

The Relationship Between Social Support and Religious Coping Strategies Towards Quality of Life of Muslim Retirees in The East Coast Region in Malaysia

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ABSTRACT

INTRODUCTION: Quality of Life (QoL) is a multidimensional concept crucial for older adults, particularly as they experience physical decline, chronic diseases, and reduced social participation. This study examines the relationship between social support, religious coping, and QoL among older Muslims in the East Coast Region of Malaysia. **MATERIALS AND METHODS:** A positivist approach was employed, utilising an online survey distributed to Muslim retirees aged 60 and above. A self-administered questionnaire assessed demographic data, social support, religious coping strategies, and QoL. **RESULTS:** 150 responses were analysed using SPSS Statistics 29.0 and Smart PLS 4.0. Most respondents (97.3%) belonged to the young-old category. The findings revealed that religious coping was positively associated with quality of life (QoL) ($\beta=0.209$, $t=2.365$, $p<0.01$), and social support was also positively associated with QoL ($\beta=0.502$, $t=4.181$, $p<0.01$). **CONCLUSION:** These findings highlight the importance of social and religious support in enhancing older adults' well-being. Future research should explore qualitative approaches to gain deeper insights into the lived experiences of older Muslims. Understanding these factors can inform policymakers and healthcare providers in developing effective ageing interventions that promote healthy ageing, social participation, and autonomy.

Keywords

Quality of Life, Elderly; Social Support, Religious Coping, Gender

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INTRODUCTION

Malaysia is on track to become an ageing nation, with the population aged 65 and above projected to reach 7.5% and rise to 14% by 2044.¹ This demographic shift highlights the urgent need to enhance social support systems and improve the quality of life (QoL) for older adults, particularly those at risk of social isolation and loneliness.

Malaysia's multicultural society, comprising Malays, Chinese, Indians, and indigenous groups, shares strong cultural values such as filial piety and care for ageing parents. However, this model is under strain due to social and demographic changes. The sandwich generation, caring for ageing parents and children, faces increasing financial, physical, and emotional pressure. Middle-income families, in particular, struggle as they do not qualify for public aid and often cannot afford private care.

While various government and NGO initiatives exist, many are short-term and lack sustainability. A key concern is the decline of family-based care, which has negatively impacted the QoL of older adults, especially among Muslims.² Healthcare and social services are often inadequate in meeting the complex needs of the ageing population.³ Social support is vital in promoting mental and physical well-being, especially for those living alone or far from family. However, research focusing on the East Coast of Malaysia, a region known for its strong religious and communal values, is limited. There is a pressing need to explore how factors like social support, access to healthcare, and religious coping affect the QoL of older Muslims in this region.

Religious coping has been linked to better mental health, emotional stability, and life satisfaction.⁴⁻⁶ Yet, its role in enhancing QoL among older Malaysian adults remains underexplored. Moreover, promoting independence and community-based programs that encourage physical activity and social engagement have shown positive outcomes.⁷ Combining social support with religious coping may offer a holistic approach to improving well-being in later life. Therefore, this study aims to explore the factors influencing the quality of life among older Muslims on the East Coast of Malaysia, focusing on the roles of social support and religious coping.

MATERIALS AND METHODS

This study employed a cross-sectional survey design, which enabled the observation of social support, religious coping, and quality of life among Muslim retirees in the East Coast Region without manipulating or controlling any variables. In this research, the selected population is limited to retirees who previously worked in the government and non-government sectors and are currently living as older adults aged 60 years and above. To be included in this study, the participants must meet the following criteria: (1) 60 years and above and (2) government or non-government retirees. This criterion focuses on retirees who have transitioned from a

professional or formal work environment, and (3) Muslims from the East Coast Region.

The study utilised convenience sampling to recruit participants during the COVID-19 pandemic, a period when public health protocols restricted traditional probability sampling and face-to-face data collection. While this approach facilitated data collection during a crisis, it necessitated a digital-first strategy. The survey was distributed via Google Forms and disseminated through WhatsApp groups and community networks. This approach required participants to possess smartphone access and basic digital literacy. The sample size calculation was conducted in G*Power, and the test used an alpha of 0.05, a power of 0.80, and a medium effect size ($f^2=0.15$). 80% is considered the minimum acceptable power in most social science studies, so the desired sample size was 85.⁸

INSTRUMENTATION

The questionnaire was distributed as an online survey via Google Forms to all participants, available in both English and Malay. A back-translation procedure was used to ensure the accuracy and consistency of the Malay version with the original English version. The survey link was disseminated through WhatsApp groups to facilitate easy access for participants. The questionnaire comprised four sections: demographic profile, quality of life, social support, and religious coping strategies. The QoL section was adapted from the Older People's Quality of Life Questionnaire (OPQOL-21).⁹ The social support section used the Multidimensional Scale of Perceived Social Support (MSPSS), comprising 12 items, to assess perceived support from family, friends, and significant others.¹⁰ Religious coping was measured using an adapted version of the Religious Coping Scale, a self-rated questionnaire consisting of 22 items, to assess the use of religion as a coping strategy in the face of difficulties, struggles, and adverse life events.¹¹ The items were derived initially from RCOPE.^{12\}

All items in the questionnaire were measured using a five-point Likert scale, ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). In the final section, sociodemographic information was collected to characterise the sample. This section included 11 items covering gender, age, religion, ethnicity, highest educational level, marital status, source of income, monthly income, living arrangement, existing medical conditions, and locality. Given the different cultural context of the present study, content validity was first established through experts' evaluation to assess the relevance, clarity, and cultural appropriateness of the items. Based on the feedback, minor wording refinements were made to enhance contextual suitability while preserving the theoretical meaning of the constructs. The data were analysed using SPSS version 29.0 and SmartPLS 4.0.

RESULTS

One hundred fifty respondents participated in the study, comprising 61 males (40.7%) and 89 females (59.3%). Most were aged 60–74 years (90%), with a mean age of 65.4 years. Regarding education, 80% had a tertiary education, 19.3% had completed secondary school, and 0.7% had only a primary education. The majority were married (86%), while others were single (4.7%), widowed (6.7%), or divorced (2.7%). Most relied on earned income (92.7%), while others received support from family (1.3%), government (1.3%), or other sources (2.7%); 2% had no income. Monthly income ranged mainly from RM 4,500–10,500 (50%), followed by RM 2,500–4,500 (32%). Most lived with spouses and children (91.3%), while a few lived alone (4.7%) or with others (4%). Common chronic illnesses were hypertension (35.3%) and diabetes (30.7%). Regarding location, 62% lived in urban areas, 26.7% in suburban areas, and 11.3% in rural areas.

Table I: Demographic Profile of the Respondents

	Frequency (n)	Percentage (%)	Mean	Sd
<u>Gender</u>				
Male	61	40.7		
Female	89	59.3		
<u>Age</u>				
60–74 years old (young old)	135	90	65.41	3.605
75 years old and above (old-old)	15	10		
<u>Highest education</u>				
University or college	120	80.0		
Secondary school	29	19.3		
Primary school	1	0.7		
<u>Marital status</u>				
Married	129	86.0		
Single	7	4.7		
Widowed	10	6.7		
Divorced	4	2.7		
<u>Source of income</u>				
Support from the government (welfare department)	2	1.3		
Various sources (rent, interest, dividends and bonuses)	4	2.7		
Family-related income (remittance from sons, daughters and relatives)	2	1.3		
Earned income (salary, pension or income from agriculture and business)	139	92.7		
No income	3	2.0		
<u>Monthly income</u>				
Less than rm 2,500	19	12.7		
Rm 10,500 and above	8	5.3		
Rm 2,500 – rm 4,500	48	32.0		
Rm 4,500 – rm 10,500	75	50.0		
<u>Living arrangement</u>				
Living with spouse and children	137	91.3		
Living with others	6	4.0		
Living alone	7	4.7		
<u>Presence of chronic illness</u>				
Cataract/vision impairment	6	4.0		
Hypertension	53	35.3		
Arthritis	6	4.0		
Diabetic mellitus	46	30.7		
Heart diseases	14	9.3		
Neurological problems	2	1.3		
Asthma	8	5.3		
Chronic kidney disease	3	2.0		
Bone and muscle disorders	12	8.0		
Cancers	2	1.3		
Others	58	36.0		
<u>Local areas</u>				
Urban	93	62.0		
Rural	17	11.3		
Sub urban	40	26.7		

MEASUREMENT MODEL

Next, the data was further analysed using SmartPLS 4.0, following the two-stage approach.¹³ This process involved assessing the measurement model for reliability and validity before evaluating the structural model. Bootstrapping with 5,000 samples was used to test significance. The first step was measuring the internal consistency. Internal consistency was assessed using Cronbach's Alpha and Composite Reliability (CR). As shown in Table III, Cronbach's Alpha values ranged from 0.883 to 0.908, exceeding the recommended threshold of 0.7.¹⁴ Similarly, CR values were above 0.7, confirming the reliability of all constructs.¹⁵

Indicator reliability was assessed by examining outer loadings of each item. Following established PLS-SEM guidelines,^{14,16} Indicator loadings of 0.70 or higher are considered ideal, while loadings between 0.50 and 0.70 may be retained if construct reliability and convergent validity remain satisfactory. In the initial model, 12 items under the religious coping construct demonstrated loadings below the acceptable threshold. Consequently, the items were removed due to insufficient outer loadings (< 0.50) to improve measurement quality. The final model retained 10 religious coping items, with loadings ranging from 0.583 to 0.851. Next, convergent validity was assessed using Average Variance Extracted (AVE), with values above 0.5 indicating that each construct explained at least 50% of the variance in its indicators. The highest AVE value was 0.524 (social support), followed by 0.517 (religious coping), demonstrating adequate convergent validity. Table II presents only the retained indicators included in the final measurement model.

Next, discriminant validity was tested using the HTMT approach.¹⁷ All HTMT values were below 0.85, indicating no validity issues.¹⁸ Bootstrapping results further confirmed that confidence intervals did not include 1.00, supporting discriminant validity.¹⁴ The findings are presented in Table III.

Table II: Results Summary for Measurement Models

Constructs	Items	Indicator Reliability	Convergent Validity	Internal Consistency
		Outer loadings >0.60	AVE >0.50	Reliability Composite Reliability >0.7
Quality of Life	F19	0.528	0.501	0.945
	H3	0.669		
	HN11	0.856		
	HN12	0.802		
	HN13	0.845		
	HN14	0.735		
	I10	0.755		
	I9	0.680		
	L1	0.665		
	L2	0.760		
	P15	0.623		
	P16	0.528		
	R20	0.745		
	R21	0.685		
	SR4	0.696		
	SR5	0.587		
	SR6	0.696		
	SR7	0.662		
	SR8	0.662		
Religious Coping	R1	0.583	0.517	0.904
	R10	0.607		
	R2	0.851		
	R3	0.626		
	R4	0.822		
	R5	0.680		
	R6	0.731		
	R7	0.798		
	R8	0.743		
	R9	0.698		
Social Support	R10	0.607		
	SS1	0.658	0.524	0.913
	SS10	0.681		
	SS11	0.803		
	SS12	0.636		
	SS3	0.736		
	SS4	0.817		
	SS5	0.677		
	SS6	0.671		
	SS7	0.684		
	SS8	0.800		
	SS9	0.767		

Table III: Discriminant Validity

Variable	Religious Coping	Social Support	Quality of Life
Religious Coping	0.719		
Social Support	0.513	0.724	
Quality of Life	0.518	0.704	0.708

STRUCTURAL MODEL

After confirming reliability and validity, the structural model was assessed. The first step was the collinearity assessment. Variance Inflation Factor (VIF) values ranged from 1.361 to 2.616, below the recommended

threshold of 5, indicating no collinearity concerns.¹⁴ Bootstrapping with 5,000 resamples was performed at a 0.05 significance level to test the hypotheses. The results indicate that religious coping has a positive and statistically significant effect on quality of life ($\beta = 0.209$, $t = 2.365$, $p < 0.01$). Similarly, social support demonstrates a positive and significant relationship with quality of life ($\beta = 0.502$, $t = 4.181$, $p < 0.01$). Thus, both hypotheses are supported. These results highlight the importance of religious coping and social support in enhancing the QoL among older adults. The findings are presented in Table IV.

Table IV: Structural Model

Relationship	Path Coefficient (β)	Std. Error	t-value	P-value	Decision	R ²	f ²	Effect Size	VIF
Religious coping -> Quality of Life	0.209	0.088	2.365	$p < 0.01$	Supported	0.529	0.069	Small	1.364
Social support -> Quality of Life	0.502	0.120	4.181	$p < 0.01$	Supported	0.529	0.209	Moderate	2.616

The moderate R2 value of 0.529 suggests that social support and religious coping together account for more than 52.9% of the variance in quality of life, indicating a significant predictive relevance of the model beyond the findings reported.¹⁴ Although both predictors are statistically significant, social support appears to have a greater practical influence on quality of life than religious coping, as indicated by the small to moderate effect sizes (f^2).

DISCUSSION

This study investigated the relationship between religious coping, social support, and quality of life (QoL) among Muslim retirees in the East Coast region of Malaysia. The findings proved that religious coping and social support are significantly associated with quality of life in this population. These results offer valuable insights with important policy, practice, and future research implications.

Demographically, the study sample comprised predominantly older adults who were relatively well-

educated, financially stable, and reported strong social support networks. Despite these advantages, a significant proportion of participants faced chronic health issues, particularly chronic illnesses. This paradox highlights the complex interplay between physical health, social resources, and well-being. It suggests a critical need for targeted healthcare interventions that address chronic disease management while promoting healthy ageing strategies tailored to this population. Even among socially and economically advantaged older adults, chronic health conditions remain a key challenge to achieving optimal quality of life.¹⁹

The finding revealed a significant relationship between religious coping and QoL among the older people in the East Coast Region. Consistent with previous studies, religious coping was found to play a pivotal role in enhancing the quality of life among older adults in this study.^{20–23} A possible explanation is that in the East Coast region of Malaysia, where religious beliefs and practices are deeply ingrained in daily life, religious coping provides emotional comfort, a sense of purpose, and psychological resilience. Positive religious coping strategies such as prayer, seeking spiritual support, and engaging in religious rituals help older individuals manage stress, accept health challenges, and find meaning in life. These practices foster optimism, emotional stability, and mental well-being, ultimately improving quality of life.

This result implies that older persons gain more from concrete and emotional support from family, friends, and other members of society. Though still important, religious coping seems more of an emotional and spiritual buffer that accentuates other help. Reflecting the model's modest explanatory power, the R² value of 0.529 suggests that other factors, including mental health, physical activity, and access to healthcare, may also be necessary in influencing quality of life and should be investigated in future studies.

Similarly, social support emerged as a significant predictor of quality of life. Older adults who reported

strong support from family, friends, and communities experienced better physical health, emotional well-being, and greater life satisfaction. This finding aligns with socioemotional selectivity theory, which suggests that older adults prioritise emotionally meaningful relationships in later life.^{21,24} This could be explained by the fact that, on the East Coast, where kinship ties and communal interactions are culturally valued, strong social networks likely enhance the availability and effectiveness of social support, further contributing to positive well-being outcomes.

LIMITATION

Despite its contributions, this study has several limitations. First, the cross-sectional design prevents establishing causal relationships among social support, religious coping, and Quality of Life (QoL). Second, the use of self-reported measures may introduce social desirability bias, particularly regarding religious coping strategies.

Most significantly, the recruitment strategy introduced a systematic sampling bias. By utilising an online survey (Google Forms) distributed via WhatsApp, the study inadvertently excluded older adults with limited digital literacy, those without smartphones, and those residing in rural areas with poor connectivity. This is reflected in the participant profile, which is heavily skewed toward highly educated (80% tertiary) and financially stable individuals. Consequently, the findings may not be representative of the broader Muslim retiree population in the East Coast region, specifically the rural poor and those with lower literacy levels.

Future research should address these gaps by employing a hybrid recruitment strategy that combines digital surveys with face-to-face interviews in community centres or mosques to ensure a more inclusive socio-economic cross-section. Longitudinal studies are also recommended to understand how these variables evolve as health and social circumstances change in later life.

CONCLUSION

This study examined the influence of religious coping and social support on quality of life among Muslim retirees in the East Coast region of Malaysia. Both factors were significant predictors, with social backing demonstrating a greater practical effect. These findings reinforce the idea that quality of life in later life is not determined solely by physical health, but also by meaningful social connections and religiously embedded coping resources.

From a healthcare and policy perspective, the results support the need for integrated ageing strategies that incorporate psychosocial and spiritual dimensions alongside chronic disease management. Community-based initiatives that strengthen family involvement, peer engagement, and structured social interaction benefit older adults' well-being. In addition, recognising the role of religious coping in providing psychological comfort and resilience may enhance culturally sensitive care planning in predominantly Muslim populations.

Given Malaysia's ageing demographic profile, policymakers and healthcare providers should consider holistic eldercare approaches that combine medical management with social and spiritual support systems. Such multidimensional strategies may help sustain functional ability, emotional well-being, and overall quality of life among older adults.

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CONFLICT OF INTEREST

The authors have no conflicts of interest to disclose.

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