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Quality Of Life Among Old Age People: Role Of Subjective Well-Being And Religiosity

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Abstract

Old Age is very important phase in anybody's life. In old age, people face various problems that drastically affect their quality of life. The present study was carried out to investigate how subjective well-being and religiosity affect quality of life of old age people. The main objectives of the study were to examine the relationship between quality of life, subjective well-being and religiosity and to find out the potent predictors of quality of life among elderly people. The data for the study comprise of 200 participants of both sex above the age of 65 years. Only those participants were selected who gave written consent and who do not have any severe psychiatric or neurological problems. The data was subjected to Pearson product moment correlation and stepwise regression analyses. Results show that both religiosity and subjective well-being are positively and significantly correlated with all aspects of quality of life. . Results of regression analysis show that two variables i.e. Perceived Ill health and Positive Affect predict Physical Quality of life. Four variables i.e. Subjective Well-being Negative Affect, Perceived Ill Health, Spirituality, and Confidence in Coping predict the psychological quality of life. When social quality of life was taken as dependent variable, four variables i.e. social support, positive affect, subjective well-being Negative Affect and Perceived Ill health are found to predict it. Three potent predictors emerge when environmental quality of life was taken as dependent variable. It can be concluded that subjective well-being and Religiosity play important role in quality of life among old age people.

Keywords: Quality of life, Subjective well-being, Religiosity, Old Age people

Aging refers to process of change in organism which occurs after maturity, whereas old age refers to the last phase of life about which mankind has through for centuries. Old age is the closing period in life span. It is a period when people "move away" from previous, more desirable periods or times of "usefulness". As people move away from the early periods of their lives, they often look back on them usually regretfully, and tend to live in the present, ignoring the future as much as possible (Haas, 1976). Age sixty is usually considered the dividing line between middle and old age. However, it is recognized that chronological age is a poor criterion to use in marking off the beginning of old age because there are such marked differences among individuals in the age at which aging actually begins. Because of better living conditions and better health care, most men and women today do not show the mental and physical signs of aging until the middle sixties or even the early seventies. In the past most Indian people lived in rural areas as joint families, in a sense many of them were self employed in business or agriculture and retirement was gradual and voluntary. The joint families had division of labour and the aged had some role to play. This kept the aged people occupied and made their life more meaningful, while their maintenance was not an undue burden of the family (Ramamurti, 1970).

The Indian society has been undergoing rapid transformations under the impact of several forces like industrialization, urbanization and education consequently the traditional; system of values and institutions are in the process of adaptation Gangrade, (1989). In an study of older adults in Israel (Isralowitz, 2000), providing eyeglasses to Ethiopian immigrants improved physical function allowed individual to better perform their personal needs, and increased their daily interaction with others, thus improving quality of life. Quality of life can generally be divided into environmental, physical, social and psychological well-being domains. The environmental aspects includes the everyday environment, both home and community of the person, older adults often want to remain in their homes and their communities as they get older. In many cases, this 'aging in place' occurs in an environment that once was a desirable place to live but is no longer safe, or may not provide the resources necessary for maintaining independence. Increase in crime, old homes that are handicapped accessible, problems with transportation minimization of community resources such as grocery stores or pharmacies and loss of long term

neighbors may adversely affects quality of life of the older person.

Lawton, moss, and Duhamel, (1995) studies the relationship of activities and contacts with others to quality of life of frail housebound elders. They concluded that continuing activity was results of cognitive as well as physical health and that frail older adult could be better served if they have activities that were more stimulating (e.g. being taken out of the house and having more verbal contact with caregivers. Rowe and Kahn (1998) placed engagement with life as one of the main components of successful aging). Spiritual beliefs and practices often play a central role in helping older adults navigate life-challenges (Barusch., 1999; Cabassa.2007: Lawrence 2006). Research has associated spirituality with: health and wellness (Koening, Mccullough& Larson 2001; Vink, Aartsen, &Schovers, 2008), life satisfaction (Yoon & Lee, 2007); and self esteem (Keys &Reitzes, 2007). Similarly spirituality has been linked to the ability to cope with a variety of issues, including adversity (Barusch, 1999), anxiety (Rajagopal, MacKenzie, Bailey &Lavizz-mourey, 2002), depression (Koenig, 2007a), fear of falling (Zhan g, Ishikawa-Takata, Yam azaki, Morita, &Ohta, 2006), HIV (Vance, 2006) vision loss (Brennan, 2002), and lifetime trauma (Krause, 2009). In short the extent empirical, research suggests that spirituality is typically strength in the lives of older adults.

In the light of this research some observers have suggested that older adults' spiritual beliefs can be harnessed to enhance outcomes (Koening, Larson, & Matthews, 1996: Lawis, 2001; Moberg, 2005; Nelson-Becker, Nakashima, & Canda, 2007). Since, spirituality is often related to outcomes of interest to geronotological social workers; it is argued that practioners should tape all relevant client strengths to address problems. Consequently, it is perhaps not surprising that the existing research suggests that most gerontological workers are at least in some form, addressing the spiritual dimension in their practices with older adults (Murdock, 2005).

Brady et al.(1999) address three question relevant to including spirituality in quality of life (QOL) measurement using a sample of 1610 ethnically diverse patients with HIV/AIDS and cancer (aged 18-90 years)m through the application of a packet of questionnaires. The authors had three hypotheses (1) spiritual well0-being is positively associated with QOL (2) the association between spiritual well-being quality of life is unique and (3) subjects with high level of spiritual well-being will report high life enjoyment even in the presence of high levels of symptoms, spirituality was found to be associated with quality of life in some degree as physical swell-being. The significant association between spirituality and quality of life was unique and spiritual well-being was found to be related to the ability to enjoy life even in the midst of symptoms, the authors concluded that the results support the move to the biopsychosocial spiritual model for QOL measurement in oncology.

Catton et al. (1999) examined the relationship among spiritual well-being, quality of life and psychological adjustment in 142 women (aged 26-78 years) diagnosed with breast cancer. Participants were given a set of questionnaire that measured spiritual well-being, QOL and adjustment to cancer. Results indicate a positive correlation between spiritual well-being and specific adjustment styles there was also a negative correlation between quality of life and use of helpless/hopeless adjustment style and positive correlation between quality of life and fatalism. Findings suggest that while spiritual well-being is correlated with both quality of life and psychosocial adjustment, the relationships among these variable are more complex and perhaps indirect than previously considered.

In order to examine the role of living arrangement in the quality of life community dwelling Chinese elders (aged 65 years) Gee and Ellen (2000) conducted a study three dimensions of Quality of life, satisfaction, well-being and social support were examined for married men and women (living with spouse vs living inter generationally). Few differences are found for married persons, especially women, for widows, living alone significantly reduces quality of life in a number of areas. Regression analyses indicate that living arrangement were not a significant predictor of life satisfaction of well-being for married men and women. For widows, living arrangement determine well-being but not life satisfaction. Overall age health status and social support are better predictors of Quality of life for elderly.

Mcauley et al. (2006) examine the physical activity has been positively linked to quality of life (QOL) in older adults; measure of health status and global well-being represent common methods of assessing QOL outcomes and determine the nature of the relationship of these outcomes with physical activity, health status and self-efficacy in global QOL (satisfaction with life) in a sample of older black and white women. Participants completed multiple indicators of physical activity, self-efficacy, health status, and QOL at baseline of a 24 month prospective trial. Structural equation modeling examined the fit of 3 models of the physical activity and quality of life, self-efficacy

and quality of life were all indirect. Specifically, physical activity influenced self-efficacy and QOL through physical and mental health status, which in turn influenced global QOL. These findings support a social cognitive model of physical activity's relationship with QOL.

Objectives of the study:
The present study is concluded with the following objectives:

1. To examine the relationship between quality of life, subjective well-being and religiosity.
2. To find out predictors of quality of life among elderly people.

Following hypotheses were framed to be tested.

1. There would be positive correlation between quality of life and subjective well-being2.
2. There would be positive association between quality of life and religiosity.
3. Some of the subjective well-being and religiosity variables will predict different types of quality of life among elderly people.

Sample

The sample for present study was drawn from rural areas of Haryana. 200 older people (100 male and 100 female) whose age varied from 60 to 98 years with a mean age 68 years. Consent was taken from the participants. All these participants are living with their families and do not have any severe psychiatric or neurological problems.

Material to be used

Three standardized tools are used for the assessment.

1. WHO Quality of Life-BREF
2. Subjective well-being inventory (SUBI)
3. Religiosity scale

WORLD HEALTH ORGANIZATION QUALITY OF LIFE – BREF (WHOQOL-BREF)

The WHOQOL-BREF- Quality of Life was developed by the WHO QOL Group to develop a quality of life assessment available in a different languages which is applicable cross-culturally (WHOQOL GROUP 1994b). WHOQOL- BREF is an abbreviated version of the WHO QOL- 100. WHOQOL- BREF contains a total of 26 questions divided into four domains. These four domains are Physical health (7 facets), Psychological (6 facets), Social Relationship (3 facets) and Environment (8 facets). In addition two items from the overall quality of life and general health facet has been included. This is a worldwide used tool for the assessment of quality of life having high reliability and validity.

SUBJECTIVE WELL-BEING INVENTORY

Subjective Well-Being Inventory (SWBI) , a very comprehensive and robust instrument, is prepared by Sell and Nagpal in 1992. SWBI is used in the present study has been standardized on adult Indian population. There are 40 items in subjective well-being inventory 21 items are positive and 19 items are negative, which assess the subjective well-being of subjects on 11 factorial dimensions. These 11 factors are as under the numbers in brackets give the number of the item constituting the factors i.e. General well-being Positive Affect (3), Expectation Achievement congruence (3), Confidence in Coping (3), Transcendence (3), Family Group Support (3), Social Support (3), Primary Group Concern (3), Inadequate Mental Mastery (7), Perceived Ill Health (6), Deficiency in Social Contacts (3), General well-being Negative Affect (3).

RELIGIOSITY SCALE

Religiosity scale was developed by Bhushan (1990) Religiosity scale contains 36 items, out which 25 were positive items and 11 were negative items. All the items are scored on a 5-point Likert scale. It gives a composite score which shows higher the score, higher the religiosity. It covered all the important dimensions of religiosity. The religiosity scale possesses fairly high reliability. The correlation between the odd-even values was calculated and corrected by Spearman-Brown formula gave reliability coefficient of .82. Similarly temporal stability after an interval of four to five weeks is .78 . The predictive validity comes out to be .50 which is relatively adequate for this study.

Procedure: At the initial stage, the participants were contacted in their respective classes. Participants who voluntarily participate in the study were administered for the measures of Quality of life, SUBI and measures of spiritual experience Index. Participants were instructed as per the measures and all the participants were assured that their responses would be kept confidential.

Data Analysis: the obtained data was subjected to a number of statistical analyses pertinent to research objectives of the study. The analyses most

pertinent to the objectives are correlation and regression analysis. Pearson Product Moment Correlation was applied to obtain the correlations among variables. In order to have a parsimonious picture of contribution of different measures of SUBI and religiosity on quality of life , step-wise multiple regressions was applied.

Results and Discussion

The present study is conducted to examine the relationship between quality of life, subjective well-being and religiosity and to find out the predictors of quality of life among older people. The results are discussed in that light. All the scores are subjected to Pearson product moment correlation and stepwise regression analysis. It is pertinent to mention here that correlation of .16 is significant at .05 level and .21 are significant at .01 level.

Table 1: Intercorrelation Matrix

	GWBPA	EAC	CC	TRNC	FGS	SS	PGC	IMM	PIH	DSC	GWBNA	PH QOL	PSY QOL	SR QOL	ENV QOL	REL
GWBPA	-	.40**	.41**	.33**	.38**	.25**	.30**	.45**	.50**	.10	.52**	.57**	.50**	.42**	.30**	.17
EAC		-	.26**	.10	.22**	.10	.01	.27**	.31**	.00	.32**	.38**	.25**	.22**	.21*	.08
CC			-	.34**	.21**	.15	.09	.24**	.25**	.01	.39**	.35**	.44**	.27**	.19*	.31
TRNC				-	.20*	.21**	.15	.25**	.20*	.07	.38**	.20*	.47**	.32**	.03	.46
FGS					-	.34**	.43**	.28**	.25**	.16*	.32**	.26**	.29**	.34**	.23**	.22
SS						-	.25**	.11	.06	.06	.13	.09	.16	.62**	.26**	.08
PGC							-	.24**	.20*	.07	.26**	.10	.20*	.14	.11	.09
IMM								-	.55**	.22**	.53**	.43**	.49**	.26**	.34**	.13
PIH									-	.20*	.47**	.68**	.54**	.07	.32	18
DSC										-	.25**	.11	.22**	.07	.07	.05
GWBPA											-	.44**	.60**	.36**	.24**	.21
PH QOL												-	.58**	.23**	.36**	.08
PSY QOL													-	.36**	.36**	.39
SR QOL														-	.33**	.19
ENY QOL															-	13
SPIRIT																-

- Correlation is significant at the 0.05 level (2-tailed)

** Correlation is significant at the 0.01 level (2-tailed).

The correlation between subjective well-being and Quality of life ranges between .20 and .68. General well-being positive affect is found to be correlated with all aspects of quality of life positively and significantly. It shows that elder people who have higher positive affect have higher quality of life also. The measure Expectation Achievement Congruence has also positive correlation with all aspects of quality of life. It reveals that older people who have high on congruence in expectation and achievement are high on physical, psychological, social relation- ships and environmental quality of life.

The correlation between Confidence in Coping with PHQOL is .35, with PSHQOL is .44, with SRQOL is .27, with ENVQOL is .19. Except one, three correlations are significant at 0.01 level which indicates that older people having good physical, psychological, social relations and environmental quality of life are confident to deal with environmental hassles. The correction between Transcendence and PHQOL, PSHQOL, SRQOL are .20, .42, .32 respectively, it shows that older people who are having good physical, psychological, social relations of quality of life have the more feeling of belongingness. The measure of Family Group Support has positive correlation with all dimensions of quality of life which means that older males and females having family support show better physical, psycho-logical, social and environmental quality of life.
Social support and PGS also correlate positively with quality of life among elder people. The correlation between Inadequate Mental Mastery and measures of quality of life is negative. It shows that elders have inadequate mastery in mental functions have poorer quality of life.

The correlation between PIH with PHQOL is .68, with PSHQOL is .54 and with ENVQOL is .32 respectively, Means that older people who are having good physical, psychological and environmental quality of life are less worried about their health and physical fitness. The correlation between DSC measure of subjective well-being correlate with psychological quality of life is .22 which means that older people those who are not worried about liking and disliking in social environment has the good psychological quality of life. The correlation between General well-being and quality of life is negative. It shows that Negative affect deteriorates the quality of life among elder people. There is positive correlation

between spirituality and psychological and social quality of life (.19). It shows that aged people high in spirituality are also high on both psychological and social quality of life.

Religiosity and subjective well-being is positively associated except one aspect i.e. general well-being negative. It shows that elderly people who are religious they perceived their well-being better. Correlation between Religiosity and general well-being positive affect is .17, correlation between Religiosity and confidence in coping is .31, correlation between Religiosity and transcendence is .46, correlation between Religiosity and family group support is .22, correlation between Religiosity and perceived ill health is .18, correlation between Religiosity and general well-being negative affect is - .21.

Multiple regression analysis:

Since one of the objectives of the study was to examine relative predictive value of subjective well-being, alongwith spirituality, in quality of life among older adults, multiple regression analysis was considered as one of the most pertinent statistics. In the present study stepwise regression analysis is applied while taking physical, psychological, social and environmental quality of life as dependent variable.

The results of stepwise regression analysis for the dependent measure physical quality of life is presented in Table 2. These results indicate that Perceived ill health is the most pertinent predictor of physical quality of life. It entered the equation at step one, The R^2 being 0.47 perceived ill health accounts for 47% of variance in physical quality of life of older people. It can be interpreted that older people perceived their poor health as the main predictor of their physical quality of life. The variable which entered in the equation at step two is General well-being Positive affect (GWBPA) with the entry of this variable multiple R increased to .73, it means that perceived ill health and general well-being positive affect jointly account for 53% (R^2=0.53) of variance among old age individuals.

Table-2: Summary of Stepwise Regression
Dependent Variable: Physical Quality of Life

Step	**Variable**	**R**	**R^2**	**F**	**p**
1	Perceived Ill Health	0.68	0.47	129.89	0.001
2	General Well-being Positive Affect	0.73	0.53	83.58	0.001

TABLE – 3: Summary of Stepwise Regression
Dependent variable : Psychological Quality of Life

Step	Variable	R	R^2	F	p
1	General Well-being Negative Affect	0.59	0.35	80.76	0.001
2	Perceived Health	0.66	0.44	57.06	0.001
3	Religiosity	0.70	0.50	47.83	0.001
4	Confidence in Coping	0.72	0.52	38.77	0.001

The Summary of Stepwise Regression of Psychological quality of life is presented in Table - 3.

The General well-being Negative affect entered the equation at step one, which is the most pertinent predictor of psychological quality of life. The R2 being .35 General well-being negative affect account 35% of variance in psychological quality of life of older people. It can be interpreted that older people founds negative feeling of well-being responsible for their quality of life. Another variable of subjective well-being i.e. Perceived ill health (PIH), entered the equation at step two with the entry of PIH in the equation along with general well-being negative affect, the multiple R increased to .66, it shows that both general well-being negative affect and perceived ill health account for 44% of variance in psychological quality of life among older people. Another variable Spirituality entered the equation at step three. With the entry of spirituality in the equation, the multiple R increased to .70 means General well-being Negative affect, perceived ill health and spirituality jointly account for 50% of variance in psychological quality of life among older people. The last variable Confidence in coping entered in the equation at step four, with the entry of this variable multiple R increased to .72, the R2 equal to .52, mean subjective well-being, perceived ill health, spirituality and confidence in coping jointly account for 52% of variance in psychological quality of life among older people.

TABLE – 4: Summary of Stepwise Regression
Dependent variable : Social Quality of Life

Step	Variable	R	R^2	F	p
1	Social Support	0.62	0.39	92.85	0.001
2	General Well-being Positive Affect	0.68	0.46	62.85	0.001
3	General Well-being Positive Affect	0.70	0.49	45.67	0.001
4	Perceived Ill Health	0.72	0.52	38.39	0.001

The results of stepwise regression for the dependent measure social quality of life are presented in Table -4. The results indicate that four predictors made significant contribution towards the prediction of social quality of life among old age people. These are Social support, Subjective well-being positive and negative affect and perceived ill health. The joint contribution of all the variables is 52% in the total variance. It shows that older people think that their social quality of life depends on social support, their positive and negative affect, and their perception about their ill health.

The result of stepwise regression for the dependent measure Environmental quality of life present in Table-5, A casual inspection of these results indicates that only three predictor made significant contribution towards the prediction of environmental quality of life among aged people. Three predictors i.e. Inadequate Mental Mastery, social support and perceived ill-health jointly contribute 19% to total variance in the environmental quality of life of older people.

TABLE – 5: Summary of Stepwise Regression
Dependent variable: Environmental Quality of Life

Step	Variable	R	R^2	F	p
1	Inadequate mental mastery	0.33	0.11	18.42	0.001
2	Social Support	0.40	0.16	13.83	0.001
3	Perceived Ill Health	0.43	0.19	11.07	0.001

DISCUSSION

In general most of the findings of the present study are in support of the hypothesis. These findings are discussed in the light of earlier research.

The hypothesis regarding gender difference on quality of life is accepted, as in the present study, gender difference are found aged female having lower quality of life as compared to their male counterparts. Similar findings are obtained by earlier studies (Jakobsson et al. (2004); Yueh-Ping et al. (2011).

Hypothesis regarding gender difference on subjective well-being is accepted, as in the present study aged male group shows significant difference on seven out of eleven variable of subjective well-being as compared to their female counterparts. Study by Fam (2008) highlighted the importance of family and cultural context of subjective well-being of oldest old. Similar findings by Liu et al. (2011) suggested that self perceived health involvement at work and socialization contribute to subjective well-being among community dwelling older adults with disabilities.

The hypothesis regarding gender differences on religiosity is accepted as older male are having higher religiosity as compared to their female counterparts. Present study show significant gender difference between two groups of aged male and female. The hypothesis regarding positive correlation of subjective well-being with quality of life is accepted. As in the present study significant correlations between subjective well-being and quality of life are found. Similar findings are obtained by earlier studies (Singh, S et al. 2007, Choi et al. (2009).

The correlation between religiosity and psycho-logical quality of life and social quality of life is significant, so the hypothesis regarding the relationship between spirituality and quality of life is accepted. Earlier study by Brady et al. (1999) confirm this hypothesis.

One of the objective of the study was to find out the predictors of quality of life four multiple regression analysis were computed by taking dimensions of quality of life as the dependent measure.

It was found that two variable predict by Physical Quality of Life are Perceived Ill Health and General Wellbeing Positive Affect. For psychological quality of life the predictors are General Wellbeing Negative Affect, Perceived Ill Health, Religiosity, and Confidence in Coping. The predictors for social quality of life are Social Support, General Wellbeing Positive Affect , General Wellbeing negative Affect and Perceived ill Health. These variables jointly account 52% of total variance.

The predictors for environmental quality of life are Inadequate Mental Mastery, Social Support, and Perceived Ill Health. Earlier study by Gee & Ellen (2000) support the hypothesis.

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