CHAPTER 2

LITERATURE REVIEW

Literature reviewed in order to define the state of the science related to this study included (a) the context of Thai family and hospitalized children, (b) hospitalized young children and their families, and (c) parent participation in the care of hospitalized child.

The Context of Thai Family and Hospitalized Children

Understanding the context of Thai family and hospitalized children is important to this study since a Thai cultural context strongly influences Thai parents' views and participation experiences in the care of hospitalized young children. The following description of the structure of Thai family and the socio-cultural context of hospitalized children in Thailand will help to understand the participation experiences of parents in the care of hospitalized young children in a Thai cultural context.

The Structure of Thai Family

Thailand, formerly known as Siam, is an old country with a well established and distinctive culture, government system, and attributes. More than 95 percent of the Thai population are Buddhists (Limanonda, 1995). Several minority religions are present in Thailand such as Islam, Hinduism, and Christianity. Buddhism is associated with the way of Thai life, beliefs and attitudes, and codes of behavior of individuals at both family and communal levels. Buddhism has provided

cognitive and evaluative elements that they have been included into Thai culture and built into the structure of Thai society (Kesten, 1989). Moreover, the concepts of karma, rebirth, merit, and sin are mainly understood and accepted by Thai people in Buddhist terms (Klausner, 1998). Besides those concepts, supernaturalism and animism are also noted to have a great power among traditional Thais (Limanonda, 1995).

The best way to understand Thai social values and culture is to give attention to its basic unit, the family. The family in Thailand is the center of all social organization (Wongsith, 1991). Family intergenerational bonds also play an important role in Thai society. During the past decades, Thailand has undergone a rapid socio-economic development toward more modernization. In this situation, many family members are forced to leave the family to seek paid employment (Wongsith, 1991), particularly in the capital city, Bangkok and other urban areas. This change has resulted in an increased number of nuclear families and a decline in the number of traditional extended families. In urban areas, the family changed from extended families toward nuclear families. Therefore, nuclear families were the largest part of households in large urban areas (Fuller, Edwards, Vorakitphokatorn, & Sermsri, 1996). However, several types of extended families are also general in the capital city and other urban areas. Moreover, the extended families are the majority in the rural areas of Thailand. They commonly have several generations living under one roof, or at least under different roofs within the same compound.

In this situation, the division of power is still by no means rigid, the husband and wife can replace each other in their respective activities and in many situations they consult each other before a decision (Limanonda, 1991). Nevertheless,

the father is regarded as the chief of the house to whom the wife and children still show due respect. Importantly, in traditional Thai families, it is viewed that husbands should work and their wives should be at home as housekeepers. Currently, since the economic condition has significantly worsened, there is an increase of working mothers. Thus, mothers are responsible for the child-rearing and housekeeping, as well as making a second income for the family.

The Socio-culture Context of Hospitalized Children in Thailand

Children's illness and hospitalization has long been considered one of the major public health problems in Thailand as many children have suffered from acute or critical illnesses, namely pneumonia, diarrhea, urinary tract infection, meningitis, dengue hemorrhagic fever, injuries, etc., while other chronic diseases in child patients included asthma, leukemia, congenital heart diseases, chronic renal diseases, diabetes mellitus, cerebral palsy, etc. Importantly, a majority of children in Thailand have been admitted to the hospital due to those diseases. For the acutely ill child and family, hospitalization is an abrupt unscheduled and frightening experience. Most Thai children get sick with acute illness more frequently but less severely than adults. Fortunately, most of the sicknesses are mild, harmless, and will resolve by themselves without any need for special medical treatment. Regarding the chronically ill child and family, the number of children requiring hospitalization due to chronic illnesses has been on the rise (Intaravichai, 1996). The chronic illness does not only put the children themselves under stresses and strains by making their behavior and emotion negatively change, but also affect badly their parents' experience, leading them to several unpleasant feelings of anger, guilt, disbelief, grief, and denial.

With the rapid socio-economic development and the growth of industrialization and technology, the health care delivery system in Thailand has received more modern medical practices from the west. Given a steadily higher number of acutely or chronically ill children admitted to the hospital, the health care delivery system has been consequently provided in Thailand to stop the unwanted tendency. This health care system can be simply classified as public and private health services such as provincial hospital, community hospital, health center, and private clinics or hospitals, provided for those ill children (Nukulkij, 1993). Moreover, regarding Thai socio-culture, the clients or parents believe in the capability of physicians and nurses who take care their ill child. This influences actions and/or interactions of Thai parents in participating in their child's care during hospitalization.

For the ill child and family, hospitalization is a stressful experience for young children and their parents (Melnyk, 2000). The fears of Thai parents regarding the hospitalization of their young children are normally related to the severity of the sickness. Although they may not totally understand the implications of their child's illness, they are able to feel their own parental tension and this turns into anxiety. Furthermore, their fears are increased by the fear of the unknown, lack of information, and disruption of their usual parental role (Melnyx & Alpert-Gillis, 1998; Miles & Carter, 1983; Schum, 1989), because they feel that they have less knowledge and power than health care professionals in the care of their hospitalized child (Kristensson-Hallstrom, 2000). Specifically, most hospitalized Thai children are young. Thus, the parents and health care providers perceive that these children are too little to know or understand their illness, conditions, or take care of themselves.

This leads the young children to accept their parents' presence and involvement in their child's care during hospitalization.

Hospitalized Young Children and Their Families

Hospitalization has been known as a stressful experience for both children and their families (Melnyk, 2000). Importantly, hospitalization has been demonstrated to be very stressful for children and their families with the potential for interrupting developmental processes resulting in negative behavioral outcomes (Shields, 2001). Studies have demonstrated that hospitalization can result in negative outcomes for children and their parents, particularly for hospitalized young children (Melnyk, 2000). Because the child's age (developmental status) affected the way that they dealt with hospitalization, that is, the younger the child, the more likely the child was to be distressed (Wright, 1995). Separation from parents has long been accepted as the major source of stress for hospitalized young children (Ziegler & Prior, 1994). This might be because their parents normally shield them from danger in their daily lives, young children are especially stressed by their parents' incapability to protect them for painful and frightening events in the hospital (Canright & Campbell, 1977). In addition, because many parents are overwhelmed with anxiety or unsure of their role during hospitalization, they are often unable to provide the emotional support that young children are familiar to at home (Knox & Hayes, 1983).

The Effects of Hospitalization on Young Children and Their Families

Hospitalization is a stressful experience for the child and their families, particularly young children. The effects of hospitalization on young children and their parents are now well known as research has provided consistent information replicated over time. Studies have shown that hospitalization can result in adverse outcomes for young children and their parents both in the immediate period, after discharge, and over longer periods of time (Melnyk, 1994, 2000).

The effects of hospitalization on young children. Frequently hospitalization is the first crisis or potential threat to confront children in their lives, especially young children. The major sources of treats or stress for hospitalized young children can be classified into several categories: (a) physical harm such as discomfort, pain, mutilation, or death; (b) separation from parents (particularly for preschool children); (c) unfamiliarity with the environment; (d) uncertainty about limits and expectations; (e) loss of control, autonomy, and competence; (f) the ability for parents to stay with the child; (g) parents' ability to shield their children from harm and injury; (h) parental anxiety level; (i) uncertain of their parental role during hospitalization; and (j) decreasing in emotional availability and supporting by parents (Jones, 1994; Melnyk, 1995, 2000; Shields, 2001; Wolfer & Visintainer, 1975; Wright, 1995). Importantly, separation from parents increases the emotional trauma felt by young children who are hospitalized. It has long been perceived as the greatest source of stress for hospitalized young children (Tiedeman, 1997). Separation from ceremony and attachment figures is scary and adds to the child's confusion and frustration (Neff & Spray, 1996). Both Bowlby and Robertson have described the adverse effects of separation from their parents on hospitalized children in three phases: (a) initial

protest at being deserted; (b) despair when protests are found to be unsuccessful; and (c) denial, resulting in depression and withdrawal (Berman, 1991; Kristensson-Hallstrom, 2000; Seidl, 1969). Additionally, this prolonged deprivation can have serious and long-term effects on the character of young child and mental development.

As part of the treatment to heal them, ill young children must endure the stress from such invasive procedures as blood examination, lumbar puncture, bone marrow aspiration, respiratory assessment, administration of oxygen, intravenous fluid, blood, and antibiotics, postural drainage, and chest physiotherapy. Furthermore, worsening the already stressful situation is the ill children's imagination and thinking that they must undergo those invasive procedures as a punishment for having done a mistake (Ziegler & Prior, 1994); meanwhile, ill children are also fearful of new surroundings and strange people in the hospital environment. Children naturally describe human characteristics as inanimate objects due to the animism of toddlers and preschool children; therefore, it is normal for them to fear equipment in their environment (Vessey, Farley, & Risom, 1991), and children are generally scared of unfamiliar things and setting (Wong, 1995). Such a strange feeling could pose a situational crisis for ill children's parents and families, as well. Meanwhile, immobility and loss of control in the hospital environment are very worrying for young children as they are making developmental strides in autonomy and independence (Wilson & Broome, 1989).

In this situation, the young child cannot develop trust in the health care providers and therefore does not know what to expect. The reactions of children to these crises are influenced by their age, previous experience with illness, separation

from their parents or hospitalization, their developmental coping skills, the severity or type of illness, the ability of parental care, and the available support systems (Melnyk, 1994; Visintainer & Wolfer, 1975; Wolfer & Visintainer, 1979). The parental anxiety level, personal characteristics, the parent-child relationship (Jones, 1994; Melnyk, 1994; Visintainer & Wolfer, 1975; Wolfer & Visintainer, 1979), and parental culture and beliefs also impact young children's reactions.

Young children are particularly vulnerable to the stresses of illness and hospitalization because stress represents a change from their usual state of health and routine and because they possess limited coping mechanisms. The impact of the stress resulting from hospitalization varies with the developmental age of the child and the coping abilities of the child (Ellis & Nowlis, 1994; Neff & Spray, 1996; Melnyk, 1994). Furthermore, young children's hospitalization experiences are correlated with increased risk of later behavioral, emotional, and educational problems. In particular, the changes of behavior and emotion that young children manifest during hospitalization can persist or even increase for weeks or months after discharge (Melnyk, 2000). Literature and research related to the hospitalized young child showed that young children's most common responses during and after hospitalization include separation anxiety, regression, sadness, apathy or withdrawal, fear of the dark and health personnel, sleep disturbances, and externalizing behaviors (e.g., hyperactivity and aggression) (Melnyk, 1994, 2000). Consequently, most of the studies have explored separation anxiety, fears, and stresses related to hospitalization (Jones, 1994).

The effects of hospitalization on parents. When a child becomes ill, it may cause a situational crisis for the family. If the illness leads to either planned or

unplanned hospitalization, family interrelationships are disrupted. During this period the child becomes the central focus of the parents' lives. Shields (2001) noted that the parents experience consequences of having a hospitalized child. When a child is hospitalized, especially young children, parents may experience fear, guilt, helplessness, inadequacy, anxiety, and stress, particularly when the family has not received preparation for hospitalization (Schum, 1989; Visintainer & Wolfer, 1975). The study suggests that parents are under a great deal of stress concerning the child's illness, hospitalization, treatment, and role change (Lesley, 1997). Interestingly, the parental role often changes when the child is admitted to the hospital. Parents may be confused and anxious as to what they can and cannot do. In this way, factors affecting parent's reactions include the child's age, concern about the child's condition, treatments, and outcomes; their child's behaviors and emotions; previous experience with their child's hospitalization; loss of parental role; parental anxieties and/or stresses levels; coping skills (Eberly, Miles, Carter, Hennessey, & Riddle, 1985; Graves & Ware, 1990); and cultures and beliefs.

Sources of parental stress regarding hospitalized young children included the sights and sounds of general physical environment; the restrictive hospital environment; communication with the health providers; staff behaviors; the child's appearance, behavior, and illness; the child's emotional responses of fear, anger, sadness, and depression; parental role deprivation; the unknown; feeling of guilt associated with the inability to protect their child from illness or injury; separation from their child; lack of time with spouse; maintaining home, work responsibilities, and extra work; finances; finding time to do all that needs to be done; changed routines; changes in behavior of the hospitalized child and siblings; concern regarding

the ability to support the hospitalized child as well as his or her well siblings; and the distance from hospital to home or problems with transportation (Melnyk & Alpert-Gillis, 1998; Miles & Carter, 1983; Schum, 1989).

Furthermore, during the period of hospitalization, parents may think they lack power because they are in an unfamiliar environment, responding to an unexpected event, and in a situation where they are dependent on health care providers (Kristensson-Hallstrom, 2000). Parents hope that nurses appreciate and understand their feelings of concern during their young child's hospitalization. They need information and knowledge and desire to be with the child (Kristensson-Hallstrom, 2000; Melnyx & Feinstein, 2001; Neill, 1996b). Importantly, they also hope that nurses will accept their presence, welcome them, and allow them to share in their young child's care.

The effects of hospitalization on siblings. A hospitalized child's siblings are also impacted by the illness episode. Siblings of hospitalized children are at risk for being neglected because the central focus for parents is the hospitalized child. In this situation, it is often difficult for children to understand why their parents' attention is shifted to their ill sibling leaving little time for the parent to meet the other children's needs. Siblings may begin to exhibit behaviors that the parents may not be able to interpret or understand. They may experience a variety of emotional responses to their sibling's severe illness. They may feel jealousy, anger, confusion, anxiety, and insecurity (Azarnoff, 1984; Morrison, 1997). Interestingly, research has shown that the sibling's perceptions of the stress they experienced were similar to the level of stress experienced by the hospitalized children (Simon, 1993).

Morrison (1997) reported that the siblings had experienced stress following hospitalization of a brother or sister. Siblings over the age of seven years, and those who had visited the hospitalized child more than once, had experienced more behavioral changes. Of those who experienced stress, they most frequently reported feelings of sadness during that time. Siblings of the hospitalized child may response to their feelings by acting out; becoming quiet and withdrawn; developing physical symptoms such as nausea, vomiting, headaches, abdominal pain, and diarrhea; or having social problems at school such as truancy. Sometimes these children demonstrate antisocial, attention-getting behaviors, regression, or anxiety including problems such as stuttering and nail biting. The amount of stress the sibling experiences varies depending on the type of relationship between the hospitalized child and siblings, the residence of the well sibling during the hospitalization, the number of siblings visitations, and the perception of hospitalized child's sibling regarding the amount of parental behavior change (Simon, 1993). Therefore, parents and nurses must evaluate the siblings experience during the ill child's hospitalization and determine the needs that these children have for assistance in coping with the situation.

Parents and Young Children Coping with the Stress During Hospitalization

Hospitalization is a stressful event which delivers a variety of real and imagined threats for both young children and their families. This problem becomes complex because young children are dependent on their parents for assistance and support in coping (Tiedeman, 1997). Coping is the process of contending with difficulties in an effort to overcome or work through them. Children often think about

the stress they try to cope with and can debate about what to do about it. How children cope with illnesses or hospitalization is related to their age, perceptions of the event, emotional and psychological predisposition, previous hospitalizations, the emotional state of the parents, the quality of parental care and support during hospitalization, and the child's and parent's coping skills (Hall, 1987; Jones, 1994; Jones, Fisher, & Livingston, 1992; Melnyk, 1994). The child's gender, as boys and girls use different type of coping strategies, is also associated with how the child copes. Young children's coping behaviors include words, descriptions, phrases, and actions directed at resolving the stressful situations. Commonly, young children use both behavioral and cognitive strategies to cope with stress. They may also cope by ignoring or refusing to recognize the event (Corbo-Richert, Carty, & Barnes, 1993). Thus, it is important that nurse determine, through talking with the child and parents, the typical coping strategies used by the young child.

Parents often experience feelings of stress when the young child is admitted to the hospital. They are also concerned over the long-term effects of the young child's illness, stresses and associated with change of parental role, distress about not understanding the information presented, needs for developing trust in the caregivers, and their ability to deal with environmental stimuli (LaMontagne & Pawlak, 1990). In this situation, there is a need for increased support for parents during the time their young child is hospitalized. Thus, helping parents cope with the event is significant to their ability to successfully adjust, such as providing information to increase parental knowledge and understanding of the situation, fostering or supporting new or existing coping behaviors, guiding parents in encouraging their young children (Tiedeman, 1997), and encouraging parents to be involved in their young child's care.

In short, it is reasonable to note that hospitalization is related to a young child's physical, cognitive, social, and emotional development. The young child's response to hospitalization is based on a number of factors, which either separately or in combination occurs throughout the course of a hospitalization. Consequently, hospitalized young children need their parent's presence and support, and most parents also desire to play a role in their child's care (Balling & McCubbin, 2001; Caty, Ritchie, & Ellerton, 1989; Evans, 1996; Graves & Ware, 1990; Kawik, 1996; Keatinge & Gilmore, 1996; Neill, 1996b; Stull & Deatrick, 1986). Therefore, health care professionals, particularly nurses, should encourage parents to participate in their young child's care during hospitalization.

Parent Participation in the Care of Hospitalized Child

There have been significant changes over the past 10 years in the environments that provide for and coordinate the care of ill children. Hospitals once characterized as facilities with visiting policies that restricted parents visits to only a few times a week, now allow parents to visit freely and provide care for their child (Kristensson-Hallstrom, 2000), particularly young children. Therefore, when young children are hospitalized their parents usually accompany them, and they stay and participate in their child's care. Parents of hospitalized young children might view them as more vulnerable and, therefore, prefer more participation in their child's care. The dependence of a very young child is a reason that parents would be inclined to participate in their child's care (Balling & McCubbin, 2001).

There have been essential changes in relation to parent participation in the care of hospitalized child in the western countries. Today parent participation in their

hospitalized child's care has increased. According to the Royal College of Nursing (as cited in Simons, Franck, & Roberson, 2001), parent involvement or participation in their children's care includes open visiting, provision of parent facilities and the encouragement of parents to actively participate in their child's care. Thus, open visiting for parents has become the norm in hospitals. Parents can now accompany their child into hospital, stay by the bedside for the entire period of hospitalization and actively participate in their child's care. Care environments for children currently reflect a philosophy of family-centered care. This is an environment that reflects, acknowledges, and facilitates the changing roles of families in care delivery. Moreover, family-centered care philosophies reflect acknowledgement by health care professionals that the child's family is pivotal to the outcome of a child's care (Bruce & Ritchie, 1997). Family-centered care models have also been used to develop practice guidelines for parent participation in their child's care. Therefore, the concept of parent participation has become a central tenet of pediatric nursing in the 21st century (Newton, 2000). With the adoption of policies based on the recognition of the central role parents play in their children's lives or as a constant in the child's life, parents are now encouraged, not only to visit, but also to participate in some aspects of their hospitalized child's care (Berman, 1991).

Terms of Parent Participation in the Care of Hospitalized Child

Parent participation is now widely accepted as an essential attribute of high quality nursing care for children and their families (Jones, 1994; Kristensson-Hallstrom, 2000; Neill, 1996a; Perkins, 1993). A number of terms have been used to replace a term of parent participation such as care by parent, parent involvement,

parent partnership, partners in care, family participation, and family-centered care (Casey, 1995; Coyne, 1995a, 1995b, 1996; Curley, 1988; Hutchfield, 1999; Neill, 1996a). Also, a variety of terms have been used to define parent participation. Key phrases used to describe parent participation such as "getting involved or being allowed to become involved in a decision-making process or the delivery of a service or the evaluation of a service or even simply to become one of a number of people consulted on an issue or matter" (Brownlea, 1987, p. 605); "allowing parents to stay and involvement in decision making related to their child's care, the negotiation of care within a partnership and involvement of the whole family as a unit of care" (Coyne, 1996, p. 739); "parents are close to their child, are involved in decisions, and are able to comfort and reassure their child" (Kristensson-Hallstrom, 1999, p. 592); and "being there for the child, being able to carry out varying degrees of the child's basic care, and being informed about all aspects of their child's care" (Neill, 1996b, p. 110).

Clearly, the common thread unifying these definitions evolved from the western literature was that parent participation is allowing parents to stay and be involved in decision making related to their child's care and being informed about all aspects of their child's care. However, a few studies specified different types of parent participation. Firstly, Stull and Deatrick (1986) divided specific activities pertaining to parent participation during a child's hospitalization into three groups: (a) direct involvement activities such as routine physical care and comforting, (b) indirect involvement activities such as conferences with staff, and (c) refueling activities such as spending time with other parents. Secondly, Schepp (1992) identified four components of parent participation, including (a) participation in routine care (e.g.,

staying with their hospitalized child, feeding the child, taking or helping a bath, and changing the child's dress); (b) participation in decision-making; (c) participation in technical care (e.g., check vital signs or blood pressure, physical examination, and taking of medications); and (d) participation in sharing information. Lastly, Jones (1994) grouped the parent participation into four categories: (a) stimulation-entertainment such as playing with the child; (b) comfort measures such as staying with the child during painful treatment; (c) activities of daily living such as bathing the child; and (d) therapeutic measures such as taking vital signs.

Benefits of Parent Participation in the Care of Hospitalized Child

Parent participation in the care of their hospitalized child has been increasingly emphasized in pediatric nursing, following publication of evidence documenting increased positive outcomes of hospitalization following increased parent participation (Caty et al., 1989; Kristensson-Hallstrom, 2000; Melnyk, 2000; Vulcan & Nikulich-Barrett, 1988). It is now widely accepted that parent participation is essential to the provision of high quality nursing care of children and their families. In the past, parents were expected to leave their child and the responsibility for their child's care to the hospital staff. Visiting hours were non-existent or severely restricted. Later, great efforts were made to eliminate adverse effects of hospitalization, chiefly by avoiding the separation of children (particularly young children) and parents and encouraging parents to accompany their child to the hospital and participate in their child's care (Kristensson-Hallstrom, 2000; Sainsbury, Gray, Cleary, Davies, & Rowlandson, 1986).

An analysis of the literature reveals that parent participation in the care of hospitalized child is beneficial for both children and parents (Evans, 1994; Jones, 1994; Knafl, 1985; Kristensson-Hallstrom, 2000; Melnyk & Feinstein, 2001; Perkins, 1993; Vulcan & Nikulich-Barrett, 1988). Benefits for the child, especially young children include reducing the incidence of infection, decreasing pain, reducing emotional stress and anxiety, reducing behavior disturbances, increasing the child's sense of security and increasing parent-child bond. Benefits for parents of participation in hospitalized child's care consist of maintaining some of the child's routines, maintaining child's contact with home and family, sharing their feelings with staff or other parents, reducing anxiety, increasing parent satisfaction, and improving post-discharge adjustment.

Factors Influencing Parent Participation in the Care of Hospitalized Child

Parent participation in the care of their hospitalized child has become a central tenet of pediatric nursing. Nurses and other health professionals have promoted parent participation in the care of their hospitalized child for many years. It is generally recognized that parent's presence and participation in the child's care has benefits for the child, one or both parents and the family. Many factors influence parent participation in the hospitalized child's care. Factors related to parents' demographic characteristics (e.g., age, gender, education, employment status, parental experience); children's demographic characteristics (e.g., number of hospitalization, child condition, age of child, length of stay); parents' attitudes toward parent participation; parental anxiety; parents' coping strategies; and communication between nurses and parents have all been reported to influence the health outcomes

for these children. Perception of nurses, including nurses' demographic characteristics (e.g., age, position, education, experience, status, parental status, number of child) and nurses' attitudes toward parent participation are also reported to influence the outcomes for these children.

Older parents are more willingly to leave their child's care to professionals, probably because their children were older and because of their child's increasing autonomy (Knafl & Dixon, 1984; Kristensson-Hallstrom, 1999). Moreover, these investigators suggest that fathers were more inclined to change their role when their child was hospitalized (Knafl & Dixon, 1984). This was inconsistent with the study by Shields (2001) finding that mothers were more likely than fathers to make adjustments to their lives. Parents who were educated were more available (Heymann, Toomey, & Frustenberg, 1999). Employment status of parents was negatively correlated with parent participation in child's routine care. Parents who were not employed wanted to participate more in child's routine care (Balling & McCubbin, 2001). In addition, parents who had other children participated less in their hospitalized child's care (Kristensson-Hallstrom, 2000; Newton, 2000; Schepp, 1992). Young mothers with less parenting experience and less hospital experience preferred to participate more in their children's care (Schepp, 1992). Parents' familiarity with the hospital setting and routines promoted their participation in child's care (Brown & Ritchie, 1990).

Snowdon and Gottlieb (1989) found that the parents' level of participation might be influenced by their child's condition (e.g., acute, chronic or critical care). Parents participated more if the child had a chronic condition (Balling & McCubbin, 2001; Casey, 1995; Kristensson-Hallstrom, 1999; Schepp, 1992). The child's age was

also related to parent participation in hospitalized child's care. Mothers of young children reported an increase desire to participate in their child's care and spend all or most of each day with their child at the hospital. Also, parents of younger children indicated a desire to participate more in routine care (Balling & McCubbin, 2001; Kristensson-Hallstrom, 1999), but mothers felt less of a need to participate in their children's care if their children were older (Schepp, 1992). Additionally, parents tend to participate more in hospitalized child's care if the child had been in hospital for more than a few days or on previous occasions (Casey, 1995; Kristensson-Hallstrom & Elander, 1994).

Parental attitude toward participation in their child's care is a potent variable that can influence parent role in child's care (Coyne, 1995a, 1995b; Kawik, 1996; Kristensson-Hallstrom, 1999; Neill, 1996b; Schepp, 1991, 1992). Some parents were willing to participate in hospitalized child's care. On the other hand, some parents may not desire to participate in their child's care because it is a stressful experience. Moreover, Kristensson-Hallstrom (1999) found that parental anxiety was a barrier to participation in the care of the child. When level of parental anxiety is high, it is a barrier to participation in care and decision-making (Dixon, 1996). An investigator also reported that parental anxiety levels decreased as the parents participated more in the hospitalized children's care (Schepp, 1991).

Parents' coping strategies also influenced parent participation in the care of their child (Kristensson-Hallstrom, 2000; Neill, 1996b). Problem-focused strategies include efforts directed at solving the problem or doing something to alter the stressful event. Emotion-focused strategies are aimed at decreasing or managing negative emotions associated with the stressful situation. These strategies included

activities such as cognitively redefining a situation, venting one's emotion, and taking drugs or alcohol. Parents who used more problem-solving coping strategies (e.g., seeking information) tend to be more actively involved in their child's care than parents who used emotion-focused coping strategies (e.g., avoidance and distancing) (LaMontagne, Hepworth, Pawlak, & Chiafery, 1992; LaMontagne & Pawlak, 1990).

Communication is another important factor influencing parent participation in the care of hospitalized child (Evans, 1996; Kristensson-Hallstrom; 2000; Neill, 1996b). Neill (1996b) divided communication into positive and negative aspects and suggested that effective communication between nurses and parents was essential for parent participation to occur. Kristensson-Hallstrom (2000) found that parents needed information to be concrete in order to make decisions related to the child's care during the hospitalization. Parents found it unacceptable when nurses provided too little information about their child's condition and treatment or provided information in the form of one-way communication (Evans, 1996; Neill, 1996b).

Acceptance of parent participation in the care of their child was greater among nurses who were older, married, were parents, had young child at home or nurses whose held a higher staff position, higher level of education, and were more experienced (Gill, 1987, 1993; Seidl, 1969). In addition, nurses' attitudes may be an important indicator of parent participation in the care of their child. There is accumulating evidence that attitude assessment can provide one means to monitor staff acceptance or rejection of parent participation (Evans, 1994; Gill, 1987; Johnson & Lindschau, 1996). Coyne (1995a) reviewed the literature and proposed that while parents desired to participate in the care of their hospitalized child, nurses often have reservations about their participation. This implies that negative attitudes of nurses

may restrict parent participation in their child's care. Similarly, Neill (1996b) found that attitudes of professionals were one factor inhibiting parent participation in hospitalized child's care.

Relevant Researches in Thailand

Relevant researches on the parent participation in the care of hospitalized child mostly come from the western literature. In Thailand, little is known about parent participation in the care of hospitalized child. Most of the previous studies have focused on the study of needs and response to needs of parents of the hospitalized children (Phongkampan, 1994; Sawangsri, 2001; Taya, Picheansathian, & U-Nak, 2002; Yapvattanapan, 1997). The results of these studies showed that parents had a variety of needs when their children were admitted in the hospital. The needs of parents included information, medical care and nursing care, security, personal and physical resources, psychological needs (emotional support), spiritual needs, financial needs, household management concerns, convenience in visiting their children, and parental role needs. Moreover, the results indicated that needs of the parents were at a moderate to high level, but the response to needs of parents was at low to moderate level. Therefore, most parents received responses that were less than their needs in most of categories of needs. Additionally, the findings revealed that there were many factors influencing the needs of the parents of hospitalized children, including educational level, family income, age of child, and severity of child illness (Phongkampan, 1994; Sawangsri, 2001).

There were a few studies regarding parent participation in the hospitalized child's care constructed from the researcher's perspective of how individuals might

think and behave, and based on the western concepts. For example, Klaigosol (1984) compared the knowledge and ability of 40 Thai parents in providing care to hospitalized child between parents prepared by routine (control group) and those prepared using a planned program (experiment group) in Children Hospital and Ramathibodi Hospital. The research questionnaires were used to test knowledge and a performance recording form was developed by the researcher. The finding showed that the knowledge and performance in providing care for hospitalized child of the parents prepared by the planned program were higher than the parents prepared by routine.

Picheansathian and Suchaxaya (1987) studied the mothers' and nurses' opinions on the maternal role in caring for a hospitalized child. The subjects included 20 professional nurses working at the Pediatric Department and 60 mothers whose children were hospitalized at the Pediatric Department, Maharaj Nakorn Chiang Mai Hospital. The research instruments were questionnaires developed by the researchers. Areas covered in the questionnaires were physical care, psychological-emotional care, and nursing care, with the total of 37 child care activities. The results showed complete agreement regarding policy of rooming-in mother and maternal participation in child care. Nevertheless, there were some child care activities that nurses and mothers had different viewpoints, such as nurses thought that mothers were not able to do some activities. However, the mothers were willing to do these activities (e.g., take pulse and blood pressure, bottle-feed or feed child receiving oxygen, and bed-bathe child having intravenous fluid or catheters). Moreover, there were other activities that nurses thought mother could do but mother did not want to do, including weight and height measurement, oral-nasal suction with bulb syringe,

cleaning bed side table and nearby area, explanation to the child about medical procedure and treatment before the action was performed. For analysis for each area of care, the finding demonstrated that mothers were either able to do or wanted to do these activities.

Similarly, Haemin et al. (1993) studied the mother's participation in caring for the hospitalized pre-school child and also the reasons why some mothers have no intention to care. The sample of this study included 80 mothers of hospitalized pre-school children at the Department of Pediatric Nursing, Siriraj Hospital. The questionnaires were developed by the researchers divided into three sections (nursing care, cleanliness environment entertainment, and nutrition). The findings indicated that the mothers needed to participate in their hospitalized child care in nursing procedures, including tepid sponging; giving pills and liquid medicine; observing and reporting to the nurse the effects after administration of drugs and the appearance of purpura, pallor rash, or wound; and training to prepare medicine are giving by mother at home. Regarding cleanliness environment and entertainment aspect, the mother needed to participate in their hospitalized child's care, including changing the child's dress upon admission, placing the child on bedpan, attending the child to the bath-room, and comforting the child. Finally, the mothers needed to participate in their hospitalized child's care in nutrition aspect, including feeding the child and keeping record of the amount of food and drinks taken by the child. In addition, the result reported that the reasons of the mothers for having no intention to participate in caring for the hospitalized pre-school child included (a) lack of knowledge, (b) being afraid of making a mistake which might harm the child, (c) being afraid of interfering in the

work of the physicians and the hospital officials, (d) lack of time to prepare meals for the child, (e) living in a far-away place, and (f) shortness of money.

Singhajindawong (1994) studied the effects of teaching by mother participation on mothers' knowledge, attitude, and child care. The sample consisted of 40 mothers whose children were admitted in the Children Hospital due to respiratory tract infection. The research questionnaires developed by the researcher were the test for child care knowledge, child care attitude questionnaires, and the Child Care Practice Observation Checklist related to mother participating in caring their hospitalized child. The findings revealed that the knowledge, attitude, and practice of mothers who were taught by the way of participating were higher than those who were taught by conventional health teaching methods. Also, the knowledge, attitude, and practice of mothers after being taught by the way of participation were higher than prior to attending the structured teaching.

In addition, Chaichana (2002) studied parent participation in caring for hospitalized children with chronic illness. The subjects were 145 parents of children with chronic illness admitted at the Pediatric Department, Maharaj Nakorn Chiang Mai Hospital. The questionnaire used in this study was based on the western concept. The results showed that all parents participated in caring for their hospitalized child in various levels of four aspects, including (a) participating in routine care (e.g., staying with their hospitalized child, feeding the child, taking or helping a bath, changing the child's clothes); (b) participating in technical care (e.g., checking vital signs or blood pressure, physical examinations, giving medicine); (c) participating in information sharing; and (d) participating in decision making. However, all parents preferred participating for their child's care, especially participating in information sharing,

participating in routine care, and participating in technical care. Moreover, the results revealed that parents preferred to participate more in the care of their hospitalized child than they actually did.

Only one study has explored personal experience of parent participation in the care of hospitalized children from the Thai parents' perspective (Pongjaturawit, 2001). The findings demonstrated six categories of parent participation in the care of hospitalized children with chronic illness; these were (a) child care provided by the parents, (b) parents' desires to participate in their child care, (c) parents' reluctance to participate in some aspects of their child care, (d) parents' feelings about participating in their child care, (e) parents' feelings when their children were hospitalized, and (f) the help or support parents need when participating. Nevertheless, this research was a small pilot study; therefore, it is limited information about the perceptions and experiences of Thai parent related to participation in their hospitalized child's care.

In summary, in a review of existing literature related to Thai parents' participation in the care of hospitalized child, little is known about parent participation in the care of hospitalized children, particularly young children. Most of the studies were constructed from the researcher's perspective and based on the western concepts. Moreover, the findings measured by using those instruments may be distorted from the perspectives of Thai parents related to participation in the care of hospitalized child. Thus, there is a strong desire for qualitative research, a grounded theory, to provide the grounding and understanding of Thai parents related to participation in the care of hospitalized young child. A substantive theory grounded in the parents' perceptions and interpretations will assist nurses and health care providers, who might have different viewpoints, to understand their actions from the

parents' perspective. The results will also inform nurses about factors and conditions that influence actions and/or interactions of Thai parents related to the process of participation in their hospitalized young child's care.