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Original Article

Parental role conflict: the nursing diagnosis in mothers of hospitalized newborns[1]

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Objective: To verify if mothers of newborns hospitalized recognize the defining characteristics of "parental role conflict" as representative of that experience. Methods: A cross-sectional and descriptive study, developed in a neonatal unit of a public teaching hospital in the state of São Paulo. The sample consisted of 100 women who assigned scores of 1 to 5 to the defining characteristics of the diagnosis, where 1 meant "not at all characteristic" and 5 meant "completely characteristic of what I am experiencing." Result: Of the total sample, 96 women self-identified with the diagnosis. The most prevalent defining characteristics were: "anxiety," "mother expresses concern(s) in relation to changes in maternal role"; "verbalizes feelings of frustration," "reports concern about family" and "fear". Women who were with their children less often during hospitalization had a higher number of defining characteristics. Conclusion: There was a high prevalence of the defining characteristics of the studied diagnosis, suggesting the relevance of the topic and the need for further studies to be developed in the neonatal unit.

Descriptors: Mother-Child Relations; Mothers; Infant, Newborn; Nursing Diagnosis; Neonatal Nursing.

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Introduction

In many countries increased attention has been paid to the psychosocial needs of mothers and families experiencing hospitalization of the newborn (NB), as well as attention to this development, which includes implementation of medical and nursing care programs designed to promote the development of babies, encouraging mother-child interaction, emotional support to families and promotion of breastfeeding in special situations[1-2]. However, not all Brazilian neonatal units consider the proposal of these programs, and some still limit the contact between mothers and children[3].

Becoming a mother is an experience that includes intense feelings and ambivalence, even under ideal conditions of pregnancy and birth[4]. The hospitalization of a child, shortly after birth, is described by mothers as the worst event of their lives[5]. Neonatal nurses are among the professionals who have the most contact with these mothers during hospitalization; therefore, they are also the ones who will have more opportunities to assist them during this difficult experience. Therefore, in addition to theoretical knowledge about the physiological and emotional aspects of maternity, they need to value the human responses presented by mothers throughout this experience.

Several human responses are possible, since the mother-child interaction and attachment formation in the neonatal unit are influenced by cultural and individual factors, the clinical condition of the baby, and the circumstances in which the family lives[4,6]. It is up to the nurse to commit to developing skills and knowledge to make clinical judgments about the nursing phenomena related to the mother, naming them as nursing diagnoses (ND) and proposing specific interventions. Nursing diagnosis is defined by NANDA International, Inc. (NANDA-I) as a clinical judgment about actual or potential human responses (individual, family or community) to health problems / life processes. It is the basis for the establishment of outcomes and the proposal of nursing interventions[7].

Since there are few studies about ND related to mothers in the hospital neonatal unit[8-9], the central focus of this work is the ND defined as the maternal "experience of role confusion and conflict in response to crisis"[7]. Thus, the present study aimed to determine whether mothers of hospitalized infants recognized the defining characteristics (DC) of "parental role conflict" (00064) as representative of that experience, and to investigate possible associations between the presence of the diagnosis and maternal and neonatal characteristics.

Method

This was a cross-sectional, descriptive study. The variables studied were the ten DC of the diagnosis "parental role conflict", proposed by NANDA-I[7]: "anxiety," "demonstrates disruption in caretaking routines", "reports concern about perceived loss of control over decisions relating to child", "fear", "reports concern about family (e.g., functioning, communication, health)", "reports concern about changes in parental role", "reports feeling of inadequacy to provide for child's needs (e.g., physical, emotional)", "reluctant to participate in usual caretaking activities", even with encouragement and support, "reports feelings of guilt", and "reports feelings of frustration"[7]. Maternal and neonatal data were also collected from the medical records to characterize the sample, considering factors that could interfere with the maternal role, according to the literature[8-10]: maternal age; marital status; education; responsibility for the care of others in the family; parity; receiving family or institutional support for transportation to the hospital; birth weight and gestational age of the baby; days of hospitalization of the baby; complexity of care for the baby; and, daily frequency of visits from mother to child.

The study was conducted in a 30-bed hospital neonatal unit, in a public teaching hospital in the city of Campinas, in the state of São Paulo (Brazil). This hospital is a referral center for more than 60 municipalities, providing specialized health care assistance to medium and high complexity women and newborns. This was a Baby Friendly Hospital, excelling at the standards and behaviors that promote breastfeeding.

Inclusion criteria for subjects were: mothers aged greater than or equal to 18 years; mothers who had been discharged from the hospital for at least seven days, and who had made at least two visits to the hospitalized child. The latter two criteria were established by considering a minimum period necessary so that they could recover from childbirth and could be present in the unit after their own hospital discharge, as well as having greater connection to the experience of being separated from her child. Exclusion criteria were: women with a diagnosed psychiatric disorder, women with visual and / or hearing impairment; mothers of infants with congenital anomalies and / or genetic syndromes, and women with multiple gestations.

Considering the inexistence of similar studies to the one proposed, a target proportion for the sample calculation was not encountered. Thus, we chose to interview ten mothers for each DC of the ND studied, yielding a sample of 100 mothers.

The preparation of the data collection instrument, with open and closed questions was supported by the literature review and operational definitions were developed through the content validation of this diagnosis[8]. The first part of the instrument included maternal and neonatal data, and the second part included the DC. This second part began with a closed question about the presence of difficulty or conflict in performing the maternal role, considering the definition of the diagnosis.

Data were collected from July 2010 to January 2011. The interviews occurred when the mothers came to the unit to visit their children, in a private room and without mothers being accompanied by others. Data were also collected from the records of the NB, for maternal and neonatal characteristics. The collection was made in a single encounter with every woman. The duration of the interviews ranged from 25 to 90 minutes.

The DC were read to the mothers interviewed and they were instructed to say how representative / unrepresentative each one was of what they were experiencing. During this, a plastic card containing a Likert Scale, with the meaning of the values 1-5, was in their hands as a guide for them, where: 1 = completely false (totally uncharacteristic of my behavior / feelings), 2 = almost always false (and uncharacteristic), 3 = sometimes false, other times true (somehow characteristic), 4 = almost always true (considerably characteristic) and 5 = completely true (very characteristic of my behavior / feelings). The researcher explained to the respondents that there were no right or wrong answers, that the important thing was their opinion about how those phrases did or did not represent what they experienced or felt.

In this study, the DC was considered "present" when the woman assigned scores of "3", "4" or "5". It was considered "absent" when it received a "1" or "2". The diagnosis was considered to be present in women who assigned values "3", "4" or "5" to, at least, one of its three major DC (signs that evidence the presence of the diagnosis), according to the literature: 1. Mother reports concern about changes in maternal role[8,10]; 2. Mother reports feeling of inadequacy to provide or child's needs[8]; and, 3. Mother reports concern about family health[8].

We used the statistical software program *Statistical Analysis System* (SAS), version 9.2, for analysis of the data. The variables were described with absolute and relative frequencies. To investigate possible associations between the presence of the diagnosis and maternal and neonatal data, we used the chi-square or Fisher's exact test, as appropriate. The level of significance adopted was 5%, or, $p<0.05$.

The study was approved by the UNICAMP Committee on Ethics in Research, under protocol number 507/08. The mothers were informed about the objectives of the study, had their doubts resolved, and were included in the study after reading and signing the Terms of Free and Informed Consent form. During the interviews, whenever it was identified that a mother had need of medical, psychological and / or nursing care, this demand was forwarded to the respective professionals on the unit, with the awareness of the interviewee.

Results

The 100 women interviewed had a mean age of 27±4.2 years and 89 reported that they had a partner. With regard to education, the majority had concluded high school or were completing it (58 women). Of the sample, 65 women lived in another city, and 53 were responsible for the care of other relatives. This was the first hospitalization of a child for 87 of them, and 37 of them were primiparous. The children of 73 mothers were receiving intermediate care. The majority of the mothers had premature babies (84), with a birth weight less than 2,000g (66). Other characterization data of the sample will be presented later, related to the DC of the diagnosis.

At the beginning of the interview, when they were asked about the experience of any conflict or difficulty in performing the maternal role with their child hospitalized, 90 women denied this. The data in Table 1 present the frequency with which they considered the DC of "parental role conflict" representative of what they were experiencing on the day of the interview, in decreasing order of frequency. From a total of 100 women, only four did not identify themselves with a DC of this diagnosis: attributing "1" or "2" to all of them. There was a mean of 4.6 DC by subject.

Table 1 - Frequency of Defining Characteristics of the ND "Parental role conflict" in mothers of hospitalized newborns. Campinas, SP, Brazil, 2011 (n=100 mothers)

Defining Characteristics present *	N
Anxiety	78
Mother reports concern about changes in parental role	64
Mother reports feelings of frustration	53
Mother reports concern about family (e.g., functioning, communication, health)	52
Fear	51
Mother reports feeling of inadequacy to provide for child's needs (e.g., physical, emotional)	47
Demonstrates disruption in caretaking routines	36
Mother reports concern about perceived loss of control over decisions relating to child	34
Reports feelings of guilt	27
Mother reluctant to participate in usual caretaking activities, even with encouragement and support	20

* Values 3, 4 or 5 attributed on Likert Scale.

Considering the presence of at least one of the three major DC, 83 of the 100 women presented with the diagnosis. Table 2 presents the investigation about possible associations between maternal and neonatal data and the presence of the diagnosis.

Table 2 - Possible associations between the presence of the diagnosis "parental role conflict" and maternal and neonatal data. Campinas, SP, Brazil, 2011 (n=83)

Maternal and neonatal variables	N	p-value
Mothers		
Age (years) *	27.4 ± 6.2	0.59
Marital status: with partner †	75	0.39
Education: High School †	44	0.24
Performance of remunerated activity	45	0.06
Responsibility for the care of other family members	46	0.28
Transportation allowance to visit NB †	75	0.12
Absence of immediate contact with NB in the delivery room	72	1.0
First child hospitalized †	70	0.23
Parity: Two or more births	43	0.93
Frequency of visit less than days of hospitalization of the child †	65	0.0046
Newborns		
Days of hospitalization on the day of the interview ‡	17	-
Baby receiving intermediate care	61	0.77
Birthweight <2000g	55	0,63
Prematurity	69	1.00

Variables expressed in absolute n; * variable expressed as mean ± standard deviation; † Fisher's exact test; ‡ variable expressed as median

Discussion

Attachment and the maternal role are processes that require physical contact between mother and child, offering opportunities for the mother to provide care to the child and for comfort of the woman in such situations[2,11]. From this perspective, the impact that hospitalization can have on the baby's mother is noted, beyond the crisis that adds to the process of constructing a maternal identity.

The DC *"anxiety"* was presented to mothers as an expectation and fear of something unspecified in relation to which they considered themselves undefended. It was considered to be a "vague uneasy feeling of discomfort or dread accompanied by an autonomic response, a feeling of apprehension caused by anticipation of danger, usually of an unknown cause"[7]. Although this DC was identified by most women, this needs careful investigation for inferences in clinical practice, because of its subjectivity and scientific knowledge of the nurse with respect to it. Furthermore, in this study, it is considered that the respondents may have had limited understanding of the meaning of the word "anxiety", however much we sought to clarify it. Some talked

about intense yearnings and expectations regarding the recovery and discharge of the baby, causing them suffering: what they described as "anxiety." Others also referred to anxiety as a discomfort and / or dread caused by the anticipation of a danger to which they would have to react. They did not refer to physical or autonomic responses, also described in the literature[7] as characteristic of anxiety.

"Anxiety" is described in several studies about the experience of the mother in a hospital neonatal unit[5,12-14], although it is not being named as a DC or as a ND. Anxiety is also present in the experiences of parents and families of healthy babies, however, its intensity and impact can be devastating when it comes to the birth of a premature and / or ill baby[1].

The DC, mother *"reports concern about changes in parental role"* describes the fact that women resented the fact that they could not care for and play with the child as imagined. The experience of not being responsible for the care with the distance imposed by hospitalization made the experience of being a mother absolutely different from what they had idealized[4,11-12,14-15].

Experiencing motherhood in a highly technological environment of the neonatal unit can make it difficult for women to feel confident about the performance of their role[11]. Given the importance of these aspects for the well-being of women and for the socio-affective development of the baby, maternal ND are important research topics for nurses working in neonatal units.

The DC *"reports feelings of frustration"* described the feeling of not having achieved the desired ideal, when faced with a birth that was completely different from what was expected, and the separation from one's children. This was also corroborated by other studies[1-2,16-27], although they did not specifically investigate the ND.

Mother *"reports concern about the family (e.g., functioning, communication, health)"* is a DC that, in the context of the neonatal unit, could describe the conflict of the mother who wanted to engage with the hospitalized child, but also with other family members, and the impact that the hospitalization had on the NB himself, and that his clinical condition had on the family[1-2,5,13,16-18].

To be with the hospitalized child is something that occurs simultaneously with other demands, such as providing information and explanations to relatives about the status of the baby, caring for other children and family members, care of the home, among other activities. The development of a trusting relationship with the nurses of the unit is very important in this very stressful period for the mothers[5,15-16]. In addition, the nurses who investigate and consider the financial and social difficulties that mothers and families face can offer individualized assistance.

"Fear" is frequently mentioned in the literature, and described the experience of mothers in the neonatal unit. This feeling was related to the risk of death of the child, the possible sequelae, the physical aspect of the NB and his fragility, the fear of manipulating the child and not properly taking care of him or hurting him, as well as the equipment and environment of the neonatal unit[1,6,11-12,15]. A mother that experienced this DC may have behaviors that could be incorrectly interpreted by the team, if not investigated and evaluated with interest and depth.

As for the other DC, less than half of the mothers acknowledged experiencing them. However, it is still considered that these are individually important, especially in clinical practice, requiring investigation, planning and interventions.

Mothers did not have confidence in their capability to care for their hospitalized infants[1,15-16,18], which was described by the DC, *mother "reports feeling of inadequacy to provide for child's needs".* In this study, some mothers mentioned the lack of emotional resources, others spoke of financial problems, and others described the lack of skill to provide the hygiene care, feeding, or special care that the baby needed.

"Demonstrates disruption in caretaking routines" and the mother who was *"reluctant to participate in usual caretaking activities"*, even with encouragement and support, are DC that were less frequently present, although described in the literature[2,15,19], which may be related to the difficulty of recognizing women who are experiencing such issues. These two signs can be more easily observed and evaluated by professionals that by the women themselves.

The DC, mother *"reports concern about perceived loss of control over decisions relating to child"* is a sign that is much discussed in the literature[1,15,18]. Many women in the study who denied experiencing this DC, said they had no such concern because they thought the team was highly qualified and was who would make all the decisions. This DC describes the discomfort that mothers felt when perceiving that their rights and needs were constrained by rules imposed by the health team and institution[1,5,15,18]. Thus, cultural differences and the way in which the health system is configured in each country may be related to the fact that these Brazilian

mothers were less bothered about the limitations imposed by the professionals and services. It is important to mention that the neonatal unit where the data were collected allowed the mother to stay throughout the 24 hours period, although it did not have comfortable accomodations for long periods.

When the mother *"reports feelings of guilt"* related to the hospitalized child, this pointed back to something she did or did not do (e.g., prenatal care) that may have unleashed a health problem and the need for hospitalization[1,15,18]. Or, she may even consider that the admission of the child was the result of a punishment. Guilt also arises from the perception that the woman is unable to provide the care that the child needs[2,19].

Most mothers denied the presence of any conflict or difficulty in performing the maternal role. However, many self-identified with the content of the studied diagnosis. Studies[1,15] point to the difficulty of mothers who experience the hospitalization of a child in identifying their own needs in times of crisis. What this denotes is that the neonatal unit is a location that is conducive to research on maternal diagnoses.

Although the literature indicates associations between maternal characteristics, as well as neonatal, and the performance of the maternal role[3,6,11], it was not detected in this sample. However, it was found that women who were present at the hospital less frequently presented with a higher number of DC of the ND studied. This result indicates the value of encouragement and support for the mother to be with her child throughout the hospitalization[2,5]. To have a hospitalized child is a painful event, however, to be with him can help the mother to cope better with the event and adapt to the real needs of the baby[11]. Thus, the neonatal nurse should investigate the factors that trigger a shorter stay of the mother in the unit, as this can result from sufferings and circumstances that interfere with the interaction with the child and with the well-being of the woman.

This study, in addition to investigating a ND in the context of neonatal care which focused on the mother, also brings a contribution to this journal, since articles published in the last two years on the issue were aimed at assisting the NB. The studies dealt with: assessment and prevention of noise in the neonatal unit[20-22]; ability of mothers to regulate their own stress to soften pain responses and stressors of their premature infant[23]; mortality of neonates less than 32 weeks gestational age[24], evaluation of the appearance and content of a virtual program for teaching ND applied to premature NB[25], and assessment of physiological adaptation of the NB during aspiration of tracheal tube and upper airway[26]. Other authors, in turn, addressed the perception of nurses regarding care in the neonatal unit[27], as well as caring for the newborn in the presence of parents[28].

The scarcity of publications on ND in neonatal nursing in our reality has been affirmed by some authors[25]. This shortage is evident, especially regarding diagnoses that describe phenomena related to mothers. Thus, it is worth emphasizing the importance of keeping mothers with their children in the neonatal unit, but also to recognize them as subjects that need to be perceived by staff and the health care team[27-28]. This is correlated to the proposal of the current study.

Conclusion

Of the hundred women interviewed, 96 acknowledged the DC "conflict in the performance of the maternal role" as representive of what they experienced or felt. If we considered the presence of the major DC, 83 of them would have the diagnosis. Five DC were the most common: "anxiety," mother "reports concern about changes in parental role"; "reports feelings of frustration," "reports concern about family (e.g., functioning, communication, health)", and "fear".

There were no statistically significant associations between the presence of the diagnosis and maternal and neonatal data. However, it was found that women who were with their children less often during hospitalization were those who considered the largest number of the DC of the diagnosis for describing what they were experiencing. This can be an alert to the importance of promoting contact and interaction between mothers and children in the neonatal unit.

We observed a high prevalence of this ND in this sample, suggesting the relevance of the topic and the need for further studies to be developed in the neonatal unit about this ND.

Implications for clinical practice and research

The literature describes specific interventions for mothers of hospitalized babies. However, for these to be proposed and implemented, these phenomena need to be investigated and named. Thus, it is considered that "parental role conflict" is an important nursing phenomenon to be studied in the neonatal unit, because it can guide interventions to alleviate emotional distress and increase the confidence of mothers. It is hoped that this study has helped to demonstrate this relevance and to inspire other nurses working in neonatal units

to develop skills to better assist the mothers, and the development of larger studies.

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