

Self-Compassion Mediates Religiosity and Social Support for the Psychological Well-Being of Health Workers During the COVID-19 Pandemic

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ABSTRACT

The COVID-19 pandemic has an impact on the psychological well-being of health workers. This study aims to examine the role of self-compassion as a mediator of the relationship between religiosity and social support with the psychological well-being of health workers during the COVID-19 pandemic. Research participants involved 289 health workers in health facilities in the Central Java region including hospitals, health centre, and clinics obtained by convenience sampling technique. Data analysis used the Process Macro v4.0 which was installed on SPSS v26.0. The results of this study indicate that self-compassion acts as a mediator of the relationship between religiosity and psychological well-being (effect =0.269; CI 0.168-0.389; R^2_{med} 0.028), and self compassion acts as a mediator of the relationship between social support and psychological well-being (effect =0.172; CI 0.113-0.240; R^2_{med} 0.040). However, self compassion as a mediator just plays a small role. The implication of this research is that health workers are focused on efforts to provide care and love for themselves such as motivating themselves, thinking positively, realizing what happens in life is human life experience.

Keywords: *psychological well-being, religiosity, social support, self-compassion, health workers*

1. INTRODUCTION

The COVID-19 pandemic has impacts on all aspects of life, one of which is related to the emergence of mental health problems in Indonesian society. The risk of mental health problems also occurs in the health workers, who is the front line in dealing with COVID-19 cases. Research results in various countries such as India, Saudi Arabia, Turkey, and China showed that health workers who work during the COVID-19 pandemic experience stress, depression, anxiety, and insomnia [1]–[3]. The results of a survey conducted in Indonesia also showed that 83% of health workers experienced burnout at risk of disrupting quality of life and work productivity in health services [4].

Factors that cause psychological problems for health workers include high workloads, physical and mental fatigue, fear of contracting or transmitting, isolation, social stigma, isolation, feeling of loss of ability in treating patients, and the increasing number of transmission and death among health workers [5]–

[7]. As the phenomenon that has been described, it can be said that the psychological well-being of health workers during the COVID-19 pandemic is disrupted.

Psychological well-being has an important influence on the aspects of health workers' life. Health workers with good psychological well-being will be able to stand social pressures, realize and develop their potential, establish warm relationships with others, interpret of life, and accept themselves [8].

Religiosity is a predictor of psychological well-being [9]. It is known that during the COVID-19 pandemic, religiosity became an important strategy used by health workers to maintain their mental health [10]. Health workers who have a good appreciation of religion will help health workers to be more accepting of all life experiences with full sincerity, so that a person will avoid disappointment and regret [11].

Social support is also a predictor in increasing or decreasing the psychological well-being of health workers. Based on surveys in Indonesia, it was reported that health workers experience inhumane

treatment such as threats, expulsion, and avoidance of health workers and their families [12]. In this situation, health workers should have received social support from various parties because social support is able to provide trust, comfort, security, direction in the life goal, reduce various forms of stress and also improve coping mechanisms, well-being, nor quality of life [13].

Finding in various previous research, religiosity and social support did not necessarily have a direct impact on increasing psychological well-being [14]–[16]. Research results found that self-compassion is one of the mediators that has a strong influence on the relationship between religiosity, social support and psychological well-being. It means that individuals who have religiosity and social support will have a strong impact on psychological well-being if mediated by self compassion for the individual.

Self-compassion is a conscious attitude towards one's own suffering and responding with understanding without judgment, unconditional acceptance, warmth, and concern [17], [18]. Individuals who are able to treat themselves with love and care when facing challenges or problems in life are able to improve their psychological well-being [19]. The high level of self-compassion in individuals cannot be separated from the level of religiosity they have [20], and the social support received from the environment [16]. It's mean that individuals who have a good level of religiosity will be able to accept their situation by believing in the destiny of God, so that it will lead to self-compassion. Likewise, the individual's closeness to the people around them can encourage the individual to express affection for themselves [21].

Self-compassion as a mediator of religiosity, social support to psychological well-being has not been widely studied. Several previous studies are still limited to students and adults with the majority of religions involved Christians. The results of the study also came from outside Indonesia with different cultural contexts [14]–[16].

Based on this explanation, this study aims to examine the role of self-compassion as a mediator of the relationship between religiosity and social support with the psychological well-being of health workers during the COVID-19 pandemic.

The hypothesis in this study is divided into two groups, namely the regression test and the mediation test. Correlation test revealed the relationship of religiosity to self-compassion, religiosity to psychological well-being, social support to self-compassion, social support to psychological well-being, and self-compassion to psychological well-being. While the mediation test revealed self-

compassion as a mediator of the relationship between religiosity and psychological well-being and self-compassion as a mediator of the relationship between social support and psychological well-being.

2. METHOD

2.1. Study Desain and Participants

This research design uses a correlational approach. Research variables consist of psychological well-being, religiosity, social support, and self-compassion.

The participants of this study involved 289 health workers in the Central Java region which included doctors, nurses, and midwives; and work in one of the health facilities including clinics, health centres, or hospitals. The data was obtained by using convenience sampling technique. The data collection was carried out by distributing the scale through a Google form assisted by health workers in Central Java. Scale links are distributed through social media including Whatsapp, Instagram, Facebook, and Twitter in November-October 2021. The ethics committee has approved the research procedure with letter number 3688/B.1/KEPK-FKUMS/IX/2021.

2.2. Measures

This study uses four instruments to measure psychological well-being, religiosity, social support, and self-compassion.

Psychological well-being is measured by Ryff's psychological well-being scale-18 which was adapted to the Indonesian version [22]. This consists of 18 items and has 6 answer choices with a range from 1 (very disagree) to 6 (very agree). Based on the results of the content validity index (CVI) which involved 9 raters shows the coefficient of validity ranging from 0.83 to 0.97 ($V > 0.72$). while the results of the Cronbach alpha reliability test (α) = 0.753.

Religiosity is measured by The Religious Commitment Inventory-10 which was developed by Worthington et al [23] and was adapted to the Indonesian version [22]. This scale consists of 10 items and has 5 answer choices with a range from 1 (very disagree) to 5 (very agree). Based on the results of the content validity index (CVI) which involved 9 raters shows the coefficient of validity ranging from 0.83 to 0.94 ($V > 0.72$). while the results of the Cronbach alpha reliability test (α) = 0.862.

Social support is measured by The Multidimensional Scale of Perceived Social Support (MSPSS) was developed by Zimet [24] and was adapted to the Indonesian version [25]. This scale consists of 12 items and has 7 answer choices with a range from 1 (very disagree) to 7 (very agree). Based

on the results of the content validity index (CVI) which involved 9 raters shows the coefficient of validity ranging from 0.77 to 0.94 ($V > 0.72$), while the results of the Cronbach alpha reliability test ($\alpha = 0.875$).

Self compassion is measured by The Self Compassion Scale Short-Form which was developed by Raes et al [26]. The scale was adapted by the researcher into the Indonesian version using measurement guidelines referring to Beaton [27]. This scale has 12 items and has 5 answer choices ranging from 1 (almost never) to 5 (almost always). Based on the results of the content validity index (CVI) which involved 9 raters shows the coefficient of validity ranging from 0.80 to 0.94 ($V > 0.72$), while the results of the Cronbach alpha reliability test ($\alpha = 0.802$).

2.3. Statistical Analysis

To investigate self-compassion as a mediator of the relationship of religiosity, social support, and psychological well-being, the analysis was carried out using the bootstrap method of 5000 samples using PROCESS Macro Analysis v4.0 which was installed on SPSS v26.0. The mediation model used a simple mediation model which consists of 1 dependent variable, 1 independent variable, and 1 mediator variable [28]. Therefore, in this study, there are two simple mediation model; (1) self-compassion as a mediator of religiosity and psychological well-being, and (2) self-compassion as a mediator of social support and psychological well-being. This study will also explore demographic variables using the independent simple t-test and ANOVA.

3. RESULT

3.1. Classic Assumption Test

Based on the results of the classical assumption test, namely normality, linearity, multicollinearity, and homoscedasticity, it can be concluded that this study meets the classical assumption test.

3.2. Descriptive Analysis

Demographic data from 289 participants in table 2 showed that the majority of participants were female (83%), profession as nurses (63.6%), education level S1 (45.3%), and the religion of all participants is Islam (100%).

To determine the condition of psychological well-being, religiosity, social support, and self-compassion on the participants, the researcher used descriptive analysis of score categories which is divided into five, namely very low, low, moderate, high, and very high. Based on the results of the analysis in Table 1, the level of psychological well-being, religiosity, social support, self-compassion of the participants is the moderate category. The data in table 1.

Table 1. Descriptive analysis of each variable

Variable	Min	Max	Mean	Std
Psychological well-being	60	107	84.05	9.09
Religiosity	26	50	41.08	5.38
Social support	47	84	69.54	8.80
Self-compassion	28	60	45.33	6.76

This study also explores demographic variables such as gender, profession, and education level which are described in Table 2. At the level of psychological well-being, it is known that there is no difference in gender ($p > 0.05$; Cohen'd 0.191); and profession ($F = 0.340$; $p > 0.05$; $\eta^2 p$ 0.002). A difference is found at the level of education ($F = 3.092$; $p < 0.05$; $\eta^2 p$ 0.032). The results of this study are relevant to previous research that the level of education affects the level of psychological well-being, but is not relevant to gender and profession [29], [30].

The level of religiosity, it is found that there is difference in gender ($p < 0.05$; Cohen'd 0.435); and education level ($F = 3.42$; $p < 0.05$; $\eta^2 p$ 0.035), but an equation is found in the type of profession ($F = 0.700$; $p > 0.05$; $\eta^2 p$ 0.005). This result is not relevant to previous research that there was no difference in the level of religiosity between men and women [23] and the type of profession [31]. On the one hand, the results of this study are relevant to previous research which stated that the level of education affects the level of religiosity [32].

The level of social support, it is known that there is no difference in gender ($p > 0.05$; Cohen'd 0.086); and type of profession ($F = 0.83$; $p > 0.05$; $\eta^2 p$ 0.006), but a difference is found in education ($F = 3.44$; $p < 0.05$; $\eta^2 p$ 0.035). Meanwhile, the level of self-compassion, it is known that there is no difference in gender ($p > 0.05$; Cohen'd 0.079), however, differences are found in profession ($F = 6.12$; $p < 0.05$; $\eta^2 p$ 0.041) and level of education ($F = 9.51$; $p < 0.05$; $\eta^2 p$ 0.091). These results are relevant to previous research that profession and level of education affect the level of self-compassion, but not relevant to gender [33].

Table 2. Categories of demographic characteristics, t-test, and ANOVA

Characteristics	N	%	Psychological well-being			Religiosity			Social support			Self-compassion		
			Mean	SD	F	Mean	SD	F	Mean	SD	F	Mean	SD	F
Gender					**			*			**			**
Male	49	16.9	82.53	10.27		43.00	5.10		70.16	9.08		44.84	8.52	
Female	240	83	84.36	8.82		40.68	5.36		69.40	8.76		45.44	6.36	
Profession					0.34**			0.70**			0.83**			6.12*
Doctor	34	11.8	84.82	11.32		40.53	5.82		71.29	9.52		45.97	7.68	
Nurse	184	63.6	84.17	8.70		41.36	5.45		69.43	8.59		46.15	6.59	
Midwife	71	24.5	83.37	8.98		40.61	4.98		68.97	9.01		42.94	6.26	
Education					3.09*			3.42*			3.44*			9.51*
D3	122	42.2	84.40	8.28		41.02	5.58		68.87	8.91		44.07	6.40	
D4	14	4.8	80.85	9.73		38.71	4.01		67.14	6.00		41.36	4.75	
S1	131	45.3	83.26	9.43		40.88	5.39		69.50	8.74		45.98	6.93	
S2	22	7.6	88.86	9.78		44.14	3.69		74.95	8.55		51.09	4.72	
Religion														
Islam	289	100	84.05	9.09		41.08	5.38		69.54	8.80		45.34	6.76	

Note: *p<.05; **p>.05; F:ANOVA (profession and education)

The results of the bivariate analysis showed statistical values as the basic hypothesis of the test. In addition, religiosity is positively correlated with self-compassion (a_1) ($\beta=0.479$; $p<.001$; R^2 0.145; f^2 0.169). Religiosity is positively correlated with psychological well-being (c'_1) ($\beta=0.531$; $p<.001$; R^2 0.148; f^2 0.173). Social support is positively correlated with self-compassion (a_2) ($\beta=0.312$; $p<.001$; R^2 0.165; f^2 0.197). Social support is positively correlated with psychological well-being (c'_2) ($\beta=0.321$; $p<.001$; R^2 0.148; f^2 0.173). The results of the analysis, obtained two correlations of self-compassion with psychological well-being. The first correlation (b_1), self-compassion by controlling the religiosity is positively correlated to psychological well-being ($\beta=0.561$; $p<.001$; R^2 0.224; f^2 0.288). The second correlation (b_2), self-compassion by controlling social supports is positively correlated to psychological well-being ($\beta=0.553$; $p<.001$; R^2 0.221; f^2 0.280).

Table 1. Bivariate correlations for all variables

	1	2	3	4
Psychological well-being		0.531*	0.321*	0.561 ₁ * 0.553 ₂ *
Religiosity				0.479*
Social support				0.312*
Self-compassion				

Note: *p<.000

The results of the first model mediation in Table 4 and Figure 1 show that self-compassion mediates the relationship between religiosity and psychological well-being. There is a significant indirect effect, which is indicated by the lower limit of bootstrap confidence interval (LLCI) and upper limit of bootstrap confidence interval (ULCI) which does not exceed zero (effect= 0.269; BootLLCI-BootULCI 0.168- 0.389; R^2_{med} 0.028).

The direct effect also indicates significant (effect= 0.531; CI=0.36-0.699; $p=0.000$), so the total effect of religiosity on psychological well-being is 0.800; CI=0.627-0.973; $p=0.000$. However, after including self-compassion as a mediator, the effect of religiosity on psychological well-being had a decreased effect. It is known that the direct effect score is greater than the indirect effect. These results can be concluded that the effect of self-compassion plays a small role as a mediator of the relationship between religiosity and psychological well-being. In this hypothesis, self-compassion is only a partial mediation.

Table 2. The first model mediation analysis

	Effect	LLCI	ULCI	Mediator
Total Effect	0.800*	0.627	0.973	Partial
Direct Effect	0.531*	0.363	0.699	
Indirect effect	0.269	0.168	0.389	

Note: LLCI (Lower Limit of Confidence Interval), ULCI (Upper Limit of Confidence Interval), *p=0.000

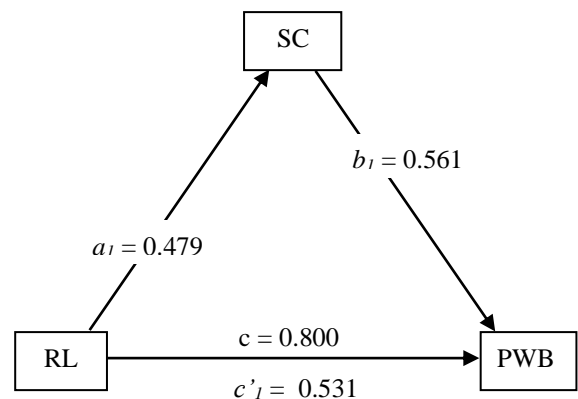


Figure 1. Self-compassion as a mediator of religiosity with psychological well-being

The results of the second model mediation in Table 5 and Figure 2, also show that self-compassion mediates

the relationship between social support and psychological well-being. There is a significant indirect effect, which is indicated by LLCI and ULCI which does not exceed zero (effect = 0.172; BootLLCI-BootULCI 0.113-0.240; R^2_{med} 0.040). The direct effect also indicates significant (effect = 0,321; CI=0.216-0.425; p=0.000), so the total effect of social support on psychological well-being 0.493; CI=0.388-0.598; p=0.000. After including self-compassion as a mediator, the effect of social support on psychological well-being also had a decreased effect. It is known that the direct effect score is greater than the indirect effect. These results can be concluded that the effect of self-compassion plays a small role as a mediator of the relationship between social support and psychological well-being. In this hypothesis, self-compassion is only a partial mediation.

Table 3. The second model mediation

	Effect	LLCI	ULCI	Mediator
Total Effect	0.493*	0.388	0.598	Partial
Direct Effect	0.321*	0.216	0.425	
Indirect effect	0.172	0.113	0.240	

Note: LLCI (Lower Limit of Confidence Interval), ULCI (Upper Limit of Confidence Interval), *p=0.000

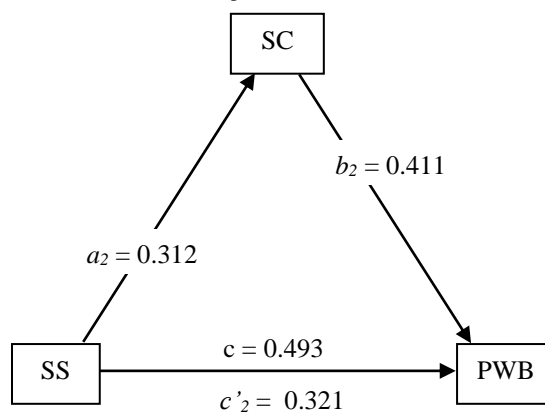


Figure 2. Self-compassion as a mediator of social support with psychological well-being

4. DISCUSSION

Self-compassion has a small effect as a mediator of religiosity and social support on the psychological well-being of health workers during the COVID-19 pandemic. According to the theory of the engine of well-being, self-compassion should be able to play an optimal role as an engine that involves religiosity and social support to achieve psychological well-being in health workers. This is considering that self-compassion is an important source of human strength because it is able to evoke the qualities of kindness, peace of mind, feelings of connectedness, helping individuals to find hope and meaning when faced with difficult problems [34].

In this study, self-compassion is not effective as an engine of well-being. When viewed from the contribution of self-compassion to psychological well-being, self-compassion has a greater influence than religiosity and social support. However, this influence is not effective as a mediator to increase the effect of religiosity and social support on psychological well-being but self-compassion as a mediator actually reduces the effect of these relations. It can be interpreted that although individuals are able to provide love, warmth, and care for themselves, they still have no major effect in increasing religiosity and social support to achieve psychological well-being.

The weak effect of self-compassion as a mediator can be explained by Markus and Kitayama [35] state that differences in cultural background affect the level of self-compassion in a person. People in Asia who have collectivistic cultures tend to have interdependent self-concepts, so that they place more emphasis on relationship with others, care for others, and harmony in behavior. While individuals with western culture are more individualistic and have self-independence that emphasizes autonomy, personal needs, and uniqueness in behavior. Although people in Asia have self-compassion, they tend to criticize themselves more than western cultures, so the level of self-compassion in Asian cultures is not stronger than in western cultures.

The concept of compassion in Javanese society also still emphasizes behavior to feel what other people feel [36]. This behavior is believed to encourage people to help and be kind with others so that individuals feel satisfied and happy with their actions. When someone often does something good for others, so person will feel a comfortable, happy, and useful. This shows that there are differences in the perspective of the concept of self-compassion in western culture with Javanese culture where Javanese society need an external role to feel positive feelings about themselves. So, it is not surprising that self-compassion has a small role as a mediator of religiosity and social support to achieve psychological well-being. Of course, this result does not support previous research that self-compassion plays a strong effect as a mediator of the relationship between religiosity and social support on psychological well-being [14], [16], [20].

In contrast to self-compassion, the concept of religiosity actually has a strong influence on culture [22], [37]. From a cultural perspective, health workers live in a society that holds a high degree of religiosity, namely Indonesia. This situation, religiosity can be the basis for improving psychological well-being because religious values become a necessity for health workers to provide strength in their souls by getting closer to God, being grateful, and practicing behaviors according to their religious beliefs. In addition, a strong belief that everything is destined by Allah in each person, makes a

significant role in improving psychological well-being. This is the reason why religiosity has a greater direct effect in achieving psychological well-being because the culture that is implanted is stronger than self-compassion. This explanation supports the previous research that religiosity has a significant role in psychological well-being [9].

The concept of social support also has a stronger influence on culture than self-compassion [22]. This statement supports Cross idea's [38] that culture is a positive resource for one's mental health. The collective culture of Indonesian people is reflected in mutual assistance behavior which is an expression of social support for people who are experiencing problems or not [22]. Mutual assistance is a cultural heritage of the nation that values and behavior become a views of life, so that it cannot be separated from the daily life activities [39].

Social support that is ingrained in Indonesian society has a significant effect on a person's mental health. For example, at the beginning of the emergence of COVID-19, many health workers experienced stereotypes, prejudice, and discrimination from the community which caused their mental health to be disturbed [5]. In contrast to the pandemic situation which has begun to be resolved, health workers have enough support from the community, so that psychological problems experienced over time can be resolved properly. This is one reason why social support has a greater direct influence than self-compassion as a mediator.

5. CONCLUSION

This study shows that self-compassion is able to act as a mediator of the relationship between religiosity to psychological well-being. Self-compassion is also able to act as a mediator of the relationship between social support to psychological well-being. Although the results of the two mediator tests have a lower effect than a direct relationship.

This study also found that cultural factors play a strong role in weakening self-compassion as a mediator. However, self-compassion is more contributes to psychological well-being than religiosity and social support, so the implication of this study is that health workers focus more on efforts to provide care and love for themselves even in unfavorable situations, such as self-motivation, think positively, realizing what happens in life is human life experience.

AUTHORS' CONTRIBUTIONS

Ulfiyatun Ni'mah collects data, conducts research designs, analyzes data, and writes papers; and Lusi Nuryanti conducts research guidance and paper revision

guidance. Both researchers share ideas to build the conceptual framework of the research.

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