DISCUSSION

Religiosity represents potentially valued resources for individuals to enhance well-being. Many people make mention of religiosity to cope within their most stressful situations particularly the senior citizens (Pargament, 2000). Religiosity serves a variety of purposes in day to day living. It plays a key role in the search for meaning, and facilitates social cohesiveness. It is said to be a mechanism of fostering, social solidarity and social identity. Intimacy with others, however often is encouraged through religiosity. In old age, people tend to become more and more inclined towards religiosity. It may, therefore, be assumed that the individual ways of coping and well-being of individuals are likely to be influenced by religiosity. In the Indian context, tendency towards ageing is more religious than materialistic, as this later period of life has been described as *Vanaprastha Ashrama* in the ancient literature i.e., senior citizens become more religious. A positive attitude towards economic security, friends and religion makes an individual less rigid and more adjustable. Adaptation and well being are important factors for senior citizens. Religiosity protects them from adversity in the near absence of interpersonal ties (Ramsey & Blieszner, 2000). In the old age home coping responses elicited within the context of religiosity are promoted by close social and religious ties (Krause, 2004). Old age home has been characterized as an essential private place which is the center of domesticity, a place of intimacy and sometimes a place of solitude (Peace, 1988, 1993). It is often linked to the idea of family. In the present study the main and interactive effects of religiosity and gender were investigated on ways of coping and well-being separately for senior citizens residing in old age homes and with families. Only few studies (Mohan, 2006; Bhattacharya, 2010) could be traced in the Indian literature, where the dependent variables were ways of coping and well being. Hence an effort will be made in the following pages to interpret and discuss the findings specifically related to the significant main effects and interactions reported in various tables and displayed in figures. An attempt has also been made to study the main effect of living place and its interactions with religiosity and gender on ways of coping and well being of senior citizens living in old age home.
and with family. It may also be pointed out that the findings related to the higher order interactions are purely exploratory as no other study could be traced in the literature where such interactions have been investigated.

Ways of Coping

Main effects

Religiosity

The results of $2 \times 2$ analysis of variance reported in Table 2 clearly revealed that high religious senior citizens living in old age had high scores on positive religious coping than low religious senior citizens living in old age home. The results reported in Table 4(a), 4(b), 4(d), and 4(e) reveal that high religious senior citizens living in old age homes had higher scores on dimension of emotion focused coping namely: confrontive coping, accepting responsibility, self control, as well as composite scores of emotion focused coping than low religious senior citizens living in old age home. The results reported in Table 5(a), 5(c), 5(d), and 5(e) also demonstrate that high religious senior citizens living in old age homes had higher scores on dimension of problem focused coping namely: distancing, seeking social support, planful problem solving, positive reappraisal, and composite score of problem focused coping.

The results of $2 \times 2$ analysis of variance reported in Table 7 revealed that high religious senior citizens living with family had high scores on positive religious coping than low religious senior citizens living with family. The results reported in Table 7, 9(a), 9(d), and 9(e) reveal that high religious senior citizens living with family had high scores on dimension of emotion focused coping namely: confrontive coping, self control, as well as composite scores of emotion focused coping than low religious senior citizens living with family. The results also reported in Table 10(a), 10(b), 10(c), 10(d), and 10(e) that high religious senior citizens living with family had high scores on dimension of problem focused coping namely: distancing, seeking social support, planful problem solving, positive reappraisal, as well as composite score of problem focused coping than low religious senior citizens living with family.
The results of $2 \times 2 \times 2$ analysis of variance reported in Table 22 revealed that high religious senior citizens had high scores on positive religious coping than low religious senior citizens. The results reported in Table 24 (a), 24 (b), 24 (c), 24 (d), and 24 (e) reveal that high religious senior citizens had high scores on dimension of emotion focused coping namely: confrontive coping, accepting responsibility, escape avoidance, self control, as well as composite score of emotion focused coping than low religious senior citizens. The results reported in Table 25(a), 25 (c), 25 (d) and 25 (e) reveal that high religious senior citizens had high scores on dimension of problem focused coping namely: distancing, planful problem solving, positive reappraisal, as well as composite score of problem focused coping than low religious senior citizens.

The results of the present study are accord with those of Pargament (2004) who found religiosity as a commonly applied coping method for the elderly. Turning to religion or positive religious coping has significant relation with positive reframing, acceptance and social interaction. In individuals with a high level religiosity has been found to effect the manner in which religiosity is used as a coping resource. Positive religious strategies would appear to assist senior citizens to have better quality of life. The author also found that religiosity facilitates greater peace of mind and improves coping. Farley et al. (2005) also reported that turning to religion has significant relation with positive reframing, acceptance and humor.

It is inferred, therefore, that religiosity influences the person’s ability to cope with the problems and to rely on one’s own strength and resilience which can increase the feelings of significance unity, awe, joy, acceptance, and consolation. Such feelings are intrinsically rewarding and help in dealing with difficult situations. Interpersonal relationships (community ties, friendship) and religiosity are important factors for well being in older population (Ramsey & Blieszner, 2000).

Religious resources protect old age homes dwelling senior citizens from adversity in the near absence of interpersonal ties. Senior citizens express greater feelings of life satisfaction relative to maintaining friendship external to the religious community (Melia, 2001). Social engagement may explain differential coping patterns among older men and women in the religious life. Many older men in the religious life
may feel they cannot effectively retire from solving the problems of persons who seek their spiritual advice and daily guidance (Hodge et al., 1995, Knox et al., 2002; Bishop, 2006).

Earlier researchers suggest that different coping activities tend to be applied selectively to different situations. Some studies have shown that problem focused coping predominates when events are perceived as controllable; while emotion focused coping predominates when events are appraised as uncontrollable (Lazarus, 1993; Folkman & Lazarus, 1980; Folkman, 1992).

Krageloh (2011) found that lower levels of religiosity tended to be associated with maladaptive or avoidant coping strategies, whereas higher levels of religiosity was more closely related to problem-focused coping. According to Krause and Hayward (2012), older adults who encountered more stressful life events sought out more informal emotional support, and thus experienced a stronger sense of God-mediated control (i.e., the belief that it is possible to work together with God to solve problems) as a result of such support.

The authors also found that increase in God-mediated control over time was associated with increase in life satisfaction. At emotional level religiosity increases the feeling of comfort, emotional responsibility, unconditional love for self, happiness, bliss, peace and all positive emotions.

James (1961) and Pollner (1989) has suggested that religious individuals especially those with a strong intrinsic faith, tend to view the world, the self and others in a positive way. James (1961) referred to this outlook at ‘healthy mindedness’ a frame of mind which excludes evil and view the world and all that is in it as good and essential. Thus positive mental health of those who practice an intrinsic faith may simply reflect a disposition to view all situations and interpret daily events through a healthy minded lens.

According to Pargament et al. (1990), religiosity is a life force that enhances the quality of emotional, psychological, societal and physical aspects of life. It develops all aspects of life and brings better ways of coping which leads to better well being. Religiosity provides sense of purpose, meaning in life, wholeness and significantly
affect the response to people and circumstances these in turn impact life choices, decision making and health behaviour resulting in positive emotions of peace, psychological well being, happiness, hope and optimism which is the sign of better well being. Pargament (1997) found that religiosity assists people in making major life transformation that is giving up old objects of value and finding new sources of significance, and maintain meaning, control, comfort, intimacy and closeness with God.

**Living place**

The results in regard to main effect of variable living place reported in Table 25(a), 25(b), 25(c), and 25(e) produced a statistically significant effect on ways of coping of senior citizens. The results clearly revealed that senior citizens living in old age homes had higher scores on emotion focused coping namely: confrontive coping, accepting responsibility, escape avoidance, aw well as composite scores of emotion focused coping than those living with family. The results reported in Table 26(b), 26(d), and 26(e) revealed that senior citizens living in old age home had high scores on dimension of problem focused coping namely: seeking social support, positive reappraisal as well as composite scores of problem focused coping than those living with family. The results reported in Table 24 demonstrate that the senior citizens living with family had higher scores on negative religious coping than senior citizens living in old age homes.

The results thus appear to be consistent with that of Ushasree (2003) who conducted a study to assess the use of religiosity as a coping strategy to cope with physical and psychosocial demands of elderly in ashrams and those living with family members in Tirupathi. The authors found that the ashramites used more positive religious coping while non ashramite preferred negative religious coping and active cognitive coping. The author also found that the subjects in depressive states were more motivated and used more religious coping, active behavioral coping, avoidance coping and active cognitive coping in comparison to nondepressed ones.

The results of the present study are consistent with the findings of Lazarus and Folkman (1984), transactional model of stress. Transactions that are appraised as stressful (i.e., as a threat challenge, or harm) require coping to regulate stress (emotion
focused coping) or manage the problem causing stress (problem focused coping). The senior citizens who are goal-directed use the problem focused coping. It includes strategies for gathering information, decision making, planning and resolving conflicts in order to solve or manage the problems that impede or block goals and create distress. Effective problem focused coping most probably contribute to positive psychological states and well being by allowing participants to experience some personal control, sense of accomplishment, meaning and values. While staying in old age homes may help the senior citizens to avoid familial conflicts, lack of physical space, they did not want to be burden on family members or they wanted to be cared in a better way which might have not been possible at their family home.

Carstensen (1995) maintain that the elderly are superior in controlling their emotions, which is reflected in a higher level of their well-being when compared to younger population; from this it follows that the problem-solving orientation is superseded by the orientation towards management of one’s emotions (Lazarus, 1993). Hence, the second innovation should be addition of factors of healthy aging, including the impact of those factors that are related to the coping style. By recognizing various socio-cultural conditions, and by testing their interactions with the coping style, one should be able to obtain information about the moderating effect of coping (Carp & Carp, 1984).

It may be inferred that senior citizens do not adopt completely any specific coping strategy because they change these strategies depending on the situation. Senior citizens do not use only problem focused and emotion focused coping but also turn to religious coping to a large extent (Mhaske, 2009).

Gender

The results of $2 \times 2$ analysis of variance, reported in Table 3 clearly revealed that females living in old age homes had higher scores on negative religious coping than their male counterparts, conversely the result reported in Table 9 (a) reveal that females living with family had high scores on confrontive coping dimension of problem focused coping than males living with family.

The results of $2 \times 2 \times 2$ analysis of variance, reported in Table 25 (d) and 26 (b) revealed that females living in old age home had higher scores on self controlling
dimension of emotion focused coping and seeking social support dimension of problem
focused coping than males living in old age homes. The results thus confirm the fifth
hypothesis that males and females differ on ways of coping. The results are thus in line
with that of Stone and Neal (1984) who found that females used more emotion focused
coping than males. Folkman and Moskowitz (2000) point out that individual and social
resource affect coping within any stressful stimuli and this may be applicable in old age
home coping.

The findings are consistent with the findings of Vitaliano et al. (1985) who
reported that women used relatively more problem focused coping wishful thinking,
social support avoidance and self blame than did men whereas Folkman and Lazarus
(1980) found that community resident women aged 45 to 64 reported more health
encounters than did men, men reported more work encounters than did women. People
drew on emotion focused coping more heavily in health encounters than they did in
work encounters, and conversely they drew more heavily on problem focused coping in
work encounters than health encounters. The author also found that gender differences
in coping were minimal when type of encounter was controlled.

Bishop (2006) examined the age and gender differences in adaptation and
coping of senior citizens, residing in monastic religious communities and found that old
persons reported greater friendship coping behaviours, personal growth, and reported
greater engagement in religious coping and greater depression. In addition women
reported greater coping behaviours, life satisfaction and personal growth, but men
reported greater depression.

Mhaske and Ram (2009) found the gender differences in coping ways and
mental health among the 200 institutionalized aged (100 males and 100 females) in the
age range of 60 to 85 years. Results showed that males scored higher on positive
reappraisal, self controlling, planful problem solving, confronting coping, seeking social
support, accepting responsibility and females scored higher on distancing and escape
avoidance.

According to Nolen- Hoeksema’s rumination and depression model (1987,
1994), women are more likely than men to respond to depression by talking about and
trying to figure out their negative feelings: rumination. By contrast, men are more likely than women to respond to depression by playing sports and by avoiding thoughts about the reasons for their depression.

However, Taylor et al. (2000) argued that gender difference in coping may be better understood as “tend and befriend”. Women seek the support of others, which may be consistent with tend and befriend ideas. Men engaged in more avoidant coping or distraction, consistent with “flight”, and men are more physically aggressive than women, consistent with “fight”. Authors also argued that women’s response to stress may have biological underpinnings. The oxytocin, might inhibit the flight response and encourage inter relationships in women. Oxytocin helps to calm down during stress (Light et al., 2000) and thus promotes affiliative behaviour.

**Interaction effects**

**Living place x Religiosity**

The results reported in Table 26 (e) and 26(f) revealed that high religious senior citizens living in old age home had higher scores on problem focused coping than high religious senior citizens living with family.

The present results are similar to that of Lazarus (1993) who reported that personal meaning and motivation often direct the choice of coping activities. In old age homes the senior citizens get more opportunities to involve in various religious activities and get rid of their daily hassles and the religious attendance and involvement help to find personal meanings. Religiosity thus plays an act of motivational force to cope with life situations. People are part of part variety of social systems, families, religious places and cultures. These various contexts can have a profound impact upon one’s ability to cope (Pargament et al., 1992, 2000).

The findings are therefore in favour of Process Evaluation Model (Pargament, 1997) according to which no single coping strategy is invariably effective or ineffective rather a combination of various strategies is often more effective and beneficial. The degree of integration in coping is understood by an analysis of the coping process (Folkman, 1992). The efficacy of coping is determined by the quality of coping itself.
The author reported that people seek a variety of significant ends in life, including intimacy, success, generativity, comfort and security. These ends are sought through a variety of means including different work or leisure practices, habits, beliefs, relationships and organizations. The outcome evaluation framework suggests that different activities tend to be applied selectively to different situations (Pargament, 1990). Some studies have shown that problem focused coping predominates when events are perceived as controllable while emotional focused coping is more common when events are appraised as controllable (Folkman & Lazarus, 1992; Lazarus, 1993).

**Living place × Gender**

The results of the present study revealed that living place and gender did not interact significantly in producing any effect on ways of coping. The results of the present study are not consistent with the findings of Folkman and Lazarus (1990) who found that people residing in community reported more on emotion focused coping when they had health encounters than they did in work encounters, and conversely they drew more heavily on problem focused coping in work encounters than health encounters.

Abjornson (1998) found that compared with non institutionalized elderly, institutionalized elderly people continued to live with increased psychological distress and used predominantly emotion focused coping strategies to cope with the problems.

**Gender × Religiosity**

The results clearly indicate that interaction between gender and religiosity of senior citizens was statistically nonsignificant. The present results are thus inconsistent with the earlier findings, women engaged in prayer more often than men, older people were found more engaged in prayer more often than younger ones (Poloma & Pendleton, 1991; Kadlor et al., 2002).

**Living place × Gender × Religiosity**

The results of the present study reported in Table 25(e) and 25 (g) reveal that the living place, gender and religiosity interacted with each other significantly so as to produce combined effect on emotion focused coping. The results reported that high
religious females living with family had higher scores on emotion focused coping than low religious females living with family. The results indicated that high religious females living in old age home had higher scores on emotion focused coping than low religious females living in old age home. The results also revealed that high religious females living in old age home had higher scores on emotion focused coping than high religious females living with family. The results revealed that low religious males living in old age home had higher scores on emotion focused coping than low religious males living with family. The results reported in (Table 25(e) and 25 (g)) reveal that high religious males living in old age home had higher scores on emotion focused coping than low religious males living in old age home and high religious males living in old age home had higher scores on emotion focused coping than high religious males living with family.

It is inferred, therefore, that religiosity practices like group prayer, meditation, and satsung may help to form social support network which may work as a coping resource and enhance well being (Cooper et al., 2001). People who define themselves as religious and who identify with a specific religious tradition tend to be less depressed, to have greater self-esteem (Keyes & Reitzes, 2007), more effective coping skills (Banthia et al. 2007; Pargament et al. 2001), greater happiness (Ellison, 1991), greater life satisfaction (Gautherier et al., 2006), and improved physical health (Wink et al., 2005).

According to Labbe (2010) young adults who reported higher spirituality ratings had lower sympathetic nervous system arousal and better emotion coping when exposed to a laboratory stressor compared to those who rated themselves lower in spirituality.

The authors also found that older people living in old age homes do not have to face work pressures, job complications and stressful circumstances anymore and these factors lead them to be happier. Older people develop the tendency to look at the bright side of life, they pay attention to the aspects or events of life that are positive in nature and this increases the level of life satisfaction in them.

According to Socio emotional selectivity theory older people mostly maintain interaction with the close friends. It is fairly established that social relationships and
connections lead towards more positive social experience while enhance well being of the older adults.

Religiosity not only enables a person to know and understand the essence of life but also teach him enjoy each moment of life. To be religious, therefore, means to take up challenge of living in the present, and embrace and enjoy life and its numerous possibilities.

**Well-Being**

**Main effects**

**Religiosity**

The results reported in Table 12 (a), 12 (b), 12 (c), 12 (d), 12 (e), 12 (f), and 12 (g) reveal that high religious senior citizens living in old age home had higher scores on all dimensions of psychological well being namely: autonomy, environmental mastery, personal growth, positive relation with others, purpose in life, better self acceptance dimension of psychological well-being, and total psychological well-being than low religious senior citizens living in old age homes. The results reported in Table 13 (a), 13(b), 13 (c), 13c (d) reveal that high religious senior citizens living in old age home had higher scores on all dimensions of subjective well-being namely: happiness, satisfaction with life, positive affectivity, and low negative affectivity than low religious senior citizens living in old age homes. The results reported in Table 14 revealed that high religious senior citizens living in old age home had better social well-being than low religious senior citizens living in old age homes.

The results reported in Table 27 (a), 27 (e), 27 (f), and 27 (g) revealed that senior citizens living with family had higher scores on dimensions of psychological well-being namely autonomy, purpose in life, self acceptance, and total psychological well-being. The results reported in Table 28 (b), 28 (c), 28(e) reveal that senior citizens living with family had higher scores on dimensions of subjective well-being namely: satisfaction with life, positive affectivity, and low scores on negative affectivity than low religious senior citizens living with family. The results reported in Table 29 reveal
that senior citizens living with family had better social well-being than low religious senior citizens living with family.

The results of the present study are thus in line with those reported by Mc Crae and Costa (2002), Chou and Hiewee (2007), Davidid et al. (2007), Gupta et al., (2010), Zini (2010), Hasian (2011) who found that well-being is positively influenced by religiosity. It increases social responsibility, love for others, compassion, forgiveness, social participation and collective self efficacy. The author reported that religiosity is a life force that enhances the quality of thoughts, emotions, physical and social aspects of life (Bhattacharya, 2010).

The results are also in line with Green and Elliot (2009) who compared the effects of religiosity on health and well-being. The results indicate that people, identified as religious, tend to report better health and happiness, regardless of religious affiliation, religious activities, work and family, social support, or financial status.

Mehta (1997) also demonstrates the positive influence of religion at the personal and social levels on the adjustment process in late life. The author reported that religiosity served as an important thread of integration in old age; it had been part of the socialization process and had been sustained through the adult years of the individual.

Kim (2003) also examined religious influences on personal and societal well-being in South Korea by systematically analyzing recent research, and by comparing the findings with those of other countries, especially those of North America, to assess similarities and differences. The research demonstrated that Koreans with religious faith generally had higher levels of satisfaction than those without religious faith with respect to such quality of life indicators as income level, interpersonal relationships, job satisfaction, marital life, and health. Among those considered to be religious, Protestants were found to be most satisfied with life, followed by Catholics and Buddhists. It is also clear that individual with strong religious beliefs, and those who frequently participate in religious activities, are more satisfied with life than those with less strong religious conviction and commitment. With regard to the relationship between religion and societal well-being, the author found that religiosity contributed significantly to societal well-being through their extensive involvement in welfare
services, socio-economic activities, such as health care and education. The democratic movement and religious beliefs and practices do matter in the lives of real people: religious resources can help individuals to feel more secure, stable and happy, and religious resources also can be mobilized to meet social needs, thereby contributing to societal progress.

The results are consistent with the findings of Mochan (2010) who demonstrated the benefits of religious involvement. The author reported that highly religious people tend to be healthier, live longer, and have higher levels of subjective well-being.

Life satisfaction is the crucial dimension of well-being of senior citizens because it is directly attributable to their over all well-being. Religiosity plays an important role to understand how individuals have changed over life span and to translate important factors and variables into programs that will have appositive effect on increasing the well-being for senior years of age. Older individuals who are more religious tend to be in better health, report more stamina, greater ability to cope with stress and tension and have positive attitudes towards work and their life satisfaction and well-being. Religiosity increases life satisfaction in the elderly by enhancing the self concept, self esteem and self efficacy (Oldridge, 1988).

Social well-being and social support has been considered as the expression of liking, admiration, respect, love, agreement and affirmation as well as the provision of the direct aid and assistance. Social well-being not only represents that the person has social relationship but also indicates that he is esteemed and is cared for. As a consequence of social activities or transactions he perceives that support can come from many different sources such as the person’s family, friends or community.

According to Aristotle (1961), theory of good life for humans, eudiamonia is perhaps best translated as flourishing or living well and doing well. Good life for a person means active life of functioning well in those ways that are essential and unique to humans or to realize their full potentialities in order to achieve a ‘Good life’. Religiosity provides an enhanced and strengthened sense of self and gives hope for positive future outcomes. The individual knows that he possesses the ‘capacity of inner strength, being, knowing and doing’ and these resources are always present (Coyle,
Religiosity can benefit well-being by providing meaning, purpose, a positive state of mind, hope, self-confidence which contribute to better well-being (Coyle, 2002; Frey et al., 2005). Religiosity than promotes the pursuit of well-being that provides hope, support, and stability and gives direction in critical times (Hill & Pargament, 2003). People with a sense of meaning and purpose survive more readily in difficult circumstances (Narayanswamy, 2004).

Well-being in late and very late life involves the use of resources. According to the Conservation of Resource Theory (Hobfoll, 1989; 2011) individual maintains ‘resource caravans’. Resources lessen the likelihood of differences in well-being. When interpersonal resources are threatened, lost, unstable or unprotected during stressful life experiences, older adults must rely on alternative resources in maintaining positive well-being. Thus older adults depend on religiosity relative to existing social ties (Melia, 2001; Wallace & Bergemen, 2002).

Living Place

The results of the present research reported in Table 27(a), 27 (b), and 27 (e) reveal that senior citizen living with family had higher scores on dimension of psychological well-being namely: autonomy, positive relation with others, and purpose in life than senior citizens living in old age home. The results reported in Table (28 (b), and 29 (c)) also demonstrate that senior citizen living with family had higher scores on dimension of subjective well-being namely: satisfaction with life and positive affectivity than senior citizens living in old age home. The first hypothesis that senior citizens living with family had better well-being than senior citizens living in old age homes was thus upheld. The results of the present study are consistent with the findings of Punia et al., (2007) who explored psychosocial status of institutionalized senior citizens in Haryana, and found that the aged had low well-being in institutional living.

The results are also consistent with the findings of Chakrabarti (2009) who conducted research on the well-being of the elderly residing in old age home vs those in family setting and concluded that both the subjective well-being and the level of satisfaction of elderly living in family setting was significantly higher than elderly living in old age homes.
The results are also in line with Srivastava (2003) who assessed the effect of living arrangements on emotional states and self esteem of aged people. The authors found that emotional states like anxiety, depression and guilt were more in old people living in institutions than those living with family.

The results are not consistent with the findings reported by Mishra (2003) who examined the loneliness experienced by elderly (aged 65-75) in an old age home in Kanpur. The author found that all the respondents, except one expressed that they didn’t feel lonely in the environment of old age home since they were engaged in various tasks in old age home. Arora and Chada (1995) found that non-institutionalized elderly were better on psychological well-being with low depression level as compared to institutionalized elderly people. Arora and Chhada (1995) found nonsignificant social support network and lower life satisfaction in institutionalized aged compared to non-institutionalized aged. In another study, Ron (2004) found institutionalized aged reported higher feeling of hopelessness, helplessness, and depression compared to senior citizens living in old age homes.

A study by Chanda and Nagpal (1991) also reports that purpose in life, positive relation with others and life satisfactions were significantly related and positive relation with others of institutionalized group was significantly smaller than the non-institutionalized counterparts. In general it can be predicted that the aged persons who live in their own homes with family and in family environment, have greater degree of family support. This can be predicted that in general elderly in old age homes do not get the care, support and affection they need for having a feeling of purpose in life and satisfaction with life. They are unable to contact their family members and peers as frequently as they want. On the other hand it can be predicted that the senior citizens living with family have more support from other groups than their primary group.

**Gender**

The results reported in Table 12 (a), 12 (b), 12 (c), 12 (d), 12 (e), 12 (f), and 12 (g) reveal that females living in old age homes had higher scores on all dimension of psychological well-being namely: autonomy, environmental mastery, personal growth, positive relation with others, purpose in life, self acceptance, and total psychological
well-being than males living on old age homes. The results reported in Table 13 (a) and 13 (b) clearly reveal that males living in old age homes had high scores on 2 dimensions of subjective well-being namely: happiness and satisfaction with life than females living in old age. The findings are consistent with the findings reported by Steverink et al. (2001); the authors demonstrated that life satisfaction was greater among older women. Older women had significantly higher levels of personal growth than older men. Personal growth involves a conceptualization of one’s life as an experience of growth, maturity and change. Melia (2001) also demonstrated that older women in religious life possess greater interpersonal resources than older men. Older women express greater feelings of life satisfaction relative to maintaining friendships external to the religious community. However, older men found closeness to God as a more salient source of subjective well-being (Dejong & Denovan, 2000). Knox et al., (2002) found that older men engaged more in private religious practices. Contrada, Goyal, Cather, Rafalson, Idler & Krause (2004) found that the effects of religious beliefs and attendance were stronger among women than men and were independent of biomedical and other psychosocial predictors.

According to Bales (1987), women networks were more intensive than men. Women had better social well-being than men. The male gender role emphasis on independence and invulnerability may inhibit men from asking for help when they need it (Burda & Vaux, 1987).

The results reported in Table 17 (a), 17 (b), 17 (c), 17 (d), 17 (e), 17 (f), and 17(g) reveal that the males living with family had higher scores on all dimensions of psychological well being namely: autonomy, environmental mastery, personal growth, positive relation with others, purpose in life, self acceptance, and total psychological well-being than females living with family. The results reported in Table 18 (a) also reveal that the males living with family had higher scores on dimensions of subjective well-being namely: happiness and satisfaction with life than females living with family. The results reported in Table 18 (d) and 19 further demonstrate that females living with family had higher scores on negative affectivity dimension of subjective well-being and social well-being than males living with family. The results of the present study are consistent with the findings of Lai and Conita (2005) who found that females predicted
a poorer status of well being. Blazer (1990) also found higher prevalence of depression in older women compared to older men, and overall elderly showed higher psychotic symptoms than younger people. Pressman (2005) also reported that older women had more phobia than men.

The results are consistent with the findings of Kaur (2001) who revealed that well-being of non-institutionalized elderly male was found to be higher compared to institutionalized males.

Family has a positive effect on well being of both men and women, but the effects are particularly strong for men (Stone & Neal, 1984, Umberson, 1987). Women report more problems in family, and more frequent negative thought. It may be attributed to family creating more problems for women because the women’s role change is more intense compared to men. Because women are more dependent than men on family for financial security, women had more at stake in maintaining the family. Thus women were more motivated to accommodate to their family members, wishes. In addition, Gove and Tudor (1973) revealed that women were inherently frustrating they lack status, structure, and recognition because their “accomplishments” often go unnoticed.

It may be inferred that women report more emotions than men and women are better able to recall more positive and more negative life events than men (Diener et al. 2002). The authors also suggest that women use more words to describe both positive and negative events than men. It may be that women pay more attention to emotional events than men because emotions occur within the context of relationships and relationships are more central to women than men self concept. Richards and Gross (2000) suggest that men are more likely than women to suppress emotion which interferes with the memory for emotional events.

Interaction effects

Living place × Gender

The results reported in Table 27 (i), and 27 (j) reveal that the females living in old age homes had better total psychological well-being than the males in old age
homes. The results reported in Table 28 (d), and 28 (e) reveal that the females living with family had higher scores on negative affectivity than females living in old age homes. The results reported in Table 29, and 29 (a) reveal that the females living in old age homes had better social well being than the males living in old age homes. The results thus support the findings reported by Bhatt (2001) and Shyam and Yadav (2002).

It may be due to the fact that senior citizens females living with family may have familial conflicts, lack of affection in family and lack of familial support. In old age homes these persons frequently depend on the support from other people living with them in old age homes or their help in stay well adjusted while living in groups, and others help to run things for them, all this gives them a sense of security. They find friends among other residents and staff.

Further research reported that females had more negative affectivity than males. The results clearly provide support to the findings by Chen (2008) and Bhattacharya (2010). In the old age homes the senior citizens do not get the opportunity to stay with their children and other family members and they are deprived from the emotional support they need. They do not get the opportunity to share their private life with other residents. On the other hand the senior citizens living with family have the loving, caring environment where they can share their feelings, emotions and responsibilities; are this ultimately enhances their psychological well-being. Acharya (2012) explained physical, economic status of different homes, their problems and challenges as well as the personal feelings of senior citizens living in there. The author reported that elderly homes are favorable for the residents and the society as a whole despite of some problems, particularly for those who are uncomfortable in their family.

Mc Auley et al. (2005) reported that positive values, attitudes, beliefs and strength contribute to the sense of well-being, physical health and happiness. Family, friends, co workers and others give the physical and emotional comfort to the individual. The individual knows that he or she is part of a community of people who love and care for, value and think well of the individual. Social support is a way of categorizing the rewards of communication in a particular circumstance. In old age homes old age persons get the social support and develop the social relation, social integration and social cohesiveness with their age mates.
The results are inconsistent with the findings of Diener et al. (1999) who reported that gender differences do not operate in subjective well-being. There is evidence that women as compared to men, across all socio economic levels and across diverse societies have a greater prevalence of psychological distress than men do. Haring, Stock and Okum (1984) showed that men were slightly happier than women and found that women experience more unpleasant affect than men.

**Living place × Religiosity**

The results of the present study reported in Table 27 (e), 27 (f), 27 (i), 27 (k) and 28 (b) and 28 (c) show that high religious senior citizens living in old age home had more purpose in life, better psychological well being and positive affectivity than low religious senior citizens living in old age homes. The results lend support to the findings reported by Bergeman (1999) who examined social support (including quantity of support from family and friends, and the perceived satisfaction with that support) and its influence on depression, life satisfaction, and self-reported perceived physical health (250 adults older than 65). Social support may facilitate well-being in older adulthood by focusing on the internal structures that may play a crucial role in the utilization of social support.

It is may be that the positive affect acts as a protective factor against poor health, independent of negative affect in older population (Goodwin, 2001; Markides, 2006). Positive emotions contribute to the building of resources that promote resilience. Positives feelings can broaden individuals’ coping abilities by facilitating the gains of social, intellectual and physical resources (Fredrickson, 2001). Positive affect increases engagement in social network activities which have been shown to be negatively associated with illness and mortality (Pressman et al., 2005). Positive affect is associated with confidence and adherence to health practices particularly focusing on and planning for future health outcomes (Singer et al., 2004).

It may be inferred that the social conditions of life of the aged have their specific effects upon well-being. According to Meisenhelder and Chandler (2002) who examined the relationship of attitudinal and behavioral measures of spirituality to physical and mental health outcomes in a sample of elderly community residents. The
authors found that prayer, faith and religious coping, correlated strongly with positive mental health.

Srivastava (2003) found that majority (81%) were fully satisfied with the conditions in old age home 12% were partially satisfied and 4% were fully dissatisfied who were found to be having smaller social network.

Further the results revealed that high religious senior citizens living in family had more purpose in life than low religious senior citizens living in old age home. The results are in line with the research reported by David et al. (2005) who demonstrates that religious involvement directly benefits in many ways. Religious practices are linked with family satisfaction, and closer relationships. Religious involvement promotes involvement and responsibility. Greater religiosity is associated with a variety of protective factors.

In the area of mental health (Koenig et al., 2001; Koenig, 1998) and coping (Pargament, 1997), positive links have been found between higher religiosity and a number of positive outcomes such as greater well-being, hope and optimism, purpose and meaning, and self-esteem; better adaptation to bereavement, greater social support, less loneliness, less depression, fewer suicides, less anxiety, less schizophrenia and other psychoses, less alcohol and drug use; and less delinquency and crime. According to Chakrabarti (2009), the subjective well-being and the level of satisfaction of elderly living in family setting was significantly higher than elderly living in old age homes. It is, therefore, important to provide more facilities for elderly living in old age homes either by government or by non-government agencies.

**Religiosity × Gender**

The results reported in Table 27 (e) and 27 (g) demonstrate that high religious females had more purpose in life than low religious females. The present results are consistent with the research done by Aflakseir (2012) who considered religiosity as a framework for the sense of meaning and purpose and found that the most important sources of meaning were taking part in religious activities and engaging in personal relationships with family/friends and the least important sources of meaning were participation in hedonistic activities and acquiring material possession. Furthermore, the
author found that there was a positive association between various dimensions of personal meaning and different components of psychological well-being, spirituality and religiosity. Similarly, Bolt (1975) reported a greater sense of purpose in life for intrinsically than extrinsically religiously oriented people. Tomer and Eliason (2000) also discovered that religious devotion was positively related to a sense of meaning in life. A sense of meaning and purpose in life, in turn, has been shown to be positively related to happiness, life satisfaction, and general psychological well-being among people of all age-groups (Debats, 2000; Newcomb et al., 1987; Reker, 1994; Shek, 1992; Wong et al., 2000; Zika & Chamberlain, 1992).

It may therefore inferred that religiosity is also positively associated with life satisfaction and recovery from grief following bereavement (Edmonds & Hooker, 1992; Ulmer, Range, & Smith, 1991) and negatively correlated with fear of death and death avoidance (Bolt, 1978; Rappaport, Fossler, Bross & Gilden, 1993; Tomer & Eliason, 2000; Van Ranst & Marcoen, 2000). Therefore, a sense of meaning and purpose in life appears to be particularly important during the later years of life when people are faced with inevitable social and physical losses and the approach of death. Brith (2005) found happiness in old age may have more to do with attitude than actual health. Happiness brings highly desirable life benefits such as better health, longer life, successful relationship and more. It has been noted that those who feel happy think and do good for self and others (Shukla, 2006) and their other forms of behaviour seems better than others. It causes mental strength, personal advantages, achievement and freedom of self, self acceptance, personal growth and purpose in life, autonomy and relationship with others.

**Living place × Religiosity × Gender**

The results of the present study reported in Table 27 (i), 27(l), 28(e) and 28(f) reveal that the living place, religiosity and gender interacted with each other significantly so as to produce combined effect on psychological well-being and negative affectivity dimension of subjective well-being. The results revealed that high religious males living in old age homes had better psychological well-being than low religious males living in old age homes. The low religious males living with family had better
psychological well-being than low religious male living in old age homes. The high religious male living with family had better psychological well-being than high religious males living in old age homes. The high religious females living with family had better psychological well-being than low religious females living with family. The low religious males living with family had better psychological well-being than low religious females living with family. Kaur (2001) assessed the life satisfaction of institutionalized and non-institutionalized elderly; the results indicated that life satisfaction of non-institutionalized elderly were found to be higher compared to institutionalized, non-institutionalized males had better life satisfaction than institutionalized males.

Srivastava (2002) examined the effect of living arrangements and gender differences on emotional states and self esteem of aged people; the results revealed that aged people living in institutions were higher than the aged living with children on anxiety, depression, and guilt. The results indicated that emotional states like anxiety, depression and guilt were more in old people living in institutions.

Ismail (2012) explored the link between religiosity and psychological well-being and found a strong positive relationship between religiosity and life satisfaction.

The results reported in Table 27(i), 27(l), 28(e) and 28(f) reveal that the high religious females living in old age homes had better psychological well-being than high religious males living in old age home. The results further revealed that low religious males living in old age home had more negative affectivity than high religious females living in old age homes. The high religious females living with family had more negative affectivity than high religious females living in old age home. The findings are, thus, accord with those reported by Pargament et al. (2003) and Bishop (2006) who demonstrated that elderly people living in old age homes are more confident in coping than elderly living with family. In old age homes senior citizens find more time for religious activities and get rid of from family responsibilities. The results can be explained on the basis of two basic models of the development of religious beliefs and practices: socialization theories and cognitive theories and a more recent theory, spiritual modeling (Mockabee, 2003). Socialization can be considered from the
Mockabee (2003) introduced a long overdue focus on spiritual models as sources of spiritual development. Based on the importance of observational learning in all human activities (Bandura, 1986), it is reasonable to think that this applies to religious activity and spiritual practice.

Soeken (1987) examined the positive and negative roles of religion on mental health. Positive influences include encouraging healthful lifestyles, encouraging social cohesiveness, providing options such as prayer to reduce anxiety and stress, and connecting one to a positive other, and helping to find meaning in life. Negative influences that religion may have upon mental health include, encouraging excessive guilt or shame, religious demands that are themselves stressful or unreasonable, escapist thoughts, the use of religion to deny life problems, and deviant religious thoughts that emphasize violence or exclusion. Fering and Filipp (1995), Smith et al. (1993) maintain that the elderly feature decline in frequency of the positive affect. Ferring and Filipp (1995) argue that the frequency of the negative affect in old age is higher. Shyam (2011) found males scored higher on overall well being. Results reveal that males have better psychological well-being as compared to females. One possible explanation of this gender difference in well-being may be that men are more likely to perform outdoor physical activities including walking, gardening, farming and exercising etc. and women are more likely to stay in home. These factors give men a better chance of maintaining their active daily living, functional performance and cognitive functioning; all this in turn enhances well being.

**Conclusion:** It can be concluded that, living place (living in old age home and living with family), religiosity (high and low) and gender (male and female) differentially produce their main as well as interactive effects on ways of coping and well-being.
Implications

- The senior citizens constitute a large segment of population. Due to decrease in mortality rate and increase in life expectancy the elderly population increases. This study will be extremely helpful to tackle the multiple physical and psychological problems that contribute to problems in the other areas of their lives.

- Since aging is a growing problem and is ignored by the youth, most of the senior citizens are forced to become institutionalized and it is paramount duty of the care takers to take care of them. The present study helps to take serious action plan required especially for the institutionalized senior citizens who need care and counseling. This planning should be at community and social level.

- Every aspect of life, particularly in east, is more or less imbued with religious sentiments or perceived as part of life. This study will also helpful to the authorities and care givers of old age homes to deeply understand the cognitive, affective, functional, physical and behavioural status of senior citizens.

- Directors of old age homes should make effort to ensure the frequent religious involvement of senior citizens residing in the old age home as religiosity appears to produce a preventative and therapeutic effect on well being especially in senior citizens.

- Moreover frequent religious involvement (attending religious activity, visiting religious places, religious programs) is also associated with more extensive social support networks and extensive social support leads to positive physical and psychological well being.

- As religiosity operates as a coping mechanism, it will certainly help in their adjustment to stressful life experiences especially institutionalized senior citizens.

- The findings may inspire older people who are stressed and forgo the positive aspect of religiosity and enable them to achieve a meaningful, purposeful, self knowledge and enlightenment to which the young can only aspire.
• The family environment should be made conducive and harmonious to provide elderly the happiness, content and peace of mind, so that they can have freedom of choice and control over situations. They should not only feel important and indispensable rather family environment should make them feel so, in their day to day life interactions and transactions.

• Last note the least, the present research will also certainly contribute and thus add to the existing body of knowledge in the fields of gerontology, positive psychology, community psychology and behavioural medicine.