nurses. There is clear indication that nurses frequently underestimate the

amount and diversity of care mothers are willing to provide for their children (MacDonald, 1969; Merrow & Johnson, 1968).

This study will seek to identify information concerning the mother's role in the hospital during her child's hospitalization for an acute, common pediatric illness. The amount and types of care that mothers actually provide will be described. Activities mothers would like to provide for the child and factors, as perceived by mothers, that influence their role assumption during hospitalization will be explored. This information will benefit the parent, child, and nursing personnel and should result in a more positive hospitalization experience for mother and child.

Assumptions

The primary assumptions upon which this study has been founded are the following:

1. Immediately upon hospitalization of the child and during the hospitalization period, mothers experience varying degrees of role disruption and uncertainty regarding the parenting role.

2. Mothers of hospitalized children desire to re-establish their parenting role during the child's hospitalization.

3. Mothers will attempt to re-establish their parenting role as they feel comfortable to do so during the hospitalization period.

4. The extent to which mothers re-establish their parenting role will be influenced by the mother's perceptions of the nursing personnel's support of the activities necessary to do so.

5. As a result of the child's illness, as well as the therapy instituted for treatment, mothers of children under two years of age

experience stress and anxiety related to the inability or difficulty in feeding and comforting the child in the usual manner.

6. Observations performed by the investigator will not influence the amount and types of care the mother will provide for her child in the hospital.

Definitions

Definitions for the terms utilized in this study are as follows:

Maternal parenting behaviors - the actions and/or skills utilized by mothers in providing care for their child to sustain and nurture the child's growth and development. These behaviors include, but are not limited to, the following: nurturing activities, such as feeding, bathing, and dressing the child; providing positive verbal and nonverbal responses to the child; intervening appropriately and being sensitive to the child's various physical, mental, and emotional states; and providing as safe an environment as possible.

Actual maternal parenting behaviors - the observed parenting activities performed by mothers during hospitalization of their child.

Desired maternal parenting behaviors - self-reported parenting activities which mothers of hospitalized children indicate they would have liked to perform during hospitalization of their child.

Mother - biological or adoptive female parent.

Nurturing behaviors - observable maternal actions that provide the child with appropriate responses and/or supplies (Johnson, 1980).

Protective behaviors - observable maternal actions that shield the child from a real or potential threat or noxious stimuli (Johnson, 1980).

Stimulating behaviors - observable maternal actions that enhance the child's growth and prevent stagnation (Johnson, 1980).

Limitations

Possible limitations to the procedures proposed in this study are:

1. The effect of environmental conditions due to the interview being performed at the child's bedside in the hospital, such as the presence of others in the patient's room and the child's physical and emotional state at the time of interviewing the mother.

2. The mother's physical and emotional state, such as fatigue and anxiety related to the child's illness.

3. Response sets of the mother regarding her perception that she should be feeling, thinking, or behaving in a certain manner.

4. The Hawthorne effect resulting from the observer's presence in the patient's room.

5. Lack of control for history of previous hospitalizations or hospital experiences by the mother and/or child.

CHAPTER II

REVIEW OF RELEVANT RESEARCH AND LITERATURE AND CONCEPTUAL FRAMEWORK

Parenting

Parenting and the primary behaviors and functions of the parental role have been described by numerous authors. Multiple views of these behaviors and functions have been generated from the various approaches and particular focuses taken by researchers. Callahan (1974) viewed parenting as "a temporary mandate, a provisional responsibility, an irreversible but one-way commitment that must operate primarily for the advantage of the child's development" (p. 106). Consequently, one of the primary functions of parenting from a developmental perspective, then, is protection of the child from environmental dangers and other individuals who may pose a threat to the child's development.

An additional aspect of parenting frequently studied by researchers is the process and ability of the mother to incorporate the parental (maternal) role. Frequently, the primary focus of these studies is the mother/infant interaction (Rubin, 1961; Sander, 1962; Yarrow & Goodwin, 1965). The mother's skill in learning to read her infant's behavioral cues is considered an important aspect in promoting a positive mother/infant interaction and parenting experience (Millor, 1981).

A large body of literature and research has been reported that describes the general behaviors and skills that new parents must attain and utilize after the birth of their child to promote a positive parent/child relationship (Bishop, 1976; Iorio, 1968; Rubin, 1961; Sumner & Fritsch, 1977). These behaviors and activities may be categorized into two basic groups: nurturing activities and guiding behaviors. Nurturing activities encompass the basic caretaking skills such as feeding, bathing, and dressing the infant, as well as emotional needs such as love and comforting. Guiding behaviors include limit-setting and enforcement of limits, positive reinforcement for desirable behavior, and stimulation for cognitive growth (Iorio, 1968).

For most mothers, feeding is the first mothering activity they undertake to nurture their infants. Developing the feeding skills and techniques individualized to the infant is an important task and, due to its direct relationship to the growth and development of the infant, feeding practices become a highly significant aspect of the parental role (Iorio, 1968; Pridham, 1981). Dunbar (1977) observed mothers during the first four days after delivery and found that success at feeding the infant was a major determinant in most mothers' perceptions of their competency in the maternal role.

All of the basic caretaking activities and the ability to attain skill in each of them provide mothers with parameters for measuring the degree to which they fulfill the parenting role. Therefore, when the infant and mother have difficulty becoming synchronized with one another or the mother has difficulty understanding the infant's behavior, these difficulties cause the mother to question her role competency. Sumner and Fritsch (1977) used a survey to explore the specific needs and

timing of those needs expressed by the mothers during the first six weeks after delivery. Their results suggested that questions concerning infant care peak at approximately two weeks, rapidly falling off from that point. Of note is the fact that the highest percentage of questions were about feeding (31%), followed by questions concerning "gastrointestinal" disturbances (21%). Information regarding the infant's skin care, sleeping, and crying was sought less frequently.

During the first several months of life, one of the major tasks of parents is to learn to interpret the infant's cues in order to be able to satisfy the infant's needs. At this time, the infant is completely dependent on others to provide her/him with the food, physical care, warmth, and touch so necessary for further growth and development. Consistent provision of this basic, yet essential, care facilitates the development of the infant's sense of trust in others (Friedman & Friedman, 1977).

As the infant becomes more interactive with the environment and significant others, her/his needs go beyond the basic care described previously. The infant needs to be increasingly involved in physical, psychosocial, and cognitive activities in order that new development tasks can be achieved. Parents need to provide appropriate learning toys, a safe area in which the infant can practice newly-developing motor skills, and periods of interactive play and verbal communication (Stone & Church, 1975).

During the second year of life the child remains emotionally dependent on her/his parents and continues to need their consistent love and support. However, at the same time the child is becoming more independent and autonomous, developing skill in communication and

ability to use language, and attaining greater control over motor functions. Consequently, parents are faced with the challenge of continuing to set limits without stifling growth and development as well as provide safety and security while promoting autonomy and independence (Friedman & Friedman, 1977). In addition, they continue to be concerned with providing the child with the basic care she/he needs. Subsequently, when the parents are unable to satisfy their infant's or child's needs for whatever reason, this inability to meet their child's needs becomes a significant source of concern and anxiety.

Parenting the Distressed Child

The ability to comfort a distressed infant is a significant aspect of parenting and has been a topic of study by various researchers. Research suggests that the most frequent behaviors utilized by mothers to comfort their infants involve close physical contact such as picking up and holding and/or feeding the infant. Bell and Ainsworth's (1972) study on primiparas showed that at least half of the comforting interventions utilized involved close physical contact with the infant. Bernal (1972) used observations and interviews to study primiparas and multiparas. She found that 69 percent of the primiparas and 89 percent of the multiparas intervened by feeding the crying infant. Thirty mother/infant pairs were observed by Dzik (1979), and her findings showed that 65 percent of the maternal responses elicited by infant distress behaviors were satisfying responses and 74 percent involved comforting in the form of cuddling, rocking, or patting the infant. In addition, the author noted that each mother responded with a particular technique individualized to her infant.

Holaday (1981) observed six chronically ill infants and their mothers in a longitudinal study. The author compared these mothers' responses to their distressed infants to 26 well infants and their mothers. She found in both groups that the most frequent intervention in response to the distressed infant was to pick the infant up. Additionally, the mothers of chronically ill infants responded more quickly and more often to crying, frequently keeping the infant in close proximity in order to visualize her/him more easily.

These studies clearly indicate the importance of mothers being able to hold and/or feed the infant to comfort her/him. The findings of these studies are especially significant for the reason that, frequently, the ill and crying infant is taken from the mother upon admission to the hospital and restrained in bed in order to carry out medical treatment. These practices prevent the mother from providing the appropriate and individualized comforting behaviors to her distressed infant.

Parenting the Hospitalized Child

The interaction between the parent and child dyad is unique, and the manner in which the infant or young child is bathed, fed, and comforted is very individualized. At a young age, infants are aware of differences between caretakers and the way they are cared for and comforted (Dzik, 1979; Scipien, Barnard, Chard, Howe, & Phillips, 1975). The child comes to depend on a consistency of care to meet her/his daily needs. The parents take pride in their abilities and have a mutual need to provide and fulfill the needs of their child.

Illness in the infant or young child places tremendous stress on the parents, putting to test many of the skills they have attained as part of their parenting role. If the condition of the infant or young child necessitates hospitalization, this places additional stress on the parents (Erickson, 1965). In addition to the anxiety produced by the event of hospitalization, parents commonly feel they have failed to care for their child properly and through this neglect the child has become ill. Subsequently, they blame themselves for not being able to protect the child and feel guilty and/or inadequate as they surrender the care of the child to others (Fillmore, 1956; Freiberg, 1972; Hardgrove & Dawson, 1972; Issner, 1972; Lewandowski, 1980). These feelings become a source of anxiety to the parents as well.

Four additional sources of anxiety listed by Scipien et al. (1975) are concern for the child's recovery, the hospital environment, sense of guilt and inadequacy for not having recognized and cared for the child's illness more competently, and subordination of the mother to the nurse with subsequent loss of confidence in mothering skills. Freiberg (1972) interviewed mothers several days after their child's discharge. She found that the three major causes of anxiety during hospitalization were related to lack of information about diagnosis, lack of information about procedures and treatment, and fears about procedures and treatments.

Miles (1979) identified similar causes of anxiety in parents, based on her clinical experience and interviews with parents in the pediatric intensive care unit. She found that fears about the outcome of the child's illness, the new and strange hospital environment, and changes in the parenting role were three major stressors experienced by parents.

Observing parents in the pediatric intensive care unit, Jay (1977) found that parents became immobilized by anxiety and unable to care for their child, were uncertain about their role as a parent, and lacked knowledge about their rights as parents. Although the author often successfully implemented nursing interventions based on her analysis of these observations, it was unclear whether any validation of her observations, either with other nurses or the parents, had been obtained other than similar findings in previous research.

In the majority of studies reviewed, it was recommended that nurses encourage mothers to actively participate in their child's care and support the mothers as they re-establish their role as a parent. Theoretically, the opportunity for mothers to be actively involved provides them with more control in such a threatening environment and lessens the amount of anxiety they experience (Baty & Tisza, 1956-1957; Fillmore, 1956; Hill, 1978; Hymovich, 1976; Jackson et al., 1978).

Jackson et al. (1978) interviewed 31 parents to determine in which activities they would like to participate. Criteria for sample selection included 1) children who were conscious, not in critical condition, and under 10 years of age, 2) parents who planned to stay throughout their child's hospitalization, and 3) voluntary parental participation. The activities were placed into three categories: nurturing (feeding, bathing, comforting), medically related (taking temperatures, giving medications), and one housekeeping duty (changing bed linen). The majority of parents wanted to perform the nurturing activities, a smaller number wanted to be involved in the medically-oriented tasks, and the majority did not want to change the bed linen. This study was conducted on a unit composed completely of private rooms,

which is not the usual situation and may have positively influenced the responses given by the parents. Nevertheless, the opportunity for the parents to participate in the child's care did lead to an increase in parent satisfaction with the child's care as well as a reduction in the amount of stress they experienced.

In a similar type of study, Hill (1978) interviewed 18 mothers at a university teaching hospital in order to identify those activities for which mothers would like to be responsible. Criteria for sample selection were children between the ages of one and four years, having no mental or physical handicap, and who were not seriously ill or unconscious. She categorized 37 activities into comforting measures, activities of daily living, and therapeutic measures. Based on all 37 activities combined, the author found that, overall, 78 percent of the mothers wanted to participate in their child's care, with 11 percent of the group desiring nursing supervision. Data obtained for the three categories showed that the majority of the mothers wanted to participate in the activities listed in each of the three measures, with percentages ranging from 94 percent to 61 percent, with varying degrees of desired supervision.

Merrow and Johnson (1968) studied the discrepancy between the amount of care a mother was willing to provide and the nurses' perceptions of the degree to which mothers wanted to be involved. The sample was obtained from two pediatric wards in general hospitals. No specific criteria for either mothers or children were used for subject selection. The authors administered a questionnaire composed of 30 child-care activities to 50 mothers. They found there was complete agreement between the mothers and nurses on those items related to basic

child-care activities (feeding, bathing, comforting). The two groups were almost in complete agreement on those items that the mothers would prefer not to do, such as giving medication by injection and taking blood pressures. Statistically significant differences between mothers and nurses were found on several activities mothers were willing to perform, including restraining the child for examination and painful procedures, feeding and/or bathing the child in a mist tent, and feeding and/or bathing the child with an intravenous infusion. Many changes in hospital practices have occurred in the area of parental participation since this study was performed. Therefore, what may have been significant then may not be now, and replication of this study could provide additional valuable information.

It is not surprising, then, that mothers often experience confusion due to unclear expectations of what the parent's role is in the hospital on the part of both the mother and nurse. Roy (1967) proposed that if mothers were given cues by nurses related to their role in the hospital, then they would function at a higher level of adequacy in caring for the hospitalized child. The level of adequacy was determined by the ratio of self-initiated, appropriate actions performed by the mother in response to needs manifested by her child to the total number of needs manifested by the child during a given time period. Using an experimental design, role cues were introduced to mothers by nurses to varying extents. Observation and interviews were utilized to obtain data for a sample of 30 mothers. Data were collected on a pediatric ward in a private, general hospital. The sample included mothers who could participate in the study early in their child's first hospitalization and excluded the first day of admission and children who

were critically ill or within six hours of a major surgical or medical procedure. The findings indicated that introduction of role cues did, in fact, contribute positively to the mothers' levels of adequacy in caring for their hospitalized children.

To summarize, the review of literature demonstrated that mothers desire to actively participate in the various aspects of their children's care, including basic caretaking activities, comforting activities, and therapeutic/medical activities, to re-establish their parenting role during hospitalization (Hill, 1978; Jackson et al., 1978; Merrow & Johnson, 1968). Research suggests that conflict exists between the major activities in which mothers would like to be involved and those activities they actually perform (Merrow & Johnson, 1968). In addition, little information is available for nurses to utilize in assisting parents to re-establish the parenting role in the hospital. Consequently, confusion and uncertainty exist in both nurses and mothers concerning the mothers' role in the hospital. Furthermore, little has been written concerning the parents' specific responses to hospitalization of their children for the treatment of common pediatric illnesses.

Respiratory Illnesses

Respiratory tract infections are one of the most common causes of illness in the young pediatric population. On the average, most infants and toddlers have between seven and eight respiratory infections per year. The two most common respiratory illnesses are bronchiolitis and pneumonia. In the majority of these cases, the etiology of the disease is a viral agent, particularly the respiratory syncytial (RS) virus

(Couvreur, 1982; Simkins, 1981). In bronchiolitis, the RS virus has been implicated in approximately 50 percent of the cases. The remaining portion are due to the parainfluenza virus, the Eaton agent (mycoplasma), and various adenoviruses (Vaughan & McKay, 1975).

Acute bronchiolitis occurs predominantly in children under two years of age, with 70-80 percent of the cases taking place during the first six months of life. The incidence of the disease is highest in the cool months during winter and early spring. The illness is more prevalent in families with crowded living conditions and in the lower socioeconomic classes (Couvreur, 1982).

The pathophysiologic changes that occur in bronchiolitis are due to invasion of the cells by the virus. Edema and accumulation of mucous and cellular debris result in bronchiolar obstruction and air trapping (Simkins, 1981; Vaughan & McKay, 1975). Oftentimes the infant or young child begins with mild upper respiratory symptoms that last several days. Gradually, signs of increasing respiratory distress develop and she/he presents with dyspnea, wheezy cough, irritability, decreased appetite, and difficulty in feeding. Presence and extent of a fever is variable, and the infant may even be hypothermic. In-hospital treatment is usually supportive and consists of cool mist, oxygen therapy, and adequate hydration with intravenous fluids (Couvreur, 1982; Scipien et al., 1975).

Pneumonia in infants and young children may have either a viral or bacterial etiology. However, viral pneumonia occurs more frequently in this age group. Frequently, the causative agent is the RS virus, and it may result in severe respiratory infections in young infants, often requiring hospitalization. Other agents associated with viral pneumonia

in children are influenza viruses, adenoviruses, varicella, and cytomegalovirus. Viral pneumonia is usually preceded by a cough and rhinitis lasting several days. These symptoms are followed by a fever up to 40° C, a dry, irritating cough, and varying degrees of dyspnea. The age of the child will influence the severity of the illness and extent of the symptoms, the younger ages being more severely affected (Pinney, 1981).

Bacterial pneumonia occurs less frequently in the younger pediatric population and is seen mainly after three years of age (Couvreur, 1982). The major organisms responsible for the illness are Pneumococcus, Streptococcus, and Staphylococcus (Pinney, 1981). The pathophysiologic changes that occur in the respiratory tract will differ depending on the causative agent. Usually involvement is localized to one or more lobes or parts of the lobes. However, in some infants, diffuse bronchial involvement may occur without localization. Frequently, bacterial pneumonias are preceded by viral upper respiratory infections with symptoms of upper airway congestion and diminished appetite (Vaughan & McKay, 1975). This is followed by increasing respiratory distress, elevated temperatures between 39.4° to 40° C and a dry, painful cough. In-hospital treatment for both types of pneumonia is symptomatic, consisting of antipyretics, increased humidity, adequate hydration, and oxygen therapy, if necessary. In the case of bacterial pneumonias, appropriate antibiotic therapy is also instituted (Pinney, 1981).

Gastroenteritis

One of the most frequently occurring symptoms in young children is diarrhea. This symptom may be either the primary disease or secondary to another disease. In the majority of cases, diarrhea is classified as infectious gastroenteritis and, in the pediatric population, it is second only to upper respiratory tract infections as a cause of illness (Silverman & Roy, 1983). Infectious gastroenteritis occurs most frequently in children less than two years of age, with the highest incidence being in the first year and particularly the first three months of age. Infectious diarrhea is a seasonal illness, with the highest incidence occurring in the cooler months, and is affected by poor health, malnutrition, and poor hygiene (Haider, 1973; Scipien et al., 1975). Due to these factors, it is a major cause of death in underdeveloped countries. However, in industrial countries, infectious gastroenteritis is generally self-limiting and benign, although it still remains a major pediatric problem accounting for 3-5 percent of hospital admissions (Silverman & Roy, 1983). The disease is commonly divided into two subgroups according to etiology: pathogenic gastroenteritis due to Escherichia coli and nonspecific gastroenteritis (viral).

Diarrhea due to E. coli colonization in the intestine accounts for 25-40 percent of the cases of gastroenteritis and occurs most frequently in infants, due to their immaturity and increased susceptibility to E. coli infections (Ironside, 1976; Vaughan & McKay, 1975). The bacteria produces an enterotoxin that results in fluid and electrolyte losses from the small intestine. Onset may be sudden or gradual. In the majority of the cases, children present with projectile vomiting, explosive stools, and abdominal distention. Due to the rapid loss of

fluid, signs of dehydration and metabolic acidosis appear soon after onset. Pathogenic gastroenteritis is the more virulent type of diarrhea and frequently necessitates prompt and vigorous therapy (Scipien et al., 1975; Vaughan & McKay, 1975).

Acute nonspecific (viral) gastroenteritis is responsible for the majority of cases of diarrhea. The causative agent is frequently undetermined; however, adenoviruses, enteroviruses, and rotaviruses have been implicated (Ironside, 1976; Scipien et al., 1975). It is highly contagious and is usually a brief, self-limiting disease. Onset is sudden, and children present with vomiting, fever, frequent stools, abdominal distention, and severe crampy abdominal pain. The majority of the cases are mild and do not result in any significant state of dehydration or acid-base imbalance (Haider, 1973; Scipien et al., 1975).

The pathophysiology in both cases entails inflammation and edema of the intestinal mucous membranes. These changes decrease the intestine's ability to absorb water, electrolytes, and nutrients. In attempts to rid itself of the irritating substances, motility of the intestine increases, resulting in frequent watery, green, mucoid stools. In the cases in which vomiting is also present, rapid depletion of body fluids and electrolyte imbalances occur (Copeland, 1977; Vaughan & McKay, 1975). These infants and young children become irritable and listless and experience a loss of appetite in addition to their vomiting. Furthermore, the frequent loose, acidic stools irritate the skin, which then breaks down quickly, resulting in increased discomfort (Copeland, 1977; Haider, 1973).

In-hospital treatment consists of rehydration measures and providing rest for the bowel. Intravenous fluids are instituted and

oral feedings are withheld until the vomiting ceases and the stools decrease in frequency. This process generally takes 24 hours. Resumption of a diet appropriate for age is gradually started, provided the disease maintains a favorable course.

Conceptual Framework

The conceptual framework for this study is comprised of role theory (Turner, 1970), transition theory (Golan, 1981), and the Johnson Behavioral System Model for Nursing (1980). According to Turner, roles are clusters of activities that divide tasks up among individuals, an example being the family unit and delegation of tasks to certain members of the family in order that they may fulfill their role within the family. One essential element of role is that, once a member assumes a certain role with its cluster of activities, there is little crossing over into another's role. A second major component is that roles occur in pairs, and individuals determine what their particular role is by taking on the role of the other as well as responding to the behaviors exhibited by the individual in the counter-role. These roles are maintained in a dynamic yet stable state. However, inability to perform a role adequately due to conflicting demands of other roles leads to role strain. Any attempts at changing the system of roles in order that a new role can be developed is usually a measure to alleviate this role strain that the individual is experiencing. Role shifts, then, usually occur, and the transitional period that bridges the relinquishing of one role and the assuming of another role - role transition - is defined by Golan (1981) as "a period of moving from one state of certainty to another, with an interval of uncertainty and change in between" (p. 12).

Transitions may be gradual or sudden, permanent or transitory, voluntary or involuntary, irreversible or reversible, anticipated or unanticipated. During this transitional state, there is a period of adaptation, not only for the individual changing roles but also for the surrounding environment in which that individual interacts. There are many persons who will attempt to influence the behavior of the individual in the transitional period. Depending on whether both parties desire the same changes or not, there is the possibility of resistance and/or conflict occurring between them. Golan assumes that the changes in the individual's behavior are a result of the situation she/he is experiencing. Furthermore, the individual attempts to maintain a stable situation by trying to predict the behavior that the other person may exhibit as well as her/his own behaviors.

The Johnson Behavioral System Model (1980) and its focus on behavioral stability is a useful framework in which role theory and transition theory can be applied to the nursing setting. The model assumes that the individual develops seven consistent behavioral patterns: attachment or affiliative, dependency, ingestive, eliminative, sexual, aggressive, and achievement. Each pattern develops in response to a universal goal of behavior. Each of the behavioral patterns are comprised of four structural elements, and these are the drive or goal sought, the set or predisposition to act, the choice or scope of alternatives, and the person's actual behavior. An example of the use of Johnson's model and, more specifically, behavioral set, is provided by Holaday (1981) in her study on mothers' responses to their chronically ill infants' behavior of crying. The author found that the behavioral set, defined as the degree of proximity and speed of maternal

response, consisted of a few rigidly define responses. In other words, mothers of chronically ill infants responded quickly to almost every cry. This finding was in contrast to mothers of well infants, who did not respond to all cries and the response time varied.

During periods of transition, usual behavioral patterns are disrupted. These disturbances in the balance of these behaviors may result in disorganized and dysfunctional behavior, increased anxiety, and personal dissatisfaction. In this model, nurses act to reinstate functional, stable behavior patterns through nurturing, protecting, and stimulating the patient. In essence, the nurses assume a parenting role. The model does not adequately address the role of the nurse when the patient is a young child accompanied by parents. Parents may wish to assume aspects of the nursing role or may be inhibited from their usual pattern of caring for the child by nurses. Hospitalization, therefore, may be a transition period wherein the parent temporarily relinquishes certain parenting behaviors to the nurse or assumes new behaviors.

CHAPTER III

METHODOLOGY

Research Design

This study utilized an exploratory descriptive research design. The aims of the study were to identify the behaviors actually used by mothers in caring for their children admitted to the hospital for common pediatric illnesses. In addition, information was sought to determine the degree to which the actual behaviors used by mothers reflected the behaviors they desired to perform and factors that mothers perceived influenced their ability to care for their children in the hospital.

The methods for data collection included four serial participant observations and a semi-structured interview. Two observations occurred in the evening. Two additional observations were performed the first and second mornings after the child's admission to the hospital. Following the second morning observation, a semi-structured interview was conducted with each mother.

Setting

A large university teaching hospital and a nonprofit private teaching hospital in the San Francisco Bay area were utilized to obtain the sample and collect the data. Access to the subjects was provided through the nursing coordinator and/or her designatee on the pediatric

unit. All staff nurses were appraised of the research study, and a copy of the research protocol was readily available in the nursing coordinator's office for the nurses' perusal. Approval by the hospitals' research review committees was obtained and the necessary requirements fulfilled prior to the initiation of data collection.

Sample

A convenience, nonprobability sample of six mothers was obtained from the two hospitals. The subjects were evenly divided between the two institutions. Criteria for selection into the study were: 1) mothers whose children were two years old or younger and 2) children who were admitted to the pediatric inpatient unit for treatment of pneumonia, bronchiolitis, or gastroenteritis.

Each subject received an explanation about the nature and the purpose of the study. All subjects were reassured of their anonymity. The researcher assured parents that all information collected for the study would be kept as confidential as possible. The subjects' anonymity was protected by coding each subject by number. Names were not matched to the code numbers at any time and no names were used on the data collection forms. Each subject was told that she had the choice of participating in the study and was free to withdraw from the study at any time without jeopardy to her child's care. All subjects were asked if they had any questions before signing the consent form (see Appendix A).

There were no anticipated risks in this study. However, discussion of the hospitalization experience potentially could have raised concerns, and questions during the interview could have made the mothers

uncomfortable. It was emphasized to each subject that she had the right to refuse to answer any question(s), and an opportunity was provided following the interview to discuss any concerns raised.

Instruments

After obtaining informed consent, data were collected through the use of four serial participant observations, a semi-structured interview (see Appendix B), and a demographic data form (see Appendix C) developed by the investigator. Demographic data were obtained from the nursing Kardex, the patient's chart, and through discussion with the mother. All observations and the interview took place in the hospital setting and were performed by the researcher.

The first observation of the mother's behavior occurred on the evening of admission within two to four hours after the child had been examined by the medical and nursing staff and medical treatment had been initiated. Medical treatment usually involved drawing blood samples and starting an intravenous infusion when necessary. The second observation took place the following morning. Approximately 24 hours after the initial observation period, the third observation was performed, and the fourth observation of the mother's behavior occurred the following morning. Immediately after the fourth observation, the mother was interviewed by the researcher.

All interviews were tape-recorded with the mother's consent and took place at the child's bedside in the hospital. An interview guide comprised of several semi-structured open-ended questions was followed during the interviewing process. The questions were designed to elicit information about the behaviors mothers had used in providing care for

their hospitalized child, any changes in their child's behavior as well as their own caretaking behaviors, and any factors that may have influenced the mother's ability to provide care, including the nurses' role. Also, at this time an opportunity for discussing any questions or concerns was provided for the mother by the investigator. All questions were answered by all six mothers, and at no time did any mother express any concerns arising from the questions asked of her and the discussion of the hospitalization experience.

Each observation consisted of 10 seconds of observation time alternating with 10 seconds of recording time and took 30 minutes to complete. This provided 15 minutes of actual recorded behavior time per observation. Each observation was performed continuously for the 30-minute duration regardless of whether the mother was present throughout the entire time period or not. Evening and morning time periods were selected for observing the mothers in order to potentially sample as many diverse kinds of behavior possible. Additionally, this method could potentially provide data marking trends in rates and/or kinds of behaviors over time as well as differences in the kinds and/or rates of behavior used in evenings versus mornings. Each of these time periods was sampled twice in order to maintain a certain degree of consistency.

The behavioral observation checklist (see Appendix D) was comprised of 38 behaviors which were grouped into four categories: nurturing, protective, stimulating, and "other". These behaviors included both quality and task-oriented kinds of behaviors that focused on the mother and her interaction with the hospitalized child. The behaviors selected for use in the checklist were compiled from various sources including

Barnard's feeding scale used in the Nursing-Child Assessment Satellite Training Project (Barnard, 1978) and previous research studies of parenting behaviors of mothers with hospitalized children (Dzik, 1979; Hill, 1978; Jackson et al., 1978; MacDonald, 1969; Merrow & Johnson, 1968) as well as the researcher's own clinical experience.

The categories of behaviors - nurturing, protective, and stimulating - were derived from Johnson's Behavioral System Model and are the functional components of behavioral patterns used by nurses and parents. Prior to collection of data for this study, these behaviors were submitted to two nursing experts in Johnson's model, to be grouped into the appropriate categories. A random listing of the 38 behaviors was given to each expert who was instructed to place each behavior in the category into which it fitted most closely and to do so independently and without consultation. The "other" category was generated for those behaviors that did not serve a particular function as defined in Johnson's model. This method was used in order to establish content validity.

An interrater reliability check was performed on the behavioral observation checklist. After instruction was given to the second observer, who was one of the thesis committee members, the investigator and observer simultaneously observed and recorded the same mother's behavior for six five-minute periods for a total of 30 minutes. The first five-minute interval was used as a pilot period and its score was not included in the final interrater reliability value. The five-minute intervals 2 through 6 had reliability scores of 77.6 percent, 86.7 percent, 90.9 percent, 93.9 percent, and 94.5 percent respectively. The average reliability score for the five intervals was 88.7 percent.

In addition, the interview guide was submitted to a panel of three nursing experts in the area of maternal/child relationships. Each nurse individually evaluated the questions to determine whether they would elicit the information sought in this study. This panel agreed that the instrument had content validity.

CHAPTER IV

RESULTS

Through the data collected in this study, information concerning actual and desired caretaking behaviors mothers used in caring for the hospitalized child and factors that mothers perceived as influencing their behavior was obtained. A demographic data form, behavioral observation checklist, and interview guide were used to gather data. Four separate observations were performed over a 48-hour period. Immediately following the final observation, an interview with each mother took place. The demographic data were collected within the same time frame.

Demographic Data

During the data collection period of January to April, a convenience sample of six mothers and their children was obtained. Characteristics of the mothers and children who entered the study were collected using the demographic data form. These data were analyzed using descriptive statistics. The children's ages ranged from 3½ to 23 months ($\bar{X}$ = 12.17). Three of the children were males and three were females. Four of the six children were the youngest child in their family. Reasons for hospitalization varied. Four of the children were hospitalized for gastroenteritis, one child for bronchiolitis, and one

child for pneumonia. The number of days the child was sick prior to admission ranged from three days to intermittent episodes lasting several months. Of the six children, three had been hospitalized previously; however, only one of these three children had been hospitalized for the same illness. This child was diagnosed with gastroenteritis.

The mothers' ages ranged from 29 to 38 years ($\bar{X}$ = 33). Educational levels of the mothers ranged from 12 to 16 years ($\bar{X}$ = 14.33). Three of the mothers were homemakers and three were employed outside of the home in one of the following occupations: maid, secretary, or teacher. Five of the six mothers were married and one mother was single. In all six families, the father of the ill child lived in the home and participated in child care either in the hospital or at home. In five out of the six families, the ill child had at least one sibling at home, aged six months to 15 years. In two families, there were three siblings at home. All mothers in the study stayed overnight with their child in the hospital during data collection.

Observations: Behavioral Data

The data obtained through the behavioral observation checklist were analyzed using descriptive statistics. Each observation lasted a total of 30 minutes and provided 15 minutes of actual recorded behavior time. Each of the 38 behaviors could potentially occur between 0 and 90 times during each 30-minute observation period. Therefore, when all four observations were combined, there was the possibility of a behavior occurring up to 360 times. Each observed behavior was scored as a single point. For each of the observation periods, the single occurring

pieces of data were collapsed to obtain a total score for each behavior. Means were generated from the combined scores, enabling comparisons to be made between behaviors and between major groupings of behaviors.

The original behavioral observation checklist was a compilation of 38 behaviors which were grouped into four categories: nurturing, protective, stimulating, and "other". Definitions for the three behavioral groupings from the Johnson model are as follows: 1) nurturing - to provide appropriate responses and/or supplies, 2) protective - to shield from a real or potential threat or noxious stimuli, and 3) stimulating - to enhance growth and prevent stagnation. Two changes were required at the completion of data collection. First, a third behavior needed to be generated from two other behaviors that originally overlapped. This resulted in three mutually exclusive behaviors, which clarified and facilitated the analysis process as well as increased the total number of behaviors to 39. Second, the "other" category unsatisfactorily grouped diverse kinds of behaviors together, thus resulting in the loss of rich information. Initially, it was thought that behaviors in this category did not serve a particular function as defined by the Johnson model, but it later became clear during the observations and analysis of data that these behaviors indeed served a purpose. Moreover, the behaviors could be seen as occurring along a continuum of the original behavioral categories. Therefore, two additional categories were developed: non-nurturing and non-stimulating. These two behavioral groupings were defined as the following: 1) non-nurturing - to provide negative or inappropriate responses and/or supplies and 2) non-stimulating - to impede growth and maintain stagnation. No non-protective behaviors were identified in the

behavioral observation checklist and therefore this category was not included in the data analysis and discussion. The 10 behaviors originally in the "other" category were then redistributed to the appropriate newly-developed categories.

Behavioral data were obtained during the four separate 30-minute observations that occurred during the initial 48 hours of the child's hospitalization. Complete observation sets were obtained for all six mothers. All observations occurred consistently at the designated times except in one case. For one mother, the final observation took place in the late afternoon instead of the morning as designated by study design. These behavioral observations were combined to form a data set. Means for the behaviors in each category were derived for comparison and description of study results.

The nurturing category consisted of 16 behaviors. The three most frequently observed behaviors in this category were "holds/cuddles the child" ($\bar{X}$ = 120.67), "pats/rubs/kisses/caresses the child" ($\bar{X}$ = 91.33), and "rocks the child" ($\bar{X}$ = 46.17). The three least frequently used behaviors were the following: "provides the child with a pacifier/ comforting item" ($\bar{X}$ = .33), "praises the child or some quality of the child" ($\bar{X}$ = 2.5), and "changes the child's diaper" ($\bar{X}$ = 5.5).

The non-nurturing category included five behaviors. None of these kinds of behaviors occurred very frequently. The three least frequently observed behaviors were "slaps or spanks the child" ($\bar{X}$ = 0.0), "rough or abrupt handling of the child" ($\bar{X}$ = 0.0), and "talks rough or abruptly to the child" ($\bar{X}$ = 1.0).

Eight behaviors originally comprised the protective category. However, during the observations it was noted that three behaviors

initially in the "other" category served a protective function as well. These behaviors were "looks at the child without making eye contact", "pays equal amounts of attention to the child and environment or others", and "sits at the bedside without interactions with the child". Thus, the three additional behaviors were included in the protective category during data analysis. Of the 11 resulting protective behaviors, the three most frequently used behaviors were "pays greater attention to the child than the environment or others" ($\bar{X}$ = 174.33), "looks at the child without making eye contact" ($\bar{X}$ = 165.17), and "sits at the bedside without interaction with the child ($\bar{X}$ = 115.17). The three behaviors least utilized by the mothers in this category were "takes the child's temperature ($\bar{X}$ = 0.0), "keeps a record of the child's intake and output" ($\bar{X}$ = 1.0), and "holds the child for a procedure, examination, and/or blood work" ($\bar{X}$ = 6.17). There were no non-protective behaviors identified in the list of behaviors used to collect data during the observations.

The stimulating category contained five behaviors. The two most frequently observed behaviors were "talks about and/or explains things to the child" ($\bar{X}$ = 30.83) and "provides the child with appropriate learning toys" ($\bar{X}$ = 21.33). "Sings and/or reads to the child" ($\bar{X}$ = 5.5) and "vocalizes in response to the child's verbalizations" ($\bar{X}$ = 13.33) were the least frequently used behaviors in this category.

The non-stimulating category was comprised of two behaviors. Originally it was thought that these behaviors had a negative function with regard to the child. However, during the observations it was noticed that these particular behaviors served the function of self-preservation for the mothers. As a self-protective mechanism, these

behaviors allowed the mothers to continue to "stand guard" at the hospitalized child's bedside and still maintain her total identity, of which being a mother is only one component. The behavior most frequently observed in this category was "pays greater attention to the environment or others than the child" ($\bar{X}$ = 98.83). The less frequently occurring behavior was "talks with other family/friends/parents - not related to the child" ($\bar{X}$ = 9.17). A summary of the most frequently observed maternal behaviors is shown in Table 1.

TABLE 1

Most Frequently Observed Maternal Behaviors

Behavior Category	Observed Behaviors	Mean No. of Occurrences
Nurturing	1. Holds/cuddles the child	120.67
	2. Pats/rubs/kisses/caresses the child	91.33
	3. Rocks the child	46.17
Protective	1. Pays greater attention to the child than the environment/others	174.33
	2. Looks at the child without making eye contact	165.17
	3. Sits at the bedside without interaction with the child	115.17
Stimulating	1. Talks about and/or explains things to the child	30.83
	2. Provides the child with appropriate learning toys	21.33
Non-stimulating	1. Pays greater attention to the environment/others than to the child	98.83

In addition to generating frequencies and means for each of the individual behaviors, the average number of behaviors observed within each of the five behavioral categories was obtained. Results showed that mothers most often used behaviors that had a protective function ($\bar{X}$ = 14.18), closely followed by non-stimulating behaviors ($\bar{X}$ = 13.50). The average number of behaviors for the three remaining categories was as follows: 1) nurturing: $\bar{X}$ = 6.79, 2) stimulating: $\bar{X}$ = 4.28, and 3) nonnurturing: $\bar{X}$ = .21. Table 2 presents the individual average scores for each of the behavior categories.

TABLE 2

Average Behavior Category Scores
(for individual subjects)

	Subject					
Behavioral Categories	1	2	3	4	5	6
Nurturing	7.52	5.00	6.55	8.53	4.89	8.28
Non-nurturing	.95	0.00	.10	0.00	0.00	0.20
Protective	10.93	10.48	16.25	16.10	14.07	17.25
Stimulating	.75	.25	3.10	3.10	3.00	15.45
Non-stimulating	11.13	19.00	10.50	15.25	20.38	4.75

Caution must be taken when comparing and interpreting the results obtained with regards to the behaviors included in the observation checklist. Due to an absence of controls, behavior frequency may have been influenced by such factors as the child's age, activity level, state of wakefulness or sleep, the mother's energy level, or parenting

skills. Other factors such as history, whether the mother was present for each observation in its entirety, and differences between behaviors and their usual rate of occurrence were not controlled and could have influenced the results.

Interview Guide: Thematic Categories

Interviews with each of the mothers were tape-recorded and then later transcribed by the investigator. The information obtained in the interviews was subjected to content analysis using a modified Delphi technique. The interviews for five of the six subjects were distributed to three nurses with graduate preparation in maternal/child relationships, who were the thesis committee members for the research study. Each of the nurses was instructed to develop thematic categories from the interview data independently and without consultation.

Instead of three iterations in which each expert is subsequently provided with her/his own as well as other experts' responses, this modified Delphi method called for one independently-rated iteration and an interdependently-rated second iteration. This modification facilitated regression to the mean. In the second iteration, all three experts met and discussed their themes and, through discussion and negotiation, generated six themes on which there was complete agreement.

The questions developed for the interview guide were designed to elicit information concerning the mother and child's general responses to the child's hospitalization, changes in the child's usual behavior, and changes in the mother's usual caretaking behaviors. In addition, information was sought concerning the factors that influence the mother's ability to care for her child in the hospital and the nurse's

role in facilitating or hindering the mother's ability to adopt her "ideal" parenting role in the hospital setting. Interviews were also used to validate observed behaviors as well as expand the set of behaviors to include behaviors not observed but reported to have been used by the mother.

Answers to the semi-structured questions generated six themes. They are the following: 1) maternal responses to hospitalization, 2) maternal perceptions of the effects of illness and hospitalization on the child, 3) reasons why mothers stay with their children in the hospital, 4) maternal-nurse roles, 5) external conditions that impinge on the hospitalization experience, and 6) mother's recommendations for improving hospitalization. Some aspect of each theme was expressed by every mother.

Theme 1: Maternal Responses to Hospitalization

Maternal responses to hospitalization are influenced and intimately related to their child's illness and treatment regimen. Mothers are so focused on their children that it is difficult to separate their perceptions of the hospital from the children's responses to their illness and hospitalization. Thus, three major components of the maternal responses to hospitalization have been identified: the mother's response to 1) the hospitalization experience, 2) the child's treatment, and 3) the child's illness.

Maternal response to the hospitalization experience. Mothers' responses to the hospitalization ranged from being glad about the child being hospitalized and feeling comfortable in the hospital setting to

not really wanting the child to be admitted and having a great dislike for hospitals. One mother stated,

> It's been interesting. It's been an experience. I've met a lot of people as we've been cared for, a lot of parental involvement. On the whole, I enjoyed my stay. It's not like home, of course, you know. I don't sleep a whole stretch, I'm up one minute . . . I felt very comfortable from the beginning.

Another mother responded,

> I'm not mad [about coming to the hospital], I'm glad and I'm worried and I'm really anxious to come right away.

But other mothers were not so eager to have their child admitted to the hospital. This feeling was clearly the experience of one mother. She stated,

> I don't like it. Of course, I've never liked being in the hospital, whether it's for me or I'm visiting someone. I just don't like the hospital. It has not been as bad as I thought when we first came here Friday evening. I said, "Oh, no, I don't know if I can take three days of this" but, as I have found before, you do what you have to do.

Another mother felt similarly:

> You know it's coming, but you don't want it to happen. That's how I felt. I didn't want him to go in, but . . .

Once the child had been admitted to the hospital, several mothers expressed tremendous relief with no longer being solely responsible for the ill child's care and treatment.

> I was concerned at home because it was all my responsibility if he was dehydrating. It was like, "Well, I don't have to worry about that anymore. They'll keep an eye on him here.

Another mother stated,

> I feel relieved. I know that she will get proper care here. If anything should arise, she would be attended to, whereas at home I would have to guess, "How is she feeling and what should I do?" Here, it's not only for me, my concern, but their's too!

A period of adjustment usually occurred after the initial response to the child's admittance to the hospital. During the two-day study period, mothers gradually learned about the new and unfamiliar hospital setting and hospital routines and over time felt more comfortable being there, even those mothers who had initially responded negatively to the child's need for hospitalization. One mother stated,

> Once the routine is set up, everything is pretty much easy to handle. The first day, though, is always the hardest as you get to know what the routines of the hospital are. After that, one day is like the next, so it's not hard.

Another mother responded,

> I have adjusted. The first night, although I had the opportunity, I did not get a lot of sleep. Walked up and down the halls a little bit, just generally not wanting to be here and getting accustomed to the idea. . . . Today it's been much better.

However, even though the mothers had adjusted to the hospital setting, the stresses of the child's illness and the procedures necessary for treatment as well as the hospitalization itself never allowed the parent to relax and feel completely comfortable. These feelings were summed up well by one mother:

> [The hospitalization is] really tiring because there's nothing to do. The baby gets tired and you get tired because there's nothing to keep you occupied and nothing really like . . . it's just not like home. You can't relax at all. It's part of it, being here, being away from your normal surroundings. No, you can't feel at home except at home, really.

Maternal response to the child's medical treatment. Blood drawing and placement of an intravenous (IV) infusion were the two procedures mothers found most painful to be involved in or watch happen to their child. In addition, those mothers whose children were admitted for gastroenteritis found being unable to feed their children anything during the first 24 hours extremely difficult. For example, one mother

said she was glad to have her child admitted, but this feeling quickly changed as she watched the distress her child felt watching others drinking and washing their hands at a nearby sink. It made her "feel bad" and she "wanted very much to sneak my child a drink". Another mother expressed similar feelings:

> I think the hardest was when he was here and he started asking for a bottle and he couldn't have it. That was hard.

These statements clearly express the distress the mothers' felt at not being able to provide for the children and comfort them as they would usually have done.

Maternal frustration and pain was also felt during IV placement or blood sampling. The inability to stop or change these medical procedures left several mothers feeling helpless. When one mother was asked how she felt about an IV needle being inserted in her child, she stated,

> I feel so sorry for him. I feel so . . . that's why I didn't like to go in [the treatment room]."

One mother had been told prior to hospitalization that her child would need an IV, and this was very hard for her. She stated,

> I knew that they were going to put an IV in, so that was the part that bothered me. I knew that; that was hard to look toward. I felt guilty as I was driving over here. He thought this was all great fun; we were going visiting. So I was feeling very guilty about that.

And, again, with blood drawing she felt much pain:

> It was hard when they took blood from him right here in the room. It was hard. Yesterday morning when they drew blood, every time they stick him, it kind of hurts a little bit.

For another mother, IVs and blood drawing were the worst part of the child's treatment. She stated,

> That's the most horrible process, when they poke your kids. It's hard to be with her because her veins are so small. They just dig and dig and dig and dig to find them. Finally, sometimes they just shake their head and give up and go away and send somebody else back to dig for awhile. And that's really . . . it's too hard on the parents for that.

Only one mother saw the placement of an IV as positive and even then only partially so. The positiveness of it was tied directly to the child's positive response from it.

> The minute they got the IV in, she just perked up. That's good. I'm kind of glad that they did that.

Maternal response to the child's illness. The child's illness significantly influenced the mother's response to the hospitalization. The helplessness, frustration, and worry felt by the mothers was repeatedly expressed throughout the interviews. For one mother, the lack of control she had over the child's illness was difficult for her:

> It's just a helpless feeling for me, that they're sick and there's nothing you can do for them. And you know, you don't really know what to expect and it's kind of a helpless . . . that's the way I feel, very frustrated.

The worry and stress of the child's illness was clearly expressed by the following mother:

> My son was having pain, I could see, and I was worried. I pity him so much. He's really weak, sick. I'm afraid. It's like he's gonna die. They said it's something inside his stomach. I was crying in my heart.

As the child's illness subsided and he was doing better, a sense of relief is strongly detected in the mother's response later. "He feels a lot better and me, too. I'm thankful he's okay."

This feeling of relief that the child would do well, and thus the mother, was expressed by others as well. "As he relaxes [and feels better], then I relax and it's easier." Another mother stated,

> The first day when we took her in, she was just totally down and out, and she was gasping and stuff. She wouldn't smile, she'd just kind of look up and then just turn over, and I knew, she's sick. The minute she started smiling and kicking around like this, I knew she's got to be feeling much better. And that takes a whole load off of my chest.

However, as one mother summed it all up, it's still never quite right or easy being in the hospital.

> [You] make the most of a situation. We're all here; we're all worried about our kids. I'm no more worried than you are.

Theme 2: Maternal Perceptions of the Effects of Illness and Hospitalization on the Child

Physical and behavioral changes occurred in the hospitalized child due to both the illness itself as well as the hospitalization and the routines and procedures. These changes were clearly apparent to the mothers and were the cause of concern. In this theme, two major maternal concerns were identified: maternal perceptions of 1) the effects of illness on the child and 2) the effects of hospitalization on the child.

The effects of illness on the child. It was often frightening and upsetting for the mothers to see their children so sick and not responding as they normally would. These feelings were expressed several times. One mother, whose child had gastroenteritis, said it "scared" her to see the child so listless and that, although it took "almost four hours to get the IV in", the child continued to be listless, just lying there, not responding much to the probing for blood and IV placement. Also, she worried about the changes in the child's appearance. "Her eyes were sunken, face thinner, and she had lost her

belly." Another mother told of similar changes in her child and her concern about these changes:

> He was really pale. I think he was a little yellowish. He was so weak, like he is dying. He didn't say "Mama" or anything. No action at all. I feel so upset, I feel sorry. I feel pity when I see him. I knew it was going to be a serious matter.

The effects of the hospitalization on the child. In addition to the physical and behavioral changes in the child caused by the illness, mothers perceived changes in their children consequent to being in the hospital. One child, who could have nothing to eat or drink for the first 24 hours, started screaming when another patient's visitor came up to talk to her mother with a cup in his hand. The mother felt that

> She was rebelling . . . because she's not normally like that. When she usually wants something she can get it, if it's alright. If it's within reason, she can have it, and all of a sudden everybody wants to tell her "No, no, no". And she starts throwing these tantrums.

One mother spoke of how her child had responded to being admitted to the hospital and having an IV placed.

> When we came back he was in pretty rough shape. He was pretty agitated and was being held down. He was just real unhappy about being here, and seeing everybody disturbed him.

Later on she noted that he didn't like to see the IV in his foot.

> I noticed he doesn't like to see his leg. He's much more comfortable when his leg is covered. If he's in bed and I uncover it for some reason, he gets very agitated and throws the blanket over it.

The majority of the mothers attributed changes in their children's behavior to having so much individual attention given to her/him. They noted that the children frequently exhibited increasingly dependent behaviors. As one mother stated,

> She's gotten a lot more dependent. She was a very independent child, and now she is much more dependent.

Another mother remarked,

> The child is different than her usual state at home. She went from at first being very passive to being very clingy, demanding, and wanting to be held, to temper tantrums. Usually she is very independent . . . doesn't like to be held or kissed; so this is very different.

This change in behavior was often a concern for the mother, not because she thought the child shouldn't behave like that in the hospital, but for the reason that it meant that there would be a difficult period of adjustment at home. This feeling was expressed by the following mother:

> He's more obnoxious here. He's usually a pretty even-tempered child who can keep himself occupied rather than needing help from the outside. Perhaps it's because I want to keep his mind occupied that he seems to require a lot more of my involvement here than he does at home; he kind of does his own thing. He'll be spoiled rotten when he gets home.

Another mother expressed similar feelings:

> It's going to be hard. We have a three-year-old, too, and when we go home she can't expect all of this attention. It's going to be really hard.

Even though there were negative behavior changes occurring in the child, there were also positive changes of adjustment to the hospital.

> Even he adjusts to the routine after the first day. The first day he was here, any time someone walked by he'd scream. He got to know some of the nurses, and a few of the nurses he'll even allow to let touch him without screaming.

This adjustment process was noted by another mother as well.

> At first, everybody that came in poked her, and every time we laid her down on the bed and somebody strange came in the room, she just fell apart. But now that she's been out of the room and everything, she's beginning to adjust to other people better.

Usually the child's positive adjustment to the hospital helped the mother to feel better as well.

Theme 3: Reasons Why Mothers Stay

The reasons mothers stayed in the hospital with their children generally centered around the need to comfort the child, meet her/his immediate needs, provide the child with a familiar face and/or surroundings, and to be an advocate for the child's routines and preferences. During the discussions it was difficult to differentiate whether these were actually the mother's needs or the child's needs. The two were often entangled.

Provision of the child with some degree of familiarity in such strange surroundings was given by the mothers and seemed to be sought and readily accepted by the children as well. One mother stated,

> I can notice when she wakes up, she'll kind of look around to see if she recognizes anything. If I was standing there she'll kind of put up her hand or something like that. That's why I'm here. I'm overly concerned with her recognition of her surroundings. I think that's why I'm here. I don't know, I'm here, I guess, because I'm her mother. And I'm just worried about those things.

This feeling is supported by another mother.

> I sit up all night here in the chair . . . she would look around [at night], and she seemed like she was content with me here.

Being an advocate for the child and providing continuity of the child's usual routines was viewed as an important means of helping the child feel as much at home as possible. One mother clearly stated this view:

> I think that's why he's pretty much as he is at home as he is in the hospital, because I'm still doing all those things for him. I'm still here when he wakes up at night. So as far as he's concerned, things are pretty much the same.

Often it was felt that the child would feel more secure or comfortable if it was the mother, and not the nurse, providing the child with her/his daily care.

> I think it makes the child feel more secure that their mother will be doing things for them and not a stranger.

And

> I think it's just reassuring to him to have me around to just hold him and when he's not feeling too comfortable with all the strangers around to see someone that he knows. I think he's more comfortable with me handling him than someone else.

Frequently, mothers felt they needed to be there to make certain the child was all right and that her/his basic, immediate needs would be met. Provision of basic needs was considered to be a way of lessening the child's potential stress or distress. One mother stated,

> Just being with her, I think that helps a lot. As much as the nurses want to be with the children, they aren't . . . they can't be here all the time and at the times when she's awake, where I could if I were here. So that's why I'm here.

Another mother expressed similar feelings about wanting to be there for her child:

> Sometimes he becomes uncovered and gets cold and cries before someone has the opportunity to come and see what's wrong. That's why I stay here. I don't want my son cold. That is not life-threatening, but I don't want my son to go through that or any more than he has to, is absolutely necessary. That reinforces my thinking that, "Mom, you need to be there."

In response to finding out that she could have given her son a bath, cared for him like she would have at home, a mother simply but powerfully stated,

> I wish they would have asked me and I give him the bath. Because he's sick and I know . . . so I could give my love to him.

Theme 4: Maternal-Nurse Roles

In response to questions designed to elicit information concerning the factors that influence the mother's ability to care for her child, the mothers answered fairly uniformly, describing the maternal role in

the hospital and how it is assumed and developed. The behaviors recounted by the mothers were basic caretaking activities that the mothers normally performed at home. In addition, these activities fulfilled and validated the three role functions observed during the observation periods. Additionally, it was clear that the nurse's role in facilitating the assumption and development of the mother's parenting role was inconsistent at best. The mothers had specific ideas about what the nurse's role entailed, as well as how it might be modified to be more helpful to the mothers. For clarity, this theme will be discussed in two parts, 1) the maternal roles and 2) the nurse roles. However, in reality the two roles were significantly influenced by one another.

Maternal roles. In most instances mothers actively participated and involved themselves in caring for their children in the hospital. Generally, this role was assumed with little guidance or facilitation by the nurses. One mother stated,

> I didn't know, I just did it. I just figured if it wasn't alright, they would say it. I know things she needs and I can do it just as well as they can.

A similar response was given by another mother: "I guess instinct. I don't know. I just did it . . ."

The majority of the mothers stated that they were able to care for their children to the extent that they wished. One mother summed it up well in the following comment:

> There hasn't been anything that I wasn't able to do. I haven't come up with, come up against anything that I've been told "You can't". I haven't done that yet. So far it's always been "sure" "go ahead". That's why I feel so relaxed about the whole thing, too. I feel so, I can still be mommy.

The behaviors used by the mothers in caring for their children fulfilled the functions of protecting, nurturing, and stimulating the child. The mothers felt strongly that this was their role and not the nurse's. This feeling was expressed by several mothers.

> I didn't feel like they [the nurses] should have to care for her other needs than administering her medication and the medical aspects. I'm the one to keep her clean, keep her diaper changed and comfortable.

Another mother stated,

> I bathe him, change his diaper, clean his nose, put drops in his eyes and in his nose. I do all the things for him that I do at home. The only things the nurses are doing, they take care of his IV, they come and take his temperature.

For another mother, although giving her child basic care was important, she found that reassuring her child and trying to keep him occupied was a key part of her role. When asked what kind of care she had been able to provide, she replied,

> Certainly not much in the way of medical care, but I think it's just been reassuring to him to have me around to just hold him . . . to see someone he knows. Trying to keep [him] pacified, keep his mind off of what he was doing, what they were doing.

Nurse roles. When it occurred, encouragement to assume the parenting role by nurses was greatly appreciated by the mothers. The opportunity to become actively involved in the child's care to the extent desired increased the mother's satisfaction in this care and lessened anxiety. The positive response to encouragement by nurses is exemplified in the following comments:

> The nurses are very nice and very helpful. They have encouraged parents to take over a large part of the responsibility of their child. I like that! I have always disliked them, sort of "keep your hands off and we'll take care of him". I've never liked that attitude, so this is, maybe that's what's made it so much easier for me.

Again, as stated by another mother,

> I've been very comfortable here, and the nurses have been just fine, just great. I don't feel that I'm in the way. They don't seem to show me that I'm in the way at all. They appreciate parents staying here.

Generally, mothers viewed nurses as being responsible for technical procedures. However, mothers also viewed the nurses as important sources for support and information. One mother remarked,

> [When] they admitted him, they treated us nice, they treated him nice right away, the nurses. They took his blood pressure, temperature, to check his fever that he had at home; they said, "No, it's normal." They said I just had to be relaxed because my son is going to be well; just relax. They do something good to my son.

Another mother said the nurses has been "terrifically" supportive.

> They brought me sheets, they told me how to get stuff to take a shower. They were very concerned about me.

It was clear, however, that sometimes the nurses were not always there to care for the mother and child, and this was not always understandable.

> The nurses, they do a good job and when they are needed, they are there. They may not be when you want it, but they are when you need them, which is important.

A slightly different view was expressed by another mother.

> A lot of times there's just not a nurse around that you can find . . . It made me feel bad because what if something had happened and we needed somebody and there's nobody here.

Suggestions were made for improving the nursing role which included providing more information, being supportive and caring, and being knowledgeable about the child's illness and treatment. One mother clearly expressed these concerns:

> I think that the nurses that handle the cases should be kind of up on things that they do and different treatments for different things because then that way they can help you . . . like sometimes after the doctor goes, you're kind of

> frustrated and then they come and talk to you, "You know, this is quite normal" or something like that. They can reassure you. [It helps], I think, the more they let you know because I think a lot of times the nurse can let you know a lot of things the doctor can't, just in little ways. The thing is, too, if the nurse is friendly and acts like she cares and that she wants to help, that makes a big difference, too . . . I know they're there to take vital signs and to see that they're fed and change their bed and things like that, but I think they need to be more of a friend. Not just a medical person that comes around and does this or that.

Theme 5: External Conditions Impinging on the Hospitalization

Various conditions were identified that impinged on the hospitalization experience and directly affected the mother's ability to develop her role in the hospital setting. These conditions included the following: 1) whether or not the mother had a job outside of the home, 2) past experiences with hospitals, 3) other minor children at home, 4) the father's ability and interest in caring for the other children, and 5) information (or lack of it) provided to the mother in the hospital. The two most significant influencing factors were past experiences with hospitals and the lack of contact and concern for the other children at home.

Four of the mothers said that past experiences in hospital settings had affected their perceptions of the present hospitalization. For one mother, a previous bad experience resulted in her not wanting to return to the hospital in which the child was hospitalized:

> Last time I was here I was rather unhappy with the nursing staff and I let the doctor know that I didn't want to return here this time, that I would prefer to go to another hospital, and they said no, they preferred for him to be here. Last time he was very small. Of course, this place was absolutely jammed with kids. That whole first room had six mist tents going, and I was the only mother who stayed over. So the nurses were very busy and really left an awful lot to me. It was like total care that I was doing.

For another mother, however, past experiences helped her feel better about having her child admitted to the hospital and knowing what to do. Her other children had been hospitalized at an earlier time, and these hospitalization experiences had occurred without incident, but it had been scary for her, and at that time she was working at a bank.

> [Then] I didn't know anything about hospital procedures; I wasn't working at [a hospital]. So how would I know about medicine? Now, I guess, that kind of helps, too, working for a medical institution. You kind of get to know the surroundings. You know what doctors are and what nurses are other than professional people. More familiar. So, that's helped me out, too.

Of greatest concern to mothers was the care of the other children at home. Four of the five mothers who had other healthy children at home expressed this concern. The fifth mother was not as concerned because her children were old enough to care for themselves. Her healthy children were 8 and 11 years of age.

One mother clearly expressed this major concern:

> I've got another daughter at home. It's very difficult. I have talked with her on the phone, and I know she's with her grandmother, and I know she's doing fine, but I'm still not there. I'm not putting her clothes on, I don't comb her hair, I don't get her breakfast in the morning. So, and even if I didn't do all those things, that would be okay if I could just see her. You know, "Mommy still cares." I get the impression sometimes that she's going to feel like "Mommy cares more about the little baby than she does about me" because we have to go to the doctor's so often. And so every time I bundle him up, she says, "Baby go to the doctor?" "Yes, darling, but we'll be back." And this time I didn't come back. So I don't really know what she's feeling.

Mothers often found that hospitalization caused them to experience role conflicts. One mother whose child had gastroenteritis summed this conflict up beautifully:

> Being away from the others and what they're doing. It wasn't any life-threatening situation. I knew that he was going to be okay so I wasn't really concerned. I didn't like him having, knowing that they were going to put an IV in him. That was hard. Once that was done, then it was all the things I should be doing that I'm not doing because I'm here with him. And what are the other kids doing at home?

Theme 6: Recommendations for Improving Hospitalization

Numerous recommendations were made by the mothers that would help other mothers and children during hospitalizations in the future. Some of the suggestions included the need to keep mothers updated on the progress of their child's illness and plan of care, to increase nursing support throughout the hospitalization but particularly during the initial settling-in period, to develop a foster grandparent program to care for the children while their mothers were absent, and to institute more liberal visitation policies. In addition, increased sensitivity by admission personnel and better accommodations, such as providing phones in patients' rooms, the ability to order meals in the patients' rooms, and to be served better food at a reasonable price were also seen as important changes for improving the hospital experience and making the mothers' stays a little easier.

Conclusions

In summary, the data gathered in this study have provided information about parenting behaviors used by mothers with hospitalized children, the extent to which these behaviors were congruent with parenting behaviors the mothers would have ideally liked to perform, and factors that influenced their actual parenting behaviors during the child's hospitalization. Analysis of interview data suggested that

although mothers enacted most of the behaviors they wished to, they experienced discomfort with their new role. Possible sources of discomfort stemmed from the inability "to do" entirely for the child, ambivalence toward nurses, uncertainty of the child's behavioral cues, hospital advocacy role, unfamiliar hospital routines, and disruption of family routines.

First, mothers experienced difficulty with their inability "to do" for the child and to provide the necessary care to fulfill the needs of the child. Although observational data were rich with the various caretaking activities that mothers "do" during their child's hospitalization, mothers expressed dissatisfaction with the inability "to do" entirely for the child throughout the interview discussions. This feeling may reflect the mothers' concerns for being unable to prevent their children from becoming ill, to visibly enhance the healing process, or "to do" all the tasks and activities needed to care for their children during the hospitalization.

Second, mothers experienced ambivalence about surrendering aspects of their child's care to nurses. On the one hand, sharing the responsibility of caring for the ill child with nurses seemed to provide mothers with a certain amount of relief. On the other hand, the inability "to do" all the tasks and activities needed to care for the child became a source of distress for the mothers. This ambivalence led to a certain amount of uncertainty about the mother's role and the nurse's role.

Third, mothers became uncertain of their child's behavioral cues. At times it was difficult for mothers to distinguish whether changes in their child's behavior were due to illness or estrangement from normal

surroundings. Mothers' perceptions of their child's behavior changes and the meanings attached to these changes influenced their interpretation of them. Consequently, mothers appeared to need interpreted reports of their child's behavior changes.

Fourth, mothers needed to assume an advocacy role during hospitalization to insure that their child would be provided with appropriate care and not be subjected to unnecessary trauma. The advocacy role enabled mothers to protect their ill child as well as provide them with a certain degree of control over the care given to the child. Again, this controlling aspect of the child's care was an additional means of fulfilling the mother's need "to do" for the child.

Finally, mothers appeared to be upset by disruption of normal family routines and unfamiliar hospital routines. Mothers had a need to know what the usual hospital routines were and to be familiarized with the hospital setting. Familiarity with the hospital environment and routines enabled mothers to gain a sense of control over what occurred during their child's hospitalization as well as allow them to parent their child to the best of their ability. Lack of information and inconsistency in nursing care can exacerbate maternal discomfort and prolong the settling-in period. Consequently, mothers may continue to experience feelings of frustration and helplessness for a longer period of time than necessary.

CHAPTER V

DISCUSSION

Significance

In this study, three main questions were addressed:

1. What behaviors are utilized by mothers in caring for their children in the hospital?

2. Do the actual behaviors used by mothers reflect the behaviors mothers desire to perform?

3. What factors, including the role of nurses, influence the behaviors used by mothers in caring for their children?

Behaviors utilized. Using the behavioral data obtained through observation to answer the question, what behaviors are utilized by mothers in caring for their hospitalized children, it was found that the group of behaviors exhibited most frequently by the mothers was protective, closely followed by non-stimulating behaviors. The average number of behaviors occurring in these two categories were 14.18 and 13.50, respectively. Nurturing and stimulating behaviors occurred less frequently, with mean scores of 6.79 for the nurturing category and 4.28 for the stimulating category. Non-nurturing behaviors were rarely observed and had an average score of .21. No non-protective behaviors were identified in the list of behaviors used to gather observational data.

If the mother's role is to be an advocate for the child and protect the child from unnecessary trauma as well as to assist the child to recover as quickly as possible, it is reasonable that protective behaviors would be most often utilized by the mothers. These kinds of behaviors buffer the child from the hospital environment with its usual procedures and routines.

Mothers provided a range of active caring behaviors, from holding, cuddling, and reassuring the child to total care for the child, including medical treatments usually performed at home, such as instilling eye and nose drops. However, no noticeable changes in kinds and/or rates of behavior over time were noted, either for any particular mother or across all mothers.

Although maternal behaviors observed in this study were used with children hospitalized for common pediatric illnesses such as bronchiolitis, pneumonia, and gastroenteritis, similar maternal behaviors were described in previous research studying parents with children requiring hospitalization for varied reasons. Merrow and Johnson (1968) administered a questionnaire to 50 mothers with hospitalized children whose ages and reasons for hospitalization were not controlled for in the study. The authors found that the mothers desired to be involved in such activities as feeding, bathing, comforting, and entertaining the child and changing the child's diaper. Hill (1978) interviewed 18 mothers with children between the ages of one and four years, who had no evidence of mental or physical handicaps and were not seriously ill or unconscious. The author found that, overall, the majority of the mothers wanted to participate in their children's care. The three areas of care the mothers desired most to participate

in were stimulation, entertainment, comforting measures, and activities of daily living.

In a similar study, Jackson et al. (1978) interviewed 31 parents to determine in what activities they would like to be involved. The study included parents who planned to stay throughout their child's hospitalization and whose children were under 10 years of age, conscious, and not in critical condition. The majority of the parents wanted to perform nurturing activities such as bathing, feeding, and comforting the child, and a smaller number desired to be involved in medically-oriented tasks such as taking temperatures and giving medications.

Due to the sample size in this study, few, if any, generalizations can be made. However, similarity in results across studies does provide a certain degree of validity for the findings. Cumulative study results suggest that mothers wish to take an active role in caring for their children in hospital and are willing to perform a variety of activities including medically-oriented tasks in order to fulfill this role.

Desired behaviors. Study results suggest that the majority of the mothers were able to care for their children to the extent that they desired to be involved. In addition, mothers assumed the parenting role with little hesitation. Those mothers who received encouragement and support to be actively involved in their children's care from nurses seemed to express more satisfaction with the hospital experience and were less anxious. These findings were in congruence with the findings of authors in other studies. Jackson et al. (1978) asked the parents in their study the degree of satisfaction they felt with the ability to be involved in their children's care in the hospital to the extent they

wished to be. Twenty-three of the 31 parents interviewed stated they were "very satisfied" and the remaining eight parents were "satisfied". Miles (1979) reported that involving parents in their children's care to the extent possible in the pediatric intensive care unit helped parents cope with the children's illnesses and increased their satisfaction with their children's care.

In 1956, Fillmore reported that parents' anxiety was often relieved when they were able to participate actively in their children's care in the hospital. In addition, their involvement in their children's care helped them to realize their important role in facilitating the recovery of their children's health. Cumulative evidence suggests that mothers want to assume the maternal role in the hospital, do so with little hesitation, and feel better when they do.

Influencing factors. This study suggests that mothers perceived that no one factor influenced their behavior more than another. In fact, the parenting role was assumed in the hospital with little guidance by the nurses or others. Several mothers stated that they cared for their children as they usually would at home. They assumed that if they had overstepped their bounds, then the nurses would let them know. However, at no time did nurses restrain the mothers.

Open support for the mother's role in caring for her child and the opportunity to accept or reject various caretaking activities were viewed positively by the mothers who experienced these conditions. Those mothers who were more uncertain and unclear of their position in caring for their children seemed to view the hospitalization less positively. More ambivalent feelings were expressed by the mothers about their role as well as the nurses' role.

As indicated by authors such as Freiberg (1972), Issner (1972), and Prugh (1972), the strange and unfamiliar environment and various routines and procedures were major sources of stress for the mothers. Uniformly, mothers expressed the pain and distress they felt when their children were subjected to IV placement and blood work. They often saw themselves helpless to change the course of action and protect their children from trauma of medical procedures. Frequently, mothers stated that the first day was the most difficult because they did not know where things were or the routines of the hospital. After the hospital setting became somewhat more familiar, the mothers often felt less threatened and more comfortable being there. Similar areas of discomfort were identified in this study. During the interviews, mothers expressed feelings of frustration and distress which were eased by increased familiarity with the hospital environment and routines. However, the painful and helpless feelings felt by the mothers which were associated with the trauma their children were subjected to continued to exist throughout the hospitalization period.

Although the sample size was small, many findings in this study were similar to findings in previous studies (Fillmore, 1956; Freiberg, 1972; Hill, 1978; Issner, 1972; Jackson et al., 1978; Merrow & Johnson, 1968; Miles, 1979; Prugh, 1972). Studying factors that mothers perceive as influencing their caregiving role provides new, additional information. One finding is that mothers received inconsistent support and guidance from nurses. Another unique finding was that mothers perceived nurses as being important resources, providing and interpreting information concerning the child's care. However, mothers reported that this role occurred inconsistently.

Limitations

The limitations of this study include the following:

1. The sample size and lack of randomness in subject selection limits the degree of external validity that can be obtained and, therefore, the generalizability of the findings.

2. The use of a select population of children with common pediatric illnesses and mothers who consistently stayed overnight in the hospital with their child limits the extent to which the findings in the study can be generalized.

3. Depending on the child's age, the kind of care needed to be provided by the mother may change (i.e. total nurturing kinds of care will be needed by young infants whereas a toddler is more independent and has a greater need for stimulating types of care). These age-dependent caregiving differences were not taken into account during data collection and analysis.

4. Due to observer presence, the Hawthorne effect may have resulted in potentially influencing the mothers' behaviors. However, several mothers stated that initially they were aware of the investigator's presence but soon adjusted to it.

5. The behavioral observation checklist included 38 behaviors; at times it was difficult to check all behaviors noted completely in a 10-second period. This problem potentially decreased the accuracy and reliability of the data collected. However, the average interrater reliability was found to be 88.7 percent for the observation checklist. Also, reorganization of the behaviors by category and frequency of occurrence would increase the efficiency by which observed behaviors could be recorded.

6. The use of time-sampling observations to collect data can potentially result in loss of information (behaviors) occurring during the "record" time period, which decreases generalizability and confidence in the results. However, the alternating 10-second record/observe time period does provide for increased efficiency of data collection in addition to being the most closely matched to continuous observation and therefore is the most accurate means of time sampling.

7. Low-rate behaviors such as bathing, feeding, and checking the child's temperature, that have been included in the behavioral observation checklist, have an increased chance of being missed with periodic sampling. Therefore these kinds of behavior may be underrepresented in the data collected. Rotating times of observation, morning and evening, were used to decrease the chances of this occurring.

8. The use of one observer (i.e. the investigator) does provide consistency in data collection: however, systematic error and/or bias may occur unchecked when only one observer is collecting all the data.

9. Due to the use of a single interview with each mother, reliability and completeness of the data collected is difficult to verify.

Implications for Nursing

Despite the small sample size, the findings in this study suggest the need for nurses to provide more consistent support and guidance to mothers, to be more available and actively involved in the care of the mother and child, and facilitate the mother's contact with the well siblings at home. In addition, nurses need to familiarize mothers to

the hospital setting and routines and provide updated information concerning the children's care in order that mothers can achieve a level of comfort that enables them to care for their children the best they can. These changes would promote a more positive hospitalization experience for mother and child. Lessening the amount of stress and anxiety that the mother experiences may also allow her to be more available to assist her child, lessen the child's anxiety and, perhaps, facilitate a more rapid recovery of the child's health. These modifications may increase the mother's satisfaction with the care the child receives in the hospital, lessen feelings of helplessness, and increase feelings of competency in her mothering skills that continue beyond the hospital experience.

Recommendations for Future Research

In order to expand and enhance the findings in this study, several recommendations for future research will be made and are as follows:

1. Replicate the study with a larger sample size and

   a) determine whether there are certain variables that influence the kinds and/or rates of behaviors used by mothers, such as the presence and/or interaction with the nurse, family presence and/or interactions, the child's age and reason for admission, the presence or absence of an IV for the child's medical treatment, and the sleep/ wake state of the mother and/or child;

   b) expand the population to include children with a variety of illnesses and/or reasons requiring hospitalization as well as determine whether variables such as family cultural

background, number of previous hospitalizations, and differences in pediatric ward environments influence the behaviors utilized by mothers to care for their children;

c) use an additional tool listing various caretaking activities that could be checked by mothers in order to validate the behaviors observed by the investigator as well as those behaviors cited by the mothers in the interviews but not actually observed;

d) provide a scaled questionnaire to the mothers at the time of their children's admission to the hospital that would allow them to rate the degree of involvement they would like to have in various specific caretaking activities in order to assess the mothers and their needs. This questionnaire could be administered a second time several days later to identify the behaviors the mothers had actually performed.

2. Develop and standardize a scaled questionnaire that could be regularly administered at the beginning of each child's admission to the hospital in order to systematically assess the mother's needs and degree of involvement she would like to have in her child's care, in addition to eliciting possible factors that may potentially positively or negatively influence the mother's ability to actively participate in her child's care.

3. Conduct a study to explore and obtain information on ways nurses perceive they facilitate the mother's role in the hospital and in participating in her child's care.

4. Conduct a study to determine the most effective ways for nurses to implement their role more visibly.

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APPENDIX A

CONSENT FORM

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

PARENTING ACTIVITIES OF MOTHERS WITH CHILDREN IN THE HOSPITAL

Principal Investigator:
Diana Dawson, R.N.

By signing this consent form, I, _____, understand that I may be a participant in a study on the various activities that mothers use in providing care for their child who has been hospitalized with diarrhea, difficulty in breathing, or unexplained fever.

My participation depends upon my continuing consent. I understand that I may withdraw from this study at any time without in any way diminishing the medical or nursing care provided for my child or myself.

WHY IS THE STUDY BEING CONDUCTED?

Having a child in the hospital is oftentimes stressful for mothers, and they are frequently anxious about their child's illness and the care the child will receive. Being able to comfort and care for their child oftentimes helps mothers feel better about the situation. By finding out what sorts of caring and comforting activities mothers provide, or would like to provide, for their children in the hospital, nurses can better help other mothers become comfortable in the hospital more quickly.

WHAT HAPPENS TO ME AND OTHER PARTICIPATING MOTHERS?

If I am selected to be in the study, I will be observed 4 times during the first 2 days of my child's hospitalization. Each time will last 30 minutes and the investigator will note the various activities that occur, such as bathing and feeding my child. After the fourth time, I will be interviewed, which will take about 1 hour. We will discuss the amount and kinds of care I was able to give my child and what influenced my ability to do so.

WHAT ARE THE RISKS OF THIS STUDY?

There are no risks to me, except for the slight possibility that discussing the hospitalization experience may raise some concerns and some of the questions may make me uncomfortable. I can refuse to answer any question(s), and I will have an opportunity to talk about any of my concerns after the interview.

WHAT HAPPENS IF I AM INJURED OR HARMED IN SOME WAY BY THIS STUDY?

I understand that University of California, San Francisco (and/or the investigator) have no special program which provides compensation for medical treatment if any complications arise from participating in this study.

Consent Form
Page 2

HOW WILL THE STUDY AFFECT MY CHILD'S MEDICAL AND NURSING CARE?

This study will not in any way affect the medical or nursing care my child normally receives on the pediatric unit.

HOW CONFIDENTIAL IS THE INFORMATION OBTAINED DURING THE STUDY?

All information gathered by the investigator during the study will be treated confidentially, and in the event of publication of this study, no individual identifiers or names will be used.

WHERE DO I GO WITH QUESTIONS?

Any questions that I may have about the study will be answered by calling the investigator, Ms. Dawson, at 751-6538.

WILL I BE TOLD WHAT THE STUDY LEARNED?

Yes, I will be advised of any significant information obtained during the course of the research, if I request the information.

I have been given a copy of this consent form and the Experimental Subjects' Bill of Rights and I have read and understood them.

Parent's Signature _____ Date _____

Witness's Signature _____ Date _____

Pediatrician's Signature _____ Date _____

#943305-01A

APPENDIX B

INTERVIEW GUIDE

INTERVIEW GUIDE

Topic	Questions/Probes
Perceptions of Hospitalization	1. What has this hospitalization been like for you? Tell me about your child's admission. How did it affect you? Your child?
	2. How has your child adjusted to the hospital? In what ways is she/he the same/different from home?
Dependency	3. What care have you given your child during her/his hospital stay? What changes, in any, have occurred in the ways you usually care for your child (comforting, bathing, feeding)?
Control; Sources of Support/ Nonsupport (Achievement)	4. What or whom has influenced the amount of care you have given to your child? How have the nurses helped you? Hindered you? How supportive have the nurses been of your efforts? In what ways could nurses have been more helpful during your child's hospitalization?
Evaluation of Experience	5. What has been the most difficult part about caring for your child during the hospitalization?
	6. As a result of this experience, what concerns do you have about caring for your child? What changes would you recommend in the way nurses presently care for children and parents during hospitalization?

APPENDIX C

DEMOGRAPHIC DATA

DEMOGRAPHIC DATA

Mother's Information

1. Subject code number _____
2. Age _____
3. Occupation _____ _____
4. Marital status (circle one): single, married, divorced, widowed
5. Ethnic background (circle one): Asian, Black, Caucasian, Hispanic

   other (please specify) _____
6. Educational level (circle highest grade of school you completed):

Grade School								High School				College			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Graduate School					
17	18	19	20	21	22

Child's Information

7. Birth date (months) _____
8. Sex _____
9. Birth order (circle one): oldest, middle, youngest, only
10. Reasons for current hospitalization _____
11. Number of days your child was sick at home before hospitalization

    _____
12. Has your child had any previous hospitalizations? _____
13. If the answer to #12 was yes, please indicate the dates of previous admissions and reasons for admission _____

    _____
14. Is your child bottlefed or breastfed? (circle one)

15. Others living with your child (father, brothers, sisters, etc.)

	Name	Relationship	Age	Occupation	Educational Level
a.					
b.					
c.					
d.					
e.					

APPENDIX D

OBSERVATION SCHEDULE

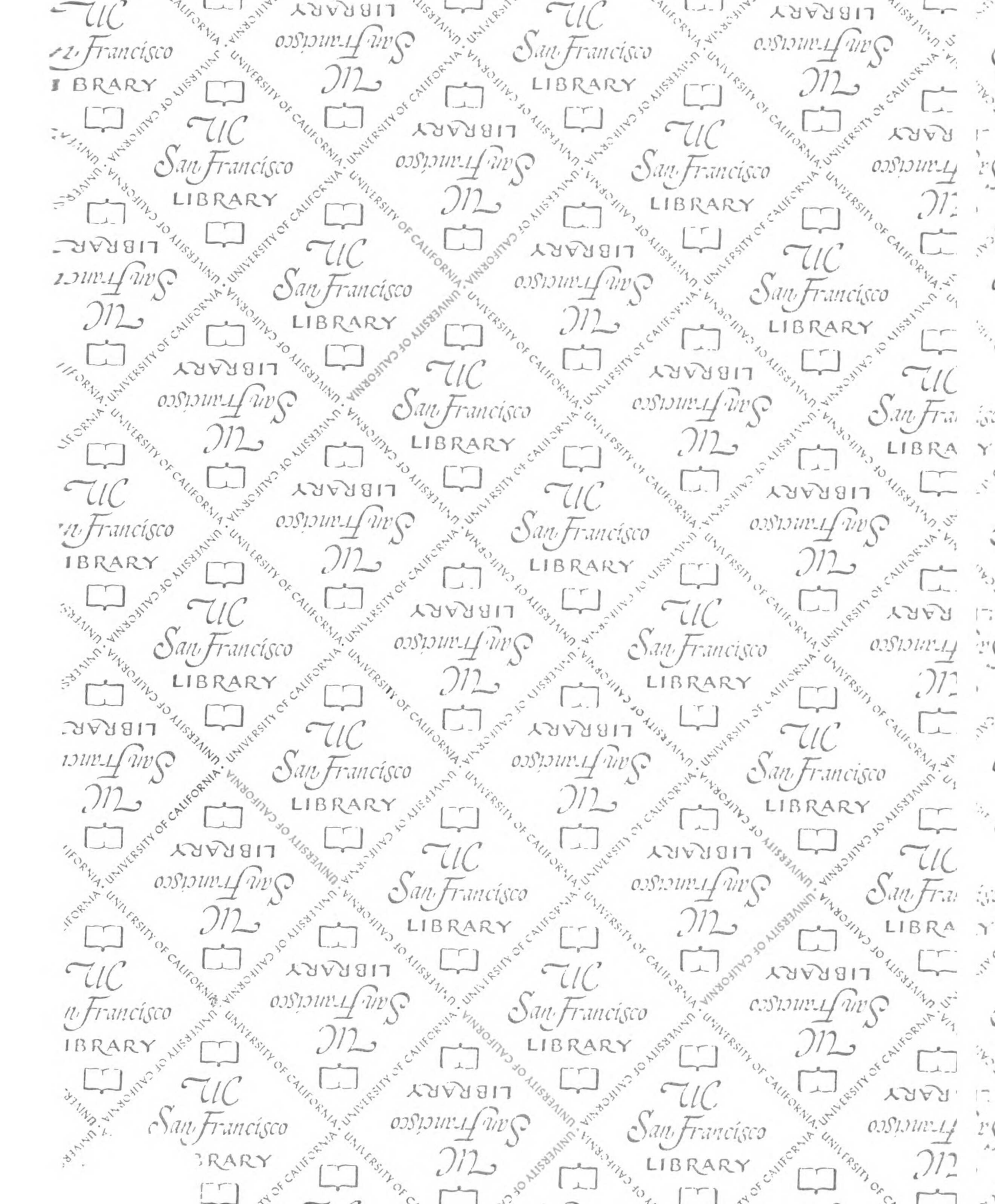
OBSERVATION SCHEDULE

Subject _____ Date _____

_____ 5 minutes

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Nurturance															
1. Holds/cuddles child															
2. Feeds child															
3. Pats/rubs/kisses/caresses															
4. Grooms child															
5. Smiles at child															
6. Bathes child															
7. Makes eye contact with child															
8. Rocks child (sitting or standing)															
9. Changes child's diaper															
10. Praises child or some quality of the child															
11. Dresses/undresses child															
12. Adjusts child's blanket or clothes (to cover)															
13. Hums/speaks softly/ soothingly															
14. Provides pacifier															
15. Distracts/diverts child's attention															
16. Makes positive/sympathetic verbalizations															
Protective															
1. Monitors IV															
2. Changes child's position															
3. Takes temperature															
4. Keeps record of intake/ output															
5. Pays greater attention to child than environment or others															
6. Talks with nurse or doctor, asking questions															
7. Holds for exam/procedure/ blood work															
8. Talks with other friends/ family/parents (related to child)															

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Stimulation															
1. Entertains/plays with child															
2. Vocalizes in response to child's verbalizations															
3. Talks about/explains things to child															
4. Sings/reads to child															
5. Provides appropriate learning toys															
Other															
1. Talks abruptly/roughly															
2. Makes negative verbal responses															
3. Slaps/spanks child															
4. Frowns/scowls at child															
5. At bedside - no interaction with child															
6. Rough/abrupt handling of child															
7. Looks at child - without eye contact															
8. Pays greater attention to environment/others than child															
9. Talks with other friends/ family/parents (not related to child)															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