



THE RELATIONSHIP BETWEEN COMMUNITY RESOURCES AND RELIGIOUS SPIRITUAL COPING WITH COPING STRATEGIES IN CAREGIVER ADAPTATION FOR POST-STROKE FAMILY MEMBERS IN KOTAMOBAGU CITY, INDONESIA

HUBUNGAN SUMBER DAYA KOMUNITAS DAN KOPING SPIRITUAL RELIGIUS DENGAN STRATEGI KOPING DALAM ADAPTASI *CAREGIVER* BAGI ANGGOTA KELUARGA PASCA STROKE DI KOTA KOTAMOBAGU, INDONESIA

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Abstract

Post-stroke depression is a major factor that decreases patients' quality of life and influences family caregivers' coping strategies during the recovery process. This study highlights the role of community resources (CR) and spiritual religious coping (SRC) in shaping adaptive coping strategies among family caregivers of post-stroke patients—a perspective that remains underexplored in local community contexts. Using a quantitative observational design, the study involved 200 family caregivers in Kotamobagu City. Chi-square analysis revealed significant relationships between CR ($p = 0.025$) and SRC ($p = 0.032$) with adaptive coping strategies. These findings extend the theoretical framework on the interaction between community-based resources and religious coping in caregiving for post-stroke patients, emphasizing the importance of integrating social and spiritual support systems to enhance caregivers' motivation and resilience.

Keywords : Caregiver adaptation, Community resources, Spiritual religious coping, Post-stroke

Abstrak

Depresi pasca-stroke menjadi faktor utama yang menurunkan kualitas hidup pasien dan berdampak pada strategi koping keluarga dalam proses perawatan. Studi ini menekankan peran sumber daya masyarakat (Community Resources) dan koping spiritual keagamaan (Spiritual Religious Coping/SRC) dalam membentuk strategi koping adaptif perawat keluarga pasien pasca-stroke dimana sebuah pendekatan yang masih jarang diteliti di konteks komunitas lokal.



Penelitian kuantitatif dengan desain observasional ini melibatkan 200 perawat keluarga di Kota Kotamobagu. Analisis menggunakan uji Chi Square menunjukkan bahwa sumber daya masyarakat (Community Resources) ($p = 0,025$) dan coping spiritual keagamaan (Spiritual Religious Coping) ($p = 0,032$) berhubungan signifikan dengan strategi coping adaptif perawat keluarga. Temuan ini memperluas kerangka teoritis tentang hubungan antara sumber daya komunitas dan coping religius dalam konteks caregiving pasca-stroke, dengan implikasi pada penguatan dukungan sosial dan spiritual berbasis masyarakat.

Kata Kunci : Adaptasi *caregiver*, Sumber daya masyarakat, Penanganan religius spiritual, Pasca stroke

1. INTRODUCTION

Stroke is a condition where brain function is disrupted quickly and lasts more than 24 hours due to disruption of blood flow to the brain (Dharma et al., 2020). Globally, stroke rates and morbidity continue to increase (Pitthayapong et al., 2017). The quality of life of acute and chronic stroke patients is influenced by post-stroke depression (Loh et al., 2017). Patients who experience it show a lower quality of life one year after a stroke compared to patients who do not experience post-stroke depression (Ariska et al., 2020).

According to the latest estimates of the Global Burden of Disease (GBD) in 2019, stroke remains the second leading cause of death and the third leading cause of disability worldwide when combined with years of life lost due to disability (disability-adjusted life-years, or DALYs). More than US\$891 billion (1.12% of global GDP) is estimated to cost stroke worldwide (Feigin et al., 2022). Worldwide, stroke is a significant public health problem. Around 5.5 million people die from stroke every year, and 44 million people experience disability. Analysis of data from the GBD 2019 study showed an increase in total stroke incidence of 70.0 from 1990 to 2019, while a decrease in the age-adjusted incidence rate of ischemic stroke of 10% and a decrease in the rate of intracerebral hemorrhage of 29.0 in the same period (Utama & Nainggolan, 2022). In addition to the impact on stroke survivors, the associated disabilities also pose significant challenges for caregivers (Hu et al., 2016).

Data on stroke sufferers in Indonesia according to Basic Health Research data (RISKESDAS) in 2018 reached 713,783 sufferers (10.9%) of the total population of Indonesia. The patients referred to are in all age categories, namely over 15 years. Strokes are often found in people between middle adulthood and the elderly (Ministry of Health Republic of Indonesia, 2019). Even though stroke is the number one cause of disability and number two death in the world after heart disease, around 90% of stroke cases can be prevented by controlling risk factors such as hypertension, smoking, unbalanced diet, lack of physical activity, diabetes, and atrial fibrillation (Direktorat Jenderal Pelayanan Kesehatan Kemenkes RI, 2023).

In 2021, the third highest number of stroke sufferers in Indonesia will be in North Sulawesi Province. In solving this problem, the public must better understand the modifiable and non-modifiable risk factors for stroke (Finny Warouw & Wilar, 2023). In 2023 it will increase to first place nationally according to health worker diagnosis with prevalence (10.8%), followed by Yogyakarta (10.3%), Bangka Belitung, and DKI Jakarta with 9.7 strokes per mile each (Halinda et al., 2023).

The long-term effects of stroke often cause increased stress for patients (Ambrosca et al., 2024). Apart from the patient, the family is also a caregiver for stroke patients (Mirhosseini et al., 2024). One of the duties of family health is to care for family members who experience



health problems, including stroke patients. The duties and roles of this family are called caregivers. Being a caregiver if a family member experiences health problems is their responsibility (Rahmani et al., 2019). A person who provides assistance to someone who is disabled and needs help because of illness or limitations, such as a spouse, child, daughter-in-law, grandchild, sibling, neighbor, friend, or other family relationship, is called a caregiver (Pesantes et al., 2017)

Families as caregivers respond to stressors directly and realize that comprehensive changes are needed within the family unit to restore factional stability, improve family well-being, and increase the happiness of each member. This process is known as family adoption (Graça & Brandão, 2024). Caregivers are tasked with helping with mobility, self-care, patient communication, emotional and psychological changes in post-stroke patients. The more chronic the illness, the greater the burden borne by the caregiver (Karahan et al., 2014).

Meeting the needs of people who have suffered a stroke is a huge task that often requires full time (Kruithof et al., 2016). Therefore, it is important for caregivers to prioritize their own needs and self-care. It is very important for the well-being of the family when caring for a stroke sufferer to take a break and ask for help and support (Jaracz et al., 2014). Stroke survivors and caregivers get help from CR such as respite services, support groups for stroke survivors and caregivers, adult child care, home health services, meal programs, and housewife assistance. If someone has had a stroke, the first thing they should do is ask their nurse, doctor, therapist, stroke care team, or organization that cares for people who have had a stroke for additional information (Stroke Support Association, 2021).

Progress in the rehabilitation and long-term well-being of stroke survivors depends on a shift in focus from a patient-centric approach to a combined patient and caregiver-focused paradigm (Okonkwo et al., 2022). Post-stroke stress disorder can impact the quality of life of stroke sufferers due to psychological trauma caused by past events (Bolgeo et al., 2022). Cognitive and behavioral coping strategies were found to be beneficial for the quality of life of stroke sufferers and the people who help them (caregivers) (Hatefi et al., 2020). Apart from that, spiritual-religious coping is also needed as part of handling stress from patients and caregivers (Kristofferzon et al., 2018). For example, in terms of the meaning of life, the benefits of having spirituality and trust, the comfort gained from having spiritual coping, intimacy and a positive life for caregivers and stroke sufferers (Peters et al., 2019). The aim of this research is to analyze the correlatetion of CR (collective efficacy; social network; social support and access to new contacts and information) and SRC (meaning; benefits; comfort; intimacy; life) with caregiver adaptation strategies.

2. RESEARCH METHOD

Secondary data analysis was conducted using surveys of adults as caregivers, family members who had a stroke family member. This study is quantitative and used designed of analytical observational studies using total sampling techniques. Variables of this study is dependent variable: coping strategies are defined as strategies caregiver performs in the face of stressors caused by adaptation processes in the care of family members with post stroke. Independent variables is community resources is defined as one of the factors that constitute a strategy coping consisting of collective efficacy, social network, social support as well as access to new contact and information. Variable spiritual religious coping is also understood as a factor strategy coping, a religious-based strategy that encompasses meaning, profit, comfort, closeness and life. Data collection



Participants consisted of caregivers of stroke sufferers who lived in Kotamobagu City, Indonesia. Caregivers were recruited from the following seven health care centres: Motoboi Kecil, Kotobangon, Gogagoman, Bilalang dan Upai Community Health Center. This research was held from January to March 2025 in Kotamobagu City. The total population of stroke sufferers spread across seven health centers in Kotamobagu City is 200 sufferers. Sampling uses total sampling is 200 caregivers namely families who care for each patient, only 1 person is sampled according to the inclusion criteria. This study was approved by the research ethics committee at each institution, and written informed consent was obtained from all caregivers. This study instrument uses questionnaires.

Demographic characteristics such as education, occupation, gender, age, and analyzed using descriptive statistics and presented in the form of a frequency distribution table. SPSS statistical software was used to perform statistical analysis. The Chi square test for bivariate analysis. This research also uses research ethics number IRB-2024-03 so that the study results are truly objective.

3. RESULTS AND DISCUSSION

The characteristics of the respondents as well as the independent and dependent variables can be seen in the table below.

Table 1. Demographic information and Related Variables of Participants (n= 200)

Variabels	n	(%)
Education		
Elementary School	1	(0.5)
Junior High School	10	(5)
Senior High School	140	(70)
Diploma	15	(7.5)
Bachelor	34	(17)
Occupation		
Farmer	54	(27)
Private	34	(17)
State Civil Service	10	(5)
Housewife	96	(48)
Retired	6	(3)
Sex		
Male	73	(36.5)
Female	127	(63.5)
Age of Caregiver		
26-35 Years Old	24	(12)
36-45 Years Old	104	(52)
46-55 Years Old	52	(26)
56-65 Years Old	19	(9.5)
>66 Years Old	1	(0.5)
<i>Mean 42,5 (SD)=0.16</i>		
Community Resources:		
Collective Efficacy		
Negative	23	(11.5)
Positive	177	(88.5)
Social Network		
Less	8	(4)



Enough	38	(19)
Good	154	(77)
<i>Social Support</i>		
Less	14	(7)
Enough	30	(15)
Good	156	(78)
<i>Access To New Contact And Information</i>		
Less	13	(6.5)
Enough	27	(13.5)
Good	160	(80)
Spiritual Religious Coping:	n	%
<i>Meaning</i>		
Negative	19	(9.5)
Positive	181	(90.5)
<i>Profit</i>		
Negative	34	(17)
Positive	166	(83)
<i>Comfortable</i>		
Negative	35	(17.5)
Positive	165	(82.5)
<i>Intimacy</i>		
Negative	32	(16)
Positive	168	(84)
<i>Life</i>		
Negative	31	(15.5)
Positive	169	(84.5)
<i>Coping Strategies</i>		
Emotional Based	10	(5)
Problem Based	190	(95)

Source: Primary Data (2024)

Based on table 1, it can be explained that the distribution of respondents based on education is dominated by high school educational background with 140 respondents (70%). The second largest number of respondents had a Bachelor's background, 34 respondents (17%). The third largest number of respondents had Diploma education, 15 respondents (7.5%) and the fourth largest number of respondents had Junior High School education, 10 respondents (5%), Elementary School background 1 respondent (0.5%); The majority of respondents' occupation was as a Housewife (IRT), with 96 respondents (48%), making up the largest number of respondents. The second largest number of farmer was 54 respondents (27%). The third largest were private, namely 34 respondents (17%) and the fourth largest were respondents who worked as State Civil Service with 10 respondents (5%) and retirees, each amounting to 6 respondents (3%). The largest number of respondents were women/female, 127 respondents (63.5%), while men were 73 respondents (36.5%). For the age category, the largest number was in the 36-45 years old category, as many as 104 respondents (52%). The second largest number of respondents were in the 46-55 years old category had 52 respondents (26%). The 26-35 years old category had 24 respondents (12%) with the third highest number. The fourth largest was in the 56-65 year old category with 19 respondents (9.5%) and the fifth largest was in the more than 66 years old category had 1 respondent (0.5%).



Community resources in particular collective efficacy were the most positive with 177 respondents (88.5%), social networking was the best with 154 respondents (77%), access to new contact and information was generally good with 160 (80%). Spiritual religious coping in terms of meaning mostly positive as 181 respondents (90.5%), most positive profit as 166 respondents (83%), comfortable most positive as 165 respondents 82.5%), the most positive intimacy as 168 respondent (84%) and the most life positive as 169 respondents (84.5%).

Table 2. Cross Tabulating Community Resources With Coping Strategies Caregiver Problem-Emotion in Kotamobagu City, Indonesia (n=200)

Community resources	Coping Strategies		Total (n, %)	p-value
	<i>Emotional-Based</i> (n, %)	<i>Problem-based</i> (n, %)		
Collective efficacy				
Negative	3 (13.0)	20 (87.0)	23 (100)	0.035*
Positive	7 (4.0)	170 (96.0)	177 (100)	
Total	10 (5.0)	190 (95.0)	200 (100)	
Social network				
Less	0 (0.0)	8 (100)	8 (100)	0.025*
Enough	4 (1.,5)	34 (89.5)	38 (100)	
Good	6 (3.9)	148 (96.1)	154 (100)	
Total	10 (5.0)	190 (95.0)	200 (100)	
Social support				
Less	0 (0.0)	14 (100)	14 (100)	0.015*
Enough	4 (13.3)	26 (86.7)	30 (100)	
Good	6 (3.8)	150 (96.2)	156 (100)	
Total	10 (5.0)	190 (95.0)	200 (100)	
Access to new contact and information				
Less	2 (15.4)	11 (84.6)	13 (100)	0.025*
Enough	2 (7.4)	25 (92.6)	27 (100)	
Good	6 (3.8)	154 (96.3)	160 (100)	
Total	10 (5.0)	190 (95.0)	200 (100)	

Table 2 explains that community resources (collective efficacy, $p=0.035$; social network, $p=0.02$; social support, $p=0.015$; access to new contact and information, $p=0.025$) have an influence on coping strategies caregiver.

Tabel 3. Cross Tabulating Spiritual-Religious Coping With Coping Strategies Caregiver in Kotamobagu City, Indonesia (n=200)

Spiritual-Religious Coping	Coping Strategies		Total (n, %)	p-value
	<i>Emotional-Based</i> (n, %)	<i>Problem-based</i> (n, %)		
Negative	2 (10,5)	17 (89,5)	19 (100)	
Positive	8 (4,4)	173 (95,6)	181 (100)	0.022*
Total	10 (5,0)	190 (95,0)	200 (100)	
Profit				
Negative	4 (11,8)	30 (88,2)	34 (100)	
Positive	6 (3,6)	160 (96,4)	166 (100)	0.032*
Total	10 (5,0)	190 (95,0)	200 (100)	



Spiritual-Religious Coping	Coping Strategies		Total (n, %)	p-value
	Emotional-Based (n, %)	Problem-based (n, %)		
Comfortable				
Negative	4 (11,4)	31 (88,6)	35 (100)	
Positive	6 (3,6)	159 (96,4)	165 (100)	0.012*
Total	10 (5,0)	190 (95,0)	200 (100)	
Intimacy				
Negative	4 (12,5)	28 (87,5)	32 (100)	
Positive	6 (3,6)	162 (96,4)	168 (100)	0.032*
Total	10 (5,0)	190 (95,0)	200 (100)	
Life				
Negative	4 (12,9)	27 (87,1)	31 (100)	
Positive	6 (3,6)	163 (96,4)	169 (100)	0.032*
Total	10 (5,0)	190 (95,0)	200 (100)	

Table 3 can explain that spiritual religious coping (meaning $p=0.022$; profit $=0.032$; comfortable $p=0.012$; intimacy $p=0.032$; and life $p=0.032$) has an influence on the strategy of coping caregiver patients post stroke.

Table 4. Summary Of Model Graph Result

Correlated	p-Value	Remark
CR Coping Strategies	0.025	Significant
SR Coping Strategies	0.032	Significant



Figure 1. Final Model of Investigation Community Resources and Spiritual Religious Coping That Correlated with Coping Strategies

Discussion

Previously it was known that there was a relationship between community resources with coping strategy caregiver adaptation with a value of $p = 0.025$. This is because at the time of the research data was obtained that community resources were generally adequate, while caregiver adaptation was dominant in providing care based on emotional (emotional adaptation). In stroke recovery and rehabilitation, self-efficacy and motivation are very important. Rehabilitation arrangements and the therapist-patient relationship play an important role in increasing patient self-efficacy and motivation (Gangwani et al., 2022). High knowledge and desire will show positive results in dealing with the disease; Patients who are aware of their



stroke will actively participate in rehabilitation programs, treatment, and schedule hospital visits (Fatmawati & Pradana, 2021).

The results of this study show that there is a influencing spiritual religious coping on caregiver adaptation with p value=0.032. This is because research data shows that spiritual religious coping is generally in the good category and caregiver adaptation is generally carried out on an problem based. After conducting a database search, 2,320 studies were found; however, after applying inclusion/exclusion criteria, 17 studies with 200 caregivers were selected. After repetition, the most common reasons for exclusion were quantitative papers with little or no qualitative data, studies that were unable to differentiate caregiver and survivor data, and unpublished studies such as dissertations. No articles met the inclusion criteria from a reference search of previous reviews (Muldoon et al., 2017).

The quality of life of stroke sufferers needs to be considered because this disease requires long-term treatment, even throughout the sufferer's life (González-Rivera & Rosario-Rodríguez, 2018). Care and assistance from caregivers is needed that is based on emotion but without ignoring the problem (Gholami et al., 2017). The study of Gholami et al. (2017) demonstrates that, in comparison to treatment techniques that solely focus on disability, those that address flexible coping skills and lessen reliance on caregivers can result in notable gains in quality of life. Compared to stroke-related factors and objective cognitive function associated with SCC, anxiety, perceived stress, and fatigue have a significant and independent correlation with post-stroke SCC (van Rijsbergen et al., 2019).

Conceptually, these results also expand on Pargament (2017), theory of religious coping, which emphasizes the difference between positive religious coping (such as gratitude, reflective prayer, and active surrender) and negative religious coping (such as anger toward God or religious despair). This study strengthens the evidence that positive forms of religious coping are closely correlated with more effective problem-based coping strategies, especially in situations of chronic stress such as non-communicable diseases. Thus, this study contributes theoretically to a new understanding of the relationship between spiritual and cognitive dimensions in stress regulation, particularly in highly religious societies.

Critically, the results of this study are consistent with the findings Graça & Brandão (2024), which show that positive religious coping plays a role in increasing cognitive flexibility and reducing dependence on emotion-focused coping strategies. However, unlike the results of the study by Rahayu et al. (2024), in Indonesia, which found that passive prayer and acceptance without reflective action are not always associated with improved problem-solving abilities, this study shows that active spirituality actually supports the effectiveness of problem-based coping. This difference can be explained by the cultural context and values of the respondents' communities, where religiosity is not only practiced as a form of surrender, but also as a source of motivation and meaning in life that encourages adaptive behavior.

The implications of these results emphasize the importance of an active spirituality approach in public health promotion policies. Strengthening community-based spiritual education programs and integrating religious values into psychosocial interventions can improve the effectiveness of coping and psychological well-being of individuals. Thus, this study not only enriches the literature on coping theory and spiritual psychology, but also makes a real contribution to the formation of a holistic health promotion policy model that is adaptive to cultural contexts and oriented towards human spiritual well-being.

4. CONCLUSION



Based on the results of the cross-tabulation, it can be concluded that there is a significant relationship between community resources (collective efficacy, social network, social support, and access to new contacts and information) and caregivers' coping strategies. The majority of caregivers tend to use problem-based coping strategies, and the better the community resources they have, the higher the proportion of problem-based coping compared to emotional-based coping. There is a significant relationship between spiritual-religious coping (profit, comfort, intimacy, and life) and caregivers' coping strategies. The majority of caregivers with positive spiritual-religious coping tend to use problem-based coping strategies rather than emotional-based ones, indicating that religiosity and spiritual meaning play an important role in encouraging caregivers to face challenges more adaptively. The implications of this study emphasize the need for health policies that focus on strengthening the social and spiritual capacity of communities as the foundation for adaptive coping among caregivers. Policy makers need to integrate community empowerment and spiritually-based intervention strategies into public health programs, especially for caregivers of people with chronic diseases or the elderly. This effort can be realized through the formation of community-based caregiver support groups, problem-based coping skills training accompanied by spiritual reflection, and cross-sector collaboration between health services, religious organizations, and social institutions. By strengthening social resources and actualizing spiritual values in caregivers' daily practices, these policies not only increase the effectiveness of individuals' adaptation to stress but also build sustainable social resilience at the community level.

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