MATERNAL ADAPTATION TO A CHILD'S HOSPITALIZATION

by

GAIL BEVERLY BISHOP

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School of Nursing

The University of British Columbia
2075 Wesbrook Place
Vancouver, Canada
V6T IW5

Date September 9, 1981

ABSTRACT

Ten mothers were interviewed during a three week period in August, 1981. The purpose of the interviews was to obtain information about their adaptation to the hospitalization of their children. The children were admitted to a pediatric unit of a large Vancouver hospital with acute medical problems. These problems were often infectious in nature and included gastroenteritis, viral meningitis, and respiratory tract infections. The ages of the children were between four months and ten years. Verbatim responses of the mothers were recorded in writing by the investigator and later analysed. The data were categorized according to Roy's Adaptation Model. Reliability of the data categorization was verified by two judges, independently. The model was suitable for classifying data in this type of research; however, one problem was encountered. It was difficult, at times, to separate the contextual and residual stimuli as they were not always mutually exclusive. Adaptive responses of the mothers were found in all of Roy's four adaptive modes. These responses included alterations in the mothers' abilities to meet their needs for nutrition and exercise and rest; role conflicts; feelings of loss, guilt, anxiety, and powerlessness; and both help-seeking and initiative-taking behaviours. The focal stimulus for the behaviours of nine of the mothers was the hospitalization of their children. Contextual stimuli included the age of the child; the help given by family and friends; work responsibilities; the presence of other children in the family; and

the behaviours and attitudes of health team members. Residual stimuli were related mainly to the mother's previous experiences with hospitalization, either as a child herself or with her own children. Several implications were apparent. These included the need for increased contact between nurses and mothers; the need to provide more information to mothers about their children's progress and care; the need to obtain information about home treatments used by the mothers in order to provide teaching; and the need to make long-term hospitalizations a positive experience for children so that they would be able to cope with their own children's hospitalizations when they are parents. Several areas for future research were identified. These areas included exploration of the effects on maternal adaptation of factors such as the severity of the child's illness, the age of the child, and prior experiences with hospitalization of the children. As well, further study could be done of the effects of the educational background of the mother and her childhood hospitalization experiences upon the frequency of admissions of her children to hospital.

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CHAPTER I

INTRODUCTION

Background of the Problem

Admission of the child to hospital necessitates some degree of adaptation, not only by the child but also by the parents and siblings, if any. Over a period of thirty years, doctors, nurses, psychologists, and sociologists have studied the effects of hospitalization upon the child and his family. The effects of various forms of intervention upon the adaptation of the child to the hospital experience have been investigated. Studies were done of adaptation, not just during the time when the child was in hospital but also of adaptation after discharge (Prugh et al, 1953; Vernon et al, 1965). Some interventions were directed at helping the parents, particularly the mother, to adapt in a positive manner to hospitalization of the child (Godfrey, 1955; Skipper et al, 1968; Johnson, 1974; Visintainer and Wolfer, 1975).

A review of the literature indicated that anxiety was a common response of the parent to hospitalization of the child. Some studies (Prugh et al, 1953; Glaser, 1960; Freiberg, 1972) found that the mothers expressed feelings of guilt because their children had become ill, and also because they neglected other siblings, while they stayed with the ill child. Roskies et al (1975) and Skipper et al (1968) found that adaptation to the hospital was difficult for some parents because of their fear of hospitals. Prugh et al (1953) and Robinson (1968) found that the parents were unable to visit the ill child

because of their own anxiety or fear. Robinson found that the parent who was very fearful of the hospital did not prepare the child for hospitalization and did not visit often, while Moran (1963) and Roskies et al (1975) found that the parent was unable to provide emotional support to the ill child.

Researchers over the years have used a variety of interventions in an attempt to reduce parental anxiety and to help the parents make a positive adaptation to the hospitalization of their child. Interventions have included pre-admission tours (Johnson, 1974), emotional support given during admission (Prugh et al, 1953; Moran, 1963), and group discussions (Glaser, 1960). Most investigators found that the parents who had received these types of interventions were less anxious than those parents who received no special preparation or support.

Almost all of the studies concerned the admission of the child to hospital for elective surgical procedures. Two of three studies that did look at admissions for medical reasons were done in the early 1950's (Prugh et al, 1953; Godfrey, 1955). These two studies, which looked primarily at children who were admitted with acute medical conditions such as acute adenitis, acute hemolytic anemia, bronchopneumonia, and pyelonephritis, were done in an era when restricted visiting was the practise. Therefore some of the anxiety in the parents in these studies could have been related to the separation of parent and child. The third study which involved children with medical health problems was done by Roskies et al, in the mid-1970's. It examined the reactions of a small group of children who were admitted

through the emergency department of a paediatric hospital and compared them to those of a small group of children who were admitted electively to the same hospital. Parental and staff reactions to both types of admission were studied also. Nearly all of the elective admission group were admitted for routine surgical procedures such as tonsillectomy while the children in the emergency admission group had problems such as asthma and head injury. The effects on the parents' adaptation when the child is admitted with an acute medical illness does not seem to have been examined adequately.

Peplau, writing in a book by Burd and Marshall (1967), stated that anxiety is aroused in individuals who find that their security is threatened. Anxiety will occur when individuals are placed in unfamiliar situations over which they have, or perceive that they have, little or no control. Hospitals qualify as anxiety-provoking places for a majority of parents and children because of their unfamiliar environments and unaccustomed routines. Anxiety may be aroused by the tests and treatments to which the child is subjected and fear of the outcomes of the tests may be present in the parents. A moderate amount of anticipatory fear is believed to be necessary for coping satisfactorily with the anxiety-causing situation (Janis, 1971). In terms of adaptation, moderate anxiety can be viewed as a desirable adaptive response by the individual. Parental anxiety when their child is hospitalized may be related to the discomfort experienced by the child in response to diagnostic tests or treatments. Also, anxiety may be related to feelings of responsibility for the child's illness or to concern over family life disruptions caused by the

hospitalization. Peplau (1967) surmised that anxiety is communicated from one person to another. The child is very perceptive of the parents' responses and anxiety can be communicated to him, making him anxious too and possibly affecting his adaptation to hospitalization. Investigators have attempted to intervene to reduce parental anxiety because of this undesirable effect on the child.

Variables which may have influenced the parents' adaptation to hospitalization appear to have received marginal consideration in the studies. The age of the child was noted as being of importance by Godfrey (1955) with the younger child having made the poorest adaptation. Parental adaptation did not show any relationship to the child's age in her study but did in Wolfer and Visintainer's study (1975). Age of the parent did not receive consideration except by Skipper et al (1968). The educational background of the parent received little consideration too, although Freiberg (1972) did report that the largest number of mothers in her study were working class and Skipper et al (1968) noted that the majority of the mothers had at least ten years of formal education. From the literature review it was not apparent if other researchers had studied these variables. The majority of the studies involved the mother and child rather than both parents and child. This may have been because the mother was usually the primary person to be with the child, caring for him at home and visiting him most frequently in the hospital. More women are being employed in occupations that take them out of the home to-day than during the time when many of the studies were done. The influence of this variable upon the adaptation of the mother to the hospitalization

of the child has not been explored.

Although all of the studies dealt with adaptation, none of them viewed it systematically within the context of a nursing model of adaptation. The intent of this study is to look at adaptation within the context of Roy's Adaptation Model. A person is in constant interaction with the changing environment. As a result of this interaction, the person must make certain physiological and/or psychological adaptations. Sister Callista Roy (1976) developed a model to assist the nurse to assess the adaptations that an individual makes and to identify problems that result because of maladaptation. Roy believed that man's positive response was dependent upon his adaptation level. This adaptation level resulted from the combined effects of three types of stimuli, which are 1) the focal or confronting stimulus; 2) the contextual stimuli, which are all other stimuli present in the environment; and 3) the residual stimuli, which are composed of things such as past experiences, beliefs, attitudes, and traits of the individual (Roy, 1976). She described man as having four adaptive modes, which were the physiologic, self-concept, role function and interdependence modes. Changes in the environment could affect any or all of these modes, leading to either adaptation or maladaptation. Roy believed that any mode could serve as a focal, contextual, or residual stimulus for each of the other modes. Anxiety could be aroused in the individual because of responses required of him which were outside of his adaptation level. Roy saw anxiety as being aroused when there was a problem in the self-concept mode. In terms of Roy's model, it is possible to think of the child's illness and subsequent hospitalization as the major focal

stimulus for the mother. Some contextual stimuli could include the child's age, the behaviour of health professionals towards mother and child, the availability of family support systems, and the occupational obligations of the mother. Residual stimuli might include some of the factors, which have been reported in the literature, such as childhood experiences of the mother with hospitalization, and prior experiences with hospitalization of her children. They could include as well the mother's beliefs about health and intervention by health team members and the value of the hospitalized child to the mother.

This study looks at how a small group of mothers have adapted to the hospitalization of the child who is admitted to a paediatric unit because of an acute medical problem. Their adaptation is described according to Roy's model. Consideration is given to the following variables: age of the child and of the mother, educational background of the mother, and occupation of the mother, if any, outside of the home.

Purpose of the Study

In this descriptive study, interviews were conducted with ten mothers whose children were admitted to a paediatric unit of a large Vancouver hospital. The children were admitted for a variety of acute medical problems such as diarrhoea, febrile convulsions and viral meningitis. The main purpose of the study and the interviews was to determine what adaptation the mother perceived that she had made to the focal stimulus of her child's illness and hospitalization. Information about the effect of the child's hospitalization upon the family and

factors which influenced the mother's responses was obtained as well. Questions which were asked by the investigator were directed towards discovering:

1. The mother's perceptions of her feelings/responses when she learned that her child was to be admitted to hospital.
2. The factors that the mother believed made her respond positively or negatively to the hospitalization of her child.
3. The mother's feelings about how she had been affected by the child's hospitalization.
4. The mother's perception of how the hospitalization of the child had affected the family.
5. The mother's perception of any factors which had made her adaptation to the hospitalization of the child either easier or more difficult.
6. Any previous experiences that the mother had with hospitalization, either as a child herself or with her own children, and her feeling about these experiences.

Demographic data were asked for as well. These included: the age of the mother and of the hospitalized child; the educational background of the mother, in terms of highest achievement in school; and information as to whether or not she was currently employed in a job outside of the home. Most of the demographic factors were chosen as a result of the literature review. This review indicated that they were possible contributory factors to the mother's adaptation or, in some studies, provided minimal information about their possible effects on adaptation. Any of the questions asked during the interview could have

provided information about the focal, contextual, or residual stimuli which had influenced the mother's adaptation in the four adaptive modes. Analysis of the data was done to categorize it according to the adaptive modes and the stimuli. Whenever possible, similarities among the mothers' adaptive responses were noted.

Assumptions

Certain basic assumptions were held by the investigator. These were that:

a. The mother is the primary caregiver for the child.
b. The mother can perceive and describe her adaptive responses.
c. The mother will state honestly her feelings about the hospitalization of the child.
d. The mother will explain honestly the reasons for her feelings about the hospitalization of the child.
e. The mother is perceptive of the effect that hospitalization of the child has upon the family.
f. The components of Roy's model are valid.

Limitations of the Study

The study is limited to a description of ten interviews with the mothers of children who were admitted to the hospital because of medical problems. The location of the study was limited to one paediatric unit of a large Vancouver hospital.

Definition of Terms

The terms in this study were taken directly from Roy. They are:

Adaptation Man's positive response to a changing environment. Roy (1976:12).

Adaptation level The condition of the person relative to adaptation, which helps to determine whether the response to a changing environment will be adaptive or maladaptive. Roy (1976:4).

Adaptive mode A way or method of coping with the changing environment. Roy (1976:4).

Adaptive response Behavior that maintains the integrity of the individual. Roy (1976:4).

Anxiety A painful uneasiness of mind due to an impending or anticipated threat. Roy (1976:210).

Contextual stimuli All other stimuli present that contribute to the behavior caused by the focal stimulus. Roy (1976:22).

Focal stimulus The degree of change or stimulus most immediately confronting the person and the one to which the client must make an adaptive response; that is, the cause of the behavior. Roy (1976:22).

Guilt Painful feelings associated with the transgression of an individual's own moral-ethical code. Roy (1976:202).

Interdependence The comfortable balance between dependence and independence in relationship with others. Roy (1976:291).

Loss Any situation, either actual or potential, in which a valued object is rendered inaccessible to an individual or is altered in such a way that it no longer has qualities that render it valuable. Roy (1976:192).

Physiologic mode One based on man's need for physiological integrity. This mode includes the following physiological needs: exercise and

rest, nutrition, elimination, fluid and electrolytes, oxygen, circulation, and regulation, including temperature, the senses, and the endocrine system. Roy (1976:15).

Powerlessness The perception on the part of the individual of a lack of personal or internal control over events within a given situation. Roy (1976:224).

Residual stimuli Factors which may be affecting behavior but whose effects are not validated. Roy (1976:22).

Role function The performance of duties based on given positions within society. Riehl and Roy (1974:138).

Self-concept The composite of beliefs and feelings that one holds about oneself at a given time, formed from perceptions particularly of others' reactions, and directing one's behavior. Roy (1976:169).

Self-consistency The part of the person which strives to maintain a consistent self-organization, and thus to avoid disequilibrium. Roy (1976:170).

Self-ideal/Self-expectancy That aspect of the personal self component which relates to what the person expects himself to be and do. Roy (1976:170).

CHAPTER II

REVIEW OF LITERATURE

Introduction

A review of the literature, which was generated over a period of approximately thirty years, showed the recurrent interest of researchers in adaptation of parent and child to hospitalization (Prugh et al, 1953; Skipper et al, 1968; Robinson, 1968; Freiberg, 1972; Roskies et al, 1975; Meng, 1980). Some researchers were interested in determining if adaptation to hospitalization could be fostered by interventions such as information-giving and emotional support of the parent and child (Prugh et al, 1953; Godfrey, 1955; Glaser, 1960; Moran, 1963; Skipper et al, 1968; Wolfer and Visintainer, 1975). A discussion of these studies will help to illustrate what the researchers learned about adaptation, what factors could affect adaptation, and what areas require further study. In order to understand the evolution of this interest in adaptation, the literature is reviewed chronologically.

Studies of Adaptation

Prugh et al (1953) examined the emotional reactions of two hundred children and their families to illness and hospitalization. They designed their study to evaluate:

> 1) the nature of the immediate reactions and modes of adaptation of children and parents to the impact of hospitalization on a medical ward in a children's hospital; 2) the incidence and character of long-range emotional reactions of children and their families to the experience of hospitalization; and 3) the degree of modifiability of such reactions with the use of an experimental program of ward management (Prugh et al, 1953:73).

One of the reasons for doing this study stemmed from a belief that the child's response to hospitalization depended upon "...the attitude and anxieties of the parents before and after the child's discharge" (Prugh et al, 1953:72). This study was done during the time when liberal visiting practises were not widespread. For the control group of mothers, the usual bi-weekly visits of two hours each were allowed, while for the experimental group daily visiting was permitted. As well, parents in the experimental group were given an information pamphlet at admission, were permitted to accompany the child to the ward, and were encouraged to participate in the care of the child. The children in the study were between two and twelve years of age and were hospitalized mainly for acute illnesses. The two groups were matched as closely as possible in relation to variables such as age, sex and diagnosis. One criterion for admission to the study was that the child must not have had more than a brief experience with hospitalization before and that this encounter must not have occurred within the six months prior to the study. The child's level of adjustment prior to hospitalization was rated according to "...historical knowledge of his emotional development, level of intelligence, relationships with siblings and contemporaries, degree of independence, handling of sexual and aggressive drives, need for symptom formation or crippling defense mechanisms and capacities for sublimation." (Prugh et al, 1953:78). From this information, more of the children in the control group were

designated as well-adjusted (fifty-six percent vs thirty-four percent), and more children in the experimental group were viewed as having an inadequate adjustment (twelve percent vs two percent), prior to hospitalization. Responses to hospitalization were measured by signs of overt anxiety in the child such as crying and screaming when approached, urinary frequency, diarrhoea, vomiting, rocking, thumb-sucking, and masturbation. Over ninety percent of the children in the control group showed some of these responses while approximately seventy percent of the children in the experimental group had some of these reactions. The parents' adjustment to hospitalization was classified as being either adequate, difficult, or inadequate based on the parents' ability "...to control their anxiety, or guilt over the child's illness, to give emotional support to the child, to accept the realities of the child's illness, and to handle visiting opportunities" (Prugh et al, 1953:79). The findings of this study, although inconclusive, showed some trends. The researchers found that "...the children in both groups who showed the most successful adjustment on the ward were those who seemed to have the most satisfying relationships with their parents, especially the mother" (Prugh et al, 1953:81-82). Prugh did not believe that the child's adaptation to hospitalization was influenced by prior experiences with hospital. No comment was made upon the possible effects of previous experiences on parental adjustment. Certain reactions of the parents to the hospitalization of the child were evident. They included overt anxiety and guilt because of possible involvement in the child's illness. Some parents in both groups were unable to take advantage of the visiting opportunities because of factors such as distance from the hospital, working hours, and home responsibilities. "A small number in each group could not bring

themselves to visit at all because of anxiety or guilt." (Prugh et al, 1953:98). A significant correlation was not found between the child's adaptation and the frequency of parental visits. This study was of interest because it considered the possibility of influencing parental adaptation by permitting greater access to the hospitalized child and by providing the parent with information and support. Subsequent studies looked at parents' responses and other ways of helping them to cope with the hospitalization of the child.

Prugh was one of the few researchers to look at reactions of parents and children to hospitalization when the children had acute medical conditions. Godfrey (1955) was another investigator whose study involved mainly children with acute medical illnesses. Godfrey was interested in "...the problem of separation that both the child and his parent have while the child is in hospital." (Godfrey, 1955;52). Her major objective was to determine if it was possible to help both mother and child to make a comfortable separation at the end of visiting time. The children selected ranged in age from two to six years as this was the age group that Godfrey believed had the most difficulty with separation. The children in the control and experimental groups were not matched in any way as Godfrey hoped that any differences would be minimized by the sample size. However, the sample contained only twenty-three children in the control group and twenty-seven children in the experimental group. No planned interventions were carried out at the end of visiting time with the children in the control group. This could have been an uncontrolled factor in her study, as some nurses may have provided some type of

assistance to the child and parent at the time of separation. In the experimental group, a nurse stayed with the child during the visiting period, at the time of the parents' departure, and for thirty minutes afterward to help the child as well as the parents separate. The nurse provided support by being available to talk to the child and parent, by meeting expressed needs of either one, by encouraging the parent to talk to the child about home activities, and by holding the child or providing him with toys when the parent left. Observers recorded the behaviour and verbalizations of the child during these times as well as the responses of the parent and the nurse. Observations and recordings of the control group were made also. One possible drawback of this methodology was that the observer-recorders were the nurses who provided the interventions for the children and parents in the experimental group. Although these observer-recorders were all student nurses with similar preparation, it was not evident if inter-recorder reliability was determined. The observer-recorders had not cared previously for the children in the experimental group so that the possibility of a prior relationship with the children influencing the results was prevented. Parents in both groups were interviewed at the end of visiting time to determine how they felt about leaving the child that day. Their answers were recorded verbatim. Parent and child were rated on a five-point scale by ten judges in relation to how they felt about the separation based on the observers' recordings. This scale ranged from very secure to very anxious. The judges had a variety of backgrounds, such as clinical psychology, social work, and pre-school education, and included the researcher who

was a pediatric nursing instructor. Reliability tests were done with the judges and accepted as valid. Generally, the results of the study were inconclusive, but a few findings were evident. One finding was that the older the child the better the adjustment, regardless of the group to which he belonged. Another finding showed that the day of hospitalization was a factor in the ease of separation for two year old children. On the second day of hospitalization, two year old children in the experimental group separated significantly better than the children of the same age and day of hospitalization in the control group. There were no significant differences found for parents in either group, according to the age of the child or the day of hospitalization.

Glaser (1960) described group discussions conducted with mothers of hospitalized children. These discussions were intended to give information to the mothers, as well as to clarify or correct information that they had and to permit ventilation of feelings. It was hoped that this would relieve maternal anxiety and improve relationships between mother, child, and hospital personnel. Another purpose of the meetings was to obtain information about the mothers' emotional reactions to the illness and hospitalization of the children. A total of thirty-three discussion groups were held, each one lasting approximately one hour. They took place following visiting hours and included all mothers of children who were admitted with acute illnesses. Attendance was voluntary. The meetings were attended by the author and a public health nurse who acted as recorder. Topics of the discussions included mothers' feelings of guilt over leaving the child, conflicts between

outside obligations and the desire to visit the ill child, the trauma of separation, and anxiety about spoiling the child while he was ill. Glaser believed that the content of the discussions "...was useful in interpreting the mother's feelings to the staff and to alter their attitude toward her." (Glaser, 1960:135).

Moran (1963) focussed her research upon children who were admitted for tonsillectomy and their parents. She discussed the preparation of the parents which included providing them with information about the hospital routine and about what to expect from the child post-operatively. Control and experimental groups were studied each of which consisted of ten sets of parents. The control group received only the routine admission procedure, which could have provided them with some information. After hospitalization, all parents were interviewed and asked if they had received adequate information about the hospital and if they were satisfied with the nursing care that their child had received. Pulse rates of the children eight hours post-operatively were compared, and their post-discharge behaviour was reviewed. This information was used to determine the effectiveness of the support that was provided by the parents. The results of this study indicated significant differences for the experimental group. Eighty percent of the parents in the experimental group felt adequately prepared as compared to twenty percent of those in the control group. In the parents' evaluations of the nursing care, twenty percent of the parents in the experimental group stated that they were dissatisfied with the care as compared to eighty percent of parents in the control group. The children in the

experimental group had "...significantly lower pulse rates than did the children of the unprepared parents." (Moran, 1963:35). Post-discharge disturbances such as eating problems, sleep disturbances, and reluctance to be separated from the mother were noted. Twenty percent of children in the experimental group had two or more of these disturbances as compared to fifty percent in the control group. Moran concluded that these findings emphasized that unprepared parents had difficulty in handling their own anxieties, which made it difficult for them to be supportive of the child. It appeared that Moran related only the preparation of the parents to their ability to be supportive of the child, without looking at other possible factors such as the parents' previous experiences with hospitalization or their usual supportive relationship with the child.

Skipper et al (1968) studied mothers' feelings of stress, adaptation, and satisfaction with hospitalization of their children. They stated:

> If a mother is anxious and fearful about the welfare of her child, in her interaction with the child her feeling state may be communicated to him and increase the stress on him. The communication of feeling states between a mother and her child may take place on a non-verbal as well as a verbal level, may occur at even a very early age in the life of the child, and may not be fully subject to the voluntary control of the mother. (Skipper et al, 1968:497).

Skipper felt that by providing additional information to the mother, as well as emotional support, that her stress would be reduced and this would lessen the stress felt by her child. Eighty mothers between the ages of twenty-five and forty years were included in the sample. Their children were admitted for elective surgery. Almost all of the mothers had more than ten years of formal education with approximately forty

percent having had more than twelve years. All of the mothers in the two experimental groups received support and information from a nurse at admission. This same nurse saw twenty-four of the mothers again on the evening of admission, shortly after the child returned from the recovery room, in the evening after the operation, and at discharge on the following day, in order to provide further support and information. Mothers in the control groups received no special preparation or support. None of the mothers was aware that she was a subject in a study, a questionable point of ethics. All of the mothers were asked at admission if they would be willing to complete a short questionnaire eight days after their child's discharge. Almost all of the questionnaires were returned. On the questionnaire, the mothers were asked to give their perception of such things as their level of anxiety before, during, and after the operation, the trust and confidence that they felt in the hospital staff, and their general satisfaction with the hospital experience. The nursing staff were asked to complete a questionnaire about the behaviour of the mothers. They were supposed to be unaware of the group to which the mothers belonged or even of what the study involved. A possible problem with methodology existed here because the nursing staff were familiar with the researchers and they could have seen them interacting with the mothers who were in the experimental groups. The nurses were asked to estimate the mothers' anxiety and adaptation to hospital. Because more than one nurse was used as a rater, it was possible that various perceptions of anxiety and adaptation could have been present among the nurses. There did not seem to be any inter-rater reliability testing done. The mothers'

responses indicated that about sixty percent of them in all groups felt intense anxiety the day before surgery. Although anxiety remained high during the operation and two hours afterwards, it was less high for mothers in the experimental groups than for those in the control groups. Mothers were asked a hypothetical question regarding the fear or anxiety they believed that they would experience if their child had to have a similar operation within a few days. The control groups reported more intense fear than did mothers in the experimental groups. The nursing staff rated more mothers in the control groups as having intense feelings of distress and great difficulty in adapting to hospitalization than mothers in the experimental groups. Trust and confidence in the hospital staff was much greater in mothers in the experimental groups. The interaction with mothers in the experimental group only at admission was determined to have been "...almost as effective in reducing stress and facilitating adaptation as the interaction at admission plus the reinforcement throughout hospitalization," (Skipper et al, 1968:505), which was employed in the second experimental group. Although the interactions were found to be statistically significant in reducing stress, they alone had not been able to decrease the majority of the mothers' perceived anxiety about a future surgery to a low level. Perhaps other factors had influenced the level of anxiety in the mothers as well as the lack of preparation.

Robinson (1968) found one possible factor which influenced mothers' responses to hospitalization of the child. While doing several hundred interviews for a social survey, he found that there was

"a significant relationship between a high level of fear of being hospitalized herself and a mother's concern about her child's grieving as opposed to its illness." (Robinson, 1968:28). He found, as well, that mothers who had the greatest fear of being hospitalized did not prepare their children for emergency admission. He reported that the more fearful the mother, the less time that she would spend in visiting the child, even when unrestricted visiting policies were in effect. A final point of interest was that Robinson found that the more fearful the mother, the less likely she was to contact the hospital staff even when she indicated that she had complaints about some aspect of the child's care.

Freiberg (1972) interviewed twenty-five mothers after discharge of their children from hospital. The children ranged in age from fifteen months to nine years. The majority of the mothers (sixty percent) were of working class background. When asked to give reasons for anxiety while the child was hospitalized the mothers gave a variety of responses. The most mentioned reasons were fear about procedures and treatments (sixty-four percent); lack of information about procedures and treatments (forty-eight percent); lack of information about diagnosis (forty percent); fear about future health of the child (thirty-two percent); and fears caused by sights of other hospitalized children (twenty-eight percent). When the mothers were asked to comment upon the nursing service, they indicated that their major concern was lack of time spent by the nurse with the child (forty-four percent). When the mothers were asked to report what new negative behaviours they had seen in the child after discharge, sixty percent reported more demands for attention. Freiberg believed that there

were many possible sources which contributed to maternal anxiety including guilt about the child's illness and the mother's own childhood experiences with illness. The twenty-five mothers reported a considerable disruption in the family life because of the hospitalization.

Roskies et al (1975) were interested in emergency admissions of children, an area that they felt had been neglected in the preceding twenty-five years. Their report was of a pilot study done to test the feasibility of studying children in a busy emergency department at a time when stress was likely to be high. Observations were made of eight children, their parents, and the staff working with them during the first six hours of emergency hospitalization. These observations were compared with ones made of eight elective admissions. The ages of the children were from eight months to four years. In order to be included in the sample, the child had to be admitted; be accompanied by at least one parent; be conscious so that his responses could be studied; be of French-Canadian background so that there was no ethnic variability; and to come from the metropolitan area of Montreal. All children who entered the hospital during a set time and who fit all of the criteria were included in the sample. Each parent was interviewed, either at the end of the observation period or upon departure from the hospital whichever came first. During this interview, parents were asked for a history of previous hospitalizations of the child, the events preceding this admission, and what the parents perceived had occurred since they came to the hospital. The primary finding of this study was that emergency admission was more stressful

for everyone involved than elective admission. A few interesting findings were described. The researchers found that seventy-five percent of the elective group of children had never before been hospitalized. This was precisely the reverse finding for the emergency admission group. Another finding was that "regardless of the type of admission, regardless of the age of the child, the almost universal pattern, with very few exceptions, was to give the child no or misleading information about the events he was to encounter." (Roskies et al, 1975:575). It was learned as well that not only did the parents fail to provide information to the child, but they did not "...function effectively in the role of protector...." (Roskies et al, 1975:577). The parents in both groups were viewed as being "...helpless and passive in the hospital environment." (Roskies et al, 1975:578). In the elective admission group, the parents initiated few interactions with the staff and did not utilize opportunities to express concerns, a similarity to the findings of Robinson (1968). Parents in the emergency admission group showed high anxiety with the major concern "...centered on whether or not the attending physician would agree to their request for hospitalization and once the decision to hospitalize was taken, they expressed considerable relief." (Roskies et al, 1975:578). The researchers in this study asked, "Could a high level of parental incompetence and/or anxiety in the face of illness, as much as the illness of the child itself, lead to a pattern of repeated admissions?" (Roskies et al, 1975:580).

Wolfer and Visintainer (1975) carried out two studies which involved the psychological preparation of children and parents for

surgical procedures. In the first study, preparation and support were given to the experimental group at six pre-supposed stress points which were at admission; shortly after a blood test; late in the afternoon on the day prior to surgery; shortly before the child received the pre-operative injection; before the child was taken to the operating room; and after the child came back from the recovery room. Observers rated the child in terms of upset behaviour and cooperation according to indicators such as pulse rate, ease of fluid intake, and first voiding after surgery. The mothers were asked to rate their satisfaction with nursing and medical care and also to rate the adequacy of the information which they were given. An observer rated the mothers on a five-point scale to measure their upset behaviour, ability to cope, and cooperation. Both verbal and non-verbal behaviours of the mothers were noted. Mothers were asked to rate their own anxiety at eight different points, including admission and during surgery. The findings indicated that the children in the experimental group showed significantly less upset behaviour and more cooperation than the children in the control group. Experimental group mothers had "...significantly lower self-ratings of anxiety, rated information received significantly higher in adequacy, and were significantly more satisfied with their care," (Wolfer and Visintainer, 1975:523), than parents in the control group. Parents of children between the ages of three to six years were discovered to be more anxious than parents of older children aged seven to fourteen years. The second study by Visintainer and Wolfer (1975) was done to determine if the six stress-point preparation was more effective in reducing parent and child

anxiety than a one-time preparation session held shortly after admission, at which all of the same information was given as in the multi-preparation sessions. The same rating scales for mother and child were used as in the first study. The results indicated that the multi-preparation sessions were more effective in alleviating anxiety and helping the child and parent adapt to hospitalization.

Some final considerations come from the review of two articles, one by Humberto (1978) and the other by Meng (1980). Humberto observed that "...experiences in early childhood are frequently responsible for the unconscious attitudes observed during adulthood towards illness, physicians and hospitals." (Humberto, 1978:13). He continued:

> Experience shows that many parents who are difficult, and somesometimes even irrational when their children are in need of hospitalization or surgical interventions have themselves suffered from negative experiences with the medical process and hospitals in their own infancies and childhood. Such parents can unconsciously influence in a negative manner the attitude of their children to physicians and to hospitals by passing to their child their own unconscious anxieties. (Humberto, 1978:14).

Meng wrote that "parents who have had little or no past experiences with hospitalization are poorly equipped to prepare their children for impending hospitalization." (Meng, 1980:83). She adds that "...since children are sensitive to parental cues, parents may also benefit from a program designed to help them act as mediators of their child's anxiety." (Meng, 1980:98).

These final two articles seem to sum up some of the problems encountered when looking at adaptation. Parents who have had little, if any, experience with hospitalization cannot assist their children adequately to adapt to the experience while parents with prior

experience may transmit more anxiety to the child. Most of the researchers have agreed, either because of parents' self-ratings or observed behaviours, that anxiety is present in the parent when the child is hospitalized. Some have attributed this anxiety to lack of preparation, lack of visiting opportunities, or fear of the hospital. Other researchers have acknowledged the possibility of the influence of factors such as the child's age and parental obligations on the parents' adaptation to the hospitalization experience. None has examined the parents' adjustment within the framework of an adaptation model.

Roy's Adaptation Model

Roy (1976) identified anxiety as resulting from problems in the self-concept mode. She described how anxiety can be apparent in all four modes when there is a problem in self-consistency. She defined self-consistency as "the part of the person which strives to maintain a consistent self-organization, and thus to avoid disequilibrium." (Roy, 1976:170). In the physiologic mode, within the eight basic needs which Roy identified, there were behaviours that she believed indicated anxiety. Examples of these behaviours, within the appropriate need are: exercise and rest with behaviours of insomnia, hyperactivity, and fatigue; elimination with behaviours of polyuria and diarrhoea; circulation with behaviours of tachycardia and palpitation; nutrition with behaviours of nausea, vomiting, and anorexia; oxygen with behaviours of hyperventilation, dyspnoea, deep sighing; and senses with the behaviour of pain, such as headache.

In the self-concept mode, Roy identified three components.

These are: 1) the physical self, which is often referred to as body image, 2) the personal-self, in which is found self-consistency with its problem of anxiety; the self-ideal, with its problem of powerlessness; as well as the moral-ethical self, with its problem of guilt, and 3) self-esteem, with the individual's perception of his value. Roy defined powerlessness as "the perception on the part of the individual of a lack of personal or internal control over events within a given situation." (Roy, 1976:224). In the role function mode, the role problems identified by Roy were role distance, role conflict and/or role failure, any of which could lead to anxiety. In the final mode, that of interdependence, either dependent behaviours such as complaining, demanding attention and crying, or independent behaviours such as withdrawal, anger at oneself, or refusal to accept help may be manifestations of anxiety.

Summary

Studies have indicated that experimental methods such as daily visiting by parents, support from hospital staff, and information-giving reduced anxiety in parent and child. Prugh's study (1953) indicated that the child's prior experience with hospitalization did not seem to help him to cope, but did not indicate how the parents' experiences may have affected their ability to cope. Robinson (1968) stated that parents who were fearful of the hospital did not visit much and did not prepare the child whether or not they had advance warning of the hospitalization. Godfrey (1955) found that separation at the end of visiting time was easier for parent and child when the child was older. Glaser (1960), in group discussions with mothers,

identified some common themes, including feelings of guilt and conflict between attending to outside obligations, such as work and family and spending time with the ill child in hospital. Preparation of parents seemed to reduce their anxiety and to make them more able to support the child, as shown by Moran (1963) and Skipper et al (1968) among others. One factor which possibly influenced adaptation in Skipper's study was that a number of mothers had post-secondary education. Age ranges of the mothers were given in Skipper's study, but relationships between age and differences in adaptation were not reported. Although many possible variables have been mentioned in the studies reviewed, it appears that further exploration could be done to determine how the mother believes she adapts to the hospitalization of her child, and to see if there is a pattern of adaptation that relates to variables such as the mother's age, educational background and outside obligations, as well as the age of the child and the mother's previous experiences with hospitalization.

CHAPTER III

METHODOLOGY

Design of the Study

An interview guide was formulated which would provide information about the adaptation of a small group of mothers to hospitalization of their children. The interview guide was designed to obtain demographic data about the mother and child. The questions in this section were included as a result of the literature review which indicated that some factors which could have influenced maternal adaptation had been given insufficient study or had not been studied at all. One area which had not been studied was the effect of employment outside of the home on the mother's adaptation. The remainder of the interview guide consisted of eleven open-ended questions. These questions were structured to obtain information about the focal, contextual, and residual stimuli and their effects on the four adaptive modes. These questions were developed, in part, from Roy's model and also from areas suggested from the literature review. One area included here as a result of the literature review and Roy's description of residual stimuli was the question of previous experiences of the mother with hospitalization.

Criteria for Selection of the Sample

Before a mother could be asked to participate in the study, it was necessary to obtain the written consent of the attending physician. (see Appendix A). This stipulation was made by the head of Paediatrics

at the hospital to ensure that the attending doctors were aware that the study was being done. The nursing staff on the unit were instrumental in obtaining the consent of the doctors. A convenience sample was obtained. The first ten mothers who met all of the following criteria were asked to participate in the study. None of the mother refused to take part in the study. The mothers had to have a sufficient understanding of English to give consent (see Appendix B), and to answer the investigator's questions. The mothers had to reside in the Lower Mainland area of Vancouver or to stay near the hospital for the duration of the child's hospitalization so that they were accessible to the investigator. The Lower Mainland area was defined for this study as including Vancouver, Richmond, White Rock, Surrey, Delta, Burnaby, New Westminster, Port Coquitlam, Coquitlam, Port Moody, North and West Vancouver. Only one mother resided outside of this area and she spent the entire hospitalization period with her child. The mothers who were included in the sample had children who were admitted to hospital because of acute medical problems. The nature of the problem varied from child to child, but most were within the category of an acute infectious disease. Examples of the types of disorders seen in the children were acute gastro-intestinal tract and respiratory tract infections, infections of the central nervous system, and skin disorders. If the children were either so acutely ill that they required constant monitoring by the nursing staff or had a life-threatening illness at the time when interviewing would have occurred, then the mothers were not asked to participate in the study. This restriction was imposed by the investigator because of a belief that

it was inappropriate to subject a mother who was likely under a major degree of stress to an interview. A mother of a child who had recovered sufficiently from viral meningitis as to be close to discharge was interviewed, while two other mothers who had children in a critical stage of viral meningitis were excluded. Mothers of children with chronic health problems such as asthma were excluded, whether or not the child had been admitted for treatment of an unrelated acute medical illness. For example, the mother of a child admitted with an acute respiratory tract infection who also had epilepsy was not considered for the study. This restriction was established because the investigator believed from past experience and from review of the literature that mothers who had to cope with a long-term or chronic health problem of their children may have had other problems with adaptation than mothers who had to cope with a relatively short, acute illness. The children in the study were hospitalized, for the most part, for less than one week. Mothers of children between the ages of four weeks and twelve years were included as that was the usual age range of children found on the nursing unit. The children could have been hospitalized prior to this admission as the effect of previous hospitalizations on maternal adaptation was one of the factors in which the investigator was interested. Five of the children had been hospitalized before this admission. All foster mothers and any adoptive mothers who had cared for the child for less than one year were excluded. This exclusion was because of the possibility that there could be a difference in the maternal-child relationship with these types of mothers. During the study period

only one adoptive mother had a child admitted to the nursing unit and this child was only two weeks old so would have been excluded anyway.

Only mothers were included in this study. They are generally the primary caretakers of the child despite trends for increased paternal participation in child care. As well, the mothers were the most accessible to the investigator during visiting hours. There were only two fathers who were present at the time of interview with the mothers. They both stayed with the child while the mother accompanied the investigator and did not participate in any way. In one case, the father did not visit at all because of long work hours and, in another instance, the father no longer resided with the family.

Procedure

Interviews were held with ten mothers during a three week period in August, 1981. These interviews were conducted by the investigator on a paediatric nursing unit of a major Vancouver hospital. The mothers were asked if they wished to stay with the child during the interview or if they would rather go to a conference room which was located on the nursing unit. Most of the mothers preferred to stay at the child's bedside. The length of the interviews varied only slightly with the majority taking twenty-five minutes and none exceeding thirty-five minutes. The investigator approached the mothers while they were visiting the children. In this paediatric unit, visiting hours for parents are unrestricted, but because of time constraints of the investigator, all interviews were conducted either late in the

morning or during the afternoon. The investigator introduced herself and explained briefly to the mother what the study involved. The consent form had a letter attached to it which outlined the purpose of the study. One mother asked for time to consider her participation and was interviewed on the following day. One mother was not on the nursing unit when the investigator arrived so the letter of explanation and consent was left with a visiting relative to give to the mother. This mother was interviewed the next day. All of the remaining mothers consented to immediate interviews.

Two methods were employed by the investigator to determine if a suitable admission had occurred. The investigator either called or visited the nursing unit daily. The nursing staff were all aware of the investigator's project and of the criteria for selection of mothers for the study. They were very cooperative in telling the investigator of any possible subjects. The nursing staff were given a supply of the physician consent forms which they placed on the appropriate charts. Spot-checking by the investigator indicated that the nursing staff were aware of all suitable subjects. One problem that was encountered by the investigator was the small number of admissions to the nursing unit during August. The nursing unit had a bed capacity of approximately forty but as a result of nursing staff shortages and bed closures the admissions had been curtailed severely. Only those children who could not be cared for at home were admitted to the nursing unit. This made it more difficult to obtain suitable mothers than had been anticipated. On one occasion over a weekend there were only eight patients on the unit.

The questions which were asked by the investigator during the interview were pre-tested with two mothers. All of the questions were understandable to the mothers and no modifications were necessary. At the beginning of each interview the mother was asked if she would be concerned if the investigator wrote down her responses while they talked. None of the mothers objected to this procedure. The investigator was able to record almost complete verbatim responses by the mothers. Tape recording of the interviews had been considered but was rejected by the investigator for several reasons. One reason was that the investigator was uncertain about how comfortable the mothers would be with this type of interview. Also, because it was anticipated that some interviews would be held in the child's room and this room was usually shared by at least one other child, the quality of the recordings could have been affected by the extraneous noise. A final consideration was that many of the children on this nursing unit were on isolation precautions and it would have been necessary to take measures to prevent contamination of the recording equipment in order to prevent possible spread of infection.

Confidentiality

Certain procedures were followed by the investigator to ensure the anonymity of the subjects. The mothers were assigned a number according to the order in which they were interviewed. This number was the only identification that appeared on the question and response sheets that were given to two judges who analysed and classified the data for two of the interviews. In the written study, the mothers are only identified by their number. Names of places in which they resided

are identified by letter only to avoid possible identification. The children are referred to by the initial of their first name to prevent identification. The letter which accompanied the consent form explained to the mother that all answers would be kept confidential. Interviews were conducted in such a way that the mother's responses could not be overheard by nursing staff or visitors. All of the interview responses were kept at the home of the investigator and were not accessible to anyone except the investigator. Upon completion of the study, all interviews were burned.

Data Collection Tool

The interview guide (see Appendix C) was used to obtain the information from the mothers. It consisted of two parts which were composed of forced-choice questions and a few open-ended questions to obtain demographic data and open-ended questions to obtain information about adaptation. The demographic data asked for in the interview guide related to the mother's age, occupation, and educational background and the child's age, sex, and diagnosis. The open-ended questions about adaptation asked for information about the child's illness prior to hospitalization; the effect on the mother and the family of the child's hospitalization; the events that could have influenced the mother's responses to the child's hospitalization; and the mother's previous experiences with hospitalization, either when she was a child or with other children. Pre-testing of the questions was carried out not only to determine their clarity but also to see if the information provided by the mother's responses gave insight into adaptation. It was evident on analysing the data that the questions

were clear and did provide the desired information. The length of the interviews was suitable. None of the mothers appeared tired at the end of the time, in fact some mothers expressed surprise when the interview was concluded. The fact that all of the interviews were conducted at the hospital during visiting time meant that the mothers had the visit with their child interrupted for a brief period of time, but none of the mothers objected or felt inconvenienced by this interruption.

Method of Analysis

The responses of the mothers to the questions were written by the investigator during the interview and were transcribed into sentence format immediately after the interview while the content of the interview was recalled easily. Whenever possible, the exact words of the mother were transcribed. Upon completion of the interviews, content analysis was done and the responses were categorized as being in one of the adaptive modes or as being one of the stimuli. Some overlap was apparent between the modes and stimuli, but this was consistent with Roy's model. Because of the small number of mothers in the study, tests of statistical significance were not appropriate. Therefore, the data is described according to the number of mothers or children who were found to have similar characteristics. A summary was made of the demographic data and information pertaining to experiences with previous hospitalization for all of the mothers. The data obtained from content analysis of the mothers' responses are presented in Chapter IV, with direct quotations from the mothers used to illustrate the findings.

Reliability of Categorizations

All of the mothers were interviewed by the investigator and they were all asked the same questions. Two independent judges were asked to do a content analysis of the interviews with the first two mothers. These judges were both nursing instructors one in Obstetrics and one in Paediatrics. One of them was familiar with Roy's model and had worked with it. The other judge was unfamiliar with the model but had done a study of parental adaptation to terminal illness of their child. This latter judge was given a summary of the components of the model and was provided with a list of Roy's definitions. The investigator had categorized the mothers' responses according to Roy's model before giving the interviews to the judges. The judges were unaware of the results of this categorization. The judges categorized the responses of the mothers according to which adaptive mode they believed was affected and according to the types of stimuli which were present. Each judge worked independently of the other. Their categorizations were compared to that of the investigator and to those of each other. It was difficult to make comparisons between judges as they differed in the detail of their content analysis of the stimuli. In the major areas of the adaptive modes, there was little disagreement between them. The identification of the focal stimulus and the residual stimuli was consistent between the judges, however one judge identified more contextual stimuli. In comparing the categorization of the modes and stimuli by each judge with the investigator's categorization the following results were obtained. For Mother #1, the level of agreement between the investigator and judge one was 82.6 percent, and with judge

two it was 89.5 percent. For mother #2, the level of agreement with the judges was 82.6 percent and 92.5 percent respectively. The categorization of the investigator was seen to be reliable based on these results.

CHAPTER IV

ANALYSIS OF DATA

Description of the Sample

Ten mothers were interviewed during the first three weeks of August, 1981. The mothers' ages were between twenty and thirty-nine years, with six of the ten mothers being over thirty years of age. Nine of the mothers lived in the Lower Mainland, while one mother came from Vancouver Island. The children were divided equally between girls and boys. Their ages ranged from four months to just over ten years. Four of the children were less than one year of age and two of them were older than nine years of age. The diagnoses of the children were varied, but all of them were within the category of an acute medical illness. Three of the children were admitted because of febrile convulsions. These children were all under two years of age. Three of the children were admitted with some type of gastro-enteritis. The ages of these children were between three and nine years. Two of the children were hospitalized with an acute respiratory tract infection. Of these latter children, one had a concurrent gastro-enteritis and so appeared twice in the data about diagnosis (see Table I). The remaining three children were hospitalized with diagnoses of viral meningitis, dermatitis, and an infection of the mouth respectively. Seven of the ten mothers had an educational level of Grade 12 or better. Four of the mothers were graduates of a university. Of

Table I

Summary of Demographic Data

Mother	Age Group	Employed	Education Level	Previous Experience in Hospital as a Child	Previous Experience in Hospital with own Children	Sex of Child	Age of Child	Diagnosis
#1	20-29	No	Attended College	Yes-dental surgery	Yes-1	Male	7 mos.	Febrile Convulsion
#2	30-39	Yes[a]	Completed University	No	No	Female	7 mos.	Viral Meningitis
#3	30-39	Yes[a]	Completed University	No	Yes-1	Male	10 yrs.	Stevens-Johnston Syndrome
#4	30-39	No	Completed University	No	Yes-1	Female	4 yrs.	Diarrhoea, Bronchopneumonia
#5	20-29	Yes	Less than Grade 8	No	Yes-8	Female	4 yrs.	Bloody Diarrhoea
#6	30-39	Yes	Completed Grade 12	Yes-tonsils	Yes-2	Female	9 yrs.	Diarrhoea, Vomiting and Dehydration
#7	20-29	No	Less than Grade 10	Yes-2 yrs.	Yes-many	Female	1 yr.	Pyrexia, Febrile Convulsion
#8	30-39	Yes[a]	Completed University	No	Yes-1	Male	4 mos.	Dermatitis
#9	30-39	Yes	Completed Grade 10	Yes-many	Yes-many	Male	6 yrs.	Pyrexia, U.R.I.
#10	20-29	No	Completed Grade 12	Yes-tonsils	No	Male	1 yr.	Febrile Convulsion

a works as a nurse aide

these four mothers, two were registered nurses in the Philippines and one had a degree in home economics from the Philippines. All three of the latter mothers were employed as health care workers; one in a paediatric unit, one in a nursing home, and one in an extended care unit. Two of them were employed by the hospital to which their child was admitted. Six of the mothers were employed in an occupation outside of their home. Of these mothers, one was on maternity leave, one was on holidays, one was on sick leave because of a car accident, and one worked part-time. The mother who was on holidays had resigned from her job with her resignation coming into effect at the end of the week during which she was interviewed. The mothers who were not on leave from their jobs had made arrangements to be absent from their work for long periods of time so that they could be with the hospitalized child. These mothers stated that they did not have to work as the family did not need the money. All of the working mothers were the primary caretakers of the child. The mother who worked part-time did have some assistance in caretaking from the maternal grandmother who lived with the family. Five of the mothers were born in a country other than Canada. All of them spoke English more than adequately as they had resided in Canada for at least seven years. For four of the mothers, the hospitalized child was their only child. Two of these four children had been in hospital before this admission. The ages of these children ranged between four months and four years. Five of the total number of children had been in hospital at least once prior to this hospitalization. As well, four mothers had experience with other children in the family having been hospitalized, generally because of an acute medical

condition, such as croup and gastro-enteritis. In total, only two mothers had not had a child in hospital before this admission and one of these mothers worked in a paediatric unit as a nurse aide. Five of the mothers were hospitalized themselves as children and two of them had negative feelings about this hospital experience. Both of these mothers were hospitalized extensively, one for a two year period and one on multiple occasions during a four year period. The three mothers who stated that they had no negative feelings about hospitals had undergone minor surgical procedures, two having had tonsillectomies and one having had dental extractions. The ages of the mothers at the time of the childhood hospitalization were from five to fourteen years. Age did not seem to be a factor in respect to how the mothers recalled the hospitalization experience. The mother who was the youngest at the time of hospitalization as a child had no negative feelings, while the mother who was the oldest at the time of hospitalization as a child had very strong negative feelings.

Reactions of the Mothers to the Hospitalization of the Child

For four of the mothers, admission of their child to the hospital was totally unexpected. These children became ill quickly, and were admitted to hospital within twenty-four hours of the onset of symptoms. Two of the children were admitted after an abrupt onset of pyrexia which led to convulsions within a few hours. The children of the other six mothers had been ill for periods of time varying from several days to several weeks prior to admission. Two of the mothers had indicated to the doctor that they wanted to have their children

admitted to the hospital. One of these mothers who worked as a nurse aide in a nursing home and whose four month old son had been ill with dermatitis for several weeks, stated "I cannot do the care at home anymore. All I can do is keep telephoning the doctor. It is better to stay here so the nurses and doctors can do something. We will stay here until he is better." The other mother was told by the doctor that she could keep her four year old daughter at home, except "if I was really worried, we could admit her to the hospital." The mother told the doctor that she wanted the girl admitted. The child had been ill for only one day, but had diarrhoea with blood in it. The mother stated that she was "used to" her children being in hospital as she had eight previous experiences with hospitalization of her other two children, a boy age nine years, and a girl age eleven years. Both of these children had been hospitalized with diarrhoea, the girl once and the boy three times and were on the same nursing unit as the currently hospitalized child. Also, the son had undergone several surgical procedures including hernia repair, tonsillectomy, and correction of "crossed eyes" making a total of seven hospitalizations for him since birth.

Mother #1, whose seven month old son had a febrile convulsion, and was flown by air ambulance to the hospital from Vancouver Island, stated that she was "scared." Mother #2 had a baby girl, who was seven months of age and who had viral meningitis. This mother, who worked as an aide on a paediatric ward, stated that she was "shocked" by the diagnosis. She said, "I was not expecting meningitis. It was right out of my mind. I cried and cried, and said, 'Why meningitis?'."

Mother #3's ten year old son developed mouth sores on the day following a dental appointment to be fitted for braces for his teeth. This mother stated, "I was really shocked. It was very sudden. The doctors said they don't know the cause." The four year old daughter of Mother #4 had developed pneumonia following an illness with "atypical whooping cough" and later developed diarrhoea as well. This mother had mixed feelings about her daughter's admission to hospital. She stated that "I didn't want her to come into hospital. I was glad that they were going to do something because she wasn't getting any better at home. I wasn't getting any sleep. I guess the way I felt was glad." Mother #5 was one of the mothers who wanted her child admitted. Her four year old daughter had diarrhoea with blood in it. This mother stated:

> You never want to believe you have to bring her in. It is the safest place to be. You are afraid that at home you are not doing everything. Safe - doctors and nurses are here. At home most people scare you. You talk to people, they tell you different experiences with kids, talking about things and make you feel worse. You start worrying. Not every child is the same. It is safer to be in. I'm afraid the others are going to catch it too - best to be in hospital with other kids.

This mother was the one who had had numerous experiences with hospitalization of her other children. Mother #6 had a nine year old daughter who was admitted because of diarrhoea, vomiting, and dehydration. The mother stated that she felt the hospital was "the best place for her. She could get dehydrated very easily, as she's not keeping things down." This mother added that "nobody likes to go, but this is where she belongs when she is that sick. Mother #7, whose child had pyrexia and febrile convulsions, said she was "quite willing" to bring her one year old

daughter into hospital. This mother stated that she had "refused" to bring the child in the day before when she had a convulsion because she "could not get the doctor to acknowledge my calls. The nurse told me to bring her into hospital," but the mother would not do so until she heard from the doctor. This mother regretted admitting the child as she said, "I could have done the same at home if I had carried on for a couple more hours." She did say that she was "relieved" by having a number of tests done, which were all negative. The other mother, who had asked to have her child admitted, and who was also a nurse aide, was Mother #8. Her four month old son had dermatitis. This mother had been to several doctors and had followed several prescribed treatments with little success before her son was admitted. Mother #9 had a six year old son, who had an upper respiratory tract infection and pyrexia. This mother had telephoned the doctor repeatedly over several days because of her concern about her son's continuing high temperature. On the day of admission, she had spoken to the doctor once. Later that day, her husband telephoned to the doctor and it was at this time that the doctor told the family to bring the child in to the hospital. This mother described her feelings as "mixed." She said, "I was relieved because they would do something, but I didn't want him to have to come in to the hospital." Mother #10, whose child was one year old on the day of the interview, which was also the day of discharge, was "very nervous" because her son had a febrile convulsion. She said, "I was relieved - if I had him at home I'd panic. Here there was somebody watching him that knew what to do." Although some mothers reacted to the need for hospitalization of their child with feelings of shock and

fear, many reactions indicated that the majority of mothers were relieved. This relief was based upon their belief that the hospital was where the children belonged when they were sick. The mothers believed that in the hospital their children would be given the proper care by the doctors and nurses, care which the mothers found that they were unable to provide for the children while they were at home.

For nine of the mothers, the illnesses and hospitalizations of the children were the only focal stimuli which confronted them. Mother #1 was the exception. She was extremely worried, not only about her son's illness, but equally she was concerned about the financial situation of the family. These two stimuli were closely connected for, if the child had not been admitted to a hospital some distance from home, the financial concern would not have been of such magnitude. This mother stated that she was "afraid" to tell the doctors or the nurses about her lack of finances because "they might make me take the baby out of the hospital because we can't pay." For this mother "things couldn't be worse." The mother, father, and another child, who was twenty months old, were living in their trailer which was parked on the street outside of the hospital, as "we have no money to pay to park it anywhere else." The father and young child had come to Vancouver two days following the admission of the baby to hospital. The mother said, "We have enough money to see that C. gets fed," and that the parents were "eating a little until the money runs out." Obviously, this mother felt very much alone as she said that "we don't know anyone east [sic] of Ontario," other than their friends in the small town on Vancouver Island where they lived. The mother referred to the financial

concerns several times during the course of the interview. After the interview, she related the problem to the head nurse on the unit and a social worker was called. The investigator saw the mother on the following day, and she said that "things are much better."

Effects on the Mothers' Physiologic Mode

The focal stimulus of the child's illness and subsequent admission to hospital produced a few effects in the mother's physiologic mode. Anxiety about the child may have been apparent in several behaviours, which affected the needs for nutrition and exercise and rest. Roy believed that behaviours such as nausea, vomiting, anorexia, insomnia, and fatigue were indications of anxiety in the physiologic mode. Nine of the mothers reported some sleep disturbances, which ranged from difficulty falling asleep to inability to sleep very much at night. Six of the mothers commented upon their lack of appetite. Four of the mothers stayed with their children day and night. Mother #2 stated, "I'm afraid to leave her alone, it's sometimes hard to settle her." When this baby, who had meningitis, had an elevated temperature, the mother woke up "q.2.h. to sponge her" during the night. Mother #3 was participating also in the care of her child, and, like Mother #2, was a nurse. She stated, "I can't sleep. I have to wake up q.2.h. to do mouth care," for her son who had a mouth infection. Mother #5, who had many experiences with hospitalization of her older children, stated that she was "tired - not too bad. I stay on the bed with a pillow. The chair was killing me. If she wakes up she sees me and goes to sleep." Mother #7 had gone home the first night that her one year old daughter was in the hospital, but "I was uncomfortable all the time and

so was she. She cried a lot." This mother stayed with the child the next night. The remaining six mothers did not stay all night, but they remained until late in the evening or until the child was sleeping before they went home. As Mother #7 stated, "I sleep, but I lay there for a while before I go to sleep." This mother felt that "I am just so tired I have to sleep."

Mother #1 was "not eating much," but this was partly related to the lack of finances. Mother #2 did not feel that she was "getting enough food. I've lost weight." Mother #3 felt that she had lost weight too. She stated, "sometimes I cannot eat, or forget to eat. It is lunch or dinner time, and I have not eaten." The husbands played a role in providing food for Mother #2, Mother #3, and Mother #5. However, as Mother #3 said, "sometimes I cannot eat it." Mother #4 said, "I can't be bothered to eat." Her husband had a part in getting her to eat as he took her out for some meals. He had taken her out to lunch on the day of the interview, the first lunch that this mother had eaten in four days. Mother #9 was not certain if the hospitalization of her child had affected her or not as she said, "I have been off my food and sleep anyway," as a result of discomfort from an injury caused by a car accident a few months earlier. Mother #10 stated, "yesterday I did not eat anything. I just wasn't hungry." This statement seems to sum up the feelings of most of the mothers.

Effect on the Mothers' Role Function Mode - Problem of Role Conflict

One of the modes most affected by the focal stimulus of the child's hospitalization was the role function mode. The ten women had a

variety of roles, which included mother, wife, daughter, and, for six of them, employee. Half of the women who were employed held jobs as health care workers, in which they had a nursing role. It was interesting to note that two of these three mothers stayed with their children all of the time and provided the majority of the care. Mother #2 saw herself as having a nursing role for she stated, "if I stay, I can share what I've observed and take care of her." For this mother, a reason to stay with the child was that "the nurses can't stay with her all the time, they have other patients to look after." Mother #3, who was taking a leave of absence from her work as a care aide in order to stay with her son, related the inter-role conflict that she experienced. She described how her supervisor had "'phoned the ward one day to ask me to come to work because they were short staffed." This mother said that she went to work but "I couldn't stop thinking about him. It affects me when I'm working." The mother felt that she was entitled to be away from work as "it's in the contract." Mother #8, who was the other nurse, was on maternity leave still, but was due to begin work at the end of the week during which she was interviewed. The mother stated that she "may not return to work" as scheduled. She said, "it depends if they will give me some days to look after my baby." This mother, whose child was the youngest of all of the children, went home in the evenings. She was not as involved in the nursing care of her baby as were Mother #2 and Mother #3 with their children. At one point during the interview, she stated that "the doctors and the nurses can give the baths and ointments," and another time she said, "I am doing some feeding and changing. The nurses ask me if I want to do the treatments,

and I do sometimes, if I know how." This mother had been doing treatments at home for many weeks before the baby was admitted. The other mothers who were employed were Mother #5, Mother #6, and Mother #9. This latter mother was on sick leave and so had no problems with inter-role conflict between the mother and employee roles. Both Mother #5 and Mother #6 had been able to take some time off from their work. Mother #5 usually worked part-time. She stated that she was supposed to be working full-time now because "it is the holiday period" for the regular full-time staff. She stated that she was "worried about my sister-in-law," who worked for the same employer and who had been responsible for helping her to get the job. She said, "my sister-in-law is doing both jobs. I worry for her that she will be tired." Mother #5 discussed as well the conflict that she felt between her role as mother and her role as employee. She said, "My children miss me, they were used to me staying home. I was home for eleven years with them. They don't want me to work, even part-time." This mother felt a need to work, not because of financial considerations, but because "I want to be interested in something outside the home." For Mother #6, staying off of work was not seen as a problem. She had continued to work when her child first became ill and her older daughter, aged fourteen, looked after the child at home. She stated, "Work is very slack, I can pretty much write my own time. That makes it easier, except it is less pay." This mother denied that finances were a concern as she said, "I don't have to work."

Concern was shown by many of the mothers who had other children at home. Intra-role conflict was evident for Mother #3, who stated,

"I'm thinking about my children too." Mother #4 seemed surprised when she realized that "I haven't even thought about him," referring to her son at home. She was reassured that this boy was "quite happy" with his grandmother and said, "I don't have to worry." Mother #5 was "concerned that I am away from the other kids." Mother #6 remarked that "I'm more uptight with my older daughter. She's fourteen, that's a bad age anyway." This mother had visited one afternoon with her older daughter, but left early because "A. got restless and wanted to go."

Inter-role conflict between the mother and wife roles was not seen as a problem for the mothers. Many of the husbands were viewed by the mothers as being supportive by bringing the mothers food or taking them out for meals. Mother #1, who had flown to Vancouver with the ill baby, was joined by her husband a couple of days later. This husband took holiday time in order to join his wife. He relieved the mother by staying with the ill baby periodically. Mother #2 described how her husband "goes to his sister's to pick up food, then comes to the hospital," after work each day. This father fed the sick baby while the mother came to be interviewed. Mother #3's husband looked after the other children during the evening. He brought them to the hospital sometimes so that the mother could see them and so they could see the ill sibling through the window. For Mother #4, the husband served as chauffeur, driving her to and from the hospital. He took her out to dinner each evening and for lunch once. This father was self-employed so he was able to leave work whenever he wished. The husband of Mother #5 brought food in for breakfast so the mother who had stayed all night would have something to eat. Mother #6 believed that one of the things

which made it easier for her to cope with her child's hospitalization was the fact that "my husband is not that demanding." This husband worked "twelve hours a day, seven days a week." Mother #7 did not have a husband. Mother #8, who was a nurse's aide, was married to a man who was a practical nurse. This father came to visit his sick baby after he was finished work each day and took his wife to dinner. The husband of Mother #9 was perceived by her as being instrumental in getting the child admitted to hospital for it was after he called the doctor that the doctor decided to admit the boy. Mother #10's husband had been away when the child became ill and had a febrile convulsion. The mother stated, "I haven't told my husband yet. He calls to-night - oh boy! He gets very panicky, worse than me."

One other type of role function problem was seen. Mother #9 was herself ill with a neck injury from a car accident and had been on sick leave from work as a result. Inter-role conflict was present for this mother between the roles of sick person and mother. She stated that, "I was exhausted trying to get his temperature down. I hurt my back putting him in and out of the tub." She found that her ability to visit the ill child was curtailed because of her injury and this was a concern to her. She said, "I'm spending as much time as I can. I would like to spend more time, but I just can't. None of the mothers appeared to be experiencing actual role failure. All of them were responding to the ill child's need for mothering, but had also made arrangements to fulfill their other obligations to children at home and to their employers when necessary. As Mother #7 said, in reference to her decision to stay all of the time with her sick child, "I didn't

think she'd get the care. They are qualified, but not in mothering, and the nurses don't have the time."

Effect on the Mothers' Self-Concept Mode

Roy (1976) described self-concept as consisting of the physical self, which is often referred to as body image, and the personal self. She divided the personal self into three components; the moral-ethical self with its problem of guilt, self-consistency with its problem of anxiety, and self-ideal/self-expectancy with its problem of powerlessness. All of the components are closely related to self-esteem. Many of them were affected in the mothers.

Physical Self. Body image was affected for some mothers as a result of the focal stimulus of hospitalization of the child and the effect on the need for nutrition. Mother #2 and Mother #3 both commented that they had lost weight. Mother #3 stated also that "I have lots of pimples - never had them before. They are on my forehead and here," pointing to her cheeks. Mother #1 and Mother #5 were concerned about being able to "get cleaned up." For Mother #5 this was made possible by having her mother-in-law stay with the ill child while she went home for a short time. Mother #1 was able to go to the trailer, which was parked outside of the hospital, while her husband stayed with the ill baby.

Problem of the Physical Self - Loss. Some mothers commented upon a problem which Roy called loss. She viewed loss as being a problem of the physical self. Roy described examples of loss, which

included loss of a job, material comforts or security; uprooting of a family; and divorce (Roy, 1976:194). In looking at ways in which people coped with loss Roy saw behaviours such as shock and disbelief, denial, anger, expressions of hopelessness, and withdrawal. In assessing how the ten mothers responded to the stimulus of hospitalization, some examples of feelings of loss were apparent. Mother #1 described the sense of isolation that she felt because she and her family were alone in a place where they had no friends or relatives, which led to feelings of insecurity. As well, the possibility existed for this family of a move to a new area because of the child's illness. The doctor had advised her that this would need to be considered. This move would mean a further loss of the security of being near friends. Mother #2 and Mother #3 related how they were "shocked" by their children's diagnoses and need to be hospitalized while Mother #5 said that "you never want to believe you have to bring her in." A different potential loss faced Mother #8. She was considering the possibility of not returning to work as scheduled if she could not get enough time off to care for her ill baby. This could have led to a termination of the employment for her.

Moral-Ethical Self - Problem of Guilt. Few of the mothers expressed feelings that could indicate a sense of guilt because of their child's illness. All of the mothers had sought medical attention for their children without delay once the child's symptoms had shown no signs of improvement. A couple of the mothers did comment that they were "glad", or "relieved" to have the child in hospital because of a lack of improvement with the mother's care at home. Mother #4 stated, "I was glad they were going to do something, as she wasn't getting

better at home." Mother #5 mentioned that she was "afraid that at home you are not doing everything." Mother #8, in discussion of the onset of her son's dermatitis, said, "He had a rash which started on his face. I didn't pay any attention to it. The doctor said 'no soap'." This same mother remarked that "I cannot do the care at home anymore." Mother #9 said that in the hospital "I knew he'd probably get help. My hands were tied at home." Mother #10 was relieved to have her son in the hospital as she felt that "if I had him at home, I'd panic. Here there was somebody watching him that knew what to do." It is difficult to know if these types of comments from the mothers indicated a sense of guilt because of their inability to help their children get well or if they were indications of adaptation in the Interdependence mode.

A possible area of guilt for some mothers was related to the neglect of their work responsibilities. Mother #5 commented that she was worried about her sister-in-law, who was doing this mother's job as well as her own job. Mother #3 had taken a leave from her work as a nurse's aide. However, when she was asked by the supervisor to return to work because of staffing problems she did, although she worried about leaving her sick child. It was probable that she was motivated by a sense of guilt to return to work and then felt guilty about leaving her child.

A different source of guilt was found for Mother #9. She was recovering from an injury and was physically uncomfortable if she stayed with the child for any length of time. She did feel guilty because of her limited visiting ability, for she said, "I would like to spend more time, but I just can't." Mother #4 may have felt a sense of

guilt for not spending the night with her daughter. At one point in the interview she said, "I knew either I was going to have to stay, or she would cry all the time." Later, when she described that she went home each evening, she said, "I hate to do it, but I couldn't stand to stay here. Staying late is bad enough."

Self-Consistency - Problem of Anxiety. Roy described the problem of anxiety as one which occurred when the person's stable self-image was threatened. She stated that acting as stimuli for the behaviours associated with anxiety were threats to self-consistency. These threats were a sense of helplessness, a sense of isolation, and a sense of insecurity (Roy, 1976:218-219). Analysis of the interviews with the ten mothers showed some responses which could have been indicative of anxiety and which resulted from one or more of these threats. Mother #1 expressed feelings of insecurity, helplessness, and isolation. She described how she felt when she and her son were brought to the hospital by air ambulance when she said "I was scared. I didn't know what was happening." Feelings of isolation and helplessness were evident when she stated that she had to leave home and "I don't know anyone here. I didn't know where to stay. The nurses found me a place for two nights." Later in the interview she stated " There is no-one to help. Our friends are in P.H., and there is no-one else east [sic] of Ontario." Mother #2 described how she "cried and cried. I said 'Why meningitis?'," when she was told the suspected diagnosis, indicating her feelings of insecurity and helplessness. Mother #3 was concerned because "no-body comes to visit." She appeared angry when discussing the lack of visitors and said, "I think it is because he is

on isolation. Maybe they think they will get something." Mother #4 described her anxiety during the early days of hospitalization. She was concerned because "nothing seemed to happen the first couple of days. They didn't know what it was." This mother was concerned because "K. was always crying, and she is never like that. I think she has gone back a few steps." She described how K. had regressed with toilet habits, as "even with her water, she did it in her pants." Mother #5 and Mother #10 appeared to feel more insecure and anxious at home than in the hospital. Mother #5 described how "at home, most people scare you. You start worrying more, not every child is the same. It is safer to be in hospital." Mother #10 had said that "if I had him at home I'd panic." Mother #6 was anxious because she felt that everything was going wrong. She said, "I am losing track of everything. I had a leak in the car radiator on the way home yesterday. On Tuesday, I plugged in the toaster and the fuse blew." This mother was anxious, also, because of the uncertainty of her child's diagnosis. She stated, "I'm worried. I wish they would find out how they were going to treat her, if they could treat it, or if it is just something that has to run its course." Mother #7's sense of helplessness and isolation before the hospitalization of her daughter was apparent. She remarked that:

> The doctor wasn't concerned with a temperature of 104° for sixteen hours like I was. I took her to the Emergency department in L., and they checked her out and said she could go home. I had packed her in ice, with a fan blowing on her, and was giving Aspirin and Tempra every two hours, first the Aspirin and then the Tempra, to try and bring her temperature down.

The mother had carried out this treatment all weekend with no effect as the child had a febrile convulsion on Monday. Mother #8's sense of

helplessness was evident as she described how she had gone from doctor to doctor to try and find some treatment that would clear up her son's dermatitis. The mother became so anxious because of the lack of improvement, that she finally telephoned the paediatrician and asked to have her baby admitted to the hospital. Mother #9, also, felt a sense of helplessness while at home, which she described by saying, "My hands were tied. I was exhausted trying to get his temperature down."

Self-Ideal/Self-Expectancy - Problem of Powerlessness. Some of the responses of the mothers, which have just been described, could have indicated a sense of powerlessness as well as anxiety. Roy believed that powerlessness was related to the fact that the individual felt he had no control over what was happening to him. She described how this sense of powerlessness could be related to lack of knowledge, helplessness, and lack of decision-making ability, such as was seen with a focal stimulus of illness and hospitalization (Roy, 1976:225-227). Anxiety can result for individuals who feel powerless. Therefore, it was difficult to determine if the cause of the mothers' anxiety was due to problems of self-consistency or problems of self-ideal/self-expectancy.

One mother felt less powerless because of the experience of hospitalization. Mother #10 felt that she would be able to cope better in the event that her child became ill another time. This mother who had stated that she would "panic," if she had not brought her son into the hospital after his febrile convulsion remarked that "I feel better now, as I know about bathing him and giving him aspirin if he had a

fever another time." Her level of knowledge had been increased by this experience so that her feelings of anxiety, because of powerlessness, were reduced.

Interdependence Mode

Roy described this mode as consisting of both dependent and independent behaviours. She classified dependent behaviours as ones where the individual exhibited characteristics of help-seeking, attention-seeking, and affection-seeking. Independent behaviours were seen as ones where the individual showed initiative-taking or obstacle-mastery (Roy, 1976:297-300). Both dependent and independent behaviours were seen in the mothers.

Mother #1 showed a reluctance to seek help with financial problems, which indicated both a lack of help-seeking and obstacle-mastery. This was related to her extreme anxiety because of her fear that her child would be sent out of the hospital once the family's financial status was known. For this mother, her fear had paralysed her so that she could do nothing to reduce it. In contrast, when this same mother related a previous experience with hospitalization of the same child, she did describe independent behaviour in regard to obstacle-mastery. She stated, "I had to fight to get him admitted," and described her persistence in her discussions with health team members. Also, she described how "I take him in to the clinic for a chest exam, whenever I think he needs looking at," which was a combination of initiative-taking, independent behaviour and help-seeking, dependent behaviour. Many of the mothers, like Mother #1, showed behaviours of both initiative-taking and help-seeking in calling the doctor, sometimes

persistently, as with Mother #7, Mother #8, and Mother #9, when their children became ill. Mother #2 showed independent behaviour when she took the initiative to suggest to the head nurse that the baby should be fed on demand instead of following the two hourly feeding routine of the hospital. The mother felt that her baby would be less likely to vomit if this feeding practise was followed and she was right.

Some dependent behaviours in terms of help-seeking from family and friends were evident in the mothers, as well. Mother #3 had relied upon her father-in-law to bring the ill child and herself to the hospital and upon her mother-in-law to care for the other children at home. Mother #4 depended upon her mother and mother-in-law to care for her other child. For Mother #5, the presence of her mother-in-law during visiting time meant that she was able to go home for a short rest. Her sister-in-law's willingness to do this mother's job, as well as her own work, meant that Mother #5 could stay with the hospitalized child. Mother #6 had left her ill child in the care of her teenage child while she went to work when the little girl was first ill. Mother #7 had left her other child in the care of a friend while she stayed with the sick baby. As well as these examples of help-seeking, the fathers were often very helpful to the mothers as was described earlier in this chapter.

Contextual Stimuli - Their Influence on the Mothers' Adaptation

As well as the fact that the mothers sought help from family and friends, the fact that this help was given served as a contextual stimulus for at least the self-concept and physiologic modes. There

were other contextual stimuli, as well, which affected the mothers' adaptation. One of these stimuli was the number of children in the family. For four of the mothers, the hospitalized child was their only child. This contextual stimulus allowed them to devote all of their time to the ill child which influenced their adaptation in the physiologic, self-concept, and role function modes. Mothers who had more than one child had a contextual stimulus which affected their inter-dependence mode as well as the other modes because they had to ask family or friends to care for these children. As well, the ages of the children were a contextual stimulus for the adaptation of these mothers. Some examples follow which will illustrate how these contextual stimuli affected adaptation.

Mother #5 was concerned because "I am away from other kids." She was "afraid others are going to catch it too," and described how her son was "weak" and that "everything around he catches, no matter how careful." This mother felt that, because the hospitalized child was her youngest one, she had to stay with her. She described how, when her son was hospitalized, she did not stay as much with him because this youngest child needed her at home. Mother #6 believed that, because her only other child was older, this made it easier for her to be with the hospitalized child. Mother #9 expressed similar feelings when she said, "The other kids are old enough to look after themselves."

Whether or not the child had been away from home before was a contextual stimulus for the mothers' adaptation, primarily in the role function mode and self-concept mode. Mother #3 felt that she had to stay with her son all of the time because "this is the first time away

from me. He would cry if he was away." Mother #5 had similar concerns and said, "I can't leave, even for a minute, even to go to the bathroom. She cries. She has never been away." Mother #7 felt that "I had to spend most of the time with her. She cried and got upset when the doctors came near her." This was the first hospitalization for this child. Mother #9 stated that "I wasn't sure how he'd react. He hasn't been in hospital for about three years." This mother went on to say that she was concerned about "how to leave, when you do leave."

The amount of travelling that the mothers had to do and the ease of travelling was another contextual stimulus for some of them. This stimulus affected their adaptation primarily in the physiologic and interdependence modes. Mother #1's problems, which arose from the distance that she and her family were from home, have been discussed thoroughly in earlier sections of this chapter. Mother #4 said that "being at this hospital is a pain in the neck," because she lived in another part of the Lower Mainland. This mother continued, "I am going to switch family doctors. It is ridiculous to have to come all the way across town." She had to rely upon her husband to bring her to visit, as "I don't drive." Mother #5 did not have the same problem as she said, "It is not too far to go home, but I don't drive." Mother #6 said that one of the things which made the hospitalization difficult for her was "the driving. I'm up at 5:30 and back at 11:30, driving back and forth." Mother #9 was disturbed also by the "extra running around." Mother #10 did not have a concern about travelling as she said, "I drive. I have my own car." She was

staying at her parents' home, and felt that this was a help when her child had the convulsion for she said, "If I was home alone, I don't know what I'd have done. It was just fate, I guess, that I'd stayed overnight."

The responses of the members of the family to the child's hospitalization may have affected the mother's adaptation in the role function and self-concept modes. It was not entirely clear if this was a contextual or residual stimulus for some of the mothers. Mother #3 described how her children had reacted to J.'s hospitalization because of a mouth infection. She stated, "The children don't want to go out to play, just stay home and watch television, especially my younger son. Their father says, 'Go outside and play', but they just stay in." The mother described how the children responded when their father brought them to the window of the hospital to see J. She said, "They are very happy to see J. They come and wave to him." Mother #4 believed that her other child was "more concerned when K. was still home." She felt that this was because she spent so much time caring for the little girl, when she was at home. She related that her son "brought her a stuffed animal. He won two at the P.N.E. Playland." Mother #5 believed that her son was affected by his sister's hospitalization. She stated that he had headaches "more than usual. He gets them when he's nervous or thinking about something." Mother #7 felt that the hospitalization of her one year old daughter had affected her son. She stated, "It is really bad - really upset him. He saw A. in convulsions." This mother did not believe that her son was concerned because she was staying all of the time with the little girl. She

said, "He understands. He wouldn't care if I went to the moon as long as she was home. He is more upset by A. being here." Mother #9 believed that her family was affected by D.'s hospitalization. She said, "They are all down about it. One of the twins is very upset. They want him home. They fight over who is going to come. He's the baby - the spoiled one." The twin whom the mother perceived as being upset had been hospitalized a year earlier. The mother said, "She doesn't like hospitals. She's like me." Very few of the mothers commented upon reactions of other family members. Mother #8 said of her husband, "He is worried." Mother #10, who was at her parents' home when her son had the convulsion, said, "My mother's a nervous wreck. My father was scared. My brother is there too; he's scared too."

Some of the mothers had experiences with health team members which could have been contextual stimuli for their adaptation in the interdependence mode. Again, some of these experiences may have been residual stimuli; it was difficult to categorize them. Mother #1 said that nothing had made coming to the hospital easier for her except "maybe that I know the doctor." She stated, "I knew he would take care of him." Mother #3 remarked about the availability of health team personnel to care for her sick son in the hospital. She said, "The doctors are here and the nurses to look after him." Also, she said, "Lots of students come in to see him. This is a rare condition. He is not so sick as some children have been." The mother did not object to the students coming in as she said, "They can study his case and learn." Mother #4 seemed to believe that more would be done for her daughter by

the hospital staff than by her family doctor. She stated, "Our family doctor had taken a chest X-ray, but nothing had been done. In hospital she would have X-rays," which was important to her as she continued, "I don't know if the pneumonia was the same as when she first had an X-ray." The mother continued, "She has never had a complete physical. Here she had a tuberculin test and everything." This was important to the mother because "my husband is positive T.B., and he always said she should have a T.B. test." Mother #5 saw the hospital as a "safe" place because "the doctors and nurses are here." The mother explained that the doctors were "really nice people; you got to have confidence. Nurses are nice too." Mother #6 had help from her doctor when her child began to have blood in her bowel movements. The doctor told the mother to take the child to Emergency, but the mother said, "I'd rather not, you are so long waiting," and so she said, "the doctor got her admitted." Mother #7, in contrast, was concerned about her doctor's lack of help. She said, "The doctor wasn't concerned with a temperature of 104° for sixteen hours like I was." She related that "I couldn't get him to acknowledge my calls." This mother believed that she had to stay with her daughter, as "I didn't think she'd get the care. They are qualified, but not in mothering and the nurses don't have the time." Mother #2, who was a nurse herself, had some similar perceptions of the nursing staff for she said, "The nurses can't stay with her all the time. They have other patients to look after." Mother #8 had seen several doctors trying to find an effective treatment for her infant son's dermatitis. She changed doctors a final time because "a friend said 'Try another

doctor'." The mother felt that the hospital was the place for her baby as she said, "It is better to stay here so nurses and doctors can do something." Mother #10 believed that she had received support from the health team. She said, "I was very nervous. The ambulance driver calmed me down. The doctor came and saw him. The nurses were nice; they calmed me down."

The educational backgrounds and occupations of the mothers could have been contextual stimuli for adaptation in the role function and self-concept modes, although it was possible that they were partly residual stimuli too. Because some of the mothers were nurses, they appeared to feel that they should do the child's care. However, some non-nurse mothers participated in the care of their children too. Mother #2, who was a nurse in a paediatric unit, said, "I want to make sure what's happening and to participate in looking after her." Mother #3, who was a nurse also, said, "I want to do the nursing care." Mother #4, who was not a nurse, but was the only non-nursing university graduate, said that she gave all of the care. She said, "At first, I couldn't bath her with the intravenous, just wash her in bed. I don't mind doing the care; it is just as easy for me to change the sheet than to call the nurse to do it. I call the nurse to take the bed pan." Mother #5 had less education than any of the mothers, having not completed Grade 8, but she had the most experience with hospitalization of her children. Mother #7, who had not completed Grade 10, also provided most of the care for her baby. Mother #8, the other nurse in the sample, did some of the care letting the nurses do many of the treatments.

A few other contextual stimuli were identified for individual mothers. Mother #1 was away from her support system of friends, which affected her adaptation in all of the four modes. Mother #2 was supposed to have gone to the Philippines for her parents' golden wedding anniversary and to sign some papers so that property could be sold. Adaptation in the role function and self-concept modes was affected as she cancelled the trip. When speaking of her reasons for this cancellation, she said that the baby was "the most important to me. She might get sick when we were away." Mother #4 had to cancel plans for a trip, also. She said, "We were supposed to go away this weekend, but couldn't go." Mother #9 had a different problem. She said, "We have company from out-of-town. They came yesterday." This mother's adaptation in the role function and self-concept modes was affected also because of the contextual stimulus of the injury to her neck, which prevented her from staying with her son as much as she wanted. For Mother #10, the fact that her husband was out of the city was a contextual stimulus affecting her role function and interdependence modes.

Residual Stimuli - Their Effects on the Mothers' Adaptation

As was discussed in the preceding section, it was not always possible to differentiate between contextual and residual stimuli. However, there did appear to be some definite residual stimuli, which influenced adaptation in the modes. These stimuli were related to the mothers' previous experiences with hospitalization, either of themselves as children or with their own children. Mother #1 was in the

hospital for dental extractions when she was fourteen years of age. She said, "I was in and out the same day. It didn't bother me. They put me to sleep, took out the teeth, and when it was over I went home." She had less positive feelings about her son's hospitalization which could have affected her adaptation. She related how J., the currently hospitalized child, was in hospital when he was five months old as "he needed to go in a croup tent." The mother said:

> I had to fight to get him admitted. The doctor told me on Friday that if he wasn't better he would put him in the hospital on Monday. I took him to the clinic on Monday when he wasn't better and they told me the doctor was too busy to see him. I called my own doctor, who had him admitted. I think it is terrible they would not admit a sick child. A mother knows when her child is sick.

Mother #2 had never been in hospital as a child nor had her only child been hospitalized before this admission. However, the fact that she worked on a paediatric unit might have been a residual stimulus for her adaptation in the interdependence mode and possibly the self-concept and role function modes too. Mother #3, although never hospitalized herself as a child, had an experience with the child now in hospital when he was seven months old. He was hospitalized in the Philippines because of dehydration. This mother recounted her feelings about this experience when she said, "I am really in shock; I thought he would go. A priest went there where he was. I thought he was dead, but it was only for a mass. My husband says, 'He must be gone!." She had stayed with the baby all of the time during that hospitalization, an adaptive behaviour which she used during the current hospitalization, as well. Mother #4 had not been hospitalized as a child either, but K., the child hospitalized at the time of the interview, had been when she was

"about a year and a half old, with croup." The mother recalled this experience as "scary", and stated:

> I didn't know it was croup. She couldn't breathe. We took her to Emergency. She was in that tent thing with cold air. She was so little, it was sad. Awful to keep her cooped up. She was in isolation and couldn't go outside the room to play, and all the toys were outside.

Despite this reaction, the mother said of that hospitalization that "it was probably relief that I felt." She had described her feelings about the current hospitalization as "glad." Mother #5 had not been in hospital as a child. She said, "I am grateful I have good health. I have to look after the children who have been sick, particularly T.," who was her son, who had so many hospitalizations. In looking at her reactions to the hospitalizations of her children, it was apparent why this mother felt so positively about her daughter being admitted this time. She said that she remembered the hospitalizations as "really nice, really good, especially the doctor, he was very nice. He retired - too bad. The new doctor is really nice too." The mother described her son T.'s hospitalization for correction of his "crossed eyes." She stated, "His eyes were fixed very well. You cannot tell anything was wrong with them." Mother #6 was in hospital "just for tonsillitis," and her tonsils were removed when she was "around eight or nine years of age." The mother said of this hospitalization, "I was in a Catholic hospital, St. M.'s in N.W.; I remember the nuns attending me. Funny, the things you remember. I remember a big monkey tree outside the window. I got ice cream that tasted horrible and Jell-o that was like rubber." This mother had experiences with her older daughter who was hospitalized twice. She said A. was in hospital

when she was six months old. "She got the smallpox needle and it was just like she was dead for three days. The doctor said it wasn't vaccinia. I don't know, she was all limp and floppy, just like she was dead." The mother recalled that the child was "crying when I came, and crying when I left. Her eyes were all swollen. They don't get that way unless she had been crying for a long time, do they?" She continued, "I was not married at the time, and she was my only pride and joy." This same girl was hospitalized for a tonsillectomy "when she was about three or four years of age." The mother said, "I was disappointed with the doctor. He took out her adenoids without telling me. He was a specialist too." The mother had referred, earlier in the interview, to the fact that she had "no concern" about her child coming to this hospital where she was now hospitalized. She said, "I had some experiences in another hospital, where D. was born, with a head nurse who nearly let her die." The mother emphasized that she had told the doctor, when D. became ill, that she would only bring her to this hospital, not the one where her other child A. had been admitted for her tonsillectomy. Mother #7 had strong feelings about hospitals. She had been in the hospital in which her child was now hospitalized when she was a child because of osteomyelitis of the leg. She said:

> I was in hospital for two years when I was about six years old. I was pretty much out of it, except for the last six months and then I hated it. I was right here in this building. It looked a lot bigger then. I guess that's because things look big when you are so small. The nurses wouldn't let me race the chair. The nurse took the chair away from me and made me hop on one leg down the hall to my room. The hall looked so long; I never thought I'd get there.

The mother said that she "did some schoolwork for the last three months," but added that she was behind in school. "They put me in a special class when I got out. They should have let me start again as I never caught up." This mother did not finish Grade 10. She had experience with her son being in hospital. She said, "He was in a number of times in his first year or so; about once a month in S." The mother said that these hospitalizations were necessary because of croup and pneumonia. She said of these experiences:

> It wasn't too bad. I stayed twenty-four hours a day. The nurses stayed out of my path as they made a lot of mistakes with him. One forgot to turn on the oxygen on the tent and he started to turn blue. I did all of the care. The nurses came to the door to hand me the medicine. It was okay because I didn't have anyone else at home to care for.

The mother stayed and did all of the care for her child in the hospital this time too. She was the mother who had said that the nurses were "qualified, but not in mothering." She said also that her baby "cried and got upset, when the doctors came near her." Mother #8 had not been in hospital as a child, but her baby had been in the hospital when he was two weeks old because of jaundice. This mother said that she was concerned because "I was breast feeding him, and had to give it up." She spent a lot of time with the baby then as she did during this hospitalization. Mother #9 had many experiences in hospital as a child. She said that she was in hospital when "I was around five years of age, and then between eleven and fourteen, I was in and out all the time." She had strong recollections of these latter hospitalizations, and said, "I didn't like it. I didn't want to be in. My parents had only been in Canada six months so they had to pay for everything. I used every excuse to leave." The child now in hospital

had been in "quite a bit" as a younger child, with the last admission for febrile convulsions when he was three years old. The mother said that they lived in another part of British Columbia then and related:

> I had a bad experience with the diapers not being changed and a mess all over the bed every time I went. The doctor walked into that kind of scene one time and, after that, it quit. He had infectious diarrhoea, and it was terrible for it to be all over like that.

Some of her other children had been hospitalized too. The last experience with hospitalization was with one of her twin daughters after the family had moved to Vancouver. The mother said, "I felt happier about that hospitalization. I have more confidence in the doctors since we moved." Mother #10's only previous experience with hospitalization was when she was a child. She said:

> It was just for tonsils. I was six, I think. I remember it really well. I remember some of the kids and having ice cream. Oh - I even remember going under the anaesthetic! The nurses were good. I had no bad experiences. I'm not afraid of hospitals.

She felt positively about the current hospitalization too as she had learned what to do if her child had a high temperature another time.

Other possible residual stimuli may have related to the value of the child to the family. Three of the children were the only children in the family and six of the children were the youngest ones in the family. Mother #9 described how her children "fight over who is going to come. He's the baby - the spoiled one." All of the mothers felt that, because the child was the only one or the youngest one, they needed to stay with him since as Mother #2 said of her child, "She's the most important to me."

Summary

In this chapter the data relevant to the stimuli which affected the mothers' adaptation to hospitalization of their ill children and the effects on the four adaptive modes has been analysed. This analysis has been very detailed and has delineated several problems of adaptation encountered by the individual mothers. In the next chapter, the significance of the information gained from the analysis of the data will be described more fully and the implications for nursing, as well as recommendations for further study, will be discussed.

CHAPTER V

DISCUSSION OF THE FINDINGS, IMPLICATIONS AND RECOMMENDATIONS FOR FUTURE STUDY

Comparison of Findings with the Literature Review

The analysis of the data obtained from the interviews with ten mothers was compared with some of the findings reported in the literature. As with Godfrey's study (1955), the age of the child did not appear to make any difference to the mother's adaptation if the amount of time spent visiting the child was used as a criterion. Prugh (1953) and Glaser (1960) had found that mothers expressed a lot of guilt because of other obligations which were neglected if they spent most of their time with the hospitalized child. In the present study, expressions of guilt from most of the mothers were not apparent. The mothers had made arrangements, which seemed to be satisfactory to them, for fulfilling their obligations related to work and family responsibilities. Mother #5 expressed some possible guilt because of job responsibilities. She commented upon her worry about her sister-in-law, who was doing her own and this mother's job. Mother #3 could have felt guilty about taking a leave from her work as a nurse aide at a time when there was a staff shortage, for she did agree to return to work when her supervisor called. However, her guilt was directed then towards the ill child whom she had to leave. Mother #9 appeared to feel guilty about not staying more with her six year old son because of

her physical discomfort which resulted from a neck injury. Also, she was the mother who had expressed concerns about how to leave the child when she did have to go home.

Prugh (1953) had discovered that distance to the hospital was a factor which influenced parental visiting practises. Although some of the mothers did find distance a problem, it did not affect the amount of time that they spent visiting the child. Several of the mothers had their own cars, a possible difference from the mothers in Prugh's study. Mother #6 had the greatest distance to travel. She commented that the "travelling bothers me," but as with all of the mothers, she visited the child daily.

Robinson (1968) postulated that mothers who were fearful of hospitalization themselves because of childhood experiences tended to be more concerned about their child's grief than about his illness. This was illustrated by Mother #7, who had spent two years in the hospital as a child. She felt that she had to stay with her daughter all of the time for, if she did not, the child would cry.

Freiberg (1972) found that the mothers' major concern about the nursing service was the amount of time spent with the child. Some of the mothers in the current study did comment upon how busy the nurses were. Mother #2 stated that the nurses could not stay with her baby because they had other children to look after. Thus, she stayed because she was "afraid that something might go into further complications, be more serious." Mother #7 expressed similar reasons for staying with her daughter when she said "the nurses don't have the time." Freiberg found that the mothers were anxious about the

uncertainty of diagnosis and treatment. Mother #6 expressed similar anxiety when she discussed her wish that the doctors would discover what was wrong with her child and if they could treat it. Mother #4 was anxious because "nothing seemed to happen the first couple of days. They didn't know what it was." Mother #3 reported that the doctor did not know what had caused her son's mouth ulcers. Freiberg had reported that the mothers in her study found that there was "considerable disruption" of the family's life. This was certainly true of the ten families in the current study. Some of the fathers spent a considerable amount of time at the hospital when they were not at work, such as Fathers #1, #2, #4, and #8. Meals were eaten with the mothers, either at a restaurant or at the hospital, with some of the fathers bringing food from home. Many of the mothers stayed with the hospitalized child for long periods, sometimes overnight. This necessitated the care of their other children by someone else. For some of the children, this meant going to stay with a person away from home, as was seen with the children of Mother #4 and Mother #7. Mother #3, along with Mothers #7 and #9, remarked about how upset the other children were because of the hospitalization of their sibling. As Mother #3 said, her children were so upset that they would not even go outside and play.

Roskies et al (1975) had speculated in their preliminary study of emergency admissions to hospital that high anxiety or parental incompetence in caring for the ill child might have led to repeated hospitalizations of the child. It was difficult to be certain if Mother #5 and, possibly, Mothers #7 and #9 illustrated this point.

Mother #5 had eight previous hospitalization experiences with her children, four of them for a condition similar to that of the child now in hospital. This mother certainly felt relieved when her child was in the hospital. As she said, it was "the safest place to be." Mother #7 and Mother #9 had both been ill for long periods of time as children so this may have made them anxious when their own children were ill. This could have been, also, an illustration of what Humberto (1978) described when he spoke of unconscious attitudes developed towards illness and hospitals because of childhood experiences. This will be discussed again with the findings about the residual stimuli.

Wolfer and Visintainer (1975) had found that mothers of children between the ages of three and six years were more anxious than mothers of children between seven and fourteen years of age. There were only two children older than seven years in this study and there were five children less than age three, so comparisons are difficult. It did appear that, if the child was older, the mother was less likely to stay all night than if the child was very young. However, if the child was a young infant, the correlation did not appear in this study for Mother #8 who had the youngest child did not stay at night. The question remains whether or not the length of time spent with the child is an indicator of anxiety in the mother.

Findings Related to the Use of Roy's Adaptation Model

One of the purposes for doing this study was to look at adaptation of mothers to the hospitalization of their children and to categorize it according to a nursing model. The model selected was

Roy's Adaptation Model. In order to be functional, a model must be useful for nursing practise, education, and research. Roy's model was suitable for the type of research done in this study. Analysis of the data obtained from the interviews with the mothers indicated that it was possible to categorize the data into the four adaptive modes quite easily. The major focal stimulus was also readily apparent and, indeed, had been anticipated. It was evident when there was more than one focal stimulus affecting adaptation as was seen with Mother #1. A little more difficulty was encountered in trying to differentiate between some of the contextual and residual stimuli as there appeared to be some overlap. For example, was the fact that a mother was employed as a nurse aide in a paediatric unit a contextual stimulus for the role function, self-concept, and interdependence modes, or was it, at least in part, a residual stimulus? It appeared to the investigator that it could have been both types of stimuli. Further study would be necessary to indicate if this was due to inexperience of the investigator in categorizing data, or if it was a problem with the model. It was evident when classifying the data that, as Roy had stated, some of the modes could serve as stimuli for other modes. This was shown in the case where the mother's role function mode served as a contextual stimulus for the self-concept mode, when guilt resulted because of role conflict. A point which helps to emphasize the usefulness of the model in this type of study was the fact that two independent judges were able to categorize the data using the model and their results were very similar to those of the investigator. One of these judges was unfamiliar with the model, but was still able to

classify after a brief introduction to it. Thus, it seems that this was a useful model for looking at adaptation of a group of mothers to the hospitalization of their children.

Findings Related to the Focal Stimulus

Some interesting findings were apparent upon looking at the mothers' adaptation to hospitalization of their children and certain of the demographic data. Five of the children had never been hospitalized, but only one mother had not had any previous experience with hospitalization, either of herself as a child or with one of her children. The mothers with the least amount of formal education, Mothers #5, #7, and #9, had the most experience with hospitalization of their children. The two mothers, #7 and #9, who had spent the most time in hospital as children were among the three with the least amount of formal education. Prior experience might have influenced the mother's decision to stay with the ill child. This is substantiated, in part, by the behaviours of Mother #5 and Mother #7, both of whom stayed all of the time. The only other mother who had a lot of experience was Mother #9 and, as has been described, she would have spent more time with the child if her own health had permitted it. The mother who had no previous experience with hospitalization was Mother #2. She also stayed all of the time with her child. This could have been a result of the fact that she worked in a paediatric unit because during the interview she remarked to the investigator "the nurses don't have the time; you know what I mean."

Admission of the child to hospital with an acute medical illness came with little warning for five of the mothers. Most of

these mothers responded with feelings of shock, disbelief, or fear. For those mothers such as #4 and #8, whose children had been ill at home for several days or even weeks, the feelings expressed were mostly ones of gladness and relief.

One of the interesting findings of this study was the persistence of the mothers in trying to treat their ill children at home. Mother #8 had followed many treatment regimes prescribed by several doctors in her attempts to alleviate her infant's dermatitis. Mother #4 had been caring for a child who was ill for several weeks, first with whooping cough and then with complications of pneumonia and diarrhoea. Mother #7 had employed several methods to try to reduce her child's very elevated temperature. Some of the methods that she had used may have increased the child's temperature because of shivering and injudicious use of acetylsalicylic acid. This raises some questions about the level of understanding that the mothers had about the treatments they were using with their children.

Findings Related to the Adaptive Modes

In the physiologic mode, the needs most affected for this group of mothers were nutrition and exercise and rest. Other needs may have been affected also, but this was not evident from the responses given by the mothers. The lack of interest in food and the inability to sleep well may have been related to anxiety about the ill child; worry about other responsibilities; concerns about finances; and the environmental factors such as the distance from home and the absence of comfortable sleeping facilities for the mothers who stayed overnight with their children.

The major finding related to the role function mode was the desire of so many of the mothers to continue their "mothering" or caretaking role with the hospitalized child. All other responsibilities became secondary, including family obligations and work responsibilities. As a result, there was some evidence of intra-role conflict between mother-of-the-ill-child role and mother-of-the-other-children role. Some inter-role conflict was apparent between mother and employee roles. The mothers who were employed and who were supposed to be working at the time of hospitalization believed that the child took precedence over the job, for they took time away from work to stay with the ill child. From the mothers' responses, there did not seem to be any conflict between mother and wife roles. The fathers spent as much time as they could with the ill child, and were instrumental in helping the mothers meet their needs. Those mothers who provided little physical care to their child were generally the mothers with the older children. The exception was Mother #3 who provided all of the care for her son who, at age ten, was the oldest in the group of children. This could have been related to the fact that her employee role was that of a nurse. One other source of inter-role conflict was apparent and that was the conflict experienced by Mother #9 between the mother role and the sick role. At least for this mother, the physical needs which resulted from her injury took precedence over her child's need for mothering.

Adaptation was evident in the self-concept mode for all of the mothers. A few of the mothers had body image changes. Most of these changes were related to problems in meeting the nutrition need in the physiologic mode. This is another example of a mode serving as a contextual stimulus for another mode. Problems in self-concept were related to loss, guilt, anxiety, and powerlessness. A feeling of

insecurity and isolation was encountered by Mothers #1 and 3 because of the absence of friends. Mother #9 could have felt isolated too, for she said, "I miss my 'phone," as she was used to talking "a lot" every day, an activity that was curtailed by her visiting of the ill child. As has been discussed, little guilt about the child's illness was apparent from the mothers' responses. The role conflicts between mother and employee roles, and mother-of-the-ill-child and mother-of-the-other-children roles could have been a source of guilt. Security was threatened for some of the mothers who worked as their return-to-work plans had been altered or were under consideration because of the child's illness. Anxiety was present to some extent in all of the mothers at some time during their child's illness. Some mothers, like Mother #4, were anxious in the early part of the hospitalization, but became less so once they knew what was being done to help their child and they began to see an improvement in the child's health. Regressive behaviour of her child was a source of anxiety for Mother #4. Although she was the only mother to comment upon this type of concern, it has been documented in the literature as a common concern of parents. Some of the mothers, such as #5 and #10, were less secure when their chilren were at home. In the hospital, they believed that the children would receive the proper care required to get well. This belief was not necessarily related to previous experiences with hospitalization, for Mother #5 had many experiences with hospitalization of her children while Mother #10 had none. Three of the mothers, #7, #8, and #9, gave responses which indicated a sense of helplessness related to their inability to get the help that they desired from the

doctors. This desired help varied from an expression of interest in the child's condition to an adequate treatment regime for the health problem. The other problem which was closely related to this sense of helplessness was the feeling of powerlessness experienced by some mothers. This powerlessness seemed to be related to the lack of assistance that they received from health personnel, but was due, to some extent also, to the lack of knowledge that the mothers had about how to care for an ill child and how to prevent a deterioration in his condition.

Help-seeking and initiative-taking behaviours were the predominant ones seen in the mothers' adaptation in the interdependence mode. For most of the mothers, there was a balance between these dependent and independent behaviours. The major help-seeking behaviours were employed when the mothers were trying to get medical attention for the sick child and when they were seeking assistance from family and friends for home and work responsibilities. One example was found of a mother who did not display help-seeking behaviours consistently. This was Mother #1, who was reluctant to seek assistance with her financial difficulties. The reasons for her reluctance were related to a misguided impression that, if one could not pay, the child would be removed from the hospital. There could have been a residual stimulus affecting her behaviour because of previous experience with health personnel in an earlier hospitalization of the child. For if she perceived the personnel as being unhelpful and obstructive at that time, it could account for some of her reluctance to confide in them now. Some of the behaviours were related to seeking help for the ill child by

persistently pursuing physicians. Some mothers initiated treatments that they believed would assist the child to improve, as was seen with Mother #7 with her ice packs, fan, and aspirin. Mother #2 utilized her nursing experience with ill children when she made suggestions for the feeding regime for her baby. Mother #8 and, to some extent, Mother #5, used initiative in asking the doctor to admit the child to the hospital.

All of the mothers showed some adaptive behaviours in each of the four modes. The modes which were affected the most differed with each mother. However, it was apparent that the mode which was affected the most overall was the self-concept mode. It was seen that some of the modes served as contextual stimuli for other modes. The contextual stimuli which were identified will be discussed in the next section.

Findings Related to the Contextual Stimuli

Roy (1976) described contextual stimuli as those stimuli which contribute to the person's responses to the focal stimulus. There were many contextual stimuli which affected how the mothers adapted to the hospitalization of their children. Several of these stimuli were common to many, if not all, of the mothers. The assistance that was provided by the husband, other family members, and friends influenced the mothers' adaptive behaviours in the physiologic, role function, and self-concept modes, as well as in the interdependence mode. Without this assistance, there could have been more intra-role and inter-role conflict and more problems with self-consistency than were found. As well, the mothers' physiologic needs might have been less adequately met, for they might have eaten less than they did and possibly had even

less rest than they did. Arrangements for the mother to stay as much as she wished with the hospitalized child were made possible because of the assistance of others, either in providing care for the children at home or, as with Mother #5, in doing her job. Analysis of the interviews with the mothers showed that the most probable contributory stimulus to their adaptation was their relationship with other people. Experiences with health team members influenced how the mothers felt about the need to hospitalize the child. If her experiences had been positive, a mother was more likely to adapt to the hospitalization than if her experiences had been less positive. Mother #8 is a good example to illustrate this point. This woman had been hospitalized for an extended period of time as a child and did not have good memories of this experience. When her child became ill, she was not able to obtain the assistance that she felt she should receive from the doctor. She had had previous unpleasant experiences with hospitalization of her child on other occasions. Her feeling about the hospitalization, this time, was that she could have coped just as well at home if only she had persisted for a little longer in her attempts to reduce her child's fever. In talking about the assistance that they received from health team members, some mothers were more cognizant of the doctor's role than of the nurse's role. Mother #1, who had so many worries, felt that the only thing that had helped to make things easier for her was the fact that she knew and trusted the doctor. Mother #5 spoke of the confidence that she had in the doctors and added that the nurses were "nice" too. Mother #4 felt that the doctors in the hospital were more helpful than her family doctor. In fact, she was planning to change

her family doctor. Her stated reason was that she wanted a doctor who admitted to a hospital closer to her home. Mother #8 had not received much satisfaction from the number of doctors who had seen her baby. Mother #7 was angry with her doctor because of an apparent lack of concern about her child's fever. She, like Mother #2, perceived the nursing staff as not having much time to spend with the child, but she commented also that the nurses were not "qualified in mothering." Mother #9 believed that she did not get as quick a response from the doctor as she wanted because she had to keep telephoning him over a period of days. It was interesting to see that action was forthcoming only after her husband called the doctor. Apparently, for several of the mothers, their perception of how ill the child was did not coincide with the health personnel's perceptions. Mother #10 felt that the doctor was prompt in seeing her ill baby and that the nurses were supportive and reassuring to her. Also, some health team members had provided her with information which she felt would help her to care for her son the next time he had a fever.

Other contextual stimuli which influenced the mothers' adaptation were related to whether or not the hospitalized child was the only child in the family; whether the hospitalized child had been away from home before; and how the other family members, particularly the siblings, were reacting to the child's hospitalization. If the hospitalized child was the only child, as he was for several of the women, then the mother was able to concentrate all of her energies on him. The other mothers had to think about their other children too; how they were reacting and who would care for them. All of these

mothers believed that their children were concerned about the ill sibling. Some of the mothers believed that the children at home were less concerned about the mother's absence than the absence of the hospitalized child. If the child had not been away from home before, as was true with six of the children, the mothers believed that they needed to spend as much time as possible with the child or else the child would be upset by the separation. This was true regardless of the child's age, for it was reported by a mother of a one year old child and by mothers of four, six, and ten year old children.

One of the findings not reported in the literature was the effect of maternal age on adaptation. The age of the mother did not appear to be a contextual stimulus for adaptation in this study. Mothers #10, #7, #1, and #5 were the youngest in the group, while Mother #9 was the oldest. Although some of the younger mothers, such as Mother #1, appeared to have many problems affecting adaptation, they were not because of age. Another mother who had difficulty with adaptation was Mother #9, who was the oldest. The best adaptation was made by the youngest mother, #10.

Another contextual stimulus which affected these mothers' physiologic and interdependence modes was the distance between home and hospital. Some of the mothers had a long way to come as they lived in parts of the Lower Mainland, such as North Delta and Burnaby. A few of the mothers, such as #5 and #7, lived within blocks of the hospital and were able to go home fairly easily. Despite the distance that some mothers had to travel they all found ways of getting to the hospital. This was true even for those mothers who did not drive a car.

Two of the mothers had to cancel plans for trips and one mother had to cope with company as well as with her own health problem. These contextual stimuli had the most influence on the mothers' self-concept and role function modes. Mother #2 is the best illustration of the effect of this type of stimulus. She and her husband had been anticipating a visit to the family members who still lived in the Philippines. It was an important occasion for the family as they were gathering to celebrate the golden wedding anniversary of the mother's parents. As well, the mother's presence was required to finalize some business arrangements concerning the sale of a piece of property owned jointly by the mother and her siblings. In spite of these obligations and the desire to see the family, the mother cancelled the trip because, as she said, her child was more important to her. Outside obligations, such as other children, job responsibilities, trips, and the mother's own well-being, were less important to these mothers than the ill child. They perceived that the hospitalized child needed them and so they stayed.

Findings Related to the Residual Stimuli

Analysis of the interviews with the mothers indicated that there were four general types of residual stimuli which affected their adaptation. One of these stimuli was the effect of experiences with hospitalization of the mother when she was a child. The overall finding was that, for this group of five mothers, experience with hospitalization for short-stay surgical procedures did not leave the negative remembrances that hospitalization for long-term, chronic health problems did. The two mothers who had been hospitalized the

most as children were Mothers #7 and #9. They described their recollections of the hospital by saying, "I hated it," or "I didn't like it. I didn't want to be in." In contrast, Mother #10, who had a short-term stay for a tonsillectomy said, "I had no bad experiences. I'm not afraid of hospitals."

Another residual stimulus was the experiences of the mothers with hospitalization of their children. The mothers' feelings about their own childhood experiences in hospital did not necessarily match their feelings about hospitalization of their children. Mother #7, however, was negative about both types of experiences. It is possible that, because of these experiences, she stayed all of the time with her baby. Mother #9 had a "bad experience" also, with hospitalization of her child. She could not stay with the child for long periods of time during the current hospitalization because of her health, but did visit frequently throughout the day and evening. Mother #1 had a short-term hospitalization as a child for dental surgery, of which she said, "It didn't bother me." However, she had to "fight" to get her son admitted one time because of lack of interest shown by some health personnel. This may have influenced her reluctance to seek help with her financial problems. Mother #6 had experiences with hospitalization as a child and with her own children. She recalled the experience when she was in hospital for a tonsillectomy as one where she had no negative feelings other than that the food was "horrible." She had two experiences with hospitalization of one of her children where she seemed to have been disappointed in the care that was given to the child. She was angry with the doctor for doing more surgery than she had been

told would be done. This mother spent most of the day with her child, although this child was among the oldest ones in the group.

Another probable residual stimulus was the mothers' feelings about the value of the child to the family. Nine of the children were either the only child in the family or the youngest one. It is quite possible that, because of this stimulus, the mother's role function and self-concept modes were affected. As was stated earlier, the mother perceived that this child needed her and she fulfilled this need. A final residual stimulus may have been that for three of the mothers their professional role was that of a nurse. This affected their self-concept mode and influenced how much they perceived that they should contribute to the care of their children. This was true for at least two of these women. Mother #2 was very emphatic about her desire to participate in the care of her baby as was Mother #3, who said that she wanted to do the nursing care.

It is not possible to generalize from the findings of such a small group of mothers. However, analysis of the data has led to the identification of several possible implications for nursing and a number of areas for future research. These will be described in the next section.

Implications of the Findings

The major finding in the physiologic mode was that the mothers did not receive adequate rest or nutrition. Newer hospitals are making provisions for sleeping and eating facilities for parents by setting up care-by-parent units. As it appears that a number of mothers in this

study wanted to stay with their children, it is important that nurses continue to encourage the development of this kind of facility. It is important, as well, in those areas where these facilities are not available, that the nurses encourage the mothers to go to eat at regular intervals, perhaps even by accompanying them to the cafeteria.

Mothers need to be reassured that their children will be well cared for during the periods when they are absent. Nurses tended to give the mothers, in this study, the impression that they were too busy to spend much time with the child. This was probably true to some extent. However, as nurses, we need to be cognizant of the impression that we create. It may be that, when a mother visited or stayed all of the time with her child, the nurse felt that she did not need to spend as much time with the child. This was not true. The mothers who were interviewed were only too willing to talk to someone about their feelings and experiences, and the time that it took for this conversation was relatively brief. It is true that the investigator as a non-staff person may have been seen as non-threatening by the mothers. However, if the nursing staff took the time to talk and to listen to the mothers, this could overcome the hesitancy that some mothers might feel in discussing their concerns with a nurse who was responsible for their child's well-being. Problems such as those found with Mother #1 could have been attended to days earlier, saving this mother needless anxiety.

Another implication is that the health team needs to be aware of impressions that are created about their interest in, and concern for, the child. Anxiety was aroused in several mothers because they

perceived that nothing was being done or that no one but themselves was concerned by the children's symptoms. Explanations should be given about what is being done, what can be done, and what to expect in regard to improvement of the child's symptoms and, if possible, how long this will take. Because the mothers are anxious, they may need to hear this information several times. Mothers who are continually telephoning the doctor may be viewed as annoying, but they are expressing an unfulfilled need.

When taking the nursing history, the nurse should try to discover what treatment the mother has been giving to the child at home. At least two of the mothers in this study either did not know how to cope with an ill child or were possibly overtreating the child. The implications for parent teaching are obvious. It is not sufficient to tell a mother what measures to use. She must be told how often to continue them and what are the indications to either stop treatment or to seek further medical attention.

A final implication is related to the childhood experiences of the mothers in hospital. When talking with a mother, the nurse could ask her about this type of experience. It might be that the effects of long-term hospitalizations are more negative than those of short-term hospitalization. If the nurse knows how the mother feels about hospitalization, she might be able to help her adapt more positively to hospitalization of the child. If long-term experiences produce negative reactions, then nurses must make the hospital experience for children with lengthy or frequent admissions as positive as possible. If we cannot help these children to cope with this

experience, we may be influencing their reactions to hospitalization of their own children. This, in turn, can affect how well the child copes with the experience.

Recommendations for Future Study

Despite the small sample size, some trends were noted and some questions were raised which would be worth further study. The questions for future research developed from looking at the mothers' behaviours in the four adaptive modes, the stimuli affecting the mothers' adaptation, and the demographic data. The following questions could be pursued in future research:

1. Does the severity of the child's illness, as perceived by the mother, influence the amount of time that she spends with him?
2. Is there a relationship between the educational background of the mother and the frequency of admission of her children to hospital?
3. How does the adaptation of the mother to the child's hospitalization compare to the father's adaptation?
4. What adaptive responses are seen in the siblings of the hospitalized child?
5. Do mothers who work visit their hospitalized child less than mothers who are not employed?
6. Do mothers who have had prior experiences with hospitalization of their children spend more time visiting than mothers who do not have this experience?
7. Do mothers of younger children provide more physical care to the hospitalized child than mothers whose older children are hospitalized?

8. Do mothers with a health care role background stay with their hospitalized child for longer periods of time and provide more of the nursing care than mothers without this background?
9. Do mothers who have been hospitalized extensively as children have their children admitted more often to the hospital than mothers who have not had this experience?
10. Do mothers who had lengthy or multiple childhood hospitalizations have more negative recollections of hospitalization than mothers who had short-term hospital stays?
11. Do mothers with strong physical and/or emotional needs of their own tend to meet these needs in preference to the hospitalized child's need for mothering?
12. What effect does the age and the placement of the child in the family order have upon the length of time that the mother spends with the hospitalized child?
13. Does the age of the mother affect her adaptation to hospitalization of the child?
14. Does the length of time the child was ill before hospitalization occurred influence the mother's adaptation?

CHAPTER VI

SUMMARY AND CONCLUSIONS

Interviews were conducted with a sample of ten mothers to discern their adaptive responses to the focal stimuli of the illness and hospitalization of their children. The children ranged in age from four months to ten years and were admitted with acute medical problems, many of which were of an infectious nature. The interviews were conducted in a paediatric unit of a large metropolitan Vancouver hospital. The interviews were done by the investigator during visiting hours. Often, because of the mother's preference, the interviews were held at the child's bedside. Roy's Adaptation Model was used to classify the information from content analysis of the data. This nursing model was found to be suitable for categorization of data obtained from this type of research. One problem encountered in using Roy's model was that it was sometimes difficult to differentiate between contextual and residual stimuli, as they did not appear to be mutually exclusive at all times. The responses of the mothers indicated that adaptation was necessary in all four adaptive modes: the physiologic; the role function; the self-concept; and the interdependence mode. Adaptations included alterations in the mothers' abilities to meet their needs for nutrition and exercise and rest; role conflicts; feelings of loss, guilt, anxiety, and powerlessness; and both help-seeking and initiative-taking behaviours. The focal stimulus of the child's admission to hospital was the only one found for nine of the

mothers. Contextual stimuli included the age of the child; position of the child in the family; the help given by family members and friends; the behaviours and attitudes of health team members; work responsibilities; and the distance from the home to the hospital. Residual stimuli included the experiences that the mother had had with hospitalization when she was a child as well as experiences with hospitalization of her own children. Other residual stimuli may have been influencing the mother's adaptation. These stimuli consisted of the value of the child to the mother and the nurse role, which was the occupation of three of the mothers.

The size of the sample was too small to draw definite conclusions, but several trends were noted which led to implications for nursing practise. These included the need to provide adequate sleeping and eating arrangements for mothers who stay with their children twenty-four hours a day; increased contact between nurses and mothers so that the nurses are aware of the mothers' concerns, and can provide them with the needed assistance; the importance of being aware of the impressions that are given to mothers about the amount of concern felt by health team members about the child's condition; the need to provide more information to mothers to help alleviate anxiety about their child's progress and care; the need to obtain information about home treatments that the mothers are using to try to relieve the child's symptoms in order to provide teaching about home care; and the need to make long-term hospitalization as positive an experience as possible for the children in order to assist them as adults to cope with their own child's hospitalization.

As a result of the findings, several areas were identified, which would be worthwhile for future studies. These areas include the influence on the mother's adaptation of factors such as the severity of the child's illness, the work obligations of the mother, the child's age and family position, and previous experiences with hospitalization. Other areas for further study are related to factors which might influence the frequency of admission of the child to the hospital such as the educational background of the mother and the mother's childhood experiences with hospitalization.

Admission of the child to hospital because of an acute, medical illness requires a sudden adaptive response for many mothers. Arrangements must be made quickly for the care of other children and, for some women, arrangements must be made to be absent from work. Mothers whose children are admitted for elective surgery have more time in which to re-order their lives than these mothers do. Despite a variety of problems, the mothers in this study appeared to be making a generally satisfactory adaptation to their child's hospitalization. If hospitalization had been prolonged, adaptation may have been more difficult for some mothers. All of the family was affected by the child's hospitalization and particularly evident was the effect on the siblings of the ill child. Hospitalization of a child is, indeed, a focal stimulus which provokes adaptive responses from everyone who is close to him.

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APPENDIX A

PHYSICIAN'S CONSENT FORM

I hereby grant permission for Gail Bishop, a student who is completing the thesis requirements for the degree of M.S.N. at the University of British Columbia, to interview _____.
Mother's Name

The purpose of this interview is to describe mothers' adaptation to admission of their children to hospital, and to discover factors, which may have influenced this adaptation.

_____
Signature of Physician

APPENDIX B

MOTHER'S CONSENT FORM

Dear Mother:

I am a nurse conducting a study to determine mothers' reactions to the hospitalization of their children, as part of the requirements for obtaining a Master's Degree in Nursing, from the University of British Columbia. If you consent to participate in this study, I will ask you to talk with me and to answer some questions. The time required will be about thirty minutes. Any information, that you give me, will be kept confidential, and will be reported anonymously in the written study. When the study is completed, I will be happy to share my findings with you, and to answer any questions about the results. Any other questions, which you may have, I will attempt to answer when I meet with you.

I invite you to participate in this study. If you agree, please sign the attached consent form, and give it to me. Thank you for your consideration.

Sincerely,

Gail Bishop R.N.

.....Tear.off.here.....

I, the undersigned, do give freely my consent, to participate in a study of mothers' reactions to the hospitalization of their child. I have been informed that there are no risks to myself, or any member of my family. I understand that I may withdraw from the study at any time without prejudicing the treatment of any member of my family or myself.

Signature of Mother_____

Date signed_____

APPENDIX C

INTERVIEW GUIDE

MOTHER'S NAME_____ SAMPLE NUMBER_____

AGE: Under 20___ 20-29___ 30-39___ over 40___

NAME OF HOSPITALIZED CHILD_____ SEX__ AGE____ DIAGNOSIS_____

EDUCATION: Completed Grade 10___ Completed Grade 12___

Attended College___ Attended University___

OCCUPATION: Are you currently employed in a job outside of your home?

Yes___ No___

1. What events led up to the hospitalization of your child?
2. How did you feel when you learned that your child had to be hospitalized?
3. Can you explain why you felt the way you have just described?
4. Can you identify anything that has made you feel good about having your child hospitalized?
5. Can you identify anything that has concerned you about having your child hospitalized?
6. What effect has the hospitalization of your child had upon you?
7. What effect has the hospitalization of your child had upon your family?
8. Are there any particular events, that are happening right now in your life, that make this hospitalization more difficult for you?
9. Are there any particular events, that have made it easier for you?
10. Have you had any previous experience in hospital yourself as a child? How old were you? How do you recall this (these) experience(s)? Can you explain what made you feel that way?
11. Have you had any experience(s) with your child(ren) being in hospital? How old was he/she (were they)? Why was he/she hospitalized? How did you feel about this hospitalization (these hospitalizations)? Can you explain why you felt the way you described?