CHAPTER 4

FINDINGS AND DISCUSSION

The purpose of this chapter is to present the findings generated from grounded theory analysis: the process of “doing anything for an ill child” in parent participation in the care of hospitalized young children. This chapter is divided into three parts: the demographic characteristics of the informants and children, namely the parents and their young children in the study; the qualitative findings; and the discussion of findings.

Part 1: Demographic Characteristics of the Informants and Children

Table 1

Demographic Characteristics of the Informants (N = 19)

Characteristics	Frequency	Percentage
Relationship with children		
Mother	14	73.7
Father	5	26.3
Age (years) ($\overline{X}$ = 27.3, SD = 6.3)		
19-25	8	42.2
26-35	9	47.4
36-40	1	5.2
> 40	1	5.2
Number of children		
One	15	79.0
Two	4	21.0

Table 1

Demographic Characteristics of the Informants (N = 19) (continued)

Characteristics	Frequency	Percentage
Education		
Primary school	6	31.6
Secondary school	7	36.9
Vocational education	4	21.0
Bachelor education	2	10.5
Occupation		
Housewife/House-husband	7	36.9
Employee	7	36.9
Merchant	2	10.5
Government official	1	5.2
Unemployed	2	10.5
Marital status		
Married	17	89.5
Divorced	2	10.5
Ethnicity		
Thai	19	100
Religion		
Buddhism	19	100
Type of family		
Nuclear	13	68.4
Extended	6	31.6
Family monthly income (baht)		
<5,000	3	15.8
5,001-10,000	8	42.2
10,001-15,000	4	21.0
>15,000	4	21.0
Adequate income		
Yes	16	84.2
No	3	15.8

Table 1 shows a total of 19 informants in this study consisting of 14 mothers (73.7%) and 5 fathers (26.3%). Parents' age ranged from 19 to 41 years, with a mean age of 27.3 years (SD = 6.3). The majority of the parents (79.0%) had one child. The education level of the parents was found to be generally low; approximately 68% of them graduated from primary and secondary school. With regard to occupations, more than half of them (57.9%) did not work or had temporary jobs, including housewife/house-husband, merchant, and unemployed. The majority of the parents (89.5%) were married. All of them (100%) were Thai and Buddhists. Approximately 68% of the parents lived in nuclear family. Over half of the parents (58.0%) had family monthly incomes less than 10,001 baht. However, the majority of them (84.2%) viewed that it was adequate. The details of demographic characteristics of each informant also provided in Appendix F.

Table 2

Demographic Characteristics of the Children (N = 17)

Characteristics	Frequency	Percentage
Sex		
Female	8	47.1
Male	9	52.9
Age ($\overline{X}$ = 13.9, SD = 15.4)		
Infants (0-12 mo.)	10	58.8
Toddlers (>1-3 yr.)	4	23.6
Preschools (>3-5 yr.)	3	17.6
Order of children		
First	14	82.4
Second	3	17.6

Table 2

Demographic Characteristics of the Children (N = 17)(continued)

Characteristics	Frequency	Percentage
Diagnosis		
Acute gastroenteritis	3	17.6
Pneumonia	3	17.6
Urinary tract infection	3	17.6
Dengue hemorrhagic fever	2	11.8
Meningitis	2	11.8
Acute febrile illness	1	5.9
Appendicitis	1	5.9
Drug allergy	1	5.9
Dysuria caused	1	5.9
Duration of admission		
≤ 1 wk.	9	52.9
> 1 - 2 wk.	6	35.3
> 2 - 3 wk.	0	0
> 3 - 4 wk.	1	5.9
> 4 wk.	1	5.9
Number of previous admission		
None	10	58.8
One	6	35.3
Two	1	5.9
Primary caregiver during hospitalization		
Mother	13	76.5
Father	1	5.9
Mother and father	3	17.6

From Table 2, a total of 17 young children in this study consisted of 8 females (47.1%) and 9 males (52.9%). The mean age of children was 13.9 months (SD = 15.4) with a range of 2 months to 5 years old. More than half of them (58.8%) were infants. The majority of the children (82.4%) were the eldest. With regard to children's diagnoses, top three diseases were acute gastroenteritis (17.6%), pneumonia (17.6%), and urinary tract infect (17.6%). The duration of admission ranged from less than one week to more than four weeks. Over half of the children (52.9%) have been admitted for less than one week. More than fifty percent (58.8%) of them have never been admitted. Of the 17 young children, the majority of primary caregivers (76.5%,) were mothers. The details of demographic characteristics and diagnostic examination and medical treatment of each child also provided in Appendix G and H respectively.

Part 2: The Qualitative Findings

By using a grounded theory approach, the data analysis showed the experiences of Thai parents from participating in the care of their hospitalized young children. The findings revealed that the basic social process, which emerges as the core category, is *"doing anything for an ill child".* This part describes the basic social process and categories generated from grounded theory analysis. These categories are linked according to the paradigm model of grounded theory.

The Process of Doing Anything for an Ill Child

By the grounded theory analysis, this study discovered the phenomenon of "doing anything for an ill child" as the core category of the process of parents' participation in the care of hospitalized young children as shown by Table 3 indicating the categories and subcategories in the paradigm model of the grounded theory (Strauss & Corbin, 1990). The findings showed two causal conditions requiring the participation of parents in the care of hospitalized young children: *"concerning about needs of an ill child"*, including *"presence of parents"*, *"being* *represented in communication"*, and *"being helped in daily care"*; and *"concerning about self"*, including *"desiring a child's well-being"*, *"a sense of caring for an ill child"*, and *"maintaining parental roles"*. Those two causal conditions lead to the phenomenon of doing anything for an ill child during hospitalization. The phenomenon consists of three phases of action/interaction strategies: the first phase is *"carrying on home practices"* with parents *"being there"* with aims of *"providing basic care"*, including physical, psychological, and emotional care as well as environmental and safety care; the second phase is *"learning new things"* by *"self-learning"*, *"observing and/or asking others"*, *"exchanging information with health care professionals"*, and *"being trained by nurses to perform nursing procedures"*; and the last phase of "doing anything for an ill child" is *"working together with health care professionals in their child's care"*--the moment during which parents must be responsible for *"deciding in their child's care"* by themselves and families and/or co-deciding with health care professionals. Also, parents are "*participating in technical care"*, including providing child's care by themselves under nurses' advices and by working together with the nurses.

The study found that the process of "doing anything for an ill child" is dynamic; having a change or movement from phase to phase in the form of a non linear manner and sometimes it emerges simultaneously. More importantly, each phase of the process cannot be isolated but is overlapped. It meant that this process did not necessarily move from phase 1 to phase 2 to phase 3 and the actions/interactions in phase 1 could sometimes occur simultaneously with phase 2 and/or phase 3. The process of "doing anything for an ill child" is undertaken under four contexts, including *"belief in the capability of physicians and nurses"*, *"ward* *environment"*, *"utensils and accessories available for an ill child"*, and *"visiting rules"*. There are also six intervening conditions on "doing anything for an ill child": *"communicating with health care professionals"*; *"being accepted by others in their child's care"*; *"accepting the maternal role in their child's care"*; *"time availability"*; *"child's dependency"*; and *"distance from home to hospital"*. The consequence of "doing anything for an ill child" is that parents realized *"perceiving the outcomes of doing anything for an ill child"* and these outcomes are divided into three aspects: the "*outcomes of children*"; the *"outcomes of parents"*; and the *"outcomes of nurses"*. The outcomes of children meant "*improving child's well-being"* while the outcomes of parents included "*overcoming exhaustion and loneliness"*--parents feel exhausted and lonely, though they are still capable of overcoming those sufferings and even developing an optimistic attitude towards "doing anything for an ill child" which leads to the outcomes also perceived by parents that are *"decreasing anxiety and stress"*, *"having willpower and self-worthiness"*, and *"learning about their child's care"*. The last consequence is the outcomes of nurses as the process of "doing anything for an ill child" helps *"decreasing workload"* of nurses. The above findings generated from grounded theory analysis can be summarized in Figure 1 and Table 3.

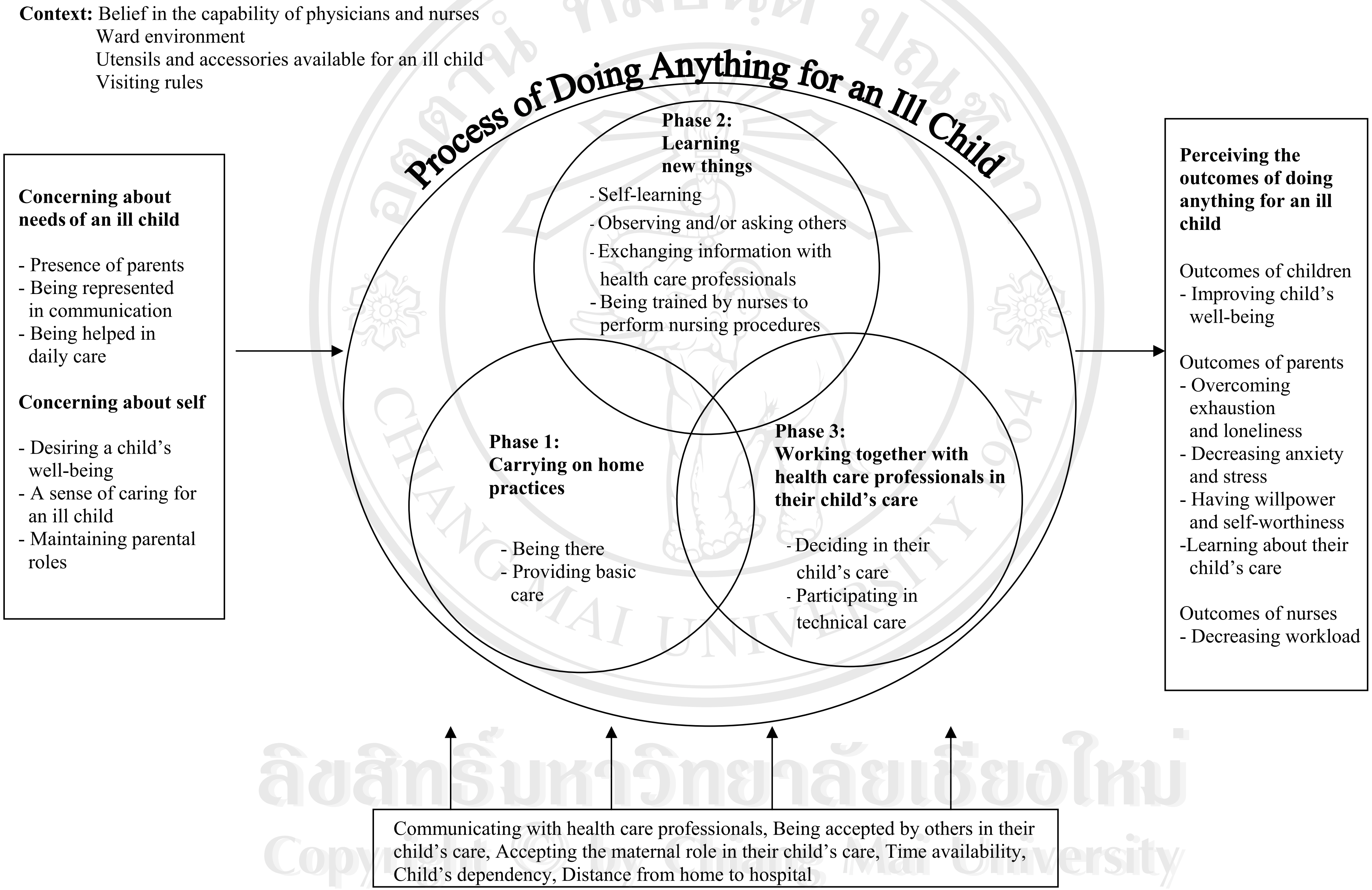

Figure 1. A Diagram illustrating the process of doing anything for an ill child

Table 3

Summary of Categories, Subcategories, and Their Properties

Type of relationship	Categories	Subcategories	Properties
Causal conditions	Concerning about needs of an ill child	Presence of parents	Children need and cry for their mothers, and fear of strangers.
		Being represented in communication	Children cannot communicate with health care professionals; parents give their child's information.
		Being helped in daily care	An ill child is too little to help himself/ herself; others cannot take as good care of an ill child as his/her parents.
	Concerning about self	Desiring a child's well-being	Parents need the child's recovery and safety from illness.
		A sense of caring for an ill child	Parents have loving, bonding, concerning and desire to be close to their ill child as well as anxiety over the child's illness, and mistrusting others to care for the child.
		Maintaining parental roles	Parents need to perform their own duty of caring for an ill child; being my child.
Phenomenon	Doing anything for an ill child: Core category	-	Parents are willing and give a top priority to provide their child's care; parents can take care of their child in every aspect.
Action/Interaction strategies	Carrying on home practices	Being there	Being with the child all the time; watching attentively their ill child.
		Providing basic care	
		Physical care	Cleaning the child's body, oral feeding of food and milk, taking care of bowel movement and sleep.

Table 3

Summary of Categories, Subcategories, and Their Properties (continued)

Type of relationship	Categories	Subcategories	Properties
Action/Interaction strategies (continued)		Psychological and emotional care	Playing with, pacifying and soothing an ill child.
		Environmental care	Making the patient bed clean, taking care of light and air in the ward, and preventing the child from mosquitoes.
		Safety care	Guarding the child from falling off the bed; preventing the child from being naughty or annoying other ill children.
	Learning new things	Self-learning	Reading books, manuals and leaflets on caring for an ill child; applying past experiences in their child's care.
		Observing and/or asking others	Observing the practices of parents of other ill children; asking or talking with friends, relatives or mothers of ill child (in case fathers are caregivers) about their child's care.
		Exchanging information with health care professionals	Giving the child's information to health care professionals; asking information from health care professionals.
		Being trained by nurses to perform nursing procedures	Learning, recognizing and practicing the nurses' instructions and recommendations about nursing procedures.

Table 3

Summary of Categories, Subcategories, and Their Properties (continued)

Type of relationship	Categories	Subcategories	Properties
Action/Interaction strategies (continued)	Working together with health care professionals in their child's care	Deciding in their child's care	
		By themselves and families	Deciding in their child's care.
		Co-deciding with health care professionals	Co-deciding with doctors and nurses in their child's care.
		Participating in technical care	
		Providing child's care by themselves under the nurses' advice	Providing simple nursing procedures under the nurses' advice.
		Providing child's care by working together with the nurses	Providing simple nursing procedures under cooperation with the nurses; providing complicated nursing procedures under the nurses' supervision.
Context	Belief in the capability of physicians and nurses	-	Providing care for their ill child according to the physicians and nurses' instructions; being relieved after the ill child is near the physicians and nurses.
	Ward environment	-	Limited space, bad environment in the ward.
	Utensils and accessories available for an ill child	-	Insufficient utensils and accessories, and inconvenience in using them.
	Visiting rules	-	Allowing mothers to watch their child all the day; preventing fathers from watching the ill child during night-time.

Table 3

Summary of Categories, Subcategories, and Their Properties (continued)

Type of relationship	Categories	Subcategories	Properties
Intervening conditions	Communicating with health care professionals	Communicating in favor of their child's care	Parents receive sufficient information about their ill child's care; health care professionals willingly giving parents information.
		Communicating that impedes their child's care	Parents receive insufficient information; health care professionals unwillingly give them information.
	Being accepted by others in their child's care	-	Parents have willpower to keep caring for the child if parents of other ill children and health care professionals have positive feelings towards their involvement.
	Accepting the maternal role in their child's care	-	Mothers and father agree that mothers take better care of ill child than fathers.
	Time availability	-	Unemployed parents have time to care for their ill child; employed parents find less time to take care of their child.
	Child's dependency	-	Parents need to take more care of young ill child than older ill child.
	Distance from home to hospital	-	Parents living near the hospital have more time for their child's care; those living far from the hospital have less time for their child's care.

Table 3

Summary of Categories, Subcategories, and Their Properties (continued)

Type of relationship	Categories	Subcategories	Properties
Consequences	Perceiving the outcomes of doing anything for an ill child	Outcomes of children	
		Improving child's well-being	Child's safety, recovery soon, and better psychological condition.
		Outcomes of parents	
		Overcoming exhaustion and loneliness	Parents overcome the exhaustion, tiredness, insufficient sleep, boredom, loneliness and desolation to take care of their ill child.
		Decreasing anxiety and stress	Parents are less concerned, but more relieved.
		Having willpower and self-worthiness	Parents have willpower, self-worthiness, and more responsibility for their child's care.
		Learning about their child's care	Parents have more knowledge about caring for an ill child, enabling them to take care of the child in the future.
		Outcomes of nurses	
		Decreasing workload	Parents do not leave the ill child with the nurses, but help in their child's care during hospitalization.

Concerning About Needs of an Ill Child

The findings showed the participation in "doing anything for an ill child" of parents in the care of a young child during hospitalization was attributed to parents' concerning about the needs of an ill child. Given their infant to pre-school age (age is less than or equal to 5 years), when young children were admitted to the hospital, they were afraid of being separated from their parents, and importantly, sick children were too little to help themselves but needed to depend on others. Therefore, the presence of their parents was sought by ill children for their care during hospitalization as parents were their most important and closest persons. The needs of ill children, described by the informants, are divided into three subcategories as follows:

Presence of parents

When a young child was hospitalized, most parents perceived that their ill child could not stay alone at the hospital for several reasons. The young child would be afraid of everything encountered by them when first being admitted to the hospital; for instance, they feared the strangers, doctors, nurses and place, etc. It was also difficult for the little child to adjust to the newly-met environment of the hospital, so the young child needed the presence of parents who must take care of their young child by themselves all day long. The parents gave two main reasons why their presence was needed for their ill child.

Needing and crying for their mothers. As ill children were so young, they wanted their parents to be with them at the hospital (especially the mothers who mostly took care of children). When ill children were admitted to the hospital, they were afraid of being separated from their parents and abandoned by them. As a result, they always cried for their mothers to be with them as told by a mother of a 2-year-old ill child about her experience:

> *A kid is always attached to his/her mother who is the closest person. If a mother isn't with her kid while he/she stays at the hospital, that kid could be depressed. Like my kid, I felt she was heartened that I was here with her. She called me to see if I was still here. If I said, "Yes, mom is here", she'd be heartened. (ID 2, p. 1)*

Fearing of strangers. When ill children were hospitalized, they were encountered by the new environment of the hospital to which they needed to adjust. However, they were too young to adapt to the new environment and frightened by the surrounding people including doctors, nurses and other health care providers and etc. or the place (the ward or the hospital). Due to these fears, sick children needed the presence of parents during illness and hospitalization as shown by the experiences narrated by a father of a sick 4-year-old child, *"My presence here makes my kid feel warm and not be afraid of the hospital. Most kids fear doctors and hospital, and they don't want to lie in bed. If parents are with them, they can stay at the hospital." (ID 1, p. 17)*

The presence of parents, therefore, means ill children want their parents to closely stay with them all the time in the hospital as they are very young and children of this young age would normally be attached to parents and cry for them amid fears over health care professionals and new environment at the hospital.

Being represented in communication

Most of the parents perceived their children were too young to communicate well with health care professionals due to the development of this age (infant to preschool children). Especially, it was too difficult or complicated for children of this age to understand their illness and nursing practices. Parents also thought when their sick children needed a medical treatment at the hospital, they could feel unfamiliar and strange with the place and people there, making the little kids dare not to talk and communicate with strangers and instead need their parents to communicate for them.

Being unable to communicate with health care professionals. Due to their young age, they had a poor ability of talking or communicating with other people, especially about their illness and nursing practice. The presence of parents was then needed to communicate with the health care professionals.

Giving their child's information. After being admitted to the hospital, ill children must be asked by physicians/nurses or other health care professionals about the information of record and conditions of their illness. Due to their inability to give the needed information to the health care professionals, parents must give their children's information instead as told by a father of a 4-year-old child about his reason why he had to be represented in communication:

> *Parents could give clearer information than anyone else when asked by doctors about the kid's conditions. The kid is too young to tell how he/she feels, so parents have to tell it to doctors instead...and the kid doesn't know how to say if he/she has a backache and doctor asks him/her if he/she has a*

> *pain in his/her back, but he/she can't answer the doctor…I think parents should stay with their little kids at the hospital in case doctor needs to know about the kids' condition, parents could tell him/her best. (ID 1, pp. 11, 14)*

In conclusion, the need of parents to be represented in communication means the sick children's need to have their parents to talk and communicate with health care professionals as well as give them information as they are too young to communicate with people.

Being helped in daily care

Parents were needed to help in daily child's care, indicating that an ill child wanted parents to assist in daily care such as helping cleaning body, feeding, helping his/her bowel movement, taking him/her to bed and etc. These needs stemmed from an ill child's poor ability to help himself/herself. Parents could therefore give better help in daily child's care than other people.

Having a poor ability to help himself/herself. Most parents viewed their sick children were too little to help themselves and thus must depend on others to aid in daily care as told by a mother of a 2-year-old child, *"My kid is too young to help himself fully, so he has to depend on others to take care of him." (ID 16, p. 5)*

Being unable to take as good care of an ill child as his/her parents. Parents did not only realize the poor ability of their ill child to take care of himself/herself, but also thought if they let others take care of their ill children, those people could not perform the duty better than parents did as told by a mother of a 5-year-old child:

> *If others take care of my kid, they won't understand her and I'm worried if my kid doesn't get what she wants as others can't know what she really wants or what to do to soothe her. I think I'm the best to take care of my kid. (ID 5, p. 15)*

In conclusion, concerning about needs of an ill child is one of the causal conditions involving parents in the process of "doing anything for an ill child". It means the parents' perception of their ill child's need of the presence of parents and being represented in communicating with health care professionals as well as being helped in daily care.

Concerning About Self

When children became ill and needed medical treatment at the hospital, their parents would be particularly worried and concerned over their young kids in all aspects such as their condition, disease progression, nursing practice, living condition and psychological state. Other concerns for parents included their responsibility of role in their child's care. All of these are causes or causal conditions driving parents to participate in "doing anything for an ill child" at the hospital. As a result, parents' concerning about self of engaging in "doing anything for an ill child" means that parents come to take care of their ill children with desire of the child's recovery and safety from the disease and a sense of caring such as loving, bonding, concerning, being closing to the child, being anxious about the child's illness, and mistrusting others to take care of their child. The process also allows parents to maintain their parental roles as told by a mother of an ill child about her reasons why she got involved in “doing anything for an ill child” for three reasons:

Desiring a child’s well-being

One of the very crucial causes why parents desired to participate in “doing anything for an ill child” at the hospital was their need of a child’s recovery and safety. It refers to the parents’ expectations that they want to do anything to make their ill children have better condition, recover and be safe from the illness, eventually.

Needing child’s recovery. When a child was hospitalized, most parents needed to take care of their ill child by themselves, believing their participation in “doing anything for an ill child” could help make their child have better condition and recovery soon.

Being safe. Apart from the need of a child’s recovery, parents wanted their ill child to be safe from the illness without any complications or threats to their life. Consequently, parents thought if they take part in “doing anything for an ill child”, their ill child will be safe from the disease rather than others as explained by a mother of a 4-year-old child about her reasons why she participated in “doing anything for an ill child” because of her need of her child’s recovery and safety:

> *I want to take part in helping make my ill kid get recovery soon. He’d receive drugs, treatment and more importantly my support. I‘d be another source of support that could help him recover soon. I think if I care for him, he’ll recover soon because he receives more support. Although he is taken care of*

by nurses, the nurses won't be like me. He'd feel lonely amid the crowd, but he feels safe if I'm with him. I think if I'm close to him while he is sick, he'll recover soon. (ID 8, p. 18)

A sense of caring for an ill child

The natural bond of loving and attachment between parents and children is greatly valuable, resulting in a sense of caring of parents towards their young children, particularly when young children are ill, parents would show more caring to the children with loving, bonding, concerning, being close to the child, being anxious about their child's illness and mistrusting others to take care of their child. That was a reason why parents needed to get involved in "doing anything for an ill child" at the hospital. The informants described their various feelings of sense of caring towards their ill children as follows:

Loving. It was one of the important reasons why parents could not leave their young children alone, especially when children were sick and needed to be hospitalized as told by a mother of a 5-month-old baby, *"I can definitely take better care of my own kid than any others as she is my kid. And I'm her mom, I love her." (ID 3, p. 6)*

Bonding. Besides from loving, bonding between parents and children became another reason why parents could not leave their ill children alone at the hospital. Loving always came with bonding, encouraging parents to take part in "doing anything for an ill child" as told by a mother of a 4-year-old child, *"I have a bonding with my kid. It's a strong bond. I've looked after him since he was born." (ID 8, p. 13)*

Concerning. When a child was ill, parents would be much concerned over his/her child, especially when his/her illness was so serious that he/she must be taken to the hospital. Parents would be concerned about everything such as the child's condition, disease, nursing practice, recovery from the illness and condition of living during hospitalization and so on. Concerning was another factor driving parents to participate in "doing anything for an ill child" as told by a father of a 5-month-old ill baby:

> *I'd be worried if I don't take care of her by myself. I want to spend as long as possible looking after her. I'm afraid if her condition is worse. I want to know her condition. (ID 18, p. 13)*

Desiring to be close to their ill child. Parents generally love and bond with their young child and this love and bond makes parents to be close to their young child all the time and do not want their young child to be out of sight or be under others' care. Therefore, when their young child were ill and must be sent to the hospital, parents wanted to closely take care of their young child as told by a mother of a 2-year-old ill child, *"I feel I care for him closely...I want to be close to him and don't want him to be far away." (ID 16, pp. 2, 4)*

Being anxious about their child's illness. This feeling was expressed by a mother of a 9-month-old ill child:

> *I'm worried about everything...I want him to be healthy, so when he becomes ill I want to look after him. I want to know how doctors treat his illness.*

> *When I go to work at the school (her workplace), I feel worried how often he moves his bowels and something like that. I want to know all the time that how he is and if he has a fever. (ID 15, pp. 1, 3)*

The experience narrated by this mother showed loving and concerning of parents given to their hospitalized young child. Parents thus felt worried and anxious about the child's illness and nursing practice and that was another cause of a sense of caring to an ill child why parents needed to participate in "doing anything for an ill child".

Mistrusting others to take care of the child. When a child was sick and admitted to the hospital, parents would be particularly concerned over their child's illness as mentioned above; therefore, other people even their relatives could not be trusted by parents to take care of their ill child. Parents strongly believed no one could take as good care of their ill child as them, so they needed to look after their ill child by themselves as told by a mother of a 9-month-old baby, *"I didn't trust others that they can take as good care of my kid as I." (ID 15, p. 3)*

As a result, a sense of caring for an ill child was another causal condition involving parents in "doing anything for an ill child". A sense of caring for an ill child in this study means the parents' various feelings towards their ill child including loving, bonding, concerning, desiring to be close to the ill child, being anxious about their child's illness and mistrusting others to take care of the child, and these feelings cause parents to participate in doing anything for an ill child at the hospital.

Maintaining parental roles

Maintaining parental roles means the parents' own need to maintain the role and perform the duty of continuously taking care of their young child. Parents viewed that the ill child was their own kid, so when the young child was ill, parents were thus responsible for looking after him/her. The informants gave two important reasons of their need for maintaining parental roles as following:

Needing to perform their own duty of caring for an ill child. Most of the parents perceived the parental roles, so they were responsible for bringing up their young child. Therefore, when the young child was ill and needed to receive treatment at the hospital, parents must participate in looking after the young child to assume the parental role as told by a mother of a 2-year-old child, *"It's a duty…it's the role of mom. It's because I love my kid, so I come to take care of him. Although the kid is already looked after by his grandparents, I need to take care of my kid. I'm his mom."(ID 4, pp. 9-10)*

Being my child. A mother of 5-year-old child explained her reason:

> *She's my own kid, so I've to take care of her by myself. When she was sick, I had to wake up at night to look after her. I came here to care for her. Taking care of my kid at home or at the hospital would make no difference for me as she's my own kid. (ID 5, pp. 8, 12)*

The above remark showed one of the reasons why parents were concerned about maintaining parental roles as most of them realized that the ill child was their own kid, so it was their responsibility to take care of the ill child at the hospital by themselves.

It can be concluded that the causal conditions leading parents to participate in “doing anything for an ill child” during hospitalization were parents’ concerning over the ill child’s need of the presence of parents, being represented in communication and being helped in daily care. Parents’ concerning about self was also noted as they wanted their ill child to recover and be safe from the illness. With a sense of caring for an ill child, parents had the feelings of loving, bonding, concerning, needing to be close to the child, being anxious about the child’s illness and nursing practice and mistrusting others to take care of the child. The last causal condition was parent’s need of maintaining parental roles of taking care of the ill child. Because of all of these reasons or causal conditions, parents needed to participate in “doing anything for an ill child” treated at the hospital.

Doing Anything for an Ill Child

“Doing anything for an ill child” was a core category of the process of parents’ participation in the care of their young children during hospitalization. During the process, parents came to the hospital to attentively watch their ill child and do anything to help in their child’s care. “Doing anything for an ill child” therefore was the process stemming from the bond between parents and young child. The child’s illness and hospitalization caused parents to get involved in their child’s care as they were concerned about the ill child’s need of presence of parents during his/her illness, being represented in communication with health care professionals and being helped in daily care. Parents’ concerning about self was also noted as they needed the ill child to get over and be safe from the illness. They also had a sense of caring for the ill child with loving, bonding, concerning, being close to the child, being anxious and mistrusting others to take care of the child. Moreover, parents' need of maintaining parental roles caused them to take care of and do anything for the ill child and during the period of being with the ill child, parents would provide basic care including physical, psychological and emotional, environmental and safety care, learning new things and working together with health care professionals in taking care of the ill child, which resulted in the outcomes beneficial for the ill child, parents, and nurses.

The process of "doing anything for an ill child" was composed of three phases of action/interaction strategies: phase 1 carrying on home practices was the phase in which parents were with their ill child and provided the same basic care as when they did at home and the care covered physical, psychological and emotional, environmental and safety care; phase 2 learning new things was the phase in which parents could learn and seek information related to take care of the ill child by several methods so as to apply that useful information to look after the ill child during hospitalization. Parents used the methods of self-learning, observing and/or asking others, exchanging information with health care professionals, and being trained by nurses to perform nursing procedures; and phase 3 working together with health care professionals in their child's care was the phase in which parents got involved in deciding in their child's care by themselves and families and co-deciding with health care officials. Parents also participated in technical care by providing child's care by themselves under nurses' advice and providing child's care by working together with the nurses. Each phase of the process was described in the following details.

Phase 1: Carrying on Home Practices

According to the informants' experiences, the way of providing care to the ill child at the hospital by parents was found to be similar to that of carrying on home practices which covered parents' being there with the child and providing the child with basic care including physical, physiological and emotional, environmental and safety care. Carrying on home practices was the first phase of action/interaction strategies of the process of parents' participation in "doing anything for an ill child" during hospitalization. Parents felt the care at the initial stage of their participation in their young child's care at the hospital was not complex or different from the daily care activities at home as told by a mother of a 2-year-old child:

> *What I do at the hospital is the same as at home. I change diapers and milk feeding to my kid…in the morning or when my kid wakes up, I would wipe his face with wet cloth and clean the eyes with cotton wool. I carry on home doings at the hospital. I clean his body, change his clothes and then powder him. I do the same as at home. (ID 16, pp. 11-12)*

Being there

As earlier mentioned, one of the causal conditions driving parents to participate in "doing anything for an ill child" was the child's need of parents to be there with him/her at the hospital. Being there refers to parents' act of following their young child to the hospital to stay with their child and watch the child closely and attentively all the time.

Being with the ill child all the time. As part of "doing anything for an ill child", one of the most important things parents did for their child was being with the ill child all the time without leaving the child alone due to the fear over the child's safety and condition as told by a mother of a 5-year-old child, *"I'm with my kid all the time. I don't go anywhere." (ID 5, p. 7)*

Watching attentively the ill child. After parents came to the hospital to be with their ill child all the time, they did not waste any minute but kept watching the ill child attentively all the time. Parents would watch for the child's disease progression or medical procedures received by the child as told by a mother of a 9-month-old sick child, *"...When I watched my kid, I couldn't sleep a wink. For the first night, I spent the whole night sitting besides the bed to watch him. Even the saline tube, I kept watching if it drips. I watched my kid all the time." (ID 15, p. 3)*

Providing basic care

It means parents provide the ill child with daily care or other simple activities which are the regular activities parents do for their young child at home. This care included physical, psychological and emotional, environmental, and safety care.

Physical care. Parents described the activities of providing physical care which included cleaning the child's body, food and milk feeding, taking care of their bowels, and taking the child to sleep. All of these activities were a part of care parents taking part in "doing anything for an ill child" as told by a mother of a 4-month-old ill child:

> *When my kid wakes up in the morning, I'd wipe down his mouth and clean inside the mouth, clean and powder his body, and put him on clothes. Then, I'd feed him with milk, carry him in my arms, then take a short walk and put him to bed…after he takes a bowel, I'd clean his body, then powder and wear him a diaper. (ID 11, pp. 12-13)*

Psychological and emotional care. An illness did not only have a physical impact on a child, but it also had an effect on the child's psychological and emotional condition, especially for the ill child who needed a treatment at the hospital. Already suffered from the disease and illness, the ill child had to encounter the tension caused by the medical treatment, especially receiving procedures including intravenous fluid, lumber puncture, blood draw and oxygen supply, etc. All of these medical procedures together with having to stay at the hospital--the setting which was new and different from the home where the ill child lived--had a great impact on the child's psychological and emotional condition, causing the child bad-tempered, peevish, fearful, aggressive, or depressed. Given the child in that state, parents were much more worried and anxious about the child, so they paid the child special care and sought ways to decrease the psychological and emotional tension of the ill child. Parents described two ways of giving psychological and emotional care as follows:

Playing with the ill child. Parents realized playing was important for all children as it could bring them amusement and thus reduce their stress, especially when they were sick and must be sent to the hospital. Playing could decrease the psychological and emotional tension of the ill child; therefore, parents sought toys for their ill child or played with the child as told by a father of a 4-year-old ill child:

> *I sometimes take my kid for a walk and find her toys to make her not to feel lonely. A kid can't stay still, so toys are important for her. If she doesn't have toys to play with, it's impossible for her to sit still like an adult. I have to find toys for her. (ID 1, p. 7)*

Pacifying and soothing. Apart from playing, parents applied the methods of pacifying and soothing their ill child to decrease the child's psychological and emotional stress as told by a mother of a 2-year-old sick child, *"An ill kid is often peevish and bad-tempered...so I've to pay him attention to soothe him what he wants." (ID 4, p. 7)*

Environmental care. When a child was ill and admitted to the hospital, the young child would face new things in a new environment at the ward which was different from the house such as bed or mattress, light, noises, air ventilation and the area in the ward, etc. This new setting had an effect on the ill child's health including his/her psychological and emotional state during hospitalization. Parents thus provided the child with environmental care to help reduce the worry and stress of the ill child and of themselves as well as to help the child have early recuperation from the illness. Parents described three ways of providing the child with environmental care as follows:

Making the patient bed clean. After being hospitalized, the ill child faced many things in a new environment: bed, pillow, bed sheet, etc. As the child must lie on the patient bed, parents must take care of the cleanness of bed and bed sheet as told by a father of a 4-year-old ill child, *"I change the bed sheet and clean everything (on the bed)." (ID 1, p. 5)*

Taking care of lights and air. Other new and different environments encountered by the ill child included lights and air in the ward. Parents thus must take care of lights and air ventilation for their ill child during hospitalization in order to make the child have better physical and psychological state as told by a father of a 4-year-old sick child:

> *My kid's sleeping time is around 8.00-8.30 o'clock in the evening. She's not familiar with the hospital and she can't sleep while the light is turned on all day long…So I've to take her out from the confined room for a walk at the corridor to get fresh air outside…I also cover my kid with a blanket as her condition could be worse if I don't keep her feel warm under the electric fan which is turned on all night. (ID 1, pp. 7, 20, 23)*

Preventing the child from mosquitoes. As the ward was an open common place where many patients and their relatives came in and out all the day, it was thus difficult to prevent the place from mosquitoes. Therefore, parents must be careful by preventing their ill child from mosquitoes while he/she was sleeping as told by a father of a 4-year-old child, *"…I also watch out for the mosquitoes. You can see red spots on the kid's skin as they are caused by the mosquitoes' bites. The ward is an open area so it doesn't have a net to prevent the mosquitoes." (ID 1, p. 23)*

Safety care. Giving safety care was another element of basic care concerned by parents who saw their ill child was too little to take care of himself/herself and the child must receive treatment at the hospital where he/she was not unfamiliar with. They were afraid that the ill child could be endangered during hospitalization. The threats included falling off the bed, falling down, playing and fighting between ill children, etc.

Guarding the child from falling off the bed. A mother of a 2-year-old ill child narrated her experience:

> *...I must protect my kid from falling off the bed. He would cry out loud if he sees me lifting up the bed rails. I must lower them, sit at his bedside and prevent him from falling off the bed. (ID 4, p. 6)*

Her experience showed parents must always keep a watch for the ill child as the child was too little to be careful and protect himself/herself from unexpected accidents. The ill child was vulnerable to any dangers, especially falling off the bed, which was found to be an accident at the ward.

Preventing the child from being too naughty or annoying other ill children. It is normal for children of this age to play childishly and naughtily. When children were ill and congregated in the same room of ward, it is natural that they would play and run together and some could annoy or fight with other ill children. Parents of ill children must be vigilant to prevent any possible accidents from the playing naughtily of the children as told by a father of a 4-year-old ill child, *"I saw two ill kids sleeping next to each other play quite violently. They scratched on the other's face. Caregivers must be cautious and separate them if they play too violently." (ID 1, p. 24)*

It can be concluded that when parents initially participated in "doing anything for an ill child" during hospitalization, they perceived that they just carried on home practices at the hospital. Parents were with the ill child and provided basic care--the daily care for their young child. The only slight different was parents must give special and close attention and care as their young child was ill and must be in a new setting. Later, parents got started to learn new things about providing care to their ill child at the hospital as to give better and more care to the child.

Phase 2: Learning New Things

After participating in "doing anything for an ill child" during hospitalization, parents would meet several peoples both related and unrelated to their ill child such as physicians, nurses, health care professionals, other ill children or patients' relatives, etc. with whom parents could have interaction. They would also encounter a new environment at the ward and hospital, the ward regulations, nursing practices, and medical tools and equipments. All of these could stimulate parents to seek and search for information and thus learn new things in order to be able to adjust to the new environment and take more care of the ill child as told by a mother of an 8-month-old ill child, *"I must help myself. It's my kid so I've to learn to seek information useful for my kid. It must be bad if I sit still and let doctors treat my kid. I've to learn by myself how doctors treat my kid and if his condition is getting worse." (ID 6, p. 9)* The process of learning new things by parents was a method by which they applied in studying and seeking knowledge or information about providing care to the ill child at hospital. It started from self-learning, observing and/or asking others, exchanging information with health care professionals, and being trained by nurses to perform nursing procedures.

Self-learning

Anyone who gets in a new environment must study, seek information or learn to live in that new setting. Likewise, when parents participated in "doing anything for an ill child", they tried to learn new things about providing additional care that was useful for both the ill child and themselves. Learning new things started from learning by themselves about easy things. Parents described two ways of learning by themselves as follows:

Reading books, manual, or leaflets on caring for ill child. Reading was one of the methods by which parents used to seek and search for information about caring for the ill child. Leaflets and manuals containing useful information about looking after an ill child were mostly prepared by the hospital to hand out to parents and relatives' patients as told by a mother of a 4-year-old child*, "I got information from books and what I happened to read. It told me about first aid and other things that I can do for my ill kid to alleviate his condition." (ID 8, p. 2)*

Applying past experiences in their child's care. Besides information from hospital leaflets or manuals, parents made use of their previous experiences of looking after their ill children or relatives and then applied the experiences to take care of the ill children as told by a mother of a 2-year-old child, *"I did by myself as I knew when the kid has high fever, he'd convulse. It's something I learnt from experiences that I used to help raising my nephews." (ID 16, p. 9)*

Self-learning therefore means parents' methods of seeking knowledge or information about caring for the ill child by reading from books, manuals, or leaflets; and adapting their previous experiences to look after the young child.

Observing and/or asking others

Apart from learning new things by self-learning, parents taking part in "doing anything for an ill child" accumulated their knowledge by observing and/or asking others including their relatives, friends, surrounding people, or parents of other ill children to see how they are, what they do and how they take care of their ill children and then applied the newly-learnt information to take care of their ill children.

Observing the practices of parents of other ill children. Most parents observed how those of other ill children who were next to their children look after them and if they found that they could be applied to take care of their children, they would do for their children as told by a mother of a 3-month-old ill baby about how to reduce the baby's fever by tepid sponge, *"I sponge down my kid with a wet cloth to lower her temperature when she has fever. I see the example from other parents and I follow them." (ID 9, p. 2)*

Asking or talking with friends, relatives, or mothers of ill child (in case fathers are caregivers). Besides from observing other parents' practices, parents used the means of asking or talking with others to learn news things for looking after their ill child as told by the above mother of a 3-month-old ill baby, *"When I couldn't do something, I asked others who were around there at that time (parents of other ill children). I'm a new mom and when I asked them this and that, they could clarify me." (ID 9, p. 2)* It was also found that in case fathers were the caregivers, they mostly asked the mothers of ill children how to look after and then they would follow their practices as told by a father of a 5-month-old ill baby, *"I asked the mother of ill* *kid about how to lower the kid's temperature when the kid has fever and then I followed her advice." (ID 12, p. 5)*

In conclusion, observing and/or asking others means the methods parents used to seek knowledge and information about providing care for an ill child by observing and/or asking and talking with friends, relatives, and parents of other children.

Exchanging Information with health care professionals

Exchanging information with health care professionals is done by an expression of refers to the verbal and nonverbal actions, which occur when there is an exchange of information between parents of ill child and health care professionals. Parents either gave or took information related to their ill child. This exchange of information between parents and health care providers was one of important elements of learning new things by parents getting involved in "doing anything for an ill child" and there were two important properties as follows:

Giving the child's information to health care professionals. When a child was sick and sent to the hospitalized, health care professionals, especially physicians and nurses who were responsible for providing treatment for the patients must seek information from the patients. In this case, however, these ill children were too young to communicate with the hospital personnel; therefore, parents must give information to them instead as told by a mother of a 5-month-old ill baby, *"I talked with them. Doctors asked me about my kid's condition and I told them." (ID 3, p. 12)*

Asking information from health care professionals. Similarly, when doctors and nurses gave treatment to the ill child, parents would ask the health care professionals about their ill child's condition, disease progression, and care as told by the above mother of a 5-month-old ill child, *"I asked him (doctor) if my kid will get over from the disease and he said the kid will recover if she gets enough injections prescribed or she could relapse." (ID 3, p. 12)*

Being trained by nurses to perform nursing procedures

Parents participating in "doing anything for an ill child" could also learn new things by being trained by nurses in nursing procedures which was more useful for the ill child. It means the ways parents use to seek new additional information about taking care of ill child by attempting to learn, recognize, and practice to do what is instructed and recommended by nurses about nursing procedures as by told a mother of a 5-month-old ill baby:

> *Initially, I let nurses do and I tried to remember how they do and how they suck the kid's phlegm. And when I tried, I could do it. They taught me everything from gavage feeding and checking if the tube is inside the kid's stomach by listening over the stomach and touching it to check if the tube is there, but I can't do, so I listen over it with my ear and I will hear a sound as the air enters the stomach. I listen over it every time. (ID 3, p. 8)*

The experience of this mother indicated that parents learnt new things for their young child's care by being trained by nurses to perform nursing procedures. Nurses started by teaching, recommending, and demonstrating nursing procedures such as gavage feeding, tepid sponge, oxygen box, nebulizer, etc. Parents then practiced these procedures by trying to learn, recognize, and follow the nurses' recommendations until they were assured of doing those nursing procedures in their child's care.

Phase 3: Working Together with Health Care Professionals in Their Child's Care

After learning new things, parents worked with health care professionals, especially nurses to care for the child as a part of the process of "doing anything for an ill child" at the hospital. Working with health care professionals in their child's care refers to the parents' actions of making a decision on taking care of the ill child and looking after the ill child in nursing procedures with doctors and nurses.

Deciding in their child's care

When a child was admitted to the hospital, the child would be treated by doctors and nurses and the nursing procedures required a decision from related people such as the child's parents, families, relatives and other health care professionals, etc. as the child was too young to make any decisions. The findings showed parents perceived that decisions on their child's care could be made on two matters as follows:

Deciding by themselves and families. After participating in "doing anything for an ill child" at the hospital, the child's parents and families were brought in to co-decide on providing care for the child as the child was still too young to make any decisions and parents and families were the child's closet people who have raised him/her from birth. Under this perception, parents viewed the ill child was their own child, so they and their families were entitled to make a decision on the treatment of the child, rather than other people as told by a mother of a 5-year-old ill child:

> *I must make a decision because I want to know how my kid is, how her condition is and how she gets this illness…If I don't inform them (doctors and nurses) of my kid's conditions, how could they know? It's me, not doctors, who live with my kid everyday. After knowing the conditions, doctors could give a right treatment to the kid…Parents of the ill child must make a decision as the treatment of a patient can't be done without the parents' decision. (ID 5, pp. 12-13, 16)*

Co-deciding with health care professionals in their child's care. A number of parents involving in "doing anything for an ill child" at the hospital viewed that health care professionals, namely physicians and nurses should also take part in the decision-making process of the treatment of the ill child because of their higher skills and expertise in the field as told by a mother of a 8-month-old sick child:

> *Decision-making involves the doctor and the ill kid's father. Doctor knows everything how the ill kid is and how he should be treated and then the mother must take a decision if she agrees with the doctor's purposed treatment. (ID 6, p. 15)*

Therefore, deciding on providing care for the ill child is a duty of the child's parents who must decide by themselves and with families and co-decide with doctors and nurses.

Participating in technical care

Apart from getting involved in making a decision on the care of their ill child at the hospital, parents took part in nursing procedures such as checking vital signs, oral medicine, oxygen supply, nebulizer, intravenous fluid, etc. Parents described two ways of taking part in nursing procedures as follows:

Providing child's care by themselves under the nurses' advice. Activities parents could do for their ill child under the nurses' advice were mostly technical care which required no complicated skills or simple nursing procedures such as tepid sponge that parents could do for their ill child by themselves according to the nurses' advice as told by a father of an 11-month-old ill child, *"Doctors and nurses used to tell me what I should do if my kid has fever. I understand it and I can do it and I do it." (ID 19, p. 5)*

Providing child's care by working together with the nurses. Besides from doing what was advised by nurses, parents participating in "doing anything for an ill child" provided care for their ill child by working with the nurses on nursing procedures which could be divided into two properties as follows:

Providing simple nursing procedures by parents under cooperation with the nurses. Parents could provide uncomplicated nursing care to their ill child but they must depend on nursing skills and capabilities. Although they were able to give the ill child those nursing care, it must be undertaken under the nurses' cooperation as told by a father of a 4-year-old ill child related to the record of intake output:

> *I'd tell nurses and they would ask me how much water my kid drinks today. Then I'd ask them if they want me to keep my kid's urine, if so, I'll do it…They'd check it and I'd record how many times my kid pees a day. (ID1, pp. 21-22)*

Providing complicated nursing procedures under the nurses' supervision. This involved quite complicated nursing procedures and if the procedures were not correctly conducted, they could endanger the ill child. Therefore, the nurses were directly responsible for providing these complex nursing procedures to the ill child and allowing parents to help in their child's care as told by a mother of a 5-month-old ill baby:

> *My kid gets intravenous fluid, so I've to see if my kid bleeds or if the tube disconnects, I must call a nurse to adjust the tube. Or when there was blood inside the tube, she warned me not to carry my kid high but kept her legs low. I've to watch out all the time. (ID 3, p. 10)*

Consequently, participating in technical care in their child's care covers parents' involvement in many activities regarding nursing practices such as tepid sponge, oral medicine, intravenous fluid, etc. These nursing procedures can be done by parents alone under the nurses' advice or with the nurses only.

The study showed when parents participated in "doing anything for an ill child" during hospitalization, they provided a continual and steady care for "doing anything for an ill child" which was done under many contexts or conditions of belief in the capability of physicians and nurses, ward environment, utensils and accessories available for an ill child, and visiting rules.

Belief in the Capability of Physicians and Nurses

Parents' involvement in "doing anything for an ill child" during hospitalization emerged under several crucial contexts or conditions. The first was their belief in the capability of physicians and nurses on the perception that when their child was ill and admitted to the hospital, the physicians and nurses were of course capable of curing the child until complete recovery. Parents described the child's care with their belief in the physicians and nurses' belief into two properties:

Providing care for their ill child according to the physicians and nurses' instructions. After their child was ill and sent to the hospital, parents participated in "doing anything for an ill child" and they attributed their involvement to the belief in the physicians and nurses' capability of curing the ill child. Thus, parents were confident to provide care to the child under the physicians and nurses' instructions as told by a mother of a 2-year-old ill child, *"I did anything to make my kid get well soon. I followed the doctor's orders that I must not feed my kid even as she was so hungry. I felt pity on my kid but I must not feed her as the consequences could be much worse than I thought. I felt pity on my kid but I must do what the doctor said." (ID 2, p. 3)*

Being relieved after the ill child is near the physicians and nurses. Parents' participation in "doing anything for an ill child" under their belief in the capability of the physicians and nurses made parents more confident over the caregiving toward their ill child. They thus felt more relieved for taking part in their child's care at the hospital as told by a mother of a 4-year-old ill child:

> *After arriving at the hospital, I was less concerned as my kid is in the care of nurses. If I care for my kid at home, there're few things I can do. I don't know the treatment, except primary aids. When I'm here, I feel relieved...at home, I'm the only one who takes care of my kid and at night I don't sleep a wink as I must carry him in my arms all night...at the hospital, he's in the patient's bed while I'm at his bedside. If I feel tired, I can take a nap and feel relieved because the nurses are around there. (ID 8, pp. 1, 9-10)*

Therefore, belief in the capability of the physicians and nurses is one of the conditions favorable to parents' participation in doing anything for an ill child. With belief and confidence in the physicians and nurses' capability, parents are more relieved and assured to take care of their ill child according to the health care providers' instructions.

Ward Environment

The ward environment includes the area, light, noise, atmosphere, and facilities within the ward and this study found that the ward environment was one of the conditions influencing parents' participation in "doing anything for an ill child". The experiences of parents about the ward environment could be described into two properties:

Limited space in the ward. A mother of a 9-month-old ill child described her feelings toward the ward environment experienced after participating in doing anything for an ill child:

> *It (the ward) is stuffy. It's like the hell...the hell indeed. There're so many bad things. It's too small and doesn't have good arrangement of the area…the visiting rules allow only one mother or relative to watch the ill child, so they should provide an area for the caregivers to sleep. It must not be too cramped. (ID 15, pp. 1, 14)*

The experience above indicated that parents viewed the ward where their ill child was treated was quite stuffy and restricted, causing an uncomfortable environment, and more importantly, there was not an arrangement of private area for parents who came to watch and take care of their child.

Bad environment within the ward. The limited space caused a bad environment within the ward, causing an inconvenience and restriction to parents as told by a father of a 5-month-old ill baby, *"...I feel the place is too small and the atmosphere is not good. It's not comfortable at all. It's not like home." (ID 18, pp. 1, 9)*

The ward environment described by the informants in this study included the limited space and bad atmosphere in the ward which were unfavorable for parents' involvement with "doing anything for an ill child".

Utensils and Accessories Available for an Ill Child

Utensils and accessories are prepared and available for an ill child at the ward, including patient' clothes, diapers, bed sheets, draw sheets, blankets, etc; these facilities were one of the important conditions under parents' participation in "doing anything for an ill child" at the hospital. Parents identified two properties from these facilities.

Insufficiency of utensils and accessories available for an ill child. Parents stated one problem faced by them was the deficiency in utensils and accessories for the patients; thus, parents must bring the clothes from home or put their ill child on old clothes as told by a father of a 4-year-old ill child:

> *The hospital doesn't prepare enough clothes for ill children. So I've to bring clothes from my house. Draw sheets and blankets are also inadequate as are diapers. Some ill children don't have clothes to change and must wear old same clothes for 2-3 times. (ID 1, p. 15)*

Inconvenience in using utensils and accessories available for an ill child. Above from the perceived insufficiency, parents encountered the inconvenience in using the utensils and accessories available for an ill child, citing that these utensils and accessories were not similar to those at home, so they did not feel comfortable to use them and that could have an impact on the child's wellness as told by a mother of a 5-month-old baby, *"Staying at the hospital isn't as convenient as at home where there is a cradle in which my kid enjoy sleeping. So she's always peevish and doesn't want to sleep as there is no cradle here (at the hospital)." (ID 3, p. 2)*

It can be concluded that utensils and accessories available for an ill child at the ward included the insufficiency and inconvenience which were not favorable for “doing anything for an ill child” by parents.

Visiting Rules

In participating in “doing anything for an ill child” at the hospital, the visiting rules of the ward were among conditions under which parents of the ill child must implement. According to the study, the visiting rules mean the regulations regarding watching the ill child and they allow female relatives to watch the ill child during the day and stay overnight, whereas male relatives are permitted to watch the child at daytime only and one bed is per one relative.

Allowing mothers to watch their ill child all the day. Parents realized that the visiting rules allowed only one relative to watch the ill child who was less than or equal 5 years old; and importantly, only female relatives were permitted to watch the child during the day and night. These regulations thus were intervening conditions that encouraged mothers to have more participation in “doing anything for an ill child”.

Preventing fathers from watching the ill child during night-time. Due to a concern over security at the ward, there were rules forbidding male relatives to watch the ill child at night-time, which were the conditions that hindered parents’ participation in “doing anything for an ill child”. Thus, fathers were not allowed to watch their sick child at the ward during the night and they must transfer the duty to mothers. However, both mothers and fathers agreed that the ward should let male relatives, especially fathers watch the ill child at night-time as they could help mothers take care of the ill child as told by a father of a 5-month-old baby:

> *Last night I wanted to stay with my kid at the ward, but I couldn't because of the visiting rules. Anyway, I want them to adjust the rules. They should allow two relatives, especially males to watch the ill kid. (ID 18, p. 13)*

As part of the process of "doing for an ill child" during hospitalization, parents provided care for their ill child under the contexts above. Belief in the capability of physicians and nurses was considered a favorable condition encouraging parents to get involved in "doing anything for an ill child, whereas other contexts of the ward environment, utensils and accessories at the ward, and visiting rules were all conditions unfavorable for "doing anything for an ill child" by parents. This study also found the intervening conditions influencing the parents' process of "doing anything for an ill child" and these intervening conditions would be later enumerated.

Communicating with Health Care Professionals

Communicating with health care professionals includes discussing, asking, or giving information about the ill child such as the illness, disease progression, medical treatment, child's care, etc. It also means the manner of discussion of physicians and nurses and duration of communication. Communicating with health care professionals was among intervening conditions to parents' involvement in "doing anything for an ill child". If communicating between health care professionals and parents of ill child was a positive communication; for instance physicians or nurses willingly gave enough information about providing care for an ill child in a manner of polite, friendly, and nice speaking, the communication was then a favorable factor encouraging parents to better and increase their participation in "doing anything for an ill child". It also promoted parents to have positive attitude towards taking part in "doing anything for an ill child". On the other hand, if it turned to be a negative communication, that communicating became an intervening condition unfavorable for parents' participation in "doing anything for an ill child" as they could be scared to talk or ask health care professionals about their child's illness and care. This study found the intervening conditions--either favorable or unfavorable--for communicating with health care professionals.

Communicating in favor of their child's care. It means parents are given by health care professionals sufficient information related to their sick child and these health care providers are perfectly willing to talk and answer ill-child care related questions from parents as told by a mother of a 2-year-old ill child:

> *Doctor looks pretty friendly. He can tell me everything I want to know. He talks in a polite and friendly manner to the patients and that removes pressure from me and my ill kid. (ID 4, p. 5)*

Communicating that impedes their child's care. It means parents do not receive enough information about their ill child from health care professionals who are unwilling to talk and discuss with parents who want information about the ill child as told by a mother of a 9-month-old ill child:

> *There isn't enough information about providing care for an ill kid and advice on each case are also inadequate such as patients with diarrhea, conditions of illness in kid, milk feeding, medicine feeding, how to treat to a kid getting a saline tube, and many other techniques of care…I think they should provide the information for each case. (ID 15, pp. 10-11)*

In the same way, parents recognized the health care professionals' unwillingness in communicating, making them dare not to ask for information or talk with these health care professionals as told by a mother of a 2-month-old sick baby, *"I never ask them. I see doctors are very busy, so I don't want to interrupt." (ID 7, p. 8)*

Communicating with health care professionals in this study involved talking and asking for information related to the ill child' illness and care by parents taking part in "doing anything for an ill child". The ways of communicating regarded as favorable included receiving enough information from health care professionals and their gesture of gladness to give information while those unfavorable ways of communicating composed of receiving inadequate information from these professionals and their gesture of unwillingness to give information to parents of ill child.

Being Accepted by Others in Their Child's Care

Being accepted by other in their child's care means that parents of ill child get willpower from others such as other parents of ill child, patients' relatives, and health care professionals in the manner of verbal and nonverbal actions showing their acceptance towards the parents' participation of "doing anything for an ill child" at the hospital. This acceptance was among favorable factors encouraging parents to better do anything for their ill child as told by a mother of an 8-month-old ill child about her experience of being accepted by others parents:

> *It'd be very nice if they (parents of other ill kids) see me as a mother take care of my ill kid…and if surrounding people view my care as good, I'd be much encouraged to care for my kid, but it'd be very bad if they say why I leave my ill kid alone. (ID 10, pp. 11-12)*

In the same way, parents of ill child realized if health care professionals have positive attitude towards those who participated in "doing anything for an ill child", that would encourage them to take more care of the ill child as told by a 3-month-old ill baby:

> *The hospital personnel? I think they could feel very good seeing me take care of my ill kid and not leaving the duty to others…that makes me have willpower, enthusiasm, and perseverance. (ID 9, pp. 20-21)*

Accepting the Maternal Role in Their Child's Care

Due to the belief and culture in Thai society, women or mothers are expected or required to play a role in bringing up children, whereas men or fathers assume the responsibility of earning the family, most parents of ill child in this study viewed that mothers had more role in raising children than their partners. Therefore, when their young children were ill and admitted to the hospital, most mothers decided to take the role in participating in taking care of the young children at the hospital on belief that they could do the duty better than their partners. Accepting the maternal role in their child's care was another intervening condition for them to participate in "doing anything for an ill child". In other words, if mothers took care of their ill child, that would increase their need to take part in "doing anything for an ill child", whereas if fathers took the duty, that would hinder their need of providing care for their ill child. As a result, accepting the maternal role in their child's care according to this study means the perception of parents of the participation their child's care at the hospital; both fathers and mothers perceive that mothers can take better care of their children than the others as told by a mother of an 8-month-old ill child about her opinion towards the role of caring for an ill child between fathers and mothers:

> *When my kid becomes ill, I want to take care of him. I think mothers can do this duty better than fathers as men aren't as tender as women, even some are. Anyway, most fathers don't take as good care of kids as mothers and women are much more careful. (ID 10, p. 16)*

A father of a 9-month-old ill child who participated in "doing anything for an ill child" also expressed the similar feelings, *"It's absolutely different. A mother can definitely take better of a kid than a father. I think men in general don't enjoy bringing up kids…I myself don't want to care for my kid, but I have no one to help me. It's because of necessity." (ID 14, pp. 2-3)*

Time Availability

Time availability means that parents are able to manage time to participate in "doing anything for an ill child" at the hospital. However, it depended on the parents' career that it was a permanent or temporary job. If parents did not work or had temporary job, that would be a factor favorable for parents to do more for their ill child, but if they were permanent workers, that could be an intervening condition unfavorable for doing anything for an ill child. Time availability thus resulted in both favorable and unfavorable intervening conditions influencing parents' involvement with "doing anything for an ill child".

Having temporary work or unemployed parents. It found that unemployed parents were mostly housewife, house-husband, or merchant, so they had more time to take part in "doing anything for an ill child" or throughout the duration of hospitalization of the ill child as told by a mother of a 5-month-old baby, *"I stay here to look after my kid. I'm unemployed so I have plenty of time to be with my kid at the hospital." (ID 3, p. 13)*

Having permanent work or employed parents. If parents of ill child were permanent employees such as government officials, workers, etc, that could impede them from participating in "doing anything for an ill child". However, if necessary as there was nobody to help them care for the ill child at the hospital or in combination with the above causal conditions, parents had to take leave or be absent from work to take care of their ill child by themselves as told by a mother of a 2-year-old child, *"I have nobody, so I've to take leave to take care of my ill kid. If the company doesn't agree with my conduct, I must quit. I have none to help look after my kid." (ID 4, p. 9)*

Child's Dependency

One of the vital conditions influencing on parents' participation in "doing anything for an ill child" was the child's dependency which means his/her own ability to help himself/herself. In other words, a little sick child must depend more on others than an older ill child; thus, parents must take more care of little sick child than the older one. Given the child's young age, parents viewed their child was too little to convey their need to others and the child was unable to help himself/herself, especially those little ill children, rather than older ill children, relied on almost everything from their parents. The properties of child's dependency on parents' participation in "doing anything for an ill child" could be detailed as follows:

Needing to take more care of little ill child than older ill child. Parents perceived the child's age required him/her to depend on adults, especially their parents when he/she was ill, viewing that the younger the child was, the more he/she needed to rely on his parents and his dependency was more necessary than that of an older child who was able to help himself/herself some as told by a mother of a 9-month-old baby:

> *An ill baby needs to be taken care of everything from milk feeding to sleeping while an older ill kid can help himself/herself in some ways. A little kid can't pee or poo by himself/herself, but an older one can call for others to help him/her. (ID 15, p. 5)*

Distance from Home to Hospital

The distance from home to hospital was one of the conditions regarded by the informants as a factor in participating in "doing anything for an ill child" at the hospital. It means the distance and convenience of going from the patients' home to the hospital, which have an effect on parents' involvement in their young child's care at the hospital. The informants described this condition into two aspects as follows:

Living near the hospital has more time for their child's care. Parents viewed if they lived near the hospital, there was no obstacle for them to participate in "doing anything for an ill child" at the hospital as it did not take much time for them to go to the hospital, thus encouraging parents to more easily, quickly, and increasingly take part in their child's care, especially for those who took turns or helped each other in their child's care as told by a mother of a 4-year-old ill child, *"It's convenient as my home is close to the hospital and I can travel by myself. In the evening, my hubby would take me home to change my clothes and then I would go back to watch my kid here. I don't feel any inconvenience." (ID 8, p. 15)*

Living far from the hospital has less time for their child's care. On the other hand, if parents' home was far from the hospital, they would find it inconvenient and difficult to take part in "doing anything for an ill child" as it could take more time for traveling; parents provided less care for their ill child as told by a father of a 5-month-old child, *"It's totally different…staying at the hospital is not as convenient as at home and travel between home and hospital is inconvenient." (ID 18, pp. 8-9)*

It can be concluded that the intervening conditions for parents' involvement in "doing anything for an ill child" during hospitalization were comprised of communicating with health care professionals, being accepted by others in their child's care, accepting the maternal role in their child's care, time availability, child's dependency and distance from home to hospital. After participating in "doing anything for an ill child" during hospitalization, there would be several consequences to be discussed in details.

Perceiving the Outcomes of Doing Anything for an Ill Child

After participating in "doing anything for an ill child" during hospitalization, the outcomes from "doing anything for an ill child" were perceived and discussed by parents into three aspects:

Outcomes of children

It means the outcomes of children stemming from their parents' involvement in "doing anything for an ill child" which improves the sick children's physical and psychological condition.

Improving child's well-being. Parents realized that their sick child had better physical and psychological condition after receiving care from their parents who got involved in "doing anything for an ill child". The ill child also had safety, early recovery and better psychological condition. According to the informants, there were two properties of the child's improved physical and psychological condition as follows:

Safety and recovery soon. Parents realized their participation in "doing anything for an ill child" brought about the safety and recovery soon for their child and children with care from their parents could even earlier recover than those without care from their parents as told by a mother of a 4-year-old ill child:

> *The kid could get over soon because he receives care from his mother at the hospital. Though the kid is already cared by nurses, they aren't like mothers. The kid could feel safe and I feel that he'll recover sooner with my close care. (ID 8, p. 18)*

Better psychological condition. Apart from resulting in improved physical condition, parents discussed about their ill child's better psychological condition; the child felt warm, became cheerful and had willpower as told by a mother of an 8-month-old ill child, *"...during his illness, he couldn't help himself, but if I take care of him, he will get more willpower." (ID 10, p. 1)*

Outcomes of parents

It means the outcomes--both are good and bad--parents receive directly from participating in "doing anything for an ill child", but they eventually have positive feelings towards their participation. The outcomes included overcoming the exhaustion and loneliness, decreasing anxiety and stress, having willpower and self-worthiness, and learning about their child's care.

According to the study, parents perceived their involvement in "doing anything for an ill child" resulted in positive and negative feelings. Negative feelings included exhaustion, suffering from taking insufficient rest and sleep, and loneliness while positive feelings were comprised of decreasing the anxiety and stress, having willpower and self-worthiness, and learning about their child's care. The informants described the outcomes as follows:

Overcoming exhaustion and loneliness. It means parents can take care of the ill child by overcoming such negative feelings as exhaustion, endurance from insufficient rest and sleep, and loneliness due to their participation in "doing anything for an ill child". The negative feelings encountered by parents could be divided into three groups:

Being exhausted. The participation in "doing anything for an ill child" made parents feel exhausted and tired as they must take care of their young child all day long and could not find time to take a rest or did not have enough rest as told by a mother of a 4-month-old baby:

> *I feel so exhausted and tired, but I don't know how to cope with it when my kid is ill and I'm so tired…and exhausted and sometimes sleepy as I have no one to take turns to look after him. (ID 11, pp. 11, 19)*

Enduring a lack of rest and sleep. As their involvement in "doing anything for an ill child" prevented parents from sleeping a wink in order to take care of their ill child all day and night long, they perceived they had to resist the sleepiness or stand a lack of sleep so as to watch their ill child as told by a mother of a 2-year-old child:

> *Since my kid was admitted to the hospital, I haven't slept a wink. The best I could do is just taking a short nap beside him. I dare not to go far from him as I'm afraid he might get worse or have fever or something worse. I don't sleep at all but I must stand it. (ID 16, p. 10)*

Feeling bored, lonely, and desolate. These feelings stemmed from parents' participating in "doing anything for an ill child" alone without the visit of their relatives or they could be overcame by these emotions from having taken care of their ill child for several consecutive days, making them feel bored, lonely, and desolate. These feelings made them feel lonely as told by a mother of a 5-month-old ill baby, *"I feel bored somewhat. I'm never in this state before so it's boring for me. I'm in the habit of being with my hubby and my kids, but now I've to be alone with my ill kid. It's so desolate and lonely." (ID 3, p. 1)*

These negative feelings--exhaustion, endurance of lack of sleep, and loneliness--were negative outcomes existing during the initial stage of participating in "doing anything for an ill child". However, the positive feelings overwhelming the negative ones combined with the child's improved condition or recovery from illness enabled parents to overcome those negative feelings, withstand the difficult situation and feel better eventually. According to the study, the positive feelings were described by the informants as follows:

Decreasing anxiety and stress. When a young child was admitted to the hospital, parents would be much anxious and worried over the child's illness; however, after taking part in "doing anything for an ill child" their anxiety and stress were reduced.

Being less concerned. Parents were less worried when engaging in "doing anything for an ill child" as they could be close to their ill child all the time, making them be updated about the child's condition as told by a mother of a 2-year-old ill child, *"It decreases my anxiety when seeing how my kid is treated. I feel less worried after seeing my kid in that state." (ID 2, p. 20)*

Feeling relieved. Besides from their decreased anxiety after taking part in "doing anything for an ill child", parents realized they were much relieved and less worried over their young child as told by a mother of a 2-year-old sick child:

> *...I feel like I can care for my kid closely. Well, it's something like I'm relieved. I'm already concerned over my kid's illness and my concern increases when I'm not close to him. So when he's within my sight, I'm relieved. (ID 16, pp. 2-3)*

Therefore, decreasing anxiety and stress is among parents' positive feelings happening after "doing anything for an ill child" with parents feeling less concerned and stressed over their child's illness.

Having willpower and self-worthiness. This optimism existed after parents got involved in "doing anything for an ill child". It created them willpower to keep looking after the child, have the feeling of *"Poom-jai"* (literally means proud) of themselves and be more responsible for their own role and duty. The informants described three properties of having willpower and self-worthiness as follows:

Having willpower. Most parents regarded their participation in "doing anything for an ill child" as a good thing as that made them feel warm and had willpower to take care of their ill child as told by a mother of an 8-month-old child, *"It gave me a lot of good things. They (health care professionals) won't have too much workload while I can look after my kid closely and have willpower." (ID 6, p. 12)*

Having self-worthiness (Poom-jai). Parents viewed that the child's illness was vital to their life and family, making them proud of themselves that they could take care of their ill child and that pride also made parents realize their self-worthiness as told by a mother of a 5-month-old ill child, *"I'm proud of myself (Poom-jai) for doing for my kid and for being able to take care of her…I can bring up her. I feel good about myself (Poom-jai)." (ID 3, pp. 9, 19)*

Being more responsible for their child's care. Parents realized their role in their young child's care when taking part in "doing anything for an ill child" as they perceived they were more responsible for their parental role and duty as told by a mother of a 3-month-old baby, *"...It made me proud that I gained hands-on experience of raising a kid. The duty exhausted me, though, but I learnt more and I think I grow up…it made me have more responsibility." (ID 9, p. 7)*

Learning about their child's care. Parents received more knowledge about providing care for an ill child, enabling them to take better care of when their child falls ill again in the future. They described learning about their child's care in two aspects:

Having more knowledge about providing care for an ill child. Parents realized that after engaging in "doing anything for an ill child" they could learn more about taking care of an ill child and found learning more as useful as told by a mother of a 3-month-old ill baby, *"I learnt what I never knew before such as how to care for an ill kid and different methods of taking care of an ill kid and a healthy kid. It's a very good experience." (ID 9, p. 18)*

Being able to provide their child's care in the future. Besides new knowledge, parents thought they were able to adopt that knowledge in the future if their child is ill again as told by a mother of an 8-month-old child, *"...It's good learning as I can adopt my direct experience this time to use when my kid has fever again. Then, I'll know how to deal with it." (ID 6, p. 14)*

Outcomes of nurses

The outcomes of nurses mean parents' participation in "doing anything for an ill child" has a positive effect on the work of nurses in the child's care as it decreases their workload. All informants in this study acknowledged their involvement in "doing anything for an ill child" helped alleviate or lessen the workload of nurses, discussing the outcomes in details as follows:

Decreasing workload. One good outcome perceived by parents participating in "doing anything for an ill child" was that it helped ease the nurses' workload of their child's care. Parents viewed that the number of health care professionals, nurses in particular, was not enough for taking care of all ill children. The decreased workload of the nurses in this study was a result of parents' participation in "doing anything for an ill child' as parents were with their ill child and did not leave their child with the nurses as well as helped the nurses in the child's care during hospitalization. Parents perceived they were able to help reduce the nurses' workload due to the following two reasons:

Not leaving the ill child with nurses. Parents perceived their participation in "doing anything for an ill child" was good as they did not leave their own children with health care professionals as told by a mother of an 8-month-old ill child:

> *There're so many patients here that I feel tired for the nurses. So if parents stay here to help look after their ill kids, they can call for nurses if something bad happens. And that's better. If none looks after the ill kid, the nurses won't know if something wrong happens with the kid. (ID 10, p. 15)*

Helping in their child's care during hospitalization. Apart from the perception of not leaving the young child with the health care professionals, parents realized that they helped much in their child's care as told by a father of a 4-year-old ill child, *"…I think I help reduce a part of their workload. The nurses don't have to rush to see my ill kid. Parents help lessen their workload." (ID 1, p. 25)*

In conclusion, parents' process of participating in "doing anything for an ill child" during hospitalization enables them to recognize the outcomes of "doing anything for an ill child". The outcomes can be divided into three aspects: outcomes of children including improving child's well-being; outcomes of parents including overcoming the exhaustion and loneliness, decreasing anxiety and stress, having willpower and self-worthiness, and learning about their child's care; and outcomes of nurses that help decreasing their workload.

Part 3: Discussion of the Findings

The findings of this study are discussed on participation experienced by the parents of hospitalized young children, with the purpose to compare the results of this study to existing literature and to identify specific contributions of the present study. Using grounded theory methodology, the findings answer the question: What is the process of parent participation in the care of hospitalized young children? and it is followed by the discussion of findings.

The Process of Doing Anything for an Ill Child

The present study found that the process of "doing anything for an ill child" during hospitalization consisted of the three interactive phases: (a) carrying on home practices; (b) learning new things; and (c) working together with health care professionals in their child's care. Parents viewed from their experiences that they moved through the phases in nonlinear manner, sometimes simultaneously, and each phase was not isolated but overlapped with one another. According to the symbolic interactionist perspective (Blumer, 1969), an attempt was made by the researcher to interpret the participation experiences of Thai parents during their young child's hospitalization within their interaction with Thai society. The findings from this study revealed that the strategies of Thai parents acting or responding to their participation in the hospitalized young child's care depended on the degree of importance of the situation as perceived by the parents. The basic social process of "doing anything for an ill child" is the parent participation process that is measured by Thai parents' perceptions, feelings, and attitudes which are used to interpret their meaning and intention of their involvement. Also, there are external influences on the parents' interpretations of that situation and they include their social interactions with others such as their families, friends, other parents, or health care professionals in the socio-cultural environment in which they exist. Although there are some similarities, significant differences related to the cultural context could be found as shown by the study of Pongjaturawit and Harrigan (2003) showing that the parent participation in the hospitalized child's care could be effected by the cultural differences. Thus, the process of "doing anything for an ill child" from this study is derived from how Thai parents interpret the circumstances at that time.

In the process of "doing anything for an ill child", carrying on home practices meant being there with the young child and providing him/her with basic care. The phase of carrying on home practices of experiences involved the process of staying with the ill child at the hospital and providing the young child with basic home care. In learning new things, parents were given a chance to gain additional knowledge about caring for an ill child through self-learning and observing or asking others such as parents of other ill child, relatives, etc. To access more information, parents also exchanged with health care professionals the information related to the child's illness and caring for the ill child and practiced what they learnt. In working together with health care professionals in their child's care, parents got involved with more complex care activities by sharing the decision on the treatment for the ill child and taking parting in technical care activities with nurses. Therefore, it can be said that the process of those three phases was not a logical progression but it was overlapping and never inseparable. The discussion related to the strategies that Thai parents utilized to participate in their young child's care during hospitalization is presented as follows.

Carrying on Home Practices

According to the process of "doing anything for an ill child", phase 1: carrying on home practice started from when Thai parents took their young child to the hospital, stayed with them all times with determination and attentiveness, and then participated in providing basic care for their child. The caring activities during this first phase were similar to home practices, including physical, psychological and emotional, environmental, and security aspects such as bathing of the child, feeding of the child, handling of the child's stool, sleeping, and taking care of the child's psychological and emotional condition, and so on. In this way, the parents expected that their ill child would safely recover from the illness and be discharged home as soon as possible. This finding is supported by the existing literature showing that parents wanted to be at their child's bedside during hospitalization (Coyne, 1995b, Hollstrom, Runeson, & Elander, 2002b; Neill, 1996b; Shields & King, 2001a, 2001b). The study by Neill (1996b), for instance, noted that parents realized "being there for the child" as a major concept of their participation in the ill child's care and it is also congruent with the study by Shields and King (2001a, 2001b) who stated that parents in developed countries and developing countries stayed with their ill child in the hospital as a normal event. Moreover, several studies found the desire of parents themselves to engage in giving their child basic care (Kristensson-Hallstrom & Elander, 1994; Kristjansdottir, 1991; Neill, 1996b; Shields & Nixon, 2004).

Learning New Things

In learning new things, Thai parents participating in the hospitalized young child's care began to learn about the activities for caring for their child through several learning methods such as self-learning by reading documents or guidebooks about caring for ill children, or applying previous experience and knowledge; observing and/or asking others including friends and relatives--in the case of fathers taking the role of caregivers, they would be asking for advice from mothers of ill child; exchanging information with health care professionals with parents mainly giving information about their ill child to the professionals and sometimes asking them about the child's illness and care; and being trained by nurses to perform nursing procedures which parents learnt and tried to follow what they were instructed and suggested by the nurses.

In this phase, the findings from this study discovered the themes of self-learning and observing and/or asking others for caring their hospitalized young children. These two themes did not exist in previous studies about the parent participation in the care of hospitalized child. Parents depended on self-learning and observing and/or asking others for caring their hospitalized young child as a strategy to acquire new knowledge in participating in their hospitalized young child in Thai context, which was different from the western context due to the social and cultural differences on the learning process of Thai parents in this study. Given the demographic characteristics of Thai parents in this study, most informants lived in an rural area and had low to middle levels of education with lower to moderate earnings; thus, they had a limited resource to acquire information about caring for the hospitalized child. However, concentrating on providing care for their young child in any circumstances--sickness or wellness, parents thus tried to learn about taking as much care of the young child during hospitalization as possible. To acquire the knowledge about caring for their ill child, parents sometimes counted on applying previous knowledge or experience or observing and asking others. It is interestingly found that the social and cultural characteristics of Thailand also had a beneficial effect on parents' learning as a majority of Thai people were regarded as generous, big-hearted, and helpful among each other, especially in difficult times of illness or sufferings. This quality enabled parents of ill child to learn from each other about looking after the ill child during hospitalization by asking or talking with parents of other ill child as discussed in the part of the findings.

This process of learning about caring for the ill child by Thai parents was different from that of the western countries as they were developed countries where most people were equipped with good education; therefore, parents taking part in the care of hospitalized child would have enough knowledge and resources for taking care of their ill child without additional knowledge. Also, western people have more privacy than Thai people, differentiating the interaction styles between western people and Thai people. Importantly, it can be said that the western people are less hospitable than Thais as they hardly let strangers come to talk or ask something from them, which is the characteristic different from that of Thais who are seen more friendly and hospitable. The process of learning new things by self-learning and observing and/or asking others for caring their hospitalized children of parents participating in their young child's care was not found or did not existed in the western literature.

In addition, the findings of this study found that parents gained more knowledge about caring for the young child by exchanging information and asking information related to the illness and treatment with health care professionals, especially nurses--the communication between parents and nurses in the care of ill child. Moreover, parents learnt how to care for the ill child by practicing the nursing procedures with nurses. In the communication between parents and nurses by exchanging information, this finding is congruent with the existing literature in which parents had the communication with health care professionals throughout the child's hospitalization by exchanging ill child relevant information with parents and health care providers, nurses in particular (Balling & McCubbin, 2001; Coyne, 1995b; Neill, 1996b; Shields & King, 2001a, 2001b). Nevertheless, as defined by Hutchfield (1999) and Schepp (1992), participation in sharing information referred to an equal power and negotiation between parents and nurses in the communication, which is different from the present study which showed that the nature or the way of communication was just exchanging information between parents and health care professionals in this study, not sharing information. It is possibly due to the social and cultural differences. That is health care professionals in Thailand, especially government health care professionals have long been considered authorized persons with a superior status than parents of ill child; as a result, the relations and communication between parents and health care professionals are distant.

The concept of being trained by nurses to perform nursing procedures--parents learnt how to care for the ill child by practicing the nursing procedures with nurses in the present study is supported by the existing literature (Coyne, 1995b; Evans, 1996; Kristensson-Hallstrom, 1999). The study by Coyne (1995b) found the parents' readiness to learn specific nursing care like catherization from nurses with an aim to do it after their child being allowed to be discharged home; however, they must be demonstrated the methods and observed when practicing them until they are assured of doing that specific care. Practicing nursing care was of importance as shown by a pilot study of Evans (1996) about teaching mothers of pediatric oncology patients to administer intravenous antibiotics to their children and it showed mothers' capability of giving intravenous antibiotics to their children, suggesting that mothers' learning or be trained by nurses enabled them to perform such specific nursing procedures in their child's care.

Working Together with Health Care Professionals in Their Child's Care

In phase 3, parents participating in the care of hospitalized young child's care got a chance to collaborate with health care professionals, especially nurses in caring for the ill child. This finding is supported by the study of Lima, Rocha, Scochi, and Callery (2001) finding that it is of importance for parents and nurses to work together in the care of hospitalized child even though stress and disagreement could erupt any time. If the coordination between those two parties is attained, there could be a positive change in the service provided by health care professionals to parents improving, the work being complete and the child being given a tremendous care. It showed that a synergy in the care of hospitalized child is an essence in the process of parent participation in their hospitalized young child's care. The present study also indicated that parents participating in the care of hospitalized young child worked with health care providers, especially nurses in making decisions on the care of the ill child such as lumber puncture, tests by special equipments like X-ray, ultrasound, computer test, operation, and so on. This entailed parents in deciding in their child's care by themselves and families and/or co-deciding with health care professionals. In phase 3, parents also joined participating in technical care, providing their young child's care by themselves under the nurses' advice including uncomplicated nursing procedures like tepid sponging and taking the samples of urine and stool of the ill child for testing and providing their child's care by working together with the nurses, including providing simple nursing procedures under cooperation with nurses such as recording intake output, checking vital signs, etc., and providing complicated nursing procedures under nurses' supervision such as observing intravenous fluid and giving a nebulizer.

In deciding in their child's care, Thai parents participating in the process of "doing anything for an ill child" stated that they must make decisions on caring for the ill child and those decisions were both easy and tough to make such as reducing the child's fever by tepid sponging, informing the nurses of noticed irregular systems of the young child, signing in an agreement letter for physicians and nurses to treat the young child during hospitalization, signing in a letter of accepting the responsibility in case of the young child falling out of the bed, allowing physicians to have special tests on the ill child (lumber puncture, ultrasound test, and operation), and so on. Parents in this study learnt from their experiences that they could decide by themselves and with their family on some activities while some activities required parents' decision with physicians and nurses.

However, the findings of this study indicated that parents mostly made decisions with physicians and nurses based on the health care professionals' judgment. This is due to the social and cultural characteristics of Thailand where

Thai general people including parents in this study, had lower level of education and economic status than that of physicians and nurses. In addition, both physicians and nurses have been valued by local people as specializing in healing and nursing the patients. Parents of ill child and other health care service recipients in general have expressed trust and reliance towards the health care professionals because they have believed in the capability of physicians and nurses. Similarly, the International Development Program of Australian Universities and Colleges (as cited in Alsop-Shields, 2002) noted that physicians in developing countries are the power holders in the health system. In other words, parents of ill children view that health care professionals with specialist knowledge are more capable of making decisions about care than them (Shields & King, 2001a). Shields (as cited in Alsop-Shields, 2002) also found in developing countries such as Thailand and Indonesia that health care professionals are willing to provide parents with as much information related to the child condition as possible, but only a small number of parents want to take part in making decision and they instead let the health care professionals make decisions.

Participating in technical care was one action of Thai parents' participation in their young child's care during hospitalization found in this study. It meant the process of providing child's care by parents under the nurses' advice such as tepid sponge, and providing child's care by working together with the nurse such as record intake output. The finding from the present study is congruent with the existing literature that parents gained experiences in participating in technical care during their child's hospitalization (Balling & McCubbin, 2001; Evans, 1996; Neill, 1996b; Shields & Nixon, 2004). Notwithstanding, most studies found that parents were not confident to undertake the responsibility of providing technical care such as taking and recording temperatures, collecting urine specimen, or giving medicine for fearing that they could make mistakes that might put their child's progress in danger. They also thought that these technical care procedures should be performed by nurses, so they had their own consideration whether to be involved in providing such technical care. In contrast, the present study found that Thai parents had no choice, but they must participate in their child's care as they were expected to do such as a routine in the hospital in Thai culture. This notion is congruent with the existing literature (Pongjaturawit & Harrigan, 2003).

Thus, there were several strategies that Thai parents acted on the process of "doing anything for an ill child" during hospitalization in this study. They were being there, providing basic care, self-learning, observing and/or asking others, exchanging information with health care professionals in their child's care, being trained by nurses to perform nursing procedures, deciding in their child's care, and participating in technical care. Some strategies from this study were similar to activities or components of parent participation in the care of hospitalized child in the existing literature (Jones, 1994; Neill, 1996b; Schepp 1992; Stull & Deatrick, 1986). According to Stull and Deatrick (1986), specific activities related to parent participation during a child's hospitalization were divided into three groups: (a) direct involvement activities such as routine physical care and comforting (e.g., active playing, quite times, general comforting, routine physical needs prior to surgery, child's schoolwork); (b) indirect involvement activities such as parent programs and/or conferences with staff; and (c) refueling activities such as spending time with other patients, spending time with other parents, and/or time spent alone. These findings were focused on common or basic care activities for their child, but it did not mention about participating in medical or nursing procedures and decision-making in their child's care found in this study.

The study by 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. According to the study by Jones, the activities involving parents in the care of the ill child included participating in basic care and technical care, which is similar to some actions in the process of parent participation in this study. However, the findings of the present study additionally indicated that Thai parents participated in their young child's care by learning new things in order to provide their young child's care, including self-learning, observing and/or asking others, exchanging information with health care professionals, and being trained by nurses to perform nursing procedures. They also make decisions on caring for the ill child during hospitalization.

According to the study by Schepp (1992), the parent participation was composed of four components: (a) participation in routine care (e.g., staying with their hospitalized child, feeding the child, taking or helping a bath, changing the child's dress); (b) participation in decision-making; (c) participation in technical care (e.g., checking vital signs or blood pressure, physical examination, taking of medications); and (d) participation in sharing information. It obviously showed that those four components were similar to the actions or strategies in each phase of the process of parent participation in this study. However, in some similarities there were some differences due to the different cultural characteristics such as the style or level of participation in decision-making and sharing information as already discussed in each phase of the process.

Neill (1996a, 1996b) studied by using a qualitative research to examine parents' views and experiences of participation in the care of their child in hospital and found that parents realized their participation in the following components: (a) being there for the child; (b) being able to carry out varying degrees of the child's basic care; and (c) being informed about all aspects of their child's care. The findings also showed that besides participating in basic care, parents wanted to get involved in providing technical care, but some parents might want to make their own decision on the level of their involvement. Those components are similar to some strategies in the present study that parents wanted to participate in their child's care by staying at the bedside with the child and participating in basic care and technical care as well as exchanging information about caring for the ill child. However, the investigator noted in the study that parents decided by themselves on their participation, which is different from the finding of this study that Thai parents had no choice to participate in the care of their hospitalized child.

In brief, the findings of this study found that the process of "doing anything for an ill child" as a basic social process of Thai parents participated in the care of young children during hospitalization consisted of the three interactive phases: carrying on home practices, learning new things, and working together with health care professionals in their child's care. Moreover, the present study found that parents' participation in the process of "doing anything for an ill child" during hospitalization was completed under four important contexts, including belief in the capability of physicians and nurses, ward environment, utensils and accessories available for an ill child, and visiting rules. These contexts were the particular set of conditions within which the action/interaction strategies in the three phases were taken to carry out parents' participation in "doing anything for an ill child". The findings from this study also indicated that parents recognized their participation in "doing anything for an ill child" during hospitalization by two causal conditions: concerning about needs of an ill child and concerning about self. These causal conditions would be discussed as follows.

Causes of Parent Participation in Their Child's Care

In this study, all informants, namely Thai parents, desired to get involved or participate in their young child's care during hospitalization which was referred to the moment during which young children were ill and sent to the hospital and their parents needed to take part in "doing anything for an ill child". The informants attributed their participation in "doing anything for an ill child" during hospitalization to two main reasons: (a) concerning about needs of an ill child and (b) concerning about self--these two important factors were simultaneously considered by the parents. The findings on the parents' needs of participating in "doing anything for an ill child" during hospitalization in this study are congruent with the existing literature (Kristjansdottir, 1991; Neill, 1996a, 1996b; Ramritu & Croft, 1999). Previous studies which were mainly directed at parents' needs towards providing care for their hospitalized children revealed that parents needed to take part in their child's care. Importantly, the finding of the present study showed that all parents needed to participate in their young child's care during hospitalization, particularly mothers who showed more need than fathers to get involved in "doing anything for an ill child".

This was possibly due to the fact that mothers have been expected by Thai culture to play a role in bringing up children; thus, mothers, rather than fathers, acknowledged the role.

Moreover, this study also pointed out the elements of the young child's needs, including the needs in three aspects--presence of parents, being represented in communication, and being helped in daily care--all of these three needs were due to the child age and development. As ill children in this study were infant to preschool children, their physical growth and development were not yet complete and they could not fully help themselves as well as their adjustment to the surrounding circumstances and society and communication with others were still poor; ill children then needed the presence of their parents throughout the hospitalization. The ill child' needs of the presence of parents was a very important reason to be taken by parents into account for getting involved in "doing anything for an ill child" as they perceived that the needs of children cannot be adequately met in separation from the parents and family (Ashwill & Volz, 1997). To attain safety and security, infants thus wanted to get close to others in the environment while toddlers may suffer from acute psychological pain after experiencing separation anxiety because of the separation from parents, the primary caregiver, for a long period. Meanwhile, preschool children who were separated from home and family would feel a deep sense of loss which would be followed by the reaction of aggression or dependency--the after-effects of pain, stress, and fear (Ashwill & Volz, 1997; Wong, Hockenberry-Eaton, Winkelstein, Winson, Ahman, 1999). All hospitalized young children therefore had fear and concern over being separated from their parents; the presence of parents was needed by these ill children throughout their hospitalization. If, for any reasons, parents leave their ill children alone or cannot stay with them at the hospital, that would result in a negative reaction of children to the separation anxiety with the responses of protest, despair, and detachment or denial being these ill children's main behavioral manner to the three phases of separation anxiety (Wong et al., 1999). Because of these negative effects from child's hospitalization, parents had concerning about needs of an ill child who needed the presence of his parents; thus, parents got involved in "doing anything for an ill child" by staying with the ill child during hospitalization.

Apart from concerning about needs of an ill child who needed the presence of parents, the findings revealed that an ill child wanted his/her parents for being represented in communication and being helped in daily care. In this way, it was possibly due to the characteristic of Thai society and culture under which parents must be responsible for bringing up their child since an infant to adult or until they were assured that the child could earn his/her living or stand on his/her own feet; thus, the strong feeling of love and bonding between child and parents was established. Due to the fact that ill children were infants and preschool children, parents perceived that their ill children were too young to help themselves like adults and they were particularly worried about their ill children in every aspect including communicating with others and helping themselves in their daily activities.

Furthermore, this study found that parents' needs to participate in "doing anything for an ill child" during hospitalization were based on their concerning about self, which meant parents came to take care of their ill child with desire of the child's recovery and safety from the disease; a sense of caring such as loving, bonding, concerning, being closing to the child, being anxious about the child's illness, and mistrusting others to take care of their child; and maintaining parental roles. Wong et al. (1999) noted that parents of hospitalized child are normally fearful, anxious, and frustrated. In this way, parents' fears regarding the hospitalization of their children are associated with the child's condition at that time which will affect the child later while their fear and anxiety is due to the child's well-being in the future (Neff & Spray, 1996; Wong et al., 1999). Taking these reasons into account, parents then needed to attentively participate in "doing anything for an ill child" during hospitalization, anticipating and desiring the child's recovery and safety from the illness. This finding is supported by the existing literature. That is, parent participation in their child's care was regarded by parents as essential for their children's emotional and physical welfare; thus, parents' decision for participation was due to their concern over the children's emotional and physical welfare (Coyne, 1995b).

Regarding a sense of caring for an ill child, it included loving, bonding, concerning, desiring to be close to their ill child, being anxious about the child's illness, and mistrusting others to care for the child. It has shown that in Thai culture, especially in rural area, the relationship between parents, children, and members in their immediate family has been so close that everyone in the family could touch bonding and warmth. Absorbed by the long-standing Thai culture and tradition about raising children, Thai parents would have deep sense of caring towards their children, which is the way that is different from that of the western culture. A sense of caring received by children was then a motivation of parents to participate in "doing anything for an ill child" during hospitalization. Interestingly, Thai parents' feelings of mistrusting others to care for the child in this study showed that parents did not have trust in others to take care of their ill child, emphasizing that though the caregivers were their relatives, they could not take as good care of the ill child as themselves. On the other hand, Coyne (1995b) studied about parents' views on participation in their hospitalized child's care and found that parents did not trust nurses to take care of their ill child as nurses were seen too busy to care for their child consistently and this concern over the consistency of care may have caused parents to mistrust health professionals in general and it thus supported their decision to stay and get involved in their child's care.

Meanwhile, several researchers cited the changes in the parental roles as a major parental stress with a purpose of maintaining the parental roles (Eberly et al., 1985; Hayes & Knox, 1984; Johnson, Nelson, & Brunnquell, 1988). That is parents would often change their roles when seeing the child admitted to the hospital as it could put them under a lot of strain and they could not know how to cope with the unexpected event. This is supported by Neill (1996b) who found that parents of hospitalized child often felt a loss of control for being unable to cure their child by themselves. Therefore, when the child is admitted to the hospital, parents found that the duty of their child's care was performed by nurses, not them anymore, that made them feel a loss of parental role. Given those reasons, parents needed to participate in "doing anything for an ill child" so as to maintain their parental roles and the need of maintaining the parental roles was a causal condition shown by this study. This finding is congruent with the previous studies of Blower and Morgan (2000) and Coyne (1995b) in the way that one of the reasons why parents decided to get involved in their child's care was the sense of parental duty; they thought it was them who must be responsible for playing and sustaining their parental roles.

In shot, the findings from this study indicated that the experiences of Thai parents participating in “doing anything for an ill child” during hospitalization showed the parents’ concerning about needs of an ill child and concerning about self which were the feelings towards their ill child and the causal conditions involving parents in “doing anything for an ill child”. These feelings and needs were partly caused by the tradition and culture of raising children and the family characteristics of Thai society which is different from those of the western culture. The findings revealed the bonding and closeness in the relationship of family members in Thai society, so when any members, especially children or babies, are ill and admitted to the hospital, that could result in a great impact on others in the family. The findings from this study also found the intervening conditions influencing the process of “doing anything for an ill child” of Thai parents during hospitalization and these conditions would be discussed as follows.

Conditions Influencing Parent Participation in Their Child’s Care

The present study found that the process of “doing anything for an ill child” during hospitalization were composed of the three phases of action/interaction strategies: (a) carrying on home practices, (b) learning new things, and (c) working together with health care professionals in their child’s care. The findings of this study also indicated the intervening conditions influencing the parents’ process of “doing anything for an ill child” during hospitalization. They were: communication with health care professionals, being accepted by others in their child’s care, accepting the maternal role in their child’s care, time availability, child’s dependency, and distance from home to hospital. These conditions were both favorable and unfavorable factors influencing parents' participation in the process of "doing anything for an ill child". The favorable factor would encourage parents to better and increase parents' participation in the process of "doing anything for an ill child" during hospitalization. It would also enhance parents to have positive attitude towards involvement in the process of "doing anything for an ill child". On the other hand, the unfavorable factor would inhibit parents' participation in the process of "doing anything for an ill child" during hospitalization. Also, it would impede parents to have positive attitude towards taking part in the process of "doing anything for an ill child".

Firstly, Thai parents in this study viewed that they would have an interaction with health care professionals by communicating with those professionals, especially physicians and nurses during hospitalization. According to the informants' experience, communicating between parents and health care professionals was found to be an intervening condition which was very important to the process of "doing anything for an ill child". The finding of this study is supported by the existing literature in which communication played an important role in the interactions between parents and health care professionals (Alsop-Shields, 2002; Callery & Smith, 1991; Neill, 1996a, 1996b; Shields & King, 2001b). Particularly, Alsop-Shields (2002) developed the Parent-Staff Interaction Model of Pediatric Care which was produced from the findings of a large multinational study that examined the way of caring for ill children at the hospital (Shields, 2001) and found that communication was a major element in the model as the tool by which the interaction took place.

Interestingly, most of Thai parents in this study expressed that the way of communicating with health care professionals were both positive and negative communication. It is congruent with the exiting literature (Neill, 1996b). The results of this study additionally indicated that the way of communicating supportive their young child’s care or positive communication included receiving sufficient information about their young child’s care and health care providers willingly giving information with physicians and nurses being kind, nice, pleasant, and friendly. This positive communication was a factor enhancing or supporting that the process of “doing anything for an ill child” actions takes place. Meanwhile, negative communication--communicating that impeded their young child’s care--was that parents received insufficient information about their young child’s care, health care providers unwillingly gave information, physician, and nurses were busy or unavailable all time and nurses provided insufficient information about the ill child’s care. This negative communication was a factor inhibiting the process of “doing anything for an ill child” actions from taking place. In Thailand, health care professionals, particularly government officials, have been considered as authorized persons with a superior status than the patients because of their higher level of education and salaries. A distance in relations and communication between the patients and health care professionals was a result.

Secondly, being accepted by others in their child’s care was valued by Thai informants in this study as a good experience gained after participating in “doing anything for an ill child” during which parents had willpower to keep caring for the young child if parents of other ill child and health care professionals had positive feelings toward their involvement. Also, being accepted by the others in their young child’s care was an essential factor that Thai informants emphasized in participating in their young child’s care which is congruent with the existing knowledge about factors enhancing parental participation in their hospitalized child’s care, including positive professional attitudes and support from other parents, nurses, and staff (Kawik, 1996; Kristensson-Hallstrom & Elander, 1994; Neill, 1996b; Palmer, 1993). The finding of this study additionally suggested that both attitudes and support from others were factors encouraging parents to be upbeat towards participating in their ill child's care at the hospital, bringing them comfort for staying with and looking after their ill child.

Next, the finding of this study found that Thai parents experienced that accepting the maternal role in their child's care was a factor influencing their participation in the care of hospitalized young child. It meant the perception of parents of the participation in their young child's care at the hospital; both fathers and mothers perceived or agreed that mothers could take better care of their young children than their partners, which was possibly due to the characteristic of Thai society and culture under which mothers have been designed to raise a child; mothers perceiving that they are mainly responsible for looking after the child during he/she is in good or bad health. Looking after the child would strengthen the relationship between the child and mother; thus, mother most understands and knows her child.

When the child is so ill that he/she is hospitalized, both father and mother realize that mother could take better care of the ill child than the other, especially providing general care physically and emotionally. Wong et al. (1999) stated that mothers, as the usual family caregiver, would spend more time than fathers to care for their ill child. Due to the changing lifestyles and sexual role, some fathers may take over all or a part of the usual mothering roles in the household and this might widen the father-child relationship which must be protected. This finding is also supported by the study of Knafl, Deatrick, and Kodadek (1982), who found that mothers tended to be with their child at the hospital, rather than father without considering about their routine responsibilities at work and home. They also noted that all fathers were not with their child all the time as it was them who decided to take part in the child's care, unlike mothers whose involvement in the care was decided by the child's needs. In brief, accepting the maternal role in their child's care was thus another intervening condition for parents to participate in "doing anything for an ill child". If the duty of caring the ill child fell to mothers, their need would be increased to take part in "doing anything for an ill child", whereas if the duty was performed by fathers, their need of providing care for their ill child would be hindered.

Moreover, time availability was an intervening condition which had an influence on the process of "doing anything for an ill child". According to the informants' experience in this study, if father or mother who took the role of caregiver had a permanent work such as a company employee, a factory worker, and a government official, the nature of these permanent jobs would be an impediment to the parent participation in "doing anything for an ill child" as the job would hinder them from taking care of their ill child all the time or they have limited time to spend with the young child at the hospital. This finding additionally indicated that in some families, parents must manage time or rotate the duty of caregiving with the father watching the ill child in the morning and afternoon and mother taking the role in the evening and at night, for instance. For those extended families, relatives would be brought in to help watch the ill child some time. In contrast, parents who were the caregivers were unemployed or did not have permanent job such as a merchant, a housewife, etc., they could take full part in "doing anything for an ill child". These notions were congruent with the existing literature (Balling & McCubbin, 2001; Callery, 1997).

However, it was interestingly found that Thai parents in this study needed to participate in "doing anything for an ill child" by themselves even they had permanent job or not as they, especially mothers, thought it was them only who most understood the needs of their ill child and could definitely take better care of the young child than anyone else. Another crucial issue revealed by this study was that although parents had permanent job, they gave priority to cure their young child's illness. Parents tried to take leaves to watch the young child at the hospital by themselves and in some cases, quitting the job was their solution to caregiving. Some Thai parents said that they could exchange their work for the time to take care of their ill child by themselves as nobody can do the duty. This case was mostly found in nucleus families.

Furthermore, one of the vital conditions influencing on parents' participation in "doing anything for an ill child" during hospitalization was the child's dependency--his/her own ability to help himself/herself. In general, when children are hospitalized, they are usually accompanied by parents to stay with them and participate in the care. Interestingly, the finding from this study found that the child age that made him/her depend on others was a factor influencing the parent participation in "doing anything for an ill child" during hospitalization. According to the parents' experience in this study, little ill child was more needed to be cared for than older ill child which is similar to the existing literature (Balling & McCubbin, 2001; Kristensson-Hallstrom, 1999; Schepp, 1992) finding that mothers of little children showed more needs to participate in their child's care and spent all or most of each day with their child at the hospital as well as desired to participate more in routine care. In mothers' eyes, older ill child was seen less necessary than younger child to be cared for.

The reason why parents put more emphasis on young children than older children during hospitalization was that they saw that young children had less ability to help themselves than older children and they had poor ability to communicate with others. In addition, young children had very low ability to tolerate if parents did not stay with them (Wong et al., 1999), or it can be said that the child age or developmental status was associated with the way they dealt with hospitalization; the younger the child was, the more likely the child was to be upset (Wright, 1995). Given those reasons, parents needed to be engaged in "doing anything for an ill child" for young children rather than older children. Additionally, they believed that others who were not bonded to their young child would never be able to interpret their young child's behavior accurately, so their young child's needs could be satisfied by mothers only. That could be an answer of the question why mothers preferred to take part in the care of young child and spend all day or most of the day with their child in the hospital.

Finally, Thai parents in this study viewed that they could take more part in "doing anything for an ill child" as their home was near the hospital and traveling from home to hospital was not a problem, whereas those whose house was quite far from the hospital would encounter inconvenience to go to the hospital, causing them reluctance to get involved in "doing anything for an ill child". The distance from home to hospital therefore had an effect on the parent participation in "doing anything for an ill child" as one intervening condition to the process of "doing anything for an ill child". Likewise, Melnyk and Alpert-Gillis (1998) showing that the tension of parents of hospitalized young children was caused by the distance from hospital to home, which is also congruent with the study of Ramritu and Croft (1999) revealing that parents who lived far from the hospital received inadequate support while their child was hospitalized. Similarly, Li (1996) stated that the distance between home and hospital affected family participation actions.

In conclusion, the findings of this study indicated that the six intervening conditions, including communication with health care professionals, being accepted by others in their child's care, accepting in the maternal role in their child's care, time availability, child's dependency, and distance from home to hospital were factors influencing parents' participation in "doing anything for an ill child" during hospitalization. These six conditions acted to both facilitate and constrain the actions/interactions of each phase of the process. The favorable conditions promoted or encouraged parents to have good interactions in each phase of the process, benefiting both ill child and their parents participating in their child's care. For example, if the interaction between parents of ill child and health care professionals is a positive communication, that will enhance parents' involvement in their child's care because of the effective actions/interactions of the process, resulting in positive outcomes. Conversely, the unfavorable conditions inhibited the interaction of parents in each phase of the process of "doing anything for an ill child" --those effects had an impact on ill child and parents. The consequences of parents' actions in the process of "doing anything for an ill child" would be discussed as follows.

Consequences of Parent Participation in Their Child's Care

According to Thai parents' experience in the present study from participating in "doing anything for an ill child" during hospitalization, parents perceived the outcomes stemming from the participation actions which were viewed useful for the ill child, parents, and nurses. Moreover, the findings of this study additionally suggested that the outcomes for the ill child and nurses were positive whereas those for parents were both positive and negative. However, all informants in this study could overcome those negative outcomes with everyone feeling better and realizing the benefits from the participation actions as well as being willing to participate in "doing anything for an ill child".

The outcomes of their actions in the process of "doing anything for an ill child" showed that all Thai parents in the study realized the benefits of the participation actions on their ill child, including the young child's safety, recovery soon, and better psychological condition. They also indicated that if parents were present and provided care for the ill child during hospitalization, the young child felt warmer, was not afraid of the hospital, felt more secure, and recovered soon. Thus, the finding of this study obviously showed that the importance of parental involvement in child's care improved child's well-being as perceived by parents. This finding is supported by the existing literature that parent participation in the care would be essential for their children's emotional and physical welfare. That is it helped make the child recover soon, less anxious, calmer, less fearful of hospitalization, less pain, and sleep disturbances or it can be said that the child's lower worry could result in better co-operation (Coyne, 1995b; Jones, 1994; Kristensson-Hallstrom & Elander, 1997; Neill, 1996a, 1996b).

Besides the outcomes of ill children perceived by parents from participating in "doing anything for an ill child", they viewed that the participation actions brought the outcomes on themselves as well. Likewise, Neill (1996a, 1996b), and Shields and Nixon (2004) stated that children were benefited from their parents' presence while parents were benefited by being able to be involved in the child's care. Furthermore, the outcomes of parents revealed by this study were found to be a mix of negative and positive feelings, including overcoming exhaustion and loneliness, decreasing anxiety and stress, having willpower and self-worthiness, and learning about their child's care. The findings from this study found that when parents participated in "doing anything for an ill child", they realized the negative outcomes from the participation actions with the bad outcomes including exhaustion, tiredness, insufficient sleep, boredom, loneliness, and desolation. This is because parents had to stay with and watch the ill child at the hospital for several consecutive days and they were also impacted by other factors influencing the process of "doing anything for an ill child" which included the ward environment and visiting rules. All of these factors prevented the caregiving parents from taking enough rest and interacting with other relatives and friends, so parents developed those negative feelings. This finding is supported by the study of Halliday (1990) reporting that inadequacy of facilities and physical exhaustion were negatively associated with parental participation while Wong et al. (1999) noted parents did not feel comfortable as they had to sleep on a chair at bedside and they could not sleep well because of the disruption of nursing procedures. If suffered for this situation only for few days, it might exhaust parents who must stay with their ill child, anyway. Similarly, Neill (1996b) found that causing parents unending weariness were the discomfort from the distant catering facilities and poor quality sleeping arrangements, intensifying the parents' stress.

Interestingly, Thai parents in this study said that the tiredness and boredom from the participation actions were also caused by the routine responsibilities they had to bear at work and at home. This finding is congruent with Ashwii and Volz (1997) who stated that the parents were usually both physically and psychologically exhausted as they spent long time at the hospital after working and trying to take care of other children in the family. Likewise, Coyne (1995b) showing that all parents were faced with anxiety about doing the care, plus with feelings of loneliness and boredom for being the main caregiver. Meanwhile, parents' readiness to participate in the child's care could be hindered by insufficient facilities, personal feelings, and loneliness. However, the finding of this study indicated that such negative feelings as exhaustion, tiredness, insufficient sleep, boredom, loneliness, and desolation to take care of their ill child were not factors that prevented the parents' participation in their young child's care because Thai parents in this study could overcome the exhaustion, tiredness, insufficient sleep, boredom, loneliness, and desolation to take care of their ill child. After the process of "doing anything for an ill child" proceeded for a while, parents were found to have positive feelings with optimism over their participation in "doing anything for an ill child" and they finally decreased anxiety and stress, had willpower and self-worthiness, and learnt about their child's care.

Regarding decreasing anxiety and stress, the finding of this study found that decreasing anxiety and stress was an outcome of Thai parents that they perceived after participating in "doing anything for an ill child" during hospitalization. It is viewed a positive outcome as Thai parents were less concerned, but more relieved. It was because Thai parents were anxious over the illness of their young child. It was an abrupt illness that parents were never physically and emotionally prepared, causing them a serious stress. They were more worried when seeing their young child was admitted to the hospital, prompting them to be concerned over anything about their young child. These notions were congruent with the existing literature (Jones 1994; Keatinge & Gilmore, 1996; Melnyk & Feinstein, 2001; Ramritu & Croft, 1999; Schepp, 1992).

In addition, the results of this study additionally indicated that parents viewed they had willpower and self-worthiness after participating in "doing anything for an ill child" which were all positive outcomes of parents, including willpower, self-worthiness, and more responsibility for their young child's care. The parents said their participation in the care of hospitalized young children made them proud of themselves and have willpower and self-worthiness as well as more responsibility for their young child's care. This might be because Thai parents viewed that the care of their ill child was their parental role. Moreover, they believed that participation in hospitalized young child's care was beneficial to the care of their young child's illness. With these positive outcomes, parents felt good about themselves. This finding, as supported by Chontawan (1997), noted that parents needed to take part in the ill child's care, believing that their involvement would be beneficial to the child and themselves as they would be proud for making their child have better condition. Furthermore, Thai parents' views on the participation actions which resulted in willpower and self-worthiness in this study were possibly due to the cultural differences. The informants from this study mostly had low or middle levels of education with low or moderate-income level, compared with those of health care professionals; thus, when parents got involved in the care of hospitalized young child, they performed some activities of care themselves while some activities, especially nursing procedures, were done with health care professionals. Importantly, the parents saw that their participation in the care could help their young child recover and safety soon, making them proud of themselves, having willpower and self-worthiness for being a part in “doing anything for an ill child”.

Another positive outcome that Thai parents viewed on the parents’ participation actions in this study was that they learnt about their ill child’s care. They saw that they had more knowledge about caring for an ill child, enabling them to take care of the young child in the future. This perception towards this outcome was probably due to the characteristics of Thai informants in this study, including age, experience of bringing up a child, and education level. According to the demographic data of informants, most informants were in late adolescence to early adulthood and they had little experience of raising a child with a majority of informants just having their first child. With the relative low to moderate levels of education and lack of knowledge about their hospitalized child’s care, Thai parents felt they learnt more about the care of ill child after participating in “doing anything for an ill child”. This finding is similar to Gill (1987) who found the advantages of parent participation recognized by nurse authors in the study and those advantages included parents’ ability to learn, improve and/or maintain their parental skills as well as chances to obtain knowledge of parenting; parents learnt and had more knowledge to take care of their child. Similarly, Keatinge and Gilmore (1996) found that many parents had more understanding about the ill child’s condition and then could deal with it more carefully after take part in the shared care or parent participation.

Apart from Thai parents' view on participating in "doing anything for an ill child" having outcomes of ill child and parents, this study showed that all Thai informants recognized that participation actions had benefits for the nurses, as well. The outcomes of nurses--decreasing workload--were that parents did not leave the ill child with the nurses, but helped in their child's care during hospitalization. All Thai informants stated that nurses were already workloaded and had insufficient time to provide care for all ill children in the hospital due to a small number of nurses and a great number of sick children. Parents felt good to take part in the care of ill child as it at least helped reduce and ease the burden of nurses, especially basic care such as cleaning the child body, feeding and excretion, etc. Some parents in this study said that they acted as assistant nurses when participating in the hospitalized child's care. This finding is congruent with the existing literature (Blower & Morgan, 2000; Coyne, 1995b; Neill, 1996b; Ramritu & Croft, 1999). That is, nurses were seen by parents too busy to consistently care for their ill child, so they got involved in their child's care to assist nurses or to help decrease some of the nurses' burden of workload.

In conclusion, the overall findings of this study are congruent with existing literature. There were some findings that were not mentioned in the previous studies. These findings included: (a) self-learning and observing and/or asking others as strategies to acquire new knowledge in participating in their young child's care during hospitalization and (b) being represented in communication as one concept of the causal conditions involving parents in the process of "doing anything for an ill child". Moreover, some concepts from this study are similar to the concepts found in the existing literature. However, in some similarities there were some differences due to the different cultural characteristics. That is, western parents decided by themselves on their participation in the ill child, which is different from the finding of this study that Thai parents had no choice to participate in their hospitalized child's care. Furthermore, participation in sharing information found in the existing literature referred to an equal power and negotiation between parents and nurses in the communication, which is different from the present study which showed that the nature or the way of communication was just exchanging information between parents and health care professionals, not sharing information. The conclusion and recommendations of this study will be presented in the next chapter.