Finding Peace in Suffering: Religiosity-Based Meaning-Making among Muslim Middle-Aged and Older Adults with Chronic Illness

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Abstract: Chronic illness generates not only physical suffering but also profound existential challenges, particularly among middle-aged and older adults. Within Muslim communities, religiosity often serves as a central framework for interpreting and coping with suffering. This study explores how Muslim middle-aged and older adults living with chronic illness construct religiosity-based meaning to foster self-acceptance and psychological adaptation. Integrating Pargament's Religious Coping Theory, Frankl's Logotherapy, and Park's Meaning-Making Model, this study employed an Interpretative Phenomenological Analysis (IPA) approach with ten participants aged 35–75 diagnosed with various chronic conditions. Semi-structured interviews were thematically analyzed. Four major themes emerged: (1) Divine Attribution, viewing illness as part of God's will; (2) Self-Acceptance through Surrender; (3) Spiritual Coping through prayer, religious practices, and medical adherence; and (4) Holistic Well-Being, where faith supports resilience and meaning reconstruction. A Religiosity-Based Meaning-Making Model is proposed, highlighting the central role of Islamic faith in promoting psychological well-being.

Keywords: Religiosity, meaning-making, chronic illness, self-acceptance, muslim middle-aged and older adults.

Menemukan Kedamaian dalam Penderitaan: Pemaknaan Berbasis Religiositas pada Muslim Dewasa Madya dan Lansia dengan Penyakit Kronis

Abstrak: *Penyakit kronis tidak hanya menimbulkan penderitaan fisik, tetapi juga tantangan eksistensial yang mendalam, khususnya pada individu usia dewasa madya dan lanjut usia. Dalam komunitas Muslim, religiositas sering menjadi kerangka utama dalam menafsirkan dan menghadapi penderitaan. Penelitian ini mengeksplorasi bagaimana Muslim dewasa madya dan lanjut usia yang hidup dengan penyakit kronis membangun makna berbasis religiositas untuk menumbuhkan penerimaan diri dan adaptasi psikologis. Dengan mengintegrasikan Teori Religious Coping dari Pargament, Logoterapi Frankl, dan Model Meaning-Making dari Park, penelitian ini menggunakan pendekatan Interpretative Phenomenological Analysis (IPA) terhadap sepuluh partisipan berusia 35–75 tahun dengan berbagai penyakit kronis. Wawancara semi-terstruktur dianalisis secara tematik dan menghasilkan empat tema utama: (1) atribusi ilahi, (2) penerimaan diri melalui kepasrahan, (3) koping spiritual melalui doa, praktik keagamaan, dan kepatuhan pengobatan, serta (4) kesejahteraan holistik, di mana iman mendukung resiliensi dan rekonstruksi makna. Sebuah model pemaknaan berbasis religiositas diusulkan untuk menegaskan peran sentral iman Islam dalam kesejahteraan psikologis.*

Kata Kunci: *religiusitas, penciptaan makna, penyakit kronis, penerimaan diri, muslim paruh baya dan lanjut usia.*

1. Introduction

Chronic diseases remain among the leading causes of death and disability worldwide, accounting for nearly 74% of global mortality (World Health Organization, 2025). These conditions—such as cardiovascular disease, diabetes, cancer, and chronic respiratory disorders—extend far beyond the physiological domain. They represent long-term disruptions that reshape individuals' physical capabilities, social functioning, and sense of identity. Chronic illness transforms daily life into a negotiation between bodily limitations and the search for meaning, especially among older adults who often experience cumulative losses in health, autonomy, and social roles. As (Behrendt et al., 2023) highlight, the psychosocial consequences of chronic illness frequently surpass the biomedical symptoms, influencing self-concept, emotional regulation, and interpersonal relationships.

From a psychosocial perspective, chronic illness is not merely a biomedical diagnosis but a biographical disruption—an event that interrupts one's life narrative and demands reinterpretation of existence. The illness experience is simultaneously personal and relational, unfolding within cultural and religious contexts that shape how individuals understand suffering and recovery (Paik & Sung, 2025; SadatHoseini et al., 2023). For Muslim individuals, illness acquires meaning through theological frameworks rooted in the Qur'an and Hadith, where health is viewed as divine trust *(amanah)*, and suffering as both a test *(ibtila')* and a means of purification *(kaffarah)*. In Muslim-majority societies such as Indonesia, faith and health are inseparable dimensions of life; health behaviors, coping strategies, and even perceptions of prognosis are influenced by beliefs about God's will, destiny, and mercy (Defifa et al., 2025; Nabil, 2025).

Religiosity, often defined as the degree of commitment to and expression of religious beliefs, values, and practices, has been identified as a significant psychological resource in coping with chronic illness(Safrilsyah et al., 2024). According (Xu, 2016), religiosity provides a meaning system that allows individuals to interpret stressful events in the light of spiritual purpose. His Religious Coping Theory distinguishes between positive and negative forms of religious coping. Positive coping includes reappraising stressors as opportunities for spiritual growth, seeking support from God, and perceiving divine benevolence. Negative coping, in contrast, involves feelings of abandonment by God or punishment for sin. Studies consistently show that positive religious coping correlates with lower anxiety, greater optimism, and improved well-being in chronic illness populations (Elkhalloufi et al., 2022; Sethuraman, 2024).

Complementary to Pargament's work, Frankl's Logotherapy introduces the existential dimension of suffering. Frankl argues that humans possess a "will meaning"—a fundamental drive to find purpose even in unavoidable pain. From this view, the inability to find meaning, rather than the suffering itself, generates despair. Logotherapy emphasizes personal responsibility and spiritual freedom: individuals can choose their attitude toward unavoidable circumstances, transforming suffering into self-transcendence. For those living with chronic illness, this approach reframes the condition from a source of hopelessness into an arena for spiritual discovery and growth (García-Alandete, 2024).

Park's Meaning-Making Model provides a psychological bridge between these two perspectives. It posits that individuals maintain global meaning systems, comprehensive beliefs, and goals that give coherence to life. When adverse events like chronic illness challenge these systems, distress arises from the incongruence between global meaning ("God is merciful") and situational meaning ("Why am I suffering?"). Through processes of meaning-making, such as cognitive reappraisal, reinterpretation of control, and spiritual

reflection, individuals reconstruct congruence, reducing emotional turmoil and restoring coherence (Park, 2010, 2013).

Together, these three frameworks illuminate chronic illness as both biological reality and spiritual journey. Pargament provides insight into religious appraisal and coping mechanisms; Frankl explains existential transformation through suffering; and Park details the cognitive-emotional reconstruction of meaning. Integrating them creates a robust lens for analyzing how individuals, especially those grounded in religious cultures, reconcile the dual experience of bodily decline and spiritual resilience.

In the Indonesian context, religiosity extends beyond private belief, it forms a collective cultural identity. Islamic values are deeply woven into social norms, family structures, and communal interactions. Core virtues such as patience *(sabr),* surrender *(*tawakkul*),* and gratitude *(syukur)* are not merely theological ideals but moral expectations shaping everyday conduct. These virtues play crucial roles in moderating emotional responses to hardship. For example, tawakkul encourages individuals to exert effort while entrusting outcomes to God, balancing agency and surrender(Nasrin, 2025). Such dialectical thinking contrasts with Western individualism, which tends to emphasize control and mastery over circumstances (Han et al., 2022).

Empirical research affirms the salience of religiosity for psychological well-being among Indonesian patients. (Onyishi et al., 2022) found that higher levels of religious commitment predicted better self-management and lower depressive symptoms among individuals with diabetes. (Iannello et al., 2022) further demonstrated that spirituality mediates the relationship between chronic illness severity and life satisfaction, highlighting the protective role of faith. However, religiosity can also yield ambivalent effects. When interpreted fatalistically, believing that illness outcomes are predetermined and immutable, religious beliefs may discourage medical adherence or active self-care. This duality underscores the need to understand how religiosity operates not as a uniform construct but as a dynamic, context-dependent coping mechanism (Hassan & Doğan, 2025).

Despite growing international attention to religion and health (Dolcos et al., 2021), there remains limited exploration of how chronic illness is interpreted through local cultural idioms. One such idiom in the Javanese Muslim context is *lilo legowo*, a phrase expressing complete surrender and peace of heart. Unlike mere resignation, *lilo legowo* reflects a deep emotional acceptance anchored in trust in God's wisdom. It embodies an equilibrium between inner calm and proactive endurance, aligning with Islamic teachings on *rida* (contentment with divine decree). *Lilo legowo* as an indigenous form of spiritual resilience that harmonizes cognitive appraisal ("this is God's will") with emotional regulation ("I must remain calm and sincere"). Yet, academic literature rarely integrates this cultural-religious hybrid into psychological frameworks, leaving a conceptual gap in understanding how Indonesians draw from both Islamic and local philosophical traditions to cope with chronic illness.

The neglect of such culturally specific expressions points to a broader issue in global health psychology: Western models of coping and resilience often overlook spiritual pluralism. Many theories emphasize individual agency and rational problem-solving, whereas collectivist societies like Indonesia locate meaning in relational, communal, and transcendent dimensions. As a result, Western measures of religiosity or spirituality may inadequately capture the lived experiences of non-Western believers (Cucchi & Qoronfleh, 2025). Addressing this gap requires qualitative inquiry that honors participants' voices and explores the embodied and linguistic dimensions of faith, how people feel, narrate, and ritualize acceptance.

The COVID-19 pandemic further accentuated the importance of spiritual meaning systems. For chronic illness patients, disruptions to healthcare, social isolation, and fear of mortality intensified psychological stress. Studies conducted after 2020 revealed that religiosity and prayer frequency increased significantly among Muslims, serving as coping mechanisms against uncertainty (El-Zoghby et al., 2020). These findings suggest that religious frameworks provide not only comfort but also cognitive structure during crises. Understanding these dynamics in post-pandemic Indonesia is crucial, given the nation's demographic transition toward an aging population and rising prevalence of noncommunicable diseases.

Building on these theoretical and empirical insights, the present study positions religiosity as a multidimensional process encompassing belief, practice, emotion, and culture. It investigates how Muslim adults and elderly individuals with chronic illnesses interpret their conditions through faith-based meaning systems. Specifically, it explores how theological concepts such as divine will *(qadar Allah),* human effort *(ikhtiar),* and surrender *(*tawakkul*)* interact with local cultural constructs like *lilo legowo* to foster acceptance and adaptation.

By integrating Religious Coping Theory, Logotherapy, and the Meaning-Making Model, this research proposes a Religiosity-Based Meaning-Making Model. The model conceptualizes four interrelated stages:

1. Divine Attribution – perceiving illness as part of God's wisdom or test;
2. Self-Acceptance – internalizing serenity through *lilo legowo* and tawakkul;
3. Spiritual Coping – engaging in prayer, dhikr, and communal worship to sustain hope; and
4. Holistic Well-being – achieving balance between physical care, psychological peace, and spiritual connectedness.

Through this integrated framework, chronic illness is understood not as a static pathology but as a spiritual-existential journey. Patients navigate between vulnerability and transcendence, redefining selfhood in relation to God, family, and society. This study thus contributes to three key advancements.

First, it extends the theoretical application of meaning-making models to a Muslim-majority, collectivist context, enriching cross-cultural psychology. Second, it introduces *lilo legowo* as an indigenous construct that complements global theories of religious coping and self-acceptance. Third, it provides empirical grounding for health professionals seeking to design interventions that respect cultural and spiritual values.

In summary, while chronic illness universally challenges human resilience, the ways individuals interpret and respond to it are profoundly shaped by culture and faith. For Indonesian Muslims, religiosity offers not only explanations for suffering but also pathways to inner peace, perseverance, and moral growth. Understanding these pathways is essential for developing holistic approaches to health care that address both the physical and spiritual dimensions of well-being. The present study, therefore, seeks to elucidate these meaning-making processes and to propose a culturally grounded framework, the Religiosity-Based Meaning-Making Model, that maps the journey from divine attribution to holistic well-being among Muslim adults and elderly living with chronic illness.

2. Methods
a. Research Design

This study used an Interpretative Phenomenological Analysis (IPA) design to explore lived experiences of Muslim individuals with chronic illnesses. IPA was chosen

because it emphasizes the subjective interpretation of personal meaning, focusing on how people make sense of significant life phenomena (Smith et al., 2021). The approach allowed the researcher to deeply examine the intersection of religiosity, illness, and meaning making within a specific sociocultural context.

b. Participant

Ten participants (five men and five women) aged between 35 and 75 years were recruited using purposive sampling. This age range was selected to ensure that participants had reached a developmental stage in which chronic illness and religiosity were meaningfully integrated into their life narratives, allowing for deeper reflection on suffering, faith, and meaning making. Inclusion criteria included: (a) being diagnosed with a chronic illness (e.g., diabetes, cardiovascular disease, stroke, autoimmune disorder) for at least six months; (b) identifying as Muslim; and (c) being able to articulate personal experiences related to illness and faith.

All participants were residents of Malang, East Java, Indonesia. Ethical clearance was granted by the Ethics Committee of the Faculty of Psychology, Universitas Muhammadiyah Malang. Participation was voluntary, and informed consent was obtained prior to interviews. The demographic characteristics of the participants are summarized in Table 1.

Table 1.
Characteristics of Respondents

Subject	Age	Gender	Profession	Religion	Chronic Disease
1	59 years old	Male	Government Employees	Islam	Coronary heart
2	73 years old	Male	Jobless	Islam	Heart Attack and Diabetes
3	58 years old	Male	Government Employees	Islam	Diabetes
4	35 years old	Female	Government Employees	Islam	Brain Nerve Dysfunction
5	52 years old	Female	Government Employees	Islam	Diabetes
6	63 years old	Female	Jobless	Islam	Diabetes
7	66 years old	Female	Jobless	Islam	Inflammation of the intestines and gallstones
8	37 years old	Male	Entrepreneur	Islam	Diabetes
9	54 years old	Male	Private Sector Employee	Islam	Stroke
10	41 years old	Female	Entrepreneur	Islam	Graves' autoimmune

c. **Data Collection**

Semi-structured interviews were conducted between February and March 2025. Each interview lasted 45–70 minutes and was conducted in Bahasa Indonesia, recorded, and later translated into English for analysis. The interview protocol included six guiding questions:

1. How did you feel after receiving your diagnosis?
2. What changes occurred in your life after the illness?
3. What efforts have you made to manage your condition?
4. How do you perceive your illness?
5. What motivates you to continue living or healing?
6. What role does family or faith play in your journey?

Follow-up probing questions were used to elicit deeper emotional and cognitive insights. Field notes captured non-verbal expressions and contextual nuances.

d. **Data Analysis**

Data was analyzed using NVivo 14 software through four IPA stages (Smith et al., 2021):

1. Immersion – repeated reading of transcripts to gain familiarity.
2. Initial coding – highlighting emotionally charged and meaning-laden phrases.
3. Emergent theme development – clustering codes into coherent meaning units.
4. Integration and interpretation – connecting themes to theoretical constructs.

Credibility was ensured through member checking (participants validated transcribed summaries), peer debriefing with two psychology researchers, and audit trail documentation. Reflexivity was maintained through journaling to monitor researcher bias.

3. **Result**

a. **Overview of Superordinate Themes**

The interpretative phenomenological analysis (IPA) generated four superordinate themes illuminating how Muslim adults and elderly individuals living with chronic illness make sense of their suffering through religiosity:

1. Divine Attribution,
2. Self-Acceptance through Surrender *(lilo legowo),*
3. Spiritual Coping, and
4. Holistic Well-being.

These themes are not discrete stages but dynamic, interdependent processes that form a cyclical pattern of faith-based adaptation. Participants continually moved between spiritual reflection, emotional acceptance, and behavioral adjustment as they faced the recurring challenges of chronic illness. Together, the themes portray religiosity as both a cognitive framework for reinterpreting adversity and an emotional resource for maintaining hope, coherence, and purpose.

Table 2.
Analytic Process in Interpretative Phenomenological Analysis (IPA)

Analytic Level	Description of Analytic Process	Illustrative Extract (Participant Quote)	Researcher's Interpretative Comment	Emergent / Superordinate Theme
1. Descriptive Noting	Researchers identified emotionally salient expressions that captured participants' immediate experiences and meaning-laden language.	"At first, I asked, why me? But now I think this illness is a way for me to get closer to Allah." (P4)	This statement reflects an early cognitive transformation, turning existential distress into moral learning through divine framing.	Divine Attribution
2. Linguistic and Conceptual Coding	Focused on the use of cultural idioms and metaphors to reveal deeper affective and spiritual meanings.	"After I learned to surrender, I became calmer." (P1)	The phrase surrender *(pasrah / lilo legowo)* represents a culturally embedded form of acceptance that merges emotional regulation with spiritual devotion.	Self-Acceptance through Surrender
3. Pattern Recognition / Cluster Development	Codes were grouped into coherent clusters that linked emotion, cognition, and faith-based coping practices.	"Every time I pray, my heart becomes lighter." (P5)	Prayer functions as embodied mindfulness — a repetitive, relational act that transforms distress into serenity.	Spiritual Coping
4. Thematic Abstraction	Emerging clusters were abstracted into higher-order interpretations that captured existential and moral transformation.	"Because of this illness, I became closer to God and my family." (P10)	Illness becomes an avenue for spiritual and relational growth, aligning with *tazkiyatun nafs* (self-purification).	Holistic Well-Being
5. Integrative Interpretation / Hermeneutic Synthesis	The researcher synthesized iterative insights into a cyclical interpretative model connecting all themes.	—	Across cases, religiosity operates as a dynamic hermeneutic system through which suffering is continuously reinterpreted into meaning and serenity.	Religiosity-Based Meaning-Making Cycle

Table 2 demonstrates the iterative analytic process of Interpretative Phenomenological Analysis (IPA) employed in this study. Each layer, from descriptive noting to hermeneutic synthesis, reflects the double interpretation central to IPA: participants making sense of their illness experiences, and the researcher interpreting those sense-making processes within a broader Islamic–Javanese spiritual framework.

b. Divine Attribution – Illness as a Gift from God

All participants began their narratives with an act of attribution to divine will (*takdir Allah*). The initial shock of diagnosis was gradually transformed into the belief that illness was not a punishment but a divine test or reminder. Such attribution provided psychological stability, reduced existential anxiety, and restored a sense of meaning.

"I used to ask, why me? But now I think this illness is a way for me to get closer to Allah. Maybe it's a reminder." (P4, 35, female, government employee, brain-nerve dysfunction)

"It's God's gift. If He gives illness, He must also prepare the cure. I just need to accept and be patient." (P7, 66, female, retired teacher, gallstones)

Through divine attribution, suffering was reframed as *hikmah Allah*—a manifestation of divine wisdom. This reappraisal echoes positive religious coping (Pargament, 1997; Xu, 2016), in which believers reinterpret stressful events as spiritually purposeful. The act of attributing meaning upward provided a cognitive anchor that shielded participants from despair. Several respondents said that remembering "every disease has its cure" (*lā dāʾa illā dawāʾ*) fostered optimism and motivated them to seek both medical treatment and divine assistance.

Nevertheless, a few narratives revealed a delicate tension between empowering surrender and passive fatalism. While most participants found strength in faith, two described moments of giving up treatment efforts, believing recovery to be wholly dependent on God. This ambivalence supports Joshanloo (2022) finding that highly fatalistic interpretations of religiosity can reduce health-seeking behavior if not balanced by *ikhtiar* (personal effort).

c. Self-Acceptance through Surrender *(lilo legowo)*

Following initial cognitive attribution, participants described a journey toward acceptance characterized by the local Javanese concept *lilo legowo*, a state of sincere surrender and inner peace in accepting God's decree.

"When I didn't accept my illness, I felt more pain. After I learned to surrender, I became calmer. Maybe this is Allah's way to teach me patience." (P1, 59, male, civil servant, coronary disease)

"I have accepted that this will not go away. What I can do is live peacefully with it." (P2, 73, male, retired, heart attack & diabetes)

Lilo legowo embodies the integration of emotion and spirituality, the movement from denial and anger to calm endurance and gratitude. It blends tawakkul (trust in God after exerting effort) and riḍā (contentment with divine decree) with Javanese ideals of *tentrem* (emotional harmony). This integrative stance represents what Park (2010, 2013) terms the "allowing" process of meaning-making: acknowledging an uncontrollable reality while reconstructing meaning within an enduring faith system.

Participants emphasized that acceptance was not resignation but active peace: a conscious choice to coexist with illness while continuing treatment and worship. In this sense, *lilo legowo* functioned as psychospiritual resilience, enabling emotional regulation without diminishing agency. Similar patterns appear in Azami-Aghdash et al.

(2025), who found that surrender-based religiosity correlated with lower emotional dysregulation and greater subjective well-being among Iranian patients.

d. Spiritual Coping – Healing through Prayer and Rituals

Across all interviews, religious rituals were central to daily adaptation. Participants consistently mentioned prayer, remembrance of God, and Qur'anic recitation as primary coping strategies that brought emotional comfort and strength.

"Every time I pray, my heart becomes lighter. Even when pain comes, I don't panic anymore." (P5, 52, female, government employee, diabetes)

"Medicine comes from God too. I take insulin, but I also read Qur'an verses for strength." (P3, 58, male, civil servant, diabetes)

These practices provided a rhythm of mindfulness and hope. For many, prayer was not a plea for instant recovery but a dialogue of trust that re-established connection with God. Participants viewed faith and medicine as complementary rather than contradictory, a belief aligned with the religious integration coping described by Sethuraman (2024).

Beyond its cognitive and behavioral aspects, spiritual coping served as affective regulation. The repetitive cadence of *dhikr* induced calmness, reduced physiological arousal, and shifted attention from pain to gratitude. Engaging in communal worship and mosque gatherings also fostered social validation, embedding individuals in networks of shared belief. This collective dimension transformed spirituality into a social ecology of healing, echoing the collectivist orientation of Indonesian religious culture.

e. Holistic Well-Being – Transforming Suffering into Growth

The final theme reflects the transformative outcome of continuous faith-based adaptation. Over time, participants experienced enhanced gratitude, empathy, and a deeper sense of life's fragility and beauty.

"I feel grateful for small things like breathing, walking, praying. It made me realize how fragile and beautiful life is." (P9, 54, male, private employee, stroke)

"Because of this illness, I became closer to God and my family. I learned to be patient and thankful." (P10, 41, female, entrepreneur, autoimmune disorder)

Illness evolved from a source of limitation into an opportunity for moral and spiritual refinement (*tazkiyatun nafs*). Participants displayed traits of post-traumatic growth (Shabani et al., 2023), reporting greater life satisfaction and emotional balance. Their holistic well-being extended beyond symptom control to include moral consciousness and relational harmony, embodying the Islamic ideal of sehat, the balance of body, mind, and spirit.

f. Analytic Integration: The Cyclical Nature of Meaning Reconstruction

Across participants, the process of meaning-making unfolded cyclically rather than linearly. Moments of relapse, pain, or emotional turmoil often prompted a return to earlier interpretative acts, reaffirming divine attribution, re-surrendering through *lilo legowo*, and re-engaging prayer. This reflexive movement reflects *the dynamic hermeneutic circle* central to IPA: understanding is continually revised as new experiences challenge prior meanings.

From the researcher's interpretative lens, this pattern illustrates that religiosity functions as both a *structure and a process*: it organizes cognition while remaining flexible to reinterpretation. Participants did not only describe faith; they *performed* it through narrative language itself became a ritual of sense-making.

"When I tell my story, I feel calmer, like I'm praying again," one participant noted, unintentionally revealing that narration and prayer converge as acts of remembering and resignifying.

Thus, the analysis concludes that the participants lived experiences exemplify how Islamic religiosity operates as a living hermeneutic, constantly negotiating between divine decree and human effort, between despair and hope, between the seen and the unseen.
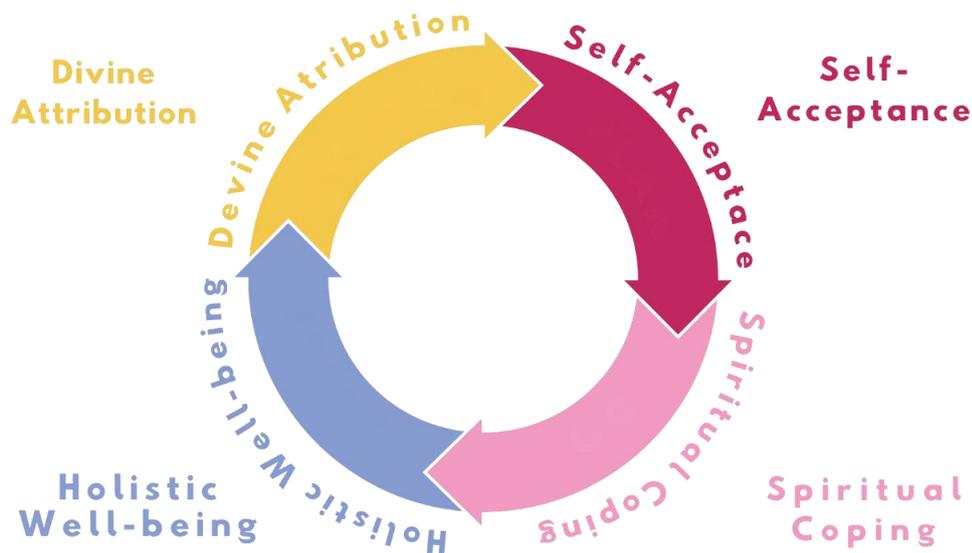

Figure 1. Religiosity-Based Meaning-Making Model

This model conceptualizes a cyclical system of adaptation to chronic illness:

1. Divine Attribution – Reframing illness as divine wisdom (*hikmah Allah*) to regain meaning.
2. Self-Acceptance – Cultivating peace through *lilo legowo* and tawakkul.
3. Spiritual Coping – Using prayer and ritual to sustain hope and emotional regulation.
4. Holistic Well-Being – Reconstructing meaning to achieve gratitude, resilience, and harmony.

The process is iterative rather than linear: when distress resurfaces, believers revisit earlier stages to reaffirm faith and acceptance.

g. Reflextive Note

Throughout the analytic process, the researcher remained aware of interpretative positioning as a Muslim psychologist analyzing narratives within shared cultural frames. Reflexive journaling helped differentiate participants' voices from researcher assumptions while acknowledging empathetic resonance. The resultant themes, therefore, are not objective truths but co-constructed meanings born from dialogical interpretation.

4. Discussion

a. Religiosity as an Integrative Meaning System

The findings reveal that religiosity operates as a psychospiritual architecture that shapes perception, emotion, and behavior when individuals confront chronic illness. For participants, faith served as both an interpretive lens and an emotional framework that

transformed disorder into coherence. By attributing illness to divine will, they situated suffering within a theological narrative of purpose and mercy, allowing them to maintain inner balance despite physical decline. This process reflects (Pargament, 1997) concept of positive religious coping, where adversity is reinterpreted as a spiritually meaningful challenge rather than a punishment, and aligns closely with (Frankl, 1958, 1959), Both perspectives emphasize that meaning, rather than the absence of pain, restores vitality and hope. This principle resonates with the logotherapeutic view that human resilience emerges through the reinterpretation of suffering, not merely through symptom elimination.

Within this context, faith functions as a cognitive map that orients individuals' appraisal and decision-making processes, while simultaneously serving as an affective refuge that nurtures endurance, patience, and gratitude. Such a mechanism aligns with the findings of Takdir et al. (2025), who demonstrated that cognitive restructuring enables individuals to transform maladaptive negative thoughts into more adaptive interpretations, resulting in increased self-confidence and psychological well-being. Their study underscores that vitality and agency are restored through active cognitive reframing, rather than through the removal of distress alone. Accordingly, illness can be understood as a spiritual and psychological journey in which individuals reconstruct identity, reaffirm their connection to transcendent values, and rediscover agency amid vulnerability. Rather than diminishing autonomy, religiosity empowers believers to reframe suffering as a source of growth, illustrating the convergence of spirituality and cognitive resilience in sustaining human well-being (Takdir, 2025; Takdir et al., 2025).

b. **The Indigenous Ethics of Surrender**

The construct *lilo legowo* offers a culturally distinctive perspective on the psychology of acceptance, reflecting an attitude of ethical surrender grounded in humility, patience, and the harmonious balance between divine trust and human endeavour. Unlike Western notions of radical acceptance that emphasize intrapsychic regulation and personal control, *lilo legowo* integrates theological awareness and communal sensitivity, situating acceptance within both relational and transcendent dimensions. This dual orientation reframes coping as an act of faith enacted through social harmony and spiritual consciousness. The construct thus extends Park (2010, 2013) meaning-making framework into a collectivist, Muslim context, illustrating how cultural idioms infuse spiritual cognition with emotional serenity and moral equilibrium. However, the findings also highlight a crucial caution: surrender should not be mistaken for fatalism. Participants who perceived divine will as absolute determinism demonstrated lower levels of proactive coping and engagement in self-care. This distinction reinforces the Islamic psychological principle that faith-based agency must accompany surrender, as tawakkul (trust in God) follows *ikhtiar* (personal effort). In this way, *lilo legowo* embodies a balanced form of spiritual acceptance that empowers rather than immobilizes, aligning inner peace with active responsibility before God and community.

c. **Spiritual Practice as Affective Regulation and Communal Healing**

Prayer and *dhikr* functioned as both cognitive reappraisal and embodied mindfulness, offering participants a meditative process through which distress was transformed into tranquillity. The rhythmic repetition of divine remembrance regulated emotion and attention, operating similarly to mindfulness techniques in Western psychology yet remaining distinct through its theocentric orientation, a conscious awareness of God rather than mere self-observation. This theistic mindfulness supports

growing evidence that religious coping strengthens resilience and emotional well-being among individuals facing chronic illness (Dolcos et al., 2021; Yoosefee et al., 2025).

Beyond the individual level, engagement in communal prayers and religious gatherings provided a shared space for empathy and containment, reducing loneliness and existential anxiety. Within the Indonesian socio-religious context, healing is inherently relational and transcendent, encompassing God, self, family, and society as interconnected agents of recovery. The participants' ability to integrate medical adherence with spiritual rituals demonstrates that faith and science are not oppositional but mutually reinforcing dimensions of care. This synthesis challenges the Cartesian dualism between body and soul, emphasizing a biopsychospiritual model of health in which emotional regulation, moral consciousness, and divine connection collectively nurture human wholeness and enduring peace.

d. From Suffering to Self-Transcendence

The transformation of pain into gratitude and service observed in this study illustrates a distinctly humanistic–religious trajectory of psychological and spiritual growth. Participants' narratives revealed that enduring illness was not solely a process of survival but a pathway toward moral elevation and existential clarity. Their reflections closely echo Frankl's logotherapeutic assertion that *"those who have a way to live can bear almost any how,"* emphasizing that the discovery of meaning transforms suffering into strength. Within this framework, illness becomes a sacred opportunity for *tazkiyatun nafs*, the purification of the self through patience, reflection, and humility before God. As participants learned to interpret pain as a spiritual discipline rather than a divine punishment, they reported a renewed sense of purpose and peace. This movement toward self-transcendence represents the highest form of well-being in Islamic psychology, where mental health is defined not merely by emotional balance but by the alignment of the soul (*nafs*), reason (*'aql*), and spirit (*ruh*) in harmony with divine guidance (Mud'is, 2023).

Central to this transformation were the virtues of gratitude (syukur) and empathy, which emerged not as defenses against despair but as manifestations of inner expansion. Through conscious remembrance of God (*dhikr*) and acts of service, participants redirected their attention from personal limitation to collective compassion, transforming individual pain into social and spiritual contribution. This evolution resonates with humanistic psychology's focus on authenticity, growth, and self-actualization, yet extends beyond it by incorporating spiritual accountability and transcendence as integral components of maturity.

Within the conceptual orientation of *Psikohumaniora*, such convergence between existential and religious elements signifies a model of psychological maturity anchored in spirituality—a state in which personal meaning, moral responsibility, and connection with the divine are unified within a single continuum of growth. In this synthesis, suffering ceases to be an endpoint of loss; it becomes a transformative medium through which believers rediscover wholeness, cultivate compassion, and experience serenity rooted in both humanity and faith.

e. Theoretical Contributions

The present study advances the field of cross-cultural and Islamic psychology by proposing an integrative, faith-based framework for understanding how Muslim adults and elderly individuals living with chronic illness construct meaning and achieve psychological adaptation through religiosity. Rather than treating faith merely as a

coping adjunct, this study positions religiosity as a comprehensive psychological system that organizes cognition, emotion, and behavior in response to suffering. The first theoretical contribution lies in its model integration, which bridges three complementary traditions, Pargament (1997) Religious Coping Theory, Park (2010, 2013) Meaning-Making Model, and Frankl (1958, 1959) Logotherapy into a unified model of religiosity-based adaptation.

Each framework contributes a distinct dimension: Pargament highlights spiritual appraisal and divine relationality in coping, Park elucidates cognitive reconstruction and coherence between global and situational meaning, and Frankl emphasizes the existential transformation that emerges from purposeful suffering. When synthesized, these perspectives yield a model in which belief, surrender, and ritual practice function synergistically to generate hope and coherence; illness becomes not solely a medical or psychological disruption but also a site of spiritual transcendence where meaning is continuously re-negotiated through faith. The second contribution concerns cultural extension, achieved by introducing *lilo legowo*, a Javanese concept of sincere surrender and emotional equilibrium, as an indigenous mediator that localizes global theories within an Indonesian Muslim worldview.

Whereas Western models of acceptance often stress intrapsychic control and individual mastery, *lilo legowo* reflects a relational and theocentric orientation, integrating the Islamic virtues of trust (tawakkul), contentment (riḍā), and emotional harmony (*tentrem*). By embedding this culturally rooted construct, the study demonstrates that spirituality is not a homogeneous phenomenon but one expressed through local idioms, social ethics, and collective practices, thereby contributing an emic perspective to the global psychology of religion. The third contribution pertains to the dynamic process of adaptation: rather than a linear sequence from distress to recovery, the findings reveal a cyclical and reflexive pattern in which individuals oscillate between divine attribution, self-acceptance, spiritual coping, and holistic well-being.

As challenges reappear, believers revisit earlier phases through prayer, reflection, and renewed trust in God, embodying the Islamic psychological principle of *tazkiyatun nafs*, the continual purification and refinement of the self. This cyclical model reframes religious coping as a living, renewable process sustained by ritual, community, and spiritual consciousness. Collectively, these insights enrich theoretical dialogue between Western existential-humanistic psychology and Islamic conceptions of patience (ṣabr), trust (tawakkul), and acceptance (riḍā), underscoring that meaning-making is both universal in its pursuit of coherence and culturally specific in its symbolic and devotional expression. By articulating an Indonesian Muslim paradigm of faith-based adaptation, this study broadens contemporary understandings of resilience and well-being, illustrating that the transformation of suffering into spiritual growth is neither accidental nor purely intrapsychic, but rather a culturally mediated process through which individuals continuously align themselves with divine wisdom and communal values.

f. **Practical Implications**

For clinical psychology and counseling, these findings highlight the importance of acknowledging clients' spiritual schemas as integral to psychological functioning, particularly when addressing chronic illness, grief, or existential distress. Therapy with Muslim clients benefits when spirituality is not treated as peripheral, but as a core dimension of meaning and resilience. Psychologists can integrate techniques such as spiritually oriented cognitive-behavioral therapy, which blends cognitive restructuring with Qur'anic reflection on patience and hope logotherapy dialogues emphasizing the

"will meaning," and dhikr-based mindfulness that cultivates calm attention through rhythmic remembrance of God. These approaches allow distress to be reframed as purposeful struggle *(jihad al-nafs)* rather than punishment, consistent with the participants' narratives of illness as a path toward purification and growth. Therapists can also invite clients to reflect on Qur'anic verses that emphasize divine compassion and guidance, such as "And We will surely test you with something of fear and hunger … but give glad tidings to the patient" (Q.S. Al-Baqarah 2:155–157; Saheeh International, 1997), reinforcing constructive faith instead of fatalistic surrender.

In health-care practice, recognizing religiosity as a coping and motivational system supports the delivery of culturally sensitive, holistic care. Physicians and nurses may respectfully engage with patients' spiritual language, provide time and space for prayer or dhikr within hospital routines, and collaborate with chaplains or religious counselors to enhance treatment adherence and satisfaction. Such acknowledgment of faith not only humanizes care but also aligns medical interventions with patients' value systems, reducing anxiety and fostering trust.

At the community level, religious leaders and social workers can create support groups and psycho-spiritual education programs that normalize acceptance, share healing narratives, and promote rahmah-based (compassion-centered) solidarity among chronic-illness survivors. These initiatives can reduce stigma, mitigate isolation, and strengthen social connectedness—core elements of communal well-being in Islamic psychology.

g. **Limitations and Future Directions**

The study's scope was limited to ten participants from a single urban region; thus, the findings may not capture the diversity of Indonesian Muslims. In addition, the study was constrained by limited access to supporting clinical documentation, such as medical records, which restricted the clarity and accuracy of participants' chronic illness status and diagnostic categorization. Future research could include rural settings, interfaith comparisons, or gender-specific analyses of spiritual coping. Longitudinal and mixed-method designs are recommended to observe temporal changes and to quantitatively validate the proposed model using standardized instruments such as the Brief RCOPE or the Spiritual Well-Being Scale. Exploring neurophysiological correlates of dhikr-induced calmness could further link spirituality with psychophysiological resilience.

h. **Integrative Reflection**

Ultimately, the participants' stories reveal that healing transcends the physical. Chronic illness became a sacred dialogue between vulnerability and faith, inviting reflection, surrender, and gratitude. In this sense, religiosity provided both structure and sanctuary—a way of making sense of suffering while nurturing compassion and inner peace. For Muslim adults and elderly, to heal is to believe, to accept, and to grow.

5. **Conclusion**

This study deepens our understanding of how Muslim adults and elderly individuals living with chronic illness make sense of their experiences through religiosity. Integrating Pargament's Religious Coping Theory, Park's Meaning-Making Model, and Frankl's Logotherapy, the findings reveal that religiosity functions not merely as belief but as a psychological system that enables individuals to interpret illness, regulate emotion, and reconstruct life meaning.

Through a culturally embedded process expressed in the Javanese concept of *lilo legowo* (sincere surrender), participants transformed despair into acceptance and

acceptance into growth. The proposed Religiosity-Based Meaning-Making Model illustrates how four interrelated processes—Divine Attribution, Self-Acceptance, Spiritual Coping, and Holistic Well-being—form a continuous cycle of adaptation.

Illness was no longer viewed as divine punishment but as an opportunity for inner purification, reflection, and service. This transformation highlights that psychological resilience among chronically ill Muslims is grounded in a dynamic integration of faith, emotion, and cognition. The model therefore provides a conceptual bridge between religious coping and health psychology in collectivist, faith-oriented societies.

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