REVIEW OF LITERATURE

A brief review of the studies based on the available literature is presented in this chapter. An attempt has been made to reveal the main trends in research of ways of coping and well-being in relation to the independent variables used in the present study:

The relevant research has been summarized under the following headings:

1. **Living place and Ways of Coping**
2. **Religiosity and Ways of Coping**
3. **Gender and Ways of Coping**
4. **Living place, Religiosity, Gender and Ways of Coping**
5. **Living place and Well-Being**
6. **Religiosity and Well-Being**
7. **Gender and Well-Being**
8. **Living place, Religiosity, Gender and Well-Being**

1. **Living place and Ways of Coping**

Vitaliano et al. (1985) reported that senior citizens living with family used relatively more problem focused coping wishful thinking, social support avoidance and self blame where as Folkman and Lazarus (1990) found that people residing in old age homes 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.

Schumacher (1997) found that older people who prefer a cognitive avoidant coping strategy were more satisfied with their life and have less complaints than sensitizers.

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.
Dunn and Horgass (2000) found that 96% of 50 community-dwelling elders with a mean age of 74 years use prayer to cope with stress.

Barbara et al. (2002) found that coping strategies including information seeking are related to positive affect while emotional strategies particularly those involving avoidance blame and emotional ventilation are related to negative affect, lowered self esteem and poorer adjustment among the elderly.

Ushasree and Basha (2003) assess the benefit 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. About 80 elderly people were interviewed by using a standardized questionnaire. Analysis of results showed no difference in the religiosity and meaning in life scores of the two groups. The authors found that all ashramites used religious coping while 40% of non ashramite for religious coping followed by active cognitive coping. Women were found with better feeling of meaning in life. Majority of ashramites used religious coping to familial problems and both the groups were found to use to some extent non religious coping also to health problems.

Pargament et al. (2004) conducted a longitudinal study on religious coping methods as predictor of psychological, physical and spiritual outcomes among elderly. The results revealed that religious coping was significantly predictive of spiritual outcome, change in mental and physical health. Generally, positive religious coping were associated with improvement in health and negative religious coping were predictive of decline in health.

Aldwin (2004) found that coping strategies differentially predicted perceived positive or negative outcomes which in turn predicted current mastery and depression levels among community dwellers.

Jain and Purohit (2006) found no significant difference between senior citizens living with family and living in old homes regarding overall spirituality. The authors found significant differences in many domains of spirituality such as god and religiosity, soul, self-awareness, interpersonal relations, flexibility, ability to use and overcome suffering, ability to transcend pain and being spiritually intelligent about death.
2. **Religiosity and Ways of Coping**

Religious coping is generally defined as the use of religious beliefs or behaviors to facilitate problem-solving to prevent or alleviate the negative emotional consequences of stressful life circumstances (Koenig et al., 1998). Religiosity being used as one way of coping by individuals facing stressful life events has raised increasing interest in the field of mental health in the past two decades. Although the prevalence and population norms of religious coping have varied with characteristics of the sample and of the stressor indicated, evidence from empirical studies has proven that religious coping is a widely employed coping strategy for various groups in a number of situations. Religiosity is used to cope with stress from illness (Hebert, Zdaniuk, Schulz, & Scheier, 2009; Lavery & O’Hea, 2010), trauma (Schuster et al., 2001; Bradley, Schwartz, & Kaslow, 2005; Fallot & Heckman, 2005; Harris et al., 2008), and bereavement (Murphy et al., 2003; Anderson, 2004).

Religiosity has been reported to be commonly applied coping method during stressful events for the elderly (Pargament, Koenig, Tarakeshwar, & Hahn, 2004; van Dyke et al., 2009; Dew et al., 2010). Moreover, evidence from studies indicated that religious coping is associated with improvement in depressive mood (Braam et al., 2006; Hebert et al., 2009; Herrera et al., 2009), and quality of life (Tarakeshwar et al., 2006; Filazoglu & Griva, 2008; Tsevat et al., 2009). Although most studies found religious coping associated with more positive outcomes, some researchers found religious coping bringing negative impact on the participants’ adjustment to stressful events. Still others found no relationship between religious coping and the outcomes of stressful events. Positive religious coping has been tied to lower levels of emotional distress and psychosomatic symptoms (Pargament, Koenig, & Perez, 2000) and even indices of better physical health (Koenig, McCullough, & Larson, 2001). Negative religious coping, on the other hand, has been tied to higher levels of anxiety and depression (Smith, McCullough, & Poll, 2003; McConnell, Pargament, Ellison, & Flannelly, 2006;), decreased self-esteem (Pargament 2003), and posttraumatic symptoms (Harris et al., 2008). Problem-focused coping is positively associated with psychological and spiritual well-being and satisfaction, and it is associated with lower depressive symptoms (Stilley et al., 1999; Christensen, Ehlers, Raichle, Bertolatus, & Lawton, 2000). However,
emotion-focused coping is associated with poor physical functioning, social functioning, and mental health, as well as physical disability and higher levels of fatigue (Myaskovsky et al., 2003; Burker et al., 2004).

Daaleman et al. (2000) reported that religious coping provides a sense of purpose and a framework for understanding the experience of a life-threatening illness and even death.

Yoon (2000) examined the impact of religiosity/spirituality on well being and coping for the three minority groups of African American, Native American, and Korean American. Ethnic differences were found with Native American elderly people using more religious and spiritual coping skills than both the African American and Korean American elderly people. It was also found that African American elderly used more religious and spiritual coping skills than did Korean American elderly people.

Tepper, Rogers, Coleman, and Malony (2001) found that the individuals who used religiosity to cope with daily difficulties or frustrations were negatively related to levels of frustration and levels of mental health symptoms.

Nooney and Woodrum (2002) found that church based support resulted in greater use of positive religious coping strategies and therefore indirectly contributed to better mental health for persons.

Krause (2004) reported that older respondents who received more church-based support had a more personal relationship with God. Moreover, older people who feel more closely connected with God are more optimistic and thus enjoy better health.

Mascaro, Rosen and Morey (2004) found that non-religious spirituality enhances effective coping during stressful situations by promoting meaning making and a sense of personal competence resulting in effective coping and positive mental health outcomes such as reduced depression, anxiety, neuroticism and general psychopathology.

Krause and Wulf (2004) found religiosity to be the most preferred coping strategy of men and women in the religious life. Although active behavioural coping patterns (e.g. seeking support and guidance for others) as well as avoidant coping strategies (e.g. seeking solitude for others) are also used.
Ano and Vasconcelles (2005) reported that religious methods of coping are significantly linked to psychological well-being for individuals facing stressful situations.

Farley et al. (2005) reported that turning to religion has a significant relation with positive reframing, acceptance, and humor, while Schottenbauer et al., (2006) found that religiosity associated with emotional support and instrumental support. In individuals with a religious affiliation, religious orientation has been found to affect the manner in which religion is used as a coping resource. An intrinsic religious orientation is more likely to be associated with problem solving and an extrinsic orientation more likely to be linked with cognitive avoidance strategies (Pargament et al., 1990; Aguilar-Vafaie & Abiari, 2007).

Sherman (2005) found elders predominantly to rely on positive religious coping and only use negative religious coping to a limited degree. Exline & Rose (2005) reviewed four types of religious struggle leading to negative coping: (a) suffering (i.e., blaming God for any suffering and being angry at God); (b) virtuous striving (i.e., blaming and not forgiving the self if the person falls short of the virtues cultivated within the religion); (c) perception of supernatural evil (i.e., blaming evil forces or believing in possession by a diabolical force); and (d) social strain (i.e., feeling hurt or offended by the religious community or feeling like an outcast by a religious group) and found that negative religious coping is associated with more psychological distress and increased mortality risk.

Harrison et al. (2001) reported that positive religious coping is found to associate with less depressive symptoms, anxiety, and mortality, and higher degree of life satisfaction, quality of life, and self-esteem. On the contrary, negative religious coping is typically found to relate to more depressive symptoms, anxiety, posttraumatic stress, mortality rate, and negative health outcome. In their meta-analysis of religious coping studies, Ano and Vasconcelles (2005) examined the association between religious coping and psychological well-being by synthesizing these studies quantitatively and evaluating the efficacy of situation-specific religious coping methods (e.g., positive and negative religious coping strategies) for the participants. The authors found that positive religious coping strategies were positively related to positive psychological well-being and
negatively related to negative psychological well-being. Moreover negative coping strategies were found to have a positive association with negative psychological well-being. However, no relationship was found between negative coping strategies and positive psychological well-being. Whereas individuals who used more positive religious coping such as seeking spiritual support or spiritual forgiveness experienced more positive affect and less negative affect (i.e., depression and anxiety). Individuals who used more negative religious coping such as punishing God appraisal experienced more negative affect such as depression and anxiety.

Joseph and Linley (2005) examined the possible links between religiosity, spirituality, and posttraumatic growth. The religiosity and spirituality were usually, although not always, found to be beneficial to people in dealing with the aftermath of trauma. Moreover, traumatic experiences led to deepening of religiosity or spirituality. Such positive religious coping, religious openness, readiness to face existential questions, religious participation, and intrinsic religiousness were typically associated with posttraumatic growth. The use of positive religious coping strategies assists people to have a better quality of life than individuals who use negative religious coping strategies (Cotton et al. 2006; Tarakeshwar et al., 2006).

Trankle (2006) examined the relationship between psychological well-being, religious coping and religiosity. The authors found that the high levels of religiosity as well as religious coping positively correlated with high levels of psychological well-being.

Pearce, Singer and Prigerson (2006) investigated the association between religious coping, mental health and the caring experience. The authors found that the more positive religious coping strategies were used, the greater the burden experienced but also the greater satisfaction for caring for the elders. In contrast, the use of negative religious coping strategies were related to more burden, poorer quality of life and less satisfaction, and was correlated with an increased likelihood of a major depressive disorder and anxiety disorders.

Prigerson (2006) investigated the association between religious coping and mental health and found that the uses of positive religious coping strategies were led to greater
life satisfaction. In contrast, the use of negative religious coping strategies was related to poorer quality of life and less satisfaction. **Prayer**

Proffitt, Cann, Calhoun and Tedeschi (2007) examined the relationship between the psychological impact of personal traumatic events and the use of religion-based coping in a sample of 30 Judeo-Christian clergy. It was found that use of positive religion-based coping strategies did facilitate posttraumatic growth, and posttraumatic growth in turn, resulted in greater well being. The use of religious coping strategies both positive and negative was directly related to one’s affiliation to a denomination and leadership within the Church.

Bormann et al. (2008) found spiritual ideas, preexisting spiritual resources and perspectives facilitating greater peace of mind and improved coping. Ahrenas, Abeling, Ahmad and Hinman (2009) examined the predictors and outcomes of positive and negative religious coping and found that positive religious coping is related to higher levels of psychological well-being whereas negative religious coping is related to higher levels of depression.

Anderson et al. (2008) conducted a study to determine the coping strategies used by adults. It was found that 74% of study participants used religion as a coping strategy which contributed towards higher life satisfaction.

Green et al. (2009) found that emotion-focused coping strategies were associated with greater stress and depression, whereas humor was associated with less emotional quality of life. In addition, negative religious coping was associated with greater depression among patients, and was associated with greater perceived stress. This study highlights that both nonreligious coping styles and religious/spiritual coping styles can be conceptualized as adaptive or maladaptive. The authors also found that particular coping styles (emotion-focused coping, humor, and negative religious coping) were associated with poorer mental health outcomes.

Herrera et al. (2009) explored the association of religious and spiritual coping with the well-being of elders and found that the negative religious coping (e.g. feelings that the caregiver burden is a punishment) predicted greater depression.
Winter et al. (2009) examined a Swiss sample of 328 church attendees in the aftermath of stressful life events to explore associations of positive or negative religious coping with the psychological outcomes. While both negative and positive religious coping were positively associated with stress-related growth, negative religious coping was additionally associated with reduced well-being, increased anxiety and increased depressive symptoms being experienced.

Krageloh (2010) found that lower levels of religiosity tended to be associated with maladaptive or avoidant coping strategies, whereas higher levels of religiosity were more closely related to problem-focused coping.

Koeing et al. (2010) found that increased religiosity predicted increased religious coping which influenced social support, and social support in turn positively influenced depressed mood and fatigue.

Ivtzan and Chan (2011) reported that religious coping was positively correlated to psychological well-being.

Krause and Hayward (2012) reported that the associated of 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.

Weber et al. (2012) reported that religious coping was significantly predictive of spiritual outcome and changes in mental and physical health. Generally, positive methods of religious coping (e.g. seeking spiritual support, benevolent religious reappraisals) were associated with improvements in health. Negative methods of religious coping (e.g. punishing God reappraisal, interpersonal religious discontent) were predictive of declines in health. Patients who continue to struggle with religious issues over time may be particularly at risk for health-related problems.

Golub et al. (2013) found relationship among religiosity, social support, and stress. Both social support and stress were found to be significant negative predictors of
well being, but religious coping and beliefs emerged as a significant positive predictor. The interaction between religious coping and beliefs and social support was also significant, and post-hoc analyses indicated that high stress was likely among individuals with high-levels of social support but low levels of religious coping and beliefs.

3. **Gender and Ways of Coping**

Stein and Nyamathi (2000) studied gender differences on ways of coping and found females showed more social support, emotion focused and avoidant coping compared to males. Stone and Neal (2000) found that males use more problem focused coping strategies than females.

Edgell, Becker and Hofmeister (2001) investigated the differences between men’s and women’s use of religion and found support for men’s increased use of religion during his stress phase of life. They found that while men’s use of religion is directly related to their role as a provider and father, women’s use of religion is directly related to their personal value and belief system.

Bishop (2006) examined the age and gender differences in adaptation and coping of senior citizens, residing in monastic religious communities and found 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.

4. **Living place, Religiosity, Gender and Ways of Coping**

Cohen and Wills (1992) reported that coping strategies used by senior citizens living in old age home were accepting situation, religion, seek professional help, positive attitude, family and friend support or keep busy. The senior citizens who used religious activity as a coping mechanism had a higher life satisfaction than those who did not and there was highly significant positive correlation between intrinsic religious activity and life satisfaction.

Wang et al. (2002) found that there was no robust impact of coping strategies in relation to various categories of stress. There was evidence that the use of pray and seek
religious help and talks to others about the situations as coping strategies by women moderated the risk of depression in the presence of financial stress and relationship stress.

Mhaske and Ram (2009) investigated 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 and found that males scored higher on positive reappraisal, self controlling, planful problem solving, confronting coping, seeking social support, accepting responsibility whereas females scored higher on distancing and escape avoidance respectively. The authors also found that females scores higher on depression, somatic symptoms, anxiety and social dysfunctions.

5. Living place and Well-Being

A few studies are available in this context that compared senior citizens living with family and living in old age homes on well-being.

Kothary and Sinha (2002) assessed the perception of old age, life style and problems faced by the elderly people in the rural areas of Rajasthan. The main problems felt individually by the elderly people as well as perceived for the elderly in general were related to health, money and loneliness. Only 2 out of 27 felt happy and satisfied with their life; both were widows with some independent source of income. The rest felt ignored and helpless.

Srivastava (2003) conducted to assess the effect of living arrangements on emotional states and self esteem of old 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.

Mishra (2003) examined the loneliness experienced by10 elderly (aged 65-75) in an old age home in Kanpur. The authors 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.

Saxena (2003) conducted an explorative study on sociological perspective of the aged in Utter Pradesh, India. 240 elderly respondents were divided into four different categories of 60 each viz., retired university teachers, civil servants, lawyers, and doctors.
and then interviewed, to assess the volume and intensity of many sorts of deprivations. The authors found that quite a large number of the aged were deprived of care from their children and relatives. 155 (65%) respondents said that there is no one to take care of them from the family. Most of the respondents’ sons live away from their parents; some of them did not have children. Fifty five (55%) respondents said that they were taken care of by their relatives. Only 12% of respondents were looked after by their son & grandsons.

Srivastava (2003) assessed the status of elderly residing in New Delhi. It was found that about 36% had been living alone before they shifted to an old age home, 10% were living with remotely related or unrelated people, 9% as couples, 24% with their son & had to leave because of difference with them and accommodation problem & 14% had no shelters. After admission in old age home almost 70% of inmates had very few interests outside the old age home, 16% had no feels & 5% reported that they watch television, listen to radio or read in their leisure activities and remaining in meditation and religious activities. A majority (81%) were fully satisfied with the conditions in old age home. 12% were partially satisfied and 4% were fully dissatisfied, they were found to be having smaller social network.

Louhlin (2004) assessed the depression and social support of elderly adults. A sample of 25 home bound elderly were screened for depression using long form of the Geriatric Depression Scale (GDS). Twenty (80%) participants were white, and five (20%) were African American. Nineteen participants were women and 6 were men. Participants ranged from age 75 to 98. Depression was significantly related to race with 55% of white participants and 40% of African American participants reporting depressive symptoms. Depression was significantly related to gender with 67% of men and 47% of women reporting mild depression. Depression was significantly negatively associated with increasing age, but positively associated with being a man, being unmarried and needing formal social support.

Shrimathi (2004) assess quality of life of institutionalized elderly in Andhra Pradesh. About 647 elderly over 60 years were interviewed using a standardized questionnaire which included reason for joining old age homes, the level of satisfaction
and general feelings regarding subjective quality of life evaluation of their relationship with staff of the institution and overall satisfaction with life at that moment. About 37% of the inmates rated their quality of life as good, 33% as average and 29% as unsatisfactory. A few (18%) expressed that instead of staying with people who did not want them, it is better to stay in old age homes, free of the teasing home environment.

Chakrabarti (2009) conducted research on the well being of the elderly residing in old age home Vs those in family setting. Structured interview method was used to collect data from the 60 samples, who were selected by purposive sampling and snowball sampling. The mean subjective well being scores were 88 and 81, median 82 and 80 and standard deviation 12.22 and 9.32 of the elderly living in family setting and those living in old age homes, respectively. The mean level of satisfaction scores was 116 and 107, median 117 and 108 and the standard deviation 5.07 and 3.71 of elderly living in family setting and those living in old age homes, respectively. The study 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.

Oberoi et al. (2010) explored the quality of life in community dwelling geriatrics. 50 people, community dwelling above the age of 60 yrs were taken for the study and survey method was used for the study. Basic demographic data, pre-validated questionnaire tailored to Indian population was used to assess quality of life, which composed of four domains namely: physical, psychological, social and environmental domains. Physical domain was most affected and 42.5% of the domain was affected. Social domain was the least affected, only about 9.33%. The component in the physical domain the need for elderly to take medical treatment to function in their daily life was affected by 76%. In psychological domain 42% of the elderly people under study had feelings like depression, anxiety or mood swings. The component of being dependent or feeling of being a burden on people is found to be the most affected in social domain and it affected about 12% of the subject under study. The feeling of not being safe in daily life was the component which was most affected, about 28%, in environmental domain. The affection of various domains increased as age advances. It was also found that because of the health problems the most affected area of life was the ability of the elderly to go for vacations and outings independently. The study concluded that the most affected
component in physical domain is the need of some medical treatment to function in daily life, psychological domain is the feelings like depression, anxiety and mood swings, in social domain is being dependent or a feeling of being a burden on society and in environmental domain is feeling safe in daily life.

Bhattacharya and Mukerjee (2010) found that institutionalized elderly had significantly high spirituality and emotional intelligence and non institutionalized elderly were significantly higher in family group support. Non institutionalized widowers were significantly higher in family group support than institutionalized widowers.

6. Religiosity and Well-Being

In a review of studies, positive relationships were documented between spirituality/religion and physical & functional status, reduced psychopathology, greater emotional well-being and improved coping (Meisenhelder & Chandler, 2000; Ellison et al., 2001; Mohan et al., 2008 & Koeing et al., 2010).

Koenig (1998) found statistically significant relationships between greater religious involvement and greater life satisfaction, happiness, better mood or higher morale. Religiosity may directly and indirectly influence mental and physical well-being (Seybold & Hill, 2001; Miller & Thoresen, 2003). This relationship is apparent in much of the counseling research on wellness (Sweeney & Witmer, 1991). Wellness models, such as those described by Sweeney and Witmer (1991) have included spirituality as a vital component of wellness. These wellness models emphasized the important link between spirituality, mental health, and physical health, as each play an equally vital role in the well-being of an individual. Spirituality has been found to be an important and unique component ability to cope (Brady, Peterman, Fitchett & Cella 1999; Ehman, Ott, & Short, 1999; Pargament, 1997). Data suggest that spirituality may be protective against physical and psychological illness as well as act as important tools for coping with life stressors (Hill et al., 2003; Miller et al., 2003).

Religiosity has been generally reported to be positively correlated with well-being including life satisfaction and happiness (Argyle, 2000). In a meta-analysis of 56 studies, Argyle (2001) reported that overall, religiousness and happiness are positively but weakly correlated ($r = .16$). Francis, Jones and Wilcox (2000) reported that the domains of
church attendance, religious commitment, and overall spirituality, satisfaction with church activities, religious beliefs, and attitude toward Christianity, all positively correlate with happiness. Similarly, six scales of religiousness (religious coping, congregational support, religious identity, spirituality, religious practice, and religious belief) positively correlated with happiness (Cohen, 2002).

With respect to the empirical examination of the relationship between religiosity and well-being traditionally the results of these studies have been mixed some provide a consistent support for a positive association (Moberg, 1984; Zuckerman, Kasl & Ostfeld, 1984; Inglehart, 1990; Veenhoven, 1997; Mookerjee & Berson, 2005). Some others (Blazer & Palmore, 1970; Adbel-Khalek & Nacuer, 2006; Dezutter & Hutrebaut, 2006) have found a negative relationship between the two.

The relationship between religion and well-being has been the focus of a number of empirical studies over the last 20 years (Maltby et al., 1999; Francis & Kaldor, 2002; Green & Elliot, 2009). The most common dimension of religious experience that is assessed in research on religious services is frequency of attendance at religious services has been linked to greater psychological well-being in most studies (Ellison et al., 2001; Francis & Kaldor, 2002; Keyes & Reitzes, 2007).

Meisenhelder and Chandler (2000) questioned 71 Native Americans over the age of 65 living in the general community on their frequency of prayer, importance of faith, and their health status. The authors found that people who prayed more often and those who indicated a high importance of their faith reported better mental health than people who did not pray.

Shaw and Krause (2001) and Koenig (2006) found that religiosity provides practical support and assistance on issues such as accommodation, food, money, counseling, pastoral care, emotional, spiritual and social support.

Ellison et al. (2001) found that church attendance and beliefs were positively associated with well-being. Prayer tends to occur among individuals who were facing more personal problems. Krause and Wulff (2005) demonstrate an indirect link between religious attendance and psychological well-being through the dimension of religious identity and social support.
Cooper et al. (2001) found that intrinsic spirituality/religiosity was identified as one of the nine key areas for senior citizens. The other key areas were health professionals' interpersonal skills, primary care provider recognition of depression, treatment effectiveness, and treatment problems, patient understanding about treatment, financial access, life experiences, and social support.

Ellison et al. (2001) found that both the frequency of church attendance and belief in eternal life positively correlated with higher levels of psychological well being. Koenig, McCullough and Larson (2001) found a significant positive association between religion and better mental health, greater well being and lower substance abuse.

Fry (2001) examined the psychological well being of 188 older Canadians and found that the high religious senior citizens had better psychological well being than those persons who were not religious/spiritual. Brown et al. (2003) also found positive relationship between religion/spirituality and health and well being. Koenig, McCullough and Larson (2001) found that religious beliefs and practices are associated with better immune functions, lower death rates from cancer, less heart disease and better cardiac outcomes, lower blood pressure, and lower cholesterol.

In general, people who are religious/spiritual report having greater social support. Van et al. (2003) has found that higher levels of social support are experienced by regular Church goers than people who do not attend Church or attend irregularly.

Doolittle and Farrell (2004) found that spirituality/religiosity was positively associated with intrinsic beliefs, such as belief in a higher power, the importance of prayer and finding meaning in times of hardship and negatively associated with depression.

Braam, et al. (2006) found that frequent church attendance for people aged between 55-85 was associated with lower depressive symptoms after a 6 year follow up. This relationship persisted even after adjusting for the variables of demographics, physical health, social support and alcohol use. People who were religious/spiritual would appeared to cope better with bereavement and resolve sooner grief issues than people who are not religious or spiritual. Spirituality/religion appear to assist in the
grieving process by creating meaning about the loss. With meaning, people are able to
gain a sense of control of their lives and work through the grief and loss issues.

Pearce et al. (2005) examined the coping of informal caregivers (e.g. family and
friends) of persons who were ill and found that high rates of religiousness and religious
coping led to better mental and spiritual health.

Moreira-Almeida, Neto and Koenig (2006) found that for the majority of well-
conducted studies higher levels of religiosity were positively associated with indicators of
psychological well-being (life satisfaction, happiness, positive affect, and higher morale)
and with less depression, suicidal thoughts and behaviour, drug/alcohol use/abuse.

Masters et al. (2006) concluded that there is no scientifically discernable effect for
intercessory prayer on health and well being. Manmade Disasters

Crawford et al. (2004); Maston and Obradović (2007) found that
religion/spirituality assists people to cope by creating meaning and purpose out of the
chaos through rituals, ceremonies and guidelines for living and through a person’s
relationship with their God / spiritual being receiving emotional and spiritual comfort.

Lee (2007) found that religious support was associated with decreased depression
and increased life satisfaction. The Australian Unity Index Report (2008) found that for
people who where religious, the stronger their religious beliefs and practices, the greater
their life satisfaction and well being.

Koenig (2008) examined nearly 3000 original studies since 1800 which looked
out the relationship between religion/spirituality and the health of individuals and
populations. It was concluded that the majority of studies reported a positive relationship
between religion/spirituality and well being including stress reduction, minimization of
depressive symptoms, enhancement of quality of life, reduced alcohol and substance
abuse, lower crime and delinquency, improve school grades, healthier lifestyles, reduced
risky sexual behaviour, quicker recovery from illness and better physical health.

Koenig (2008) also found that the studies examined indicated that communities
with a high percentage of religious involvement recovered more quickly from depression
and anxiety.
Mohan, Sehgal and Tripathi (2008) investigated the relationship of psychological well-being with spiritual well-being and personality and found positive correlation between various dimensions of psychological well-being and spiritual well-being but negative correlation between various dimensions of psychological well-being and personality dimensions of neuroticism and psychotics.

Koenig (2008) also concluded that religiosity predicted slower progression of cognitive impairment with aging, and may be associated with a slower progression of Alzheimer’s disease. Religious involvement predicted less functional disability with increasing age, and faster functional recovery following surgery.

Rai and Gupta (2008) found that spirituality is an influential variable in determining the psychological well-being of elderly person. High spiritual oriented people have more satisfaction in life, happiness and joy; whereas low spiritual oriented people have low psychological well-being and they are dissatisfied in their life and may frequently feel anger and anxiety.

Lazar and Bjorck (2008) assessed perceived support from a person's religious community, and religious leaders, for 277 religious Jewish persons residing in Israel. It was found that even after controlling for general social support, Religious Leader and God Support were related to lower emotional distress, Religious Leader and Religious Community Support contributed to a higher level of life satisfaction, and Religious Community and God Support contributed to the prediction of perceived health.

Samuel-Hodge, Watkins, Rowell, and Hooten (2008) found that regular church attendance (at least once a month) was associated with overall greater positive general mental health. Similar results were found by Chang (2009) who examined the relationship between religious attendance and subjective well-being in an Eastern culture country and found that religious attendance had positive relationships with happiness, interpersonal relationship, and health

The importance of spirituality to health and well being for Indigenous Australians as part of the Family Well-Being (FWB) empowerment program was examined by Tse (2005) found that a strong and positive relationship existed between spirituality and well being.

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Herrera et al. (2009) explored the association of religious and spiritual coping with the well-being of old age persons, was found that negative religious coping (e.g. feelings that the caregiver burden is a punishment) predicted greater depression.

Vissar, Garssen, and Vingerhoets (2009) studied the relationship between spirituality and emotional well-being. The majority of the cross-sectional studies (31 of 36) found a positive association between well-being and spirituality.

Koenig and Valliant (2009) examined the effect of church attendance (at age 47) on four different indicators of later health (age 70) in a sample of inner city men. The four indicators were mortality, objective physical health, subjective physical health, and subjective well-being. It was found that the indirect effects of church attendance on health were clearly observed, with alcohol use/dependence, smoking, and mood being possible mediators of the church attendance-health relationship. The effects of church attendance on more subjective ratings of health, however, may have been more direct.

Green and Elliot (2009) found the people who identify as religious tends to report better health and well-being, regardless of religious affiliation, religious activities, work and family support or financial status, on the other hand people with liberal religious beliefs tend to be healthier but less happy than people with fundamentalist beliefs.

Abdel-Khalek (2010) also found religiosity may be considered as a salient component of and a contributory factor to quality of life, based on the significant and positive correlations between quality of life, subjective well-being and religiosity.

Bekelman et al. (2010) found that greater spiritual well-being, particularly meaning/peace, was strongly associated with less depression.

Hasian (2011) investigated spirituality and happiness as correlates of well-being in religious women and found non significant relationship between well-being and religiosity. Son and Wilson (2011) found the positive association between religiosity and physical health.

Hunted and Merrill (2011) found that individuals of pro-religious orientation reported significantly worse health for physical functioning, role limitations due to physical health, and energy or fatigue when compared with those of all other religious
orientations; however, no dose–response relationships were found between religious orientation and self-rated health. The results of this study indicate that deleterious health effects may accompany pro-religious orientation. Caution is provided for directors of religious programs for older adults.

Ismail and Desmukh (2012) suggest that a strong, negative relationship existed between religiosity and loneliness (r = -0.852) and between religiosity and anxiety. A strong positive relationship was also found between religiosity and life satisfaction.

Lutjen and Silton (2012) found that religious participation may likewise have a positive influence on health by increasing forgiveness and diminishing hostility. A structural equation analysis of data collected from a national survey of 1,629 participants indicated (a) religiosity is related to greater forgiveness, (b) greater forgiveness, in turn, is related to reduced hostility and finally, (c) reduced hostility is related to better subjective health.

7. Gender and Well-Being

Brandthill (2001) found high religious older women tend to value social engagement and used coping behaviers (social engagement and social interaction) more than the high religious older men.

Kaur and Gaur (2001) revealed that well being of non institutionalized elderly male were found to be higher compared to institutionalized males.

Melia (2001) found 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 older men engaged more in private religious practices.

Contrada, Goyal, Cather, Rafelson, Idler and 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.
A number of studies have identified the positive relationship between prayer and mental health. For a sample of African-American Women on the East Side of Detroit, Van (2000) found that women who engaged in regular prayer reported fewer depressive symptoms than women who did not pray. Meisenhelder and Chandler (2000) examined the relationship of frequency of prayer on health outcomes in a national sample of 1,014 church lay leaders. Frequent prayer was significantly associated with high mental health scores, regardless of age or gender.

Jaffe et al. (2003) examined the effects of living in religiously affiliated and unaffiliated neighbourhoods on mortality risks above that of individual risk factors using data from the Israel Longitudinal Mortality Study. After accounting for individual demographic and socioeconomic (SES) characteristics as well as area-SES, men and women living in religiously affiliated neighbourhoods had lower mortality rates than those living in unaffiliated areas. Furthermore, the beneficial effects on mortality of living in a religiously affiliated area were consistent across age groups, middle-aged and elderly.

Jesse and Reed (2006) examined the relationships of spirituality and psychosocial well-being among women. It was found that higher levels of spirituality (spiritual perspective and religiosity) were significantly correlated with greater satisfaction with social support, higher levels of self-esteem, and decreased levels of smoking.

Maselko (2008) found that those who attended religious services were 30% less likely to have had depression in their lifetime, and those who had high levels of existential well-being (i.e. sense of meaning and purpose in life) were 70% less likely to have had depression than those who had low levels of existential well-being. Similarly, for a sample of African-American women on the East Side of Detroit, Van et al. (2000) found that regularly attending church (i.e. weekly) resulted in the reporting of fewer depressive symptoms and better health than women who did not attend church.

Religiosity has also been studied in association with gender. Studies on religious beliefs and gender have consistently shown that women tend to be more religious and participate in more religious behaviour than men (Koeing, 2008).
Koenig and Valliant (2009) examined the effect of church attendance (at age 47) on four different indicators of later health (age 70) in a sample of inner city men. The four indicators were mortality, objective physical health, subjective physical health, and subjective well-being. It was found that the indirect effects of church attendance on health were clearly observed, with alcohol use/dependence, smoking, and mood being possible mediators of the church attendance-health relationship. The effects of church attendance on more subjective ratings of health, however, may have been more direct.

Gupta, Gupta, and Narayan (2010) studied the religious involvement and internality in men and women and found that more women go to the temple or participate in religious activities daily than men, more women participate in religious activities weekly than men, more men go to temple or participate in religious activities occasionally than women and men have higher levels of internal locus of control than women.

Mohanty and Begum (2013) found that males were better in perception of control than females; there was no significant gender difference in psychological well-being.

8. Living place, Religiosity, Gender and Well-Being

Konkle-Parker, Erlen and Dubbert (2007) found that a key facilitator for better well being was prayer and spirituality and support from family and friends to deal with life stresses in the senior citizens living with family than those in old age homes.

Dubey et al. (2011) conducted a study to understand the feeling of the elderly residing in the old age homes and within the family setup in Jammu. The data was collected using a specially designed interview schedule and observation technique through a house-to-house survey for those residing in the families. A sample of 30 elderly women from the old age home as well as a similar number from the family setups was selected using the purposive sampling technique to select. The study revealed that 63.3 % of the elderly women living in families felt that it was a period of dependency because they were dependent upon their family for support, 16.6 % of them felt economically insecure, where as 20 % of the respondent’s now perceived old age as a stage of loneliness. In case of institutionalized inmates 40 % stated economic insecurity and loneliness as the reason for their negative perceptions. The study revealed that most of
the elderly felt the attitude of the younger generation is unsatisfactory towards them especially those who were in old age homes in terms of getting respect, love and affection from the family members instead they were considered as burden for others. Women living in the families had a positive attitude towards old age. The study concluded that the general feelings of the elderly women living in the families had better position than that of the elderly women of the institution.

Mhaske (2013) found that institutionalized senior citizens were different on spiritual involvement and beliefs. Females scored higher than males on well-being.

**The Present Study**

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 gatherings with whom the senior citizens could share their thoughts. 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 persons 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 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; Mhaske & Ram, 2009).

The review of literature given above makes it quite clear that some studies have investigated the relationship of religiosity and health, involving well being, quality of life, longer life expectancy, adjustment, higher marital satisfaction, lower crime rate, reducing stress, anxiety and depression, less alcohol and drug use etc. But these findings highlight the inconsistent relationship between religiosity and human functioning
sometimes positive and sometimes negative. However despite the issue being tackled the concept still continues to be elusive and the inconsistencies in the literature need to be clarified. One significant limitation of the current literature on religiosity is that existing studies have focused almost exclusively on west and knowledge about religiosity in Indian population specially with reference to senior citizens living in old age homes and institutionalized setting is quite limited (Tarekeshwar, Pargament, and Mohaney, 2003; Bacchus, et al., 2008).

The present study will focus on elderly because there is also a need to investigate the relevance of religiosity to evaluate the ways of coping for better understanding the utilization of coping styles and enhance the well-being among senior citizens. The population of elderly is growing rapidly across the globe and is emerging as a serious area of concern. According to WHO, there is an estimated 600 million people above the age of sixty years and this will go up to an estimated 1.2 billion individuals by the year 2025. In India alone, the elderly population is over 82 million, it has gone up by 285 percent in the last fifty years and the figure is expected to reach the mark of 177 million by the year 2025. Old age dependency ratio has also increased over the years. While the number of elderly has gone up, the quality of their life has gone down. A study (Mhaske, 2008) was conducted to assess the quality of care received by vulnerable elders. It was found that the vulnerable older adults receive poorer quality care in the old age homes. So, in the absence of familial support the quality of care has become worse. In contrast to other stages of the lifespan, the aged have to face many problems such as death of spouse, decline in physical, mental and social functioning, decrease in social interaction, relationships and the declining capacity to deal with life situations.

So far, no study in Indian setting has tried to explore systematically how the individual level of religiosity affects the use of coping strategies and well-being in senior citizens living in old age home and living with family. Empirically, studies also suggest that religion may be unique form of motivation, source of value and significant, contributor to longevity, health, well-being and ways of coping (Pargament, 2000; Pargament, 2004; Rai & Mohan, 2008). But these findings point out the need for theory and research on religion, religious beliefs and practices, to explore how individuals apply these religiosity resources to their resolution and draws on their unique entities and
strength. The most important aim of the present study is to identify religious-integrated treatments which can support coping by mobilizing religious resources to achieve better management of stress and enhance well-being.

The title of the present study is “Effect of religiosity on ways of coping and well-being: A comparative study of senior citizens living with family and in old age homes.”

Objectives

The major objectives of the present study are:

1. To study the main and interactive effects of religiosity and gender on ways of coping and well-being in senior citizens living in old age homes.
2. To study the main and interactive effects of religiosity and gender on ways of coping and well-being in senior citizens living with family.
3. To study the main and interactive effects of living place, religiosity and gender on ways of coping and well-being in senior citizens.

Hypotheses

Based on the trends in the literature the following hypotheses were proposed:

1. The senior citizens living with family may have a more intense feeling of well-being than those living in old age homes.
2. The senior citizens living with family may have more diverse ways of coping than those living in old age homes.
3. High religious senior citizens are likely to have more intense feeling of well-being than low religious senior citizens.
4. High religious senior citizens are likely to adopt more diverse ways of coping than low religious counterparts.
5. Females may score higher on emotion focused coping while the males may score higher on problem focused coping.
Females may have higher scores on social well-being while the males may have higher scores on subjective well-being, psychological well-being and physical well-being.

No hypothesis was proposed for the interactive effects of living place, religiosity and gender on ways of coping and well-being; the objectives were purely exploratory.