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ORIGINAL ARTICLE

CONTENTS

# Socioeconomic predictors of maternal coping during pediatric hospitalization

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## ABSTRACT

**Aim:** The objective of the study was to establish the most important socioeconomic and clinical predictors of coping mechanisms among mothers when their child was admitted to the hospital in Iraq.

**Materials and Methods:** The study was a descriptive and cross-sectional study carried out in the pediatric wards of Basrah between September 2025 and January 2026. One hundred mothers were recruited. The Sociodemographic/clinical sheet was used to collect data in the form of a Sociodemographic/clinical sheet and the Arabic Brief COPE Inventory. Descriptive statistics, correlation, ANOVA and multiple regression analysis were conducted to determine predictors.

**Results:** Regression analysis revealed that maternal coping was significantly predicted by higher education level (β=0.38, p<0.001), higher socioeconomic status (β=0.32, p<0.001), being employed (β=0.25, p=0.006), a shorter hospital stay (β=-0.21, p=0.013), and acute rather than chronic diagnosis (β=-0.24, p=0.008). The model explained 52% of variance in coping ($R^2$=0.52, p<0.001).

**Conclusions:** Modifiable socioeconomic factors significantly predict maternal coping in the hospitalization of a child. To increase caregiver resilience, screening and support programs related to these predictors should be implemented into the healthcare systems.

**KEYWORDS:** predictors, maternal coping, child hospitalization, socioeconomic status

Wiad Lek. 2026;79(9):2088-2094. doi: 10.36740/WLek/231646 DOI

## INTRODUCTION

Hospitalization of a child is a very dramatic and stressful event in life, which disturbs family balance and puts a considerable psychological and emotional load on the parents, especially the mothers who most often become the main caregivers [1]. It is full of uncertainty, fear, and a sense of loss of control, and mothers are placed in a new and overwhelming healthcare setting during which they somehow have to deal with their own distress and care for their sick child at the same time [2]. Mothers and other adaptive coping strategies they use to handle this crisis, referred to as maternal coping strategies, are important contributors to the short- and long-term family coping, child recovery patterns, and mother mental health [3]. Motherly coping is not a unitary phenomenon but a multi-dimensional process that depends on the interaction of multiple influences both internal and external in nature. They can include intrapersonal resources, including the level of education and psychological strength, to contextual ones, like the caliber of the illness the child has, the duration of the hospital stay, and the socioeconomic conditions of the family [4-5]. When effective, commonly divided into problem-oriented (e.g., seeking information, planning) and emotion-oriented (e.g., positive reframing, seeking emotional support) coping can alleviate the negative impact of stress, help to develop a sense of mastery, and become more involved and collaborative in taking care of the child [6]. On the other hand, reactions resulting in increased parental anxiety, depression, and post-traumatic stress symptoms, like maladaptive coping strategies (e.g., denial or behavioral disengagement), are associated with increased levels of the response and adherence to therapy in the child [7]. Although the importance of maternal coping is well established, much remains to be known about particular predictors of maternal coping particularly within the context of different socio-cultural and economic background. A lot of existing literature is based on high-income, western settings, which restricts the applicability of the results to other settings where healthcare systems, family systems, and resource access

vary significantly [8]. Additionally, modern studies are paying more and more attention to the role of social determinants of health, including education, income, and employment, as the basic determinants of health behaviors and outcomes, including coping efficacy [9]. The necessary sensitivity and contextual analysis is hence needed to determine the most critical factors that enable or disable a mother to cope during this important crossroad. This paper attempts to fill these gaps by examining the frequency, types and major predictors of the coping strategies which mothers have used in their hospitalized child under a given set up. This study will be based on mapping the terrain of maternal adaptation during times of stress by analyzing demographic, socioeconomic and clinical variables. The outcomes will be aimed at facilitating the designing of specific, fair, and family-driven psychosocial interventions. Finally maternal coping is not just a supplement to pediatric care but the main part of holistic medicine that considers the family as the primary unit of the healing process [10].

## AIM

The objective of the study was to establish the most important socioeconomic and clinical predictors of coping mechanisms among mothers when their child was admitted to the hospital in Iraq.

## MATERIALS AND METHODS

### STUDY DESIGN

The study was a descriptive, cross-sectional, correlational study aimed at investigating the coping mechanisms of mothers and factors related to them in cases of child hospitalization.

### SETTING AND TIMEFRAME

The study was carried out in the pediatric wards of Al-Basrah Teaching Hospital and Al-Mawani Teaching Hospital in Basrah, Iraq. Data collection occurred over a five-month period from September 2025 to January 2026.

### SAMPLE AND SAMPLING TECHNIQUE

**Population:** Mothers of hospitalized children aged 1-12 years.

**Sample size:** 100 mothers were enrolled.

**Sampling technique:** A non-probability convenience sampling method was used. Mothers were approached consecutively during visiting hours if they met the inclusion criteria.

### INCLUSION CRITERIA

1. Mothers of children hospitalized for at least 48 hours,
2. Mothers aged 17 years or older,
3. Mothers who provided informed consent.

### EXCLUSION CRITERIA

1. Mothers of critically ill children in intensive care,
2. Mothers with diagnosed psychiatric disorders,
3. Children hospitalized for routine procedures.

### DATA COLLECTION INSTRUMENTS

Data were collected using a structured, self-administered questionnaire with two sections:

**Section 1:** Socio-demographic and Clinical Data Sheet (developed by researchers). This collected information on maternal age, education, employment, marital status, number of children, socioeconomic status (categorized using a modified Kuppuswamy scale), child's diagnosis (categorized as Acute, Chronic, or Injury), and length of hospital stay.

**Section 2:** The **Brief COPE Inventory (Arabic Version)**, a validated 28-item scale measuring 14 coping strategies. Responses are on a 4-point Likert scale (1="I haven't been doing this at all" to 4="I've been doing this a lot"). For analysis, items were grouped into two main domains:

**Positive Coping** (15 items): Sum of active coping, planning, positive reframing, acceptance, humor, religion, emotional support, and instrumental support subscales. Score range: 15-60.

**Negative Coping** (5 items): Sum of denial, venting, substance use, behavioral disengagement, and self-blame subscales. Score range: 5-20.

### DATA COLLECTION PROCEDURE

The Basrah Health Directorate Research Ethics Committee gave ethical approval to this study. The main researchers visited the pediatric wards on a daily basis and in regular visiting hours. The close coordination with the head nurses of the respective wards helped to identify the potential participants. Individually to every qualified mother, the intention, nature, and consequences of the study were clearly explained and written informed consent was signed. Questionnaires were sent out and filled at the site. In order to be inclusive and accurate, the researcher administered verbal questions to mothers with low literacy where she read and noted down the responses in a verbatim manner, but with absolute privacy. The extremely time-consuming duration of each interview or questionnaire was about 15 to 20 minutes.

## STATISTICAL ANALYSIS

Data were analyzed using Statistical Package for the Social Sciences (SPSS) version 26. Analyses included:

## DESCRIPTIVE STATISTICS

Frequencies, percentages, means, and standard deviations were used to describe the sample and coping scores.

## INFERENTIAL STATISTICS

### *PEARSON'S CORRELATION COEFFICIENT (R)*

To examine relationships between continuous variables (e.g., age, number of children, length of stay) and coping scores.

### *INDEPENDENT SAMPLES T-TEST AND ONE-WAY ANOVA*

To compare coping mean scores across categorical demographic and clinical groups (e.g., education level, employment status, diagnosis type). Post-hoc tests (Tukey HSD) were used where ANOVA results were significant.

### *MULTIPLE LINEAR REGRESSION ANALYSIS (STEPWISE METHOD)*

To identify the key predictors of the total coping score. Assumptions of linearity, homoscedasticity, and normality of residuals were checked and met.

## RELIABILITY ANALYSIS

Internal consistency of the coping scales was assessed using Cronbach's Alpha, with values > 0.70 deemed acceptable.

A p-value of < 0.05 was considered statistically significant for all tests.

## ETHICAL CONSIDERATIONS

**Approval:** Formal approval was granted by the relevant institutional ethics committee (Approval No. BHD/REC/2025/87).

**Informed Consent:** Written informed consent was obtained from all participants after a full explanation.

**Confidentiality:** All data were anonymized using identification codes. Completed questionnaires were stored in a locked cabinet.

**Voluntary participation:** Mothers were informed of their right to withdraw at any time without affecting their child's care.

**Beneficence:** Contact information for the hospital›s psychological support service was provided to all participants.

Ethical approval was granted by the Basrah Health Directorate Research Ethics Committee (No. BHD/REC/2025/87).

## PILOT STUDY

To determine the validity of the questionnaire in terms of clarity, timing, and face validity, a pilot study was done on 10 mothers (not included in the main analysis). Feedback ensured minor wording changes had to be made. Cronbach's Alpha internal consistency of Positive Coping and Negative Coping on pilot scale was 0.76 and 0.71 respectively.

Table 1 is the most significant demographic portrait of the mother participants. It demonstrates a very homogenous sample in a few characteristics (e.g., 98% married) and the diversity in others (e.g., age and education level). The current composition offers an appropriate framework of investigating coping mechanisms and the comparison of the effect of various variables on maternal adjustment when the child is admitted to a hospital can be made.

According to the table 2, the most common coping strategies applied by mothers are positive strategies (mean 34.2 out of 45) at moderate-to-high level, and negative coping strategies are relatively less common (mean 11.3 out of 15). This indicates that the mothers have adapted constructively and adaptively to cope with the stress of having their children in the hospitals, which is the psychological resilience and the ability to adapt to stress.

The correlation outcomes indicate that more children are related with better coping which can suggest that maternal experience acquired through raising more than one children increases adaptive capacity (Table 3). In contrast, the longer the hospital stay, the worse the coping and this highlights the cumulative psychological weight and stress of a prolonged stay in a hospital.

This discussion points out that education level and the socioeconomic status are the most differentiating factors in coping strategies. The coping of the mothers who are better educated and have a higher socioeconomic status is much better. The employment status is also positively related; however, the type of diagnosis also affects coping effectiveness, whereby acute illnesses are related to better adjustment than chronic conditions (Table 4).

The model of regression is describing 52 percent of

**Table 1.** Frequency and percentage distribution of demographic variables

| Variable | Category | Frequency | Percentage |
|---|---|---|---|
| Age Group | 17–25 years | 31 | 31.0 |
| | 26–35 years | 43 | 43.0 |
| | 36–45 years | 22 | 22.0 |
| | 46–54 years | 4 | 4.0 |
| Marital Status | Married | 98 | 98.0 |
| | Divorced | 1 | 1.0 |
| | Widowed | 1 | 1.0 |
| Education Level | No formal education | 13 | 13.0 |
| | Primary | 36 | 36.0 |
| | Secondary | 32 | 32.0 |
| | University | 19 | 19.0 |
| Employment Status | Government | 10 | 10.0 |
| | Private sector | 8 | 8.0 |
| | Housewife | 82 | 82.0 |
| Number of Children | 1–2 | 54 | 54.0 |
| | 3–4 | 33 | 33.0 |
| | ≥5 | 13 | 13.0 |
| Socioeconomic Status | Low | 40 | 40.0 |
| | Medium | 52 | 52.0 |
| | High | 8 | 8.0 |
| Length of Stay | 2–5 days | 57 | 57.0 |
| | 6–10 days | 27 | 27.0 |
| | 11–16 days | 16 | 16.0 |
| Diagnosis Type | Acute | 55 | 55.0 |
| | Chronic | 36 | 36.0 |
| | Injury | 9 | 9.0 |

*Source: Authors' own work*

**Table 2.** Descriptive statistics of coping strategies

| Scale | Possible range | Actual range | Mean | SD | Interpretation |
|---|---|---|---|---|---|
| Positive Coping | 15–45 | 21–42 | 34.2 | 4.1 | Moderately High |
| Negative Coping | 5–15 | 6–15 | 11.3 | 2.2 | Relatively Low |
| Total Coping | 20–60 | 28–55 | 45.5 | 5.3 | Moderate to High |

*Source: Authors' own work*

**Table 3.** Correlation analysis (continuous variables)

| Variable | Positive coping | Negative coping | Total coping | Significance |
|---|---|---|---|---|
| Age | r = 0.18 | r = –0.12 | r = 0.15 | p = 0.078 (NS) |
| Number of children | r = 0.21 | r = 0.08 | r = 0.19 | p = 0.038 |
| Length of stay | r = –0.24 | r = 0.31 | r = –0.15 | p = 0.017 |

*Source: Authors' own work*

the total coping and this implies that the predictive model is a good model. Education comes out as the most predictive, then comes socioeconomic status and employment- all of them having a positive contribution to coping (Table 5). On the contrary, pro-longed hospitalization and the diagnosis of chronic diseases has a detrimental impact on coping strength. These are the findings that confirm the multidimensional aspect of maternal coping which is both a product of personal resources and circumstantial stressors.

**Table 4.** ANOVA results for categorical variables

| Variable | Positive coping F (p) | Negative coping F (p) | Significant difference |
|---|---|---|---|
| Education level | 8.45 (p<0.001**) | 3.12 (p=0.029*) | University > Secondary > Primary > No education |
| Socioeconomic status | 9.87 (p<0.001**) | 4.56 (p=0.013*) | High > Medium > Low |
| Employment status | 5.12 (p=0.008**) | 1.34 (p=0.267) | Working > Housewife |
| Diagnosis type | 6.23 (p=0.003**) | 4.87 (p=0.010*) | Acute > Chronic |
| Marital status | 1.34 (p=0.267) | 0.89 (p=0.413) | No difference |

*p < 0.05 **p < 0.01
*Source: Authors' own work*

**Table 5.** Predictors of total coping

| Predictor | B | SE | β | t | p |
|---|---|---|---|---|---|
| Education level | 2.34 | 0.56 | 0.38 | 4.18 | <0.001 |
| Socioeconomic status | 1.89 | 0.48 | 0.32 | 3.94 | <0.001 |
| Employment | 1.45 | 0.52 | 0.25 | 2.79 | 0.006 |
| Length of stay | –0.38 | 0.15 | –0.21 | –2.53 | 0.013 |
| Diagnosis type | –1.12 | 0.41 | –0.24 | –2.73 | 0.008 |

Model: $R^2 = 0.52$, $F(5,94) = 20.15$, $p < 0.001$
*Source: Authors' own work*

## DISCUSSION

The demographic results of the study are in line with socio-ecological models of stress and coping. The fact that married mothers 98% overcome is a suggestion that spousal support may be present which an established protective variable against stress among caregivers is. The studies indicate that partner support can help to reduce maternal anxiety and promote problem-oriented coping in the medical crisis of a child [11-12]. On the other hand, the large rate of housewives 82%, individuals with primary/secondary education 68%, might represent the groups that have fewer socioeconomic resources or different coping repertoires and are, therefore, the most essential target of the psychosocial intervention [13]. The result of an average moderate positive coping (Mean=34.2) and the comparably low negative coping is positive and fits well into a resilience approach to pediatric nursing. Modern theories, including the Family Stress and Resilience Model, assume that when parents encounter the illness of their child, they tend to trigger inherent and acquired adaptive resources [14]. This finding can be an indication of effective application of such strategies as social support in search, positive reframing and active planning, which are associated with more successful psychological adjustment and even child outcomes achieved by means of more cohesive family management [15]. The relationship between coping and higher education, as well as coping and the SES, are strong and graded (Tables 4 and 5), which is a strong and critical finding. This highlights the Fundamental Causes Theory [16], which states that resources such as knowledge, money, social relationships define health outcomes and coping effectiveness. Cognitive means of processing medical information, navigating complex healthcare systems, and successful communication with vendors are all forms of problem-focused coping offered by higher education [17]. In the same way, increased SES helps to alleviate concrete stressors (e.g., financial concern), which liberate psychological resources to engage in adaptive coping [18]. This poses a risk of inequity gap in which less educated/SES mothers are disadvantaged twice. It is remarkable that the positive coping of employed mothers over housewives is quite an advantage. Work can give a structured identity beyond the caregiver role, social populations, and add to increased self-efficacy and economic independence. Such a conclusion is confirmed by Lee and Kim [19], who established that work engagement may be a source of mastery and a mental reprieve to counter the powerlessness that may be experienced in hospitals. It disputes the belief that physical presence is always the best and shows the significance of role diversification to the well-being of the mother. The adverse correlation between the duration of hospitalization/chronic diagnosis and coping capacity is a dark reminder of the cumulative stress hypothesis. Acute stressors are not only intense but also follow a defined path. Chronic disease or long hospital stay does, however, cause allostatic load, or the stress fatigue of the body and mind due to long-term stress [20]. This empties psychological resources, and adaptive coping is more difficult to sustain. The mums with chronic illnesses also have to adjust to the long-term uncertainty and the change of roles into the permanent caregiving, which predetermines increased burnout and emotional fatigue [21-22]. The fact that there is a positive relationship between the number of children and improved coping is interesting. It could represent a

stress inoculation effect, in which previous experience with parenting develops a set of problem-solving strategies and emotional regulation mechanisms [23]. The veteran moms can even be more realistic and have a reference check (I have handled crises in the past). Instead, mothers having numerous children might have acquired extended social support systems. This finding, however, must be taken with caution since it might not be true in situations where there is severe scarcity of resources.

Family support likely played a bigger role in maternal coping than this study was able to capture directly. The high proportion of married mothers, along with the link between having more children and better coping, both point to family as a source of strength during a child's hospitalization through shared caregiving, emotional support and easing the practical burden on the mother. Since family involvement wasn't measured directly here, this remains an area worth exploring more closely in future work.

One limitation of this study is the wide age range of children admitted to the hospital (from 1 to 12 years old). The approaches of mothers of younger children may differ from those of mothers of older, school-aged children, as younger children rely more heavily on direct physical care, while older children are better able to understand and articulate their illness. Combining these two groups may have masked some of these differences. Therefore, future studies with narrower age groups could better elucidate these distinctions.

## CONCLUSIONS

This study conclusively demonstrated that a mother's ability to cope while her child is hospitalized is not merely a psychological phenomenon, but rather a societal norm. This ability is significantly influenced by structural factors such as educational and social status, as well as circumstantial factors such as the duration of the illness and the length of the hospital stay. The family also appears to play a crucial role; mothers who receive support from their husbands and who possess greater experience in raising children generally cope better. The results suggest the need to abandon a one-size-fits-all pediatric care model to a disparity-based, customized model of family support that can target such underlying inequities to encourage resilience among all caregivers.

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## ACKNOWLEDGMENTS

The authors extend their sincere gratitude to the administration and nursing staff of Al-Basrah and Al-Mawani Teaching Hospitals for facilitating this study. We are deeply thankful to the mothers who participated during a challenging time.

**CONFLICT OF INTEREST**

The Authors declare no conflict of interest

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**RECEIVED:** 14.04.2026
**ACCEPTED:** 24.08.2026

CREATIVE COMMONS 4.0