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Stress and Coping Strategies Among Parents of Children Admitted to the Isolation Unit

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ABSTRACT

Hospitalization of a child in isolation units often heightens parental stress, forcing reliance on culturally, religiously, and socially rooted coping mechanisms. **Objectives:** To explore stressors and coping strategies among parents caring for children in pediatric isolation units. **Methods:** A qualitative case study design was employed in the Pediatric Isolation Departments of major government hospitals in Peshawar, KP. Purposive sampling recruited 12 parents (7 mothers, 5 fathers) whose children had stayed at least one week. Data were collected through semi-structured interviews, audio-recorded, and transcribed verbatim. Thematic analysis was conducted using open, axial, and selective coding. **Results:** Four themes emerged: (1) Emotional distress parents experienced intense anxiety, helplessness, and sleep disturbance due to uncertainty and restricted caregiving roles; (2) Social and financial strain loss of income, disruption of daily life, and social isolation intensified stress; (3) Trust and reassurance in healthcare professionals clear communication from doctors and nurses reduced fear and enhanced confidence; and (4) Coping through faith and mutual support religious practices, prayer, spousal communication, and sharing comfort with other parents emerged as dominant coping strategies. Parents emphasized spirituality (Tasbih, supplications) as their primary source of resilience, alongside emotional reassurance from family and peers. **Conclusions:** Parents of children in isolation units face severe psychological, social, and financial stress. Coping strategies centered on faith, family communication, peer reassurance, and medical assurance were vital in maintaining resilience. Culturally sensitive, family-centred interventions are essential to strengthen parental coping and reduce distress.

INTRODUCTION

Stress is described as a psychological and physiological reaction to apparent problems or threats that are above the coping capacity of an individual [1]. Coping mechanisms are behavioral or cognitive actions that are consciously employed in order to deal with stressors [2]. Parents are nurturers who are critical in the physical, emotional, and social support of their offspring [3]. Isolation units: These are special hospital sections that house patients infected with contagious illnesses or those with low immunity as a way of isolation and preventing infection spread to the rest. The knowledge of stress and coping mechanisms in parents whose children work in isolation units is critical to holistic care in a family [4]. Stress levels of parents whose children are in the hospital are so high that there has been a record of a high rate of up to 70 % stress among parents of these children. It has been found that parents whose children are admitted to isolation units tend to have an even greater level of stress than parents whose children are in general and non-isolation wards. The most common ones include anxiety, depression, and helplessness [5]. According to studies that have been done in Asian nations, it has been noted that 60 - 80% of mothers and 40-60% of fathers who have children in the isolation units of hospitals are highly psychologically distressed. This prevalence is so

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high that systematic evaluation and support systems are necessary to reduce parental stress within hospital settings [6]. Children being kept in isolation units due to hospitalization lead to emotional stress because of the critical state of the child, fear of infection, as well as minimal access to a parent. Visitation policies and lack of direct involvement are some of the factors that make parents feel powerless. These emotional issues add up to the psychological burden and may harm the parent-child relationship and the process of child recovery [7]. Parental adaptation revolves around coping strategies. Problem-focused coping involves the pursuit of medical information, the continued participation in child care, and bargaining with the medical staff [8]. Emotion-oriented coping involves spiritual coping, denial, avoidance, or social support. The combination of both strategies is common among parents, as some tend to rely on their cultural, social, and personal backgrounds. The success of coping mechanisms would be a major determinant of the psychological outcomes and resilience of parents in the long run [9]. Parental stress and coping are greatly affected by social and cultural contexts. In collectivist societies, it is more likely that extended family support and religious coping are the more likely approaches, whilst in individualistic societies, it might be more likely to focus on self-reliance and psychological counseling [10]. This knowledge of these differences is of utmost importance to the healthcare workers in designing interventions that are sensitive to culture and parental preferences [11]. The role of healthcare givers in alleviating the stress of parents cannot be underestimated. Physicians and nurses can reduce suffering through providing timely information, including parents in care planning, and psychological support [12]. The involvement of parents in teaching on infection control also boosts confidence and lessens doubt. The holistic care of the supportive services in the isolation units has to therefore offer a holistic care which is beyond the patient and to the well-being. The literature on stress and coping techniques of parents in isolation units is also insufficient, especially in the low- and middle-income countries. Previously discussed factors, such as limited resources, the cultural stigmatization of infectious diseases, and the lack of support systems at a hospital, are unique to the challenges of parents in such situations and should be investigated more thoroughly.

This study aims to investigate the stress and coping behavior of parents of children admitted to isolation units to provide evidence on interventions that enhance the mental health of parents and child care outcomes.

METHODS

The approach used to conduct a qualitative study involved the investigation of the stress and coping mechanisms of parents of children who were admitted to isolation units. This design permitted a deep comprehension of the personal experiences of parents, and at the same time selected different views of various cases. It was carried out in Peshawar, Khyber Pakhtunkhwa, pediatric isolation units of the large state-owned hospitals, where children with contagious diseases are treated. The experiment was conducted from December 2023 to May 2024, to include the changes in parental stress and coping during various medical conditions. The study was initiated with the help of ethical approval. The participants were told about the objective of the research, the right to withdraw at any point, and the confidentiality. The pseudonyms were used in transcripts and reports in order to create anonymity. Data storage was done securely and was only accessible to the research team. Written informed consent was obtained after explaining the study in Urdu or Pashto. Participation was voluntary, with the right to withdraw anytime. Confidentiality was ensured through pseudonyms and secure data storage. The purposive sampling technique was employed to sample 12 parents, and the sample was finally arrived at due to data saturation. Eligible parents were identified with the help of healthcare staff in pediatric isolation units. Those who met the inclusion criteria were approached individually, informed about the study, and invited to participate. From these, 12 parents who provided written consent were enrolled until data saturation was achieved. The sample size of 12 was considered sufficient as qualitative research emphasizes depth rather than breadth. Data saturation was reached when no new themes emerged, making the number appropriate for capturing diverse parental experiences in this context. They were included based on the exclusion criteria that included a patient having stayed in the isolation unit for at least one week, being 18 years and older, and needing to speak Urdu or Pashto. Neither mothers nor fathers were left out in having different viewpoints. Parents who were not willing to take part were locked out. Informed consent was written with the help of healthcare professionals, and eligible participants were identified. Interviews lasted 30–45 minutes in a private hospital room, using an open-ended guide to ensure consistency across participants while allowing flexibility for personal experiences. Data were collected through face-to-face semi-structured interviews using an interview guide with open-ended questions exploring stressors, coping strategies, and their effectiveness. Interviews were audio-recorded with consent and later transcribed for analysis. Interpretation of the interview transcripts was done using thematic analysis. Data were open-coded in order to identify the key ideas, and then there was an axial coding process to narrow down the categories and a selective coding process to come up with overarching themes on stress and coping. Transcripts were first open-coded line by line, then

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grouped into categories through axial coding, and finally refined into overarching themes using selective coding. Illustrative quotes were linked to each theme to maintain a clear connection with the raw data.

RESULTS

The study included 12 parents (P1–P12) of children admitted to pediatric isolation units. Their ages ranged from 28 to 45 years, with most participants between 30 and 40 years. Seven participants were mothers, and five were fathers, ensuring both maternal and paternal perspectives. Education levels varied, with some having no formal education while others were graduates, reflecting diverse literacy backgrounds. Occupations ranged from housewives and farmers to teachers, drivers, and healthcare workers, showing socioeconomic diversity. Monthly household income ranged between PKR 15,000 and 60,000, highlighting financial strain in lower-income families. Mothers (n=7) were primarily housewives, while fathers (n=5) contributed through varied employment. This demographic diversity provided a broad understanding of parental stress and coping strategies across different social and economic contexts (Table 1).

Table 1: Demographic Characteristics of Participants (P1–P12)

Participants	Age (Years)	Gender	Education Level	Occupation	Monthly Income (PKR)	Relation to Child
P1	28	Female	Secondary	Housewife	25,000	Mother
P2	35	Male	Graduate	Teacher	55,000	Father
P3	32	Female	Primary	Housewife	20,000	Mother
P4	41	Male	Higher Secondary	Shopkeeper	40,000	Father
P5	39	Female	No Formal Education	Housewife	15,000	Mother
P6	30	Female	Graduate	Nurse	50,000	Mother
P7	45	Male	Secondary	Farmer	30,000	Father
P8	33	Female	Higher Secondary	Housewife	35,000	Mother
P9	37	Male	Graduate	Office Worker	60,000	Father
P10	29	Female	Secondary	Housewife	28,000	Mother
P11	42	Female	Primary	Housewife	22,000	Mother
P12	36	Male	Graduate	Driver	45,000	Father

Theme 1: Faith and Spirituality as an Arc of Resilience: Parents were in a state of strong emotional distress after their child lived in the isolation unit, and these feelings were revealed through feelings of anxiety and fear. The fact that they could not be certain about what was wrong with the child and that there was no control over the process of treatment made them vulnerable and emotionally exhausted. This psychological burden of the situation was manifested in many parents who were constantly worried about the outcome and spent sleepless nights. The feeling of helplessness was frequent in parents, who did not feel any power to alleviate suffering in their child or accelerate the healing process. These emotions were exacerbated by the limited surroundings of the isolation unit because parents could not carry out regular caregiving duties and activities. One of the participants confessed that at night, he would weep without saying words, as he did not know how long his child was going to remain in the isolation room, and he could do nothing but see how his child was suffering. This line describes the agony that parents had to go through when in the hospital. These feelings were further enhanced by the alienation of family life and regular social life. Parents explained that because they were so concerned about the hospitalized child, the rest of the family members were unable to connect with them, which resulted in an emotional imbalance. The mixture of anxiety, fear, and distance created a mood of constant anxiety, highlighting how isolated care had taken its psychological toll on them. Theme 2: Mutual Support and Open Communication: parents have become significantly faced with social and financial problems when the child stays in the isolation unit. A lot had to forego work or their day-to-day duties, and this further burdened the family. The long-term care in hospitals affected the routine, poor relationship, and their reliance on others to manage the household, further worsening their already stressful condition. The financial problems were more pronounced for the parents who depended on the wages they earn daily or from small companies as their main source of income. The fact that they had to stay in the hospital resulted in the total loss of income, which directly affected their capacity to cover household costs and costs related to medicine. One of the parents said that she lost her daily income as she had to stay with the child, and even close relatives shunned us due to fear of infection. This is an indicator of the joint impact of economic instability and loss of social support. The social isolation was an additional source of stress, and friends and extended relatives tended to keep a distance because of being scared of getting infected. Parents reported their feelings of being abandoned or stigmatized because they were no longer able to be supported by the support networks they normally depended on. The financial

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insecurity, coupled with a lack of social interaction, created a loop of tension, and parents had to grapple with a series of other issues in addition to the sickness of child. Theme 3: Relationship of Trust and Reassurance by Healthcare Workers: Thousands of parents got strength by faith, spirituality, and prayer, even though their child was in a hospital bed at a time when most parents found hope and support in these three areas. The belief in divine intervention soothed their emotional pain, and they could cope in the face of the uncertainty of being isolated. When parents could not cope with the situation and had to endure numerous stresses, they often resorted to religious measures, i.e., reciting verses or consulting a religious leader to gain some strength. Although little, the support systems were effective in reducing the burden. Certain parents pointed out the emotional support of spouses, siblings, or close friends who would visit frequently. One of them told me, when I prayed, I felt better, and when my husband consoled me, I felt that I was not all alone. This underscores the combined role of both faith and supportive relationships in sustaining parents' emotional well-being during a difficult period. Healthcare staff were also mentioned as a crucial source of support, particularly when they showed empathy and communicated effectively. Parents valued the reassurance given by nurses and doctors, as it reduced fear and strengthened their ability to cope. Together, faith, family, and healthcare providers created a buffer against the stressors of isolation, enabling parents to maintain hope and resilience despite adversity. Theme 4: Sharing Comfort and Hope with Others: Parents expressed that supporting other families in similar situations became an important coping mechanism during their child's hospitalization. Sharing personal experiences and encouraging words helped them create a sense of solidarity with others facing the same struggles. By exchanging stories of recovery and resilience, they cultivated collective strength and eased the isolation that many felt within the hospital setting. Providing reassurance to others also gave parents a sense of purpose and agency amidst their own uncertainty. One parent said, *"In this way, I also give comfort to other parents. We believe that Allah is the one who gives health."* This reflects how faith was not only a personal coping strategy but also a foundation for uplifting others. Encouraging fellow parents reinforced their own hope and helped them focus on positive outcomes. Through these interactions, parents built small but meaningful support networks, turning individual suffering into shared resilience. As one participant shared, *"We reassure others that our child was in a perilous condition, but now, thankfully, he has recovered."* Such exchanges reduced feelings of helplessness, fostered hope, and highlighted the power of compassion in coping with the challenges of caring for a child in isolation (Table 2).

Table 2: Thematic Analysis of Parental Stress and Coping Strategies

Theme	Description	Illustrative Quotes
Faith and Spirituality as a Pillar of Strength	Parents relied on religious practices, prayer, and belief in Allah as key coping mechanisms that provided hope, peace, and emotional strength.	"We mention Allah in tasbih to reduce our anxiety, and because of this, we get peace." "Engaging in prayers and supplications, and regularly visiting the mosque, helps alleviate our stress." "We believe that Allah is the one who gives health."
Mutual Support and Open Communication	Open communication within families, particularly between spouses, reduced stress and fostered emotional support.	"We talk to each other, which reduces our stress to a great extent." "She talks to her husband on the phone to reduce her stress." "She is very worried, so I tell her that the baby is getting better, now drink it, and we will know."
Trust and Reassurance from Healthcare Workers	Clear communication and reassurance from doctors and nurses provided confidence and reduced parental anxiety.	"The doctors reassure us that the baby will be fine, and hence our stress is reduced." "The doctor was telling me that he has measles and that it is not that dangerous... which has reduced our worries to a great extent." "We are just awaiting the results of this test."
Sharing Comfort and Hope with Others	Parents supported other families in similar situations, sharing experiences and reassurance to build collective resilience.	"In this way, I also give comfort to other parents... We believe that Allah is the one who gives health." "We reassure others that our child was in a perilous condition, but now, thankfully, he has recovered." "We tell other parents that there is nothing wrong with their isolated child because your child suffers; other children suffer."

DISCUSSION

The results of this research were that there was great emotional distress to the parents who were full of anxiety, fear, and helplessness about their child being in isolation units. Similar findings have been reported in earlier studies, which showed that hospitalization of children, especially under isolation, causes significant psychological distress among caregivers due to uncertainty and disruption of family life [13]. Nevertheless, in comparison with the studies carried out in high-resource environments where psychosocial support programs are

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more accessible, the present study pointed out that the lack of external support added to the emotional burden. This highlights that the background of coping resources is highly context-specific, depending on the healthcare setting. The social and financial strain is yet another reason for stress in parents that was identified in the study. According to the respondents, the shortage of income, work-life imbalance, and the decline of social support were caused by stigma and fear of infection. This is in line with the results of [14], who further indicated that families where children were isolated had financial problems and were socially isolated. On the contrary, research in European countries showed that financial pressure was less pronounced due to the state-financed medical care system [15]. This analogy reinforces the thesis, which is that the socioeconomic and healthcare situations determine the level and nature of parental stress. In this study, religion and spirituality turned out to be among the primary coping mechanisms because they provided the parents with hope and emotional support. This finding concurs with earlier studies in the highly religious societies, e.g., [16], where prayer and belief in divine intervention played a vital role in alleviating caregiver stress. Conversely, studies conducted in secular contexts emphasized problem-solving and cognitive restructuring as dominant coping strategies [17]. These differences underscore how cultural and religious values shape coping mechanisms, with faith serving as a powerful source of resilience in religious societies. The other significant observation was the need to live by supporting each other and maintaining contact in families. Parents who talked about their fears with their spouses and close family members reported feeling more relieved and connected. This finding supports the work of Kasat *et al.* [18], who emphasized the protective role of family cohesion in pediatric hospitalizations. Nevertheless, whereas in Western contexts professional counseling services are often integrated as part of communication-based coping [19], the present study revealed little evidence of such institutionalized support. This gap highlights the limited availability of psychosocial care provisions in the local healthcare system. Healthcare professionals' trust and reassurance were found to be vital in the management of parental stress. Parents appreciated effective communication and frequent updates, which led to a decrease in uncertainty and enhanced trust in treatment. This finding is consistent with [20], who reported that parental stress was significantly reduced when medical staff maintained clear and empathetic communication. Conversely, studies conducted in overburdened healthcare systems have shown that poor communication contributes to heightened stress and dissatisfaction. Thus, the present results reinforce the critical role of empathetic provider-parent interactions in parental coping. The issue of comforting other parents and offering hope expressed the role played by peer support in resilience. Parents reported feeling stronger when sharing experiences, inspiring others, and narrating success stories. This highlights the therapeutic value of community-based peer support in mitigating parental stress. On the whole, the results of the present research confirm and extend existing literature by demonstrating both universal and context-specific aspects of parental stress. Emotional distress, economic pressure, and reliance on support systems were consistent with global findings, while the prominence of faith and spirituality made the present context distinctive. Therefore, interventions must not only address financial and psychological stressors but also integrate culturally grounded coping strategies such as faith-based counseling and peer support programs. These insights can guide healthcare practitioners and international scholars in developing holistic and culturally appropriate support systems for parents of children in isolation units

CONCLUSIONS

Parents of children in isolation units' experience profound emotional, social, and financial stress, often fearing for their child's recovery. Despite these challenges, coping mechanisms such as faith, spirituality, family support, trust in healthcare providers, and reassurance from peers help sustain resilience. Stress levels are shaped by cultural, social, and healthcare contexts, emphasizing the need for holistic interventions. Healthcare systems should address not only the medical needs of isolated children but also the psychosocial well-being of their caregivers.

Authors Contribution

Conceptualization: UU
Methodology: UU, HK, FK, AAK
Formal analysis: FK
Writing review and editing: AU, FK, MK

All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

All the authors declare no conflict of interest.

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