Jurnal Psikologi Tabularasa
Vol.20(2) October 2025, 266-291
p-ISSN: 1693-7007 e-ISSN: 2541-013x
https://jurnal.unmer.ac.id/index.php/jpt/index

An Overview of Self-Acceptance Among Homosexual PLHIV in the Kariadi Peer Support Group (PSG), Semarang

Gambaran penerimaan diri pada ODHIV homoseksual di Kelompok Dukungan Sebaya (KDS) Kariadi Semarang

Aldi Kristianto, Siska Adinda Prabowo Putri, I Rheny Arum Permitasari

Universitas AKI Semarang
Jalan Imam Bonjol No.15 - 17, Kota Semarang, Indonesia

ARTICLE INFO:

Received: 2025-06-07
Revised: 2025-08-07
Accepted: 2025-08-20

Keywords:
HIV, kübler-ross, PLHIV, self-acceptance

ABSTRACT

HIV cases in Semarang City have increased annually, with a high prevalence among Men who have Sex with Men (MSM). The dual stigma associated with being both HIV-positive (PLHIV) and homosexual often leads to social sanctions, which in turn elicit negative emotional reactions as a form of grief in response to such stigma. This study aims to explore the self-acceptance process among homosexual PLHIV members of the Kariadi Peer Support Group (PSG) in Semarang, based on the Kübler-Ross grief model. The research employed a qualitative case study approach. The participants were three homosexual men living with HIV, who contracted the virus through same-sex intercourse and were members of the Kariadi Semarang PSG. Data were collected through semi-structured interviews and overt observation. Data analysis was conducted using the interactive model by Miles & Huberman. Data validity was tested through triangulation and verification with significant others. Findings indicate that all three participants went through the stages of denial, bargaining, depression, and acceptance in their journey toward self-acceptance. Only one participant did not go through the anger stage. Each participant had unique strategies and personal approaches in achieving self-acceptance of their HIV status. The implication of this research highlights the importance of openness among PLHIV in order to gain social support, which plays a critical role in facilitating self-acceptance.

Kata Kunci:
HIV, kübler-ross, ODHIV, penerimaan diri

ABSTRACT

Kasus HIV di Kota Semarang mengalami peningkatan dari tahun ke tahun dengan prevalensi kasus pada Lelaki Seks dengan Lelaki (LSL). Status ODHIV dan homoseksual memberikan sanksi sosial ganda kepada individu, sehingga menimbulkan reaksi negatif sebagai bentuk kedukaan atas sanksi tersebut. Penelitian ini bertujuan untuk mengetahui gambaran proses penerimaan diri pada ODHIV homoseksual di Kelompok Dukungan Sebaya (KDS) Kariadi Semarang berdasarkan teori Kübler-Ross. Metode penelitian yang digunakan adalah metode kualitatif dengan pendekatan studi kasus. Partisipan penelitian ini adalah tiga orang laki-laki berstatus ODHIV homoseksual yang tertular melalui hubungan badan sesama jenis dan tergabung ke dalam KDS Kariadi Semarang. Metode penggalian data menggunakan wawancara semi terstruktur dan observasi terus terang. Analisa data yang digunakan adalah model interaktif oleh Miles & Huberman. Uji validitas data partisipan menggunakan triangulasi data dan pengecekan terhadap *Significant Others*. Temuan penelitian menunjukkan bahwa untuk mencapai penerimaan diri, ketiga partisipan menunjukkan tahapan penolakan, tawar-menawar, depresi, dan penerimaan diri. Hanya satu partisipan yang tidak melalui tahapan kemarahan. Solusi yang dilakukan oleh tiap partisipan untuk dapat menerima diri dengan status ODHIV mereka berbeda satu sama lain, dan memiliki keunikan masing-masing. Implikasi temuan penelitian berupa pentingnya keterbukaan diri ODHIV terhadap lingkungan guna memperoleh dukungan sosial sehingga penerimaan diri dapat dicapai.

How to cite: Kristianto, A., Putri, S. A. P., & Permitasari, I. R. A. (2025). An Overview of Self-Acceptance Among Homosexual PLHIV in the Kariadi Peer Support Group (PSG), Semarang. Jurnal Psikologi Tabularasa, 20(2), 266-291.
doi: http://doi.org/10.26905/jpt.v20.i2.15623

Corresponding Author: **Aldi Kristianto** | E-mail: 521210045@student.unaki.ac.id

1. INTRODUCTION

The Indonesian Ministry of Health (Kemenkes RI) recorded 35,415 new HIV cases and 12,481 new AIDS cases from January to September 2024, with 71% of cases found in men and 29% in women (CNN Indonesia.com, 2024). Meanwhile, the Semarang City Health Office (2024) reported 7,607 HIV cases up to October 2024. Among these cases, 39.7% came from the Men who have Sex with Men (MSM) risk group, dominated by young adults with a percentage of 62.8%, and concentrated in several districts in Semarang City, such as West Semarang (5.7%), North Semarang (5.4%), and Pedurungan (4.8%).

Based on interviews conducted with three homosexual participants living with HIV (PLHIV), psychological dysfunctions emerged due to the awareness that HIV is a disease that can lead to death. These dysfunctions gave rise to negative feelings among PLHIV, leading to self and social dysfunction. An interview with participant W (male, 27 years old) revealed that he felt sad about being HIV positive and was afraid of societal stigma.

> "Kayak ngerasa sedih, ngerasa kurang percaya diri sih. Karena dulu kan emang pas awal tuh nggak, nggak tahu HIV. HIV itu apa? Pas udah tahu, terus pas punya kenalan dan ternyata kenalan atau masyarakat itu tuh stigmanya masih kuat. Jadi ya yang bikin ngerasa down tuh ya itu."
>
> (W, W1, 8-2-2025, N 75).
>
> (I feel sad and less confident. Because at first, I didn't really know what HIV was. After I found out, and then realized that acquaintances or society still hold strong stigma, that's what made me feel down).

Negative feelings were also experienced by participant N (male, 19 years old), who stated that he once had suicidal thoughts due to worries about his future and fear of being rejected by his family after being diagnosed as a person living with HIV.

> "Tapi aku pernah... kepikiran kayak... buat... bunuh diri tapi nggak terlalu dipikirin Cuma kepikiran aja gitu. Tapi kalo aku bunuh diri, juga nggak mengubah kondisi kan, dijalani se, dijalanin aja gitu. Paling Cuma dapet kekhawatiran aja mungkin kayak masa depan gimana, kerja gimana, orang tua gimana gitu-gitu." (N, W1, 18-2-2025, N 940).
>
> (I once thought about committing suicide, but didn't really think too much about it, just the thought crossed my mind. But if I commit suicide, it also will not change the condition, right? Just live it, just go through it like that. At most, it only brings worries, maybe like how about my future, about work, about parents, things like that).

Participant A (male, 32 years old) almost experienced an accident on his way home from counseling after finding out that he was HIV positive. This was caused by the shock of the VCT test results showing HIV positive, which made A lose focus while riding home.

> "Waktu dikonseling sih oke-oke aja ya, cuman pas perjalanan pulang ya nangis. Sambil nangis, ya nangis, sampe hampir ketabrak truk tronton gara-gara nge-blank. Karena

kan hilang fokus, nge-blank, jadi emang eee... hampir kena musibah. Cuma nggak yang sampe, nggak yang sampe kena, alhamdulillah." (A, W1, 20-2-2025, N 150)

(During the counseling, I was okay, but on the way home, I cried. While crying, I cried until I almost got hit by a trailer truck because I blanked out. Because I lost focus, blanked out, so I almost had an accident. But it didn't get to the point of actually happening, thank God).

Based on interviews with the three participants, it was found that they experienced negative feelings such as fear of societal stigma, shock, and suicidal thoughts after learning their HIV-positive status, as well as anxiety about the future and rejection from their families. These various negative feelings represent a form of grief experienced as a person living with HIV (PLHIV). Simoni et al. (Sarafino & Smith, 2011) stated that when first learning of their HIV status, PLHIV regard it as an initial major problem. They tend to feel anxious, show withdrawal behaviors from their surroundings, and choose to keep the information tightly guarded. This anxiety arises from the fear of stigma and discrimination from the community, and even from their closest family. Such stigma often emerges due to the community's lack of knowledge about HIV.

Yani et al. (2020) explained several forms of stigma directed at PLHIV, including: first, instrumental stigma, which is the fear of contracting a deadly disease, creating discomfort when in close proximity to PLHIV. Second, symbolic stigma, in which people assume that PLHIV deserve the infection due to their so-called deviant behaviors, thus subjecting them to social punishment. Third, courtesy stigma, which includes prohibitions on socializing with PLHIV, with the belief that it is better to avoid and isolate them.

In dealing with negative feelings related to grief, Kubler-Ross (Kessler, 2018) described five stages of self-acceptance experienced by individuals with chronic, life-threatening illnesses (terminal illness). These stages are denial, anger, bargaining, depression, and acceptance. Self-acceptance is defined as an individual's ability to view their true self in a positive light. It does not occur spontaneously but must be developed by the individual (Germer, 2009).

A person living with HIV (PLHIV) with a homosexual orientation experiences double social sanctions in society. These sanctions cause negative feelings such as depression and anxiety, which affect self-acceptance and the quality of life of PLHIV. The lower the level of self-acceptance in PLHIV, the lower their adherence to ARV therapy (Prabunusa, 2024), which may lead to drug resistance and trigger opportunistic infections. Suryanto et al. (2024) explained that good self-acceptance is the foundation of successful adherence to ARV treatment among PLHIV, as an expression of gratitude for being able to continue living. With both physical and psychological well-being, gratitude arises, thereby improving the quality of life of homosexual-oriented PLHIV (Rohman & Prof. Taufik, 2022).

Self-concealment and distrust of the surrounding environment are the main factors contributing to the lack of self-acceptance among homosexual PLHIV. Difficulties in

communicating with the social environment due to feelings of insecurity and distrust become barriers for PLHIV to be open about their status (Dwianita, 2018). PLHIV tend to isolate themselves and maintain distance, which prevents interaction with the surrounding environment and hinders access to social support needed for self-acceptance. Other obstacles that influence self-acceptance include unpleasant or unwelcoming attitudes from community members, environmental barriers, severe emotional difficulties, and a persistent negative outlook toward the future (Sheerar, 1963).

The process of self-acceptance among PLHIV takes various forms. Research by Wisnudiputro (2019) states that the stages of self-acceptance experienced by each PLHIV differ and do not always follow the sequence proposed by Kübler-Ross. PLHIV adopt different approaches to achieve self-acceptance. According to Qo'imah (2019), these include having realistic expectations of oneself, being able to fully accept oneself, not being fixated on others' opinions, and maintaining freedom in carrying out activities and realizing their dreams.

Peer support group (PSG) provide meaningful social support, enabling PLHIV to recover from a difficult state. PLHIV who have accepted themselves demonstrate characteristics of good self-acceptance, such as being consistently grateful, optimistic about always doing their best, having healthy self-esteem, a desire to prove themselves, feeling equal in rights with others, resisting differential treatment, wanting to help and share with others, engaging in self-reflection, and strengthening their relationship with God (Putri & Tobing, 2018). In line with this, Koritelu et al. (2021) explain that PLHIV who have accepted themselves with all their strengths and weaknesses are still able to carry out daily activities while consistently taking ARV with full commitment.

In this study, the researchers introduced novelty by selecting participants with a homosexual orientation who contracted HIV through risky same-sex intercourse. This was based on statistical data and interviews showing that HIV cases in Semarang City are predominantly among MSM groups. The difference in the length of time since diagnosis served as another innovative aspect, allowing for comparison of the self-acceptance processes of each research participant.

The purpose of this study is to explore the self-acceptance of homosexual-oriented PLHIV, from the moment they first learn of their HIV diagnosis to the point of accepting themselves as part of PLHIV in PSG Kariadi Semarang. Various negative reactions after diagnosis, the processes undertaken, and the solutions applied to reach self-acceptance are the central focus of this study.

2. METHODS

Research Design

This study used a qualitative method with an intrinsic case study model. Stake explains that an intrinsic case study is conducted to gain a deeper and more detailed understanding of

the characteristics of a particular individual, group, event, or organization (Miles & Huberman, 1984). The intrinsic case study was chosen because it focuses in depth on the process of self-acceptance among PLHIV in PSG Kariadi Semarang and is not intended to generalize to PLHIV in other populations.

Participant's Characteristics

The participants in this study were three men living with HIV who were members of PSG Kariadi Semarang, with the following criteria: (1) homosexual orientation, and (2) contracted through same-sex sexual intercourse. The sampling technique used to determine the research participants was non-probability with a snowball sampling type. Snowball sampling was used to help the researcher identify individuals who had important information for the study. The researcher began with a key participant who was considered to have good knowledge of the context being studied. The researcher then asked the key participant to recommend others based on their knowledge of who might know a lot about the context in question. The researcher started with a relatively small list of participants, which continued to grow (like a snowball) as more names were added through participant recommendations (Mertens, 2020). The sample selection was carried out by approaching participants at Poncol Community Health Center, Semarang. The characteristics of the research participants can be seen in Table 1.

Table 1 Characteristics of Research Participants

No.	Description	Participant W	Participant N	Participant A
1.	Age	27 years old	19 years old	32 years old
2.	Occupation	Self-Employed	Student	Self-Employed
3.	Domicile	North Semarang	East Semarang	West Semarang
4.	Date of Diagnosis	August 20, 2018	July 18, 2024	July 29, 2016
5.	Duration of Diagnosis	6 years 9 months	0 years 10 months	8 years 10 months
6.	Spouse Status	Single	Single	9 years

Data Collection Methods

This study used semi-structured interviews and both overt and covert observations of each research participant. Semi-structured interviews allowed participants the freedom to provide answers, while still remaining within the flow of the predetermined theme (Sugiyono, 2015). The interview guidelines for participants were prepared based on the Stages of Self-Acceptance by Kubler-Ross (Kessler, 2018), which were then further developed according to facts found in the field during the interviews. The participant interview guidelines can be seen in Appendix 1. Overt observation was carried out by the researcher during the data collection process by stating the purpose and objectives of the study to the participants (Sugiyono, 2015). Thus, participants being studied during the interviews were aware from beginning to end of the researcher's activities.

Data Analysis Method

This study used manual data analysis techniques with the interactive model proposed by Miles & Huberman (Miles & Huberman, 1984b). Data collection was carried out from the beginning to the end of the research and was compiled in the form of concepts throughout the process. Data reduction was conducted by selecting, simplifying, and transforming raw data during field data collection, so that the reduced data provided a clearer picture and facilitated the search process. The data were then presented in the form of narrative information, allowing for conclusion drawing and decision-making. Finally, verification or conclusion drawing was conducted once the data had been analyzed in a standardized manner, so that the initial conclusions could be considered reliable. However, these conclusions could change after the discovery of strong and consistent supporting evidence, leading to new and more credible conclusions.

3. RESULTS

Denial is the first stage faced by an individual immediately after learning the fact that there is a disease in their body that can take their life at any time. At this stage, the individual tends to experience shock and denial due to disbelief in the diagnosis conveyed. In the anger stage, the individual who has realized that death is getting closer may begin to blame themselves or even others, such as their partner, because they feel like a victim who contracted the disease. Bargaining is the stage when the individual tries to negotiate with God in hopes of healing and the possibility of changing their condition. The fourth stage, depression, develops when the individual feels that death is very near and that there is no longer any hope of recovery, which leads to despair, prolonged sadness, and pessimism about life. The final stage is acceptance, when the individual has released all forms of grief experienced, found peace in accepting everything that has happened, and is ready to face death (Kubler-Ross, 2008).

There are several factors that support self-acceptance according to Kubler-Ross (2008), including: (1) openness within the individual; (2) trust in others; (3) good quality of life; (4) personal satisfaction; (5) adequate information about the illness suffered; and (6) social support.

Participant W

This study categorized six main themes and several superordinate themes in participant W which can be seen in Table 2.

Table 2 Main Themes

No.	Main Themes	Superordinate Theme
1.	Denial	Unprepared for the stigma
		Not accepting reality
		Limiting oneself
2.	Anger	Blaming others
		Blaming oneself
3.	Bargaining	Committing to or praying to God
		Hoping in health workers
4.	Depression	Quarter-Life Crisis*
		Worry about the future
		Prolonged sadness
		Feelings of hopelessness
5.	Acceptance	Accepting reality (legowo)*
		Stoicism*
		Atonement*
		Being a peer supporter*
		Calmness and peace
		Having realistic life goals
		Preparedness for death
		Regularly taking ARVs
		Conversion therapy*
		Coping with stress*
		Desire to marry*
		Openness
6.	Solution	Trust in others
		Having a good quality of life
		Self-satisfaction
		Obtaining good information about HIV
		Obtaining social support

Note: An asterisk (*) indicates a new finding in the research.

The denial that occurred with participant W was quoted through an interview:

> *"Eee... aku lebih ke membatasi diri sih. Kalo untuk denial sing kayak yang ngerasa kok bisa kena atau apa, ada, pasti ada. Itu aku hubungan seksual setahun setengah, atau setahunan, itu udah mulai apa, pas setahun setelah hubungan itu tuh langsung kena. Jadi ya ngerasa kok, gini juga, maksudte baru-baru terjun di eee... hubungan seksual tapi kok selang setahun udah kena."* (W, W1, 8-2-2025, N 90).
>
> (I tend to denied myself, like feeling "how could I get this" or such. I had sexual relations for about a year and by that time, I immediately got the infection. So, I felt like, how could this be? I mean, I had just recently gotten involved in sexual relations, yet only takes one year to get me infected).

Participant W experienced denial in the form of disbelief that engaging in sexual relations for less than a year had already made him HIV positive. In addition, W was not prepared to face the stigma, as society still perceives HIV as a disgraceful disease. This condition led W to choose to limit interactions with the surrounding environment in order to avoid such stigma. The form of anger expressed by Participant W was reflected in the interview as follows:

> *"Marah sama diri sendiri, marah sama yang partner yang nggak jujur. Jujur kan aku, ya gimana ya mas, aku kan baru setahun terjun di eee... apa ya hubungan badan kayak gitu. Masa iya udah langsung kena kan? Pasti marah ada eee... pastinya marah sama partner, terus marah ke diri sendiri, kenapa tidak aware, dan manut-manut wae kayak gitu."* (W, W1, 8-2-2025, N 135).
>
> (Angry at myself, angry at the partner who wasn't honest. I was honest, but how should I put it? I had only been involved in that kind of sexual relationship for about a year. How could I have gotten infected so quickly, right? Of course, there was anger, definitely anger at the partner, then anger at myself for not being aware, and just blindly going along like that).

Participant W felt angry toward the partner who was not honest about his health condition, which led to Participant W contracting HIV. In addition, Participant W also blamed himself because, despite having limited knowledge about HIV, he still recklessly engaged in risky same-sex intercourse. Nevertheless, the participant only kept those feelings inside and did not express his anger to the partner, as there was not enough evidence to show that the partner was HIV positive.

The bargaining expressed by Participant W is reflected in the statement:

> *"Eee... pasti... ada mas, kayak dulu-dulu kan emang... pernah eee.... simpang-siur kayak semisal kita operasi tulang sumsum belakang atau apa kan itu kita bisa sembuh. Nah dari situ kayak aku pun juga berharap bisa sembuh gitu lho. Tapi kan kayak gitu butuh biaya, biaya nggak sedikit ya. cuman ya berdoane ya ke Tuhan, maksudte kalo semisal emang ada obatnya atau emang bisa disembunyiin ya semoga bisa sembuh kayak gitu. Pasti ada sih mas, siapa sih yang nggak mau sembuh?"* (W, W1, 8-2-2025, N 280).
>
> (Of course, there were rumors, for example, if we had spinal cord surgery or something like that, we could be cured. From there, I also hoped to be cured, you know. But something like that requires money, a lot of money. So, I just pray to God, I mean if there really is medicine or if it can really be hidden, then hopefully I can be cured. Of course there is, who wouldn't want to be cured?).

Participant W did not show any religious behavior while living with HIV, but still hoped for healing from God as a form of the bargaining stage. Participant W placed hope in healthcare workers through increasingly advanced health technologies for more efficient ARV treatment.

The depression stage experienced by participant W was expressed in the interview results as follows:

"Sedih berkepanjangan, tapi... nggak yang sampe mengurung diri atau apa." (W, W1, 8-2-2025, N 445).

(Prolonged sadness, but not to the point of isolating myself or anything).

"Nggak-nggak. cuman kayak ngerasa sedih, sedihnya tuh pas sendirian, di kamar atau apa. Kan pas, pas nggak sendirian atau di tempat pas kerja tuh... pikiran itu tuh ilang. Tapi pas udah sendiri di kamar, atau pokoknya pas lagi sendirian deh, pasti ke-trigger. Tapi kalo semisal udah ngelakuin aktivitas yang eee... umum, maksudte nggak sendirian... itu biasa aja." (W, W1, 8-2-2025, N 450).

(No, it's just feeling sad, the sadness comes when I'm alone, in my room or something. When I'm not alone or when I'm at work, those thoughts disappear. But when I'm alone in my room, or basically whenever I'm by myself, it always gets triggered. But if I'm doing some activities, meaning not being alone, then it feels normal).

Participant W often felt sadness and despair about whether he would be able to continue living, having been diagnosed with HIV at such a young age. These feelings of depression arose when the participant was alone in his room.

The form of self-acceptance by participant W was shown through a sense of resignation and acceptance of being an PLHIV, as expressed in:

"Nek cara penerimaan diriku itu... apa ya mas ya... nek dibilang... egois nggak sih? Eh... kayak... ya itu... tak bilang tadi lho (stoikisme) mas. Yang udah terjadi yo uwes meh di... meh dipikirke apa pun yo nggak bakal bisa mengubah apa pun. Nek dipikir banter pun atau di... gimana ya mas cara penerimaan diri... lebih legowo... aku kan tipe orang, sebenernya tipe orang sing semisal ada masalah tak pikir, tapi nggak sing tak pikir tenanan gitu lho mas, paham orak?" (W, W1, 8-2-2025, N 550).

(The way I accept myself is, how should I put it? Wouldn't it be called selfish? Eh, like, yeah, it's like what I said earlier (stoicism). What has already happened, well, no matter how much I think about it, it won't change anything. Even if I think really hard about it or, how do I say this, my way of self-acceptance is more about accepting. I'm actually the type of person who, if there's a problem, I think about it, but not too deeply, you know what I mean?).

Participant W developed the concept of *legowo* (sincere acceptance) within himself and chose not to dwell too deeply on the problem. The reason Participant W thinks this way is because what has already happened to him cannot be changed, even if he thinks about it deeply.

The solution implemented by participant W to be able to accept himself was in the form of a stress coping strategy which was explained in the interview results:

> *"Alhamdulillah nggak ada mas, aku tipe ya itu, eee... yang udah terjadi ya udah. Kalo ngerasa sedih, putus asa, putus asanya tuh lebih ke... ada mas, tapi maksudte putus asanya bukan yang sampe yang bener-bener putus gitu lho mas. Tapi ada pemikiran kayak eee... bisa nggak sih melanjutkan hidup atau... kayak orang-orang lain itu pasti ada, cuman... eee... aku tak, tak motivasi... atau nggak tak kasih kalimat afirmasi, biar nggak kepanjangan. Soalnya kalo tak pikirin terus kan nantinya jadi depresi kena mentalnya kan."* (W, W1, 8-2-2025, N 460).
>
> (Alhamdulillah, there's none. I'm the type who thinks that what has happened, has happened. If I feel sad or hopeless, yes, I do feel that way, but what I mean is the hopelessness isn't something that goes to the extreme. But there are thoughts like "can I still continue living?" or such. Like other people, those thoughts are definitely there. But then I motivate myself or give myself affirmations, so it doesn't drag on. Because if I keep thinking about it, it will eventually lead to depression and affect my mental health).

> *"Itu, apa, stoik... stoikisme itu lho, tak terapin juga di HIV sih mas. Kayak, lebih... apa ya, lebih ke... nggak terlalu memikirkan apa yang udah terjadi. Ya, ya uwes kayak gitu." (W, W1, 8-2-2025, N 580)*
>
> (That's, you know, stoic... stoicism. I also apply it to myself as HIV patient. Like, how should I put it, more about not thinking too much about what has already happened. Yeah, just letting it be like that).

Participant W adopted stress coping strategies in the form of self-affirmations and stoicism in carrying out daily activities to maintain mental health, thereby preventing stress that could negatively affect physical health.

Participant N

This study categorized six main themes and several superordinate themes for participant N, which can be seen in Table 3.

Table 3 Main Themes

No.	Main Themes	Superordinate Theme
1.	Denial	Refusing to take ARVs* Not accepting reality Shock
2.	Anger	Looking for second option (justification) Blaming oneself

No.	Main Themes	Superordinate Theme
3.	Bargaining	Guilt
		Committing or praying to God
		Committing to oneself
		Religiosity
4.	Depression	Desire to die
		Feeling guilty about past actions
		Worrying about the future
		Feelings of regret about the current situation
		Feelings of hopelessness
5.	Acceptance	Legowo*
		Atonement*
		History of chronic illness*
		Calmness and peace
		Understanding the meaning of life
		Realistic life goals
		Readiness for death
		Regularly taking ARVs
6.	Solution	Openness
		Trust in others
		Having a good quality of life
		Self-satisfaction
		Obtaining good information about HIV
		Obtaining social support

Note: An asterisk (*) indicates a new finding in the research

Partisipan N mengalami tahapan denial yang dikemukakan dalam hasil wawancara sebagai berikut:

> *"Kalo denial ya ada. Setelah tes, tahu hasilnya kan nggak ekspek juga kalo hasilnya reaktif. Paling juga non-reaktif kan kiranya gitu, ternyata reaktif. Setelah itu, aku coba tes lagi pakai tes yang, tes individu, yang di-swab di mulut, itu hasilnya non-reaktif. Non-reaktif jadi kan agak sedikit di hati kan jadinya tenang. Tapi terus aku dihubungi sama pihak puskesmas di Bandarharjo, buat dateng ke sana, buat memastikan juga, memastikan lagi. Nah aku minta tes ulang karena emang belom percaya. Karena masih kayak, 'kok bisa?' kayak gitu. Terus setelah dites darah selanjutnya hasilnya juga reaktif. Yaudah terus pulang, pulang ya sambil percaya nggak percaya, tapi udah terlanjur dan udah dikasih ARV juga kan, yaudah mau nggak mau diminum."* (N, W1, 18-2-2025, N 55).
>
> (If denial, yes, it was there. After the test, when I found out the result, I didn't expect it would be reactive. I thought it would most likely be non-reactive, but it turned out to be reactive. After that, I tried testing again using an individual test, the one swabbed in the mouth, and the result was non-reactive. Non-reactive, so in my heart, it felt a bit calmer.

But then I was contacted by the public health center in Bandarharjo, asked to come there to confirm again, to be sure. Then I requested another test because I really didn't believe it yet. I was still like, "how could this happen?" like that. Then after the next blood test, the result was also reactive. Well then, I went home, still half-believing and half not, but since it had already happened and I was also given ARVs, like it or not, I had to take them).

When learning of the initial HIV diagnosis, participant N experienced shock because he could not accept the VCT test result that showed he was HIV positive. Participant N sought reassurance by doing a self-administered HIV swab test, which showed a negative result, making him feel calm and causing him to delay treatment for one week. However, one week after taking the swab test, the participant was asked to undergo another VCT test, which then showed a reactive HIV result.

The anger stage felt by participant N was revealed in the interview results:

"Kalo marah nggak, cuman kayak me... menyalahkan diri sendiri kenapa bisa jatuh ke... bisa terjerumus gitu lah. Kayak kalo misalkan partner kan emang sama-sama mau jadi ya udah, terus udah sama-sama risiko juga kan dari apa yang kita perbuat pasti ada balasannya. Dan itu kita harus mau bertanggung jawab atas semua risiko yang kita lakukan di kegiatan sebelumnya." (N, W1, 18-2-2025, N 175).

(If anger, no, but more like blaming myself for why I could fall into... could get carried away like that. Like, if it's about the partner, well, we both agreed so that's it, and we both already knew the risks too, right, that from what we did there would definitely be consequences. And we must be willing to take responsibility for all the risks from the activities we did before).

Participant N felt angry at himself for falling into same-sex sexual activity, which ultimately led to being diagnosed with HIV. Participant N did not blame his partner because the act was based on mutual agreement, so he had to be ready to accept the consequences faced.

Then, the bargaining stage experienced by Participant N was described through the following interview:

"Kalo ke dokter aku... nggak pernah ya mas, tapi kalo ke Tuhan pernah mas. Tapi kalo aku logika negosiasi sama petugas layanan kesehatan juga, mereka bukan yang mengatur hidup, mereka bukan yang membuat hidup, yo aku mikirnya ke Tuhan. Buat apa aku negosiasi sama mereka gitu, mau negosiasi semacam apa pun itu aku udah di fase pelayanan gratis aja itu, ya udah Alhamdulillah, tapi kalo sama Tuhan ya pasti negosiasinya sebelum aku menerima diriku sebelum minum ARV kan, aku sebelum tes yang di Bandarharjo kan aku negosiasi sama Tuhan juga itu kan, kalo hasilnya, aku tes kali ini non-reaktif seperti aku tes mandiri, mungkin aku janji akan

bertobatlah, tidak melakukan kesalahan yang sama dan sebagainya gitu. Malah lebih mendekatkan diri ke Tuhan ke pemilik hidup, lebih mencurahkan hidup untuk lebih beribadah dan bermanfaat bagi orang lain gitu." (N, W1, 8-2-2025, N 445)

(If going to a doctor, I've never done that, but to God, I have. But if I were to logically negotiate with healthcare staff, they're not the ones who control life, they're not the ones who give life, so I direct my thoughts to God. What's the point of negotiating with them? No matter what kind of negotiation, I was already in the free service phase, so Alhamdulillah. But with God, the negotiation happened before I accepted myself, before taking ARV, before the test at Bandarharjo, I also negotiated with God. If the result of this test were non-reactive like my independent test, I would promise to repent, not make the same mistakes, and so on. It even brought me closer to God, the owner of life, dedicating my life to worship more and be useful to others).

At the bargaining stage, participant N only negotiated with God as the giver of life. The bargaining involved a personal commitment to God: if the VCT test result was non-reactive, participant N promised to repent, stop engaging in risky same-sex sexual activities, and try to draw closer to God.

At the depression stage, participant N described the symptoms of depression experienced through the following interview:

"Nggak sih mas, tapi sekarang Alhamdulillah, kadang dimintai tolong ini, dimintai tolong itu. Nah aku tuh sempet kepikiran bunuh diri, walaupun kepikiran gitu aku tetep masih mikir lagi tuh, semisal aku masih dibutuhin, dibutuhin orang-orang sekitar gimana gitu. Sedangkan banyak di sekitarku tuh yang butuhin aku, mungkin dari mbahku, orang tuaku." (N, W1, 18-2-2025, N 630).

(No, not really, but now Alhamdulillah, sometimes people ask me for help here and there. I did have thoughts of suicide, but even though I thought about it, I still considered whether I am needed, how the people around me might need me. Many people around me do need me, maybe my grandparents, my parents).

The participant N once thought about committing suicide because he felt he had lost his purpose in life as a PLHIV at a young age. However, participant N was able to abandon the idea by convincing himself that he is useful and needed by the people around him.

The stage of self-acceptance for participant N is expressed in the following interview excerpt:

"Mencoba buat berpikir legowo aja sih mas, kayak mungkin dengan ini aku nggak bakal melakukan hal-hal yang salah lagi, lebih dekat dengan Tuhan, lebih memikirkan segala sesuatu tuh dengan logika yang mateng gitu, nggak angger ceroboh, grusak-grusuk gitu. Menghindari

kesalahan-kesalahan kek bisa berpikir positif, Tuhan ada, Tuhan mendukung, Tuhan tidak akan membiarkan umatnya itu dalam kesusahan terus-menerus gitu, misalkan diuji yo nggak akan di atas kemampuannya gitu." (N, W1, 18-2-2025, N 1020).

(Just trying to think with acceptance, like maybe with this I won't do wrong things anymore, get closer to God, think about everything with mature logic, not recklessly or carelessly. Avoiding mistakes, I can think positively, God exists, God supports, God will not let His people be in hardship continuously, if tested, it won't be beyond their capacity).

"Aku juga sebelum konsumsi ARV kan juga udah minum obat hipertensi yang diminum seumur hidup kan, jadi ya udah diminum aja." (N, W1, 18-2-2025, N 215)

(Before taking ARV, I was already taking hypertension medication that I have to take for life, so I just take it anyway).

The self-acceptance demonstrated by participant N involves feeling at peace with their condition, becoming more cautious and logical in making decisions, and consistently surrendering to God. Participant N, who has a history of chronic illnesses such as hypertension and heart disease since high school, perceives HIV as a similarly life-threatening disease, which aids the process of self-acceptance.

Participant N's self-acceptance can be achieved through the solutions they applied, as expressed in the interview results:

"Ini kan aku emang yang nggak bisa bohong sama keluargaku, aku tuh paling nggak bisa terutama sama ibu. Jadi apa pun kondisinya, apa pun yang sedang aku lakukan, aku bilang. Nah kemarin waktu aku berusaha bohong tuh rasanya kayak ganjel banget di hati gitu. Kayak... aku tuh selama menjalaninya nggak bisa tenang kayak keinget-keinget terus. Nggak bisa aku. Terus akhirnya, nggak ada seminggu setelah aku minum ARV aku... langsung ngomong ke mereka. Ya mereka Alhamdulillah support, support sih. Karena aku dapet, aku dapet, biasanya aku kalo refill vitamin atau ARV itu ya, itu kan 2, langsung 2..." (N, W1, 20-2-2025, N 250).

(Since I really can't lie to my family, especially to my mother, I always tell them whatever my condition is or whatever I'm doing. Yesterday, when I tried to lie, it felt really heavy in my heart. Like… I couldn't feel at peace while going through it, kept thinking about it constantly. I just couldn't. So finally, less than a week after taking ARV, I… immediately told them. Alhamdulillah, they were supportive. Because I got it, I got it… usually when I refill vitamins or ARV, it's two at a time, right, so two).

"Iya. Karena aku, maksudnya aku biar nggak bolak-balik gitu, aku langsung di kasih 2. Dua itu pun orang tuaku yang kayak ngelepasin kulitnya, biar jadi botol polosan gitu. Terus ngingetin minum obat gitu." (N, W1, 20-2-2025, N 255).

(Yes. So, I wouldn't have to go back and forth, they just gave me two at once. My parents even removed the labels so they'd become plain bottles. Then they reminded me to take the medicine).

Participant N's openness about their PLHIV status to their parents became the main solution in achieving self-acceptance. Participant N received strong support from both parents, including reminders to take medication, keeping track of ARV schedules, and removing the labels from the medicine bottles.

Participant A

This study categorizes six main themes and several superordinate themes which can be seen in Table 4.

Table 4 Main Theme

No.	Main Theme	Superordinate Theme
1.	Denial	Not accepting reality
		Shocked
2.	Anger	-
3.	Bargaining	Guilt
		Wishful thinking
		Committing to or praying to God
		Hoping in healthcare workers
		Committing to oneself
		Religiosity
4.	Depression	Suffering as a PLHIV
		Worry about the future
		Prolonged sadness
		Feelings of hopelessness
5.	Acceptance	Legowo*
		Atonement*
		Becoming a peer supporter*
		Serenity and peace
		Understanding the meaning of life
		Realistic life goals
		Preparedness for death
		Regularly taking ARVs
		Desire to marry*
6.	Solution	Openness
		Trust in others
		Having a good quality of life
		Self-satisfaction
		Obtaining good information about HIV
		Obtaining social support

Note: An asterisk (*) indicates a new finding in the research.

The denial stage in participant A is stated in the interview results:

> *"Kalo menolak sih nggak ya, tapi lebih tepatnya kayak merasa nggak percaya. Merasa kayak 'Serius? Aku HIV?' seperti itu, jadi ngerasa kayak, belom percaya sama sekali. 'Masa sih aku HIV?' padahal kan emang selama ini membatasi banget eee... HS (Hubungan Seksual) sama siapa pun. Terakhir apa namanya, menjalani hubungan juga sudah kurang lebih satu setengah tahun dan cuman melakukan hubungan yang berisiko cuman dua kali dan ternyata... VCT terakhir dinyatakan reaktif. Sempet terpukul sih, cuman ya sudahlah, sudah terjadi mau gimana lagi, cuman masih kadang, bukan kadang ya emang pertama-pertama belom nerima sih, nggak percaya sama sekali."* (A, W1, 20-2-2025, N 40).
>
> (When it comes to denial, not exactly, but more like disbelief. Feeling like, "Seriously? I'm HIV positive?"—so I felt like I couldn't believe it at all. "Could I really be HIV positive?" even though I had been very careful with sexual relations. The last time, well, I had been in a relationship for about a year and a half and only engaged in risky sex twice, and yet… the last VCT test came back reactive. I was a bit shocked, but well, it happened, what can I do? Still, at first, I really couldn't accept it, didn't believe it at all).

Participant A felt deeply shocked by the VCT test results showing HIV positive. Participant A claimed to have limited engagement in risky sexual behavior. After receiving counseling upon learning the fact that he had become a PLHIV, Participant A experienced shock and disbelief at the reality he faced.

Participant A did not experience the anger stage, as reflected in the interview excerpt:

> *"Nggak pernah menyalahkan siapa pun, nggak pernah cari tahu dapet dari mana, eee... karena memang aku melakukan hubungan yang berisiko dengan sadar, dengan eee... apa ya, suka sama suka, jadi memang tidak ada yang perlu disalahkan. Karena memang atas dasar suka sama suka, dan salahnya, melakukan hubungan yang berisiko lewat belakang, jadi ya, eee... apa pun hal negatif yang telah aku perbuat, itu sudah menjadi konsekuensi atas apa yang aku lakukan."* (A, W1, 20-2-2025, N 260).
>
> (I never blamed anyone, never tried to find out where I got it from, uh… because I knowingly engaged in risky sexual activity, with, uh… mutual consent, so there's really no one to blame. Since it was based on mutual consent, and the mistake was engaging in risky sexual activity anally, uh… any negative consequences from what I did are simply the results of my own actions).

Participant A strives not to blame anyone, neither their sexual partner nor themselves. This is because Participant A consciously understands that engaging in same-sex sexual activity carries risks and was done with mutual consent, so they must be prepared to take responsibility for the consequences.

Participant A made the bargaining described in the interview results:

> *"Eee... aku orangnya memang, eee... gimana ya, ya pasti lah, orang pasti pengen lebih baik lagi lah, cuman kalo berjanji untuk mungkin lebih agamis atau mungkin lebih apa, kayaknya nggak deh. Jadi ya lempeng aja lah ya, jalani aja lah"* (A, W1, 20-2-2025, N 565).
>
> (I'm that kind of person, uh… how should I say. Of course, everyone wants to be better, but if it's about promising to be more religious or something like that, probably not. So I just take it easy, just go with the flow).
>
> *"Iya, bisa jadi (religiositas hilang). Karena merasa nggak ada efek samping sama sekali, jadi memang karena terlena dengan kondisi badan yang sehat, pasca sakit-sakitan, jadi memang, main, apa segala macem."* (A, W1, 20-2-2025, N 610).
>
> (Yes, that could happen (loss of religiosity). Because I feel there are no side effects at all, so I got complacent with my healthy condition, after being frequently sick, so I just… go out, do everything).

Participant A negotiated with God by hoping to become a better person. This made Participant A more religious in practicing Islamic worship. However, Participant A lost religiosity because he did not experience any side effects from the ARV treatment after receiving the TLD regimen in 2020, and was also influenced by his partner, who rarely performed religious practices due to work commitments. Participants N and A did not place hope in healthcare workers because they have no power to cure HIV.

The depression stage experienced by Participant A is described in the following interview:

> *"Dulu sampe beberapa, berapa minggu yo? Beberapa minggu karena memang setiap malem pasti nangis. Tiap malem pasti nangis, karena dulu kan ngekos sendiri, nggak ada temen, nggak ada yang mendampingi, nggak ada yang apa ya, yang mengarahkan harus apa jadi setiap malem selalu nangis."* (A, W1, 20-2-2025, N 175).
>
> (In the past, for several… weeks I presume? A few weeks, because every night I would cry. Every single night I cried, since I was living alone in a boarding house, had no friends, no one to accompany me, no one to guide me on what to do, so every night I would just cry).
>
> *"Dua mingguan kurang. Kurang dari dua minggu."* (A, W1, 20-2-2025, N 200).
>
> (For less than two weeks).

Participant A became deeply saddened after receiving his HIV diagnosis. His despair stemmed from the fear that if he were HIV positive, he would surely die. Participant A exhibited symptoms of depression during the first two weeks after his HIV diagnosis due to the loneliness he felt without support.

Participant A's self-acceptance was expressed through the interview:

> *"Iya. Bener-bener yaudah, legowo aja, lagian nggak sakit juga kan, nggak sakit, kita cuma, kita cuma harus rutin minum ARV kan. Nggak ada penyesalan, nggak ada rasa-rasa sedih lagi sih." (A, W1, 20-2-2025, N 1100).*
>
> (Yes. Really, just accept it, be at peace, anyway I'm not sick, right? Not sick, just have to take ARV regularly. No regrets, no more feelings of sadness).

The stage of self-acceptance for participant A is reflected in a sense of being at peace with the PLHIV status experienced. Participant A believes that as long as he takes ARV medication regularly, his physical condition will remain healthy, preventing any feelings of regret.

The form of solution that participant A found in achieving self-acceptance is explained through the interview results:

> "*Salah satu dukungan terbesar dari temen-temen PSG. Kalo mungkin aku nggak kenal mereka, aku nggak bisa survive, nggak bisa eee... nggak tahu ya mungkin putus obat karena banyak efek samping, jadi ngerasa kayak 'Ini aku sehat, minum ARV kenapa malah jadi sakit?' mungkin kalo nggak ada mereka aku nggak bakalan minum obat sama sekali. Aku takut minum ARV, karena ada dorongan dari temen-temen, jadi memang tetep mengonsumsi ARV, dengan sekian banyak efek sampingnya.*" (A, W1, 20-2-2025, N 760).
>
> (One of the biggest supports came from friends at PSG. If I hadn't known them, I wouldn't have survived, I wouldn't have… I don't know, maybe I would have stopped taking the medication because of all the side effects, feeling like 'I'm healthy, why does taking ARV make me sick?' Maybe without them, I wouldn't have taken the medication at all. I was afraid of taking ARV, but with encouragement from my friends, I kept taking ARV despite all its side effects).
>
> "*Iya. Dan memang kan dia (pasangan) sudah positif sudah lebih lama dari aku. Jadi memang, relasi dia kan memang orang-orang yang udah lama positif juga. Lima belas tahun, 28 tahun, jadi aku dikenalkan sama mereka, jadi aku timbul semangat, untuk sehat terus, salah satunya ya dari dia, karena memang relasinya dia memang orang-orang yang sudah lama.*" (A, W1, 20-2-2025, N 940).
>
> (Yes. And indeed, he (peer-support partner) has been positive longer than I have. So, his circle consists of people who have been positive for a long time. Fifteen years, twenty-eight years, so I was introduced to them, which gave me motivation to stay healthy, one of the reasons is him, because his circle consists of people who have been positive for a long time).

The solution that participant A used to achieve self-acceptance was by receiving support from fellow PLHIV members in PSG and from his homosexual partner. The support provided included moral support and consistently accompanying participant A in his treatment.

Based on the research findings, it can be seen that the three participants exhibited different denial responses upon learning their HIV diagnosis. Participant W did not believe it because he contracted HIV despite only engaging in risky same-sex sexual activity for one year. Participant N experienced shock and sought justification through independent swab testing, even refraining from ARV treatment for the first week after the HIV diagnosis. Participant A experienced shock and did not believe the VCT results because he felt he had limited risky same-sex sexual activity. The denial in all three participants was triggered by fear of societal stigma and disbelief in the diagnosis results.

Among the three participants, only two went through the anger stage. Participant W expressed anger toward his partner, who was considered dishonest, and blamed himself for not being careful during sexual activity. Participant N only blamed himself for engaging in same-sex sexual activity but did not blame his partner because the action was based on mutual agreement. Participant A did not experience the anger stage and did not blame anyone, as he recognized that the risky actions were consciously chosen and that he had to take responsibility for the consequences.

All three participants engaged in bargaining by praying to God for healing and committing to become better individuals. Participants N and A increased their religious practices as an expression of religiosity. Participant N's negotiation with God included a promise to repent if the VCT test result came back negative. However, participant A lost some religiosity due to not experiencing side effects from ARV treatment and being influenced by his partner.

The depression stage was experienced by all three participants, marked by feelings of hopelessness, prolonged sadness, and concerns about the future. Loneliness due to being unmarried and a quarter-life crisis triggered depression in participant W. Participant N had suicidal thoughts but abandoned the idea because he felt needed by people around him. For participant A, isolation without social support was the main factor causing depression, leading to nightly crying for two weeks.

The self-acceptance stage was achieved through a sense of acceptance toward their condition. Participant W applied stoicism and positive self-affirmation as strategies to manage emotions. Participant N equated HIV with his chronic illnesses (hypertension and heart disease), which facilitated self-acceptance. Participants W and A became Peer Supporters as a way of seeking meaning and purpose in life. All three participants demonstrated full self-acceptance, evident from their consistent adherence to ARV treatment.

Solutions that helped the participants achieve self-acceptance included social support through openness and trust with close people such as family members, partners, and fellow PLHIV. Participant W used stoicism and self-affirmation as coping strategies to achieve self-

acceptance. Participants W and A expressed a desire to marry as part of the self-acceptance process, with participant W undergoing conversion therapy to realign his sexual orientation. Adequate knowledge about HIV also assisted all three participants in achieving self-acceptance.

Based on interviews with all participants, the self-acceptance process of the three participants can be seen in Diagram 1.

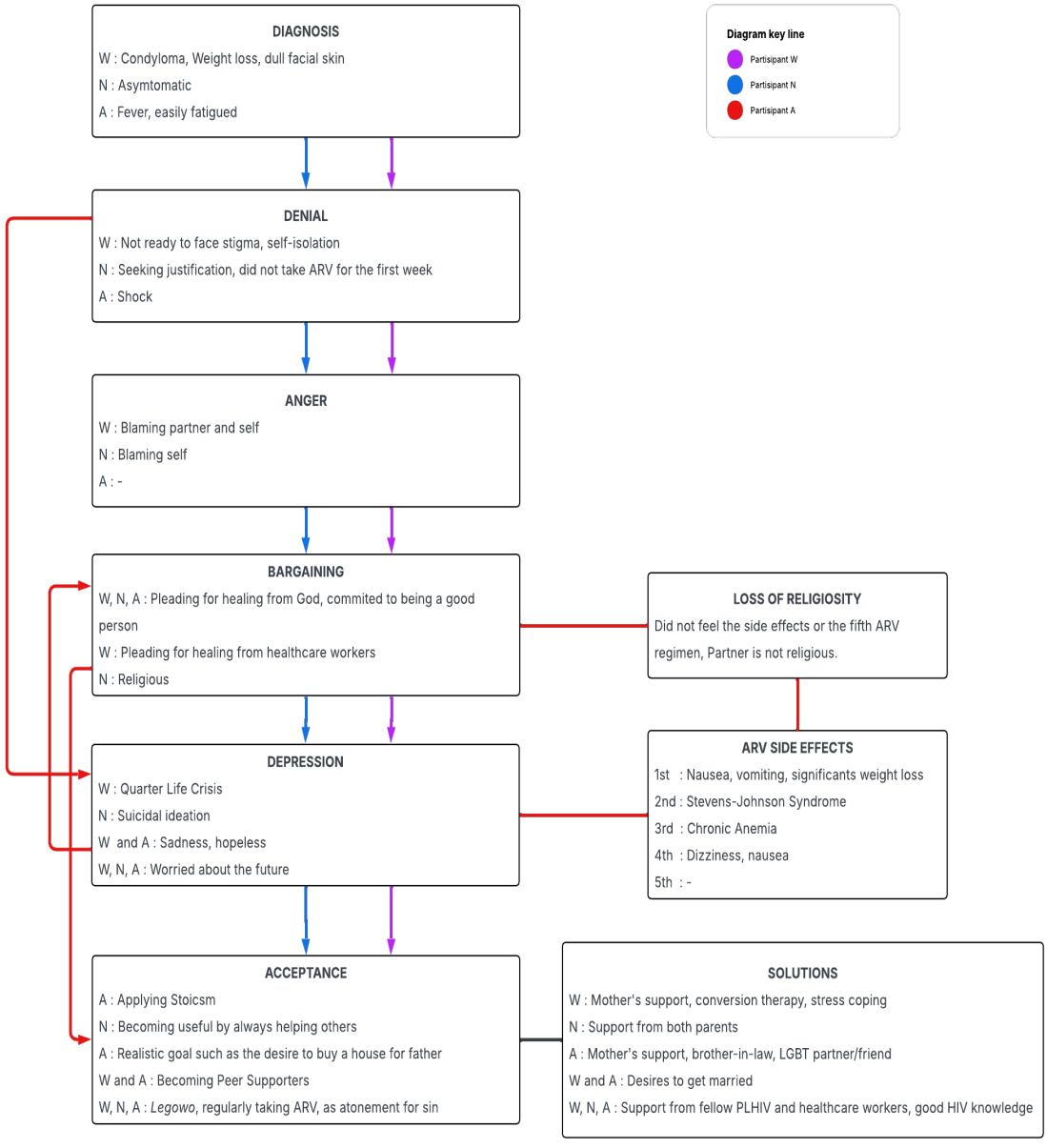

Diagram 1 Overview of the self-acceptance process of all participants

4. DISCUSSION

This study aims to describe the self-acceptance process of homosexual PLHIV at PSG Kariadi Semarang based on Kübler-Ross's theory. Using a qualitative case study method, the three male participants with a homosexual orientation showed that to achieve self-acceptance, all participants went through the stages of denial, bargaining, depression, and self-acceptance. These stages were not experienced in the sequential order proposed by Kübler-Ross. One out of the three participants did not experience the anger stage. The study findings indicate that the solutions each participant employed to accept their condition were unique.

Kübler-Ross (2008) stated that when individuals receive a diagnosis of a chronic illness such as HIV, they often experience shock due to being unprepared for the news. Participant W did not experience shock at that time because he was not yet aware that HIV is a life-threatening chronic disease. All three participants went through the denial stage, which aligns with Wisnudiputro (2019), who noted that denial is felt by most PLHIV upon receiving their diagnosis. Participant W began to feel denial one year after becoming PLHIV, after obtaining information about HIV through the internet and PLHIV communities. This is consistent with Asiah (Ayu Suartini, 2021), who explained that individuals with high knowledge levels tend to have broader thinking patterns, which increases their tolerance to stressors. The denial experienced by all three participants represents a response to fear and anxiety about facing death (Kübler-Ross, 2008).

Participant W blamed their partner, feeling like a victim of dishonesty regarding their partner's health status, which resulted in contracting HIV. This aligns with Kübler-Ross (2008), who stated that anger in individuals often arises from feeling victimized by others. Participant N did not blame their partner because the sexual activity occurred by mutual consent. Sheerar (1963) explained that individuals who take responsibility for themselves demonstrate an important aspect of self-acceptance. Both participants W and N blamed themselves for not being careful in engaging in high-risk same-sex sexual activity. This situation corresponds with Kübler-Ross (2008), who noted that anger can stem from multiple factors, not just the illness itself; in this case, both participants were angry about past actions. Participant A did not blame anyone, including themselves. This behavior differs from Kübler-Ross's (2008) description of the anger stage, which typically involves blaming others. Participant A was able to manage their emotions effectively to achieve self-acceptance, consistent with Sheerar (1963b).

All three participants entered the bargaining stage, demonstrated by seeking healing from God. Participants N and A increased their religious practices as a form of religiosity and preparation for death. Kübler-Ross (2008) stated that PLHIV negotiate with God to seek healing as an expression of guilt for past sins. However, participant A became less religious due to feeling healthy after experiencing no side effects from the fifth ARV regimen and having a partner with low religiosity.

This aligns with the study by Koritelu et al. (2021), which stated that motivation from close people can inspire individuals to become closer to God and engage in religious practices according to their beliefs. Without such motivation, religiosity may decline. Participant W's request for healing from healthcare providers reflects a form of negotiation with doctors to seek recovery, consistent with Kübler-Ross (2008). All three participants committed to self-improvement by striving to become better individuals. This aligns with Putri & Tobing (2018), who found that self-introspection is a key factor in achieving self-acceptance.

The depression stage was experienced by all three participants. According to DSM IV–TR and NIMH, common signs and symptoms of depression include physical, psychological, and social manifestations (Dirgayunita, 2016). The participants exhibited physical symptoms such as insomnia, loss of appetite, loss of interest, fatigue, and poor concentration. Psychological symptoms included anxiety, prolonged sadness, hopelessness, pessimism about the future, guilt, feelings of worthlessness that diminish self-confidence, and even thoughts of death or suicide. Social symptoms manifested as self-isolation and lack of motivation to engage in daily activities. Additionally, participant W experienced a quarter-life crisis due to loneliness and societal pressure to marry at the age of 27. Artiningsih & Savira (2021) explained that loneliness can trigger a quarter-life crisis, which in turn may lead to depression in individuals.

All three participants were able to reach the stage of Self-Acceptance. They perceived HIV as a form of expiation for sins, which aligns with Suzanna et al. (2021), who viewed HIV as a divine punishment and a way for PLHIV and their families to atone for sins. A culture of *legowo* (acceptance/gratitude) significantly influenced the participants' self-acceptance. Boleyn-Fitzgerald (Carr, 2016) defined *legowo* as a response of acceptance toward all experiences, whether pleasant or unpleasant. This is consistent with Firdayanti (2018), who showed that PLHIV can achieve a better quality of life through a mindset of acceptance or gratitude. Participants W and A became peer supporters, in line with Izzah (2019), which indicated that gratitude brings positive changes in PLHIV involved in peer support groups, helping them accept themselves and find meaning and purpose in life. Participant N demonstrated self-acceptance through prosocial behavior toward others, consistent with Putri & Tobing (2018) regarding self-acceptance among PLHIV.

Stoicism applied by participant W proved effective in controlling emotions related to fear and challenges faced as a PLHIV. Menzies & Whittle (2022) stated that stoicism effectively reduces anxiety about death. Participant N's history of hypertension and heart disease facilitated self-acceptance by viewing HIV as equal to their other chronic illnesses, free from added stigma or discrimination. Balderson et al. (2013) explained that the quality of life of PLHIV is influenced by other chronic illnesses and social functioning. All three participants adhered to ARV treatment consistently, in line with Suryanto et al. (2024), who noted that PLHIV who have achieved self-acceptance demonstrate compliance with ARV therapy as a form of gratitude for being given the chance to live. Adherence to ARV is a critical factor in treatment success; according to Cohen et al. (2016), PLHIV with undetectable viral loads show no risk of transmitting HIV to others.

The solutions adopted by the three participants to achieve self-acceptance were based on factors identified by Kubler-Ross (2008), including openness and trust toward people around them, social support, a good quality of life, and adequate information about HIV. All three participants were open and trusting toward selected family members. This aligns with the study by Dhaniswar & Santosa (2021), which found that disclosing one's PLHIV status is best done by carefully choosing family members who are likely to accept the information. Participant W was open with his mother, participant N with both parents, and participant A with his late mother and brother-in-law. These family members were chosen for their positive attitudes toward HIV and the belief that they would provide support compared to other relatives. In addition to family, social support from fellow PLHIV was also crucial.

Social support emerged as one of the most influential solutions in promoting self-acceptance among PLHIV. This aligns with Windiramadhan (2021), who stated that support from peers in Peer Support Groups motivates PLHIV to maintain their health. Moreover, stress-coping strategies such as self-affirmation, used by participant W, effectively reduced stress levels. This is consistent with Kim et al. (2015), who found that self-motivation is a key factor for successful treatment among PLHIV because it helps maintain mental health, enabling consistent adherence to ARV therapy.

Participants W and A expressed a desire to marry, despite long-term homosexual lives. Participant W sought to restore his sexual orientation through conversion therapy under a psychiatrist's supervision. This is in line with Mahathanaya & Lestari (2018), who stated that conversion therapy can be undertaken by individuals wishing to change their sexual orientation under professional health supervision.

The alignment of findings in this study with previous research is evident in the varied and non-sequential process of self-acceptance among the three participants, as well as the presence of denial toward the diagnosis results, consistent with Wisnudiputro (2019). Social support was identified as a key factor in self-acceptance for all participants, in line with Windiramadhan (2021). The form of self-acceptance shown by the participants included adherence to ARV treatment, consistent with findings by Suryanto et al. (2024). The sense of atonement and religiosity experienced by the participants aligns with Suzanna et al. (2021), who describe HIV as a divine punishment.

The novelty of this study lies in its focus on participants with homosexual orientation infected through same-sex sexual activity. Additionally, one participant (A) did not experience the anger stage but instead took responsibility for himself, aligning with the self-acceptance aspects described by Sheerar (1963). New concepts identified in this study, such as *legowo*, stoicism, and the influence of other chronic diseases, provided a comparative perspective on the self-acceptance process among the participants.

The study's limitations include the fact that all participants were infected through same-sex sexual activity, which restricts the data to this transmission mode, while other routes of HIV transmission exist. Differences in participants' chronic disease histories also influenced the self-acceptance process. Furthermore, two of the three participants had been living with HIV for more than five years, limiting the ability to examine the self-acceptance process in

newly diagnosed individuals. Future research is expected to include participants recently diagnosed with HIV through diverse transmission routes and varied chronic disease histories to better examine and compare the self-acceptance process.

The findings of this study have practical implications for PLHIV, highlighting that openness toward the surrounding environment can generate social support, thereby facilitating self-acceptance.

5. CONCLUSION

Based on the results and discussion of the study, it can be concluded that self-acceptance varies among each participant and does not follow the sequential chronology described by Kübler-Ross. All three participants went through the stages of denial, bargaining, depression, and acceptance, but only two out of three experienced the stage of anger.

The participants demonstrated self-acceptance through stoicism (legowo), consistent adherence to ARV treatment, self-satisfaction, and finding meaning in life to pursue realistic goals. Solutions that helped participants achieve self-acceptance included openness and trust, which led to social support from family, partners, fellow PLHIV, LGBT peers, and healthcare providers.

The study's implications for PLHIV highlight that self-acceptance is a key factor in improving quality of life and adherence to ARV treatment. This research offers hope by showing that feelings of despair and worry are normal parts of the process, and being open with one's environment can help obtain social support, facilitating self-acceptance. Coping strategies and stoicism were found to be effective methods for managing emotions and fears when facing chronic illness and mortality.

ACKNOWLEDGEMENT

The researcher would like to express gratitude to all the staff at Poncol Public Health Center in Semarang, fellow PLHIV at PSG Kariadi Semarang, and the Peduli Kasih Foundation (PEKA) for providing the space for the researcher to meet, interact, and gain a deeper understanding that being a PLHIV does not signify the end of life, but rather serves as a beginning to empower oneself and contribute positively to others.

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