

ORIGINAL RESEARCH

THE CORRELATION BETWEEN RELIGIOSITY AND SELF-EFFICACY IN PATIENTS WITH CORONARY ARTERY DISEASE

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Abstract

Background: In managing life with coronary artery disease, having self-efficacy is considered important. Self-efficacy reduces risk factors for coronary artery disease by encouraging the self-control process. The involvement of religiosity aspects can be a motivation to increase self-efficacy in maintaining an individual's health status.

Objective: This study aimed to examine the correlation between religiosity and self-efficacy in patients with coronary artery disease.

Methods: This was a correlational study with a cross-sectional approach involving 112 respondents selected using an accidental sampling method in a hospital at Jember District, East Java, Indonesia. Data were collected from December 2019 to January 2020 using the Religiosity Scale and Cardiac Self-Efficacy (CSE). The Spearman's rank test was used to analyze data.

Results: The results showed that the respondents' religiosity had a median value of 3.84 (min-max: 3.00-4.00), while the median value of self-efficacy was 3.60 (min-max: 2.90-4.00). There was a significant correlation between religiosity and self-efficacy ($p < 0.001$, $r = 0.540$, $\alpha = 0.05$).

Conclusion: The moderate positive correlation between religiosity and self-efficacy indicated that the higher value of religiosity leads to a higher value of self-efficacy. The religious value through rituals of prayer or meditation could increase the self-efficacy of patients with coronary artery disease. Nurses are recommended to maintain the religiosity of patients at a good level to improve their self-efficacy and maintain the optimal health status.

KEYWORDS

coronary artery disease; cross-sectional study; nursing; religiosity; self-efficacy

BACKGROUND

Coronary artery disease (CAD) is a general term used to describe obstruction of blood flow due to plaque or a buildup of fatty material in the coronary arteries (Putra & Adam, 2015). Patients usually feel pain in the chest, such as being crushed by a heavy burden, pressured, or punctured when climbing stairs or doing heavy work (Puspita, 2018). This condition causes a decrease in physical ability, the emergence of feeling threatened because it can occur at any time, and suddenly death (Hamzah et al., 2014). Besides, this condition also causes denial, anxiety, and depression (Hamzah et al., 2014). Negative physiological and psychological responses related to CAD influence disease prognosis. If this continues, it will lead to the disease's complications, which adds to the burden of new problems on the patient's health, such as dependence on others. The powerlessness of patients to be independent will affect self-confidence in caring for themselves or low self-efficacy.

A study in the United States states that the average CAD patient has low self-efficacy associated with poor health management (Sarkar et al., 2009). The study was conducted on 1024 heart disease patients in

various places in San Francisco and obtained an average self-efficacy score of 9.7 from a range of 0 to 20 (Sarkar et al., 2009). Putra and Adam (2015) conducted a study on self-efficacy and found that 47.1% of 34 patients had low self-efficacy, while Wantiyah (2010) stated that as many as 71% of the total 107 respondents had low self-efficacy in maintaining diet control behavior, and 32.7% showed a lack of individual confidence in their ability to control symptoms and maintain bodily functions. This self-efficacy is an essential factor in managing and restoring the health of CAD patients and social support and health service providers (Fors et al., 2015; Putra & Adam, 2015).

Self-efficacy plays a vital role in daily life, especially in health (Fors et al., 2015; Rustika, 2012). Self-efficacy results from one's cognitive processes to shape confidence about how far someone can estimate his ability to carry out life activities (Bandura, 1997). Someone who has functional self-efficacy will be able to use the potential within themselves optimally (Rustika, 2012; Siregar et al., 2018). Daly et al. (2002) explained that in maintaining individual behavior to reduce risk factors that cause CAD, self-efficacy is needed to drive the patient's self-control process. Self-efficacy will encourage patients' beliefs about their ability to perform self-management. Patients who have

good self-efficacy management will maintain health behavior in a good range and can set choices, goals, overcome problems, and be persistent in reducing the risk factors that cause CAD ([Ghufron & Risnawira, 2010](#)).

[Bandura \(1994\)](#) states that four sources can increase self-efficacy, i.e., successful experiences, others' experiences, social persuasion, and physical and emotional conditions. [Ellison and Levin \(1998\)](#) state that the involvement of religiosity aspects can be a motivation for increased self-worth, self-esteem, and self-efficacy in maintaining an individual's health status. Religiosity is related to methods, techniques, or particular religious practices, while spirituality is related to seeking meaning, purpose, both in religious and non-religious environments ([Zinnbauer & Pergament, 2005](#)). Religiosity will encourage positive feelings in patients through social, experience, life, and intellectual factors ([Thouless, 2000](#)). Positive perceptions of patients with high religiosity can directly influence health-related behaviors, beliefs, and attitudes ([Ellison & Levin, 1998](#)). According to the research of [Tina and Utami \(2016\)](#), religiosity has a significant influence on the lives of CAD patients in accepting their disease conditions and facing pressure, so they can overcome problems that arise and help maintain mental health. Patients with high religiosity can influence themselves to be more optimistic, brave, accept their conditions, able to handle life, and able to have a stoic attitude ([Kartikasari, 2014](#)). Therefore, based on those explanations, the researchers were intrigued to analyze the correlation between religiosity and self-efficacy in patients with coronary artery disease.

METHODS

Study Design

This research was a correlational study with a cross-sectional approach. This study aimed to examine the correlation between religiosity and self-efficacy.

Sample and Setting

The population in this study were patients with CAD at the heart outpatient unit of a hospital at Jember District, East Java, Indonesia. The samples were 112 patients recruited using accidental sampling. Samples in this study were patients with CAD who could communicate well and be willing to be research respondents. The exclusion criteria were patients with heart attacks. The sample size was calculated using the G* Power 3.1.9.2 (<https://www.download82.com/download/windows/g-power/>) application developed at the Institute for Experimental Psychology in Dusseldorf, Germany, with a power analysis of 0.90.

Instruments

This study used three questionnaires: respondents' demographic characteristics, Religiosity Scale, and Cardiac Self-Efficacy (CSE). All of the questionnaires were using Indonesian Language.

1. Respondents' demographic characteristics include age, gender, education, occupational status, income, marital status, history of illness, and heart attack history in the past month.
2. Religiosity Scale was used to measure religiosity. It was compiled by [Kartikasari \(2014\)](#), referring to the concept of [Glock \(1962\)](#). There are 19 question items with five indicators (ideological, ritualistic, experience, intellectual, and consequences). This

questionnaire consists of ten favorable and nine unfavorable questions. The answers to favorable questions were rated on a four-point Likert scale (4=strongly agree, 3=agree, 2=disagree, 1=strongly disagree) and vice versa for unfavorable questions. The Religiosity Scale was valid and reliable with r values of 0.302-0.619 and alpha Cronbach $\alpha > 0.839$. The result of religiosity was analyzed using the Likert scale varies from 1 to 4; the higher score implies a higher level of religiosity.

3. Cardiac Self-Efficacy (CSE) was adopted from [Sullivan et al. \(1998\)](#), and it has been translated and modified to an Indonesian version by [Wantiyah \(2010\)](#). The CSE Questionnaire consists of 20 question items related to risk factor management and maintenance of functions. This questionnaire uses a four-point Likert scale with 20 questions and has been declared for validity and reliability with a Cronbach α value of 0.77 ([Wantiyah, 2010](#)). The Likert scale of self-efficacies varies from 1 to 4; the higher score implies a higher level of self-efficacy.

Data Collection

Data sources were obtained from primary and secondary data. Primary data were obtained directly using a questionnaire, while secondary data were gained from control letters and patient medical records. Data were collected by the researchers in the heart outpatient unit of a hospital at Jember District from December 2019 to January 2020.

Data Analysis

Univariate analysis was used to determine the frequency of each variable. For the bivariate test analysis, we used Spearman's Rank correlation test with a 95% confidence interval because the data were not normally distributed, and the scale was an interval. The data analysis used SPSS Statistics 20.

Ethical Consideration

The study was ethically approved by the Health Research Ethics Committee, Faculty of Dentistry, University of Jember, Indonesia, with approval number No. 707 / UN25.8 / KEPK / DL / 2019. All of the respondents in this study were given formally informed consent. The respondents had the right to refuse to participate without penalty if they want to do so.

RESULTS

Based on the result of the statistical analysis in Table 1, the majority of respondents aged 55-64 years (54.5%) and male (81.3%). Most of them had an educational background in high school (40.2%). Most respondents did not work (47.3%), and most had to earn more than Rp. 2.000.000,- (56.3%). Almost all respondents are married (92.9%). 68.8% of respondents said they had smoked, had hypertension (42.9%), and did not complain of a heart attack in the past month (72.3%).

While as shown in Table 2, the religiosity shows a median value of 3.84 with a minimum value of 3.00 and a maximum value of 4.00. Almost all indicators have a high value, such as experience, ideology, consequence, and ritual (median: 4.00), except for intellectual indicators (median: 3.63).

Table 1 Demographic Characteristics of Respondents in the Heart Outpatient Unit (N= 112)

Characteristics	Frequency (n)	Percentage (%)
Age		
<45 years old	4	3.6
45-54 years old	15	13.4
55-64 years old	61	54.5
65-74 years old	27	24.1
>74 years old	5	4.5
Gender		
Male	91	81.3
Female	21	18.8
Educational background		
No school	7	6.3
Graduated from elementary school	17	15.2
Graduated from middle school	45	40.2
Graduated from high school	26	23.2
College		
Occupational status		
Does not work	53	47.3
Labor	9	8.0
Farmers	8	7.1
General employees	12	10.7
Entrepreneur	17	15.2
Civil servants	11	9.8
Indonesian National Army/Indonesian Republic Police	2	1.8
Income		
<2000000 IDR	49	43.8
≥2000000 IDR	63	56.3
Marital status		
Married	104	92.9
Widowed	8	7.1
Smoking history		
No	35	31.3
Yes	77	68.8
History of illness		
None	48	42.9
Hypertension	48	42.9
Diabetes mellitus	14	12.5
Others (Stroke, CKD, etc...)	2	1.8
History of chest pain (angina) in the past month		
No	81	72.3
Yes	31	27.7

Table 2 Religiosity Value in Patients with CAD in the Heart Outpatient Unit (N=112)

Religiosity	Median	Min-Max
Experience	4.00	3.00-4.00
Ideology	4.00	3.00-4.00
Consequence	4.00	3.00-4.00
Rituals	4.00	3.00-4.00
Intellectual	3.63	2.75-4.00
Overall religiosity	3.84	3.00-4.00

Table 3 Self-Efficacy Value in Patients with CAD in the Heart Outpatient Unit (N=112)

Variable	Median	Min-Max
Self-efficacy	3.60	2.90-4.00

Table 3 shows that the self-efficacy of the respondents had median value of 3.60 (min-max: 2.90-4.00). Table 4 shows that each subscale of religiosity had a significant correlation with self-efficacy ($p = 0.001$), with the ritual indicator had the highest correlation value ($r = 0.509$). Overall, there was a moderate and positive correlation between religiosity and self-efficacy in CAD patients ($p = 0.01, r = 0.504, \alpha = 0.05$). The higher or better the religiosity, the higher or better the self-efficacy of the CAD patients.

Table 4 The Correlation between Religiosity and Self-Efficacy in Patients with CAD in the Heart Outpatient Unit (N=112)

Religiosity	Self-Efficacy	
	p-value	r
Experience	0.001	0.350
Ideology	0.001	0.389
Consequence	0.001	0.304
Ritual	0.001	0.509
Intellectual	0.001	0.430
Overall religiosity	0.001	0.540

DISCUSSION

The study aimed to determine the correlation between religiosity and self-efficacy in patients with CAD. The findings of this study revealed that there was a significant relationship between religiosity and self-efficacy in patients with CAD in the heart outpatient unit of a hospital at Jember District. This finding indicated that good religiosity has a positive effect on self-efficacy, which leads to a better condition. [Schwarzer \(2008\)](#) explained that self-efficacy plays a role in health behavior change models, namely, mediator, predictor, and moderator. According to the Health Beliefs Model, someone with good self-efficacy will be able to adopt positive health behaviors, such as being willing to engage in health promotion, being able to choose behaviors that can prevent disease events, and able to maintain health regularly ([Shahed et al., 2019](#)). So, patients will be fully aware without coercion anyone to reduce behaviors that can trigger risk factors for relapses such as stopping smoking, reducing consumption of salty foods, having adequate rest or regular sleep, and exercising according to doctor's recommendations.

The results of our study were in line with [Kobayashi et al. \(2015\)](#), which showed that people who are strong in religiosity tend to be able to stop smoking, reduce alcohol consumption, and increase exercise. These are included in the risk factor management and maintenance of health functions contained in the self-efficacy. [Ellison and Levin \(1998\)](#) stated that the involvement of aspects of religiosity could be a driver of increased self-esteem, self-worth, and self-efficacy in maintaining an individual's health status. American researchers also stated that there is a positive relationship between religiosity and evaluation of life, which is the evaluation itself includes experiences in life that have been experienced by individuals, both pleasant and painful experiences ([Diener & Chan, 2011](#)). Based on the concept of self-efficacy ([Bandura, 1994](#)), the experience is one source that supports an increase in self-efficacy, verbal perception, physical conditions, and emotional conditions.

The religiosity in patients with coronary artery disease in our study was also in a high value. The religiosity is very important for patients with

CAD because religiosity provides the functional components needed by humans (Tina & Utami, 2016). In patients with the acute coronary syndrome (ACS), most of them said that praying is an effort to improve health, gain strength, and get comfort (Abu et al., 2018). Another research also showed that, in stressful life conditions, such as being diagnosed with chronic illness, patients could utilize their beliefs, such as praying for their health or seeking strength from God to gain meaning, hope, and support in managing their illness (Jors et al., 2015). According to Kobayashi et al. (2015), CAD patients who are more religious are better able to regulate lifestyles so that they have fewer cardiovascular risk factors at the onset of the disease. Therefore, the relationship between religiosity and self-efficacy can have a strong value.

Although previous studies have not yet provided a definite reason why religiosity can be associated with better health behaviors, most researchers believe that religion provides a way out for stress, thereby reducing a person's desire to turn to maladaptive behavior. Another explanation is that almost all scriptures contain the obligation to respect one's own body and avoid risky behavior (Kobayashi et al., 2015). Religion can help a sick individual to accept someone's situation and disappointment by asking Allah's blessing (Cholifah, 2012). Someone who involves a belief in a higher power tends to have prosperity in his/her life, has good regulation in living arrangements, and can avoid stress (Kobayashi et al., 2015). Religiosity can make individuals more optimistic, though, accept their condition, have a handle on life, and be steadfast (Kartikasari, 2014). Thouless (2000) stated that religiosity would encourage positive feelings and improve the self-efficacy of CAD patients through social, experience, life, and intellectual factors. Individuals who have religious information will go through a verbal thought process that is influenced by intellectual factors. The thought process in the development of religious attitudes was in line with cognitive processes that can form self-efficacy attitudes. Patients with good religiosity will view that God gives trials in the form of illness as a form of affection for His servants so that adaptive coping arises in individuals (Tina & Utami, 2016). The ability to maintain this belief is related to the effective process in the formation of self-efficacy. Parents, relatives/relatives have a significant influence on the development of individual attitudes, one of them as a motivator.

Furthermore, individuals will be placed in two choices for the right decision, whether they choose to increase their health status by minimizing the risk factors that cause CAD or staying in the stage of denial to lead to maladaptive conditions. This will undoubtedly provide valuable experience in supporting the patient's self-control process, whereby accepting illness conditions and trying to change lifestyle for a better, healthy, and prosperous state. Thus, signs and symptoms of low self-efficacy, such as feelings of inferiority, anxiety, grieving, and despair, will not be experienced by these individuals (Wahyuni & Dewi, 2018).

The self-efficacy of patients is driven by the patient's religiosity itself both in physiological and psychological effects. In our study, the relationship between religiosity with self-efficacy is at a moderate level due to religiosity has a strong enough influence in increasing patients' confidence in their ability to overcome health problems, such as being able to reduce consumption of salty foods, smoking, medication adherence, and exercise by controlling the coping process through prayer and meditation in order to be free from destructive copings, such

as stress which can increase the prognosis of the disease. Therefore, nurses need to plan activities to help patient's religiosity needs, such as spiritual healing, spiritual care, spiritual group therapy, relaxation, meditation, and other activities to increase self-efficacy and self-independence.

There are several limitations of this study, including 1) the implementation process, which we did not include the information about the various types of religions held by respondents and the length of time since CAD was diagnosed for the first time, 2) the questionnaire about religiosity was also general and the questions asked were self-report and sensitive that might influence the results, and 3) the respondents involved in this research tended to give the ideal answer according to religious guidance, but we have anticipated this by providing an informed consent sheet signed by the respondents. Future studies may need to address these limitations for confirmation of the findings. In addition, experimental research can also be carried out to determine the effect of religiosity done routinely on the self-efficacy of patients with CAD.

CONCLUSION

There was a significant relationship between religiosity and self-efficacy in patients with CAD. The results indicated that the higher the religiosity of the patients, the higher the self-efficacy they have. Nurses are expected to identify patients' religiosity during patients' assessment as the basis for giving comprehensive intervention to the patient, especially in improving patients' self-efficacy to enhance patients' quality of life.

Declaration of Conflicting Interest

There is no conflict of interest.

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Authorship Contribution

Wantiyah contributed to study conception and design, study supervision, manuscript writing, data analysis and interpretation, and critical revisions for important intellectual content. Firda Romadhonia contributed to study conception and design, data collection, data analysis, data interpretation, literature review and analysis, and manuscript writing. All authors agreed with the final version of the manuscript. Mulia Hakam contributed to study supervision, methods, and critical revisions for important intellectual content.

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Data Availability Statement

The datasets generated and analyzed during the current study are available from the corresponding author on reasonable request.

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