Spirituality and Its Association with Quality of Life among Patients with Mood Disorders in Kelantan

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ABSTRACT

INTRODUCTION: Mood disorders, such as Major Depressive Disorder (MDD) and bipolar disorder, deeply affect a person's spirituality and Quality of Life (QoL). While spirituality is a vital part of mental health care, especially in deeply religious communities like Kelantan, Malaysia, local research on this connection remains limited. **MATERIALS AND METHODS:** This cross-sectional study was conducted between December 2024 and May 2025 at two major hospitals in Kota Bharu. We recruited adults (aged 18–60) diagnosed with mood disorders. Participants completed validated Malay versions of questionnaires measuring spiritual well-being, depression severity, and QoL, while clinicians assessed mania severity. Data were analyzed using SPSS version 29.0. **RESULTS:** Among the 169 participants, the majority were female (73.4%), Malay (93.5%), and Muslim (94.7%). Most reported moderate spiritual well-being (75.7%) and moderate average QoL scores. Regression analysis showed that being married (adjusted b=3.92, p=0.034), being female (adjusted b=5.66, p=0.007), having milder depression (adjusted b=-0.56, p<0.001), and having higher mania scores (adjusted b=0.52, p=0.030) predicted better spiritual well-being. Additionally, better psychological (adjusted b=0.28, p<0.001) and environmental QoL (adjusted b=0.36, p<0.001) strongly predicted higher spirituality. Overall, spirituality was strongly tied to all areas of QoL. **CONCLUSION:** Demographic factors, symptom severity, and everyday quality of life are closely linked to a patient's spiritual well-being. In highly religious communities, bringing spiritual assessments and care into standard psychiatric practice is essential for truly holistic healing.

KEYWORDS: Spirituality, Quality of Life (QoL), Mood Disorder, Depression, Bipolar Disorder

INTRODUCTION

Mood disorders such as Major Depressive Disorder (MDD) and bipolar disorder create significant emotional and behavioural disturbances that impact daily functioning. It is predicted that 8% to 12% of Malaysians suffer from MDD, which is expected to become the major source of disease burden in the globe by 2030.[1,2] Bipolar disorder is a leading cause of disability and has a prevalence of over 1% worldwide.[3,4]

The bio-psycho-social model has long dominated psychiatry, but rising research indicates that spirituality is an important fourth dimension, resulting in a more comprehensive "bio-psycho-social-spiritual" paradigm.[5] Patients can make sense of suffering through spiritual beliefs and practices, which decreases pessimism and enhances resilience.[6,7] For example, practices such as prayer and meditation assist in controlling emotions[8,9], and faith communities offer social support that enhances adherence to treatment.[5]

Religion is a system of organised beliefs, but overlaps with spirituality, which is a human search for meaning and purpose.[10,11] Several studies have examined the relationship of spirituality and QoL in people with mood disorders and have reported that increased spirituality is associated with greater QoL and less

severe symptoms.[7,12] Positive religious coping predicts increases in all areas of QoL, and negative coping exacerbates symptoms.[9]

However, this relationship is mediated by culture. Western spirituality tends to be more individualistic, and Asian spirituality is more relational and community-oriented.[13] This is a particular environment to investigate in Kelantan, where the population is largely Malay-Muslim and Islamic values are strong.[14] But there is still limited local study, with most of the studies coming from the West or general populations.[15-17]

The integration of spirituality into psychiatric care may improve doctor-patient interaction, treatment adherence, and satisfaction with care.[18] This study attempts to fill this gap by exploring the association between spirituality and QoL among the mood disorder patients in Kelantan, thus supporting a more holistic and culturally sensitive mental health care.

MATERIALS AND METHODS

This cross-sectional study was conducted from December 2024 to May 2025 at the Psychiatry Departments of Hospital Pakar Universiti Sains Malaysia (HPUSM) and Hospital Raja Perempuan Zainab II (HRPZ II) in Kota Bharu. Using convenience sampling, an independent researcher recruited stable inpatients and clinic attendees aged 18-60 with a DSM-5-confirmed mood disorder (MDD or bipolar disorder) who were literate in Malay. Individuals with active psychosis, severe depressive or manic episodes, or intellectual disabilities were excluded.

Sociodemographic data were collected via face-to-face interviews and structured self-report forms. The religious education variable was categorized as: formal - structured, certified instruction from recognized institutions; non-formal - uncertified, community-based learning (e.g., *pondok*, *tahfiz* schools); not related- no prior religious education beyond cultural exposure. For regression analysis, formal and non-formal categories were grouped together due to conceptual similarity and sample size limitations. Clinical history, including illness duration (years since symptom onset), was verified through medical records. All assessments were managed by the researcher or trained medical officers.

Participants completed four validated, Malay-language scales, which include:

1. Beck Depression Inventory-II (BDI-II) - It has been translated into the Malay language and validated in a local study.[19] It consists of a 21-item self-report tool measuring depression severity over the past two weeks, rated on a 4-point scale (0-3) with excellent reliability (α=0.89). Scores classify depression as normal (0-10), mild (11-20), moderate (21-30), severe (31–40), or very severe (41-63).
2. Young Mania Rating Scale (YMRS) - A clinician-administered instrument with 11 items, which assesses manic symptom severity and has high internal consistency (α=0.8-0.91) and strong convergent validity with other mania measures.[20]
3. Spiritual Well-Being Scale (SWBS) – It was developed by Paloutzian et al.[21] and validated in Malay-language[22], which includes 20 items measuring Religious Well-Being (RWB) and Existential Well-Being (EWB). In this study, the word "Tuhan" replaced "Allah" to represent a more universal concept of God. Items were rated on a 6-point Likert scale, with strong reliability (r=0.78-0.94) and good convergent validity between subscales (r=0.89-0.90).

4. The WHOQOL-BREF Malay-language version is a 26-item instrument assessing four domains (physical, psychological, social, and environmental) of QoL. Each domain is scored on a 0-100 scale, with higher scores indicating better QoL. In addition, two single items assess Overall QoL and General Health, rated on a 1-5 scale, with higher values indicating greater perceived QoL and health satisfaction. It has good internal consistency (0.64-0.80) and validity in Malaysian populations.[23]

Data were analyzed using SPSS Version 29. Descriptive statistics summarized baseline characteristics. Pearson's correlation assessed the relationship between spirituality and QoL. Simple and multiple linear regression (MLR) analyses identified factors associated with spirituality. Variables with $p < 0.25$ from univariate analysis, alongside clinically significant factors, were entered into the multivariate models. Significance was set at $p < 0.05$.

RESULTS

Table I displays data from 169 patients (mean age: 34). Most were female (73.4%), Malay (93.5%), Muslim (94.7%), low-income (82.8%), and college-educated (59.8%). Almost half had religious education (46.1%). Chronicity was high (mean illness: 82 months), with 52.7% having MDD and 47.3% bipolar disorder. Depressive symptoms were mild-to-moderate (mean BDI-II: 18.3), while bipolar patients were largely in remission (mean YMRS: 3.8).

Table II shows the level of spirituality of the participants. The mean overall spiritual well-being score is 84.2. Most participants reported moderate levels (75.7%), while 23.1% experienced high spiritual well-being. The Religious Well-Being mean score was 45.8, with 58.6% moderate and 40.2% high. For Existential Well-Being, the mean score was 38.4, with most participants reporting moderate levels (74.6%), followed by 18.9% high and 6.5% low.

For QoL, the mean scores reflected moderate-to-good well-being. The environmental domain scored highest (mean: 59.5), followed by social (54.3), physical (53.8), and psychological (52.6) domains. Global indicators showed moderate perceptions for both overall QoL (mean: 3.16) and general health status (mean: 2.96).

Table III displays the regression and correlation findings. In simple linear analysis, higher overall spiritual well-being (OSWB) was significantly associated with older age (b=0.49), being married (b=8.38), longer illness duration (b=0.07), bipolar I disorder (b=13.60), and all QoL domains (p<0.01). Conversely, MDD (b= -12.95) and severe depression (b= -1.01) were linked to lower OSWB (p<0.001). Education, income, sex, religion, religious education, and YMRS scores were also retained for multivariate analysis based on clinical relevance or a p<0.25 threshold.

Table I: Sociodemographic characteristics among patients with mood disorders in Kelantan (n=169)

Variables		n (%)
Facility	HRZII	66 (39.1)
	HPUSM	103 (60.9)
Age		34 (10.54)^
Sex	Male	5 (26.6)
	Female	124 (73.4)
Race	Malay	158 (93.5)
	Chinese	7 (4.1)
	Indian	1 (1.8)
	Others	3 (1.8)
Religion	Muslim	160 (94.7)
	Non-Muslim	9 (5.3)
Education level	Low (up to secondary school)	68 (40.2)
	High (college and above)	101 (59.8)
Religious education	Formal	70 (41.4)
	Non-formal	8 (4.7)
	Not related	91 (53.8)
Marital Status	Married	75 (44.4)
	Single / Widow / Divorcee	94 (55.6)
Personal Income[1]	B40 (<RM4850)	140 (82.8)
	M40 (RM4851-10970)	23 (13.6)
	T20 (>RM10970)	6 (3.6)
Household members	Nuclear family	131 (77.5)
	Extended family	20 (11.8)
	Friend	9 (5.3)
	Alone	9 (5.3)
Substance use	Yes	5 (3.0)
	No	164 (97.0)
Diagnosis	MDD	89 (52.7)
	Bipolar I disorder	45 (26.6)
	Bipolar II disorder	35 (20.7)
Duration of illness (months)		82.3 (94.30)^
Severity of symptoms	Depressive symptoms (Total BDI-II score)	18.3 (13.23)^
	Mania symptoms (Total YMRS score) *	3.8 (5.60)^

[1]Department of Statistics Malaysia 2020. *Assessed only among patients diagnosed with bipolar I or II disorder (n=80). ^Mean (SD)

Table II: Level of spirituality (using SWBS) among patients with mood disorder in Kelantan (n=169)

DOMAINS	n (%)
Religious Well-Being (RWB)	45.8 (9.33)^
Unsatisfactory relation with God (score: 10-20)	2 (1.2)
Moderate sense of religious well-being (score: 21-49)	99 (58.6)
Positive view of one's relation with God (score: 50-60)	68 (40.2)
Existential Well-Being (EWB)	38.4 (11.87)^
Low satisfaction with one's life and possible lack of clarity about one's purpose in life. (score: 10-20)	11 (6.5)
Moderate level of life satisfaction and purpose. (score: 21-49)	126 (74.6)
High level of life satisfaction with one's life and a clear sense of purpose. (score: 50-60)	32 (18.9)
Overall Spiritual Well-Being (SWB)	84.2 (19.18)^
Sense of low overall spiritual well-being. (score: 20-40)	2 (1.2)
Sense of moderate spiritual well-being. (score: 41-99)	128 (75.7)
Sense of high spiritual well-being. (score: 100-120)	39 (23.1)

^Mean (SD)

After adjustments, six independent predictors of higher OSWB emerged: being female (adjusted *b*=5.66, *p*=0.07), being married (adjusted b=3.92, p=0.034), milder depression (adjusted b=-0.56, p<0.001), higher YMRS scores (adjusted b=0.52, p=0.03), better psychological QoL (adjusted b=0.28, p<0.001), and better environmental QoL (adjusted b=0.36, p<0.001).

Furthermore, OSWB strongly correlated with all QoL domains (p<0.001), peaking with psychological QoL (r=0.731), followed by environment (r=0.658), physical health (r=0.609), and social relationships (r=0.601). It also tied strongly to overall QoL (r=0.634) and general health (r=0.533).

Looking at subscales, Existential Well-Being (EWB) showed the strongest links to QoL, particularly the psychological (r=0.79) and physical (r=0.637) domains. Meanwhile, Religious Well-Being (RWB) correlated moderately, peaking in the environmental (r=0.552) and psychological (r=0.499) domains.

Table III: Linear regression analysis to determine factors associated with OSWB

VARIABLES	Simple Linear Regression			Multiple Linear Regression		
	Crude b (95% CI)	T stat	p-Value	Adjusted b (95% CI)	T stat	p-Value
Age	0.49	3.62	<0.001*			
Sex (Female)	-1.37	-0.41	0.684*	5.66	2.75	0.007**
Race (Malay)	-1.39	-0.23	0.817			
Religion (Muslim)	-1.13	-0.17	0.864*			
Education level (High)	-5.26	-1.76	0.081*			
Religious education (Yes)	-0.29	-0.369	0.713*			
Marital status (Married)	8.38	2.88	0.004*	3.92	2.14	0.034**
Personal income						
B40	-6.52	-1.67	0.096*			
M40	4.75	1.11	0.271			
T20	10.73	1.35	0.179*			
Household member						
Nuclear family	1.15	0.32	0.746			
Extended family	3.91	0.86	0.394			
Friends	-7.20	-1.10	0.274			
Alone	-4.86	-0.74	0.462			
Substance use (yes)	-11.49	-1.32	0.188*			
Diagnosis						
MDD	-12.95	-4.64	<0.001*			
Bipolar I	13.60	4.28	<0.001*			
Bipolar II	3.48	0.96	0.342			
Duration of illness (months)	0.07	4.48	<0.001*			
BDI-II score	-1.01	-12.64	<0.001*	-0.56	-5.10	<0.001**
YMRS score	0.02	0.07	0.945*	0.52	2.19	0.030**
WHOQOL-BREF domains						
Overall QOL	11.94	10.61	<0.001*			
General Health	9.62	8.14	<0.001*			
Physical Health	0.57	9.92	<0.001*			
Psychological	0.65	13.86	<0.001*	0.28	3.43	<0.001**
Social Relationship	0.49	9.73	<0.001*			
Environment	0.66	11.31	<0.001*	0.36	4.87	<0.001**

*Significant variables with p<0.25 or theoretical/clinical relevance were included in the multiple linear regression (MLR) analysis.
**Variables with p<0.05 were retained for the final model. For MLR, the backward linear regression method was chosen as the final model.

DISCUSSION

The present study explored the association between spirituality and quality of life (QoL) in people with mood disorders in Kelantan, Malaysia while identifying important predictors of spiritual well-being. In general, participants reported moderate levels of spirituality and QoL, with the greatest score in the environmental area. In addition, higher spiritual well-being was significantly associated with female gender, being married, less severe depression, manic symptoms, and better psychological and environmental QoL. The findings point to the interaction between personal attributes and community factors in shaping mental health outcomes.

The participants' modest spiritual scores suggest that the underlying structure of the Spiritual Well-Being Scale (SWBS) is composed of two unique dimensions. Religious Well-Being (RWB) is the vertical aspect of spirituality that measures one's felt relationship with a higher power whereas Existential Well-Being (EWB) is the horizontal dimension, which focuses on a person's sense of purpose, meaning, life satisfaction and connectedness to others and the environment.[24,25] The high scores recorded for the environmental QoL domain are a reflection of Kelantan's unique social structure which promotes both dimensions. The environment domain includes exterior variables such as safety, access to healthcare, financial security, and possibilities for recreation.[26] High environmental happiness frequently indicates a person's faith-based ideals are in congruence with his or her lived environment.

This dynamic offered a unique context in Kelantan, a mostly homogenous Malay-Muslim community, where Islamic traditions are intertwined into everyday life.[14] Local religious institutions such as mosques and Islamic councils are not merely places for spiritual teaching. They are active social safety nets, conducting welfare work, humanitarian outreach and building communal togetherness.[27] Furthermore, dynamic neighbourhood associations promote social participation and mutual aid, thus boosting the community's social capital.[28] Traditional pondok institutions, which are ancient Islamic educational systems, also strengthen communal identification and moral grounding.[29] Together, these ecological variables help residents convert their spiritual convictions into daily support for the community, contributing to emotional resilience and environmental stability.[11]

Psychological QoL was significantly associated with spiritual well-being, suggesting a conceptual connection between the two variables. The psychological domain of the WHOQOL-BREF measures positive and negative moods, self-esteem, body image, cognitive functioning, and spiritual beliefs.[26] Given that this domain is essentially ingrained in spirituality, it is fair to expect a correlation with the SWBS, especially with the subscale of existential well-being (EWB), which is a measure of life purpose and inner peace.[30] Both scales are essentially measuring how a person views life events, deals with feelings and keeps internal balance. Higher existential well-being is associated with improved emotional stability, optimism, and cognitive clarity, which are crucial components of psychological QoL. This shared focus is thought to be why psychological health was a strong predictor of spiritual well-being.

Demographic variables also played a role. Female participants reported higher spiritual well-being, consistent with historical evidence indicating women tend to participate more actively in church societies and display more emotionality around faith.7 Married individuals had higher spiritual well-being as well. Marital support

and collective religious coping mechanisms seem to provide significant meaning and stability while managing mental health issues.[8] These results indicate that spiritual aspects should be included in family psychoeducation, which could be an important aspect of emotional healing in mood disorders.

In this cohort, religious education background was not statistically significant, although structured formal or informal religious training remains conceptually valuable. It provides people with cognitive and moral models to understand suffering through religion, which may serve as a potential buffer from psychological distress.[31]

Interestingly, illness severity was associated with spiritual ratings in different directions. Depressive conditions generate despair and pessimism, hence, prior studies have found severe depression to be connected with reduced spiritual well-being.[9,18] On the contrary, higher mania ratings (YMRS) were correlated with higher spiritual well-being. During manic or hypomanic episodes, the high mood, expansive thinking, and increased self-importance may drive the patient to assign deep or transcendent meaning to their events.[8] This contrast needs careful clinical attention. Mental health providers need to gain the cultural and spiritual competence to differentiate between adaptive, authentic spiritual coping and abnormal symptom manifestation consistent with mood.[32] Clinicians should first fully explore the context and personal significance of a patient's spiritual experiences before deciding whether they are clinical symptoms.

This study is strengthened by its concentration on a specific cultural population with verified Malay language instruments. It is in consonance with the modern bio-psycho-social-spiritual model in psychiatry in tracing the religious and existential factors.[5] By integrating individuals with both Major Depressive Disorder (MDD) and bipolar illness, we also gain helpful comparative insights on how different mood states interact with faith and well-being.

Clinically, the findings underscore the importance of routine spiritual examinations and culturally relevant therapies. Therapies that promote meaning-making, emotional resilience, and personal growth, such as mindfulness, acceptance-based therapy, or spiritually orientated counseling, may be highly beneficial to patients coping and self-awareness. Furthermore, environmental QoL is a strong predictor of spiritual well-being, suggesting that clinicians and policymakers should engage with close religious and traditional networks in Kelantan to develop community-based psychological interventions that enhance social connectivity and shared responsibility.

But it is important to highlight that there are certain limitations. First, it is not possible to draw direct cause-and-effect inferences from the cross-sectional study design. Second, self-reported data may be subject to recall and social desirability biases. Third, the use of convenience sampling at two specific hospitals might not be fully representative of other parts of Malaysia.

CONCLUSION

This study underscores the vital role of spirituality in patients with mood disorders in Kelantan. Spiritual well-being was influenced by gender, marital status, depression, mania severity, and QoL, especially in psychological and environmental domains. These findings highlight spirituality's multidimensional influence

on mental health and suggest that spiritual assessment may be a valuable adjunct in culturally sensitive psychiatric care. Future longitudinal and interventional studies are needed to clarify causal relationships and assess the therapeutic benefits of spiritual support in mood disorder management.

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None

CONFLICT OF INTEREST

None declared. The outcomes will guide publications and strategic planning to improve patient management, providing indirect benefits to participants.

INSTITUTIONAL REVIEW BOARD (ETHICS COMMITTEE)

This study was approved by the Human Ethical Committee of the School of Medical Sciences (JEPEM), Universiti Sains Malaysia (USM/JEPeM/KK/23060519), and the Medical Research and Ethics Committee (MREC), Ministry of Health, Malaysia (NMRR ID-24-03508-RYT).

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