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RESEARCH ARTICLE / ARAŞTIRMA YAZISI

The Relationship Between Loneliness Religious Coping and Care Burden in Primary Caregivers of Individuals with Mental Disorders

Ruhsal Bozukluğu Olan Bireylerin Birincil Bakım Verenlerinde Yalnızlık ve Dini Başa Çıkma ile Bakım Yükü Arasındaki İlişki

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Abstract:

This study aims to examine the relationship between loneliness, religious coping, and care burden among primary caregivers of individuals with chronic mental disorders. The study used a cross-sectional, descriptive, and correlational research design. A convinience sampling technique was used, and the sample included 250 primary caregivers of individuals with mental disorders. Data were analyzed using multivariate linear regression analysis. The results showed that caregivers had moderate levels of loneliness, their use of positive religious coping was relatively high, and their use of negative religious coping was moderate. Care burden levels were also moderate. A one-unit increase in loneliness raised the care burden by 0.316 units ($p < .001$), while positive and negative religious coping had no significant effect on care burden ($p > .05$). These findings suggest that loneliness significantly affects care burden, and the two factors are closely linked. These findings suggest that loneliness is a significant predictor of care burden, highlighting the critical role of social and emotional support for caregivers. Providing structured social support programs, caregiver support groups, and psychological counseling may help reduce loneliness and, in turn, alleviate care burden. These results emphasize the need for targeted interventions to enhance caregivers' well-being and improve their ability to manage caregiving responsibilities effectively.

Keywords: Care burden, mental disorder, religious coping, loneliness.

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Öz:

Bu çalışma, kronik ruhsal bozukluğu olan bireylerin birincil bakım verenlerinde yalnızlık, dini başa çıkma ve bakım yükü arasındaki ilişkiyi incelemeyi amaçlamaktadır. Çalışmanın tasarımı kesitsel, tanımlayıcı ve ilişki arayıcı araştırma desenidir. Amaçlı örnekleme tekniği kullanılan araştırmanın örneklemini 250 ruhsal bozukluğu olan bireyin birincil bakım vereni oluşturmuştur. Veriler çok değişkenli doğrusal regresyon analizi kullanılarak analiz edilmiştir. Bakım verenlerin yalnızlık düzeyleri orta seviyede, pozitif dini başa çıkmayı ortalamanın üzerinde, negatif dini başa çıkmayı ise orta düzeyde kullandıkları belirlenmiştir. Bakım yükü düzeyleri de orta seviyede tespit edilmiştir. Yalnızlık düzeyindeki 1 birimlik artışın, bakım yükünü 0,316 birim artırdığı bulunmuş ($p<.001$) ancak pozitif ve negatif dini başa çıkma ile bakım yükü arasında anlamlı bir ilişki saptanmamıştır ($p>.05$). Sonuçlar, yalnızlığın bakım yükü üzerinde önemli bir etkisi olduğunu göstermektedir. Çalışmanın bulguları, yalnızlık ve bakım yükünü hafifletmek için sosyal destek gruplarının oluşturulması, psikolojik danışmanlık hizmetlerinin sağlanması gibi müdahalelerin önemine işaret etmektedir. Bakım verenler için yapılandırılmış sosyal destek programları, destek grupları ve psikolojik danışmanlık sağlanması yalnızlığın azaltılmasına ve dolayısıyla bakım yükünün hafifletilmesine yardımcı olabilir. Bu sonuçlar, bakım verenlerin iyi oluşunu artırmak ve bakım verme sorumluluklarını etkili bir şekilde yönetme becerilerini geliştirmek amacıyla hedefe yönelik müdahalelere duyulan ihtiyacı vurgulamaktadır.

Anahtar Kelimeler: Bakım yükü, ruhsal bozukluk, dini başa çıkma, yalnızlık.

Introduction

Mental disorders represent a significant global health concern, impacting the lives of millions around the world (Chan et al., 2022). These conditions not only impact individuals directly but also place significant stress and burden on their family caregivers. Mental disorders often necessitate prolonged and intensive caregiving, leading family caregivers to encounter substantial physical, emotional, and social difficulties that significantly impact their daily functioning (De Bruyne et al., 2024; Thomas et al., 2024). Primary caregivers, in particular, carry a unique responsibility, devoting a substantial portion of their time to the care of their loved ones (Alves et al., 2024; Özkan et al., 2024).). As caregiving responsibilities increase, the role becomes more demanding, unbalanced, and prolonged (Lok & Kerime, 2018). Over time, these responsibilities can lead to a range of difficulties, significantly impacting caregivers' overall well-being (De Bruyne et al., 2024).

The caregiving burden increases both physically and psychologically as caregivers navigate the challenges of providing care. In addition to the practical difficulties of meeting a patient's daily needs, caregivers also face emotional and social pressures that contribute to their overall burden (Piran et al., 2017). Increased levels of care burden may adversely impact caregivers' quality of life, potentially resulting in outcomes such as social isolation, burnout, and a range of mental health issues (Gümüş & Kaçan, 2024; Chan & Lam, 2018; Hasson-Ohayon et al., 2017).

These challenges are often intensified by feelings of loneliness. Loneliness is a negative emotional state that arises when an individual's social relationships fail to meet their expectations or needs (Sarıçam, 2023). Caregivers of individuals with chronic mental disorders face not only physical and emotional strain but also significant social and psychological difficulties (Guan, Poon, & Zwi, 2023; Zhang et al., 2021). Among these, social isolation stands out as one of the most pressing challenges, leading caregivers to withdraw from their social environments and lose access to support systems (Guan et al., 2023). Given that caregiving requires substantial time and emotional investment, many caregivers feel compelled to limit social interactions and disengage from previously routine activities (Guan et al., 2023).

Caregivers who lack adequate social support and experience persistent loneliness may find their responsibilities increasingly exhausting and overwhelming (Zhang et al., 2021). In this context, loneliness emerges as a key factor that exacerbates the caregiving burden (Hua et al., 2024). Evidence suggests that loneliness not only intensifies physical and psychological strain but also undermines caregivers' emotional resilience (Hua et al., 2024; Zhang et al., 2021). Existing research indicates that caregivers of individuals with mental disorders (CIMD) frequently experience moderate to high levels of loneliness, a condition that is strongly linked to their perceived care burden (Wang et al., 2025; Cham et al., 2022; Hua et al., 2024).

Most existing studies have been conducted in Western and Asian countries, offering limited insight into how loneliness and caregiving burden interact within diverse cultural contexts. There is a noticeable lack of comprehensive research exploring this relationship in societies like Türkiye, where strong family bonds and a culture of social solidarity are deeply rooted (Lok & Kerime, 2018). The current body of literature on loneliness and care burden primarily addresses the general population or caregivers of individuals with physical illnesses, while those supporting individuals with chronic mental disorders receive comparatively less attention (Kobos et al., 2023; Smith & Victor, 2022). This highlights the need for additional research to more fully explore the role of loneliness in shaping the caregiving experience within specific cultural contexts.

In the reciprocal cycle between loneliness and caregiving burden, the coping mechanisms caregivers adopt to manage stress play a crucial role in shaping this dynamic (Eş et al., 2020; Lok & Kerime, 2018). Evidence suggests that CIMD employ a range of coping strategies—including problem-focused approaches, emotional regulation, avoidant behaviors, and seeking social support—to manage their care burden. These approaches have been extensively examined in the literature (Thakur, Nagarajan,

& Rajkumar, 2022; Walke, Chandrasekaran, & Mayya, 2018). In contrast, the number of studies exploring the relationship between religious coping and caregiving burden remains relatively limited. Religious coping refers to seeking support through spiritual beliefs, rituals, and religious communities to manage stress (Bozkurt & Bulut, 2025). Positive religious coping includes practices such as placing trust in God, praying, and finding spiritual meaning in adversity, while negative religious coping is associated with feelings of divine punishment, abandonment, or religious guilt (Bozkurt & Bulut, 2025).

Existing research has primarily emphasized the benefits of positive religious coping (Nguyen & Nguyen, 2023; Rao et al., 2020; Pearce et al., 2016). Nonetheless, additional research is required not only to investigate the beneficial aspects of religious coping but also to assess the potential negative consequences of negative religious coping strategies on caregivers' burden (Herrera et al., 2009). Additionally, research investigating how religious coping operates across different cultural contexts remains scarce (Triana & Sudjatmiko, 2021; Rao, Grover, & Chakrabarti, 2020). Although religious beliefs, rituals, and community dynamics play a crucial role in shaping individuals' experiences with religious coping, few studies have specifically examined the influence of cultural and religious diversity on these processes (Rao, Grover, & Chakrabarti, 2020).

In Türkiye, religion plays a central role in daily life, influencing individuals' values, social relationships, and coping mechanisms. Within this cultural context, religious coping may serve as a vital psychological and emotional resource, particularly for CIMD. In the collectivist culture of Türkiye, religious beliefs and practices often serve as sources of meaning, emotional comfort, and psychological resilience for caregivers facing the challenges of caregiving. Nevertheless, the influence of religious coping in caregiving contexts remains insufficiently explored. Gaining a deeper understanding of this dynamic could contribute to the development of culturally appropriate, family-oriented interventions aimed at reducing care burden (Mirhosseini et al., 2024; Rashid et al., 2023). Accordingly, the present study aimed to investigate the association between loneliness, religious coping, and care burden among primary CIMD.

Method

Design

The study follows a cross-sectional, descriptive, and correlational design.

Research questions

1. What are the levels of care burden-religious coping-and-loneliness among CIMD?

2. Is there a relationship between caregivers' care burden-religious coping-and-loneliness levels in CIMD?

3. What are the predictors of care burden?

Population and sample

The study population consisted of CIMD receiving treatment at a private psychiatric clinic. To determine the appropriate sample size, the researchers utilized G*Power software (version 3.1.9.2), and at least 154 participants were needed with a 95% confidence interval-99% test power, and 0.312 correlation value (ρ) (Zhang et al., 2021). In order to increase generalizability, the study was completed with 250 caregivers. According to the results of the post-hoc analysis; -the 95% confidence interval-, -ρ = 0.336 correlation value- and the power of the test -with 250 participants- was calculated as 99%. A convenience sampling approach was utilized in the study, and two participants were excluded due to incomplete data. The inclusion criteria required that patients be diagnosed with a mental disorder according to ICD-11, have had a chronic illness for at least 1 year, and be over 18 years of age. Exclusion criteria for patients included the presence of an organic disease or mental incapacity, as well as a serious physical illness. For caregivers, the inclusion criteria required that they be the primary caregiver of the patient, have been providing care for at least six months, be over 18 years old, be literate, agree to participate in the study, and speak Turkish. Caregivers who assumed this role as part of their professional duties (e.g., paid caregivers, social workers) were excluded from study.

The mean age of the caregivers who participated in the study was 45.04±12.71 (min:19, max:78) years, 56.8% were female, 72% were married, 46.8% were employed, and 55.2% perceived their income as moderate. Among the participants, 38.4% identified their son as the primary caregiver. Other demographic and clinical characteristics are presented in Table 1.

Instruments

Information Form

The form includes 10 questions designed to gather demographic and relevant background data (Gümüş & Kaçan, 2024; Hasson-Ohayon et al., 2017; Ciydem, 2024; Kurtgöz and Genç, 2024; Ülger & Söyler, 2025).

Zarit Caregiver Burden Interview (ZBI)

ZBI was initially introduced by Zarit, Reever, and Bach-Peterson (1980). It was later translated and culturally adapted into Turkish by İnci and Erdem (2008, as cited in Avci et al., 2021). The scale includes 22 items that evaluate different aspects of caregiver burden. Items are scored using a 5 point Likert-type format (0-4). The total score can vary between 0-88. A higher total score is interpreted as indicating a heavier perceived burden. The instrument aims to assess the caregiver's difficulties in emotional, physical, and social domains. In both the original and the present study, the Cronbach's alpha coefficient was reported as 0.75 (İnci & Erdem, 2008, as cited in Avci et al., 2021).

Religious Coping Scale (RCS)

The RCS, originally developed by Abu-Raiya and colleagues in 2008. A Turkish adaptation of the scale was later carried out by Ekşi and Sayın (2016, as cited in Bozkurt & Bulut, 2025), ensuring its cultural relevance and linguistic appropriateness. The scale is composed of 10 items. Each sub-dimension is scored separately to reflect the frequency of different coping styles. Higher scores in each section indicate greater use of the respective coping strategy. In terms of reliability, the original version of the scale showed Cronbach's alpha values of 0.91 and 0.86 for the two subscales (Ekşi and Sayın, 2016, as cited in Bozkurt & Bulut, 2025). The Turkish version reported a reliability coefficient of 0.91, indicating high internal consistency.

UCLA Loneliness Scale Short Form (UCLA-6)

UCLA-6 was developed by Neto (2014) and adapted into Turkish by Sarıçam (2023). The scale measures loneliness and has six items. Item 2 is reverse-coded. The total score

represents the individual's degree of loneliness, where higher values denote increased levels of perceived loneliness. In both the original and the present studies, Cronbach's alpha coefficients were reported as 0.77 and 0.75, respectively. The scale was developed to measure individuals' perceived levels of loneliness (Sarıçam, 2023).

Analysis

The data were analyzed using SPSS version 23.0. Independent samples t-tests were conducted for pairwise comparisons, while one-way ANOVA was employed when comparing more than two groups. Post-hoc evaluations were carried out using the Bonferroni correction method. Pearson correlation analysis was utilized to explore relationships between variables, and backward multiple linear regression was performed to identify predictors of caregiver burden. The statistical significance threshold was set at $p < 0.05$.

Ethical issues

Ethical approval for the study was obtained from the Bandırma Onyedi Eylül University Health Sciences Non-Interventional Research Ethics Committee (BOEU-HSNREC) (Approval No: 2024-188; Date: 08.07.2024; Decision No: 2024-7). Additionally, authorization was granted by a private psychiatric clinic. Written consent obtained. Study conducted alignment with Declaration of Helsinki.

Results

As presented in Table 1, no statistically significant associations were identified between the other examined variables and the overall mean score of the ZBI ($p > 0.05$) (Table 1).

Table 1. *Distribution of Individual Characteristics of Caregivers and Patients and Comparison of Mean Scores on the ZBI (n=250)*

Variables	**Number(n)**	**Percentage (%)**	**$\bar{x}$**	**±SS**	**t/F**	**p**
Gender						
Woman	142	56,8	45,99	11,49	t=2.597	**p=0.010***
Male	108	43,2	42,03	12,47		
Age			45,04	12,71		
Marital status						
Married	180	72,0	44,65	11,87	t=0.768	p=0.443
Single	70	28,0	43,34	12,58		
Employment status						
Working	117	46,8	43,70	12,52		
Not working	73	29,2	46,27	11,08	F=1.474	p=0.231
Retired	60	24,0	43,00	12,19		
Perceived income level						
High	39	15,6	45,97	11,98		
Moderate	138	55,2	44,39	12,08	F=0.701	p=0.497
Low	73	29,2	43,16	12,12		
Degree of closeness with the patient						
Wife[a]	28	11,2	41,21	7,82		
Daughter[b]	88	35,2	44,34	12,69	F=2.051	p=0.107
Son	96	38,4	46,18	12,14		
Other	38	15,2	41,60	12,39		
Duration of the caregiving (years)			7,01	7,09		
Gender of the patient						
Woman	113	45,2	43,52	12,31	t= - 1.906	p=0.366
Male	137	54,8	44,91	11,86		
Age of the patient			31,65	12,60		
Duration of illness (years)			7,64	7,57		

Diagnosis		
Major Depressive Disorder	48	19.2%
Bipolar Disorder	41	16.4%
Anxiety Disorder	28	11.2%
Schizophrenia	28	11.2%
Obsessive-Compulsive Disorder	23	9.2%
Panic Disorder	15	6.0%
Sleep Disorders	15	6.0%
Post-Traumatic Stress Disorder	14	5.6%
Eating Disorders	10	4.0%
Substance Use Disorders	9	3.6%
Borderline Personality Disorder	7	2.8%
Alcohol Use Disorder	5	2.0%
Attention Deficit and Hyperactivity Disorder	4	1.6%
Dissociative Disorder	2	0.8%
Delusional Disorder	1	0.4%

*F:One-way ANOVA test; t: Independent sample t test; *: p<0.05; **: p<0.001*

Table 2. *Mean Scores of Caregivers on the Scales*

Scales	X	±SD	Min.	Max.	Scale range
Zarit care burden scale total	44,28	±12,06	21	74	0-88
Positive religious coping	22,27	±4,92	13	28	7-28
Negative religious coping	7,67	±2,72	3	12	3-12
Loneliness	15,24	±3,61	9	24	6-24

The mean total ZBI score of CIMD, the positive and negative religious coping, and the loneliness scores were 44.28 ± 12.06, 22.27 ± 4.92, 7.67 ± 2.72, and 15.24 ± 3.61, respectively (Table 2).

Table 3. *The Relationship between ZBI and RCS, Loneliness and Continuous Variables in Caregivers (n= 250)*

Variables		Zarit care burden scale
Positive religious coping	r	0,032
	p	0,610
Negative religious coping	r	0,108
	p	0,088
Loneliness	r	**0,336****
	p	0,000
Age of the caregiver	r	0,000
	p	0,997
Duration of the caregiving (years)	r	-0,002
	p	0,978
Age of the patient	r	-0,051
	p	0,418
Duration of illness	r	0,001
	p	0,990

Note: r: Pearson correlation coefficient. *: p<0.05, **: p<0.001

Table 3 shows a moderate positive correlation between the total ZBI and loneliness ($r = 0.336$, $p < 0.001$). No statistically significant correlations were observed between the total ZBI and either positive or negative religious coping ($p > 0.05$). Furthermore, the ZBI score did not significantly correlate with caregiver's age, duration of caregiving, patient's age, or disease duration ($p > 0.05$).

Table 4. *Factors Affecting Care Burden in Caregivers (n= 250)*

Variables	**Unstandardized coefficient**		**Standardized coefficient**	**t**	**p**	**95% CI**	
	B	**SE**	**Beta**			**Lower**	**Upper**
(Constant)	29,284	3,344		8,757	0,000	29,284	3,344
Loneliness	1,055	0,202	0,316	5,212	0,000	1,055	,202
Gender of caregiver-Male[a]	-2,498	1,475	-0,103	-1,693	0,092	-2,498	1,475

Note*: F(2, 249)= 17.312, *p<0.001; Adj. R2=0.116. a: reference category: Female. Variables included in the regression model: Positive religious coping, negative religious coping, loneliness, gender of caregiver*.

Table 4 presents the results of the regression analysis conducted to identify the factors associated with care burden. The model accounted for 11.6% of the variance in care burden (Adj. $R^2 = 0.116$, $p < 0.001$). An increase of one unit in loneliness was linked to a 0.316-unit rise in burden level ($p < 0.001$). In contrast, positive and negative religious coping, as well as gender, were not found to be significant predictors of care burden ($p > 0.05$) (Table 4).

Discussion

An observed relationship between loneliness and caregiving burden indicates that as loneliness intensifies, caregivers are more likely to experience elevated levels of burden. This observation aligns with the results of Hua et al. (2024), who identified a link between increased loneliness and greater caregiving stress among CIMD in China. Similarly, Zhang et al. (2021) identified a positive relation between loneliness and care burden in their study population. In contrast, a study by Lok and Kerime (2018) involving primary caregivers of individuals with schizophrenia in Türkiye revealed only a weak positive relationship between loneliness and caregiving burden. Moreover, differing from the current study's results, Saleem et al. (2024) found no significant association between loneliness and care burden in their research with mothers of children with intellectual disabilities. Loneliness may contribute to social withdrawal and reduced access to support systems, leading caregivers to perceive their responsibilities as more overwhelming (Lok & Kerime, 2018; Saleem et al., 2024). Moreover, loneliness may weaken the resilience of caregivers, reducing their ability to manage stress and consequently increasing the caregiving burden. In these situations, caregiving encompasses not only physical duties but also significant psychoemotional challenges.

No significant association was found between positive and negative religious coping and the care burden of individuals providing care for patients with chronic mental disorders. In line with the current findings, previous studies have also reported no significant relationship between religious coping and care burden (Herrera et al., 2009). However, a study on Mexican American caregivers indicated that increased use of negative religious coping was associated with a higher perceived care burden (Herrera et al., 2009). Similarly, Pearce et al. (2016), in their research conducted in the United States, found that caregivers who more frequently employed positive religious coping reported a reduced objective care burden after accounting for non-religious coping strategies. In an Indian study, Rao et al. (2020) reported that caregivers using positive religious coping experienced lower psychological distress and morbidity. In contrast, those relying on negative religious coping exhibited higher psychological stress and were more likely to adopt avoidant coping strategies. These findings indicate that religious coping does not exert a direct or consistent impact on care burden. The findings indicate that religious coping does not exert a direct influence on alleviating care burden. Since religious coping is a mechanism that functions mostly in the inner world of the individual, religious coping may not have a significant effect on the physical, economic and time-related difficulties encountered in daily life. Therefore, religious coping may have limited effect on a more concrete and multidimensional concept such as care burden.

Based on the distribution of scores on the care burden scale, CIMD in the current study were found to experience a moderate level of care burden. Similarly, a study conducted in China by Wang et al. (2025) involving caregivers of individuals with schizophrenia reported comparable results, indicating moderate care burden levels. In addition, Cham et al. (2022) conducted a meta-analysis which revealed that 36.9% of caregivers for individuals with mental disorders experienced care burden at varying levels—mild, moderate, or severe based on the ZBI. Findings from Türkiye align with these results, as Yıldırım, Yalçıner, and Güler (2017) found that caregivers in Türkiye perceived their care burden as moderate to severe. These results suggest that caregivers of individuals with mental disorders worldwide may share similar perceptions of burden. However, findings from Thailand indicate some differences. According to a study by Kaewchum et al. (2025), 29% of caregivers of individuals with schizophrenia reported experiencing a severe level of care burden as measured by the ZBI scale. The variation between Türkiye and Thailand may be attributed to cultural values, family structure, and differences in access to healthcare services. In particular, Türkiye's strong family support system and extended family structure may help reduce the perceived severity of care burden. Additionally, traditional and community-based support mechanisms in Türkiye may help alleviate some of the emotional and physical strain associated with caregiving.

The analysis of caregivers' use of religious coping strategies showed that they scored above the mean in positive religious coping and at a moderate level in negative religious coping. In a qualitative study, Azman et al. (2015) reported that 80% of participants perceived positive religious coping strategies as playing a significant role in alleviating caregiving-related stress. Similarly, a study examining primary caregivers of schizophrenia patients indicated that caregivers frequently relied on positive religious coping (Triana & Sudjatmiko, 2021). In the same study, Islamic and Christian caregivers reported high levels of positive religious coping, whereas Catholic caregivers used these methods at a moderate level (Triana & Sudjatmiko, 2021). Evidence from India indicates that primary caregivers of individuals with schizophrenia exhibited below-average levels of positive religious coping and very low levels of negative religious coping (Rao, Grover, & Chakrabarti, 2020). Similarly, Pearce et al. (2016), in a study conducted in the United States, reported that CIMD engaged in positive religious coping at a moderate level. Variations in positive religious coping across countries may be influenced by cultural, religious, and social factors. In Türkiye, where religious and spiritual values hold an important place in daily life, individuals may have a greater tendency to utilize positive religious coping strategies. The observed moderate level of negative religious coping may indicate that some caregivers perceive their caregiving responsibilities as a form of divine punishment.

Scores obtained from the loneliness scale indicated that participants experienced a moderate degree of loneliness. This outcome is in alignment with findings from a study conducted in China (2021), which reported that 54.7% of CIMD experienced moderate to high levels of loneliness (Zhang et al., 2021). Similarly, Guan, Poon, and Zwi (2023) found that more than half of caregivers in the same population experienced moderate or high levels of loneliness. In another study involving caregivers of dementia patients, 43.7% reported moderate loneliness, and 17.7% experienced severe loneliness (Victor et al., 2021). A study conducted in Türkiye found that CIMD reported above-average levels of loneliness (Altan Sarıkaya, Öz, & Ozturk, 2019). These findings suggest that loneliness is a prevalent issue among CIMD and appears to occur at comparable levels across various cultural settings. However, the lower levels of loneliness reported by caregivers in Türkiye compared to other studies may be influenced by cultural factors, such as family structure and social solidarity. The strong traditional family ties in Türkiye, where family members support each other, may help reduce feelings of loneliness to some extent.

Limitations

A key limitation of this study is its sample, which consisted solely of CIMD receiving treatment at a private psychiatric facility. Consequently, the findings may not be fully generalizable to all CIMD in Türkiye. Furthermore, due to the cross-sectional nature of the study, it was not possible to draw causal conclusions despite the examination of variable relationships.

Conclusions

In this study, CIMD were found to experience a moderate degree of care burden. While they tended to rely heavily on positive religious coping methods, their use of negative religious coping remained at a moderate frequency. Feelings of loneliness among participants were also observed to be at a comparable level. Notably, as loneliness increased by one unit, care burden scores rose by approximately 0.316 points. In contrast, neither form of religious coping—positive or negative—showed a meaningful correlation with care burden within the sample. Overall, these results emphasize that loneliness plays a meaningful role in the caregiving process for CIMD. However, the findings suggest that religious coping mechanisms may not exert a direct influence on the perceived burden in this particular context.

Implications for practice

The results of this study underscore the significance of implementing interventions aimed at reducing loneliness, as it was identified as a key predictor of care burden among CIMD. In light of these findings, facilitating social support groups and related activities may contribute to reducing caregivers' sense of social isolation and, consequently, help alleviate their care burden. Psychological counseling services can be offered to strengthen caregivers' individual resilience and support them in coping with the emotional challenges associated with caregiving. Additionally, training programs focused on stress management and coping strategies can be developed to equip caregivers with the necessary skills to navigate the caregiving process more effectively.

Since religious coping did not show a significant effect on caregiving burden, interventions should primarily focus on reducing loneliness rather than emphasizing religious coping strategies. Given the cross-sectional nature of the current study, future research employing longitudinal designs is required to establish causal relationships and to gain deeper insight into the complex association between loneliness and care burden. Tailoring interventions to the specific needs of caregivers while considering cultural and social factors will enhance their overall effectiveness.

Declarations

Ethics Committee Approval

Ethical approval received from the BOEU-HSNREC (Approval No: 2024-188, Date: 08.07.2024).

Consent to Participate

"All participants gave informed consent."

Consent for Publication

"Not applicable."

Availability for Data and Materials

"Data available on request."

Competing Interests

"None."

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Authors' Contributions

"AA contributed to the study's design, data collection, analysis, methodology, visualization, and writing, and approved the final manuscript."

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