Research Article

Türk Fen ve Sağlık Dergisi
Turkish Journal of Science and Health

Volume 2
Number 3
Year 2021
Pages 67-77

e-ISSN: 2717-7173 https://dergipark.org.tr/tr/pub/tfsd

Received: 24.05.2021 *Accepted:* 26.09.2021 https://doi.org/10.51972/tfsd.941683

The Effect of Religious Coping Strategies Used During the Care Process on Quality of Life of Caregivers of The Elderly Patients Hospitalized in Palliative Care Unit and Internal Medicine Clinic

Müjde Kerkez [1]*, **Behice Erci** [2]

[1]Vocational School of Health Services, Şırnak University, Şırnak, Turkey
[2]Faculty of Nursing, İnönü University, Malatya, Turkey

ABSTRACT:
Purpose: This study was conducted with descriptive-correlational design to determine the correlation between religious coping strategies and quality of life of the caregivers of elderly patients, staying in the palliative care unit and internal medicine clinics, during the care process.
Material and Methods: The sample of the study was composed of 69 caregivers of elderly patients staying in the internal medicine clinics and palliative care unit of Sahinbey Research and Application Hospital. Caregiver Information Form, World Health Organization Quality of Life Instrument Short Form and Religious Coping Scale were applied to the participants and the data were analyzed using SPSS 22.0. Log linear model and regression analysis was used to examine the correlation between the scales.
Results: A significant correlation was determined between the caregivers' ages and the quality of life and its subscales (p=0.001). The caregivers did not use religious coping methods as their ages increased (p=0.005).
Conclusion: It was determined that age and financial situation did not affect quality of life of the caregivers. There was a positive correlation between religious coping status and quality of life of the caregivers. Consequently, it was found that religious coping methods used by the caregivers to be at peace enhanced their quality of life. It is recommended for nurses to provide training and counselling to caregivers about how care burden will be used and how quality of life will be enhanced.
Keywords: *Palliative care, Caregiver burden, Religious Coping, Quality of Life*

**Corresponding author: Müjde Kerkez, email: mujde_@hotmail.com*

INTRODUCTION

Old age is defined as individuals' decreased physical power, increased consumption, increased disability, and irreversibly impaired functions of the organism (Bahar et al., 2009). The WHO defines old age as "the decrease in the ability to adapt to environmental factors". Likewise, the WHO defines psychogeriatric aging as "old" for 65 years old and over and "very old" for 85 years old and over (Beğer and Yavuzer, 2012). Aging is a public health issue requiring a multidisciplinary service that concerns the healthcare, social, and economy systems. One of the most important social risks observed in developed communities is the need for aging-related care (Koldaş, 2017). Many countries face population aging. Today, 8.5% of the world population is over 65 years of age. In "An Aging World: 2015" report, it is estimated that this rate would increase to 17% by 2050 and the number of elderly population would reach to 1.6 billion by 2050. America's elderly population is estimated to double over the next 30 years and increase from 48 million to 88 million people by 2050 (Koldaş, 2017). According to TSI data, Turkey's elderly population was 6 million 192 thousand 962 people in 2014, it increased by 16% in the last five years and reached to 7 million 186 thousand 204 people in 2018. 44.1% of that population are male and 55.9% are female. Its rate in

the total population increased from 8% to 8.8% within five years. In accordance with all these data, it is believed that especially the second half of the current century will be "century of elderly people" in Turkey (TÜİK, 2018).

People look for a safe harbor to take refuge in whenever they are in trouble and whenever they are unable to overcome or experience an important loss in their lives. Many people find this safe harbor in religion (Beğer and Yavuzer, 2012). In their study, (Ayten and Sağır, 2015) determined that men interpreted favorably negative events and situations more and tended to ask more for God's help and support compared to women. In a challenging event, religion represents an important part of the coping structure. Religion can structure the character of an event, coping activities and consequences of this event, or may be a result of coping (Kabalak et al., 2013). According to the researchers, people's selecting any of active and passive coping methods is based on the types of religiosity which are tried to be identified (Mattis, 2002). When the results of positive and negative coping are compared, it is better understood why they got these names. This is because positive religious coping methods increase the positive development based on stress, cognitive functions and the probability of reaching spiritual results; whereas, negative religious coping methods reduce the possibility of reaching a spiritual result, the quality of life, and the ability to act independently in daily activities, and increases the possibility of having a depressive temperament. Furthermore, a study demonstrated that positive religious coping methods were used more than negative religious coping methods (Pargament et al., 2004). Religious coping is the use of cognitive and behavioral elements by using religious and spiritual sources in difficult situations (Ayten and Sağir, 2015; Ayten, 2012). In a study on the civil servants' methods of coping with stress, it was stated that the civil servants used coping methods including cognitive and behavioral methods. The study demonstrated that coping in the cognitive dimension can be beneficial if it continues in a controlled manner. In another study, it was reported that those who were satisfied with their job and did not have problems with the administration, developed a more religious attitude (Robinson and Griffiths, 2005). In another study examining prayer as a coping method in adolescents, it was stated that prayer, described as a problem-focused coping style, enables to recognize the problem, to develop alternative ways to solve the problem, to plan and to actively cope by collaborating with the Creator. According to the study, if the stressful life cannot be changed, prayer reduces emotional stress. At this point, prayer also functions in an emotion-oriented coping style by enabling to reinterpret or accept the event (Aslan, 2007). Religion brings satisfactory explanations to situations like death, birth and injustice and increases effectiveness in coping (Ayten, 2012). The studies on the spiritual beliefs and practices of high-risk pregnant women have reported that women's spirituality improves the condition of themselves and their unborn children and is a protective factor in suicide attempts. It is stated religious belief increases pregnant women's self-confidence and ability to cope with crisis (Price et al., 2007; Benute et al., 2011). A traumatic event does not necessarily take place for religious coping process; religion is only as much a part of in the coping process as it is a part of a person's life orientation system. In addition to the benefits provided by religion in coping with the challenging life events and creating a general life philosophy, it can also be asserted that it is also effective in leading a happy and satisfied life. Enjoying life and being happy are among essential criteria for defining mental health. It is generally accepted that people, who are happy and satisfied with their life, have good mental health. It is seen that many factors such as achieving happiness through meaning in life and enjoying life by participating in different activities are associated with life satisfaction (Connor et al., 2003). In a study examining the correlation between life satisfaction, holiday, and regeneration experience, it was found that individuals feel comfortable and independent from work when they have control over what they want to do and they are more satisfied with their general life (Chen and Petrick, 2013). A person's views and expectations about life constitute the characteristics of quality of life; this, of course, differs from individual to individual. When an individual is angry about the events he/she

experiences, questioning the existence of divine power and failing into despair can adversely affect the quality of life. Subjective positive evaluations of the individual who take refuge at the mercy of divine power and hoping can positively affect the quality of life (Şahin et al., 2009; Pargament et al.,2000; Pargament, 1999; Pargament et al.,1990).

Quality of life is generally defined as an individual's physical, social and psychological well-being. The World Health Organization expresses quality of life as "the perceptions of individuals about their position in the culture and values of the society they live in by considering their interests, hopes, standards, and goals" (Arpacı, et al., 2015). In a study examining the effective components on life satisfaction, it was stated the individual's physical and mental health status, lifestyle, and his/her relations with the social environment positively influenced his/her quality of life (Korkmaz et al., 2015). It is stated that health, socioeconomic level, and psychological state of the caregivers negatively affect their quality of life in case of providing long-term care. The caregivers can face situations like depression, anxiety, burnout, impaired physical health, social isolation, and economic obstacles as a result of the care burden they experience (Masat, 2018). In a study examining the effects of daily living activities of the elderly on caregiver's anxiety, it was stated that there was a very strong correlation between daily living activities of the elderly and the anxiety of the caregiver. The impaired health status of the elderly individuals was stated to increase the anxiety and depression levels in caregivers (Mahoney, et al., 2005). Providing a consultancy service prepared in line with the needs of the patient and caregiver enhances the quality of care, reduces the stress burden of the caregiver individual, and enhances the quality of life of the patient (Lampley-Dallas et al., 2001). Increasing the number of centers that can provide care to the patients and easing the access to these centers are important in terms of protecting and maintaining the mental and physical health of caregivers (Tremont, 2010; Tel et al., 2012). There are numerous factors affecting the care burden and quality of life of the caregiver. These factors are examined in three groups including caregiver's characteristics (socio-demographic characteristics, characteristics about affinity with the patient), patient's personal characteristics (disease or cancer-related characteristics) and care-related characteristics (time, intensity, type and changes in activities, etc.). All of these factors also affect the life and experiences of the caregiver (such as disruption in his/her life, economic obstacles, etc.) in addition to the care burden and quality of life (Doğan, 2015). It was reported in the studies that upon increased care burdens of the caregivers of the patients, the prevalence of infectious diseases and depression increased in caregivers, anxiety, stress, burnout, and behavioral disorders were seen in them, negative changes occurred in their health perceptions, and their quality of life were impaired (Aşiret and Kapucu, 2013; Ustaalioglu et al.,2018; Okka et al., 2018). In addition to all of these, palliative care is extremely important in order to integrate spiritual help and support services into the care provided within the scope of the healthcare services and to have healthcare professionals to support caregivers, plan proper multidimensional interventions, apply these interventions routinely, and evaluate their results (Ayten, 2012; Gökulu, 2018). The World Health Organization (WHO) emphasizes addressing the needs of family caregivers and family as one of the primary objectives of palliative care.

MATERIAL and METHODS

Purpose and Type of the Study

The purpose of this study is to determine the effect of religious coping strategies of the caregivers of elderly patients staying in palliative care unit and internal medicine clinics on their quality of life during care process.This study was conducted with descriptive-correlational design to determine the correlation between the religious coping strategies and quality of life among the caregivers of elderly patients staying in palliative care unit and internal medicine clinics during care process.

Hypotheses of the Study

H0: Religious coping strategies do not affect caregivers' quality of life.

H1: Religious coping strategies affect caregivers' quality of life.

Sampling and participant

The population of this study was composed of the caregivers of elderly patients staying in internal medicine clinics (neurology, geriatrics) and palliative care unit of Gaziantep University Sahinbey Research and Application Hospital. Because we aimed to include the entire caregiver population (n= 110) in the study, we did not calculate the sample size and did not use any sampling method. In total, 69 caregivers who provided care to an impaired elderly individual were included in this study, representing 65 % of the target population inclusion criteria were as follows: (i) caregivers who were able to speak Turkish, (ii) lived with an aged care recipient and had been bedridden for at least six months and the elderly individual was 65 years or older, (iii) caregiver who takes care of an elderly patient for at least 15 days in the hospital and It's about being ill with dementia, nutritional deficiencies or health at least 6 years old while living. Exclusion criteria were as follows: (i) being hospitalized in surgical clinics due to short hospital stay.

Data Collection Tools

The researchers collected the data of the study from the caregivers meeting the inclusion criteria using face-to-face interview method within the day-shift working hours between March and May 2021 in internal medicine clinics and palliative care unit of Sahinbey Research and Application Hospital. Data were collected by the investigator through face-to-face interviews with caregivers. The interviews lasted for approximately 40 minutes A caregiver ınformation form, World Health Organization Quality of Life Instrument Short Form and Religious Coping Scale were used. The study's independent variables included socio-demographic characteristics of the caregivers and their problems, caregiving-related characteristics, and religious coping strategies; on the other hand, the quality of the life was the dependent variable of the study.

Caregiver Information Form

The caregiver information form prepared by the researcher includes the evaluation questions about the socio-demographic characteristics of the caregivers, their caregiving-related characteristics, and their problems.

The World Health Organization Quality of Life Instrument Short Form

This questionnaire consists of four domains (Physical health, Psychological health,Social relationships, and Environment) and two items concerning Overall QoL and General health. Higher scores indicate a better subjective QoL (De Vries and Van Heck, 1995). Its Turkish adaptation was carried out Eser et al (Eser et al., 1999). Cronbach's Alpha reliability coefficients of the scale were determined as 0.76 in the physical health subscale, 0.67 in the psychological health subscale, 0.56 in the social relationships subscale, and 0.74 in the environment subscale. In the present study, Cronbach's Alpha reliability coefficients were found to be 0.67 in the social relationships subscale, 0.68 in the physical health subscale, 0.64 in the psychological health subscale, and 0.83 in the environment subscale.

Religious Coping Scale

Religious Coping Scale was developed by Pargament et al., (1988) based on the correlation between coping, religious coping and a series of psychological data of three groups having different life events. This scale has a total of 14 items and 2 subscales including 7 items (Items 1, 2, 6, 8, 9, 11, and 13) for Positive Religious Coping and 7 items (Items 3, 4, 5, 7, 10, 12, and 14) for Negative Religious Coping. Religious Coping Scale was adapted to Turkish population by Eksi in 2001 by conducting its validity and reliability. The scale is a 4-point Likert type scale. In the study by Eksi (2001), it was determined that Cronbach's alpha reliability coefficient was 0.64 for the Positive Religious Coping subscale, 0.63 for the Negative Religious Coping subscale, and 0.69 for the overall scale. In the present study, it was determined that Cronbach's alpha reliability coefficient was 0.74 for the overall scale, 0.76 for the Positive Religious Coping subscale, and 0.69 for the Negative Religious Coping subscale.

Statistical Analysis

The data were analyzed by using SPSS 22.0 statistical package program. Number, percentage, and standard deviation values were used in the data

distribution. Log linear model and regression analysis were used to compare dependent and independent variables.

Ethical Approval

All procedures performed in studies involving human participants were realized in accordance with the ethical standards of the institutional and/or national research committee and with the Declaration of Helsinki and its later amendments or comparable ethical standards. This is an observational study. The Application Hospital Research Ethics Committee has confirmed that no ethical approval was required. İnönü Üniversity ethics committie (23.03.2021/ decision number: 2021/1837) recevied.

RESULTS

The data collected from the caregivers of the patients staying in palliative care unit and internal medicine clinic are present below. It was determined in Table 1 that the average age of the caregivers was 45.42±11.10 (25- 70 years), 66.7% were female, 66.7% were married, 71.0% had children, 40.6% were primary school graduate, 59.4% were unemployed, 52.2% had a middle level of income, 95.7% had social security, and 60.9% had no chronic disease (Table 1).

It was determined that 26.1% of the caregivers were the patients' daughters, 76.8% were living together with the patient, care process of 33.3% took 3-6 hours, 53.7% had difficulties mostly in meeting mostly physiological needs, 47.8% were trying to solve difficulties in patient care without receiving any help, 59.4% saw the care process as a religious obligation, 62.3% had no change in religious dimension during the care process, and 56.5% did not need psycho-social support during the care process (Table 2).

Table 1. Socio-Demographic Characteristics of Caregivers (n = 69)

Introductory Features	Number (n)	Percent (%)
Age (45.42±11.10; 25-70)		
Gender		
Female	46	66.7
Male	23	33.3
Marital Status		
Married	46	66.7
Single	13	18.8
Widowed/divorced	10	14.5
Number of children		
Yes	49	71.0
No	20	29.0
Educational background		
Illiterate	8	11.6
Primary school	28	40.6
High School	13	18.8
Associate degree	2	2.9
Bachelor's degree	18	26.1
Graduate degree	-	-
Working Status		
Employed	28	40.6
Unemployed	41	59.4
Income		
Low	19	27.5
Middle	36	52.2
High	13	18.8
Very high	1	1.4
Social Security		
Yes	66	95.7
No	3	4.3
Chronic disease		
Yes	27	39.1
No	42	60.9
TOTAL	69	100.0

Table 2. Process, Time and Religious Dimension of Care for the Caregivers

Characteristics	Number (n)	Percent (%)
Affinity		
Caregiver	8	11.6
Brother/sister	6	8.7
Spouse	16	23.2
Daughter	18	26.1
Son	11	15.9
Other	10	14.5
Status of Living Together		
Yes	53	76.8
No	16	23.2
Time Allocated for Care		
Doesn't take time	3	4.3
0-3 Hours	18	26.1
3-6 Hours	23	33.3
7-12 Hours	16	23.2
13 Hours and more	9	13.0
Care Difficulties		
Continuous Talking	12	17.4
Committing Violence	2	2.9
Physiological Needs	37	53.7
Suffering	7	10.1
No Care Difficulty	11	15.9
Coping with Care Problems		
Not getting help	33	47.8
Receiving support from family members	23	33.4
Caregiver support	3	4.3
Empathy	10	14.5
Religious Dimension of the Care Process		
I see it as a religious obligation.	41	59.4
I don't see it as a religious obligation.	28	40.6
Change in Religious Dimension		
Praying More	26	37.7
No Change	43	62.3
Need for Psycho-social Support		
Yes	30	43.5
No	39	56.5
TOTAL	69	100.0

Table 3. Distribution of the Mean Scores of the Scales and Their Subscales

Scales And Their Subscales	Scale Min-Max	Scale Mean±Sd
Religious Coping Total Score	**1.00-3.14**	**2.2±0.5**
Positive Religious Coping	1.00-4.00	2.8±0.7
Negative Religious Coping	1.00-2.71	1.6±0.5
Quality of Life Total Score	**43.00-97.00**	**80.36±13.76**
Quality of Independent Domain	2.00-9.00	5.3±1.9
Quality of Physical Domain	13.00-29.00	21.36±3.7
Quality of Psychological Domain	8.00-22.00	15.57±3.5
Quality of Social Domain	3.00-15.00	8.1±2.8
Quality of Environment Domain	12.00-36.00	28.86±6.1

It was determined in Table 3 that the religious coping total mean scores were 2.2±0.5, positive religious coping total mean scores were 2.8±0.7, and negative religious coping total mean scores were 1.6±0.5. WHO quality of life mean scores were 80.36±13.76, independent domain mean scores were 5.3±1.9, physical domain mean scores were 21.36±3.7, psychological domain mean scores were 15.57±3.5, social domain mean scores were 8.1±2.8, and environmental domain mean scores were 28.86±6.1

(Table 3).

Regression analysis indicated that the descriptive characteristics of caregivers, age, perceived income, and Positive Religious Coping Styles affected the quality of life and descriptive characteristics and Religious Coping Styles of the caregivers accounted for their quality of life with a variance of 56% (Figure 1).

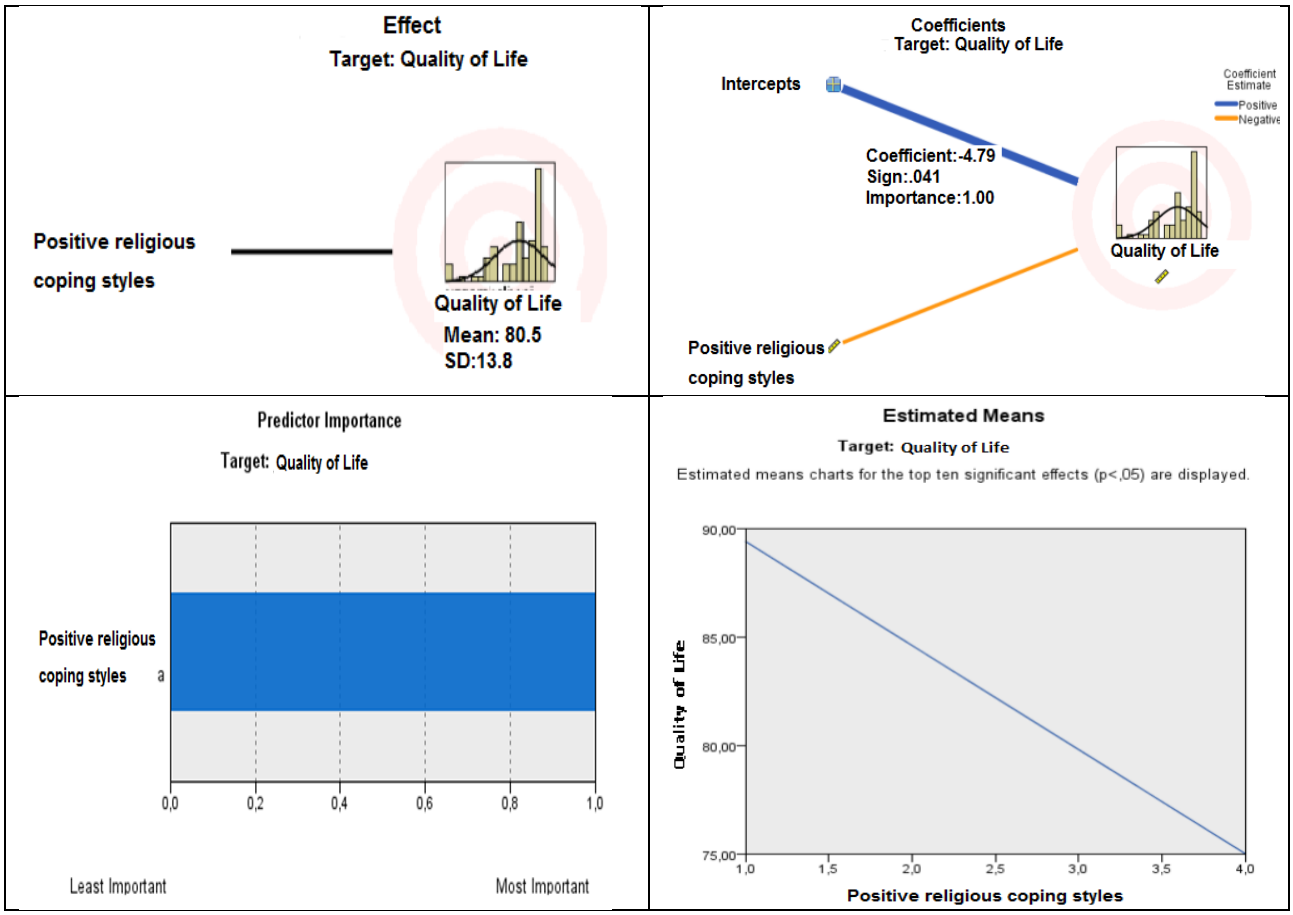

Figure 1. The Effect of Religious Coping Styles of the Caregivers on Their Quality of Life. According to the log linear model, the Positive religious coping of the caregivers was found to be the most important factor affecting the quality of life.

DISCUSSION

In this study assessing the religious coping methods used by the caregiver family members of patients suffering from chronic disease during caregiving process and their quality of life, the characteristics of the caregivers can be said to be similar to the literature (Han et al., 2017; Küçükguclu, 2009; Yeşil et al., 2016).

In the studies, it is stated that family relations of caregivers deteriorate, their family responsibilities are negatively affected, and they experience social, physical, economic and psychological problems due to their caregiving roles. All of these problems are defined as care burden (Gökulu, 2018.). In the present study, it was determined that a majority of the caregivers were the daughter and spouse of the patient, they were residing with the patient, they were unemployed and their economic status was not high. In fact, when the studies are examined, results similar to the literature are seen (Gökulu, 2018; Kalav et al., 2018; Han et al., 2017). This is associated with the necessity of showing respect for the elderly and patients in the family due to tradition and customs in Turkish society and the fact that the children feel gratitude for their parents in terms of care, the caregivers are mostly the children and spouses of the patients, the caregiving roles expected from women are adopted, and women are primary caregiver.

The socioeconomic status of family members was one of the reasons affecting the quality of life (Table 4). Individuals who had economic difficulties experienced more stress and more problems. This negatively affected their life satisfaction. There are studies in the literature reporting that the caregivers with lower socioeconomic level have higher burden and worse health (Aşiret and Kapucu, 2013; Chen and Petrick, 2013; Chen et al., 2015). Caregiver not only meets the care needs of the patient but also helps in issues like buying the medicine, shopping and providing financial support. This brings financial burden along with the care burden. The other studies showed that caregivers having economic problems had lower quality of life and high income level enhanced the quality of life (Hacialioglu et al., 2010). Economic status indicators are one of the important variables predicted by quality of life within the scope of personal social area. This result may be associated with the fact that caregivers with a good income level can identify and monitor the disease-related problems, they apply complicated treatment process without interrupting the treatment of the patients, and they can get better care, thus having a better standard of life.

As the age of the caregivers increases, their quality of life is negatively affected. In their study conducted to determine the quality of life characteristics of individuals aged 65 years and over and the influencing factors through SF-36 quality of life questionnaire, Durduran et al., in their study stated that the quality of life impaired with increasing age. It was also determined in the present study that the quality of life was negatively affected with increasing age (Durduran et al., 2018). In the study by Kalınkara et al., it was stated that caregivers experienced social isolation with age and especially their mental health was affected more by entering a new care process without experiencing exactly the self-sufficiency situation brought by age and their burnout level increased (Kalınkara and Kalaycı, 2017). In young adulthood period, the frequency of applying positive religious coping strategies such as “turning towards God, interpreting favorably, religious begging, religious convergence” increases. This result indicates that individuals question religion more with increasing age. According to Ryff who is known for her works on life satisfaction and well-being of the individual, the relationship between the age and life satisfaction is mostly affected by the evaluations about health and financial situations (Ryff, 1989). Ryff expresses that some of the individuals could better adapt to chronic diseases, weaknesses and dependency experienced along with old age while some others are negatively affected. Likewise, Balcı and Ayten could not find any significant correlation between age and life satisfaction in their study conducted on religious coping (Arvas, 2017; Ayten, 2012). However, age was found to be positively correlated with both life satisfaction and religion in some other researches (Özdemir and Taşçı, 2013). Responding to the difficulties by praising as a religious coping method and seeing these problems as a mean of test can be considered as factors that will affect the quality of life of the individual. In this context, individuals who have problems and are stuck in difficult situation tend to use more frequently religious coping activities both positively and negatively.

The most important factor affecting the quality of life is positive religious coping styles. Positive religious coping involves an individual's attitudes and behaviors to believe that Allah’s actions have a cause and negative life events have a meaning (Cirhinlioğlu, 2014). In positive religious coping, the individual tends to cooperate with Allah, believes that his/her suffering has a spiritual meaning and actively participates in problem solving. Accordingly, the use of positive religious coping mechanisms by individuals strengthens their coping of physical and mental problems. The fact that people evaluate any negative event patiently and as a test of Allah, see what happens to them as a part of spiritual maturation and are able to say "There is a charity in what is occurring" increases their life satisfaction and optimism levels. It is reported that believing in a superior being is always a guide to interpret the individual’s existence and the ultimate object of life and to endure difficulties (Çelimli and Tozlu, 2016). With the increased meaning and purpose of life, it provides additional energy to the person in struggling with difficulties and makes an important contribution to overcome the problems (Çelimli and Tozlu, 2016). Accordingly, the quality of life of

individuals increases as their tendency to interpret favorably any problem, deal with these problems patiently, turn to Allah in the difficult situation, and ask for help from Allah by judging him/herself increases. In this study, high spiritual level of the caregivers may be due to the fact that human beings have always needed to believe in a divine power and seek refuge from a superior being abinito (De, 2014). People's use of positive coping activities in the process of making sense of what happened to them and turning towards Allah enhances their quality of life. These results are compatible with the results of many studies on the correlation between religious coping and quality of life.

Mostly the social and environmental domain quality of life scores of the family members were found to be low. In the study conducted by Fertelli et al. on individuals who provide care to stroke patients at home, they found that the quality of life environment domain scores of caregivers were low (Fertelli and Tuncay, 2019). It was determined in the study conducted by Wong et al. (Wong et al., 2012) on caregivers that the quality of life of caregivers was low in psychological domain and high in physical domain. In their study Tel et al. found that the physical and environmental quality of life of individuals providing care to individuals with lung disease at home was low. The quality of life environmental domain contains items related to the individual's daily activities, recreation, access to information and health perception (Tel et al., 2012). In the present study, it was determined that Positive Religious Coping Styles and age and perceived income from descriptive characteristics of the caregivers affected the quality of life and descriptive characteristics of the caregivers and their Positive Religious Coping Styles explained their quality of life with 56% of variance. This result supports our acceptance ''Religious coping strategies affect caregivers' quality of life''. Even though it is stated in the literature that they use religious coping more with increasing age, it was estimated in the present study that religion was used more in adulthood and it predicted the quality of life together with the socioeconomic status. In the study conducted by Masat with oncologic patients, a positive and weak correlation was stated between the quality of life and religious coping methods (Masat, 2018). In their study conducted to investigate the correlation between the religious coping and life satisfaction in adults, Uysal et al., stated that there was a positive and significant correlation (Uysal et al., 2015). The reason for the differences between the literature and the present study may be the socioeconomic causes and cultural differences.

CONCLUSION

In the study, it was found that the caregivers with low socioeconomic status had low quality of life and young adults prefer religious methods more. It was concluded that the quality of life of the caregivers of elderly patients hospitalized in the internal medicine clinic and palliative care unit increased when they were using positive religious coping styles. In line with these results, to reduce care burden and to increase life satisfaction must be provided multidisciplinary approach (physician, nurse, psychologist, spiritual care professionals etc.) both caregivers and elderly patients. Day care homes should be opened to reduce the burden of care and the patient provide to support services to patients' relatives as well as to their relatives. Problems and solutions proposed in elderly care should be added to the education curriculum.

Acknowledgment

We thank the participants who contributed to our research.

Conflict of Interest

This article did not receive any financial fund. There is no conflict of interest regarding any person and / or institution.

REFERENCES

Arpacı, F., Tokyürek, Ş., Bilgili, N. (2015). Life quality of elderly living in the nursing home. Elderly Issue Research Journal, 1(1), 1–11.

Arvas, F. B. (2017). A review of the relationship between subjective well-being and religious beliefs. Uludag University Faculty of Theology Journal, 26(2), 165–201.

Aşiret, G. D., Kapucu, S. (2013). Burden of caregivers of stroke patients. Turkish Norology Journal, 19(1), 5–10. doi:10.4274/Tnd.60234.

Aslan, Ş. (2007). Investigation of attitudes to deal with biological stress in an organizational environment. Selçuk University Institute of Social Sciences Journal,

18, 67–84.

Ayten, A. (2012). Religious Coping, gratitude and life satisfaction relationship: An ampric study of patients, relatives and hospital staff. Journal of Academic Research in Religious Sciences, 12(2), 45–79.

Ayten, A., Sağır, Z. (2015). Relationship between religiosity, religious coping and depression: A study of Syrian refugees. Marmara University Faculty of Theology Journal, 47, 5. doi:10.15370/muifd.86222.

Bahar, G., Bahar, A., Savaş, H. (2009). Social services for the elderly and the elderly. Fırat Health Services Journal, 12(4), 85–98.

Beğer, T., Yavuzer, H. (2012). Epidemiology of old age and old age. Clinical Development , 25, 1–3.

Benute, G. R. G., Nomura, R. M. Y., et al. (2011). Risk of suicide in high-risk pregnancy: An exploratory study. Revista da Associacao Medica Brasileira, 57(5), 570–574. doi:10.1590/S0104-42302011000500017.

Chen, C. C., Petrick, J. F. (2013). Health and wellness benefits of travel experiences: A literature review. Journal of Travel Research, 52(6), 709–719. doi:10.1177/0047287513496477.

Chen, H. M., Huang, M. F., Yeh, Y. C. et al. (2015). Effectiveness of coping strategies intervention on caregiver burden among caregivers of elderly patients with dementia. Psychogeriatrics, 15(1), 20–25. doi:10.1111/psyg.12071.

Connor, K. M., Davidson, J. R. T., Lee, L. C. (2003). Spirituality, resilience, and anger in survivors of violent trauma: a community survey. Journal of Traumatic Stress. doi:10.1023/A:1025762512279.

Cirhinlioğlu F. (2014). Psychology of Religion. 2. Edition, Istanbul: Nobel Publication Distribution.

Çelimli Ç, Tozlu G. Ş. (2016). Methods and techniques of psychotherapy with spiritually oriented counseling: examples from east and west. Ekşi, H, Cinar, K. Editor, Spiritually Oriented Psychotherapy And Psychological Counseling. 1st Edition, 106-107. Istanbul: Cactus Publications.

De, L. (2014). Old age and social change. Turkish Journal of Social Research, 182(182), 53–60. doi:10.20296/tsad.22722.

De Vries, J. and Van Heck, G.L. (1995). The Dutch version of the WHOQOL-100. Tilburg: Tilburg University

Doğan, T. (2015). Turkish adaptation of the short psychological robustness scale: Validity and reliability study. The Journal of Happiness & Well-Being,3(1), 93–102.

Durduran, Y., Okka, B., Şafak, Ş. et al. (2018). Quality of Life Assessment in Old Age: Example of Public Hospital Admissions. Journal of General Medicine, 28, 3(113-120). doi:10.15321/geneltipder.2018343484.

Eser, E., Fidnner, H., Eser, S. Y. et al. (1999). Psychometric properties of the WHOQOL-100 and WHOQOL-BREF. 3P Journal, Supplement.2, 6-24.

Fertelli, T., Tuncay, F. (2019). The relationship between care burden, social support and quality of life in those who care for the stroke individual. JAREN, 5(2), 107–115. doi:10.5222/jaren.2019.52386.

Gökulu, G. (2018). Factors affecting the quality of life of the elderly aged 65 and over in the center of Canakkale. International Journal of Social Research, 34(7), 666–677.

Hacialioglu, N., Özer, N., Yilmaz, K. et al. (2010). The quality of life of family caregivers of cancer patients in the East of Turkey. European Journal of Oncology Nursing, 14(3), 211–217. doi:10.1016/j.ejon.2010.01.017.

Han, Y., Liu, Y., Zhang, X. et al. (2017). Chinese family caregivers of stroke survivors: Determinants of caregiving burden within the first six months. Journal of Clinical Nursing, 26(23–24), 4558–4566. doi:10.1111/jocn.13793.

Kabalak, A. A., Öztürk, H., Çağil, H. (2013).End-of-life care organization; palliative care. Journal of Intensive Care, 11(2), 56–70.

Kalav, S., Gör, A., Bektaş, H. (2018). Chronic care model in the prevention of recurrent stroke : self-directed care approaches. Izmir Katip Çelebi University Faculty of Health Sciences Journal, 3(2), 27–32.

Kalınkara, V., Kalaycı, I. (2017). Life saturation, burden of care and burnout in individuals providing home care to the elderly, Journal of Elderly Problems Research, 10, 2(19-39).

Korkmaz, M., Germir, H. N., Yücel, A. S. et al. (2015). An analysis of sociodemographic components that influence life satisfaction. International Journal of Peer-Reviewed Psychiatry and Psychology Studies,3(2), 78–111. doi:10.17360/UHPPD.2015310996.

Küçükguclu, Ö., Esen, A., Yener, G. (2009). The burden of care is to examine the validity and reliability of the inventory for Turkish society. Journal of Neurological Sciences, 26(1), 60–73.

Koldaş, L. Z. (2017). What is aging and cardiovascular aging? Turk Kardiyoloji Derneği Arşivi, 45, 1–4. doi:10.5543/tkda.2017.40350

Lampley-Dallas, V. T., Mold, J. W., Flori, D. E. (2001). Perceived needs of African-American caregivers of elders with dementia. Journal of the National Medical Association, 93(2), 47–57.

Mahoney, R., Regan, C., Katona, C. et al. (2005). Anxiety and depression in family caregivers of people with alzheimer disease: The laser-ad study. American Journal of Geriatric Psychiatry. doi:10.1097/00019442-200509000-00008.

Mattis, J. S. (2002). Religion and spirituality in the meaning-making and coping experiences of African American women: A qualitative analysis. Psychology of Women Quarterly. doi:10.1111/1471-6402.t01-2-00070.

Masat, S. (2018). The relationship between the psychological problems and spiritual orientation and religious coping strategies of oncology patients. Institute of Health Sciences, Department of Nursing. Master's Thesis: Ondokuz May University, Samsun-Turkey.

Ustaalioglu, B., Acar, E., Caliskan, M. (2018). The

predictive factors for perceived social support among cancer patients and caregiver burden of their family caregivers in Turkish population. International Journal of Psychiatry in Clinical Practice, 22(1), 63–69. doi:10.1080/13651501.2017.1358370.

Özdemir, Ü., Taşçı, S. (2013). Psychosocial problems and care in chronic diseases. ERU Faculty of Health Sciences Journal was accessed from 1(1), 57–72. http://sbfe-dergi.erciyes.edu.tr/article/view/1051000090.

Pargament, K. I. (1999). The psychology of religion and spirituality? yes and no. International Journal of Phytoremediation. doi:10.1207/s15327582ijpr0901_2.

Pargament, K. I., Ensing, D. S., Falgout, K. et al. (1990). God help me: (I): Religious coping efforts as predictors of the outcomes to significant negative life events. American Journal of Community Psychology. doi:10.1007/BF00938065.

Pargament, K. I., Koenig, H. G., Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. Journal of Clinical Psychology, 56(4), 519–543. doi:10.1002/(SICI)1097-4679(200004)56:4<519:AID-JCLP6>3.0.CO;2-1.

Pargament, K. I., Koenig, H. G., Tarakeshwar, N. et al. (2004). Religious coping methods as predictors of psychological, physical and spiritual outcomes among medically ill elderly patients: A two-year longitudinal study. Journal of Health Psychology. doi:10.1177/1359105304045366.

Price, S., Lake, M., Breen, G. et al. (2007). The spiritual experience of high-risk pregnancy. JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing, 36(1), 63–70. doi:10.1111/j.1552-6909.2006.00110.x.

Robinson, O., Griffiths, A. (2005). Coping with the stress of transformational change in a government department. Journal of Applied Behavioral Science. doi:10.1177/0021886304270336.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personality and Social Psychology, 57(6), 1069–1081. doi:10.1037/0022-3514.57.6.1069.

Şahin, Z. A., Polat, H., Ergüney, S. (2009). Determination of the burdens of care for patients receiving chemotherapy. Ankara University School of Nursing Journal,12(2), 1–9.

Tel, H., Demirkol, D., Kara, S. et al. (2012). Care load and quality of life in care donors of patients with COPD. Turk Thorax Journal, 13(3), 87–92. doi:10.5152/ttd.2012.21.

Tremont, G., Davis, J. D., Bishop, D. S. et al. (2010). in Dementia Caregivers. Dementia, 7(November 2006), 503–520. doi:10.1177/1471301208096632.

TÜİK. (2018). They're old with statistics. Avaliable from: https://hsgm.saglik.gov.tr/depo/birimler/kronik-hastaliklar-engelli-db/hastaliklar/Yasli_Sagligi/raporlar_istatistikler/TUIK_Yasli_Istatistik_2018.pdf. Accessed On: 7.3.2021.

Uysal, N., Şenel, G., Karaca, Ş. et al. (2015). Symptoms seen in patients in palliative care clinic and the effect of palliative care on symptom control. Journal of Pain, 27(2), 104-110. doi: 10.5505/agri.2015.26214

Wong, D. F. K., Lam, A. Y. K., Chan, S. K. et al. (2012). Quality of life of caregivers with relatives suffering from mental illness in Hong Kong: Roles of caregiver characteristics, caregiving burdens, and satisfaction with psychiatric services. Health and Quality of Life Outcomes, 10, 1–9. doi:10.1186/1477-7525-10-15.

Yeşil, T., Çetinkaya, U., E., Korkmaz, M. (2016). Examination of the burden of care and quality of life of caregivers for those with Chronic Diseases. Journal of Health Sciences Gümüşhane University, 5(4), 54–66.