The aim of the present study was to investigate psycho-social correlates of QOL in POK displaced persons and non-displaced persons. A cross-sectional correlation design was employed in this study, to study Personality, Social support, Sense of coherence, Resilience and its relationship with QOL of displaced and non-displaced persons. Group comparison, Gender differences and age differences were also studied using t-tests on the sample of 320 adults out of which 160 adults were Pok DP’S and 160 were Non-Displaced persons (Permanent residents of Jammu City) Each group i.e. Pok DP’s and Non-displaced persons comprising 80 male and 80 female. The two groups further comprising of two age groups of (50-65yrs) and (66-80yrs) (40 in each group) using Purposive sampling. Stepwise multiple regressions were also used to study the predictors of QOL.

5.1 QOL AND ITS CORRELATES

According to Perls, Silver, and Lauerman (1999) Personality is one of the most important factors in survival. Quality of life was expected to be positively related with personality in various groups, viz. Total sample, Displaced persons and Non-displaced persons (H1). Results revealed that QOL was significantly positively related with Extraversion, Agreeableness, Conscientiousness, Emotional stability and Openness to experience in the total sample, Displaced persons and Non-displaced Persons, accepting our first hypotheses. Terracinno and colleagues (2008) in their study found that individuals who were high in Conscientiousness, low in emotionally stability, and high in activities had higher longevity. Physical health significantly positively related with Extraversion, Agreeableness, Conscientiousness, Emotional stability and Openness to experience in the total sample, Displaced persons and Non-displaced Persons, supporting our hypotheses(HI). Psychological health significantly positively related with Extraversion, Agreeableness, Conscientiousness, Emotional stability and Openness to experience in the total sample, Displaced persons and Non-displaced Persons, supporting our hypotheses (HII). Different studies links personality with different health outcomes. According to Goodwin & Friedman (2006) high Neuroticism and low Conscientiousness were predictors of poor health outcomes, such as psychological and physical health and mortality. Margrett et al. (2010) in their study on oldest old found Neuroticism to be
related to increased levels of depressive symptoms. Social relationships significantly positively related with Extraversion, Agreeableness, Conscientiousness, Emotional stability and Openness to experience in the total sample, Displaced persons and Non-displaced Persons, supporting our hypotheses (HIII). Further, Environment significantly positively related with Extraversion, Agreeableness, Conscientiousness, Emotional stability and Openness to experience in the total sample, Displaced persons and Non-displaced Persons, supporting our hypotheses (HIV). Weber et al (2015) in their study on Personality, Psycho-social and health related predictors of QOL found a positive association between quality of life and Openness to experience and Agreeableness. Good QOL in older age is associated with lower level of Physical problems and depression. Magee, Miller & Heaven (2013) examined changes in personality traits influencing life satisfaction and found extraversion, conscientiousness, and agreeableness associated with higher Life Satisfaction, moderated by age, and were less evident in older adults.

Quality of life was expected to be positively related with social support in various groups, viz. Total sample, Displaced persons and Non-displaced persons (H2) and the results revealed that QOL was partially significantly negatively related with Social support, rejecting the second hypotheses. Physical health was significantly negatively related with Social support in total sample and non-displaced persons (HI), Psychological health was not significantly related with Social support in total sample and displaced persons except non-displaced persons (HII), Social relationship was not significantly related with Social support in total sample and displaced persons except non-displaced persons (HIII) and Environment was not significantly related with Social support in total sample and displaced persons except non-displaced persons (HIV), rejecting Hypotheses HI, HII, HIII and HIV. Research in relation to Personality, resilience and quality of life is scarce. Kim et al (2000) examined the impact of providing and receiving support on the quality of life (QOL) of the elderly and found a significant correlation between support and physical functions and a less strongly correlation between support and age was found. When physical function was controlled, providing support to their children and friends was more strongly related to QOL than receiving support. Overall, the elderly who exchanged support frequently, both providing and receiving support, showed the highest QOL in most situations. Individuals with enhanced social relationships improve
psychological well-being by gaining a sense of belonging and by lessening depression, but social relationships also improves physical health by enhancing immune function and reducing heart attack risks (Cohen, 2004). Various studies have found that Perceived social support is positively correlated with both mental and physical health (Cornwell & Waite, 2009; Newsom & Schulz, 1996). But in this study it was negatively correlated. Person with less perceived support and contact with others have poorer health, whereas those with more perceived support have better health (Cornwell, 2011). Another study by Garcia et al. (2005) on Social network and health-related quality of life in older adults found that older adults having poorer social network also had worse quality of life. Wang, Chan, Ho, & Xiong (2008) in their study on social networks and health related QOL found that isolation and poor lifestyle results in physical and mental health problems, which affects QOL. Further good social network were important determinants of quality of life. Only one study by Barutcu and Mert (2013) found a moderately significant negative correlation between social support and QOL. As quality of life of the patients improved with increasing social support. Frequency of contacts with the Family and friends positively relates to the level of quality of life in older adults. (Garcia et al., 2005; McKelvey et al., 2005). Various cross-sectional studies have found that SOC is positively associated with physical and psychological health (Lundberg & Nystrom Peck 1994, Larsson & Kallenberg 1996, Flannery & Flannery 1990, Lundberg 1997, Suominen et al. 1999, Dahlin et al. 1990, Nyamathi 1991, Dangoor & Florian 1994, Soderberg, Lundman & Nordberg 1997). Eriksson (2007) in his study found that SOC predicts quality of life, as stronger the SOC, the better the quality of life and also found a positive association between optimism and quality of life.

Quality of life was expected to be positively related with sense of coherence in various groups, viz. Total sample, Displaced persons and Non-displaced persons (H3). Results revealed that QOL was significantly positively related with Comprehensibility, Manageability and Meaning in the total sample, Displaced persons and Non-displaced Persons. Physical health was significantly positively related with Comprehensibility, Manageability & Meaning in total sample, displaced persons & non-displaced persons (HI) and Psychological health was significantly positively related with Comprehensibility, Manageability & Meaning in total sample, displaced persons & non-
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Displaced persons (HIII) accepting both hypotheses. Social relationships was significantly positively related with Meaning only in total sample, & displaced persons. Rejecting our hypotheses (HIII). Environment was partially significantly positively related with Comprehensibility & Meaning in total sample, displaced persons & non-displaced persons (HIV). Accepting our hypotheses. Jueng, Tssi and Chan (2016) investigated relationship of SOC with personal and environmental factors among older adults and found relatively low SOC scores compared to their counterparts in Western countries, Personal factors as well as environmental factors play a significant role in SOC among older adult. A study by Nygren et al. (2005) showed significant correlations between scores Resilience, SOC, Purpose in Life and Self-Transcendence. Significant correlations were also found between these scales among women but not in men. There was no significant correlation between perceived physical and mental health and the oldest old have the same or higher scores than younger age groups. Regression analyses also revealed sex differences regarding mental health. Studies have shown association between SOC and mortality in older age groups. (Surtees et al. 2003, Poppius et al. 2003, Lundman et al. 2010). A study by Feldt et al (2007) found a negative association between SOC and neuroticism which was also associated with health. Eriksson & Lindstrom (2005) found a negative association between SOC and Hostility, which were further associated with health and wellbeing. Wolff and Ratner (1999) in their study found that Person who were exposed to trauma in their childhood predicted stronger SOC as compared to persons who were exposed in adulthood.

Quality of life was expected to be positively related with Resilience in various groups, viz. Total sample, Displaced persons and Non-displaced persons (H4). Results revealed that QOL was significantly positively related with Resilience in the total sample, Displaced persons and Non-displaced Persons. The results supported the fourth hypotheses. Physical health was significantly positively related with resilience in total sample, displaced persons and non-displaced persons (HI), Psychological health was significantly positively related with resilience in total sample, displaced persons and non-displaced persons (HII), Social relationships was partially significantly positively related with resilience in non-displaced persons (HIII) and Environment was significantly positively related with resilience in total sample and non-displaced persons (HIV).
Partially accepting hypotheses HI, HII & HIV and rejecting HIII. Hildon et al. (2010) investigated the relationship among quality of life, resilience and exposure to adverse events. Resilience was positively associated with quality of relationships, integration into the community and adaptive coping strategies. Beutel et al. (2010) assessed the impact of vulnerability factors, individual and social resources on satisfaction with life and stress and found association between satisfaction with life and resilience, good job, partner, self-esteem, absence of anxiety and depression. Hildon et al. (2008) in another study found the relationship between resilience and adversities Resilient participants exhibited individual and social resources in face of adversity, especially maintenance of social roles and social support. Resilience also depends on level of impact of the adverse experience. Mertens et al. (2012) studied the impact of social support, income and Resilience on physical, social and mental functioning and found a significant association between resilience and physical, mental and social functioning. Social support and income were the significant contributors of successful ageing. Gooding et al. (2012) investigated the effects of psychological resilience on depression, despair and general health and found older individuals were more resilient, especially in relation to emotional regulation and problem solving. Younger individuals were more resilient in terms of social support.

Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience were expected to significantly predict the dimensions of quality of life across two groups, viz. Displaced persons and Non-displaced persons (H5). Results partially supported our hypothesis, as many predictors predicted QOL of displaced and Non-displaced persons. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Physical health in Displaced persons (HII). The results revealed Openness to experiences and Meaning as significant predictors, rejecting our hypothesis. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Psychological health in Displaced persons (HIII) and the results revealed three significant predictors i.e Meaning, Openness to experience and comprehensibility, rejecting our hypothesis. Delgado (2007) in
his study found sense of coherence (SOC) and spirituality were correlated with low stress and high quality of life (QOL). Regression analyses showed 73.2% of the variance in QOL was explained by SOC. Mowad (2004) in his study found Health-promoting lifestyle, SOC, and autonomy positively correlated to quality of life. Regression analysis showed health-promoting lifestyle and autonomy explaining 38% of the variance in quality of life. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Social relationships in Displaced persons (HI III) and the result revealed openness to experience as the only significant predictor, rejecting the hypothesis. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Environment in Displaced persons (HIV). The result revealed Openness to experiences, Meaning, Emotional stability and Social support as significant predictors, rejecting the hypothesis. Steel et al. (2008) in their meta-analysis on personality and life satisfaction found that personality explained 18% and 29% of the variance in individuals life satisfaction. Friedman, Kern, and Reynolds (2010) in their study on Personality and health found Neuroticism as strong predictor of poor subjective well-being in late life and predicted mortality in women, decreased the risk of mortality among men. Extraversion predicted old-age competence in gender. Conscientiousness predicted productivity in men. Empirical studies have shown that individuals with a strong SOC avoid stressors more easily and experience fewer negative life events, whereas those with a weak SOC are more likely to interpret stressors as threatening and anxiety-provoking (Anson et al. 1993, Antonovsky & Sagy 1986). Individuals with a weak SOC tend to experience more distress and anger when confronted with stressors, and are more likely to report minor stressors as a chronic source of stress (Antonovsky & Sagy 1986, McSherry & Holm 1994). Gonzalez Gutierrez et al (2005) examined the association between the Big Five personality dimensions, sex, age and relationship status and subjective well-being. Regression analysis showed personality as one of the most important correlates of subjective well-being, especially through Extraversion and Neuroticism. There was a positive association between Openness to experience and the positive and negative
components of affect. Gomez, Krings, Bangerter and Grob (2009) investigated the relation between personality and positive and negative life events as predictors of subjective well-being in young, middle and old adults. Results indicated a strong relation between neuroticism and SWB, and reconstructed life events on SWB with a stronger effect for negative as compared to positive events. Age differences in the prediction of SWB emerge for personality and life events: extraversion is only a predictor of SWB in young adults and the effect of neuroticism is more pronounced in old adults. Moreover, the influence of negative life events on SWB is stronger in young and middle-aged adults as compared to old adults. Different studies have shown that old age is associated with lower levels of income, less social networks, social support (Berkman and Gurland, 1998), poor socio economic status (Weyers et al, 2008), Poor health (Rundall, 1992). According to a study by MacLeod et al. (2016) older adults are capable of high resilience despite socioeconomic backgrounds, personal experiences, and declining health. Resilience was associated with mental, social, and physical characteristics. Higher the resilience higher it is positively associated with positive outcomes. Resilience further includes successful aging, lowers depression, and increase in longevity. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Physical health in Non-Displaced persons (HV). The results revealed Social support, Comprehensibility, Resilience and Conscientiousness as significant predictors, rejecting the hypothesis. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Psychological health in Non-Displaced persons (HVI). The results revealed Openness to experiences, Resilience, Comprehensibility and Meaning as significant predictors, rejecting our hypothesis. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Social relationships in Non-Displaced persons (HVII). The results revealed only two variables i.e. Social support and Resilience as significant predictors, rejecting our hypothesis. Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social
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support, Comprehensibility, Manageability, Meaning and Resilience was expected to significantly predict Environment in Non-Displaced persons (HVIII). The results revealed Comprehensibility, Social support, Meaning and Manageability as significant predictors, rejecting our hypothesis. Various Studies investigating the relationship between personality factors and resilience demonstrates a positive relationship between extraversion, openness to experience, conscientiousness, agreeableness, and optimism and a negative relationship with neuroticism or emotional instability (e.g. Davey et al., 2003; Furnham, Crump & Whelan, 1997; Karanci et al., 2012b; Riolli, Savicki & Cepani, 2002). Rakizadeh and Hafezi (2015) in their study on SOC as predictor of QOL found out a correlation between sense of coherence and quality of life. As SOC was not associated with marital status whereas married people significantly scored higher on QOL in the domains of psychological health, social relationships, and environment. A significant positive relationship between meaningfulness, manageability, and comprehensibility was found with all domains of QOL. King (2000) in their study found that resilience was positively related to life satisfaction and it also predicted life satisfaction.

5.2 GROUP DIFFERENCES

Traumatized people with high social support have indicated high resilient levels than those with low social support (Ozbay, Douglas, & Southwick, 2007). Non-displaced persons were expected to differ and score higher than displaced persons on Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning, Resilience, Physical health, Psychological health, Social relationships and Environment (H6) and the results revealed a significant difference between the two groups and Non-displaced persons scored higher than displaced person, accepting our hypotheses. Khechuashvili (2014) did a comparative study on displaced and non-displaced persons on psychological wellbeing. No statistically significant difference were found between IDPs and non-IDPs in psychological well-being and PTSD. While, there were significant differences within groups. Non-IDPs with low social-economic conditions and IDPS with poor living conditions reported less psychological well-being. Seery, Holman, and Silver (2010) in their study found out that individuals with history of some lifetime adversity were more
likely to report higher levels of mental health and well-being compared to individuals with no history and high levels of historical adversity. In addition, those with prior lifetime adversities were less likely to be affected by current adverse life events. McSherry and Holmes (1994) examined how SOC affected individuals' psychological or physiological responses before and after a stressful situation and found differences among low, middle, and high SOC groups and revealed group differences in psychological distress, cognitive appraisal, coping processes, and pulse rate, indicating that low SOC subjects show more distress and appraise and cope with stressful situations in ways less likely to resolve or eliminate their distress. Park et al (2016) in their study evaluated impacts of earlier traumatic events on the mental health of older adults. Five-hundred and seventy-seven subjects reported a history of Lifetime trauma exposure. Among older people with Life time trauma, lower extraversion and higher neuroticism increased the risk of current mood or anxiety disorders, whereas higher extraversion increased the probability of experiencing mental well-being after adjusting for socio-demographic and trauma-related variables. Akinyemi, Owoaje, Ige, and Popoola (2012) in their study of mental health and QOL compared long term refugees with non-refugees. Overall QOL scores were significantly lower for the refugees. Refugees were three times more likely than non-refugees to have poor mental health. Unskilled workers, skilled workers and the unemployed had two or more times the odds of poor mental health compared to professionals. A study done by Katiman et al (2009) have found that victims who received the attention and assistance from the government or other agencies at the time of trauma shows better quality of life. As victims who were given early treatment physically and emotionally after tragedy, Better results found reduced anxiety, stress and depression faced by the victims, level of physical health, quality of life and wellbeing also improved if given early treatment. Basheti, Qunaibi and Malas (2015) in their study investigated types and prevalence of psychological distresses on refugees and found refugees who were living in caravans had high satisfaction with the medical care services than the refugees who were living in tents. Jibeena and Khalidb (2010) studied the impact of sense of coherence and perceived social support and coping strategies on positive well-being and negative mental health outcomes of immigrants. Higher positive functioning in immigrants were associated with low stress, high sense of coherence, good income, Good
comfort level with family and friends and use of problem focused strategies. While negative outcomes were associated with high stress, low sense of coherence, low income, poor social network and use of emotion focused strategies. According to Furnham & Bochner (1986) displacement negatively effects mental health of an individual. Both Breslau et al. (2007) & Iglesias et al. (2003) in their different studies on immigrants found that displacement increases the risk of mental health problems and distress when compared with non-displaced persons. As Porter and Haslam (2005) in their study found refugees with more mental health disorders than non-refugees. Halcon et al (2004) did a study on trauma and coping among refugees and found out that pre migration trauma is associated with Physical and Psychological health problems. They further found trauma associated with social problems. Matheson et al (2008) did a study on traumatic experiences of Somali refugees and found out traumatic experiences to be associated with physical health problems. Two different studies on refugees found trauma to be associated with Psychological distress (Robertson, et al., 2006; Schweitzer et al. 2006). Simich, et al. (2006) did a study on Sudanese refugees and found out psychological distress and poor health to be associated with post-migration economic problems and unmet expectations of future in the host country.

5.3 GENDER DIFFERENCES

Males were expected to differ and score higher than Females on Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning, Resilience, Physical health, Psychological health, Social relationships and Environment (H7) and the results revealed a significant difference between the two groups and Males scored higher than Females, accepting our hypotheses. Displaced male was expected to differ and score higher than displaced females on all dimensions (HI) and the results revealed a significant difference between the two groups and Males scored higher than Females, accepting our hypotheses. Non-Displaced male was expected to differ and score higher than non-displaced females on all dimensions (HII) and the results revealed a non-significant difference between the two groups and Males scored higher than Females, rejecting our hypotheses. Non-Displaced male was expected to differ and score higher than displaced males on all
dimensions (HIII) the results revealed a significant difference between the two groups and Non-displaced males scored higher than displaced males, accepting our hypotheses. Non-Displaced female was expected to differ and score higher than displaced females on all dimensions (HIV) the results revealed a significant difference between the two groups and Non-displaced females scored higher than displaced females, accepting our hypotheses. Dalgard (2006) in his study found that Men receive less social support and are at higher risk of not being adequately supported by the informal network than women. As women have more socially-oriented life-style, are more concerned about establishing social relations, and appear to receive support from multiple sources, whereas men tend to rely usually on the wife. Nilsson et al. (2010) in their studies have found that males had stronger SOC and well-being as compared to females, a relationship between SOC and age, with stronger SOC in the older age groups and an increase in SOC was related to a decrease in psychological well-being, i.e. a stronger SOC leads to higher well-being. Wolff and Ratner (1999) in their study found that Person who were exposed to trauma in their childhood predicted stronger SOC as compared to persons who were exposed in adulthood. A study by Larsson and Kallenberg (1996) found gender, age, occupation, income, total number of friends, and the number of persons in the household related to SOC, but educational level was not related in this study. Men with a good income and support of friends and family reported highest levels of SOC. Deshmukh et al (2015) in their study on older adults to study QOL and found out that older men were better than older women as they perceived better quality of life also found out that even having one chronic morbidities adversely affect QOL. Unsar, Erol & Sut (2016) did a study on elderly social support and QOL. Men and married participants were better on QOL than the others. As participants living with their spouse and children showed better social support as compared to participants living alone. Matsuo and Poljarevic (2011) did a study on life satisfaction of Refugees. Only education came out to be significant predictor of life satisfaction out of other demographic variables. No gender differences were found. While SOC was found to have positive impact on life satisfaction, Discrimination came out as negative predictor on life satisfaction.
5.4 AGE GROUP DIFFERENCES

Younger age groups (50-65 years) were expected to differ and score higher than older group (66-80 years) on Extraversion, Agreeableness, Conscientiousness, Emotional stability, Openness to experiences, Social support, Comprehensibility, Manageability, Meaning, Resilience, Physical health, Psychological health, Social relationships and Environment (H8) the results revealed a significant difference between the two groups, accepting our hypotheses. Younger displaced males (50-65 years) were expected to differ and score higher than older displaced males (66-80 years) on all dimensions (HI). The results revealed a significant difference between the two groups and Younger displaced scored higher than older displaced, accepting our hypotheses. Younger displaced females (50-65 years) were expected to differ and score higher than older displaced females (66-80 years) on all dimensions (HII). The results revealed a non significant difference between the two groups and Younger displaced scored higher than older displaced, rejecting our hypotheses. Younger Non-displaced males (50-65 years) were expected to differ and score higher than older non-displaced males (66-80 years) on all dimensions (HIII). The results revealed a non significant difference between the two groups and Younger non-displaced scored higher than older non-displaced, rejecting our hypotheses. Younger Non-displaced females were expected to differ and score higher than older Non-displaced females on all dimensions (HIV). The results revealed a non significant difference between the two groups and Younger non-displaced scored higher than older non-displaced, rejecting our hypotheses. Younger Non-displaced males were expected to differ and score higher than Younger displaced males on all dimensions (HV). The results revealed a non significant difference between the two groups and Younger non-displaced scored higher than younger displaced, rejecting our hypotheses. Younger Non-displaced females were expected to differ and score higher than Younger displaced females on all dimensions (HVI). The results revealed a significant difference between the two groups and younger non-displaced scored higher than younger displaced, accepting our hypotheses. Older Non-displaced males were expected to differ and score higher than older displaced males on all dimensions (HVII). The results revealed a significant difference between the two groups and older non-displaced scored higher than older displaced, accepting our hypotheses. Older Non-displaced females were expected to
differ and score higher than Older displaced females on all dimensions (HVIII). The results revealed a significant difference between the two groups and older non-displaced scored higher than older displaced, accepting our hypotheses. Montross et al. (2006) in their study found that successful aging was related to number of close friends a person have rather than other demographic variables. A study by Chou & Chi (2002) on old people in china found positive relationship between friendship and ageing. As higher the number and contact with close friends and relatives higher the successful ageing. Newsom and Schulz (1996) examined the relations among physical functioning, social support, depressive symptoms, and life satisfaction in older adults and found Impairment associated with fewer friendship contacts, fewer family contacts, less perceived belonging support, and less perceived tangible aid, but only measures of perceived support predicted depressive symptomatology. Lower social support is an important reason for decreases in life satisfaction and increases in depressive symptoms. Studies have shown that resilient individuals are more likely to have more social support than non-resilient individuals (Hickling et al., 2011; Lee et al., 2011; Prati & Pietrantoni, 2010; Simmons & Yoder, 2013; Waters, 2002; Smith et al., 2011). Some studies have shown that Married individuals have more perceived social support than unmarried individuals, further it has been associated with better health. Community-dwelling older adults, despite their marital status, claim they have high levels of social support (Berkman, 2001; Cornwell, 2011). Heylen (2010) in his study found out that being aged 70–74 or 80–84 years was associated with low social support. Previous literature also confirmed that the oldest people are more isolated and less socially supported. A recent study done by Ang and Malhotra(2016) on older adults aged 62 to 97, found that by availing social support such as receiving money, food, clothing and housework help, reduced depressive symptoms among older adults but at the same time made them feel like they had lost their control over their lives. This turn increased their depressive symptoms, counteracting the positive effect of receiving social support. Lost of control over was greater in Women than in men. A study by Sorkin, Rook & Lu (2000) on older adults found that Adults remain connected socially but have limited source of social support. Another study by Ashida & Heaney (2008) on older adults found that due to absence of personal relationships or reduced participation in social activities though
surrounded by Multiple Providers, older adults remain socially disconnected. Cornwell, Laumann, & Schumm (2008) in their study on social connectedness in elderly persons found that due to smaller social networks and less closeness with connected members, older adults have difficulty maintaining personal contacts with other people leading towards less social support. Various studies on sense of coherence have found that SOC predicts good physical and mental health. As all these studies have shown that Good SOC leads to Good health.( Bernstein & Carmel 1991; Carmel & Bernstein 1989; Kivimaki et al. 2000; Kouvonen et al. 2008; Kouvonen et al. 2010; Poppius et al. 1999; Sagy & Antonovsky 1990; Suominen, Helenius & Blomberg 1996;Suominen et al. 2001). Onunkwor et al. (2016) studied the quality of life and its associated factors among the Elderly. Quality of life was significantly associated with age, gender, education, economic status and outdoor activity, duration of residence, type of accommodation, co-morbidities, and social support. Among the four domains, the physical domain had the highest score while the social domain had the lowest score. A study by Belanger et al. (2016) on adults aged 65–74 years found different sources of support i.e from friends and partner affected health across societies and as it were related to good health in Canada, whereas in Latin America, support from family, children and partner were associated with less depression and better QOL. Different studies have shown that positive social relationship with family, friends, and neighbors promotes QOL. As decreased social contacts (loss of members of a social network) is significantly associated with poor QOL. (Sok and Choi,2012; Chan et al.2006). A study done by Reblin and Uchino,(2008) and Seeman(2000) found link of good social support with mental disorders, diseases, mortality and improved QOL.

Aslund et al. (2014) in their study on older adults found that person facing financial stress and lack of social support have low psychological wellbeing whereas people receiving emotional support from family in the time of stress have been related to reduction in Psychological stress. But support from friends is not perceived as the buffer of stress. A study by Rapaport et al (2005) on QOL have shown that psychological issue experienced by the persons impacts their QOL and becomes important predictor of QOL that one can benefit from. Different studies have shown that social support reduces stress and enhance the quality of life of an individual. The Social support received from family,
friends, co-workers and the community members helps in enhancing the psychological wellbeing and in reducing stress. Studies also found out that social support from life partners, friends and family members helps in reducing psychological impact towards an individual (Ammar, Nauffal & Sbeity, 2013; Ben & Gill, 2004; Hamid, 2001; Khadijah et al., 2011; & Samah et al., 2010). Samsinar, Murali and Izhairi Ismail (2010) studied the relationship between conflict and QOL in work and family environment and found out that social support given by family plays an important role in enhancing quality of life. Cobb (1976) in his study on social support and life stress found out that person with good social support will not face physical and psychological problems as it reduces the amount of medication, help in recovery and help people in time of crisis. Shin & Sok (2012) did a comparison of factors influencing life satisfaction and found out that older people living with their family have better health, self esteem and life satisfaction than older people living alone. They also found a relation between social support and QOL. Tran and Nguyen (1994) in their study on refugees found out that younger refugees were more satisfied than older refugees in host countries. As female didn’t show any life satisfaction and its association with other variables. Werkuyten and Nekuee (1999) in their study on Iranians residing in Netherlands found that while cultural conflict and discrimination had negative effect on QOL of refugee, length of staying in host country had positive effect on the life of refugees. Van Selm, Sam, and Van Oudenhoven (1997) in their study on life satisfaction of Bosnian refugees found that high locus of control and more positive reactions received from the host society increases life satisfaction. They also found out that older refugees have higher life satisfaction than younger refugees, as older refugees were no longer in the age of looking for employment. Matsuo (2005) in his study on refugees found out that life satisfaction of refugees varies according to the quality of connection they had with the host country. While uneducated refugees have better satisfaction with life as compared to young refugees as they have to go for search of jobs in the host country.

To conclude, it may be said that Personality, Social support, Sense of Coherence and Resilience were significantly positively related to QOL, except social support which were significantly negative related to QOL. Stepwise multiple regression results showed more predictors predicting QOL in non-displaced persons as compared to displaced.
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persons. As openness to experience, Meaning, Comprehension, Emotional stability and social support were the significant predictors of QOL in Displaced persons while Social support, Comprehensibility, Resilience, Conscientiousness, Meaning and Manageability were significant predictors of QOL in Non-displaced persons. Non-displaced persons scored higher than displaced persons. Males scored more than females on most of the dimensions. Young displaced scored more on most of the dimensions and show Good QOL than Older displaced persons.