The International Journal of Indian Psychology
ISSN 2348-5396 (e) | ISSN: 2349-3429 (p)
Volume 7, Issue 1, DIP: 18.01.094/20190701
DOI: 10.25215/0701.094
http://www.ijip.in | January- March, 2019

Research Paper

Religiosity and Anxiety Relationship in Mediation by Self-Acceptance in Patients with Chronic Disease

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ABSTRACT

The number of cases of chronic disease is a problem in accepting the reality of their condition. Based on the results of previous studies many people with chronic diseases are prone to feel anxiety. This study aims to examine the relationship between religiosity and anxiety through self-acceptance as a mediator in people with chronic disease. With the research hypothesis: (1) there is a negative relationship between the level of religiosity with anxiety in patient with chronic disease, (2) there is a positive relationship between religiosity with self-acceptance in patient with chronic disease, (3) there is relation between religiosity and anxiety mediated by self-acceptance in people with chronic diseases. The results show that self-acceptance may mediate the relationship between religiosity and anxiety in people with chronic disease.

Keywords: *Religiosity, Self-Acceptance, Anxiety, Patients with Chronic Disease*

Chronic disease is one example of a health problem that cannot be avoided; because chronic disease has a prolonged people who suffer chronic disease will undergo a series of long-term treatments, such as cardiovascular, diabetes and heart failure routinely have to do an examination at the hospital. impact and sometimes difficult to cure it completely. This will cause complications, anxiety and even depression in patients with the disease (Rodrigues, Gebara, Gerbi, Pierri, & Wajngarten, 2015). Anxiety and unpleasant feelings have physical effects such as trembling, sweating, and increased heart rate. While the psychological effects such as panic, tense, confused, and unable to concentrate (Taylor, 2006).

According to Taylor (2006) anxiety in sufferers arises not only because it is intrinsically distressed but also can interfere with living functioning. Anxiety experienced by a person can be categorized into two types, namely, trait anxiety (personality) and state anxiety (due to circumstances). The anxiety felt by patients with chronic diseases is state anxiety. State anxiety arises because of the situation the patient must undergo treatment (Alloy, Riskind, & Manos, 2005).

Anxiety arises because patients have to make adjustments, related to treatment and changes in diet also routine activities (Ambarwati, 2008). This depends on how the patient reacts, if the

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Received: February 19, 2019; Revision Received: March 12, 2019; Accepted: March 18, 2019

patient can respond positively then what happens to the sufferer is also a positive attitude, such as someone's religiosity can bring a positive attitude for him. The research conducted by Maryam (2008) explains that there is a negative relationship between religiosity and anxiety levels. Similarly, the results of the study described by Morse et al (2009) religiosity are negatively related to anxiety experienced by sufferers with chronic diseases as well as those who experience anxiety facing death. In previous studies conducted by Widiastuti (2011) also conducted mediation studies with variables of anxiety, religiosity and also self-acceptance, but this was given to patients with level two diabetes mellitus. The difference in this study was on the subject, namely the subject who was undergoing treatment due to chronic disease, in other words all diseases that could endanger a person's life and had to do intensive care in a hospital or outpatient.

Religiosity is an integrated system of beliefs, practices, rituals, and symbols designed to facilitate closeness to things that are considered sacred or very important in a person's life such as God or other beliefs (Koenig, 2009). Religiosity is an integrated system of beliefs, practices, rituals, and symbols designed to facilitate closeness to things that are considered sacred or very important in a person's life such as God or other beliefs (Koenig, 2009). Pargament (1997) identifies the relationship of religiosity and health then concludes that someone who engages God in his life as coping when facing a stressor will have low levels of anxiety, good in physical and mental health, and also good at psychosocial competencies.

Because of the circumstances experienced, sufferers must face changes in their lifestyle, such as dietary arrangements, drug administration, reduction of activities, and also the provision of medical treatment that patients must face and adjust to the situation. For that sufferers must be able to apply the attitude of self-acceptance in themselves with the existing conditions, previous research explains that a lack of self-acceptance in someone can increase the level of anxiety that can have an impact on physical health (Macinnes, 2006).

In the research conducted by Subandi (1997), explained that patients were able to accept the situation with all its shortcomings and weaknesses in a trustful manner to foster an attitude of acceptance towards something, for that sufferers must have the knowledge of religion and a belief that outside there was a fear. This explains that between religiosity can affect one's self-acceptance. Self-acceptance is someone who can realize and recognize personal characteristics and use them in living their lives and is shown by someone's recognition of their strengths while accepting their weaknesses without blaming others and having a continuous desire to develop themselves (Helmi et al., 1998).

Religiosity that is applied by sufferers must be able to generate self-acceptance by accepting the reality, that lack of self-acceptance to someone can increase the level of anxiety which can have an impact on physical health (Macinnes, 2006). Religiosity acts as a spiritual support and is able to reduce the psychological burden (Pfeifer & Waelty, 1999) so that it can improve self-acceptance (Macinnes, 2006) and reduce anxiety for sufferers (Morse et al, 2009). Based on the existing compression, the researcher will propose a study entitled The Effect of Religiosity and Anxiety in Mediation by Self-acceptance in Patients with Chronic Disease.

Anxiety

According to Atkinson (1999) anxiety is an unpleasant emotion and is characterized by worry, concern, and a sense of a situation that can threaten physical well-being, self-esteem,

and pressure to do something beyond ability. Anxiety usually occurs continuously which arises because of certain situations which if continuing anxiety is felt to be increasingly severe (Anoraga & Suyati, 1995). These factors are biological factors, environmental social factors, behavioral factors, and cognitive and emotional factors (Durand & Barlow, 2006). Anxiety occurs because of a stressor where the individual responds to the situation with feeling depressed because it is considered a threat and endanger themselves (Safaria & Saputra, 2009). Symptoms of anxiety include 3 aspects, namely cognitive, emotional and physiological aspects.

Anxiety is not only about how someone responds to an existing stressor. If individuals have good cognitive judgment, then the individual can respond to anxiety positively, giving rise to feelings of pleasure and relaxation. Whereas if the stressor is responded negatively it can lead to anxiety, tension and fear (Tosi et al., 1990). Anxiety is not only about how someone responds to an existing stressor. If individuals have good cognitive judgment, then the individual can respond to anxiety positively, giving rise to feelings of pleasure and relaxation. Whereas if the stressor is responded negatively it can lead to anxiety, tension and fear (Tosi et al., 1990). Anxiety arises because there is fear of something threatening, Freud said, the weakness of the ego will cause a threat that triggers anxiety. Freud argues that the source of the threat to the ego comes from an instinctive impulse from the id of the demands of the superego. Freud also said that if the mind controls the body, the ego that controls the mind and mind is in absolute power.

Freud divides 3 levels of anxiety, namely realistic threats or real dangers that are in the environment, neurotic anxiety, fear or instinct (impulse id) of the reward or punishment that will be obtained. Then moral anxiety is (super ego) fear of feeling embarrassed. In addition, Stuart (2007) also explained that anxiety has 4 levels. (1) Mild anxiety, namely tension in everyday life so as to increase alertness, (2) moderate anxiety which makes someone more focused on one concern by putting aside other things in order to be able to do something more directed, (3) heavy anxiety that is the individual too centered something very specific and detailed without regard to other things to reduce the perceived tension, and (4) panic related to fear but lack of self-control and generating motor activities, decreased ability to relate to others, distorted perceptions and thoughts that are not rational.

Anxiety occurs due to various factors such as disappointment, dissatisfaction, feeling insecure or having feelings of hostility with others. According to Kaplan and Sadock (1997), the factors that influence patient anxiety are divided into intrinsic factors (inside) and extrinsic (outside) factors. Intrinsic factors are related to age, sex, level of education, experience of patients undergoing treatment and extrinsic factors, namely duration of therapy, type of financing and family support.

Relationship between religiosity and anxiety

Daradjat (1991) explains religiosity is a complex system of beliefs and trust through attitudes that connect the individual with something that is divine. Religiosity is a religious element, which makes a person become religious and claim to have a religion (having religious). According to Glock and Stark (Ancok & Suroso, 2004) the dimensions of religiosity consist of 1) Religious belief is a degree to which individuals receive dogmatic things in their religion. 2) Religious practice, which is the level of the individual, is questioned how far it is to carry out the ritual obligations set by religion. 3) Religious feeling that is a religious experience, feelings, perceptions and sensations experienced by individuals when

communicating with the creator. 4) Religious knowledge that is the side of individual knowledge towards religion, especially in seeking knowledge. 5) Religious effect, which is an individual consequence of the teachings of his religion and manifested in his behavior with fellow human beings.

Someone who has been diagnosed with a chronic disease will definitely feel anxiety. This anxiety stems from fear of what will happen, such as fear of being abandoned and shunned, feeling helpless and death. The treatments from doctors can only provide therapy to reduce pain and symptoms that are felt. The level of anxiety that each patient feels is different, the thing that can distinguish it is the level of individual religiosity. Individuals who have high religiosity will feel sincere, trust and accept the situation (Rahmawati, 2005). Based on the research of Roff, Butkeviciene and Klemmack (2002), religiosity can significantly reduce anxiety or fear about things that are not clear. According to Malinowski, religiosity can reduce anxiety caused by religion or belief in people to reduce fear (Bryant 2003). This shows that there is a negative relationship between religiosity and anxiety, which means that the higher a person's religiosity, the lower the anxiety felt.

Relationship between religiosity and self-acceptance

According to Gargiulo (2004) self-acceptance is a condition where a person can accept the conditions of himself and others who are not in accordance with his expectations. The attitude of self-acceptance is shown by one's recognition of their strengths and accepting their weaknesses without blaming others and having the desire to continue to develop themselves (Helmi et al., 1998). Hurlock (1994) mentions individuals who are able to accept themselves means being able to accept the conditions as they are (real self) rather than what they want (ideal self). That someone is able to judge something realistic about the resources they have, combined with an appreciation of the whole self, making it difficult to criticize themselves or their own situation.

Sheerer (Cornbach, 1963) explains there are several aspects of self-acceptance, (1) individuals who have the confidence and ability to deal with problems, (2) individuals who consider themselves valuable as human beings, (3) individuals who do not perceive themselves as strange or abnormal (4) individuals who are not ashamed of themselves, (5) individuals who dare to be responsible for their actions, (6) individuals who can receive praise and reproach, and (7) individuals who do not blame themselves for their limitations. Individuals who are able to accept their nature with all deficiencies in trust will foster an attitude of acceptance, for that sufferers must have the knowledge of religion and belief that outside of themselves there is a fear that religious psychologists call the religion instinct or diversity instinct (Subandi, 1997). For this reason, a person's religiosity influences his level of acceptance, so that anxiety that arises will be reduced as well as his level of acceptance.

Religious belief is able to encourage internal locus of control so that it affects a person's mental health (Almeida et al., 2006), so as to prevent anxiety arising from external Locus of control that is associated with depression and anxiety, to minimize someone doing actions that endanger themselves and others. The research conducted by Badari and Astuti (2004) explains that there is a significant relationship between religiousness and self-acceptance. Likewise, the research conducted by Widiastuti (2011) explains that there is a positive relationship to religiosity as well as self-acceptance. This shows that a person with a higher religiosity will have higher acceptance too.

Relationship between self-acceptances and anxiety

Sheerer (Cronbach, 1963) explained that self-acceptance is an attitude in evaluating oneself objectively, accepting strengths and weaknesses. Sheerer (Wrastari, 2003) added that someone who can accept himself, if he has confidence in his ability to face life, considers that he is valuable and equal to other people capable of being responsible for his behavior.

In a study conducted by Machdan (2012), it was explained that there was a negative relationship between self-acceptance and anxiety in individuals who were physically challenged. Widiastuti (2011) also explained that there is a significant relationship between self-acceptance and anxiety in patients with diabetes mellitus, which means that the higher self-acceptance the lower the anxiety felt by individuals.

Anxiety factors according to Nevid et al (2003), namely biological factors, social and environmental factors, behavioral factors, cognitive and emotional factors can decrease or become low if one's self-acceptance of his condition is high so there is no perceived anxiety including factors existing anxiety.

The relationship of religiosity and anxiety at mediation by self-acceptances

Religiosity acts as a spiritual support that can reduce the psychological burden (Pfeifer & Waelty, 1999) so that it can improve self-acceptance (Macinnes, 2006). Whereas according to Morse (2009) both of them can reduce anxiety for persons with disabilities. This shows that self-acceptance can be a mediating variable because it can reduce the anxiety experienced. The purpose of this study is to see whether self-acceptance can really mediate religiosity and also self-acceptance. According to Pargament (1997), the success of integrating a person's experience in dealing with a disease with a belief in belief can affect the self-acceptance of the sufferer and can reduce the anxiety they experience. Religiosity is related to anxiety experienced by patients with chronic diseases (Morse, Afifi, Morgan, Stephenson, Reichert, Harrison, & Long, 2009). This is explained by Koenig (2009) that religiosity can bring up a source of strength from comfort, hope, and meaningfulness in life.

Framework for Thinking and Hypotheses

1. There is a negative relationship between religiosity (X) and anxiety (Y) in patients with chronic diseases.
2. There is a positive relationship between religiosity (X) and self-acceptance (M) in patients with chronic diseases.
3. There is a negative relationship between self-acceptance (M) and anxiety (Y) in patients with chronic diseases.
4. There is a relationship between religiosity (X) and anxiety (Y) that is mediated by self-acceptance (M) in patients with chronic diseases.

METHODOLOGY

Sample

The sample in this study are sufferers of chronic diseases such as cancer, tumors, heart disease, diabetes, bronchitis and other life-threatening diseases. Subjects were patients diagnosed by doctors and had to undergo treatment in hospitals and outpatients. The age of subjects was determined to be up to 60 years and willing to fill out the questionnaire provided. The data used are primary data on participants who are taken by snowball data retrieval technique, which is taking a number of cases through a relationship between one

person and another or one case with another, then looking for further relationships through the same process, and so on (Neuman, 2003).

Instruments

Three measures were used in this study,

1. The Hamilton Anxiety Rating Scale (HARS) for anxiety scale. A scale that has a range of 0-4 with a description of the different scales depends on the questions given about the anxiety and the pain that is felt. Number 0 indicates that a person does not experience or feel the thing being asked at all, while in number 4 indicates if someone strongly shows the symptoms or statements that exist. The items on the HARS scale are as many as 14 items (McDowel, 2006) Examples of items presented are "Do you feel restless, uneasy, tremor, tension, rapid breathing". With the item correlation 0.74 - 0.93 and reliability coefficient 0.78.

2. Revised Religious Orientation Scale (ROS-R) for the scale of religiosity. The scale which was originally called the religious orientation scale was developed by Alport in 1967 and later revised by Gorsuch & McPherson in 1989. The ROS-R consists of 14 items in the form of extrinsic and intrinsic questions, which are made with a Likert scale, which strongly agree, agree, neutral, disagree, and strongly disagree, with a score of 0 to 4 (Hill & Hood, 1999) Examples of items presented are "I like reading religious books or magazines". With item correlation 0.38 - 0.89 and reliability coefficient 0.83.

3. Scale of self-acceptance. Compiled by Masyitah (2012) with reference to aspects of self-acceptance put forward by Sheerer and Hurlock (Cornbach, 1963). With 40 items that will be scored with a Likert scale that is strongly agree, agree, neutral, disagree and also strongly disagree, with a score of 0-4, Examples of items are presented "I feel valuable in front of my friends". With total item correlation 0.43 - 0.56 and reliability coefficient 0.89.

Procedure

In general, procedures and data analysis are as follows: First, determine research variables, discuss theories, and determine the right instruments. Second, data is collected using a questionnaire that has been adapted in Indonesian, the data that is displayed uses Google Form to facilitate the retrieval, filling and confidentiality of donors. The third data analysis used by SPSS Statistics 23 for Windows applications.

RESULTS

Research data obtained through questionnaires distributed. A total of 50 research subjects filled out the questionnaire correctly and according to the criteria the researchers mentioned. This is a general description of the subject or respondent in this study:

Table No. 1 General description of research subjects

Personal Data	Category	Number	Percentage
Gender	Male	24	48%
	Female	26	52%
Age	0-10	0	0%
	11-20	5	10%
	21-30	24	48%
	31-40	8	16%

Personal Data	Category	Number	Percentage
	41-50	4	8%
	51-60	9	18%
Type of disease	Kidney illness	9	18%
	Heart disease	5	10%
	Cancer	26	52%
	Stroke	2	4%
	Diabetes	8	16%

In this study also found 3 classifications of low, medium, and high based on each variable, it is described in the following table:

Table No. 2 Classification per-variable

Religiosity		
Classification	**Total**	**Percentage**
Low	1	2%
Medium	6	12%
High	43	86%
Anxiety		
Classification	**Number**	**Percentage**
Low	14	28%
Medium	20	40%
High	16	32%
Self-acceptance		
Classification	**Total**	**Percentage**
Low	9	18%
Medium	30	60%
High	11	22%

Through the explanation in the table, it can be seen that most chronic disease sufferers who are undergoing intensive care, outpatient care or hospitalization in this study fall into the high category in the level of religiosity. Variables of self-acceptance possessed by chronic disease sufferers fall into the moderate category, as well as the anxiety variables included in the moderate category but the anxious variable at the presentation is under the self-acceptance presentation. This proves that the majority of chronic disease sufferers in this study have good religiosity, and they also have a fairly good self-acceptance of what they experience even though their feelings of anxiety can still be felt even though they are not excessive.

Furthermore, based on the results of the mediation regression analysis using Hayes produces a coefficient of X to M On the results of the test of religiosity and self-acceptance is equal to 0.550 with a significance of $p < 0.05$, religiosity significantly has a positive effect on self-acceptance. Next, the coefficient M with Y is 0.441 $p < 0.05$ this means that the relationship between M and Y (anxiety) is positive and not significant. Then the coefficient between X to Y which is the direct effect is -0.758 $p < 0.05$, this means that the relationship between X and Y has a negative and significant effect. Finally, the coefficient value for the total effect is known to be -0.516 and $p = 0{,}000$, this means that the relationship in the total effect is negative and significant.

DISCUSSION

The mediation model is when the coefficient value and significance of c '<c after being controlled by M, has decreased or is not significant at all (Winarsunu, 2010). Based on the explanation above it is known that hypothesis 3 in this study was not accepted. However, the coefficient and significance of X towards Y when controlled by M remain significant and show a negative relationship (coefficient = -0.758 p = 0.00; coefficient = -0.516 p = 0.00). This makes the researchers can conclude that self-acceptance is proven to mediate religiosity and anxiety indirectly or partially.

The results of the study on 50 subjects proved that person with a high level of religiosity, it can increase his acceptance of his condition, so that he can reduce the anxiety, especially for someone who is in the category of patients with chronic diseases who will face death, the consequences of treatment intense medical and limited activities. Psychological disorders such as anxiety can occur to anyone, according to Freud Sigmud, anxiety is an ego function to warn individuals about the possibility of a danger so that appropriate adaptive reactions can be prepared (Alwilsol, 2009). Priest (1992) explains that anxiety is a feeling experienced by someone when they think that something unpleasant will happen. Anxiety as a fear, uncertainty, confusion, life full of pressure, and uncertainty. Priest (1992) also added that anxiety is a general condition experienced by individuals from time to time in response to threatening situations.

According to Lehto and Stein (2009) religiosity has a principle as a form of one's ability to shape the attitudes and beliefs of individuals in dealing with their anxieties. The belief in question is the belief or religion adopted by the individual. High religiosity can affect self-acceptance of his condition in the context of weaknesses and strengths. However, in people with coronary disease tend to lack because of situations and anxiety to deal with treatment and even the possibility of death. But self-acceptance becomes one of the determinants as in the research conducted by Rachmawati (2005) that a person with high religiosity will be more trustworthy and accept whatever circumstances or destiny given by his Lord.

From the results of the study it was found that the level of religiosity of a person can be influenced by age and how long the subject has the chronic disease. From 50 subjects aged 13 years and 58 years, the level of religiosity was higher for clients aged 25 years and over. This can be influenced by the level of cognitive and also one's knowledge (Ancok & Suroso, 2004). Thouless (2000) explains that various verbal thought processes (intellectual factors or knowledge) are also related to the education level factor. The average level of education of the subject is high school and also the level 1. The influence of education or teaching and various social pressures, including education from parents, social traditions, social environment pressure agreed upon by the environment (social factors) can affect religiosity (Thouless, 2000).

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Acknowledgements

Thank you to all participants who helped and filled out the questionnaire in this study. Thanks also to our beloved campus, University of Muhammadiyah Malang, for supporting us to do this research well. We thank Mr. Latipun and Mr. Tulus as a lecturer on methods and statistics. And thanks to all my friends at the Department of Psychology, University of Muhammadiyah Malang for all kinds of support and assistance that have been given, because without your help this research cannot run optimally.

Conflict of Interest

The authors carefully declare this paper to bear not conflict of interests

How to cite this article: D N A Eka Setiawati, A Baitina, Roselina D H, & Latipun (2019). Religiosity and Anxiety Relationship in Mediation by Self-Acceptance in Patients with Chronic Disease. *International Journal of Indian Psychology*, *7*(1), 836-846. DIP:18.01.094/20190701, DOI:10.25215/0701.094