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Research Article

Examining the Relationship among Religious Coping, Burdens, and Life Satisfaction of Those Who Care for the Homebound Elderly

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Abstract

Caregiving is a challenging process for caregivers. When encountering a life stressor, some people turn to a greater power and try to deal with stress through religious rituals. In line with previous findings, it is important to state the difficulties caregivers face and whether religious coping positively affects the burdens and life satisfaction of those who care for the homebound elderly. The objective of this study is to examine the relationship among the burdens, religious coping, and life satisfaction of those caring for the elderly receiving home-care in Zeytinburnu, Istanbul. The results suggest that religious coping does not positively affect caregivers' burdens. It was believed that this result is related to social desirability. Also, a negative correlation was found between caregivers' burdens and their life satisfaction. In this sample, providing care for a very close family member seems to increase a caregiver's burden. In light of these results caregivers should use more active coping ways and for future research it was recommended to focus on effectiveness of other coping ways. These results are discussed in light of the related literature, and recommendations have been presented.

Keywords

Caregivers' burdens • Religious coping • Homebound elderly • Life satisfaction • Caregiving

Evden Çıkamayan Yaşlılara Bakım Verenlerde Dini Başa Çıkma, Bakım Veren Yükü ve Yaşam Doyumu Arasındaki İlişkinin İncelenmesi

Öz

Bakım verme, içinde çeşitli zorluklar barındıran bir süreçtir. Stresli bir yaşam olayı ile karşı karşıya kalındığında bazı insanlar bu stresle başa çıkmak için dini ritüelleri kullanır ve yüceliğine inandığı bir varlığa yönelir. Geçmiş araştırmaların sonuçlarına göre bakım verenlerin karşılaştıkları sorunları belirlemenin yanı sıra dini başa çıkmanın bakım verenlerin yüküne ve yaşam doyumuna etkisini belirlemekte önemlidir. Bu çalışmanın amacı Zeytinburnu'nda yaşayan ve evde bakım hizmeti alan yaşlılara bakım verenlerin; bakım veren yükü, dini başa çıkma tutumları ve yaşam doyumları arasındaki ilişkinin incelenmesidir. Sonuçlara göre dini başa çıkma, bakım veren yükünü olumsuz etkilemiş. Ancak bu sonucun sosyal azruedilebilirlik ile ilişkili olduğu düşünülmektedir. Ayrıca bakım veren yükü ile yaşam doyumu arasında ise olumsuz bir ilişki gözlenmiştir. Yakın bir aile bireyine bakım vermenin bakım veren yükünü arttırdığı gözlenmiştir. Bu sonuçlar ışığında bakım verenlerin daha aktif başa çıkma yolları kullanmalarının daha etkili olabileceği düşünülmektedir ve gelecek araştırmaların farklı başa çıkma yollarının etkililiğine odaklanması önerilmektedir. Bu sonuçlar ilgili literatür ışığında tartışılmış ve öneriler sunulmuştur.

Anahtar Kelimeler

Bakımveren yükü • Dini başa çıkma • Evden çıkamayan yaşlılar • Yaşam doyumu • Bakım

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People live longer ın the 21st century than they did previously; this is considered an accomplishment in terms of developments in medicine and sanitation. However, these developments come with a price: an increased number of people with chronic illnesses and immobile and disabled elderly people. The increased number of elderly incapable of self-care leads to an increased number of caregivers. Caregivers' burdens refer to the physical, emotional and psychological difficulties that come with providing care to an elderly, disabled, or homebound person. Burdens are represented by the caregivers' stress and feelings of pressure and tension (İnci & Erdem, 2008).

In Turkey, the family of the elderly or disabled child usually takes responsibility for being the primary caregiver. A research study conducted with the elderly living in Zeytinburnu suggests that most of the elderly (58.5%) live with their children (Balcı & Dazkır Erdendoğdu, 2015). Being a caregiver for a disabled or elderly person is a major life stressor. Caregiving for an elderly person consists of providing emotional and financial support, arranging doctor appointments, and administering medication. All of these responsibilities have a negative effect on the caregiver's quality of life and is an added burden (Rha, Park, Song, Lee, & Lee, 2015). Providing care to the elderly or people with a chronic illness has also been related to some psychological problems for the caregiver, such as depression, anxiety, feelings of guilt (Lkhoyaali et al., 2015) and helplessness, and fatalistic attitudes (Özlü, Yıldız, & Aker, 2015).

While caregiving is a stressful responsibility, each caregiver copes with this stress differently. Religious coping is one way to cope with such a stressor. Caregivers of disabled children adopt religious coping more to deal with caregiving, such as committing to a higher power, using religious rituals, reading the Quran, gaining power from one's beliefs, and acknowledging the benefits of providing care for a person in need (Karataş, 2011). Another research study has been found where female caregivers adopted more positive religious coping methods than men, and caregivers' life satisfaction was found to positively correlate with religious coping. Applying positive religious coping methods relates with caregivers' increased age (Ayten, Göçen, Sevinç, & Öztürk, 2012).

Caregiving for a homebound person, whether elderly or disabled, requires the full-time presence of a caregiver, which means the caregiver's social and self-care activities become hindered (Altuntaş & Koç, 2015; Lkhoyaali et al., 2015). This negative effect on caregivers' social lives is especially important in younger caregivers (Özel-Kızıl, Altıntaş, Baştuğ, Durmaz, & Altunöz, 2014). Determining the level of hardship caregivers face during the caregiving process is important for ensuring their quality of life and psychological health (Honda, Abe, Aoyagi & Honda, 2014; Yıldırım, Engin, & Başkaya, 2014). Providing care for the chronically ill has negative effects on the caregiver. Some of these negative effects lead to a lower

quality of life and include being unable to meet familial responsibilities, not having support from other family members, and having a low economic status (Yakar-Karabuğa & Pınar, 2013). Caregiving for some patients might last longer than others, when comparing a terminal cancer patient to a disabled child. Caregivers' burdens increase the longer the caregiving process lasts (Atagün, Balaban, Atagün, Elagöz, & Yılmaz-Özpolat, 2011). A caregiver's relationship with the one receiving it is also an important determinant of the psychological effects of caregiving. For instance, in the review of Caceres, Frank, Jun, Martelly, Sadarangani, and de Sales, (2015), female and spousal caregivers for frontotemporal dementia patients were found to be more depressed and experience more distress, sleep disturbances, and burdens than male caregivers. A different research in Turkey examined the psychological and physical effects of caregiving that are found when caregivers experience many hardships in the following areas: physical health, mental health, or obstacles to social interactions (Kılıç Akça & Taşçı, 2005). Caregivers are usually unfamiliar with the specific responsibilities for a certain patient; therefore, they may feel even more hardships in caregiving. One research study has found that knowing one's responsibilities in the caregiving process and receiving familial support lessen caregivers' burdens and depression (Butler, Turner, Kaye, Ruffin, & Downey, 2005).

In light of these findings, the aim of this research is to observe the relationship among caregivers' religious coping, life satisfaction, and burdens in caring for the elderly. The specific objectives of this study are to analyze the difference in caregivers' life-satisfaction scores according to the level of religious-coping usage; the difference in caregivers' burdens when the person being provided care is a relative; whether caregivers adopt more positive or negative religious coping methods when handling the stress of caregiving; and whether any demographic variables influence the relationship among caregivers' religious coping, burdens, and life satisfaction.

Method

This study has been conducted in two stages, the first searching the related literature and the second applying the measurement tools on the study's participants.

The participants of the study are the caregiver residents of the municipality of Zeytinburnu, who provide home care for a homebound elderly person, disabled child, or patient with a chronic disease whom they live with. The inclusion criterion of the study was providing care for a homebound elderly person, disabled child, or patient with a chronic disease. The researchers reached the participants through the Zeytinburnu municipal database which has some demographic information on residents receiving homecare. According to database records, this service was being actively provided to 256 residents. Because this service is provided for various reasons such as

patients who need medical bandages or extremely short-term needs, we only included caregivers of homebound elderly people, disabled children, or patients with chronic diseases. The excluded residents were omitted in order to work with a specific group of caregivers who have been providing long-term care. Through the exclusion criterion, we reached 75 (29.2%) caregivers, five of whom refused to participate. Participation was voluntary and took place in the caregivers' homes. However, some caregivers refused to participate in the study because they thought that revealing information about their religious beliefs was private and they did not want to share. Even though the researcher explained that the aim of this study was to examine religiousness, some of the participants did not participate in the study. The data collection took approximately two months. The caregivers were given a battery of scales while the homecare crew was in their house providing care for the homebound elderly person, disabled child, or patient with a chronic disease. The measurement instruments consisted of an informed consent form, a demographic information form, the burden interviews, the Satisfaction with Life Scale, and the Religious Coping Scale. The following sections provide detailed information regarding the instruments that were used in this study.

Demographic Form

The researchers prepared a demographic form where the participants were asked to answer questions about certain aspects of their lives. The following information was gathered through the demographic form: sex, age, education level, relationship status, economic status, number of children, presence of physical illness, duration of caregiving, relationship with the care recipient, and if they had health insurance.

The variables of the study (caregivers' burden, religious coping, and life satisfaction) were examined using the following measurement tools.

Burden Interviews

The burden interview, developed by Zarit, Reever, and Bach-Peterson (1980), measures the difficulties that caregivers face under the responsibility of caregiving. The scale can be filled by the caregiver or by having the researcher read it to the caregiver. The burden interview measures the different changes in life that accompanies caregiving. As a 5-point self-report scale with 22 items, the burden interview's answers range from 0 (*Never)* to 4 (*Almost Always)*. As the score gets higher, the caregivers' burden increases. İnci and Erdem (2008) studied the psychometric properties of the Turkish version of the burden interview with those caring for the elderly. Twenty-two items from the burden interview are loaded onto one factor; Cronbach's alpha coefficient was found to be .95 and the test-retest correlation coefficient to be .90. These results suggest that the Turkish version of the burden interview is a valid and reliable tool for measuring the difficulties that accompany caregiving.

The Brief Religious Coping Questionnaire (RCOPE)

The Brief RCOPE was developed by Pargament, Smith, Koenig, and Perez (1998) to measure positive and negative methods of religious coping. The scale consists of 14 items and two factors (positive religious coping and negative religious coping). Positive religious coping is represented by items like "Sought help from God in letting go of my anger," and "Tried to put my plans into action together with God." Negative religious coping is represented by items like "Wondered whether God had abandoned me," and "Felt punished by God for my lack of devotion." The scale was adapted to Turkish by Eksi (2001). The adaptation study resulted in similar results regarding the factorial structure of the original scale. The reliability of the scale was measured with a Cronbach's alpha of .69. The Brief RCOPE is a valid and reliable tool for measuring negative and positive religious coping methods among Turkish samples.

Satisfaction with Life Scale

Diener, Emmons, Larsen, and Griffin (1985) developed the scale to measure universal life satisfaction. As a self-report scale, the Satisfaction with Life Scale has five items with a Cronbach's alpha of 0.87, as well as a test-retest correlation coefficient of 0.82. The psychometric properties of the scale have also been examined among the elderly population. The Turkish adaptation of scale was studied among three different samples: university students, the elderly, and correctional officers. According to the results, the scale's Turkish version has a Cronbach's alpha of .89 with one factor. Also, the results of this study suggest that there is a statistically significant positive correlation among the participants' life-satisfaction scores, monthly salary, and current health status. The scores obtained from the scale are negatively correlated with elderly depression (Durak, Durak, & Gençöz, 2010).

The data of the research was analyzed through the Pearson product-moment correlation coefficient, one-way ANOVA, paired-samples T-test, and descriptive statistical analysis using SPSS 21.0.

Results

In this study, data were collected from caregivers of homebound elderly individuals, disabled people, or patients with a chronic illness using three measurement tools: Satisfaction with Life Scale, Religious Coping Scale and burden interviews. According to the results, all scales were valid, reliable, and normally distributed.

The sample consists of 70 participants between 22 and 80 years old. Participants' mean age is 50 years old. The majority of the sample was women (90%), married (78%), elementary school graduates (67%) with an economic level considered to be

fair (62%). For this sample, we aimed to see whether participants smoke, have any disease, and how they perceive their own health. According to results, the majority did not smoke (75%) and reported their health status as fair (50%); only 14% had problems related to blood pressure.

Regarding the caregiving process, most had been in a caregiver position for four to 10 years (39%) or more than 10 years (13%); the majority (70%) provide care to a close family member, such as a wife, husband, mother, or father.

One of the aims of this study is to examine the correlations among participants' scores for the burden interview, Religious Coping Scale and Satisfaction with Life Scale. The Pearson product-moment correlation coefficient was computed to assess the relationship among these. A positive moderate correlation was found among participants' scores from the burden interviews and the Religious Coping Scale, $r = 0.399$, $n = 70$, $p = .001$. A weak positive correlation was found between participants' scores for caregivers' burden and negative religious coping, $r = 0.206$, $n = 70$, $p = .018$.

A negative moderate correlation was found between the burden interview scores and Satisfaction with Life Scale scores, $r = -0.381$, $n = 70$, $p = .001$. These results suggest that as a caregiver's burden increases, religious coping also increases. However, as a caregiver's burden increases, life satisfaction decreases.

The relation between the caregiver and care-receiving person was predicted to affect a caregiver's burden negatively. One-way ANOVA test was run to see whether being a caregiver's family member differs in terms of the scores received from the burden interviews. There was a statistically significant difference between participants' relation to caregivers and their total scores from the burden interview, $F_{(2,67)} = 7.24$, $p = .001$. Three groups of relations to the care-receiver, defined as the patient's child, son-/daughter-in-law, or other (e.g., paid caregiver), differ from each other. The burden of the caregiver was higher for the patient's children compared to the patient's son- or daughter-in-law.

The time spent as a caregiver was predicted to negatively affect caregivers' life satisfaction and burden scores. However, one-way ANOVA results suggest no difference in caregivers' life satisfaction and burden scores in terms of duration of being a caregiver in our sample. The duration of caregiving did not affect using religious coping, either.

Caregivers were asked to rate their current health status from terrible to very good. According to one-way ANOVA test results, participants' caregiver burden scores were affected by their self-reported health status, $F_{(4,65)} = 6.45$, $p = .000$. Post Hoc test results suggest that, as caregivers' self-reported health diminishes, caregivers' burdens increase.

Participants' religious coping scores did not distribute normally; therefore, analyzing this variable was conducted through non-parametric tests. The two subscales of religious coping are positive and negative religious coping. Positive religious coping is predicted to relate to better self-reported health, higher life satisfaction, and less caregiver burden. The participants' scores obtained from positive and negative religious coping subscales did not differentiate according to gender, age, self-reported health, duration of being a caregiver, education level, or relation to the care-receiver.

Discussion

The objective of this research study is to examine the relationship between religious coping, caregivers burden and life satisfaction among caregivers of homebound elderly.

In the literature, the relationship between religious coping and caregiver burden yields contradictory results (Heo & Koeske, 2013; Herrera, Lee, Nanyonjo, Laufman, & Torres-Vigil, 2009; Pearce, Singer, & Prigerson, 2006). According to the results of this study, religious coping seems to have harmful effects on caregiver burden (rather than positive) for this sample. The results suggest that as caregiver burden increases, religious coping increases, as well. Moreover, negative religious coping is found to relate to caregiver burden. These results could be interpreted as religious coping perhaps not working for our sample. This might be due to negative views of God, which might lead to anger towards God for such a responsibility.

As expected, we found a negative correlation between caregiver burden and life satisfaction. Caregiver burden that is related to negative consequences such as lower life satisfaction (Bergström, Eriksson, von Koch, & Tham, 2011; Fianco, Sartori, Negri, Lorini, Valle, & Delle Fave, 2015) accompany the caregiving process; therefore, these consequences are expected to negatively affect caregivers' life satisfaction. While the researchers collected data, caregivers' main problem was weak social interactions as a result of providing full-time care. This lack of social interaction might also cause decreased life satisfaction. Therefore, providing caregivers with a rehabilitation program that emphasizes taking a break from caregiving with the help of other family members, friends, or professional caregivers is important for increasing life satisfaction. In Zeytinburnu, home-care crews provide limited-time substitute caregivers for housebound patients so that the caregiver can take a break from the stress of the responsibility of caregiving to do other things such as shopping.

One of the study's hypotheses is that as the duration of caregiving increases, caregivers' burdens and life satisfaction decrease. However, this hypothesis was not confirmed in our study, perhaps due to the unequal distribution of duration of being a caregiver among the participants.

Participants answered some questions about specific aspects of their lives. One of these questions was their health status. Participants' self-reported health was related to caregiver burden. As a participant's self-reported health diminishes, burden increases. This result is expected because caring for a patient while feeling unhealthy will increase the burden related to caregiving. Furthermore providing care and its accompanying hardships can naturally lead to health impairments.

Differences in terms of demographic variables among the participants who adopt positive or negative religious coping was expected. However, no statistically significant difference between participants' scores for positive/negative religious coping subscales with caregiver's age, gender, self-reported health, duration of being a caregiver, relation to the patient, or education level was found. This was an unexpected result because while visiting the caregivers in their homes, home-care crews observed some caregivers talking about religious coping and how it provided them with a positive attitude towards caregiving. Some research studies have proven that people who adopt positive religious coping positively appraise the stressor in their lives; therefore, adopting positive religious coping led to positive effects and better health (Freitas et al., 2015; Kaliampos & Roussi, 2015; Maltby & Day, 2003).

Like any other study, the current research has its limitations. This study was conducted on caregivers living in Zeytinburnu, a cosmopolitan neighborhood of Istanbul. In Zeytinburnu, we only reached caregivers who had applied to the municipality to receive some form of care for homebound residents, such as the elderly, disabled, or patients with a chronic illness. In our sample, caregivers' genders were not equally distributed; therefore, this inequality might have affected the results. Also, reaching mostly female caregivers living in Zeytinburnu decreases the generalization of results. For this study, we only observed religious coping among caregivers. However, future research should focus on intrinsic or extrinsic religious orientation, whether differences in religious orientation cause one to adopt different religious coping styles, and whether how one views God affects caregivers' religious coping. However we still believe that the results regarding religious coping might be affected by social desirability because the validity results show the sample understood the questions correctly and continued to talk about how turning to God helps them cope with the responsibility of caregiving during the data collection. Therefore, we believe that the results in this study might be different if the data was collected through interviews.

In accordance with the study's results, the following recommendations are made for municipalities and their social services: provide informative seminars for caregivers, arrange social support groups for caregivers to share their needs and experiences by providing the substitute caregivers, determine caregivers' personal needs, and lead

them to individual psychotherapy as needed. It is also important to include the whole family in the process. All family members should be informed about the difficulties of caregiving and encouraged to be more sympathetic to the caregiver. As a result, all family members should be encouraged to share the responsibility of caregiving. This should include taking turns providing care so that no single member of the family provides full-time care but instead can take some time off from the demanding responsibility of caregiving. In line with the results of this study, encouraging caregivers to utilize more active coping methods might be useful in order to decrease the burden, as religious coping, instead of working, had harmful effects for this sample. Future studies might examine the effectiveness of other coping styles that caregivers' adopt. Therefore, more thorough interventions can be conducted over caregivers of the homebound elderly.

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