

Religious Coping Styles and Psychological Resilience Among Mothers of Children Hospitalized in a Pediatric Intensive Care Unit: A Cross-Sectional Study

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Abstract

Objective: To determine levels of positive/negative religious coping and psychological resilience among mothers of children admitted to a pediatric intensive care unit (PICU) and to examine their associations with sociodemographic characteristics and perceived psychosocial support needs.

Method: This descriptive, cross-sectional study was conducted between June and December 2025 in a pediatric intensive care unit; 100 mothers were recruited via face-to-face interviews. Data were collected using a sociodemographic form, the Brief RCOPE (positive/negative subscales), and the Brief Resilience Scale.

Results: Scores for Positive religious coping were high (mean = 3.20 ± 0.60), negative religious coping was low (mean = 1.55 ± 0.50), and resilience scores were moderate (mean = 19.35 ± 5.18). Mothers who reported needing psychosocial support had higher positive and negative religious coping scores but lower resilience. Negative religious coping was negatively associated with resilience ($r = -0.246$, $P = 0.014$), whereas positive religious coping was not.

Conclusion: The findings suggest that, in addition to psychosocial support, targeted spiritual care may be particularly important for mothers showing elevated negative religious coping during their child's PICU hospitalization.

Key words: Mothers; Pediatric Intensive Care Units; Psychosocial Support; Psychological Resilience; Religiosity Copings

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Pediatric intensive care units provide advanced, technology-assisted care for children with life-threatening conditions and require highly specialized clinical practices (1). A child's critical illness and hospitalization can adversely affect family members physically, socially, cognitively, emotionally, and spiritually. During this period, parents may experience guilt and uncertainty while trying to understand the causes of the illness and navigate an unfamiliar environment and complex hospital rules (2). Previous studies of mothers accompanying their children in the pediatric intensive care unit have shown that anxiety and depressive symptoms may negatively affect their quality of life (2, 3). Similarly, neonatal intensive care settings have been associated with increased maternal stress during hospitalization (4).

Psychological resilience is commonly conceptualized as the capacity to adapt to adversity and to recover after stressors (5, 6). In difficult situations, spirituality and religiosity can influence coping and meaning-making processes, thereby fostering optimism, stress management, and overall well-being (7, 8). Within Pargament's religious coping framework, positive religious coping (e.g., seeking spiritual support, benevolent religious reappraisal, prayer) is generally associated with better adjustment, whereas negative religious coping (e.g., spiritual struggle, feeling punished or abandoned) is more consistently linked to distress (9–11). Religious coping has been examined across different groups, and prior studies emphasize that adaptive and maladaptive patterns may coexist depending on the severity of stress and contextual factors (12–14).

Given the profound uncertainty and emotional burden in the pediatric intensive care context, mothers' religious coping and resilience may be clinically meaningful for planning family-centered psychosocial and spiritual support. Therefore, this study aimed to determine mothers' levels of positive/negative religious coping and psychological resilience and to examine their associations with sociodemographic characteristics and perceived psychosocial support needs.

Materials and Methods

Study design and setting

This descriptive, cross-sectional, correlational study was conducted between June and December 2025 in the pediatric intensive care unit of a tertiary training and research hospital.

Population and sample

The target population consisted of mothers of children hospitalized in the pediatric intensive care unit during the study period. Sample size was calculated for the planned correlation analysis using Power Analysis & Sample Size (PASS v11.0.10); the required sample size was estimated as 150 (power = 80%, alpha = 0.05). The

final sample comprised 100 mothers. Twenty mothers who met the inclusion criteria declined to participate. In addition, 12 mothers were excluded from the dataset due to incomplete questionnaires. A post hoc power analysis was performed using G*Power (Version 3.1.9.2). The sample included 100 mothers who volunteered to participate, were literate in Turkish, and had no diagnosed psychiatric disorder. For a two-tailed alpha = 0.05, the power analysis indicated 80% power to detect correlations of $|r| \geq 0.28$. Accordingly, the achieved power and sample size were considered adequate.

Data collection instruments

The Personal Information Form: Developed by the researchers, this form consists of 11 items.

Religious Coping Styles Scale (Brief RCOPE): The brief form comprises two dimensions—positive and negative religious coping—each with 7 items (11). Items are rated on a 4-point Likert scale; higher scores indicate greater use of the corresponding coping style. The Turkish adaptation was conducted by Ekşi (12). In the present study, the Cronbach's alpha was 0.803 for positive religious coping and 0.752 for negative religious coping.

Brief Resilience Scale: This is a 6-item self-report scale rated on a 5-point Likert scale that assesses the ability to "bounce back" after stress (5). The Turkish validity and reliability study was conducted by Doğan (6). In the present study, the Cronbach's alpha was 0.846.

Statistical analysis

Data were analyzed using statistical software. Descriptive statistics (number, percentage, mean, and standard deviation) were calculated. Reliability analyses were performed to assess internal consistency. Normality was evaluated using Q–Q plots and descriptive indices; skewness and kurtosis values between -2 and $+2$ were accepted as indicating approximate normality (15, 16). The study variables were normally distributed. Independent-samples t-tests were used for comparisons between two groups, and a one-way ANOVA was used for comparisons across more than two groups; Bonferroni post-hoc tests were applied when appropriate. Associations between continuous variables were tested using Pearson correlation analysis.

Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki. Approval was obtained from the institutional ethics committee (No: 2025/321). Written informed consent was obtained from all participants prior to data collection.

Results

Participant characteristics are summarized in Table 1. The mean age of the mothers was 37.20 ± 9.65 years; 56% were aged < 37 years, and 44% were aged ≥ 37 years. Most participants were married (85%). Regarding educational attainment, 32% had a secondary education, 29% had an associate degree, and 13% had a bachelor's

degree or higher. Among the participants, 52% were employed and 39% were homemakers. Sixty percent of mothers perceived caregiving as a religious

responsibility, 40% reported that their religiosity increased during the caregiving process, and 56% reported needing psychosocial support (Table 1).

Table 1. Sociodemographic Characteristics of Mothers Whose Children Are Being Treated in the Pediatric Intensive Care Unit

Variables	n	%
Age (years) (Mean ± SD = 37.20 ± 9.65)		
< 37 years	56	56.0
≥ 37 years	44	44.0
Marital status		
Married	85	85.0
Single	12	12.0
Widowed	3	3.0
Education level		
Illiterate	6	6.0
Primary school	20	20.0
Secondary school	32	32.0
Associate degree	29	29.0
Bachelor's degree or higher	13	13.0
Employment status		
Employed	52	52.0
Not employed	48	48.0
Occupation		
Housewife	39	39.0
Civil servant	31	31.0
Worker	10	10.0
Private sector employee	18	18.0
Retired	2	2.0
Perceived income level		
Low	22	22.0
Moderate	75	75.0
High	3	3.0
Living arrangement		
Alone	12	12.0
Family	86	86.0
Relatives	2	2.0
Perceiving caregiving as a religious responsibility		
Yes	60	60.0
No	40	40.0
Change in religiosity during caregiving		
Yes (increased religiosity, started to pray, etc.)	40	40.0
No	60	60.0
Perceived need for psychosocial support during caregiving		
Yes	56	56.0
No	44	44.0
Total	100	100.0

Scale scores are presented in Table 2: the mean positive religious coping score was 3.20 ± 0.60, the mean

negative religious coping score was 1.55 ± 0.50, and the mean Brief Resilience Scale score was 19.35 ± 5.18.

Table 2. Average Score of Mothers on the Brief Psychological Resilience Scale

Scales	Min–Max	Mean ± SD
Positive Religious Coping	1.29–4.00	3.20 ± 0.60
Negative Religious Coping	1.00–2.86	1.55 ± 0.50
Brief Psychological Resilience Scale	7.00–30.00	19.35 ± 5.18

Min: minimum; Max: maximum; SD: standard deviation.

Group comparisons are shown in Table 3. Positive religious coping scores were higher among mothers aged ≥ 37 years ($P = 0.031$). Educational attainment was associated with positive religious coping ($P = 0.032$) and resilience ($P = 0.027$); Bonferroni post-hoc tests indicated higher positive religious coping among primary school graduates compared to associate degree graduates ($2 > 4$) and higher resilience among the non-literate group compared with associate degree graduates ($1 > 4$). Mothers who perceived caregiving as a religious obligation and those who reported increased religiosity

during the caregiving process had higher positive religious coping scores ($P = 0.006$ and $P = 0.001$, respectively). Mothers who reported needing psychosocial support had higher positive and negative religious coping scores but lower resilience scores ($P = 0.025$; $P = 0.020$; $P = 0.001$, respectively).

Pearson correlation analysis (Table 4) showed a significant negative association between negative religious coping and resilience ($r = -0.246$, $P = 0.014$); no association was found between positive religious coping and resilience ($r = -0.045$, $P = 0.659$).

Table 3. Positive and Negative Religious Coping and Resilience Scores by Sociodemographic and Caregiving-Related Characteristics

Variables	Groups	Positive RC	Negative RC	Brief Psychological Resilience Scale
		Mean ± SD	Mean ± SD	Mean ± SD
Age	< 37 years	3.08 ± 0.70	1.63 ± 0.54	18.82 ± 5.68
	≥ 37 years	3.36 ± 0.49	1.45 ± 0.47	20.02 ± 4.43
	t	-2.191	1.702	-1.154
	P	0.031*	0.092	0.251
Marital status	Married	3.25 ± 0.64	1.56 ± 0.53	19.55 ± 4.92
	Single	2.95 ± 0.56	1.49 ± 0.48	17.58 ± 7.00
	Widowed	2.86 ± 0.25	1.38 ± 0.22	20.67 ± 4.04
	F	1.681	0.275	0.859
	P	0.191	0.760	0.427
Education level	Illiterate (1)	3.38 ± 0.64	1.36 ± 0.74	24.67 ± 6.09
	Primary school (2)	3.47 ± 0.55	1.64 ± 0.62	18.15 ± 4.83
	Secondary school (3)	3.18 ± 0.59	1.62 ± 0.46	20.19 ± 5.16
	Associate degree (4)	2.94 ± 0.68	1.42 ± 0.37	17.90 ± 4.61
	Bachelor's degree or higher (5)	3.37 ± 0.58	1.60 ± 0.61	19.92 ± 5.16
	F	2.762	0.990	2.874
	P	0.032*	0.417	0.027*
	Bonferroni	$2 > 4$		$1 > 4$
Employment status	Employed	3.13 ± 0.63	1.59 ± 0.54	19.40 ± 4.87
	Not employed	3.29 ± 0.63	1.51 ± 0.49	19.29 ± 5.54
	t	-1.291	0.743	0.108
	P	0.200	0.459	0.914
Occupation	Housewife	3.36 ± 0.60	1.59 ± 0.57	19.51 ± 5.90
	Civil servant	3.06 ± 0.70	1.50 ± 0.46	18.45 ± 4.87
	Worker	3.10 ± 0.69	1.41 ± 0.41	21.20 ± 3.94

Variables	Groups	Positive RC	Negative RC	Brief Psychological Resilience Scale
		Mean ± SD	Mean ± SD	Mean ± SD
Perceived income level	Private sector employee	3.11 ± 0.51	1.60 ± 0.55	19.56 ± 4.95
	Retired	3.71 ± 0.00	1.57 ± 0.40	19.00 ± 1.41
	F	1.492	0.353	0.562
	P	0.211	0.841	0.691
	Low	3.19 ± 0.64	1.59 ± 0.52	18.50 ± 6.15
	Moderate	3.23 ± 0.59	1.55 ± 0.51	19.72 ± 4.91
	High	2.71 ± 1.36	1.29 ± 0.49	16.33 ± 3.06
Persons living with	F	0.969	0.467	0.998
	P	0.353	0.628	0.373
	Alone	3.00 ± 0.73	1.52 ± 0.41	18.00 ± 4.71
	Family	3.24 ± 0.60	1.55 ± 0.53	19.55 ± 5.15
	Relatives	3.07 ± 1.31	1.64 ± 0.71	19.00 ± 11.31
Perceiving caregiving as a religious responsibility	F	0.780	0.047	0.470
	P	0.461	0.954	0.627
	Yes	3.35 ± 0.51	1.52 ± 0.47	18.68 ± 5.01
	No	2.99 ± 0.73	1.59 ± 0.57	20.35 ± 5.32
	t	2.835	-0.705	-1.589
Change in religiosity during caregiving	P	0.006*	0.482	0.115
	Yes	3.45 ± 0.45	1.53 ± 0.49	18.65 ± 5.48
	No	3.04 ± 0.68	1.56 ± 0.53	19.82 ± 4.95
	t	3.397	-0.375	-1.105
	P	0.001*	0.709	0.272
Perceived need for psychosocial support while caring for the child	Yes	3.33 ± 0.56	1.65 ± 0.52	17.86 ± 5.23
	No	3.05 ± 0.68	1.42 ± 0.48	21.25 ± 4.48
	t	2.281	2.357	-3.425
	P	0.025*	0.020*	0.001*

RC: Religious Coping; SD: Standard Deviation.

*P < 0.05.

t = Independent-samples t-test.

F = One-way analysis of variance (ANOVA).

Table 4. Results of Correlation Analysis Conducted to Determine the Relationship between Religious Coping Mechanisms and Resilience

Variables	Brief Psychological Resilience Scale	
	r	P
Positive Religious Coping	-0.045	0.659
Negative Religious Coping	-0.246	0.014*

*r: Pearson correlation coefficient; p: probability value; p < 0.05.

Discussion

In our study, mothers' levels of positive religious coping were high, whereas their levels of negative religious coping were low. This pattern is broadly consistent with Pargament's framework, suggesting that positive religious coping supports meaning-making, perceived control, and connectedness to social/spiritual resources, while negative religious coping reflects spiritual struggle and is more consistently linked to distress (9–11). In intensive care contexts, parents frequently draw on themes of prayer, patience, surrender/acceptance, and "test/meaning," and report a need for spiritual support during their child's hospitalization (2–4, 17). In the study by Bozdog and Baştas, mothers had high mean scores on the positive subscale and low mean scores on the negative religious coping subscale (18). Similarly, a 2021 study reported that parents of children hospitalized in intensive care due to congenital heart disease had higher mean positive religious coping scores than negative religious coping scores (19). Our findings are consistent with the literature and suggest that mothers of children hospitalized in pediatric intensive care may use religious coping resources to manage stress.

We found that mothers' psychological resilience scores were at a moderate level. A study conducted in 2025 reported moderate levels of psychological resilience among mothers (20). Another study likewise found that mothers' psychological resilience levels were moderate (21). Thus, our findings appear to be consistent with the literature. These results may indicate that mothers possess a moderate capacity to cope with the stress associated with their children's treatment processes in the hospital environment.

Mothers aged ≥ 37 years exhibited higher levels of positive religious coping. A study conducted among family members of children requiring care indicated that positive religious coping increased with age (22). This association may reflect more established religious meaning systems, greater experience in coping with adversity, and culturally embedded coping mechanisms (23).

Mothers' educational attainment was associated with both positive religious coping and resilience. Post-hoc comparisons showed higher positive religious coping among mothers with a primary school education compared with those with an associate degree ($2 > 4$) and higher resilience among non-literate mothers compared with those with an associate degree ($1 > 4$). This pattern may reflect cultural/contextual differences whereby religious practices and religious community-based support are more salient in groups with lower educational attainment (12, 13, 23). Alternatively, higher educational attainment may facilitate the use of alternative coping strategies that can support psychological resilience.

While perceiving caregiving as a religious responsibility and reporting increased religiosity during the caregiving process were associated with higher positive religious

coping, these variables were not associated with psychological resilience. These findings suggest that religious meaning-making may motivate and structure coping attitudes during caregiving, but may not translate directly into resilience scores in the short term. Qualitative studies among mothers of children with cancer have reported that viewing caregiving as a sacred duty can provide a sense of purpose and endurance (24, 25). However, studies have also demonstrated that a heavy caregiving burden can lead to the emergence of negative religious coping in certain contexts (26, 27).

We observed that mothers who reported a need for psychosocial support had higher positive and negative religious coping scores but lower psychological resilience scores. This finding reflects the "dual" nature of religious coping: under high stress, individuals may seek consolation and meaning through religion while simultaneously experiencing spiritual struggle (11, 28, 29). In this context, the heightened uncertainty and emotional distress among mothers who attempt to cope through religious means may have contributed to a sense of spiritual burden. Accordingly, it is plausible that the combined cognitive load, uncertainty, and emotional distress among mothers, who cope through religious means, may have led to a perception that the process has become "heavier" at the spiritual level as well.

We found a significant negative correlation between psychological resilience and negative religious coping ($r = -0.246$, $P = 0.014$). Accordingly, as mothers' resilience increased, their tendency toward negative religious coping decreased. Negative religious coping represents a qualitatively different response that can increase psychological burden under severe stress (e.g., feeling punished or abandoned or experiencing spiritual struggle) (9–11). One of the major stressors experienced by mothers in intensive care may be uncertainty. This uncertainty may exacerbate the psychological burden associated with their children's illnesses and thereby predisposing mothers to negative religious coping methods.

No significant association was observed between mothers' psychological resilience and positive religious coping. Our review of the literature revealed a limited number of studies in this field, each focusing on different patient groups (30–32).

Clinical implications

These findings support the need for systematic assessment of both dimensions of religious coping and resilience in pediatric intensive care. Screening questions regarding psychosocial support needs may help identify high-risk mothers, particularly those showing signs of negative religious coping. Collaborative psychosocial and spiritual care interventions involving intensive care clinicians, mental health professionals, and spiritual care providers may contribute to strengthening family-centered care (31–34).

Limitation

This descriptive cross-sectional study has several limitations. Reliance on mothers' self-reports may limit the generalizability of the findings. Another limitation is that we could not ascertain whether mothers had received a psychiatric diagnosis in the past, which may have influenced our results. In addition, we did not assess mothers' adverse past life experiences, which may also have affected the findings. Furthermore, our findings may have been influenced because we could not account for stressors related to environmental factors in the hospital setting, along with the stress of the children's recovery process. Despite these limitations, our findings could potentially direct future research. We recommend intervention studies focused on enhancing psychological resilience among mothers of children treated in intensive care. In particular, implementing these concepts in in-hospital training that also includes healthcare professionals providing treatment and care and developing related policies are recommended. We also did not collect clinical severity indicators of the child's condition (e.g., PRISM score), length of PICU stay, or parent-rated illness severity, which may influence maternal stress and coping. In addition, perceived social support (including potential support from religious communities) was not directly measured, limiting our ability to examine its confounding or mediating role. Finally, the final sample size ($n = 100$) was smaller than the planned sample ($n = 150$), which may have limited statistical power to detect small associations, particularly for the null finding between positive religious coping and resilience. Future studies should consider brief screening tools for maternal anxiety/depression (e.g., PHQ-4) and prior trauma and employ longitudinal designs to clarify directionality.

Conclusion

In this study, mothers demonstrated high levels of positive religious coping and low levels of negative religious coping, alongside moderate psychological resilience. Positive religious coping was higher among mothers aged ≥ 37 years and varied by educational attainment. Mothers who reported a need for psychosocial support exhibited higher scores on both positive and negative religious coping but lower resilience. Psychological resilience was inversely correlated with negative religious coping ($r = -0.246$, $p = 0.014$), whereas no significant association was observed between resilience and positive religious coping.

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Conflict of Interest

None.

Author's Contributions

Author contributions concept: T.A. and MB; Design: T.A. and MB; Control T.A. and MB; Data collection and/or processing: T.A.; Analysis and/ or interpretation: T.A. and MB; Literature review: T.A. and MB; Article writing: T.A. and MB; Critical review: All authors.

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