Spirituality, Religiosity, and the Quality of Life among Elderly Adults in Malaysia

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Malaysian older adults will be accounted for 10% of the population by 2020 as the consequence of the global ageing demographic revolution. Malaysian studies showed poor quality of life (QOL) among Malaysian older adults despite their long life expectancy. Studies showed the positive relationship between religiosity, spirituality, and QOL. However, previous studies did not distinguish spirituality from religiosity and it has presented insufficient persuasiveness of findings. This study aims to investigate spirituality and religiosity as the predictors for QOL. Quantitative and cross-sectional survey designs were used in this study. 180 participants from aged 60 to 88 were recruited. This study used multiple linear regression analysis to examine the predictors of religiosity and spirituality on QOL. The result showed only spirituality predicted QOL among elderly adults, but not religiosity. The findings of the study implied the importance of internalising spiritual virtues instead of focusing on religious activities which may not improve QOL among older adults significantly.

Keywords: religion, elderly, spirituality, quality of life, religiosity

The older adult population in Malaysia is fast growing and the quality of life (QOL) of this group of people needs to be addressed. The retirement stage has lengthened due to the life expectancy extension and Malaysians have approximately 17 more years to live beyond their retirement age which is 60 of age (Kok & Yap, 2014) which defines the cut-off age due to the differentiation of social role, one being working adults another being retirees. Those aged 60 and above can be considered older adults in Malaysia. This definition of older adult is consistent with the United Nations (Abdul Rashid et al., 2016). The older adult population in Malaysia comprises 10% of the Malaysian population by 2020 (Zin et al., 2015). Malaysia will become an aging country in the year 2030 with approximately 15% of the Malaysian population as older adults (Hamid, 2010). The long life expectancy among older adults does not equate to better quality of life (QOL). Even though older adults are able to live longer than history, they will also be having increased physical fragility, living dependency, and liability of diseases (Antonucci et al., 2016).

Quality of life (QOL) is a subjective concept and the appraisal of own quality of life which varies across different cultures as it is multifaceted and involves multilevel dimensions. Lawton (1991) has identified behavioural competence, perceived quality of life (QOL), psychological well-being and environmental dimensions. Ibrahim and his team proposed directing attention to different influential factors, especially the cultural differences (Ibrahim et al., 2013) and it is defined according to individual's perception (Onunkwor et al., 2016). Quality of life (QOL) research has become an increasingly important concern in Malaysia. The well-being of Malaysians is

the primary focus of government on the eleventh Malaysia plan (2016-2020) in order to actualise the vision 2020. The vision 2020 is the objective of Malaysia to become a developed country (Ministry of Economic Affairs, 2015). The journey of Malaysia in transforming into a developed country requires much effort. Improving the quality of life among Malaysian citizens is just as crucial as making progress in economic development (Idris et al., 2016).

Studies in the recent decade indicated that Malaysian older adults showed a poor condition in quality of life (QOL). Hamid, Momtaz, and Ibrahim (2012) found the psychological well-being among older population decreases along with age. The finding of Chan et al. (2015) showed poor self-rated health was more likely to be reported by older adults compared to younger people. The study of Hamid et al. (2012) found only 13.8% of older adults who fit the criteria of not having major diseases, abled body, and good psycho-cognitive functioning. Those studies suggested that the increased population of older adults over the recent decade (7.1% to 8.3% from 2005-2015) in Malaysia Hamid (2016) did not indicate a better quality of life (QOL) of older adults.

Religiosity and spirituality can be important factors on studying quality of life (QOL) in Malaysia context. The culture of Malaysia is multicultural. The demographic composition of Malaysia comprised of different groups of ethnic-culture (Leong & Liu, 2013). Malaysia is ideologically pluralistic. The multiculturalism of Malaysia is conceptualized within religious beliefs. Religious beliefs represent the identity of ethnicities in Malaysia (Scotti, 2016). The study of Stavrova, Fetchenhauer, & Schlösser (2013) showed that the country religiosity level affects the religiosity of individuals. Religious people who are staying in a country with high religiosity are likely to receive respect and thus influence the relationship between religiosity and well-being.

Previous studies have supported the direct relationship between religiosity, spirituality, and quality of life (QOL) (Ali, Marhemat, Sara, & Hamid, 2015; Hajiaghababaei, Saberi, Rahnama, & Montazeri, 2018; Stroppa, Colugnati, Koenig, & Moreira-Almeida, 2018; Triveni, Grover, & Chakrabarti, 2017). The examination of associations between religiosity, spirituality, and quality of life (QOL) in Gallardo-Peralta (2017) showed a significant positive relationship between religiosity, spirituality, and quality of life (QOL). However, the further analysis of hierarchical analysis found spirituality associated specifically with the quality of life (QOL). Religiosity, on the other hand, did not fully associate with the quality of life (QOL). Trevino & McConnell (2015) found that participation in religious activities improves functioning among older adults and they hold that older adult participated less in religious activities due to poor health. Therefore the benefits may not apply to them. The intrinsic commitment, faith towards God, and social support from religious affiliation declined over the period of time. Their finding suggested individuals may receive positive effects from religion at the beginning of coping stressful events, as they adjusted from the stressful events, the need for religion as a coping resource decreased. Furthermore, many studies regarding religiosity using older adult population in Malaysian (Abdul Rashid et al., 2016; Loke, Abdullah, Chai, Hamid, & Yahaya, 2011; Momtaz, Ibrahim, Hamid, & Yahaya, 2011; Yahaya & Momtaz, 2013), have employed religiosity to measure spirituality. Therefore there was no differentiation between religiosity and spirituality as if the two terminologies were identical and overlapped. Hamid (2015) has encouraged researchers to further investigate the role of spirituality

among Malaysian older adults. Therefore it is necessary to investigate the role of both concepts in the quality of life (QOL) among older adults.

Scholars have recommended an approach to distinguish the interrelationship between religiosity and spirituality. Spirituality is an emergent concept in the study of religiosity. It is to define religiosity as an organised belief and worship. Subsequently, the approach distinguishes spirituality from religiosity by viewing spirituality as a personal transcendental experience with the meaning in life (Zinnbauer & Pargament, 2005). Sirgy (2012) holds that spiritual well-being (spirituality) is acquired through the practice of religiosity and its positive effect will be transferred to overall domains of quality of life (QOL). Even though religiosity is recognised as a resource of quality of life (QOL), religiosity might not fully explain its effect on quality of life (QOL), spiritual well-being (spirituality) can be the core factor on providing a positive influence on the quality of life (QOL). Therefore, the objective of the present study was to examine the predictions of religiosity and spirituality on the quality of life (QOL) among older adults. The research question that guided our study was: Are religiosity and spirituality able to predict the quality of life (QOL) among the older adults?

Method

Research Design

The present study adopted a quantitative approach and cross-sectional survey as the research design. Nonprobability sampling technique was employed in the present study. Nonprobability sampling technique is best suited for research with an exploratory purpose. The implementation of nonprobability sampling allows the researcher(s) to focus on the specific elements of the population (Daniel, 2012). The older adults are geographically scattered across states and the application of nonprobability sampling fits into the nature of the present study.

Participants

A total of 180 participants were recruited by using non-proportional quota sampling method. Of 182 participants, 2 were excluded from the study due to terminal illness and lack of interest in the study. Participants were recruited based on the following criteria. They must be in the age range of 60-88 years old, without any mental-health issue, and not participating in any psychological program welfare. The sample size calculation for regression analysis was based on Green (1991), where $N \geqslant 50 + 8p$, where p is the number of predictors. The required sample size was calculated based on the formula $\geqslant 50 + 8(2) = 66$ participants. Therefore, a sample of 180 was deemed sufficient. The religion of the participants is Islam, Buddhism, Hinduism, and Christianity. The study locations were at Perak and Penang states. Perak and Penang showed high ethnic diversity compared to other states in Malaysia, such as Kelantan and Terengganu (Evers, 2014). These two states have a higher percentage of older adults population in which Perak has 17% of older adult population and Penang has 12.6% of the older adult population in Malaysia (Department of Statistics Malaysia, 2017). Additionally, Perak resembles the socio-demographic background of Malaysia (Yeong, Tan, Yap, & Choo, 2016) whereas Penang constituted of diverse religions (Ferrarese, 2014). Table 1 shows the descriptive statistics of the participants.

Table 1
Socio-demographic variables of participants, such as gender, current occupation status, marital status, religion, education level, religiosity, spirituality, and quality of life (QOL)

Socio-demographic variables	All participants (n=180) n (%)
Gender	
Female	87 (48.3)
Male	93 (51.7)
Current Occupation Status	
Full time employed	28 (15.6)
Part time employed	6 (3.3)
Self-employed	28 (15.6)
Retired	90 (50)
Housewife	21 (11.7)
Jobless	7 (3.9)
Marital Status	
Single	19 (10.6)
Married	129 (71.7)
Divorced	6 (3.3)
Widowed	26 (14.4)
Religion	
Buddhism	45 (25)
Hinduism	41 (22.8)
Islam	38 (21.1)
Christianity	33 (18.3)
Chinese Folk Religion	15 (8.3)
Sikhism	2 (1.1)
No religion	6 (3.3)
Education Level	
Illiterate	14 (7.8)
Primary education	51 (28.3)
Secondary education	82 (45.6)
Tertiary education	26 (14.4)
Postgraduate	7 (3.9)
Religiosity	
High	106 (59.2)
Low	73(40.8)
Spirituality	
High	104 (59.1)
Low	72 (40.9)
Quality of Life (QOL)	
High	77 (43.5)
Low	100 (56.5)

Procedure

The ethical clearance was obtained from the Institute of Postgraduate Studies and Research of the university in which the researchers were located. The questionnaire data were collected using face to face method which conducted between the months of May and August 2018. A pilot study was conducted prior to the actual study. The researchers explained the purposes of the study and the

participants were provided with informed consent prior to the completion of the paper-and-pencil survey. The participants were recruited from religious institutions (E.g. mosques, Hindu centres, Hindu temples, churches, and Chinese temples), and elderly nursing homes. Researchers first built rapport with participants at religious institutions during prayer activities. The rapport building effort was followed by home visiting participants who were interested to participate in the study. Participants were given tokens of appreciation upon the completion of the questionnaire via interview. Older-aged participants were given more time to complete the interview session. Data were analysed by using IBM SPSS version 21.

Instruments

World Health Organization Quality of life (QOL) for Older Adults (WHOQOL-OLD). WHOQOL-OLD was developed by Power, Quinn, and Schmidt. This instrument has 24 items that measure the quality of life (QOL) of elderly adults. The quality of life (QOL) is measured by the 5-point Likert scale, which the point range is 5= (extremely) to 1= (not at all). The reliability of this scale is α = .724 in the present study (Power, Quinn, Schmidt, & WHOQOL-OLD Group, 2005).

The Duke University Religion Index (DUREL). DUREL was developed by Koenig. This instrument has five items. DUREL measures the three dimensions of religiosity, which are (1) organizational religious activity (ORA) for an item, (2) non-organizational religious activity (NORA) for an item, and (3) intrinsic religiosity (IR) for 3 items. This instrument is assessed by 6-point Likert scale with the measuring of ORA and NORA in 6= (more than once a day), 5= (once a week), 4 = (a few times a month), 3 = (a few times a year), 2 = (once a year or less), 1= (never). This scale displayed α = .855 as the reliability coefficient (Koenig & Büssing, 2010).

Spirituality Index of Well-Being (SIWB). SIWB was developed by Daaleman and Frey. This instrument contains 12 items to measure spiritual well-being. SIWB is assessed using a 5-point Likert scale, which the point range is from 5 as "strongly disagree" to 1 as "strongly agree". This scale was found to have adequate reliability with Cronbach's alpha = .756 (Daaleman & Frey, 2004).

Result

A multiple linear regression analysis was conducted to evaluate the influence of religiosity and spirituality in quality of life among elderly adults. Preliminary analyses were conducted to ensure no violation of the assumptions of multicollinearity, independence of residuals, normality, linearity, and homoscedasticity. The regression model was statistically significant, $F(2, 177) = 14.896$, $p = .001$ and it is accounted for 13.4% of variance. As displayed in Table 4, it was found that spirituality was a significant predictor (β = .328, $p = .001$), but religiosity did not significantly predict the quality of life among elderly adults (β= .112, $p = .128$). Given that spirituality is the only significant predictor, it has the strongest influence on elders' quality of life. This reflects that a stronger level of spirituality significantly contributes to a better quality of life.

Table 2

Multiple regression of the effects of spirituality and religiosity on quality of life among older adults

Variables	Unstandardized Coefficients		Standardized Coefficients Beta	t	significance *p*-value
	Beta	Standard Error			
Constant	59.378	5.366		11.065	.000
Spirituality	.575	.129	.328	4.465	.000
Religiosity	.207	.136	.112	1.529	.128

Discussion

The present study aims to address the well-being of the ever increasing population of older adults by aligning with objectives of the eleventh Malaysia plan (2016-2020) in materializing Vision 2020. The result of the present study showed only spirituality significantly predicted the quality of life (QOL) among the older adults.

Religiosity and Quality of Life (QOL)

The findings of this study contradicted with the majority of the past empirical studies (Moon & Kim, 2013; Trevino & McConnell, 2015) by showing that religiosity is unable to reliably predict the quality of life (QOL) of older adults. Religiosity was not found to be significant predictors of quality of life (QOL). This could be explained by the differences in research methodology. The current research methodology, including participant recruitment and participant selection were targeting healthy functional older adults who may or may not be living with spouse and family under one roof. Contrary, the majority of the past research targeted niche population such as individuals with depression (e.g., Moon & Kim, 2013) and patients with cardiovascular diseases (e.g., Trevino & McConnell, 2015). Trevino & McConnell (2015) found that participation in religious activities improves functioning among older adults and they hold that older adult participated less in religious activities due to poor health. Therefore the benefits of religious participation may not be applied to them. The intrinsic commitment, faith towards God, and social support from religious affiliation declined over the period of time. Their finding suggested individuals may receive positive effects from religion at the beginning of coping stressful events (E.g.: an individual with health issues), as they adjusted from the stressful events, the need of religion as a coping resource decreased. Thus, an individual's health or perceived health status could potentially mediate the relationship between religiosity and quality of life (QOL).

Spirituality and Quality of Life (QOL)

Other than that, this study echoes the importance of spirituality in quality of life (QOL), similar to several other studies (Daaleman, Perera, & Studenski, 2004; Lee & Salman, 2018). The concept of spirituality defined in this study is in line with the common notion of previous studies, which emphasised the importance of meaningfulness in life and self-efficacy from spirituality, rather than the involvement of religion. Spirituality is commonly associated with meaning and purpose in life (Sawatzky, Ratner, & Chiu, 2005). Moreover, the finding of this study resonates with the meta-analysis by

Sawatzky et al. (2005), showing that a stronger level of spirituality significantly contributes to a better quality of life. The majority of the participants in this study acknowledged that they are cognizant of their own identities, and showed acceptance towards their fates in life. Furthermore, self-efficacy would able the participants to cope with their present and future situations (Çetin, Aylaz, & Kargin, 2018), which is their increasing of physical fragility, living dependency, and liability of diseases. The meaningfulness in life and self-efficacy from the concept of spirituality allows these participants to have a higher quality of life (QOL). The distinguishing of spirituality and religiosity is able to give specific contents that contribute to healthcare related implications (Traphagan, 2005).

The results of the present study have contributed a new perspective of the predictions of religiosity and spirituality on the quality of life (QOL) among the Malaysian older adults. As aforementioned, the local studies would measure spirituality using religiosity which led to the low persuasiveness of findings. The present findings have clarified the prediction of religiosity and spirituality on the quality of life (QOL). The result showed that spirituality predicted the quality of life (QOL) instead of religiosity in Malaysia context. The implication is to increase the level of spirituality in order to improve the quality of life (QOL) among older adults instead of focusing solely on religious activities.

Limitations

The study was conducted based on the assumption of the existence of conceptual differences in spirituality and religiosity. Similar with the findings of Mattis (2000), religiosity in this study was associated with the act of worship in organized institutions with specific worship rituals; whereas spirituality is perceived as internalized positive values and transcendental experiences. Furthermore, the conceptual differences of religiosity and spirituality were not fully explored with the older participants of the study. Most of the older adults in this study perceived religiosity and spirituality to be interchangeable and would equate both concepts on the same ground. Apart from that, this study also did not seek to explore the mechanisms pertaining to increasing religiosity and spirituality, which could potentially provide practical significance.

Conclusion

Findings from this study revealed the importance of spirituality in predicting quality of life (QOL) of older adults. This conclusion has provided a unique implication as spirituality in this study is not related to any forms of religious involvement. Thus, the lack of overt behaviours in rituals has placed various stakeholders, including the older adults and health care professionals in a difficult position as the findings of this study suggests that the quality of life (QOL) can be achieved by emphasizing on meaningfulness in life and self-efficacy from spirituality. In return, spirituality demands subjective and abstract exploration of existentialism. Older adults of various backgrounds, institutions, religions, ethnicities will be benefited from this study by actively engaging in the search of the purpose in life, enhancing their self-efficacy to cope with life difficult situations. However, the approaches to improving one's spirituality, in terms of improving self-efficacy, existential search for meaning and purpose in life. These approaches remained unanswered in this study, and this calls for continued effort in exploratory research.

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