

Assessing the Psychological Effect of Children Hospitalisation on their Mothers

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Abstract – This research work was a non-experimental design and exploratory type which was aimed at assessing the psychological effects of children's hospitalisation on their mothers. The sample was from mothers of ill and hospitalised children of two selected hospitals, a government and a private hospital in Ibadan, Nigeria with a sample size of 50 respondents selected by convenience sampling technique, and analysed, interpreted, and discussed. The questionnaire was used for data collection and its validity and reliability were ascertained among mothers before the final use. The major findings of the study were that mothers find it very uneasy to handle their children illness and hospitalisation and would require support and encouragement in their mothering tasks. A longer period of dependency is needed by these mothers to rearrange their resources for coping. The recommendations from the study made centred on the effort of the World Health Organisation to prevent and reduce maternal and infant mortality and morbidity with the involvement of the registered nurse.

Keywords: Hospital Hospitalised Child, Mother, Psychological Effect.

1. INTRODUCTION

From time immemorial women have assumed the major role in childcare along with the food gathering and preparation, clothing manufacturing, crafts and maintenance of the home. Whether she is a wife to a farmer, a business-woman, a professional woman employed in any or a number of jobs outside home, women still remain responsible for the care of the children and the maintenance of the household. In view of the workload demands, child hospitalisation appears to be a stress to the woman which in turn affects her coping efforts.

In general, couples plan to have children for a variety of reasons not the least of which is that children are perceived as necessary to the happiness of the family. The pride that parents take in the child and the psychological satisfaction they derive from a well and useful child are worth the cost to the parents. In so much that when a child is ill and needs hospitalisation, everybody in the family will be anxious to know how the illness would end, mothers would start to cry and may refuse to eat. At this time most parents are emotionally disturbed and there may be alteration in family process thus affecting the coping ability of mothers.

Since mothers of hospitalised children cannot predict events or outcome of their hospitalised children's condition either for quick recovery or prolonged stay in hospital, the amount of money they will pay as hospital bill would usually affect their capabilities for coping. Whaley and Wong (1987) noted that when a child's illness needs hospitalisation, it creates crisis for the child and parents, such that parents who are trying to cope with the many stressful events associated with the hospitalisation of their children have described their experiences as "hard", "difficult" and "draining". The concept of Primary Health Care declares the importance of working on multiple strategies to improve maternal and childcare services. Currently, the masses are going through socio-economic difficulties, with anger due to economic hardship facing many families and in turn increasing the parents' sources of stress. Under the stimuli of child's illness and hospitalisation, coping tolerance becomes ineffective.

Halm (1993) in a study of some problems encountered by mothers of hospitalised children observed that each child admitted to the children's ward was accompanied by a parent. The parent would remain in the hospital throughout the child's stay, some sharing the child's bed or sleeping on the floor, while some have to join chairs to sleep on. It was realized that some of the parents were unable to cope with such situations. This may reflect a lack of care to the mothers of hospitalised children in some hospitals which could also affect their coping mechanism during their children's hospitalisation.

1.1 Background of the study

As a health care provider working at the secondary level of health care industry, observation were made over the years on mothers of hospitalised children crying, feeling sad, worried and depressed, some of them often plead with the doctors and nurses to prescribe take home drugs for their sick children while some abscond with their ill children and some sign against medical advice to leave the hospital. This behaviour does not only cause health problem for the ill child but to the mother as well. When a mother is distressed, she may have headache, indigestion, tachycardia, fear and anxiety. Other psychosomatic problems are not ruled out, such as backache, palpitation, gastric or peptic ulcer, colitis, loss of appetite and frequent micturition. When the mother is being threatened by the child's illness, anxiety and fear of the prognosis, she finds it difficult to control her emotion.

Physiologically, extreme fear can lead to rapid pulse, dry mouth and throat, increase in gastric acid secretion, trembling and cold sweat. It hampers the ability to think and reason clearly. Anxiety over financial matters, health, personal inadequacy or lack of confidence give rise to worry which is sometimes associated with mild cases of mental disturbance. Psychologically, there may be dysfunction leading to cerebral pathophysiology by impairing the capacity to cope with needs and goals, by aggravating unresolved intrapsychic conflicts, by impairing the ability to meet sexual, social and economic role demands and to maintain identity by altering sensory inputs and feedbacks, by changing the body image and by disturbing the normal sleep pattern.

1.2 Statement of problem

This is to assess the mothers of hospitalised children on their feelings when their children are ill and hospitalised and their reactions and methods of adjustment or coping with the situation.

1.3 Significance of the study

The study is an effort made to assess the psychological effect of children hospitalisation on their mothers. The findings of this study will be useful particularly in aiding health professionals to assess the need for intervention strategies which could be used to improve the psychological effect of children hospitalisation on their mothers.

It will increase the nurses' knowledge base in the application of holistic approach in the paediatric ward, and improve their professional skills which will improve their professional image and public acceptance of their role in the health care delivery system. The mothers will be aware of the truthful, direction and simple explanation of their children's conditions and their implication for the future.

1.4 Limitations of the study

Random sampling method of selecting the subjects would have been adopted but for the fact that some of the respondents did not cooperate because of their children health condition, hence, the method was not used. Moreover, the scope of this study was limited to only two health care institutions in Ibadan, Oyo State Nigeria, hence the findings of the study cannot be generalised on all mothers of hospitalised children in other states of the country. Time and financial constraints were other factors that limited the scope of the study.

1.5 Research questions

1. What are the effects of selected demographic variable (child's sex, number of siblings and family social status) on mothers of ill and hospitalized children?
2. Can financial problems contribute to the coping disability of mothers of hospitalised children?
3. If the hospitalised children do not respond to treatment, can it affect their mothers psychologically?
4. What is the impact of fear and anxiety on the mothers of hospitalised children?
5. Does control of events have any impact on mothers' reaction to their children hospitalisation?
6. Can change of environment affect mothers of hospitalised children psychologically?
7. Does work-load demands have any effect on mothers of ill and hospitalised children?

1.6 Assumptions

Psychological effect of children's hospitalisation could be lessened in their mothers if sufficient knowledge of their children illness has been given to prepare them for their children's admission. Doctors need to know that mothers want a truthful, direction and simple explanation of their children condition, information about available care and her ability to get a realistic goal. Mothers' confidence in their children's doctors' recommendations and the devoted interest of warm, intelligent and understanding nurses will reduce their fear and anxiety.

2. LITERATURE REVIEW

Literature supports the observation that children hospitalisation is a stressful event to the parents. Savedra, Tesler and Ritchie (1987) noted that when parents' effort is directed towards coping with stressful events in the hospital environment, parents have less energy to expend on attending to their own needs and needs of their ill children. A child's illness and hospitalisation can cause a shift in family roles. When the child faces a long hospital stay and recovery, the impact on family life can be serious. For example, the mother of a hospitalised infant may take a leave of absence from her job to spare her child, the emotional trauma of a long separation. In another family the expense of therapy might cause a parent to take an extra job.

Dunst et al. (1988) stated that the extent to which a person perceives a threat corresponds directly to that person's level of anxiety. Therefore, assessment of anxiety in both children and parents is most important. High levels of anxiety, intense expressions of emotional changes in appetite, insomnia and lack of personal hygiene are indicators of disruption. The nurse may notice impaired ability to manage the day to day tasks of living other children at the home may not attend school because the household is too disorganised for them to be fed, dressed and transported as usual. When children are diagnosed as having serious illness, their parents often feel that the situation is unjust. For many parents, it seems most inconceivable that their children might become seriously ill, die, or experience serious confinement. Parents often say they would do anything in the world to change places with the children.

Prugh et al, (1953) in a study of the emotional reactions of children and families to hospitalisation and illness found that serious illness and prolonged hospitalisation could result in uncontrollable emotional responses; for example one parent might blame the other for the child's illness, feeling that the child was inadequately supervised and that this caused the illness, or the parent might be so overwhelmed by the first emotional response to the child's illness that subsequent information or unfavourable reports may then produce further feelings of anger. Although those close to the child need to express their feeling openly, they must also listen and try to understand other people's feelings. Parents may direct their anger and accusation toward nurses and physicians as well as toward each other, thus the nurse needs to recognise the inappropriately directed anger, listen to the parent concerns, and continue to care for the child and family.

Burns (1984) carried out a study on single parenting and found that they are usually headed by a mother or grandmother in approximately one third of American households. The stress of illness and hospitalisation is greater on these families. Single parents often feel guilty because the child is ill and because the child does not have the company of the second parent. Poverty is often a stressor, and approximately 60% of households headed by a woman in America live at or below the poverty level because women's earning power is usually less than that of men and her work may prevent her from staying with the hospitalised child.

Adolescent parents have their own unique problems in dealing with an ill child, because of the adolescent's normal developmental task of attaining independence; hospitalisation of the child of an adolescent can severely disrupt their functioning. The adolescent may be unable to make decisions, feel guilty at the inability to maintain contact with the child, not understand what is involved with the child's care, and experience an altered parent - child relationship (White-Trait and Pabst, 1987). In another study carried out by Savedra, Tesler and Ritchie (1987) waiting was perceived by parents to be one of the most stressful experiences during a child's hospitalisation. Situations that involved waiting included surgery, procedures such as radiography and diagnostic studies, waiting without communication from health care professionals caused feelings of powerlessness, loneliness and uncertainty. In order to prevent these feelings, nurses need to provide frequent updates on the child's condition, encourage the parents to feel comfortable in the waiting area.

According to Carpenter (1980) most of the complaints of mothers of hospitalised children seemed to arise from anxiety or boredom when their coping strategies are affected while Mishel (1983) found that children break-down when they are admitted to hospital wards. Often the mothers are emotionally vulnerable at this time and the ill infant hospitalised may cause her to be more emotionally unable to cope with the situation. Berenbaum and Hatcher (1992) indicated that some mothers worry continuously about the result of tests which had been done on their children with fear of poor prognosis as a reason for sleeping less with a poorer quality of sleep and insomnia. Carpenter (1980) anxiety due to anticipated problems on returning home and husband reaction act as stressors to the mothers which consequently affect their coping behaviour when their children are hospitalised. Carpenter also affirmed that mothers of hospitalised children exhibit fears about future admissions to hospitals which in turn affect their coping strategies. Fear and anxiety became most apparent if the child had fit.

Piercy (1985) argues that parents coping behaviour is affected when the ill child is seen on intravenous therapy, screaming and struggling due to pains. Jolly (1981) also says that mothers are disturbed when diagnoses are made which carry along anxiety even to other members of the family. Also noted, is that if the investigation result of one of the test is abnormal, the parents may sway their coping behaviours. When this happens, the anxious mothers sometimes band together to protect their babies. Lazarus and Launier (1978) broadly defined coping as efforts to adapt in relatively difficult situations and that the assessment of a situation as potentially stressful or is being dependent on the person's appraisal of the nature of the demands and the resources of both the person and the environment. Coping also consist of efforts that are both action-oriented and intrapsychic to manage (master, tolerate, reduce, minimize) the environment and internal demands and conflicts among them which tax or exceed a person's resources.

However, if the stimulus is outside the mother's adaptation level, it may result in ineffective coping. At this juncture, the mothers may burst into tears, become uncooperative, refuse to eat, become sad and may attempt to abscond with the ill-child from the hospital. Folkman and Lazarus (1988) reported that coping can be viewed in two angles, namely: problem-oriented and affective-oriented which predominantly depend on the appraisal of the stressful situation. The author further explained that the problem-oriented form of coping increase in situations appraised as changeable for example job, while affective oriented coping is heightened in situations perceived as not amenable to change, such as child's illness and hospitalisation.

Skipper, Leonard, and Rhymes, (1968) studied mothers' feelings of stress, adaptation and satisfaction with respect to their children hospitalisation. They found that mothers who received care from a nurse who was trained to support, provide information and facilitate communication were able to take an active role in child care and consequently reported less difficulty in being helpful to their children. In a sequential setting, Wolfer and Visintainer (1975) studied paediatric surgical patients and parents stress responses and adjustments. Children and parents who received systematic psychological preparation and continued supportive care, in contrast to those who did not, showed less upset behaviour and more cooperation in the hospital, and fewer posthospital adjustment problems. In a study to test a stress inoculation training program for parents and children, Meng and Zastowny (1986) found that parents' self-reported stress correlated with the children's stress level as measured by observation of the child by parents and researchers.

According to Whaley and Wong (1987) when child's illness requires hospitalisation it creates crisis for the child and the parents leaving them with inability to cope. Parents must deal with separation from home and other siblings familiar parent role or care giving environment, child exposure to painful experiences, loss of independence, disruption of nearly every aspects of their usual life style. Furthermore, emergency admission in which some parents is unable to cope, due to separation from home, siblings and neighbours may be more traumatic. Lavigne and Ryan (1979) described coping mechanisms used by families to adjust to living with a chronically ill child and manage their intense emotional responses. Externally directed coping mechanisms include search for information in order to understand the cause and possible cures; anger directed at the medical team who "caused" the illness or who cause any discomfort to the child; active participation in the child's care; and attempts to maintain the normal routine at home. The success of these coping styles is determined by the parents ability to take care of their children while continuing to fulfil outside responsibilities.

Klinzing and Klinzing (1977) identified one problem of behaviour that many parents exhibit, which is an inability to leave their hospitalised children without playing a major role in a disruptive scene. This inability can be caused by separation, anxiety, guilt, a lack of faith in the medical staff or various other factors. Parents view their hospitalised children as being very fragile, and they try to ensure that their children will not cry or become upset. This

usually means giving in to the child's demands, using bribes to obtain cooperation, being inconsistent with expectations and making promises that the child uses his parents to get whatever he wants, the parents may have a concern that their children's condition may worsen or that their children may die, an over-identification with their children's illness conditions, and an inability to cope effectively with seeing their children ill. Also over-protectiveness can be a defensive reaction that results when parents feel that they have not provided their children with enough love and care. All parents hope that their children will grow and develop free of physical and emotional problems. When a child acquires an acute or chronic illness, this expectation and all its attending hopes are directly challenged. Responses to the diagnosis and course of the illness vary from intense emotional upset to a positive integration of the experience. Most parents experience at least some sense of disequilibrium in the initial phases of the child's illness. It also requires that they somehow learn to live with the stress imposed by a chronic illness.

2.1 Immediate Impact of the Diagnosis

Grief is the response of an individual to a loss. In the case of chronic illness, parents' grieve the loss of their children good health, the loss of their own lifestyle, and perhaps ultimately the loss of the child. Grieving can be an intense and lengthy experience, marked by periods of denial, anger, bargaining, depression and acceptance (Kübler-Ross, 1969). It is not a linear, stage process but rather an emotional fluctuation among these states. A parent's emotional state may change from day to day and month to month. Parents' reaction to the diagnosis of a chronic illness includes shock, disbelief, denial, anger, resentment, guilt, worry, sadness and acceptance (Sabbeth 1984). The first few hours and days after the diagnosis are a time of crisis filled with anxiety, fear and emotional upset. Expressions of grief may vary. Parents may cry, become angry, or block their feelings. Regardless of their observable responses, the parents, siblings and extended family members are in crisis and their usual individual and emotional patterns are upset. The response of each parent and of each family is unique.

2.2 Adaptation

Leonard (1983) found that some parents are unable to share their feelings. These families seem to be on an emotional see-saw, when one parent is up, the other is down. All of these families recognised that they had made major adjustments in a short period of expression of feelings and of commitment, were all within normal. Although the diagnosis of chronic disease in childhood is very upsetting and stressful, it may not be as devastating as earlier researchers believed (Lavign and Ryan 1979).

In describing families under stress and those approaching crisis, Hill (1965) emphasised pre-crisis variables and proposed that the family's response is not so much a product of the event itself as of the family's perception of the event and the resources available to help deal with stress. Essentially, the stressor event interacts with both the family's definition of the situation to produce a crisis. It was suggested that physical, social and emotional resources affect family member's perceptions of the impact of chronic illness. For example, a family with an unemployed parent might perceive the child's chronic illness as especially stressful because of limited financial resources. A parent might need to work longer hours to cover additional expenses, which could in turn create another set of concerns. McCubbin and Patterson (1983) expanded on Hill's model of family crisis by including post crisis variables that influence a family's adjustment over time, the stress of the specific event, the support system and the family's perception of the event.

2.3 Post Crisis Stress

In the post crisis phase, influencing factors include the actual stressor, its specific long-term hardships, normal growth and development issues, consequences of the family's efforts to cope and issues of ambiguity and uncertainty.

2.4 Support Systems

McCubbin and Patterson (1983) also assert that personal resources (financial, educational, physical, emotional and psychologic), family resources (degree of cohesion and adaptability), and social support help to buffer the impact of the stressors. Social support offered by extended family members, neighbours and friends is especially important to a family's ability to adjust to a chronic illness.

2.5 Perception of the Event

A family's perception of stress influences the family's adjustment. The meaning the family members give to the stress and then attempts to clarify the issues and integrate the experience into their lives, affect their ability to cope. Families, who define the situation as a challenge, or as an opportunity for growth, can more easily adapt to the stress.

2.6 Changes in Family Routine

Once a diagnosis is made the family must have changes in their daily routine. For instance, mothers of children with diabetes are concerned about long range health implications, dietary restrictions, limitations to the child's social activities (Ory and Kronenfeld, 1980), impact on job and care possibilities, daily injections, hypoglycaemic reactions, overall diabetic control and financial issues.

2.7 Emotional, Social and Developmental Impact

In addition to the practical changes in their lives parents must face the emotional impact of chronic illness. The long-term stress of a chronic illness can cause mental disruption. Parents may argue about whom or what caused the illness, or about the division of labour in the household (Lavigne and Ryan, 1979), According to Sabbeth (1984), the diagnosis of a chronic illness can increase the pre-existing stress and tension in a family. Conflicts between family members may be emphasised. Differences in coping style may give rise to tension, for example, a wife who is verbal and emotional and a husband who is quiet and withdrawn may have difficulty supporting each other during a crisis.

Various studies have been conducted on principles of child and family psychological assessment, which have led to the observation that some families need assistance in coping with acute and chronic illness and transitions in family life. Sargent (1983) opined that an individual is simultaneously an independent entity, a member of the family and a member of smaller groupings within the family. As two adults form a family, they develop methods of interaction that encourage the expression of mutual satisfaction, psychological needs and confirmation of accepted behaviours. Spouses help each other succeed and support each other when stress occurs. Through history taking, observation of family interaction, and assessment of the manner in which the family relates to the physician, it is possible to assess the family's pattern of interaction, their skills, capacities, assets and difficulties as the family members relate to the presenting problems.

Few studies have separated the different impacts of various illness and diseases but a number of investigations have confirmed that the more chronic the illness are, the more immediate will be the resulting concern and embarrassment. "When one mother looked into her baby's eyes, he seemed to plead not to be abandoned." Roskeie (1972). The parents attached great importance to the approach and general attitude of the medical and nursing staff. Most importantly, they often did not recall the words of the nurse, obstetrician, or paediatrician but did remember their general attitude. Mothers who were hurt by an apparent lack of sympathy tended to attribute the abruptness to a lack of feeling in the informant, rather than to the likely cause - the difficulty of imparting such painful information. Most mothers were impressed by the kindness and sympathy extended to them by the nursing and medical staff. Small acts of kindness were clearly remembered years after the event; Davis (1993) concludes that effective communication facilitate mother's adaptation to their child's illness. The key to this is counselling of themothers of sick infants to make a deep and lasting impression.

In studies carried out by Drotaret al. (1975) they went through identifiable stages of emotional reactions which is a generalisation of the complex reactions of individual parents. However, the amount of time that a parent needed to deal with the issues of a specific stage varied. First stage, shock, most parents' initial response to the news of their child's illness was overwhelming shock, two out of twenty parents, reported reactions and sensations indicating an abrupt disruption of their usual states of feeling. One mother, "it was a big blew which just shattered me". One of the fathers explained "it was as if the world has come to an end". Many parents confided that this early period was a time of irrational behaviour, characterised by much crying, feelings of helplessness and occasionally an urge to flee. The stage of disbelief or denial is the second stage, whereby many parents tried either to avoid admitting that their child had an anomaly, although every parent reported disbelief, the intensity of the denial varied considerably. Intense feelings of sadness, anger and anxiety followed the stage of disbelief. The most common emotional reaction was sadness. The fourth stage is equilibrium, as their feeling of emotional upset lessened, they noted increased comfort with their situation and confidence in their ability to care for the child, while during the last stage, reorganisation. Parents deal with responsibility for their children's problems. Despite the

important similarities in parental reactions to various diseases, parents progressed through the various stages of reaction differently. A lack of opportunity to discuss the infant's diagnosis can create a situation in which the parents feel over-whelmed and unable to gauge the reality of their child's abnormality.

By dealing with occurrences that other people might find embarrassing and distressing in the course of daily life with their children, parents of the disabled learn how to treat these events routinely. These special qualities which may be characterised as "understanding" and "self-sacrifice" provide a rationale for the "deep philosophy" that persons with a stigma are said to evolve, Goffman (1968). Several studies note outcomes in which parents, because of unresolved guilt and anger, develop an overprotective attitude toward the child, which can thwart his development. Other members of the family may be neglected if parents ward off the grieving process by establishing a guilty attachment to the child.

2.8 Theoretical framework

2.8.1 Family theory

The field of family theory is most accurately called relationship theory, as it can contribute to the understanding of any relationship. There is no such thing as an absolutely healthy family. Every family, by virtue of its existence over time will experience some dysfunction periodically (Lazarus and Folkman 1988). Fluctuations in jobs, amount of money available, births, deaths, developmental needs of children, and the many other facts of everyday life would rule out an absolutely harmonious family life. Ackerman (1958), notes that the family has two basic functions, the first of which is to ensure the physical survival of the young. Physical wellbeing, sufficient food and clothes and safety are characteristics of a successful family. The second function of families is to provide the framework in which a person's humanness can grow. The affection bonds among family members are the matrix within which personal identity, sexual identity, social responsibility and learning develop. A healthy family may be defined as one that fulfils these two functions adequately.

2.8.2 Systems framework

Family theory is based on systems which is a totality or more than the sum total of its parts. Therefore the family is a totality, a system. Individuals in families are subsystems interacting to form a system. Just as theoretically, there is no such thing as the absolutely healthy family, so also there is no such thing as the absolutely sick family. Changing life circumstances cause stress in all families. Frequently families seek help around stressful issues. Family therapy should be considered the treatment of choice in dysfunctional families characterised by marital conflict, hospitalisation of a child or children, and adequate or inadequate reciprocity.

Dysfunctional families are often symptomatic in a way that is upsetting to them or to society. It is not uncommon to see people trickling in one at a time or for one parent to show up with the sick child, sometimes one family member does not come at all as a result of emotional disturbance. In most distress families a genogram may help to decrease guilt in individual family members. It shows that the issues which occupy them and cause them distress have a history in the family. It is not that the individuals are uncaring or unlovable but rather that the family over generations has been characterised by emotionally distant men or women. Acknowledgement of past health and happiness serves to spur well intentioned parents to cooperate so that their child will not have to suffer. The goals of family therapy according to Friedman (1962) are to decrease fusion among members, to increase the family's ability to handle stress, and to help them avoid falling into triangular communication patterns. Because family therapist has all the members of the family to work with, they are not limited by the perceptions of one member talking about the rest of the family. She can help individuals to share any secrets they may have and relieve the family of the burden of a taboo area.

2.8.3 Family Theory in Nursing Practice

Nurses are concerned with people and their environments in health and illness, from before birth until death. The nurse is constantly seeking through research and clinical expertise, correlates of health and illness. Family theory offers a perspective on a major source of health in individuals, family and communities. No matter what the area of practice, nursing diagnosis and treatment can be enhanced by a family orientation. In primary health care where the goal is promotion of health, nurses can utilise this framework to aid the young family. The birth of the first child is especially pivotal. The parents move from a relatively adult relationship to a relationship that incorporates a

dependent, needy infant. Families that are relatively differentiated can benefit from education about the developmental process and about the fact that the baby is going to change their current life.

The major focus in secondary care is early case finding and it is obvious from the theoretical presentation that children, especially sick children, are very vulnerable to family fusion. The Paediatric nurse can be of great assistance in clarifying to the child and the family the meaning of a diagnosis. Many families who have experienced a great deal of illness will react with guilt and blame when a sick child is sick. It is as if they believed in genetic cause for every illness. In tertiary care, since it is unusual to find whole families hospitalised family therapy concepts can be very helpful to nurses, helping them to understand some of the reactions of clients and families during visiting hours. Regardless of the settings, nurses' responsibility for giving comprehensive care to their clients can be carried out better with the help of an understanding of family theory. Whether the illness is an acute, brief chronic, the client family will be strongly affected by the situation and therefore in need of the nurse who is knowledgeable in family theory.

3. RESEARCH METHODOLOGY

3.1. Research design

This study is a non-experimental design and it is an exploratory type.

3.2 Settings of the study

Two health care centres in Oyo State Nigeria were the settings for this study. They were:

1. Paediatric Ward, Adeoyo General Hospital Ibadan, Nigeria.
2. Paediatric Ward, Alafia Hospital, Adamasingba, Ibadan, Nigeria.

Consent was obtained from the subjects for the study and from the authorities of each hospital used before the questionnaires were distributed.

3.3 Population and sample

The target population for this study were the mothers whose ill and hospitalised children were between the ages of one month to sixty months (1 month - 60 months) found in the paediatric wards of Adeoyo General Hospital, Ibadan and Alafia Hospital, Ibadan, Oyo State, Nigeria.

3.4 Sampling technique and sample size

Convenience sampling technique was used in selecting both the environments and the subjects for the study.

The subjects were screened based on the following three criteria:

- a) Mothers that were willing to participate in the study;
- b) The child must have been on admission in the Paediatric Ward from 2 to 7 days prior to the time of data collection;
- c) The sample size was 50 subjects. 40 participants (80%) from Adeoyo Hospital because it is a government hospital and bigger than Alafia Hospital, Adamasingba, Ibadan, which is a private hospital where the researcher obtained 10 participants (20%) of the subjects.

3.5 Instrumentation

A 22 item questionnaire was developed using the data obtained from analysis of interviews of some mothers in the paediatric wards of Adeoyo General Hospital and knowledge gained from review of literature, knowledge gained personally as a mother whose child has been hospitalised and as a practising nurse in a general hospital. The instrument was made of both closed and open-ended questions. The responses were of "Yes" or "No" design. The open-ended questions requested for some suggestions from the respondents.

3.6 Test of instrument for validity and reliability validity

The developed instrument was examined by the project supervisor, for face and content validity.

3.7 Tests for reliability

The test—retest method was adopted for testing the instrument for reliability.

The validated instrument was issued to 5 mothers of hospitalised children at Alafia Hospital Paediatric Ward. The same instrument was administered to the same group of women after one week. There was a high correlation of responses, which was 0.88 at 0.05 level of confidence, which therefore indicated a high reliability of the instrument, using Pearson’s coefficient correlation.

3.8 Procedure/method of data collection

The validated instrument was administered, to the respondents that were met by the researcher personally at each of the two selected health care centres.

3.9 Method of data analysis

On the whole, a total of sixty eight (68) copies of questionnaires were distributed, 50 copies were returned by the respondents (73.52%) and analysed. The data analyses were based on the result of the responses from the respondents from the two health care institutions.

3.10 Statistics used

Descriptive statistics was used as analysis was carried out using percentage and frequency distribution tables.

4. DATA ANALYSIS AND INTERPRETATION OF RESULT

Descriptive statistics was used to analyse the findings of the study.

Table 1: Number of days spent in the hospital prior to the interview

Variables	Frequency	Percentage
2days	8	16%
3days	10	20%
4 days	7	14%
5 days	5	10%
6 days	3	6%
7 days	5	10%
8 days	3	6%
9 days	1	2%
10 days	3	6%
11 days	1	2%
12 days	2	4%
13 days	1	2%
14 days	1	2%
	50	100%

N=50

Where N = the total number of respondents. The above table shows that 16% of the respondents spent two days in the hospital prior to the interview while 20% spent 3 days (indicating the mode of the data); 14% spent 4 days, 10% spent 5 days, 6% spent 6 days, 10% spent 7 days, 6% spent 8 days, 2% spent 9 days, 6% spent 10 days, 2% spent 11 days, 4% spent 12 days, 2% spent 13 days, and 2% spent 14 days.

The days spent by the respondents in hospital prior to the interview ranges from 2 to 14 days.

Table 2: Ages of ill and hospitalised children.

Variables	Frequency	Percentage
1 – 10 months	15	30%
11 – 20 months	10	20%
21 – 30 months	11	22%
31 – 40 months	8	16%
41 – 50 months	4	8%
51 – 60 months	2	4%
	50	100%

N = 50

From the above data table, the age of the children ranges from 1 – 60 months, Age 1 – 10 months that were 15 (30%) constitutes the modal class, while ages 11 – 20 months were 10 and 11 in number (20 and 22) respectively. Children within 31 – 40 months were 8 (16%), while 41 – 50 months and 51 – 60 months old were 4 and 2 (8% and 4%).

Table 3: Sex of hospitalised children

Variables	Frequency	Percentage
Male	27	54%
Female	23	46%
	50	100%

N = 50

As shown in the above table, 27 (54%) of the hospitalised children were male and 23 (46%) were females.

Table 4: Position of hospitalised children in the family

Variables	Frequency	Percentage
1 st	14	28%
2 nd	17	34%
3 rd	8	16%
4 th	6	12%
5 th	4	8%
6 th	1	2%
	50	100%

N = 50

From the above data analysis, it is noticed that 34% of hospitalised children were 2nd born, 28% were 1st born, 16% were 3rd born, 8% were 5th born, 4th born in family were 12% and only 2% of the children were 6th born child of the family.

Table 5: Total number of children per respondent

No of Children	(No. of Respondents) Frequency	Percentage
1	7	14%
2	13	26%
3	12	24%
4	11	22%
5	5	10%
6	1	2%
7	1	2%
	50	100%

N = 50

In the above Table 5, 7 women had one child each which is the hospitalised child.13 women had 2 children each while 12 women had 3 children each and 11 women had 4 children each 5 women had 5 children each. While 1 woman had 6 children and another 1 woman had 7 children.

Table 6: Age groups of respondents

Age Group of Mothers	Frequency	Percentage
18 – 22	1	2%
23 – 27	6	12%
28 – 32	16	32%
33 – 37	14	28%
38 – 42	12	24%
43 – 47	1	2%
	50	100%

N = 50

In table 6 above, the analysis shows that only 1 (2%) respondent was in age group 18 - 22, 6 (12%) respondents came from age group 23- 27. From age group 28 - 32 were 16 (32%) respondents, showing the highest frequency. Age group 33 - 37 was another high frequency of 14 (28%) while age group 38 - 42 showed frequency of 12 (24%) and only 1 (2%) respondent came from age group 43 - 47.

Mean age of respondents (x) = 33.3 years and the standard deviation (S.D.) = 5.4 years.

Table 7: Marital status of respondents

Age Group of Mothers	Frequency	Percentage
Married	46	92%
Single	4	8%
	50	100%

N = 50

Table 7 above indicates that 46 (92%) of the respondents were married while 4 (8%) of them were single.

Table 8: Respondents levels of education

Level of Education	Frequency	Percentage
No formal schooling	-	-
Partial Primary Education	3	6
Complete Primary Education	8	16
Partial Secondary Education	14	28
Complete Secondary Education	21	42
University Education	4	8
	50	100%

N = 50

In the above table, 3 (6%) of the respondents had partial primary education, 8 (16%) of them had complete primary education, 14 (28%) had partial secondary education, 21 (42%) had complete secondary education and 4 (8%) were University graduates.

Table 9: Occupation of the respondents

Occupation	Frequency	Percentage
Civil Servant	36	72%
Self Employed	14	28%
	50	100%

N = 50

Majority of the respondents 36 (72%) were civil servants as shown in the above table 9 and the self-employed were 14 (28%). None of the respondents was unemployed.

Table 10: Respondents reaction when their children are hospitalised

Form of Reaction	No. Of Respondents	Percentage
Cried	15	30%
Worried	20	40%
Depressed	6	12%
Sad	9	18%
	50	100%

N = 50

The different forms of respondents reactions when their children were hospitalized were as follows: 15 (30%) of them reported that they cried while 20 (40%) were worried, 6 (12%) were depressed and 9 (18%) were sad.

Table 11: Respondents reaction when the hospitalised children could not eat

Form of Reaction	No. Of Respondents	Percentage
Sad	11	22%
Worried	29	58%
Indifferent	-	-
Not eating too	10	20%
	50	100%

N = 50

11 (22%) respondents from the above table indicated that they were sad about their children inability to eat, while 29 (58%) pointed out that they were worried and 10 (20%) could not eat too like their children. None of the respondents remained indifferent about the situation.

Table 12: Responses to statements concerning anxiety

Statements	Yes	%	No	%	Total %
Worried seeing other very ill children	44	88	6	12	100%
Hospital equipment very frightening	30	60	20	40	100%
Afraid of blame from society if child dies	25	50	25	50	100%

N = 50

As indicated above, 88%of the respondent had emotional disturbance seeing other very ill children in the ward but 12% were not. Also 60% were frightened seeing hospital equipment's while 40% were not frightened. 50% of the respondents were afraid of anticipated blame from the society if the child dies while 50% were not.

Table 13: Responses to statements concerning predictability of events

Statements	Yes	%	No	%	Total %
Worried about result of Tests	48	96	2	4	100%
Insecurity in leaving the child alone	49	98	1	2	100%
Probability of losing the child	45	90	5	10	100%
Interest in preventive measures for the illness	50	100	-	-	100%
Duration of stay in the hospital	48	96	2	4	100%
Child' s responses to medical treatment	40	80	10	20	100%
Other siblings may have the same illness	30	60	20	40	100%
Positive effect of child' s discharge on the family	50	100	-	-	100%

N = 50

According to the results of data analysed above, one would notice that 96% of the respondents were worried about laboratory results while only 4% were not, and 98% did not feel secure leaving their sick children alone in hospital bed, while 2% of them remained indifferent. 90% of the respondents felt a high probability of losing their children while 10% did not.

All the respondents were interested in knowing the preventive measures for the illness. For the fact that 9 of the respondents could not foretell the duration of their children's stay in the hospital, they were worried while the remaining 4% were not. 80% of the respondents indicated that they were satisfied with their children's response to medical treatment while 20% were not. 60% of the respondents were worried that other siblings might be hospitalised due to same illness while 40% were not worried about it. All the respondents thought their family members would be affected positively after their children's discharge from the hospital.

Table 14: Responses on statement concerning work load demand

Statements	Yes	%	No	%	Total %
While hospitalising your child, do you visit home for home management?	32	64	18	36	100%
Were you able to participate in social activities?	48	96	2	4	100%
Have you stopped going to work?	47	94	3	6	100%

N = 50

64% of the respondents agreed that they visited home for some home management while the remaining 36%, did not visit home, mainly those that spent three to four days in the hospital prior to the interview. Due to their children hospitalisation, 96% of the respondents were not able to participate in their usual social activities while 94% had to stop going to work.

Table 15: Respondent feeling about separation from family

Statements	Yes	%	No	%	Total %
Worried having to leave other members of the family	47	94	3	6	100%

N = 50

The above table indicate that 94% of the respondents were worried about other members of the family left at home.

Table 16: Responses on statement concerning financial problems

Statement	Yes	%	No	%	Total %
Is there any added financial problem?	48	96	2	4	100%

N = 50

From the responses on table 17, it indicates that 96% of the respondents were anxious due to added financial problems while the remaining 4% were not.

5. DISCUSSION OF FINDINGS

Parents are glad that there are hospitals with all the resources of skill and equipment for restoring their child to good health, but when their children's illness need hospitalisation, parents sometimes feel bad about it in unexpected ways (Robertson 1970).

However, a brief discussion of the findings of the study on assessing the psychological effect of children hospitalisation on their mothers is presented under discussion of findings.

5.1 Demographic data - Tables 1 - 9

Table 1 shows the total number of days spent in the hospital by the respondents prior to the interview and 10 (20%) of the respondents spent 3 days, (16%) spent 2 days (14%) spent 4 days while (2%) spent 9, 11, 13 and 14 days respectively. Their ages ranges from 1 month to 60 months. 7

In Table 2, 30% of the children were between the ages of 1-10 months, while 20% and 22% were within age 11-20 months and 21-30 months respectively and children between 31-40 were 8 % and 41-50 and 51-60 months were 8% and 4% all the hospitalised children were admitted into the paediatric ward at least 2 days prior to interview, with their ages ranging between 1 month and 60 months.

In table3, 27 (54%) of the hospitalised children were males which increase the level of anxiety of some mothers because of children value to them in the society especially male and 23 (46%) were females. There is also importance attached to position of children while in table 4, (28%) of the hospitalised children were first children of their parents and the highest number was (34%) which the second children while only 2% were the 6th children. This indicates how precious those particular children were to their families, and also the total number of children by each mother, (26%) had 2 children, while 24% had 3 children and 22% had 4 children, 10% had 5 children and only 2% of the respondents had 6 and 7 children respectively. As seen by Whaley and Wong (1987) when child's illness requires hospitalisation, it creates crisis for the child and the parents, leaving them with ability to cope because parents must deal with separation from home and other siblings.

The findings of Tables 6 and 7 shows that 2% of the respondents had their children between ages 18 - 22 years and 43 - 47 years while 32% had their children between Age 28 - 32 and 92% of the respondents were married and 8% were single. Burns (1984) carried out a study on single parenting which is usually headed by a mother and grandmother and found out that the stress of illness is greater on these families. Single parents often feel guilty both because the child is ill and because the child does not have the company of the second parent; while in married families, serious illness and prolonged hospitalisation can result in uncontrollable emotional responses whereby one parent might blame the other for the child's illness, feeling that the child was inadequately supervised and that this caused the illness, while the adolescent parents have their own unique problem in dealing with an ill child. Because of the adolescent's normal developmental task of attaining independence, hospitalisation of an adolescent's child can severely disrupt functioning. The adolescent may be unable to make decisions, feel guilt at the inability to make contact with the child, and experience an altered parent-child relationship (White-Traut and Pabst 1987).

In Tables 8 and9, the respondents educational level attained, and occupation shows that all ofthem had between partial primary and university education, while 42% had complete secondary education and 28% had partial secondary education while others (16%) has complete primary school and 6% partial primary school education and 8% with university degree and 72% were civil servants while the regaining 28% were self-employed, though all these variables did not have much effect on their coping effect because of the importance of these variables, sex of children, position in the family and age of the child.

The findings of (Tables 10, 11, 12) show the respondents reactions due to their children hospitalisation, their children inability to eat and their own statements concerning anxiety. 40% of them were worried and 30% really cried while the remaining 30% were depressed and sad, also 20% could not eat as their children had anorexia and all of them were anxious, 50% were afraid of the blame from society if the child dies, while 60% were frightened by the hospital equipment add 88% were worried seeing other children with various health conditions.

Dunst et al. (1988) stated that the extent to which a person perceives a threat corresponds drastically to that person's level of anxiety. Therefore, assessment of anxiety in both children and parents is most important. High levels of anxiety, intense expressions of emotional changes in appetite, insomnia and lack of personal hygiene are indicators of disruption.

Table 13 shows the responses statements concerning predictability of events and the control with feelings of insecurity leaving the child alone as 98%, 96% were worried about laboratory test results while 90% were afraid about the probability of losing the baby and all of them (100%) were interested in having the knowledge of preventive measures of their children illness.

Klinzing and klinzing (1977) identified problem behaviour that many parents exhibits, which is an inability to leave their hospitalised child without creating or playing a major role in a disruptive scene. This inability can be caused by separation, anxiety, guilt, a lack of faith in the medical staff or various other factors. Parents view the hospitalised child as being fragile; they may have a concern that their child's health condition may worsen or that their child may die, an inability to cope effectively with seeing their child ill.

On workload demand and feeling about separation from home, (Tables 14 and 15) shows that the workload was much on the mother with multiple roles, while 94% were worried over the other members of the family left behind at home as a result of the potentially stressful situation they are when they have to deal with separation from home, herself concept and role function as a mother, a wife interdependence between the siblings and the husband as well as the society in which she belongs. As a result, when the transaction between these variables is perceived as stressful and which may be beyond the mothers normal or usual behavioural repertoire, the mothers then call on the use of coping strategies. However, if the stimulus is outside the mothers adaptational level, that may result in ineffective coping.

In table 16, on variables concerning financial problems, 96% answered yes to the fact that their children's hospitalisation was an added financial problem. Burns (1984) in her studies on single parenting found that poverty is often a stressor, and approximately 60% of households headed by a woman in America live at or below the poverty level, because woman's earning power is usually less than that of men and her work may prevent her from staying with the hospitalised child.

5.2 Suggestions for further research study

1. A study of a larger sample of mothers of hospitalised children may help to support or refute the findings of this study, where the same findings are arrived at; generalisation of findings may provide a firm base on which to base recommendations.
2. A study on the factors that affect the implementation of positive coping strategies that may help the mothers coping efforts in the hospital. Based on results of findings, remedies may be recommended to aid the mother's response to stressful events.
3. Are there clear cut differences in maternal and paternal patterns of overall adjustment to psychological effect of children's hospitalisation?
4. Factors influencing the choice of coping and adaptation behaviours by mothers of hospitalised children.

5.3 Implications of the study

In view of the above findings, it then implies that there are effects from different systems that children's hospitalisations have on psychological make-up of their mothers. They are from the society as a supra-system, family system, economic system, technological system, hospital system and paediatric ward as a system. However, the mere fact that some degree of stressors exist from the above mentioned systems affect the mothers during their children's illness and hospitalisation, therefore, advocacy for "Holistic" care is justified, and training of more paediatric nurses and social workers because nurses might need orientation into the rationale and techniques of "Holistic" care, and effective use of nursing process and nursing care plan in rendering quality care to the clients and mothers. The study encourages mothers to participate in their children's care during hospitalisation and adept to hospital environment while they ask questions about their children's illness and the probable outcomes, laboratory results and preventive measures.

5.4 Recommendations

Considering the background of this study, the findings, and the effort of the World Health Organisation to prevent and reduce maternal and infant mortality and morbidity, the following recommendations are made to the Doctors and Nurses, the Ministry of Health, the Nursing and Midwifery Council of Nigeria:

5.4.1 To Doctors and Nurses

1. It is imperative that doctors and nurses understand the culture and social perceptions of their clients towards the disease in question.
2. Should improve interpersonal relationship with their clients.
3. Include parents in care plan.
4. Should request for improved ward facilities.

5. Nurses should utilise nursing care plan and concept of holistic care.
6. And should be involved in research to improve their services.

5.4.2 To the Ministry of Health

1. Improve facilities in hospitals, such as rooming - in facilities for the parents.
2. Adequately staff the paediatric ward.
3. Provide appropriate avenue for staff training.
4. Have trained family health practitioners, social workers, parent advisers, counselling and guidance centres in urban as well as rural areas.
5. Provide in hospitals, units for parent's group pre-hospital admission especially for those families whose children's illness and hospitalisation need a long-time nursing (medical care).
6. Include stress Inoculation Training Programme for parents in EPI programme and children of school age.
7. Until our socio-economic circumstances improve, child care/health services should be declared free.
8. Provide adequate stationeries for nurses to document nursing process and nursing care plan.
9. Attach mini library to hospitals and subscribe for academic and professional journals for health care providers to read and update their knowledge.
10. Attach research unit and trained researchers to hospitals both at State and Local Government levels.
11. Have liaison Health visitor attached to the wards who can often build up a supportive relationship with the mothers, who will follow up the child and mother on discharge.

5.4.3 The Nursing and Midwifery Council of Nigeria should:

1. Make effort for Nurses to implement the blueprint on nursing process and care plan.
2. Help Nurses have their own areas of specialty and that University based education to streamline their work.
3. Influence the Ministry of Health to employ more qualified/registered Nurses and other health personnel to reduce Nurses' workload.
4. Provide all licenced practising Nurses with documented standard of nursing practice.
5. Have monitoring units both in hospitals and in the Ministry of Health.
6. Give incentive to graduate Nurses to control staff turnover.
7. Formulate strategies to motivate Nurses in managerial positions to read, carry out research and present papers in seminars, workshops, conferences and attend continuing education programmes.

6. CONCLUSION

This research was conducted to assess the psychological effects of children's hospitalisation on their mothers. It was obvious that there are various factors that affect mothers when their children are sick or ill and hospitalised, such as sex (gender) and position of the ill child in the family, the number of children a mother has, marital status, home management, financial problem and the hospital environment itself.

The study was a non-experimental design of explorative type, using non-probability sampling technique and 50 subjects whose opinion were sought using a questionnaire.

The questionnaires were given to the respondents using face to face approach and collected back the following day. The data were analysed and persecuted frequencies and percentages. Descriptive analysis of the data indicated that all the respondents reacted negatively when their ill children were hospitalised. Some were worried, depressed and sad.

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