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Coping Strategy, Religiosity, and Chronic Elderly's Life Satisfaction

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Abstract

The decrease in physical or biological conditions that occur in the elderly will result in disruption of various organs of the body so that it can cause chronic disease. Chronic diseases would have an impact on the elderly's life either physically or mentally, for instance, increased stress life and decreased life satisfaction. This study was aimed to analyze the role of coping strategies and religiosity on the life satisfaction of the elderly with chronic disease. The design used in this study was a cross-sectional Study. The research was conducted at Medika Dramaga Hospital, Bogor Regency, Indonesia. Samples in the study amounted to 60 people who have had chronic diseases, and had suffered for more than six months and were selected by accidental sampling technique. The results of t-test or independent test showed no difference between coping strategies, religiosity, and life satisfaction of elderly men and women with chronic disease. The duration of an older person suffering from a disease is significantly positive related to coping strategies and life satisfaction. Besides that, the more religious the elders, the more satisfied they are with their life.
Keywords: chronic diseases, coping strategy, elderly, life satisfaction, religiosity

Abstrak

Penurunan kondisi fisik atau biologis yang terjadi pada lansia akan mengakibatkan terganggunya berbagai fungsi organ tubuh sehingga dapat menimbulkan penyakit kronis pada lansia. Penyakit kronis akan menimbulkan berbagaidampak dalam kehidupan lansia tidak hanya secara fisik namun juga secara mental, seperti meningkatnya tingkat stres dan atau menurunnya kepuasan hidup pada lansia. Penelitian ini bertujuan menganalisis peran strategi koping dan religiusitas pada kepuasan hidup lansia yang berpenyakit kronis. Desain yang digunakan dalam penelitian ini adalah *cross-sectional study*. Lokasi penelitian dilakukan di Rumah Sakit Medika Dramaga, Kabupaten Bogor, Indonesia. Sampel dalam penelitian berjumlah 60 orang lansia yang memiliki penyakit kronis yangsudah diderita oleh lansia selama lebih dari enam bulan. Lansia dipilih dengan teknik *accidental sampling*. Hasil penelitian menunjukkan bahwa rata-rata penyakit yang diderita oleh lansia adalah hipertensi, stroke, tuberculosis paru, diabetes mellitus, dan jantung. Hasil uji t-test menunjukkan tidak adanya perbedaan antara strategi koping, religiusitas, dan kepuasan hidup pada lansia pria maupun wanita yang berpenyakit kronis. Adapun hasil uji korelasi menunjukkan bahwa semakin lama lansia menderita penyakit kronis, maka kemampuan strategi kopingnya juga meningkat dan

kepuasan hidup lansia juga meningkat. Selain itu, semakin religious lansia maka akan merasa puas dengan kehidupannya.

Kata kunci : kepuasan hidup, lansia, penyakit kronis, religiusitas, strategi koping

Introduction

Old age or commonly referred to as the elderly is the last stage of the process of human development. According to the Government Regulation of the Republic of Indonesia Number 43 of 2004, an elderly is someone who has reached the age of 60 years and over. The number of elderly people in Indonesia reaches 20.24 million people, equivalent to 8.03 percent of the total population of Indonesia in 2014 (BPS, 2014). This number is still high compared to the number of the elderly population in other ASEAN countries such as The Philippines (7.3%), Cambodia (6.8%), and Laos (6.0%). By gender, the number of elderly women in Indonesia is 8.2 percent and 6.9 percent for elderly men (BPS, 2015). The rapid growth rate of the elderly is a challenge for the government, especially in the social and economic fields. The increasing population of the elderly will require prominent attention from the government due to the emergence of various problems in their lives. The reason behind this is because aging will make a person experience development in the form of repressive changes, namely the decline of biological, psychological, and social physical functions that occur gradually. Changes that occur will influence all aspects of life, including health (Pamungkas, Wiyanti & Agustin, 2015). Based on the National Socio-Economic Survey or BPS Susenas (2015), the number of sick elderly from 2013-2015 has increased in both urban and rural areas from 24.8 percent, 25.05 percent, to 28.62 percent.

Decreasing physical or biological conditions that occur in the elderly is a normal process due to aging. The aging process, which is characterized by a decrease in biological function will result in a decrease in various functions of essential organs. Roach (2001) states that elderly people tend to suffer from chronic diseases and about 80 percent of the elderly in the world suffer from at least one type of chronic disease such as hypertension, arthritis, diabetes mellitus. Chronic disease is a disease with permanent characteristics, causing disability to the sufferers, and to cure it sufferers need to take care for an extended period and also has experienced continuous pain for six months or more (Mayo, 1956 in Lubkin & Larsen, 2006; Sarafino & Smith, 2011). Factors that can increase the risk of chronic diseases include unhealthy daily lifestyle, such as smoking, alcohol, inadequate nutrition (WHO, 2014).

Most elderly complaints are the effect of chronical diseases, namely uric acid, high blood pressure, rheumatic, low blood pressure, and diabetes. The period of chronical diseases that relatively longer experienced by the elderly will affect chronical disease become more vulnerable destructing them physically, psychologically, and socially. The decreased biological function that occurs in the elderly will have an impact on their physical condition, therefore the elderly tend to behave unsatisfied with what they have in their life and what they have been through.

Life satisfaction is the benchmark to measure happiness, integrity, and successfulness in the old age. The elderly who satisfied have their own life goals and better self-acceptance. The elderly who successfully going through their old life can develop and learn from and benefited from using as the coping strategy to be able to survive in this life and to determine their future (Fisher, 1995 in Lazar, 2000). The chronical diseases will affect the elderly life satisfaction indirectly, through their

financial condition. O'Toole (2012) in his research, showed that the economic condition of the elderly is one of the factors to determine elderly's who have chronical disease discipline in medical treatment. In emotional condition, the elderly can be so sensitive, and easily offended by others compare to the healthier elderly (Godsoe, 2008).

Chronic diseases can also affect the interpersonal relationships that the elderly have (Morrison & Bennett, 2009). Also, chronic diseases can have an impact on increasing stress in the elderly. Edelstein and Segal (2011) state that significantly depressive disorders are found in the elderly population who have chronic diseases. According to Sarafino and Smith (2011), this can be caused by the difficulties experienced by the sufferers of chronic diseases in adapting to changes in the body due to illness. In order to overcome the increase in stress in the elderly, coping strategies are needed. Coping is a strategy that can help someone reduce stresses and help to solve the problems. Active coping to do is coping that helps a person to tolerate and accept pressing situations and does not worry about the pressure that a person cannot control (Rasmun, 2004). Adaptive coping strategies can cause a decrease in stress levels, and patients will get positive emotions, such as captivated feelings. Elderly people have different coping strategies in dealing with stressful situations, one of which is a spiritual approach.

The spiritual quotient or SQ can measure spirituality, according to Zohar and Marshall (2000) SQ is one of the intellectual aspects that helps people to solve their problem regarding the way to define the value of life (Septariana, 2019). Spirituality and religiosity have a different definition, though both strongly related to the family function (Beit-Hallachmi, 1984 in Bornstein, 2017). Religiosity is one of the coping strategies for the elderly to deal with various changes and losses experienced during their old age (Weinert, 2011). Religiosity is knowledge, action, and behavior that arises because of perceived awareness or interaction, which is considered to play an essential role in fulfilling human life needs (McCullough & Willoughby, 2009). Religiosity is an effort to overcome anxiety in the elderly who have chronic diseases. Religiosity makes individuals able to reduce negativity, such as stress, anxiety, and despair (Nashori, 2007). Fais (2004) also found that the high religiosity in a person who has the chronical disease would escalate the well-being. Based on the background, this research is necessary to be conducted to explore the relationship between coping strategies and religiosity and life satisfaction in the elderly who have chronic diseases. The purposes of the study were to analyze differences in coping, religiosity, and life satisfaction strategies of elderly men and women who have chronic diseases and analyze factors related to coping, religiosity, and life satisfaction strategies of the elderly.

Methods

The study used a cross-sectional study design by definition the research conducted at a specific time. The research was conducted at Dramaga Medika Hospital, Bogor Regency, West Java Province, Indonesia. Determination of the location of the study was conducted purposively with the consideration of the hospital was visited by many elderly to check-up their health. The research was conducted from January 2018 to August 2018 which included preparation, data collection, and report writing.

The population in this study were all outpatients over the age of 60 at Medika Dramaga Hospital during March 2018. The samples in this study were patients who came to the internal medicine clinic in Medika Hospital which met the criteria of aged

outpatients over 60 years old, has a chronic illness that suffers in a certain period, and Muslim believer. The number of samples taken in this study were 30 elderly male respondents and 30 elderly female respondents. Sampling is done by accidental sampling method that is sampling technique taken simultaneously in a place and accordance with the research context (Notoatmodjo, 2010). Respondents who meet the requirements and are visiting the outpatient clinic are used as the research samples until the specified research period ends.

Data collected in this study were primary data and secondary data. Primary data is the dataobtained directly from respondents through interviews using questionnaires covering respondent characteristics, coping strategies, level of religiosity, and life satisfaction of the elderly. Characteristics of respondents were the condition of the elderly which included the age of the elderly, gender, length of education, size of family, length of the marriage, employment status, residence status, illness, and suffering duration ofdisease. Coping strategies are ways that the elderly do to reduce their level of stress experienced due to suffering from an illness. The coping strategy questionnaire was adapted and modified from Folkman et al. (1988) consisting of Problem-Focused Coping (PFC) and Emotion-Focused Coping (EFC). PFC is a method used to reduce stress due to illness that is focused on solving the problem and consists of aspects of confrontative, seeking for social support, and planful problem solving while EFC is a method used to reduce stress that focuses on emotions in dealing with the diseases suffered and consists of aspects of self-control, distancing, positive reappraisal, accepting responsibility, and escape and avoidance. The results of the reliability test of the coping strategy questionnaire were Cronbach's Alpha at 0.800. Variable coping strategies consisted of 50 items with four rating scales (1 = Never; 2 = Rarely; 3 = Often; 4 = Always).

Meanwhile, the questionnaire used to measure the level of religiosity was adopted from Djakiman (2013). Religiosity is the belief of the elderly to God which is measured based on the three values, namely: (1) the creed (*akidah*), namely the Muslim belief regarding the teachings of Islam; (2) worship (*ibadah*), namely the experience of individuals in getting closer to God/ Allah through the procedures regulated in the teachings of Islam such as prayer, zakat, reading the scriptures, and fasting; and (3) morals (*akhlak*), are individual attitudes and behaviors that refer to religious values. The questionnaire Cronbach's Alpha value of 0.904. The total number of religiosity variable questions were 25 items with four rating scales (1 = never; 2 = sometimes; 3 = once; 4 = always).

Life satisfaction variables in this study used the Ryff and Singer (1996) questionnaire, which were then modified by researchers following the needs of the study with a Cronbach's Alpha value of 0.903. The total number of questions variable life satisfaction is as many as 30 items with four rating scales (1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree). The variable of life satisfaction is measured by the perceptions of the elderly about their living conditions, what they have experienced and reflects the compatibility between the ideals of the past with the present conditions of life. This variable consists of 6 dimensions, namely self-acceptance, positive relations with others, autonomy, environmental mastery, life goals, and self-development.

Secondary data is the data collected by other parties obtained from relevant agencies, namely Medika Dramaga Hospital, studies from books, the internet, and the results of previous studies. Secondary data collected is the population of elderly Bogor

City and Regency and references. The data obtained is processed through editing, coding, scoring, entry, cleaning, and data analysis. All data is processed using Microsoft Excel and SPSS 22.0 for Windows software. The statistical analysis used to process the data is the reliability test used for consistency tests between questions and produced Cronbach's alpha values. After the index has gotten for each variable, the index is grouped into three categories based on Bloom's cut-off point index score: (1) Low: <60, (2) Medium: 60-79, (3) Height: ≥80 (Abdullahi et al., 2016). The results of the data obtained will then be analyzed descriptively, including maximum values, minimum values, and averages to present an overview of the various variables examined in the questionnaire. The inferential analysis used includes t-test (difference test) and correlation test.

Findings

Characteristics

Age. The age range of the elderly in this study is from 65 to 90 years. Papalia (2008) divided the elderly based on chronological age, namely young elderly (65-74 years), middle elderly (75-84 years), and very old elderly (≥85 years). The most significant percentage of elderly men (73.34%) and women (80%) were included in the category of young elderly (65-74 years). Only about 3.3 percent of elderly men and no elderly women included in the category of very old elderly (≥ 85 years). The average age of elderly men and women is not much different. Also, evident from the results of the independent sample t-test showed that there was no significant difference in age between elderly men and women ($p > 0.05$).

Working status. The results also found that as many as 90 percents of elderly men were unemployed and only 10 percent were still working, while there was as many as 93.3 percents of elderly women who were unemployed and only 6.6 percent were employed. Physical conditions that began to decline is the caused of most elderly not to work anymore.

Suffering duration of disease. According to Sarafino and Smith (2011), chronic disease is the experience of pain that is experienced continuously for six months or more. The results of this study indicate that 46.7 percent of elderly men and 56.7 percent of elderly women have suffered from chronic illness for more than 24 months or two years. The common disease that affects many elderly people is hypertension, stroke, pulmonary tuberculosis, diabetes mellitus, and heart disease. Based on the independent sample t-test showed that there were no significant differences in the duration of the chronic illness between elderly men and women ($p > 0.05$).

Coping Strategy

Coping behavior is a behavior performed by individuals through interacting with the surrounding environment to complete tasks or solve the problems (Chaplin, 2004). The coping strategy consists of two dimensions, namely PFC and EFC. Most elderly men have coping strategies in the medium category, the rest have coping strategies in the low and high categories. Meanwhile, the elderly women have coping strategies in the high category and the rest are in the medium category. The results of the independent sample t-test showed that there were no differences in coping strategies between elderly men and women. Table 1 shows that elderly men and women have the

highest average index on the dimensions of Emotion-Focused Coping (EFC). In the EFC dimension, elderly men and women have the highest average index on the distancing aspect. This is due to more than half of the elderly men and women receiving the illness and continuing to live as if nothing had happened. Meanwhile, the lowest index average on the dimensions of Problem-Focused Coping (PFC). In the PFC dimension, elderly men and women have the lowest average in the confrontative aspect. This is due to elderly men and women always allowing feelings that are being felt and adamant to the desired. The test results of the independent sample t-test showed that there were differences between elderly men and women in rediscovering the critical things in life, not telling others about the illnesses suffered, and refusing to believe that they suffered from a chronic illness.

Table 1 Distribution of coping strategy based on gender

Coping Strategy	Men		Women		*p-value*
	Min-Max	Mean	Min-Max	Mean	
Problem-Focused Coping	**40.7-90.7**	**67.7**	**50.0-92.5**	**69.3**	**0.520***
Confrontative	5.5-77.7	44.07	16.6-77.7	49.81	0.156
Seeking Social Support	50.5-100.0	79.81	44.4-100.0	79.25	0.877
Planful Problem Solving	44.4-100.0	79.44	61.1-100.0	79.07	0.905
Emotion-Focused Coping	**55.2-84.3**	**73.7**	**56.2-92.7**	**74.1**	**0.836***
Self Control	23.8-100.0	65.55	23.8-100.0	67.93	0.606
Distancing	61.1-100.0	84.07	61.1-100.0	83.14	0.755
Positive Reappraisal	52.3-100.0	80.47	57.1-95.2	76.50	0.123
Accepting Responsibility	58.3-100.0	84.16	58.3-100.0	81.94	0.519
Escape or Avoidance	37.5-95.8	62.08	45.8-95.8	66.94	0.202
Total	**5.5-77.7**	**70.7**	**16.6-77.7**	**71.7**	**0.897***

Note: * = Significant p<0.10, ** = Significant p<0.01

Religiosity

Religiosity is knowledge, action, and behavior that arises because of perceived awareness or interaction, which is considered to play an essential role in fulfilling human life needs (McCullough & Willoughby, 2009). Lubis (2009) sees the involvement of individuals in Islam based on three values, namely faith, worship, and morals. Table 2 shows the highest average of the elderly is in the dimensions of morals or aqeedah while the lowest average in the dimension of worship with men is 76.44 and women 80.22, yet this shown women have better worship towards god than the men.

Two-thirds of elderly men have religiosity in the high category, the rest have religiosity in the low and medium categories. Meanwhile, more than two-thirds of elderly women have religiosity in the high category and the rest are in the moderate category. The t-test results show that there were no differences in religiosity between elderly men and women in terms of creed, worship, and morals, but there are differences in terms of reading the Koran regularly between elderly men and women.

Table 2 Distribution of religiosity based on gender

Religiosity	Men		Women		*p-value*
	Min-Max	Mean	Min-Max	Mean	
Creed	60.0-100.0	95.22	80.0-100.0	93.88	0.538
Worship	26.6-100.0	76.44	56.6-100.0	80.22	0.348
Morals	53.3-100.0	81.77	46.6-100.0	83.11	0.755
Total	26.6-100.0	84.5	56.6-100.0	85.7	0.668

Note: * = Significant p<0.10, ** = Significant p<0.01

Life Satisfaction

Life satisfaction is psychological well-being that is generally felt by someone as a whole (Santrock, 2002). Life satisfaction can be measured using the dimensions of Ryff's psychological well-being (1995) in Papalia (2009), namely self-acceptance, positive relations with others, environmental mastery, autonomy, self-development, life goals.Table 3 shows that elderly men with chronic disease have the highest average index on the dimensions of self-acceptance. All elderly men remain confident even though they have grown older, are grateful for living conditions today, and are not jealous of the lives of others. Whereas elderly women have the highest average index on the dimensions of life goals. All elderly women feel happy to see their children succeed, prioritize family needs, increase worship, and prepare provisions for children. Besides that, elderly men and women with chronic diseases have the lowest index average on the dimensions of personal development. Elderly people are not interested in adding insight from the media, are not involved in activities that develop potential, and are not interested in events in the surrounding environment.

The results of the independent sample t-test showed that there were no differences between elderly men and elderly women in terms of friends who still cared for him and were grateful for their current living conditions. As many as half of the elderly men and women with chronic diseases have life satisfaction in the high category, the rest in the moderate and low category. The independent sample T-test results also showed that there were no differences in life satisfaction between elderly men and women in terms of self-acceptance, positive relations, environmental mastery, autonomy, self-development, and life goals.

Table 3 Distribution of life satisfaction on gender

Life satisfaction	Men		Women		*p-value*
	Min-Max	Mean	Min-Max	Mean	
Self-acceptance	75.0-100.0	93.8	66.6-100.0	89.4	0.132
Positive relation	73.3-100.0	90.8	40.0-100.0	86.0	0.191
Environmental mastery	26.6-100.0	76.6	26.6-100.0	68.8	0.153
Autonomy	58.3-100.0	87.5	66.6-100.0	84.7	0.412
Self-development	0.0-100.0	63.6	25.0-100.0	65.5	0.765
Life goals	66.6-100.0	90.5	66.6-100.0	90.2	0.932
Total	0.0-100.0	83.4	25.0-100.0	79.7	0.985

Note: * = Significant p<0.10, ** = Significant p<0.01

Correlation

Pearson test results show that there are no elderly's characteristic that have significantly positive with the coping strategy, religiosity, and life satisfaction other thansuffering duration of disease of the elderly which have a significantly positive relationship with coping strategies (r= 0.265, p<0.10) and life satisfaction (r=0.294, p<0.10) (Table 4). This means that the longer the elderly suffer from an illness, the coping strategies and life satisfaction will be higher. Besides that, the religiosity of the elderly found positively related to the satisfaction of the elderly (r= 0.439, p<0.01), meaning that the higher of the religiosity of the elderly, the higher the satisfaction of their life.

Table 4 Correlation between elderly's characteristics, coping strategy, religiosity, and life satisfaction

Variables	Coping Strategy	Religiosity	Life Satisfaction
Characteristics			
Gender (0=Men; 1=Women)	0.017	0.056	-0.002
Age (years)	-0.054	-0.120	0.088
Working status (0=non-work; 1=work)	0.248	0.225	-0.108
Suffering duration of disease (months)	**0.265***	0.167	**0.294***
Coping strategy	1	0.012	0.013
Religiosity	0.012	1	**0.439****

Note: * = Significant p<0.10, ** = Significant p<0.01

Discussion

More than three quarters of elderly men and women with chronic diseases have coping strategies in the moderate category. This can be seen from coping behavior carried out on elderly women, especially coping strategies that focus on relieving emotions caused by stressors. Elderly sees the good side of the disease suffered, hopes for sympathy and understanding of others, or tries to forget everything related to things that have suppressed his emotions, but only temporarily (Folkman & Lazarus, 1985).

As many as two-thirds of the elderly have religiosity which is in the high category. This can be seen from the high value of the trust of the elderly in religion. Besides that, the elderly also always carry out the practice of worship well. Aqeedah or creed and morals (worship practices) have a good impact on the lives of the elderly because both can provide meaning and inner strength to the elderly. Practices of worship such as reading the Qur'an can help reduce tension, worries, and other negative emotions (Barhem, Younies, & Muhamad, 2009).

More than half of the elderly men and women with chronic diseases have life satisfaction in the high category. This can be seen from the elderly who feel grateful for what they have, accept the illness suffered in old age, and remain confident. According to Sousa and Lyubomirsky (2001), someone's life satisfaction refers to one's acceptance of the state of life and the extent to which a person can fulfill everything he wants in its entirety. When someone accepts his life condition, he will feel satisfied with life. When a person is always optimistic, grateful for his life, and a positive mood will give life satisfaction (Papalia, 2009). The results of different tests show that there is no difference between the life satisfaction of elderly men and women who have chronic diseases. This can be due to several factors, namely that the elderly live in a supportive and active environment in social activities, (Turk & Winter, 2005; Yalom & Leszcz, 2005). Also, Nursolehah and Krisnatuti (2017) also found that social support plays a vital role in the success of the elderly's life. Supportive environments can be obtained from families such as spouses, children, and grandchildren. This environment provides its life satisfaction for the elderly, although they suffer from chronic diseases. Besides that, social activities will boost the elderly 'happiness since they will interact with other people and bring much joy during the activities.

Pearson test results show that the elderly suffer from chronic diseases such as diabetes mellitus, hypertension, heart disease, and mild strokes are significantly positively related to coping strategies, meaning that the longer the disease is suffered, the coping strategies will be higher. Coping behavior aims to reduce painful environmental conditions, adjust to adverse events or realities, maintain emotional

balance, maintain a positive self-image, and to continue satisfying relationships with others (Cohen & Lazarus, 1977 in Folkman, 1984). Elderly people who have been suffering from chronic diseases for a long time will be accustomed to coping and do not consider the illness to be a burden or source of stress. Most of the elderly are familiar with the treatment process that must be undertaken.

Older people suffering from chronic diseases have a significantly positive relationship with the life satisfaction of the elderly, meaning that the longer the elderly suffer from the disease, the higher their life satisfaction will be. Based on the results of interviews, elderly people who have chronic illnesses feel confident and grateful for living conditions. In addition, most elderly people still feel happy even though they have to undergo continuous treatment. Most of the elderly also use the services of the Social Security Organizing Agency (BPJS), so there is no need to think about the costs that must be incurred for the treatment. This can also be explained by the results of a study conducted by Megari (2013) which suggested the life satisfaction of elderly people who have chronic diseases is the psychological condition of patients. Elderly people who suffer from chronic diseases still have satisfaction with life in old age. The psychological condition of patients who suffer from the disease more and more can accept the conditions they experience sincerely. Even though the elderly suffer from an illness, it still makes them happy because children and grandchildren accompany the treatment. The psychological condition of the elderly becomes happy because they get support from the family environment. Elderly people who have chronic diseases still feel happy because even though they have an illness, the elderly can do their activities. Routines carried out by the elderly such as medication, taking drugs, and checking-up health routinely has become habits and still enjoy the routine so that the elderly still feel satisfied with life in their old age.

Religiosity is positively related to the life satisfaction of the elderly, meaning that the higher the religiosity, the higher the life satisfaction of the elderly and vice versa. This is in line with the results of Indriana (2004), who found that the type of activity, religiosity, and level of independence are related to the elderly's life satisfaction. According to Glock and Stark (1988) religiosity is reflected in various dimensions of beliefs, religious practices, experiences, religious knowledge, and consequences. These dimensions illustrate that religiosity involves every side of human life to the daily consequences of life, thus when ones have to confrontthe problems, religion will have influence and involvement. Most elderly men and women have faith in the teachings of their religion so they can improve their life satisfaction. The results of this study are also in line with Koening and Larson (1998) in Santrock (2002) which suggested that religiosity plays an important role in the satisfaction of the elderly, namely to assist the elderly in facing death, discovering and maintaining valuable feelings in life accepting shortcomings in the old age. In addition, Koenig (2004) suggests that elderly patients with severe or chronic health problems are more religious because they feel more comfortable with religious activities such as praying when struggling with their illness. Religion can be a source of support to overcome various challenges related to aging (McInnis-Dittrich, 2014 in Roh et al., 2015). For example, special forms of religion such as prayer can alleviate the adverse effects of illness, retirement, loss of partners, and provide an excellent coping mechanism to recover from adverse life events (Nelson-Becker et al., 2006 in Roh et al., 2015). Religion provides a protective effect that allows the elderly to discover the meaning and purpose of life (Moschella, 2011).

Working status is negatively related to life satisfaction, indicating that the elderly who are still working in old age can reduce their life satisfaction. The study is in line with research conducted by Atchley (1976) in Santrock (2002) which suggests that old age is a time when someone starts to develop their hobby which so far cannot be developed due working hours. Been old makes a person feel delighted both physically and spiritually because they find freedom in their lives. Elderly people who have not worked in old age can enjoy their lives by gathering with family. Elderly people who are still working in their old age still enjoy their lives, because the work done can reduce the burden on the family. Elderly workers prefer to reduce working hours compared to work during youth and adjust working hours to their health conditions (Bell & Rutherford, 2013). However, this study still has limitations such as the measuring instruments used are improper to the different tests, so the results of this study do not indicate a difference between elderly men and women who have chronic diseases in the aspects of the variables studied. The results of this study cannot be generalized to the overall life satisfaction of the elderly in Bogor Regency because the selection of respondents was done purposively.

Conclusion and Recommendation

Conclusion

This study found that the average age of the elderly were 68 years. The majority of the elderly do not work. Most of the elderly have suffered from chronic diseases for around two years. More than three-quarters of elderly men with chronic disease have coping strategies in the moderate category, while older women are in the high category. Two-thirds of the elderly have religiosity in the high category. More than half of the elderly have life satisfaction in the high category.

There is no difference in coping, religiosity, and life satisfaction strategies for elderly men and women who have chronic diseases. The duration suffering from the disease of the elderly is positively related to coping strategies. Older people suffering from illness and religiosity are positively related to life satisfaction. Working status has a negative effect on the life satisfaction of the elderly. Elderly people who do not work in their old age can increase life satisfaction.

Recommendation

Based on the results of the study, the role of the family is needed to give attention and listen to things that are being felt by the elderly so that they can increase their life satisfaction. Elderly people are expected , and in the elderly living environment, regular recitations are held. The community around the elderly is also expected to provide support thus the elderly can develop their potential despite suffering from chronic diseases.

Suggestions for government institutions to pay more attention to the welfare of the elderly population because they also influence economic development in the country. It is better for developing countries like Indonesia to adopt the way of developed countries treatment towards the elderly, such as South Korea, China, Singapore, and Japan.

The suggestion for further research is that the research should be done through interviewing both parties, namely the partners and children of the elders so that the

results obtained are more concrete. In addition, the location and sample selection should be done by random sampling thus the results can be generalized.

References

Abdullahi, A., Hassan, A., Kadarman, N., Saleh, A., Shu'aibu, Y., B., Lua P., L. (2016). Food safety knowledge, attitude, and practice toward compliance with abattoir laws among the abattoir workers in Malaysia. *International Journal of General Medicine9*(2), 79-87. doi: 10.2147/IJGM.S98436

Barhem, B., Younies, H., Muhamad, R. (2009). Religiosity and work stress coping behaviour of Muslim employees. *Journal of Education Business and Society Contemporary Middle Eastern Issues 2*(2): 123-137. doi:10.1108/17537980910960690.

Bornstein, M., H. (2017). Mixed blessings: parental religiousness, parenting, and child adjustment in global perspective. *Journal of Child Psychology and Psychiatry, 58*(8), 880-892. doi: 10.1111/jcpp.12705.

[BPS] Badan Pusat Statistik. (2012). Statistik Penduduk Lanjut Usia 2012 : Hasil Survei Sosial Ekonomi Nasional. Jakarta (ID): BPS. Retrieved from: https://www.bps.go.id/publication/download.

_____. Badan Pusat Statistik. (2014). *Statistik penduduk lanjut usia Indonesia 2011*. Jakarta (ID): BPS.

_____ . 2015. *Statistika penduduk lanjut usia*. Jakarta (ID): BPS.

Bell, D., N., Rutherford, A. (2013). Older workers and working time. *The Journal of the Economics of Ageing1*(2), 28–34. doi: 10.1016/j.jeoa.2013.08.001.

Chaplin, J., P. (2004). *Kamus Lengkap Psikologi (Terjemahan Kartini dan Kartono)*. Jakarta : Raja Grafindo Persada.

Christianson, J. (1998). The growing presence of managed care in rural areas. *Journal of Rural Health 14*(3), 166-168.

Djakiman, R. (2013). *Hubungan dukungan sosial, tingkat religiusitas dengan kepuasan hidup lansia pria dan wanita* (thesis). Institut Pertanian Bogor, Bogor.

Edelstein, B., A., Siegal, D., L. (2011). *Assessment of emotional and personality disorders in older adults*. Dalam KW, Schaie & SL. Willis (Eds.), Handbook of the psychology of aging (7th edition) (pp. 325-337). San Diego: Elsevier Inc.

Fais, M., S. (2014). Pengaruh religiusitas terhadap tingkat depresi, kecemasan, stres, dan kualitas hidup penderita penyakit kronis di kota Makassar (kajian survei epidemiologi berbasis integrasi islam dan kesehatan). *Jurnal Kesehatan, 7*(1).

Folkman, S. (1984). Personal control and stress and coping processes: A theoritical analysis. *Journal of Personality and Social Psychology 46* (40), 839-858.

Folkman, S., & Lazarus, R,S. (1985). If it changes it must be a process: A study of Emotion and Coping During Three Stages of a College Examination. *Journal of Personality and Social Psychology48* (1), 150-170. doi: https://psycnet.apa.org/doi/10.1037/0022-3514.48.1.150.

Folkman, S., Lazarus, R,S., Gruen, R,J., Logis, A. (1988). Appraisal, coping, health status, and psychological symptoms. *Journal of Personality and Social Psychology*. *50*(3), 571-579. doi: http://dx.doi.org/10.1037/0022-3514.50.3.571

Godsoe, M., R. (2008). Acceptance of chronic pain, attachment style, affectivity and treatment use. New Hampshire: Antioch University New England. Retrieved from: http://search.proquest. com/docview/304324906.

Glock, C. Y. & Stark, R. (1988). Dimensi-Dimensi Keberagamaan. Robertson, Roland (ed.), Agama: Analisa dan Interpretasi Soiologi. Jakarta: CV Rajawali.

Indriana, Y. (2004). *Religiositas Orang Lanjut Usia ditinjau dari Tingkat Pendidikan*. Laporan Penelitian. Semarang: Program Studi Psikologi Fakultas Kedokteran Universitas Diponegoro.

Koenig, H,G. (2004). Religion, spirituality, and edicine: research findings and implications for clinical practice. *Southern Medical Association 97*(12), 1194-1200. doi: 10.1097/01.SMJ.0000146489.21837.CE.

Lazar, K,A. (2000). Current life engagement factors as a predictor of elder Life satisfaction.Retrieved from: www2.uwstout.edu/content/lib/thesis/2000/2000lazark.pdf

Lubis, M,R. (2009). Nilai agama dalam kehidupan. *Jurnal Multikultural dan Multireligius8* (29).

Lubkin, I,M., & Larsen, P,D. (2006). *Chronic illness: Impact and interventions (6th Ed.)*. USA: Jones and Bartlett Publishers Inc.

McCullough, M,E., Willoughby, L,B. (2009). Religion, self-regulation, and self-control: associations, explanations, and implications. *Psychological Bulletin135*(1), 69-93. doi: 10.1037/a0014213.

Megari, K. (2013). Quality of life in chronic disease patients. *Health Psychol Res 1*(3), e27. 10.4081/hpr.2013.e27

Morrison, V., Bennett, P. (2009). *An introduction to health psychology (2nd ed.)*. Spain: Pearson Education Limited.

Moschella, M. (2011). Spiritual autobiography and older adults. *Pastoral Psychology60*(1), 95-98. doi: 10.1007/s11089-010-0307-6.

Nashori, F. (2007). Manusia sebagai homo religious. *Jurnal Psikologika*. 3, 3-5

Notoatmodjo, S. (2010). *Metodologi Penelitian Kesehatan*. Jakarta : Rineka Cipta

Nursolehah, E., Krisnatuti, D. (2017). Communication elderly-children and elderly-children in law, social support, and successful aging in elderly men and women. *Journal of Family Sciences, 2*(2), 11-22. doi: 10.29244/jfs.2.2.11-22.

O'Toole, T. P. (2012). Staying healthy during hard times: the impact of economic distress on accessing care and chronic disease management. *Medicine & Health 95*(11), 363-366.

Pamungkas, A., Wiyanti, S., Agustin, R., W. (2015). Hubungan antara religiusitas dan dukungan sosial dengan kecemasan menghadapi tutup usia pada lanjut usia kelurahan Jebres Surakart. *Jurnal Ilmiah Psikologi Candrawijaya 2*(1), 1-10.

Papalia, D., E. (2008). *Psikologi Perkembangan(Ed 9th)*. Alih bahasa: Anwar AK. Jakarta: Kencana.

_____ (2009). *Human development (11th edition).* USA: McGraw-Hill.

Rasmun.(2004). *Stres, koping dan adaptasi. (ed.1).* Jakarta : Sagung Seto.

Roach, S,S. (2001). *Introductory gerontological nursing.* Philadelphia: Lippincott. Williams & Wilkins.

Roh, S., Lee K., H., Kim, Y., Lee, I. (2015). Religion, social support, and life satisfaction among American Indian older adults. *Journal of Religion & Spirituality in Social Work: Social Thought 34*(4), 414-434. doi: 10.1080/15426432.2015.1097094.

Ryff, C,D., Singer, B (1996). Psychological well-being:meaning, measurement, and implications for psychotherapy. *Journal of Psychother Psychosom1996* (65), 14-23. https://doi.org/10.1159/000289026

Santrock, J,W. (2002). *Life–Span Development: Sixth Edition.* New York: Brown and Benchmark Publisher

Sarafino, E,P., & Smith, T,W. (2011). *Health psychology: biopsychosocial interactions (7th edition).* USA: John Wiley & Sons, Inc.

Septariana, F. (2019). Pengaruh kelekatan dan pola asuh spiritual orang tua terhadap karakter remaja smp laki-laki dan perempuan (thesis). IPB University, Bogor, Indonesia. doi:10.13140/RG.2.2.27679.00168.

Sousa, L., & Lyubomirsky, S. (2001). Life satisfaction. In J. Worell (Ed.), *Encylopedia of women and gender: Sex similarities and differences and the impact of society on gender* (Vol. 2, pp. 667-676). . San Diego, CA: Academic Press.

Turk, D.C. & Winter, F. (2005). The Pain Survival Guide: How to Reclaim Your Life (APA Lifetools). Washington, DC: American Psychological Association.

[WHO] World Health Organization. (2014). *Noncommunicable diseases*. Retrieved from: http://www.who.int/mediacentre/factsheets/fs3 55/en/

Weinert, I., M. (2011). *The influence of religiosity on psychological well being and life satisfaction in an elderly population* (dissertation). Arizona State University, Arizona.

Yalom, I.D. & Leszcz, M. (2005). The Theory and Practice of Group Psychotherapy (5th ed.). New York: Basic Books.