INTRODUCTION

Religion has been defined as the feelings, thoughts, experiences and behaviours that arise from a search for the sacred (Hill et al., 1998; Pargament et al., 2004). While the term religiosity refers to the extent to which an individual feels that religious beliefs influence his or her life (Pittman, Prince-Bonham & Mckenry, 1983), WHO (2004) defined human religiosity as that which is in total harmony with perceptual and non-perceptual environment.

Religiosity is a complex phenomenon that takes many shapes and forms (Pargament, 1997). According to Webster’s New Universal Unabridged Dictionary (1996) religion is a set of beliefs concerning the cause, nature, and purpose of the universe, especially when considered as the creation of a superhuman agency or agencies, usually involving devotional and ritual observances, and often containing a moral code governing the conduct of human affairs. James (1902) defined religion as the feelings, acts and experiences of individual men in their solitude; so far as they apprehend themselves to stand in relation to whatever they may consider the divine. Pargament (1997) defined religiosity as a process and a search for significance in ways related to the sacred.

Although religiosity and spirituality have often been used interchangeably in the literature, there is a general consensus that religiosity emphasizes an organized system of tradition, beliefs, and practices, whereas spirituality expresses a more universal experience and includes religion and relationships with others in a faith community (Josephson & Dell, 2004). The terms “religiosity” and “spirituality” are conceptually different despite being used interchangeably (O’Neill & Kenny, 1998; Tanyi, 2002; Rowe & Allen, 2004). Religiosity refers to an organized system of beliefs, practices, and congregational activities related to God or a higher being (Plante & Sherman, 2001; Thoresen & Harris, 2002). Spirituality, on the other hand, frequently includes a search for meaning and purpose in life along with a connectedness to others and God (McSherry & Cash, 2004). Although spirituality and religiosity overlap, an individual can be spiritual without being religious (Tanyi, 2002; Rowe & Allen, 2004). Both religiosity and
Religiosity is not a uni-dimensional concept (Glock, 1962; Faulkner & DeJong, 1966; Allport & Ross, 1967; Stark & Glock, 1968; King & Hunt, 1972). It includes various elements of religion; namely belief, practice, knowledge, experience and the effects of those elements on daily activities (O’Connell, 1975). Although the terms “religiosity” and “spirituality” have been defined by psychologists in a number of different ways over the past century (Zinnbauer et al., 1999; Zinnbauer & Pargament, 2002), there has been general agreement that both concepts are multidimensional (Hill et al., 2000; Moberg, 2002). Furthermore, psychologists have traditionally regarded religiosity as a “broad-band” construct, not explicitly differentiated from spirituality (Pargament, 1998; Zinnbauer et al., 1998 & Hill et al., 2000). From this perspective, religiosity and spirituality have been subsumed beneath the broad umbrella of the construct religiosity, or the terms religiosity and spirituality have been used interchangeably (Spilka & McIntosh, 1997). A feature of traditional approaches is the understanding of religious phenomena from both substantive and functional perspectives. Substantive approaches define religion by its substance: the sacred. Research thus investigates those emotions, thoughts, behaviors, relationships, and the like that are explicitly related to a transcendent or imminent power (Bruce, 1996), or that have acquired sacred qualities themselves (Pargament & Mahoney, 2002; Emmons, 1999).

Functional approaches examine the purposes religiosity serves in an individual’s life. Beliefs, emotions, practices, and experiences are investigated as functional mechanisms that are used to deal with fundamental existential issues, such as meaning, death, suffering, isolation, and injustice (Bruce, 1996; Pargament, 1997). The definition of religiosity by Batson, Schoenrade, and Ventis (1993) captures the functional approach: whatever we as individuals do to come to grips personally with the questions that confront us because we are aware that we and others like us are alive and that we will die.

The dimensions of religiosity and spirituality include different levels of analysis and different strands of human activity and experiences (Emmons & Paloutzian, 2003). Religiosity is not just belief about God. Spirituality is not just oneness with life. Both
constructs contain multiple dimensions including, biology, sensation, affect, cognition, behavior, identity, meaning, morality, relationships, roles, creativity, personality, self-awareness, and salience, with purpose.

Religiosity and religious belief, behavior, perception, and so on are reflective of and change with different stages of development for individuals and groups (Worthington et al., 2002). Religiosity has their own developmental trajectory (and are not reducible to other developmental strands), but are also impacted by other changes, such as developments in cognition, affect, and morality. Thus, religiosity is not a lower level of development. Hill et al. (2002) reported that religiosity develop across the lifespan. An adequate understanding of religiosity must account for the process of development and change over time.

The first construct that is critical to religiosity is “significance.” Pargament (1997) states that significance is a phenomenological construct that involves the experience of caring, attraction, or attachment. Significance also refers to a particular set of valued, meaningful, or ultimate concerns. These concerns may be psychological (e.g., growth, self esteem, comfort), social (e.g., intimacy, social justice), physical (e.g., health, fitness), material (e.g., money, food, cars), or related to the divine (e.g., closeness with God, religious experience). The concept of “search” is a second critical feature of both religiosity and spirituality (Pargament, 1997). The process of search involves the attempt to discover significance. But the searching process does not end with discovery. Once people find something significant in their lives, they attempt to hold on to or conserve that significance. Although people are often successful in their efforts to sustain significance, pressures within the individual or within the individual’s world may prompt the need for fundamental change. At times, then, the process of search involves a transformation of the individual’s understanding of or relationship to significance (Paloutzian, 2003). Finally, the concept of the sacred is the substantive core of religiosity, the construct that distinguishes these phenomena from all others. The sacred refers to concepts of God, higher powers, transcendent beings, or other aspects of life that have been sanctified (Idinopulos & Yonan, 1996). Thus, the designation is not limited to higher powers or imminent forces, but includes others aspects of life that take on divine character and meaning through their association with or representation of the holy
Sacred aspects of life can be found at multiple levels of analysis: health (vegetarianism, body as temple), psychological attributes (self, meaning), people (saints, cult leaders), roles (marriage, parenting, work), social attributes or relationships (compassion, patriotism, community), cultural products (music, literature), and global concerns (Gaia, world peace) (Emmons, 1999; Pargament & Mahoney, 2002).

Finally, religiosity may involve both unique and universal phenomenon. Religiosity may include local truths, such as particular aspects of sacred belief or worship among identified cultural groups, or single unique experiences of the sacred. Religiosity involves supra cultural truths such as the identification of core mystical experiences (Hood, 2003), worldviews such as the great chain of being (Huxley, 1994; Wilber, 1995, 1999), and meta group developmental processes (Beck & Cowan, 1996).

Religiosity is a continuous rather than a discrete variable (Beit-Hallahmi & Argyle, 1997). Religiosity is not an all or none question but every individual will have a certain degree of it. McDaniel and Burnett (1990) defined religiosity as “a belief in God accompanied by a commitment to follow principles believed to be set by God.” Another definition for religiosity is the condition or state of being religious (O’Brien & Palmer, 1993). Weaver and Agle (2002) reported that religiosity has an impact on human behavior and attitudes. According to Hunt-Vitell model (1986, 1992), religiosity is one of the main personal elements embedded in the character of human beings. Religious self-identity has its impact on behavior, and this is shaped by the role expectations offered and defined by religion (Vitell et al., 2005). Within the psychological community religiosity has been recognized as a form of diversity (American Psychological Association, 2002).

Religiosity plays an important role in the lives of Americans with recent surveys reporting that 92% describe themselves as religious (Gallup Jr., 2004). As religiosity is often a powerful force in people lives, philosophers and psychologists have studied its impact on human development and functioning. Consequently it is of critical importance to investigate psychological processes associated with religiosity.

In the psychological literature, there are two basic models of the development of religious beliefs and practices: socialization theories and cognitive theories.
**Socialization Theories**

Socialization can be considered from the standpoint of its influences on the individual’s religiosity. It can also be viewed as a contributor to adaptation and adjustment to social roles and norms, including its potential protective role against antisocial behavior and risky health behavior. There is no doubt that the influence of one’s parents, as well as of one’s peers, is important in the acquisition and maintenance of religious beliefs and behavior. Traditionally, religiosity forms were passed down, virtually unaltered, from one generation to the next. Oman and Thoresen (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. All spiritual traditions emphasize the importance of teachers of spiritual practice who not only know how to instruct verbally, but who exemplify the practices and their results. Oman and Thoresen (2003) further propose that the exemplary behavior of spiritual models can serve as interventions to promote better mental and physical health. They are actually proposing that spiritual development, facilitated by models, can be an important source of positive human development, beyond mere religious socialization, a position long espoused by spiritual traditions themselves.

**Religious Cognition**

Fowler (1981) pioneered the contemporary study of religious cognition. Following other stage theories of development, especially that of Kohlberg (1984), Fowler’s theory of stages of faith development follows the time-honored developmental tradition of positing universal, sequential stages of development. These stages are consistent with stages of cognitive development. The stages move from the “intuitive-projective” faith of small children, corresponding to Kohlberg’s obedience through fear stage, through the stage of “universalizing faith,” corresponding to Kohlberg’s stage seven (Kohlberg & Ryncarz, 1990). Interestingly, the latter stage does appear to correspond to “unity of being” systems such as those found in Sufism (Islamic mysticism; Shah, 1964) and unitive Buddhism.
Oser and Gmunder (1991) have presented another stage theory of the development of religious cognition that has a decidedly motivational aspect. The theory describes stages of religious judgment based on the “solutions” of seven simultaneous tensions with respect to the influence of the divine on human life. These are freedom versus dependence, transcendence versus immanence, hope versus despair (of the influence of the divine), the hidden ness versus the transparency of divine will, faith versus fear, the sacred versus the profane aspects of life circumstances, and the eternal versus the ephemeral import of life choices. The solutions of these dilemmas are reflected in five stages of development of religious judgment. These stages begin with religious heteronomy in which the ability of the individual to influence the divine (by prayers and good or bad deeds) is produced. The third stage has the divine withdraw to a place of hidden influence while the individual is, for all practical purposes, completely responsible for him- or herself. This is, essentially, the opposite of stage 1. The fourth stage reintroduces the divine as self. Religious relativism becomes acceptable. Finally, in the fifth stage, the seven dimensions are coordinated, resulting (somehow) in an experience of union with the divine. Stage 5 is clearly dependent on religious/spiritual experience, often based on spiritual practice, of which no mention is made. In the traditional religious developmental systems of Buddhism, contemplative Christianity, and others, renunciation is regarded as the doorway to spiritual attainment. Oser and Gmunder (1991) presented renunciation is as a materialist tragedy, entailing the loss of material success, “paying” (grudgingly, it would appear) for one’s survival, rather than gaining liberation from worldly desires.

One specific topic that stands out as a needed focus of future research is the relationship of religious/spiritual experience to adult development. Boyatzis (2000) asserts that “the core of spirituality is a sense of self-transcendence and the core of religion is seeking or being in relationship with the sacred. Thus, the crux of spirituality and religion is experience (Spilka & McIntosh, 1997; Boyatzis, 2000; Emmons & Paloutzian, 2003). The founder of U.S. psychology, James (1902) put experience at the center of psychology and wrote about religion in entirely experiential terms.

excellence” older adults’ preferred approach to coping with the challenges of aging involves religion (Koenig et al., 1988). Compared to all other age groups, older people demonstrate the highest levels of religiosity and receive many important forms of support from religious institutions (McFadden, 1995).

Aging is a highly complex process unfolding in time and regulated by interrelated biological, psychological, and social systems (McFadden & Atchley, 2001). Whether viewed from the “bottom up” in light of molecular structures affected by genes, or from the “top down” in terms of the regulating function of consciousness enabled by the human nervous system, aging cannot be separated from the passage of time. Although the psychology of aging has been defined as the study of “regular changes in behavior after young adulthood” (Marler & Hadaway, 2002).

According to psychoanalytic theory, old people often show an increase in anxiety because of their unconscious fear that they are loosing control. To compensate for this, they frequently develop “ego rigidity” i.e. they become restricted in their situational changes. If this rigidity does not provide relief from anxiety, the old people may well regress to more primitive defenses and behaviour in a continued attempt to regain a sense of control. Ego rigidity may be seen in Freudian (1961) framework as an adaptive behaviour rather than as mere stubbornness. From a psychoanalytic perspective, rigidity serves a function in that it allows the ego to conserve energy needed to cope with new social problems and decreasing ego strength.

Other analysis drawn from the psychoanalysis tradition also addressed to the personality work of late life. Jung (1933) believed that human beings are motivated by a desire to achieve selfhood. As a persons move into middle and late life they show an increase in introversion and a reorganization of values toward the inner self. Old age is not just a time of reworking the past or regressing. It is rather a time for completion and integration of the personality. Jung believed that men would assume more feminine traits and women would become more accepting of their masculine self as they attempted to develop their self potential in late life.

Erikson (1968) postulated that personality evolves out of the life-long resolutions of various psycho-social crises. For Erikson (1968) there are eight crises that must be
resolved. The final stage of theory, ego integrity vs. despair, presents the culmination of personality growth. This is the stage of old age. In it old people evaluate their lives critically and arrive at an over all assessment that will give them satisfaction and acceptance. The productivity and intimacy gained in the earlier adult stages make this closure possible. The person, who is alone or without meaningful accomplishment, inevitably despairs. From his perspectives of late life psycho-social development, in contrast to Freud (1961) view, the need for personal growth continues up to the moment of death. Erikson (1968) optimistic views have been supported by research on successful aging.

Old age is the closing period in the life span. Many people have a half conscious and irrational fear that one day he will find himself old. For many people it comes as a phase of life in which human being can still grow towards completion of his personality and inner values. So, aging does not destroy the continuity between what the old person has been, what he is and what he will be. The individual who has little motivation to learn new things to keep up to date in appearance, attitudes or patterns of behaviour will deteriorate much faster than one whose modern societies the process of aging is characterized by a positive labeling of aging by people as well as a positive self-image on the part of the aged thus leading to what may be called “successful aging”.

For the past 50 years there has been a distinct change in the Indian family system. Joint families are turning into nuclear families. Most of the nuclear families in our society are actually extended nuclear families with one or more members related to the spouse or parents and grandparents living in the family. The status of elderly has also changed in the present family system. Few years ago aged members were regarded as having supreme power and their experience and wisdom were utilized to solve important family issues. However, younger members of family are a product of a changed social system. This conflict in the value pattern makes elderly people, particularly those who are returned from service and other occupation, mentally isolated from the family. The feeling of loneliness along with the natural age related decline in physical and physiological functioning makes them prone to psychological disturbances. In some cases elderly members of relatively rich families or aged persons who has nobody to look after takes shelter in old age homes. The elderly live in these homes merely in terms of
existence to complete the last phase of their lives. Many factors given below have contributed to the alienation of the elders (Rajan, Sharma, & Mishra, 2003).

- Migration of young couples from the rural areas to cities in search of better employment opportunities to fend for themselves.
- Elders who have been in control of the household for a long time are unwilling to give up the responsibility to their children.
- Youngsters on their part are sometimes resentful of the attitude of their parents.
- Many youngsters have moved to places far away from their native homes and in the recent past to many countries abroad. So even if they want to they cannot accommodate their parents in their own homes.
- Elders are sometimes too incapacitated or unwell to look after themselves or get medical care especially in an emergency.

All these have made the old age homes seem more relevant in the Indian context than ever before. There are two types of old age homes in India. One is the "free" type which cares for the destitute old people who have no one else to care for them. They are given shelter, food, clothing and medical care. The second type is the "paid" home where care is provided for a fee. Nowadays, such "retirement" homes have become very popular in India and they are well worth considering. The process of old age home does not mean far more than simply moving from one physical place to another. During the settling period, the old person has to come in terms with all aspects of his new environment. It is a difficult process at an old age.

Religiosity has been concerned with the development and enhancement of one’s physical, spiritual and psychological well-being in elders (Plante, 2001). In old age people tend to become more and more inclined towards religion. To an extent, religion provides a sort of social support in the form of personal contact with other people at religious gathering with whom the senior citizens could share their thoughts. Although religiosity enables many older people to cope with suffering (Krause & Ellison, 2003) the senior citizens need the understanding, love and care of their fellow human beings. It is our duty to see that they do not spend the twilight years of their life in isolation, pain and
misery. Older persons are, therefore, in need of vital support that will keep important aspects of their lifestyles intact while improving their over-all quality of life. Family is the main source of care giving to all its members. Nowadays, the role of families in case of older person has changed due to structural changes which have taken place in the Indian society and the concomitant disintegration of the joint family system. People go to institutions mainly because they have no relatives to care for them (Bergeron, 2001 & Bhatt, 2001). Old age homes have 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; Mhaske & Ram, 2009).

Identity theory predicted that older adults would experience more deleterious effects of religious doubt due to their loss of multiple role identifications. In contrast, Erikson (1966) worked on the late life struggle between integrity and despair and suggested that doubt would be less problematic for older people because they are actively engaged in a life review process to formulate an integrated perspective on the life span. Krause and Ellison (2003) in his studies on forgiveness and older adult’s health reported that religious doubt was related to a reduction in psychological well-being and older people experienced less vulnerability to the effects of religious doubt than younger people.

Eisenhandler (2003) identified two dimensions of older adults’ religious faith: reflexive faith based on “religious folkways” that guide behaviors without a person’s conscious investment in their meaning, and reflective faith that involves wrestling with what is believed, why religion is important, and the way faith shapes responses to the challenges of late life. Ramsey and Blieszner (2000) investigated spiritual resiliency in older women and uncovered the significance of the communal component of religious life, emotions shared in religious settings, and the religious roots of interpersonal relationships.

Religiosity gives meaning to people’s lives and may be an important coping resource that enables people to manage their conditions. (Cronbach & Shavelson, 2004). According to Tse, Lloyed and Petchkovsky (2005) the use of coping strategies and religious coping depends on the individuals’ level of religiosity and spirituality.
Ways of Coping

Coping is a mental process utilized to manage life demands that are considered difficult or that surpass an individual’s current mental, physical, or social resources (Taylor, 2003). When an individual encounters a situation that is interpreted as threatening or challenging, the process of coping helps reduce the stress and demands of the situation by allowing the individual to reinterpret the situation as more favorable and less threatening (Lazarus & Folkman, 1984; Pargament, 1997; Hockenbury & Hockenbury, 2003). Coping strategies have been broadly categorized into problem-focused coping and emotion-focused coping (Folkman & Lazarus, 1980). Problem-focused coping refers to doing something to alter the stressful situation, and it is often used when an individual views the situation as changeable (Folkman & Lazarus, 1980; Folkman & Lazarus, 1985; Carver, Scheier & Weintraub, 1989). Emotion-focused coping includes acceptance, planning, positive reframing, and instrumental support (Carver et al., 1989; Wolf & Mori, 2009; Carver & Connor-Smith, 2010). Emotion-focused coping refers to reducing the emotional distress associated with the stressful situation, and it is mainly used when the situation is appraised as unchangeable (Folkman & Lazarus, 1980; Folkman & Lazarus, 1985; Carver et al., 1989). Emotion-focused coping includes denial, behavioral disengagement, substance use, venting, self-blame, self-distraction, and seeking emotional support (Wolf et al., 2009; Carver et al., 2010).

Coping is a process that unfolds in the context of a situation or condition that is appraised as personally significant and as taxing or exceeding the individual’s resources for coping (Lazarus & Folkman, 1984). The coping process is initiated in response to the individual’s appraisal that important goals have been harmed, lost, or threatened. These appraisals are characterized by negative emotions that are often intense. Coping responses are thus initiated in an emotional environment, and often one of the first coping tasks is to down-regulate negative emotions that are stressful in and of themselves and may be interfering with instrumental forms of coping. Emotions continue to be integral to the coping process throughout a stressful encounter as an outcome of coping, as a response to new information, and as a result of reappraisals of the status of the encounter. If the encounter has a successful resolution, positive emotions will predominate; if the resolution is unclear or unfavorable, negative emotions will predominate. To date,
emphasis has been given to negative emotions in the stress process. However, new research about the role of positive emotions in the stress process and the role of coping in generating and sustaining these emotions has been prompted by recent evidence that positive and negative emotions co-occur throughout the stress process.

Research has indicated that choice of coping also depends upon the nature of the situation in which coping occurs (Lazarus & Folkman, 1984, 2000). Types of situations that require coping range widely, both in their objective severity and in the way in which they are perceived by an individual (Maltby et al., 1999; Schottenbarrer et al., 2006) for example death of a loved one and chronic illness might evoke different types of coping than solving a particular problem such as finding a new job. Research has shown that people tend to utilize religious coping deal with situations where they have little control, compared with situations over which they have high control (Pargament, 1997, 2005). Religion serves a particular function in that it can help people create meaning out of their experience while coping with uncontrollable situations such as personal illness (Gall & Cornblat, 2002). Although some studies find that traumatic experiences may reinforce current religious belief following traumatic events (e.g. increase reliance on faith following a traumatic event), other research suggests trauma may disrupt previously held religious beliefs (Falsetti, Resick & Davis, 2003).

Considerable research has been conducted on one form of religiousness in particular- religious coping (Pargament, 2005). Religious coping is simply a subset of general coping methods and positive religious appraisal of situations could be explained in terms of the more basic propensity to see situations positively.

Religious coping is associated with a number of positive outcomes, including better physical health (Harris et al., 1995), increased mental health status (Pargament, 2001) and decreased levels of depression (Lazar & Bjorick, 2007). Pargament (2005) reported that religious coping was associated with better health and mental health outcomes in a wide variety of life situations including illness, victimization war and the death of a loved one (Lazar & Bjorick, 2007).

Religious coping is defined as the use of religious beliefs or behaviours (prayer seeking strength from god) to facilitate problem solving and prevent or alleviate the
negative emotional consequences of stressful life circumstances and has been categorized into positive and negative construct (Pargament et al., 1998; Koeing et al., 2001). Positive religious coping includes a variety of methods that generally involve aspects of social support and positive cognitions and usually results associate beneficial outcomes—examples include turning to God for support and strengthening one’s religious convictions. Negative religious coping on the other hand, is generally associated with negative attributions, cognition and outcome examples include becoming discontented to God or claiming that the stressful event is the work of the devil. Global indicators of religiosity (i.e., frequency of congregational attendance) are often used to assess religious beliefs and spirituality.

This theoretical perspective views religion as a coping process (Pargament, 1990, 1996, 1997; Pargament & Park, 1995). Pargament (1990, 1996, 1997) suggests that a religious coping model might better explain the relationship between religiosity and well-being. Thus theoretical model of religious coping could address complex and continuous process by which religion interlocks with an individual life and allows them to deal with stresses in life. Pargament (1997) uses and extends coping theory by arguing that religion may enter the coping process in a number of ways, be it in terms of using religious coping to appraise the causes of stressful events, using religious coping to cope with stressful events, or using religious coping to come to terms with critical life events. Furthermore, views religious coping as a mediating factor in the relationship between religious orientation and well-being. However, Pargament, Smith, Koenig, and Perez (1998) suggest a two-factor model of religious coping in response to stressful life events; positive and negative religious coping. This model of coping encompasses a number of positive and negative religious coping styles including religious forgiveness, collaborative religious coping, spiritual connection, and religious purification. These authors report that positive coping is associated with fewer symptoms of psychological distress, while negative religious coping is associated with higher levels of depression and reporting of psychological symptoms.

Indeed, when religious coping is differentiated into positive and negative coping strategies, the relationships between religious coping and various variables becomes less ambiguous. Positive coping strategies refers to those practices that demonstrate the
believer’s benevolent attitude or appraisal toward God and the situation, and one’s beneficial use of the stressor by seeking out connection with God or other people (Pargament et al., 1998). These include believing God will use the difficult situation for a good purpose or getting closer with God and other believers. Some researchers hypothesize that positive coping style implies a secure relationship or attachment with God (Pargament et al., 1998; Cooper et al., 2009). Negative coping strategies are behaviors or beliefs that think punitively or pessimistically about God and the situation or focus on the dark side of the stressful event, such as doubting God’s power or believing the situation as God’s punishment.

Religious coping received little attention until relatively recently. Now it has become one of the most fertile areas for theoretical consideration and empirical research. The interest in religious coping is spurred in part by evidence that religion plays an important role in the entire stress process, ranging from its influence on the ways in which people appraise events (Park & Cohen, 1993) to its influence on the ways in which they respond psychologically and physically to those events over the long term (Seybold & Hill, 2001). But people also use religion specifically to help cope with the immediate demands of stressful events, especially to help find the strength to endure and to find purpose and meaning in circumstances that can challenge the most fundamental beliefs. The recent interest in religious coping has been fueled by increasing evidence that religious involvement affects mental and physical health (Seybold & Hill, 2001). Religious involvement is not synonymous with religious coping. Religious involvement can be a part of an individual’s life independent of stress in that person’s life. However, some people do become involved with religion as a way of coping with stress.

Religious coping is defined as the use of cognitive and behavioral techniques, in the face of stressful life events, that arise out of one’s religion or spirituality (Tix & Fraser, 1998). Most often, religious coping has been conceived as an emotion-focused way of coping (i.e., a way to deal with negative emotions); however, recent evidence suggests that it has cognitive (e.g., appraising an illness as part of God's plan) and behavioral (e.g., praying) components (Thune Boyle et al., 2006). In general, it is found to be an adaptive (helps a person to accept and adapt to a new state of affairs or to an illness), active (a person may seek comfort and reassurance through religious actions),
and problem focused (through religious expressions such as prayer, the individual may seek ways to solve a situation; or the person may engage in painful medical procedures such as surgery) way of dealing with adversities and especially life threatening illnesses such as cancer (Harrison et al., 2001). Pargament (1997) presents religious coping as multipurpose, serving a variety of functions, such as finding and giving meaning, significance, comfort, belonging, problem-solving, and spiritual orientation. Among coping strategies utilized by individuals, religious coping is among the most commonly reported (Pargament, 1997). Pargament (1997) proposed that religious coping is a function of the availability of religion to an individual (i.e., people more embedded in a religious system are more likely to make use of religious coping), and the degree to which religion offers compelling solutions to problems (i.e., religion tends to come to the forefront when people face major life events and find other secular solutions less compelling).

Well-being

Religiosity is increasingly being recognized as an important aspect of the health and well-being (Richards & Bergin, 1997; Koeing, 2008). It is a universal and widespread phenomenon that is integral to numerous cultures and influences people of all ages, socio-economic status, and educational levels. It continues to live because of, among other things, social influences and need satisfaction. Every aspect of life, particularly in the East, is more or less imbued with religious sentiments or perceived as part of religious life (Mohan, 2001). The role of religiosity as a factor in the health outcome has diverted the attention to enhance the well-being (Latha & Yuvraj, 2006). Well-being refers to optimal psychological functioning and experience (Ryan & Deci, 2001). Well-being comprises people’s evaluation, both affective and cognitive, of their lives (Diener et al., 2000). It is an outcome of a complex usage of biological, socio-cultural psychological, economic and spiritual factors. The conceptualization of the state of well-being is closer to the concept of mental health and happiness, life satisfaction and actualization of one’s full potential. There are theories of well-being: the theory of subjective well-being propounded by Diener (1984) and the theory of psychological wellbeing advocated by Ryff (1989). Diener et al. (2000) reported that subjective well-being has three main components: life satisfaction, positive effect and negative effect.
Psychological inquiry on well-being has largely divided well-being into three primary positions: a) psychological well-being, b) subjective well-being and c) social well-being.

**Psychological Well-Being**

Psychological well-being refers to the achievement of one’s full psychological potential (Ryff, 1989). Ryff (1989) conceptualizes psychological well-being as a positive component of mental health which can be viewed as a multi-faceted domain encompassing six distinct components, namely; positive self-regard (self acceptance), mastery of the surrounding environment (environmental mastery), quality relations with others (positive relations with others), continued growth and development (personal growth), purposeful living (purpose in life), and capacity for self-determination (autonomy). Research using Ryff's scale has revealed that psychological well-being is through a combination of emotional regulation, personality characteristics, identity and life experience (Helson & Srivastava, 2001) which increases with age, education, extraversion and consciousness and decreases through neuroticism (Keyes, Shmotkin & Ryff, 2002).

The psychological well-being tradition draws much emphasis on the formulation of human development and existential challenges of life (Keyes, Shmotkin & Ryff, 2002). Edwards et al., (2005) reported that psychological well-being is promoted through regular religious activities.

**Subjective Well-Being**

Diener (1985) defined subjective well-being as a person’s cognitive and affective evaluation of his/her life. Diener and Suh (1984) reported that overall high subjective well-being is comprised of the combination of three specific factors: life satisfaction, happiness and affect.

**Satisfaction with Life**: An internally imposed cognitive judgmental process providing a cumulative score of one’s subjective satisfaction with one’s life (Diener, Emmons, Larson, & Griffin, 1985). Satisfaction with life is one of four subdivisions of subjective well-being, the others being happiness, affect, and quality of life (Steel, Schmidt, & Schultz, 2008). It should be noted, though, that not all assessments of
subjective well-being include the fourth component, quality of life. (Diener et al., 1985) define satisfaction with life as a cognitive, discriminating review of one's satisfaction with one's own life, with comparison models of one's own choosing. Pavot and Diener (1993) reported that this process is a conscious one in which different individuals put differing interpretations on similar circumstances. Diener et al. (2000) contend that because individuals assign differing levels of importance to different variable such as health or energy, an assessment measure that asks the individual for an overall evaluation of one's life is necessary.

**Happiness** is the feeling of accepting oneself as one is or of being content with oneself, without justifications through specific achievements. It is an “on-line at the moment” (Diener et al, 2002) feeling of elation which relieves from obligations, past failures and future plans, in brief, from all self-concerns. Moreover, happiness is an involuntary feeling, which cannot be produced or distorted at will and rests particularly on a person’s self-transcendence. Happiness is an emotional or affective state that is characterized by feelings of enjoyment and satisfaction. According to Altson and Dudly (1978) happiness is the ability to enjoy one’s experiences, accompanied by a degree of excitement. Argyle, Martin and Crossland, (1989) believe that happiness is composed of three related components: positive effect, absence of negative effect, and satisfaction with life as a whole.

**Affect**

Affect is a person’s immediate, physiological response to a stimulus, and it is typically based on an underlying sense of arousal. Watson et al. (1988) reasoned that affect involves the appraisal of an event as painful or pleasurable that is valence and the experience of autonomic arousal.

**Positive Affectivity** is the degree to which a person is high in enthusiasm, energy, mental alertness, full concentration, pleasurable engagement and determination (Watson, Clark, & Tellegen, 1988) which impacts one’s mental health conditions.

**Negative Affectivity** is the degree to which one feels subjective distress, such as irritability, anxiety, or nervousness, unpleasurable engagement that subsumes a variety of
aversive mood states including anger, contempt, guilt and fear, with low (negative affect) being a state of calmness and serenity (Watson & Tellegen, 1984).

Theoretically, Continuity theory of ageing by Atchley (1989) states that older adult usually maintain the same activities, behaviours, personalities as they did in their earlier years of life by adapting strategies that are connected to their past experiences that enables them to gain a sense of continuity between past and present which helps to contribute to their well being in later life.

Social Well-Being

Keyes et al. (2002) defined social well-being as a state of well-being characterized by acceptance, actualization, contribution, coherence, and integration with others. World Health Organization (1948) has identified social well-being as a central component of an individual’s overall health. However, social well-being has been operationalized in a myriad of ways that have occluded the state of social health. Generally speaking, individual-level social well-being can be conceptualized as having two facets: Social adjustment and social support (McDowell, & Newell, 1987). Social adjustment refers to the subjective satisfaction with relationships or the performance of social roles. Social support refers to the quality and number of persons whom an individual trusts and can rely on, as well as the degree to which one is needed and matters to others and society (Larson, 1983). Thus, social well-being can be defined as an individual’s appraisal of their social relationships, how others react to them, and how they interact with social institutions and community (Larson, 1993; Keyes, 1998).

Social well-being may be conceptualised according to individuals' perception of social support. Procidano and Helier (1983) conception of perceived social support is understood as the extent to which the individual perceives that his/her needs for support, information and feedback are fulfilled by friends and family. The perception of social support plays an important role in coping behaviour of individuals. Good social networks and relationships are often associated with lower risk and greater well-being. However, little is known about the potential of physical activity to alleviate social exclusion (i.e. where communities or individuals suffer from clusters of problems such as poor education, housing, employment and health) or to enhance social outcomes (such as
increased social interaction and feelings of "community"). It is likely that the impact of physical activity on such social outcomes is greater than the limited evidence base suggests. Many community-based projects involving physical activity programs have been carried out but they have rarely been rigorously evaluated and results are rarely published in scientific journals (Acheson, 1998).

The quality of the social environment has far-reaching effects on the human capacity to cope. Supportive relationships with family and friends may be crucial in sustaining individuals through life crises (Caplan, 1974). One assumption in community mental health practice is that while some stressors can neither be avoided nor modified, interventions which increase available social supports can facilitate coping in the face of stress (Caplan & KilliJea, 1976; Silverman & Murrow, 1976).

Physical Well-Being

Physical well-being is described as the optimal functioning of the body’s major physiological systems (i.e. cardiovascular, digestive, reproductive etc). Selye (1976) the ability to return to homeostasis can prove fatal to various organ tissues and eventually to the host organism.

A substantial amount of research has been conducted which indicates the role that stressful life has on the development of physical and psychological problems. One potential moderator of the effects of life stress is physical fitness (Roth & Holmes, 1985). In addition to the well accepted notion that physical fitness generally enhances physical health, a variety of research has suggested that fitness training programs lead to improved psychological functioning (Roth & Holmes, 1985). Roth and Holmes (1985) examined the utility of stressful life events and physical fitness for predicting physical and psychological problems. The authors found that individuals who experienced high life stress were more likely to experience subsequent physical and psychological health problems than individuals who experienced low life stress. Among individuals who were exposed to high life stress, only those who were relatively low in physical fitness developed more problems with physical health and depression. Individuals who experienced high levels of life stress and were physically fit, did not develop more physical health problems than did individuals who did not experience high levels of life
stress (Roth & Holmes, 1985). Sinyor et al. (1983) demonstrated that aerobically trained persons were able to recover faster from experimentally induced psychosocial stress than untrained persons on physiological, biochemical and psychological measures. Various similar physiologically orientated studies have demonstrated similar effects (Anshel, 1996; Scully, 1998). Roth and Holmes (1987, 1985) have also reported that physical fitness moderates the stress-illness relationship and that increasing fitness, through aerobic training, decreases the experience of stressful life events. Moderate intensity of physical activity was found to reduce the short-term physiological reactions to brief psychosocial stressors.